Global norms and local brokers
An ethnography of an international NGO project to
‘reduce teenage pregnancies’ in rural Malawi

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Original papers

1. Pot, H. (2019). Public Servants as Development Brokers: The Shaping of INGOs' Reducing Teenage Pregnancy Projects in Malawi's Primary Education Sector. *Forum for Development Studies* 46 (1), 23-44, DOI: 10.1080/08039410.2018.1427624 (published online 29 Jan 2018).
2. Pot, H. (2019). INGO behaviour change projects: culturalism and teenage pregnancies in Malawi. *Medical Anthropology* [1-26]. DOI: 10.1080/01459740.2019.1570187 (accepted version printed in thesis).
3. Pot, H., de Kok, B.C., Finyiza, G. (2018). When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi, *Reproductive Health Matters*, 26 (54), 126-136, DOI: 10.1080/09688080.2018.1535688

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List of acronyms

BLM	Banja La Mtsogolo
CBO	Community Based Organization
CHAM	Christian Health Association of Malawi
CHC	Catholic Health Commission
CONGOMA	Council for Non-Governmental Organisations in Malawi
CSO	Civil Society Organization
DAC	Development Assistance Committee
DC	District Commissioner
DEM	District Education Manager
DfID	The UK Department for International Development
DHO	District Health Officer
FAWEMA	Forum for African Women Educationalists Malawi
FBO	Faith Based Organization
FPE	Free Primary Education for all
GABLE	Girls' Attainment in Basic Literacy and Education
GDP	Gross Domestic Product
HSA	Health Surveillance Assistant (community health worker)
ICEIDA	Icelandic International Development Agency
IE	Inclusive Education (INGO project)
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
IO	International Organization
KGIS	Keeping Girls in School (INGO project)
MDG	United Nations Millennium Development Goals
MoH	Ministry of Health
MoEST	Ministry of Education Science and Technology
MP	Member of Parliament
MSG	Mother Support Group
NGO	Non-Governmental Organization
NGOMA	NGOs and the transfer of Global Maternal Health Policies (research)
Norad	Norwegian Agency for Development Cooperation
PEA	Primary Education Advisor

RTP	More Educated Girls - Reducing Teenage Pregnancies (INGO project)
Save Malawi	Save the Children International in Malawi
Save Norway	Save the Children Norway
SDG	United Nations Sustainable Development Goals
SLA	Service Level Agreement
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector-Wide Approach
TA	Traditional Authority
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YFHS	Youth Friendly Health Services
YONECO	Youth Net and Counselling

Abstract

International non-governmental organisations (INGOs) play an increasingly prominent and multifaceted role in the field of global health – as policy advocates, recipients of donor funds, and implementers of donor-funded programmes. Many such NGOs and their local affiliates have become highly professionalized and oriented towards the priorities of global-level actors, with potential negative consequences for their ability to represent the grassroots and to challenge structures of power and inequality. In this thesis, I examine the dynamics around INGO project implementation in Malawi, within the broader context of overlapping development initiatives, shifting priorities, conditions of scarcity and donor dependence, and poor health outcomes. I draw on ethnographic research conducted in rural Malawi between May 2015 and August 2016, which focused on the implementation of a Save the Children project that aimed to improve maternal health by reducing teenage pregnancies, primarily by keeping girls in school and increasing their use of reproductive health services, notably contraceptives. My ethnographic gaze is on the individuals who serve as intermediaries between donors, northern (I)NGOs and local recipients, who I conceptualise as brokers. They include INGO district staff, primary school teachers, health workers, village heads, and community representatives. Through a focus on their practices, I examine how they translate global norms and aims into programmatic practice. The thesis brings together three peer-reviewed articles. The first (in *Forum for Development Studies*) discusses how primary school teachers deal with, and implement, various overlapping NGO initiatives targeting girls, and the implications for public sector institutions. The second article (in *Medical Anthropology*) examines how INGOs' programmatic focus on behaviour change interventions inadvertently results in staff blaming culture for teenage pregnancies and school dropout, reinforcing ethnic stereotypes originating in historical inequalities and previous health development initiatives which targeted harmful cultural practices. The third article (in *Reproductive Health Matters*) analyses the responses of village heads, midwives and women to the reintroduction of user-fees for maternal health services resulting from donors' suspension of budget support, shifting national priorities, and unstable service delivery contracts. Overall, I argue that examining the practices of the brokers who implement and reshape health development initiatives can shed light on policy-to-practice gaps and how unintended consequences occur. My ethnographic research thus helps to explain why initiatives might not be sustainable despite the intention of donors and INGOs to strengthen existing public and community structures.

1. Introduction: dynamics between NGOs and local actors

In this thesis, I examine the dynamics around the implementation of international Non-Governmental Organizations' (INGOs) projects in Malawi, within the broader context of overlapping development initiatives, shifting priorities, conditions of scarcity and donor dependence, and poor health outcomes. I ask, *how do dynamic interactions between INGOs and local actors shape the implementation of donor-funded health development projects, and what does this tell us about the changing role of INGOs within today's aid landscape?* In order to answer this question, I draw on ethnographic research conducted between May 2015 and August 2016 on the local implementation of a Save the Children reproductive health project and within a semi-rural village in Mangochi district in Malawi. This is part of a larger research project 'NGOMA' that examines the changing role of international NGOs in the transfer of global maternal health policy initiatives to Malawi.¹

In July 2015, I visited the group village headman of the semi-rural area I was interested in. I had spent several weeks in Mangochi district with the aim of selecting a village to conduct fieldwork. The project manager at Save the Children's local affiliate had told me that many NGOs were attracted to the district because of its "low" reproductive health and education indicators. Indeed, the local civil society organisation network listed 69 different organisations as being active in Mangochi in 2015. In addition to Save the Children, which was best known for providing water to the school and to the villages, the Group Village Headman singled out ICEIDA (which built school blocks), a local NGO (which provided toys for children under five and helps HIV positive people), another local NGO (which helped orphans), and a private school for orphans. Others listed many more NGO activities. The local health centre and especially the primary school were the main targets for NGO projects, many of which focused on 'the girl child'. I was told that every area in Mangochi district had its own patchwork of often short-term NGO initiatives, a microcosm of the fragmented NGO landscape in Malawi and Sub-Saharan Africa at large.

When I started this research into the role of international NGOs in the local implementation of 'global' donor-funded initiatives, the end of the Millennium Development Goals (MDGs) era was approaching and the Sustainable Development Goals (SDGs) were being formalised. The global policy landscape on maternal health was rapidly changing in

¹ This research is led by Professor Sidsel Roalkvam, Co-Investigator Katerini Storeng, and senior researchers at the University of Malawi – Professor Blessings Chinsinga, Peter Mvula and Joseph Chunga. Fieldwork in Malawi has been carried out by three University of Oslo PhD candidates – Maren Olene Kloster, Johanna Adolfsson and myself.

tandem. A strong focus on skilled birth attendance and antenatal care that had been prominent during the MDGs gave way to a focus on reducing teenage pregnancies and keeping girls in school; a multi-sectoral approach underpinning the SDGs. This relative priority shift was observable in Norwegian foreign policy, but also globally. It was particularly observable in Malawi; a donor-dependent country where international and national NGOs have a large role as implementers of donor-driven policy. In Malawi, reducing teenage pregnancies was framed within the larger aim of reducing maternal mortality. Because of its donor dependence and numerous NGOs, estimated at 451 in 2015 (GoM unpublished document), Malawi is a particularly interesting country in which to study the changing role of INGOs and their role in the implementation of global policy priorities. As I entered the field and started having conversations, I became specifically interested in the social dynamics between implementers and recipients of NGO projects on the ground. I examined these through an analysis of Save the Children's *More Educated Girls – Reducing Teenage Pregnancies* (RTP) project, funded by the Norwegian Agency for Development Cooperation (Norad), which was designed to prevent adolescent pregnancies by keeping girls in school and increasing the use of Sexual Reproductive Health and Rights services. The RTP project had multi-sectoral aims combining reproductive health and education and thus engaged with public health and international development ideas. But the project also had an emphasis on sociocultural norms, behaviour change, and increasing girls' self-efficacy. I was interested in how local staff implemented the project, how local actors influenced interactions, how the project related to local realities and how project staff took these into account. In this thesis, I engage with debates in medical anthropology, global public health, and the anthropology of development.

The RTP project is an example of trends in the current global aid landscape in which policies are designed ever further away from the local realities on which they impact (Feierman et al. 2010:122). Development initiatives are implemented through long chains of actors: from donors in the global north, through INGOs and national NGOs, to volunteers conveying development messages to their fellow villagers (Watkins, Swidler, and Hannan 2012). In this thesis, I will refer to this as the 'aid chain', although my ethnographic focus is predominantly on locally situated actors. Medical anthropologists have associated this remote policy-making process with the failure of development programmes to work as intended, because they become more uniform and, thus, less tailored to the local context (Adams, Burke, and Whitmarsh 2014; Biehl and Petryna 2013:8; Olivier de Sardan, Diarra, and Moha 2017; Whiteford and Manderson 2000:2). In fact, they often produce unintended consequences. Such unintended or unanticipated effects emerge because of the working or

influence of local contexts which could not have been predicted from a rational evidence-based policy design process (Herrick 2016). Yet, an understanding of how unintended consequences occur, Herrick (2016) argues, is lacking in many anthropological contributions to global health.

My thesis contributes to Lewis and Mosse's (2006:8) argument that "the need for critical analytical description of the processes of international development has never been of more practical importance." Because of persistent large gaps between development buzzwords and a lack of progress in reality there is a need for conceptualising their relationship in the context of a global political economy that shapes what development agencies and institutions, and thus (I)NGOs, can do (Lewis and Mosse 2006). Lewis and Schuller (2017) call for more anthropological research on NGOs, which they suggest is a "productively unstable" category. Instead of perceiving NGOs as a fixed category, we need to examine their practices and relationships (Hilhorst 2003). As Pigg (2013:133) suggests, ethnographic examination of activities and practices on the ground can illuminate "the structural, political-economic, and discursive global workings of the system" of global health, which, in this thesis, is examined through the role of INGOs. This is urgently needed because, as Dionne (2018) argues, without a "critical study of global interventions and thoughtful analysis of the local realities of these interventions, we will continue to recycle ineffective policy. [...] interventions that proceed despite misaligned priorities can have negative consequences in young democracies..." like Malawi (p.5).

Studying the role of intermediary actors is crucial to finding out what happens to policies and projects on the ground (Lewis and Mosse 2006) and can illuminate broader contexts and processes (Lindquist 2015). Such an ethnographic approach can thus open up 'the black box' of development aid and public health projects. It can explain how interventions work in practice; how particular discourses are transformed by actors who employ them and how differently situated actors enact their role. It can also shed light on the interplay between hidden and public goals (Lewis and Mosse 2006). As I will show through my ethnographic research, focusing on how intermediary actors implement and reshape global policy ideas provides insight into policy-to-practice gaps and into how unintended consequences occur. Even though priorities and aid paradigms shift, some underlying practices remain the same, and may repeatedly produce similar inadvertent effects.

Outline

In this thesis, I situate my ethnographic focus on NGO project implementation in the broader context of the changing role of international NGOs as development actors and justify the need for anthropological engagement with this topic. The purpose of this synopsis is to bring three peer-reviewed articles together in a wider discussion and justify my methodology and theoretical choices.

Chapter 2 discusses the changing role of NGOs within global health and development. I situate the RTP project within broader global trends of INGOs as service deliverers and policy advocates. I then present Malawi as an interesting case in which to study the changing role of NGOs. I outline important shifts in development priorities relating to reproductive health and education, within which INGOs like Save the Children work. I end the chapter by describing the RTP project's structure rationale within the content of the contemporary global and national focus on adolescent girls and teenage pregnancies as targets for projects to improve maternal health outcomes.

In chapter 3, I set out my ethnographic approach. I discuss my use of what Fassin (2013) terms, "multi-layered ethnography" – examining several places or levels in one society and the dynamic interactions between them. I introduce the RTP project as a 'site', and describe the location of my community-based ethnography in historical and contemporary perspective. I account for how, not only this community, but also the health centre and especially the primary school, emerged as important ethnographic sites for studying dynamic interactions. I elaborate on how I conducted participant observation in each of these sites.

In chapter 4, I reflect on positionality, ethics, and analysis. The local realities of the aid landscape presented particular challenges for conducting ethnographic research. I discuss how this influenced my methods, triggered specific ethical challenges and how I dealt with this analytically.

In chapter 5, I discuss the theoretical concepts that have shaped my analysis. I discuss the concept of *brokerage* in order to analyse the roles, practices and agency of differently positioned actors in the aid chain. The concept of *travelling models* provides an analytical lens through which to examine globally originating and often uniform policy ideas that disregard context. I conceptualise the current focus on modifying the behaviour of girls and that of their community – which RTP is part of – as a travelling model, while skilled birth attendance and user-fee exemption policies for maternal health services are others. Finally, I discuss the

concept of *culturalism*, which proved particularly useful in analysing RTP's programmatic focus on behaviour change and sociocultural norms.

Chapter 6 provides a summary of the three peer-reviewed articles. The first article discusses how primary school teachers deal with, and implement, various overlapping NGO initiatives targeting girls, and the implications for public sector institutions. The second article examines how INGOs' programmatic focus on behaviour change interventions inadvertently results in staff blaming culture for teenage pregnancies and school dropout, reinforcing ethnic stereotypes originating in historical inequalities and previous health development initiatives targeting harmful cultural practices. The third article situates the objective of reducing teenage pregnancies in the broader context of maternal health and Malawi's health system. It analyses village heads', midwives' and women's responses to the reintroduction of user-fees for maternal health services following the suspension of budget support by donors, shifting national priorities, and unstable service delivery contracts.

In chapter 7, I draw connections between the articles in a comparative discussion and answer my research question. I argue that an ethnographic examination of how brokers implement, translate, and reshape travelling models provides insight into policy-to-practice gaps, how certain unintended outcomes repeatedly occur and why INGO projects are often not sustainable despite donors' and INGOs' intention to strengthen existing public and community structures.

2. Donors, NGOs, policy: global trends in the Malawian context

The patchwork of NGO initiatives in Malawi is the outcome of their growing significance in development aid in general and in global health and education in particular – as policy advocates, recipients of donor funds, and implementers of donor-funded programmes (Lewis and Kanji 2009; McCoy, Chand, and Sridhar 2009; Mundy et al. 2010). In this chapter, I describe how the role of NGOs in health and development has changed historically. I then present Malawi as an interesting case in which to study this changing role of NGOs and outline important shifts in development priorities relating to reproductive health and education, in which donors have played a significant role. I end with a presentation of Save the Children's project within the current focus on reducing teenage pregnancies to improve maternal health.

The changing role of NGOs

My aim in this chapter is to describe general trends in the changing role of NGOs in relation to the aid landscape and the consequences for health service provision. I acknowledge that there are different roles for NGOs, and that the landscape encompasses a huge diversity. NGOs can, for example, be distinguished from labour unions or social movements, which are generally considered to have a stronger connection to the grassroots (Banks, Hulme, and Edwards 2015). Banks and colleagues note that many development NGOs apply a mix of approaches; both service delivery and transformative missions of empowerment and social justice. Yet, they argue, the former generally comes at the expense of the latter. A general trend is that NGOs and their local affiliates have become highly professionalized and oriented towards the priorities of global-level actors, with potential negative consequences for their ability to represent the grassroots and to challenge structures of power and inequality (Banks et al. 2015; Buse and Harmer 2007; Doyle and Patel 2008; Edwards and Hulme 1996; Kamat 2004).

From representing the grassroots to service provision

Many NGOs have roots in grassroots movements that aimed to hold post-colonial states accountable for providing services to the poor; they thus often had a political agenda and challenged structures of power and inequality (Kamat 2004). NGOs' role as service providers, by contrast, took off in the 1980s when Structural Adjustment Programmes were implemented in developing countries as a core neoliberal policy (Edwards and Hulme 1996; Kamat 2004;

Reich 2002). As a condition for receiving loans, the IMF and World Bank required governments to cut public spending, which in effect meant outsourcing many public services to the for-profit and non-profit private sector. Much aid was provided off-budget and was project based – meaning it was outside the Ministry of Health’s budget and planning, as opposed to involving on-budget long-term strengthening of health systems (Pfeiffer et al. 2017; Sridhar 2010) and education systems (Riddell and Niño-Zarazúa 2016). Many international donors perceived NGOs as having a comparative advantage over cumbersome states because of their assumed reliability, efficiency, and transparency (Edwards and Hulme 1996). Furthermore, donors saw NGOs and grassroots organizations as key to democratization and good governance, “as an integral component of a thriving civil society and an essential counterweight to state power, opening up channels of communication and participation, providing training grounds for activists, and promoting pluralism” (Edwards and Hulme 1996:962). During this time, not only grassroots organizations became involved in service provision, but also new NGOs were established as a response to available donor funding.

An English-language literature review on NGOs across sectors and geographies indicates that governance and health are the most examined sectors (Brass et al. 2018). Although research on NGOs as service deliverers has reported largely positive results, broader issues of health systems and population health are under-examined and there is a need for researchers to engage more with complexity and context (Brass et al. 2018). Medical anthropologists, have made important contributions, to this end, and have associated the emergence of NGOs as health service providers with undesirable consequences. A proliferation of NGOs as service providers has contributed to overlapping, uncoordinated, competing and unsustainable initiatives and to the creation of parallel systems of service provision (Doyle and Patel 2008; Pfeiffer and Chapman 2010; Pfeiffer et al. 2008). Furthermore, relying on NGOs has been associated with undermining local control over public services resulting in demotivated health workers, and reduced quality of, and access to, health services for the poor due to the introduction of user-fees (ibid). Jennings (2015), however, argues that the proliferation of NGOs did not cause these consequences but merely exacerbated the problems of already fragile health systems in Sub-Saharan Africa.

For critics like Kamat (2004), NGOs’ involvement in service delivery signifies a depoliticization and professionalization of civil society – away from engaging with structures of power and inequality and towards more technical managerial approaches which foregrounded neoliberal notions of empowered entrepreneurial individuals. Similarly, in 1996 Edwards and Hulme (1996) argued that dependency on donor funding was undermining

NGOs' legitimacy and accountability to the grassroots. Twenty years later, the same authors assert that NGOs generally have made limited progress in the area of social change; they are palliative rather than transformative in a development landscape concerned primarily with short-term results and value for money (Banks et al. 2015). Doyle and Patel (2008) argue that NGOs' dependence on donor funding and the pressure to achieve quick results has led to competition over short-term funding, bureaucratization, communicating success over failure, and scaling-up homogenized interventions that are not always successful (Doyle and Patel 2008; Rajkotia 2018). Banks et al. (2015) contend that NGOs have become implementers of donor priorities at the expense of their civil society function to challenge structures of power and inequality and that the current aid system limits their ability to be flexible and innovative.

The new global aid architecture

By the mid-1990s – in 2004 in Malawi -, likeminded donors initiated 'sector-wide approaches' (SWAs) to curb uncoordinated aid flows, NGO proliferation and competing donor interests in the sectors of health, education and agriculture (Sweeney and Mortimer 2016). In the 2000s, global guidelines for aid effectiveness were formulated: the Paris Declaration on Aid Effectiveness (2005), the Accra Agenda for Action (2008), and the Busan Partnership for Effective Development Cooperation (2011). Donors and recipient countries, multilateral and bilateral development institutions and a number of civil society organizations endorsed the aim of aid harmonization through the adoption of multiple principles. These included country ownership, strong institutions and less corruption, working through local systems, better coordination and avoiding duplication of projects, inclusive partnerships, measurable impact, mutual accountability, and capacity development (OECD n.d.). The resulting new aid modalities – in the form of Programme-Based Approaches, general or sectoral budget support, and the strengthening of SWAs – were meant to reduce fragmentation, provide a more holistic approach and align aid with domestic sector plans. This 'new global aid architecture' is characterised by a focus on internationally agreed development targets – such as the United Nations Millennium Development Goals (MDGs) - and a broad focus on good governance and policy reform rather than individual projects (Mosse 2005b).

Despite the commitment of many – though not all (e.g. USAID) – donors to these aid guidelines, the number of actors and initiatives at the global level, continues to multiply, suggesting that 'country ownership' seems to be more rhetoric than practice (Addison, Niño-Zarazúa, and Tarp 2015; Sridhar 2010). The global health landscape is characterised by a

diversity of actors and partnerships with various ideologies and levels of power, who implement multiple, short-term, fragmented projects and facilitate rapid policy shifts (Adams et al. 2014; Biehl and Petryna 2013). The prominent position of international actors continues to distort national priorities in favour of continuously shifting priorities set by donors, especially in countries whose health budgets largely consist of donor funds (Sridhar 2010). However, Chasukwa (2018) argues that, within these aid modalities, bureaucrats in recipient countries can exercise informal power – such as foot dragging, withholding of information, and including or excluding certain actors in decision-making – directed towards various professional and personal goals.

From service provision to NGOs' role in policy development

The creation of public-private global health initiatives starting in the late 1990s – exemplified by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), GAVI the Vaccine Alliance, and the Partnership for Maternal Newborn and Child Health –further changed the role of NGOs and privileged ‘vertical’ or disease-specific funding, notably to fight the AIDS epidemic. With funding from private foundations, notably the Bill and Melinda Gates Foundation, international NGOs – often in partnership with national NGOs – increasingly became implementers of disease-specific programmes and involved in decision-making and policy advocacy in the global arena (Buse and Harmer 2007; Doyle and Patel 2008). The launch of the MDGs around the turn of the century generated massive amounts of funding, and the number of NGOs skyrocketed in many developing countries, especially in the health and education sectors (Leiderer 2015; Sridhar 2010). In 2016, Development Assistance Committee (DAC) countries channelled 15% of their Official Development Assistance through civil society organizations, predominantly NGOs registered in their own country (OECD 2018a). The amount of funding to NGOs increased from USD 9.8 million in 2000 to 40.4 million in 2016 (OECD 2018b).

Although global health initiatives improved disease-specific health services, critics argue they also contributed to overall weakening of public services (Birn 2009). As Pfeiffer et al. (2017) show for Mozambique, the persistence of several donors – the Global Fund, U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), and GAVI – in funding vertical or off-budget initiatives has weakened the SWAp in favour of NGO implementation and continues to undermine the health-system. Furthermore, Structural Adjustment Programmes have been replaced by Poverty Reduction Strategies, which continue to limit government spending on public services and the ability of the state to coordinate donors and NGOs, and

will hinder the achievement of the third Sustainable Development Goal – that of attaining Universal Health Coverage (Pfeiffer et al. 2017). Furthermore, Bierschenk (2014a) argues that with this changing role of NGOs in the direction of policy advocacy, local implementers of donor-funded NGO projects have increasingly become ‘norm entrepreneurs’, aiming to modify the conduct of beneficiaries according to ‘global norms’ – with regard, for example, to women’s rights or education (Fichtner 2012; Merry 2006). Yet, such global norms are reshaped along the aid chain.

The co-production of policy

As I will show in this thesis, the relationship between donors, (I)NGOs and the government is complex. This is the result of the “co-construction” of policies by government, donors, IOs, INGOs and national NGOs, and the implementation of such policies in the public sector in order to strengthen capacity (Bierschenk 2014a). It is important to examine what this means in practice. Evaluations of the Paris declaration, for example, focus on national level processes and outcomes (Wood et al. 2011), not on what the rhetoric of “strengthening existing structures” actually means for local public health systems. Terms like ‘ownership’ and ‘partnership’ can mean different things in different contexts and time periods, and as Mosse (2005b:10-11) argues, can obscure the unequal power relations that characterise the actual workings of aid on the ground. Brada (2011) suggests we should critically investigate how differently situated actors deploy, shape, and give meaning to terms such as ‘partnership’.

Furthermore, policy reforms are not implemented on a blank page, but in dynamic systems where past policy reforms have made their mark (Bierschenk 2014a). Bierschenk (2014b) refers to this as “sedimentation”, or the accumulation of public service reforms, that, together with the historical basis, shape the fragmentation of bureaucracies. Bierschenk argues that the increased speed of reforms during the last 20 years has tended to intensify fragmentation. Norms are implemented on top of other partially implemented norms. Similarly, Pfeiffer and Chapman (2015) argue that new interventions are implemented in overburdened health systems, resulting in an increased workload, especially for frontline workers. Furthermore, training workshops might lure health personnel away from their regular duties. However, few studies describe the experiences of public sector health workers in navigating under-resourced, fragmented landscapes created by ‘vertical’ or disease specific global initiatives and aid fragmentation and how this climate influences patient care (Livingston 2012; Mussa et al. 2013; Prince and Otieno 2014). My thesis contributes to filling this gap in the literature.

Malawi's donor-dependence

Since its independence from Britain in 1968, Malawi has depended heavily on donor funding. Currently, around 40% of the total budget is donor funded. In the 2018/19 fiscal year, 189 external donors funded 75% of the USD 639 million health budget (9.5% of the Gross Domestic Product - GDP), with the Global Fund, the United States, the Health Sector Joint Fund (an initiative from Norway, the United Kingdom, and Germany), the United Kingdom, the World Bank, Germany, GAVI, Norway, and the Bill and Melinda Gates Foundation as most important donors (GoM n.d.-a). The 181 smallest donors together fund 7.5% of the budget. Following HIV/AIDS, Reproductive, Maternal, Newborn and Child Health is the second most important priority, receiving 8% of the total health budget.

Malawi's donor dependence gives donors considerable power. Although donors formally committed to country ownership following aid efficiency guidelines, they have suspended aid during every presidency, following mismanagement of resources, poor political and economic governance and violation of human rights, with the intention of changing the government's behaviour (Banik and Chasukwa 2016; Wroe 2012). At the time of fieldwork (May 2015 to August 2016), national newspapers reported a "zero aid budget", which meant that donors had suspended on-budget support. This stemmed from a corruption scandal in the National AIDS Commission that came to light in 2013 (Dionne 2018:84-85) and the subsequent 'Cashgate' corruption scandal of 2013.

Donors' share of health expenditure² decreased from 68% in 2012/13, to 63% in 2013/14, and 54% in 2014/15, whereas government, household, and employers and local NGOs' share increased (World Bank 2017). Despite a decrease, donors, thus, continued to provide aid. They mainly provided off-budget support, channelling funding through pooled funds, programmes and projects that they could control (Chasukwa 2018). Currently, 74% of the total donor funding to the health sector consists of off-budget support, which results in a high level of fragmentation (GoM n.d.-a). Yet, of 261 different implementers of health sector projects, the government is the largest implementer (50%), followed by NGOs and foundations (29%), multilateral partners (12%), private companies (6%), bilateral partners (2%), and the Christian Health Association of Malawi (CHAM) (1%).

Similar trends are observable in the education sector. In the 2016/17 fiscal year, government's expenditure on education was 17% of GDP (UNICEF 2017). Donors funded

² Health expenditure refers to the actual amount of money spent, whereas the health budget is a projection.

40% of the education budget in 2015/16 (Hall and Mambo 2015), of which 63% was provided off-budget. The largest donors are DfID, World Bank, African Development Bank, USAID, and UNICEF, together providing 78% of all donor funding (GoM n.d.-b).

NGOs are thus important implementers. In 2000, the government established the NGO board to regulate NGOs through mandatory registration using the 2001 NGO Act and creating linkages between the state and NGOs. Currently, the government is drafting an NGO policy to strengthen the collaboration with them (GoM unpublished document). According to the draft document, the number of NGOs registered at the NGO board increased from 87 in 1994 to 451 in 2015. Yet Chasukwa (2018) notes that the exact number of NGOs remains unknown due to poor registration. NGOs also founded their own coordination network, CONGOMA, in 1999.

The government defines NGOs as follows: “A Non-Governmental Organization (NGO) is a not for profit making, autonomous and apolitical entity whose primary activities include service provision, development initiatives, humanitarian response, awareness raising and advocacy, provided under framework of human development and good democratic governance” (GoM unpublished document:17). The policy regards the terms NGO and CSO (Civil Society Organization) as synonymous and distinguishes between INGOs, NGOs and CBOs (Community-Based Organizations). This supports Lewis (2017) argument, who notes that NGOs are often mixed in with discourses on civil society and social movements, or taken as proxies for civil society, and that definitions of NGOs are contextual. In this thesis, I distinguish between INGOs, NGOs, FBOs (Faith Based Organisations) and CBOs, and use the term CSOs when discussing the ‘Mangochi CSO network’ active in the district I conducted fieldwork.

Development indicators

Despite decades of development intervention, Malawi remains one of the poorest countries in the world (ranked 171 out of 188 – UNDP (2018)). Malawi has an estimated population of 17.2 million and an extremely low gross national income of \$1.064 per capita (UNDP 2018). The unemployment rate is 21%, and 89% of the working population works in informal arrangements (NSO 2014). Moreover, 71% of Malawians live on less than USD 1.90 a day (IMF 2017). Malawi experiences problems with nearly every part of society. Public services are weak and the burden of disease high. The repeated shifting between aid modalities has not improved the situation. Withdrawals and redirection of funds have resulted in public sector

funding crises (Anderson 2018; Anderson and Patterson 2017; Dionne 2018:69; Khunga 2018). It is within this context that the RTP project is implemented.

The most recent Demographic and Health survey (NSO and ICF 2017) estimates that the pregnancy-related mortality ratio is extremely high, at 497 per 100,000 live births, and there are many teenage pregnancies (29% of girls aged 15-19), and early marriages (47% of girls marry before the age of 18). Although the net attendance ratio for primary school is 94%, it is 17% for secondary education (NSO and ICF 2017) and only an estimated 4% complete secondary school (Frye 2012). As in many other Sub-Saharan African countries, socioeconomic inequalities in primary education are now larger than gender inequalities (Grant 2017). The gender gap that still existed in secondary education in 2010 (Grant 2017) has now evened out (NSO and ICF 2017).

Understanding the focus on “teenage pregnancies” in historical and contemporary perspective

To understand the strong focus on girls in development initiatives like the one I have studied, we have to explore the historical interactions between Malawi and its donors in co-shaping policy. Many donors and NGOs have had a specific focus on reproductive health challenges, addressing these variably through interventions in the health and education sectors. I therefore discuss both these sectors. Robinson (2017) argues that “knowing the history of health interventions in a country increases our understanding of how and to what extent countries respond to new health threats” (p.1). Referring to teenage pregnancies as a “population explosion ‘time bomb’” (Chilunga 2017; Khunga 2017), Malawian newspapers indeed seemed to frame teenage pregnancies as a threat. Robinson (2017) argues that Malawi’s patterns of response to population control, HIV, and maternal mortality are strikingly similar: relatively late response and demonstrating the capacity to implement donor-supported technical solutions. However, as Anderson (2018) shows for Malawi, Western donors have considerable influence on national policies and priorities; but try to conceal their influence through “shadow diplomacy”.

After independence from Britain in 1964, Dr. Hastings Kamuzu Banda became the first president. Malawi would experience 30 years of dictatorship. Banda had particular ideas about state building, through agricultural development and strengthening culture and tradition. He ruled through an ideology of unity, loyalty, obedience and discipline, and exiled, imprisoned or killed people who opposed his regime, including many intellectuals who could have provided technical leadership to the ministries or played a role in building an active civil

society (Robinson 2017). Although Kamuzu Banda preached education for all Malawians during the independence movement, in his policies he favoured male students and the central region through quotas, in order to create a loyal group of followers. As such, education played a central role in maintaining social, economic and political inequality that had its origins in colonial times (Kendall 2007:285-286). During Banda, school enrolment was among the lowest in sub-Saharan Africa, and government spending was skewed towards higher education (Mundy 2002:14-15).

Donors provided budget support because they saw in Banda an anti-communist ally during the Cold War, but they had little influence on the country's policies (Mundy 2002). The implementation of several Structural Adjustment Programmes – aimed at reducing government expenditure – between 1981 and 1986 further weakened the education, agricultural and health sectors (Kalipeni 2004). This had severe negative consequences, especially for the poor (Chinsinga 2002). Banda's government saw it necessary to increase the primary tuition fees to cope with budget cuts, making education even more inaccessible (Mundy 2002:18). The health sector faced scarcity of medical supplies and medicine (Kalipeni 2000:969). Yet, Banda and other presidents since then have not introduced user-fees to control the challenges in the health sector, even though the World Bank pressed for this (Messac 2014). As Messac (2014) suggests, user-fees are a historically sensitive issue in Malawi. In 1964, Banda's decision to introduce user-fees – as recommended by the British – had caused a political crisis, the resignation of several ministers, and an uprising in Mangochi led by one of these ministers against Banda's ruling, after which Mangochi received fewer state resources (Messac 2014:44-45; Thorold 1995). Banda abandoned the plan and made hospitals a core policy focus; however, he did not invest in preventive care and health centres (Banda and Walt 1995; Messac 2014). Banda supported the growth of private health care and, from 1988, he allowed public sector medical personnel to work part-time in private clinics in which user-fees were required (Banda and Walt 1995; Lwanda 2002). Although the official regulation prescribed opening private clinics in rural areas, most practices were opened in peri-urban and urban areas (Banda and Walt 1995). The weak health system, in effect, resulted in continuous reliance on traditional healers and self-treatment for many people (Lwanda 2002; Vaughan 2013).

Robinson (2017) argues that “the economic turndown of the 1980s provided donors with further justification for encouraging a more explicit population policy” (p.111-112). Banda's ideology was population growth which went against the grain of the global development trend at the time to reduce fertility. Banda allowed for the distribution of

contraceptives starting in 1982, but the purpose was child spacing rather than reducing fertility (Chimbwete, Watkins, and Zulu 2005; Robinson 2017:108). The acceptance of this child spacing programme emerged from powerful voices in the medical field and an UNFPA organised workshop in 1981, after which a strategically written memo urged Banda to allow child spacing to reduce maternal mortality (Chimbwete et al. 2005). BLM, a family planning NGO provider and partner in the RTP project, was founded in 1987 and now provides half of all family planning services in Malawi via their clinics and outreach activities (Robinson 2017). In 1992, when Banda's position started to weaken, some of the criteria for accessing contraceptives, such as spousal consent, the minimum age of 18, and parity, were removed. At the same time however provider attitudes made it difficult for young people to access contraceptives (Solo, Jacobstein, and Malema 2005).

In 1993, USAID initiated the GABLE – Girls' Attainment in Basic Literacy and Education - programme to increase girls' enrolment in primary education. USAID's focus on gender inequality – rather on than perhaps other more pressing inequalities (regional, rural/urban, socioeconomic) – was linked to broader fertility and population goals (Mundy 2002:23). This was in line with international development discourses at the time. After the "Education for All" conference in Jomtien in 1990, there was international consensus that education was the solution to many of the world's problems, including gender inequality, poverty and population growth (Vavrus 2003). Banda eventually allowed for the implementation of the programme, because it gave legitimacy to a government that was losing its grip on the population (Mundy 2002:25;29). The current focus on girls' education and reducing teenage pregnancies is thus not a new topic in Malawi.

Modernity and democratic freedom: opening up for donor-driven policy

Banda eventually lost power. The Cold War was over, and donors did not need Banda's support as an ally in the region any longer. Instead, democracy and human rights became important for donors, and in the light of Banda's human rights violations, they suspended aid (Wroe 2012). Because of Banda's inability to balance his power and maintain aid flows, critical voices became louder (Wroe 2012). In 1992, the Catholic Church responded with a letter calling for democratization in response to the many health challenges the country faced (Robinson 2017:118). Intensifying the pressure university students, urban workers and political activists organised demonstrations.

In 1994, Bakili Muluzi became the first elected president. Muluzi's political focus and policies differed from his predecessor's in important ways. The most visible policy was Free

Primary Education for All (FPE), which Muluzi presented as part of a set of new democratic freedoms and entitlements (Kendall 2007:287). With financial support from donors, Malawi became one of the first countries in Sub-Saharan Africa to implement free primary education (Mundy 2002), serving to both gain legitimacy from the Malawian people and secure international support (Kendall 2007:288). Although donors were willing to assist with funds, the education system could not handle double the number of new pupils, and the quality of education declined because there were not enough teachers, school buildings, or materials (Chimombo 2005; Mundy 2002). Furthermore, GABLE and FPE were implemented at the cost of investing in secondary and tertiary education (Mundy 2002). The government and private actors tried to bridge this gap with the construction of Community Day Secondary Schools and private schools (Grant 2017).

Like Banda, Muluzi also implemented liberalisation and structural adjustment policies in exchange for World Bank and IMF loans. These economic liberalisation policies pushed for by donors resonated with Muluzi's state building ideals which highlighted the importance of commerce in achieving economic growth and development (Chinsinga 2002:26). However, the economic decline that followed resulted in an increase in extreme poverty, violent crime and corruption. Muluzi did not prioritise health (Lwanda 2002). Vaughan (2013) argues that towards the end of Muluzi's presidency there was a "general disillusionment with democracy" (p.338). Civil servants lost many of their privileges, in tandem with increasingly uncertain livelihoods (Anders 2002). Furthermore, Kendall (2007) suggests that the failure of free primary education and the failed promises of better livelihoods delegitimized the state as an effective provider of public services. However people's responses were conditioned by historical regional differences. The Southern region, where Mangochi is located, was hardest hit by the AIDS epidemic and suffered from land and food insecurity following democratization, making schooling even less relevant in people's livelihood strategies. Villagers interpreted democracy in a neoliberal individualistic manner: everyone could "engage – or not – with the school as they wished" (Kendall 2007:298). FPE became a symbolic gesture without economic or cultural value.

In 1994, Muluzi also immediately adopted a population policy, which promoted small families and the free use of family planning methods in the name of development (Chimbwete et al. 2005). This policy was based on the 1967 Kenyan policy, whose approach was based on a Population Council report with a neo-Malthusian ideology: population growth was the main cause of poverty and an obstacle to development (Berro Pizzarossa 2018; Chimbwete et al. 2005). The 1994 UN International Conference on Population and Development in Cairo

marked a global paradigm shift from this neo-Malthusian ‘vertical’ ideology to a horizontal, holistic and human rights-based approach to sexual and reproductive health, with a strong focus on gender equality and empowerment of women (Austveg 2011; Berro Pizzarossa 2018). The concepts of reproductive health and rights were introduced, in a direct challenge to the population control policies. This was reinforced during the Fourth World Conference on Women in Beijing in 1995. The UNFPA and the Department of Population Services in Malawi revised the policy in light of the Cairo conference, which resulted in a new reproductive health policy in 2002 (Chimwete et al. 2005; GoM 2002). Critics argue, however, that although the language of reproductive health and rights was adopted by many countries, the shift never materialised (Austveg 2011). The political commitment to improving sexual and reproductive health and rights largely fell apart in 2001 when the UN Millennium Development Goals (MDGs) were adopted; they initially narrowly focused on a depoliticized goal to improve maternal health (Austveg 2011; Crossette 2005; Yamin and Boulanger 2014). Reproductive health and rights thus was narrowed down to only one aspect of a broad agenda: maternal health – or, in practice, to the MDG5 process indicator: “the proportion of births attended by skilled personnel” (Austveg 2011; Yamin and Boulanger 2014).

Muluzi valued democratic freedom, progress and modernity. Donors, international organisations and INGOs entered the country on a large scale and Malawi became a development friendly country. Muluzi allowed NGOs and donors to implement initiatives according to modern western cultural models, such as human rights, education, gender equality, modern family ideals centring around reducing fertility and delaying marriage (Thornton, Dorius, and Swindle 2015), and HIV prevention and democracy (Robinson 2017:107). Civil society organizations with transnational connections educated rural populations on human rights and democracy, which Englund (2006) argues, took a particular depoliticized meaning as individual freedoms. This framing of human rights is still highly relevant today, as is the framing of ‘tradition’ and ‘modernity’. Within the context of a burgeoning HIV epidemic, several so-called ‘traditional’ practices such as widow inheritance, wife swapping, and sexual cleaning were labelled ‘harmful’ and were specifically targeted in HIV prevention campaigns (Peters, Kambewa, and Walker 2010; Swidler and Watkins 2017). After an initial period of inaction, Muluzi – during his second term – and his successor, Bingu wa Mutharika, whose term of office began in 2004, put HIV firmly on the national agenda (Lwanda 2002; Peters et al. 2010; Robinson 2017). The first interventions promoted behaviour change and condom use, and later programmes made testing and treatment

available. Malawi's approach to HIV prevention builds on its approach to reproductive health, defined by relatively late action followed by strong political commitment and the rapid implementation of donor-supported technical solutions that make use of the same distribution channels – BLM and community-based distribution (Robinson 2017). Both interventions were met with initial suspicion at the local level and seen as something foreign, which is likely due to Banda's legacy, and the fact that the focus on HIV/AIDS somewhat displaced attention on, and funds for, family planning (Robinson 2017:130).

These responses to the HIV crisis mark the start of internationally-backed "sexual and reproductive health and rights" (SRHR) programmes specifically targeting youth, which are relevant to the RTP project I studied. UNICEF was one of the leading organizations to include HIV information in the life skills curriculum in the early 2000s (UNICEF 2006). Prompted by a 'needs assessment' conducted by UNICEF in 2002, the Malawian government together with UNFP, WHO, and other stakeholders, designed an Youth Friendly Health Service (YFHS) strategy to make SRHR services more acceptable, accessible, and affordable to youth, with the ultimate aim of reducing unwanted pregnancies, sexually transmitted infections, and HIV/AIDS (USAID 2014). From 2007, the government, NGOs and development partners trained, supervised, and provided programmatic support to districts. Yet, a review in 2010 found that service uptake remained largely unchanged and called for the involvement of key community gatekeepers to increase community acceptance (USAID 2014). In 2014, between 50 and 75 percent of the sites met the YFHS standards, with a vast variation between sites and regions (USAID 2014). During fieldwork, the government was revising the YFHS strategy.

The Presidential Safe Motherhood campaign

Bingu wa Mutharika, President of Malawi from 2004 to 2012, managed to restore economic stability in Malawi (Dionne and Dulani 2013). He reintroduced a fertilizer subsidy programme which had been cancelled under Muluzi's neoliberal policies. Although he fought corruption during his first term, Mutharika displayed some authoritarian tendencies during his second term, and he passed several restrictive laws (Dionne and Dulani 2013). The country's economic situation worsened, and to make matters worse, donors suspended budget support (Dionne and Dulani 2013).

After Mutharika's sudden death in 2012, Joyce Banda became President, with two years remaining until the next elections. As one of the few female leaders in Sub-Saharan Africa with a political track record, Joyce Banda was popular among donors. She reversed some of Bingu's restrictive laws and, following advice from the IMF, liberalised the foreign

exchange market, and restored donors' confidence (Dionne and Dulani 2013).

The focus on Safe Motherhood to curb Malawi's high maternal mortality ratio (497 deaths per 100,000 live births – (NSO and ICF 2017)) became one of the core areas in her quest for gender equality and women's empowerment. Banda moved the Safe Motherhood Initiative from the Ministry of Health to the Office of the President. Since the Initiative was launched in 1996 various strategies and road maps were developed and implemented (MoH 2007, 2012), but until Banda, maternal health had not been a core national priority (Family Care International 2007:62-66). Joyce Banda claimed that 'traditional' practices – such as Traditional Birth Attendant-assisted home deliveries – contributed to the high maternal mortality ratio (Vaughan 2013:308), and she aimed to increase the number of institutional deliveries. Again, there was a relatively late but powerful response (Robinson 2017), and again an initiative was coupled with the aim of acquiring legitimacy and securing donor funding (Wendland 2016). As such, the UN Millennium Development Goal to improve maternal health became hugely important for Banda's Presidency.

Reducing teenage pregnancies as development imperative

In 2014, Joyce Banda lost the election due to a large-scale corruption scandal, 'Cashgate', in her administration, after which donors suspended budget support. The current President, Peter Mutharika, has continued the Safe Motherhood policies, though not with the same intensity. Chinsinga and Mvula (personal communication, January 9, 2018) suggest that Malawian presidents can place certain initiatives temporarily in the spotlight. NGOs that previously wanted to be associated with Safe Motherhood, because of accompanied donor funding, now stopped focusing on the issue.

At the time of fieldwork in 2015 and 2016, there was a strong focus among NGOs on teenage pregnancies, early marriages and girls' education. This reflects recent global trends towards multisector approaches to improve adolescent³ girls' health, wellbeing and empowerment, including reducing teenage pregnancies (Patton et al. 2016; UNFPA 2013; WHO 2015b). Specifically, health and education are presented as closely linked, and schools are seen as promising venues for health education, which includes comprehensive sexuality education (Patton et al. 2016; WHO 2015a:78-79).

Until recently, Safe Motherhood policies did not differentiate between subgroups

³ Various age range definitions of adolescents, youth, and young people exist (see Patton 2016). For the purpose of clarity I follow the definition used in the RTP proposal (girls between 15 and 19 years of age), which is also the MDG5b indicator. However, SDG target 3.7 added the age group of 10 to 14 as an indicator.

(Vogel et al. 2015), even though pregnancy and birth-related complications is the leading cause of death for girls between 15 and 19 years of age (WHO 2018). In Malawi, approximately 1 out of 3 girls between the ages of 15 and 19 have begun child bearing (NSO and ICF 2017). After long-term lobbying, the MDG5b goal to achieve “universal access to reproductive health”, with the “adolescent birth rate” among 15 to 19 year old women among its indicators, was added to the maternal health goal in 2005 and implemented in 2007 (Yamin and Boulanger 2014). The launch of the new Global Strategy for Maternal, Children’s and Adolescents’ Health 2016-2030, to accelerate political commitment to achieving global health goals, really seems to mark a shift as it explicitly includes adolescents (WHO 2015b).

In Malawi’s government strategies, there is also a connection between education, teenage pregnancies, and maternal mortality. The Malawian Youth Friendly Health Service (YFHS) strategy links a reduction in teenage pregnancies to reducing maternal mortality, unsafe abortions and a shift in the population’s age structure – 31.6% of the population is between 10 and 24 years of age (NSO and ICF 2017) – outcomes which can result in economic growth (USAID 2014). The revised national Population Policy (GoM 2012) makes a causal connection between girl’s education, early marriage, teenage pregnancies, and maternal mortality: “The previous policy [1994] focused on reducing the growth rate of the population, while the current one is aimed at supporting the achievement of sustainable socioeconomic development. [...] Among the main features of Malawi’s fertility is the high adolescent fertility rate that results from low levels of educational attainment and early marriage among women.” (p.6). The policy links these characteristics to maternal deaths (p.5). The link between teenage pregnancies and girls’ education is at the heart of the Save the Children RTP project I studied.

Globally, the discourse on girls takes a particular economic framing in which corporate actors – such as the Nike Foundation – have played a large role (Chaaban and Cunningham 2011; Hickel 2014; Moeller 2013; Richey 2014). Many NGOs and development projects have adopted this economic framing of “Leveraging the unique potential of adolescent girls to end poverty for themselves, their families, their communities, their countries and the world” (*The Girl Effect* 2010). The Girl Effect stresses that empowered through education, girls can overcome the ills in society, such as teenage pregnancies, early marriages, HIV/AIDS, illiteracy and poverty. The Girl Effect clearly discursively entered the field of maternal health. At the 2016 Women Deliver conference in Copenhagen, several high level speakers referred to women and girls as “the world’s largest untapped potential” or a “resource” and asserted that investing in them would create a “positive ripple effect”.

The UK's Independent Commission for Aid Impact criticised a joint Nike/DfID initiatives for “failing to reflect the complex social context” and putting “undue pressure on vulnerable girls” (Moeller 2013:613). As I discuss in article 2, the Girl Effect discourse has been criticised by anthropologists and feminist scholars, mainly for its neoliberal underpinnings that construct individual personhood and kinship as the main drivers of, and the solution to, poverty while ignoring structural factors (Hayhurst 2013; Hickel 2014; Shain 2013; Switzer 2013; Switzer, Bent, and Endsley 2016). Yamin and Falb (2012) argue that, although family planning has returned to the global agenda since 2012, this seems to be driven by “‘sustainable development’ rather than reproductive rights. [...] Women’s roles are apparently seen as of instrumental value, and civil rights appear to be perceived as potential barriers to economic development” (p.369-370). The global health development project that is the focus of my analysis fits into this emerging logic.

Save the Children’s RTP project

More Educated Girls – Reducing Teenage Pregnancies in Malawi (RTP) is a project funded with NOK 30 million (USD 3.8 million) by the Norwegian Agency for Development Cooperation (Norad) and implemented between January 2014 and December 2016. Save the Children Norway (Save Norway) was responsible for the project and Save the Children International Malawi (Save Malawi) implemented the project, in partnership with Malawian NGOs, The Forum for African Women Educationalists Malawi (FAWEMA) and Banja La Mtsogolo (BLM⁴). Malawi is one of Norway’s priority countries and, as described by Kloster⁵ (under review), the combined focus on health and education emerged from a convergence of factors. With the election of a new government, Norway shifted its priorities in foreign policy from maternal health to girls’ education, which was in line with the current global discourse. Furthermore, focusing on teenage pregnancies was a way for Norad and key policy makers to sustain the focus on maternal health. Moreover, the multisector approach was a game changer for Save Norway.

Save the Children International in Malawi (Save Malawi) is the local affiliate of Save the Children International – a large development INGO headquartered in London and with operational management over 120 offices worldwide (Kloster 2018). Save Malawi implemented projects funded by different donors; funding which was channelled through the

⁴ Marie Stopes International in Malawi

⁵ I studied the implementation of the project in one locality, whereas my colleague, Maren Kloster, studied the same project across global, national and district level.

UK head office. This structure had emerged after the different Save the Children member organizations united in a global alliance called Save the Children International (Kloster 2018).

Following the principles of country ownership, Save Norway tasked Save Malawi with designing the project. In effect, this responsibility was given to a team consisting of Save Malawi staff, a consultant from Save Norway and one from Save US (Kloster under review). I analyzed the project proposal, both prior to my fieldwork and afterwards. I focused on its framing of teenage pregnancies and girls' education, the underpinnings of the design, the intervention strategy and – based on my analysis of local realities – what was not discussed. I discuss this critical analysis in article 2. Here, however, I aim to provide a broad overview of the project.

As described in the RTP proposal (Save the Children 2013), after reviewing existing approaches, a project was developed with a multisector approach to address the high prevalence of teenage pregnancies. A situation analysis of programmes, partners and donors in Malawi identified two gaps: addressing environmental (family, friends and institutions) and individual (risk perception, vulnerability, opportunity) barriers against the use of Youth Friendly Health Services (YFHS), with an emphasis on sociocultural factors and improving the school environment (p.6). The project's approach was based on several 'building blocks' of global guidelines and best practices, in line with Malawian policies, and experts' perceived connection between teenage pregnancies and education. The project's main aim was to reduce teenage pregnancies by 10% by achieving three outcomes: increasing the use of key sexual and reproductive health practices and services, reducing girls' school dropout rate by 5%, and increasing school re-entry rates after pregnancy by 5%. Although the connection between teenage pregnancies and maternal health/mortality is absent from the final version of the proposal, the link is explicitly made in a previous version, and Save Malawi's project reports (e.g. the final project report). There were five medium term outcomes: improved learning environment and self-efficacy, knowledge about and access to SRHR, changing the social environment, operationalization of policies and monitoring and evaluation.

The theory of change projects a linear understanding of development. A lack of access and utilization of SRH information and services, a lack of quality learning environment and self-efficacy, and a lack of community and social support towards girls' education are the causes of teenage pregnancies, and by improving these issues the three outcomes and main aim will be achieved (Millard, Msowoya, and Sigvadsen 2016:5-6).

The RTP project worked across different levels and sectors and aimed to work through existing structures in line with the Theory of Change of Save the Children. The main

Ministries involved were the Ministry of Health (MoH), and the Ministry of Education, Science and Technology (MoEST), and to a lesser extent the Ministry of Youth and Sports Development and the Ministry of Gender, Children, Disability and Social Welfare. RTP worked at the ministerial level to influence national policies, aimed to strengthen thematic platforms at district level, and trained senior civil servants and lower level public servants – such as teachers and health workers – to implement project activities and integrate them in their daily work. RTP district staff explained they were coordinating the project, but civil servants were implementing it. In the words of Watkins et al. (2012), they “outsourced social transformation”.

RTP also worked through community structures. The British colonisers left the chief structure intact, and there still exists a parallel structure of traditional law (by-laws) in addition to customary law. Every district is divided into several Traditional Authorities headed by a chief referred to as the ‘TA’. Every Traditional Authority is subdivided into groups of villages headed by a group village head. In turn each village has its own village head, with a number of advisors or elders. Village heads are accountable to group village heads, who are in turn accountable to the TA. The TAs serve as non-voting members of the district council. Furthermore, every group of villages has a village development committee consisting of community representatives, and every TA has a number of area development committees. Moreover, there are councillors who are part of the government structure and in charge of a certain area (ward). The level above the councillor is the Member of Parliament (MP). Furthermore, every village and group village has numerous committees for different topics; many were created as a response to NGO and other development projects, particularly related to the “AIDS enterprise” (Swidler and Watkins 2009). There are also Community-Based Organisations (CBOs), which are a bit more formal than the committees. There are several committees connected to schools, such as mother support groups, teacher parent associations, and school committees. RTP aimed to strengthen relevant community structures with the idea that these community actors would continue the activities after RTP had phased out, making the project sustainable.

3. Methods: ethnography in NGOs and global health

My analysis of the local implementation of the RTP project in rural Malawi draws on ethnographic research conducted during three visits between May 2015 and August 2016, lasting a total of 10 months⁶. Participant observation – the close involvement of the researcher in everyday natural settings over an extended period of time – is the core method of any ethnographic study (Hammersley and Atkinson 2007; Stewart 1998). The ethnographer's aim is to create a holistic construct of society, with data that has sufficient breath. Although ethnographers have moved away from thick-descriptions of cultures towards more specific topics, observations still often transcend academic disciplines (Stewart 1998). Furthermore, Stewart argues, ethnography should provide a contextualized analysis and capture the subjective vision of the actors. Thickness, Ortner (2006) contends, should focus on contextualization.

In this chapter, I introduce the field site through the INGO project I studied (RTP). Its multi-sectoral approach to reducing teenage pregnancies had particular implications for my methods. This reflects the fact that ethnography is always characterised by a flexible approach, shaped by the research objectives and the realities on the ground (Hammersley and Atkinson 2007). The RTP project aimed to strengthen the health and education sectors, and community structures. Therefore, my method became multi-layered (Fassin 2013). Through participant observation, informal conversations, in-depth interviews, and document analysis, I examined different sites in one locality – namely the project, a village, a primary school and a health centre (see Table 3.2 at the end of the chapter for an overview). I also reflect on how my research assistant – Gertrude Finyiza – played a role in co-producing the methods, especially within the community (Gupta 2014; Middleton and Cons 2014).

Multi-layered approaches and the invisible spaces of global health

Multi-layered ethnographic approaches, Fassin (2013) argues, involve studying several social sites in one locality, which reveals a diversity of perspectives and provides a nuanced analysis

⁶ Initially, I had planned to conduct fieldwork during two periods (May through July 2015, and September 2015 through February 2016). However, to obtain the necessary data, I had to extend my fieldwork and I returned to the field a third time (July and August 2016). I spent a total of 10 months in the field; of which three months were in Lilongwe/Mangochi town and seven months in a semi-rural village. In between the second and third fieldwork period, my research assistant continued data collection.

considering multiple positions. As (Wittel 2000:11) maintains for multi-sited ethnography⁷, revealing complexity is one of the core objectives: “the network, its dynamic and the interplay of relations between people, things, activities and meanings” between sites is the focus of the ethnography; rather than a classic thick description of a ‘culture’ in one site.

Furthermore, multi-layered ethnography gives precedence to a political-economy analysis over a behavioural and cultural focus (Fassin 2013), which I will show is particularly important in the case of NGO initiatives which boast a behaviour change approach. Political-economy analyses gained popularity in the 1980s (Ortner 2016) and are central to the field of critical medical anthropology, a subfield of anthropology that is interested in how structures of power shape health and inequalities. A core strength of critical medical anthropology is its engagement with global policies, practices and discourses and their impact on local lived realities (Panter-Brick and Eggerman 2018). Such analyses have provided a necessary corrective to the assumption underpinning many public health interventions that changing apolitical and ahistorical health beliefs will change health behaviour (Panter-Brick and Eggerman 2018).

However, I also seek to move beyond this by answering recent calls in medical anthropology for examinations of how the field of global health is made (Pigg 2013), through considering the practices of different local actors in relation to the implementation of NGO initiatives. In a Social Science and Medicine volume dedicated to rethinking ethnography’s contribution to global health, Pigg (2013) advocates looking beyond a political-economy analysis that has – according to Janes and Corbett (2009) – the ultimate goal of reducing global health inequalities. Therefore, according to Pigg, this kind of analysis limits its focus to ‘the local’ and, as noted by Herrick (2017), to ‘suffering’. Instead, following Brada (2011) and Fassin (2012), Pigg (2013) argues for an ethnography of global health itself; an “inquiry into the who, what, where, when, why, and how of all the activities that call themselves projects of global health” (p.128). Such an ethnography would be dedicated to exploring the broader local implications of global health interventions that are formulated from specific social localities.

Drawing on research in Nepal, Pigg (2013) demonstrates the presence of global-local power relations in the design of AIDS projects. Local NGO workers were of the opinion that the globally-designed AIDS projects did not match Nepalese realities, but they had no power to change the content. Rather, their superiors held them accountable for reaching the intended

⁷ Multi-sited ethnographies include several geographical locations in one study (Marcus 1995).

beneficiaries. These findings lead Pigg (2013) to argue for “ethnographic sitting”: an attitude of “attentiveness and openness to being taken off course” (p.132). This would facilitate the examination of “important things happening in the social arenas created by global-health activities other than those already accounted for by the medical and public-health frameworks that define problems and structure solutions” (p.128). Ethnography, argues Pigg, should focus on the spaces that are created by activities and relationships in the name of global health, but that often remain invisible. These spaces of social change might very well lie beyond the domain of health and could be “contradictions, incommensurability, contested categories, ethical dilemmas, and unintended political consequences” (p.133). By shedding light on these usually unobserved spaces, ethnography might provide insights into “the structural, political-economic, and discursive global workings of the system’ of global health (Pigg 2013:133). Pfeiffer and Nichter (2008) see “illuminating the social processes, power relations, development culture, and discourses that drive the global health enterprise” at various levels, as a key contribution that critical medical anthropology can make to the field of global health (p.413).

Influenced by these methodological arguments, my ethnographic examination of RTP is not so much an evaluation of the project itself. Rather I look upon the project as a lens to examine how various local actors are involved in its implementation in a context of overlapping NGO initiatives, resource scarcity, and aid-dependence. These revelations enable me to draw wider conclusions about the system of global health – how it is made ‘on the ground’ by NGOs.

RTP in Mangochi district

Save Malawi implemented the RTP project in six administrative districts: Machinga, Balaka, Phalombe, and Mangochi in South and Ntcheu and Mchinji in the Central region. These districts were selected based on incidence rates of teenage pregnancies, the total fertility rate, and current use of contraceptives, as well as a review of other adolescent sexual and reproductive health programmes. Using this selection strategy, the project aimed to target those districts with the greatest need, avoid duplication of initiatives, identify opportunities for complementation, and create synergies with existing Save Malawi education programmes.

Figure 3.1 Map of Mangochi district in Malawi (source: Wikimedia)

Figure 3.2 Percentage of girls aged 15-19 who have begun childbearing (NSO and ICF 2011, 2017; NSO and Macro International Inc. 1994; NSO and ORC Macro 2005, 2001).

I decided to focus my fieldwork on one of RTP's implementation sites, the district of Mangochi (Figure 3.1), after an RTP staff member I met during a preliminary field visit in May 2015 referred to the district's "bad indicators" compared with the rest of the country. The staff member was worried about the indicators in Mangochi but at the same time I could sense some enthusiasm in his voice. "There is economic activity, it is accessible, there are facilities," he asserted. "But the district is still very far behind". As an explanation for this apparent contradiction, he mentioned cultural values and practices. In other districts, he claimed, people were more accepting towards programmes. He added: "if the project manages to succeed in Mangochi, the project will also work in other districts with some minor adjustments." However, a comparison of Mangochi's indicators with the national average reveals nothing exceptional (Table 3.1). Over time, there seemed to be a similar pattern: a slight decline, followed by an increase in teenage pregnancies in recent years. The median age of 19 at first birth remained largely stable over time (Figure 3.2). This indicates that in the whole of Malawi, young motherhood seemed to be the norm rather than the exception.

A couple of days later I attended the RTP annual meeting together with full RTP staff, partner NGOs BLM and FAWEMA, and government officials at a conference hall in one of the many tourist lodges in Mangochi. When I queried participants' perception that there are more teenage pregnancies in Mangochi than in other districts, I heard various explanations. But many had one common denominator: there was something intrinsic about the Yao, the dominant ethnic group in the district, which determined their behaviour. People explained that the Yao did not value education *because* they were Muslims and had resisted mission

education – as if there was a causal connection between religious affiliation and the importance given to education. I also heard that the Yao highly valued traditional practices such as initiation ceremonies and early marriages, intended to protect their culture and therefore resisted development initiatives – as if there was a fixed dichotomy between tradition and modernity/development.

Indicators	Mangochi 2010	National 2010	Mangochi 2015-16	National 2015-16
Girls (15-19) who have begun child bearing (%)	28.3	25.6	36.7	29.0
Fertility rate per woman	7.0	5.7	5.3	4.4
Median years of completed education – women (15-49)	2.7	4.9	3.7	5.6
Median years of completed education – men (15-49)	4.3	6.1	5.1	6.6
Median age at first marriage women (20-49)	N/A	17.9	17.7	18.2
Median age at first marriage men (25-54)	N/A	22.6	21.9	23.0

Table 3.1 Indicators – Mangochi and Malawi. Source: (NSO and ICF 2011, 2017).

Such cultural stereotypes are historically contingent. They have been shaped by the construction of ethnic tribes by the British, unequal distribution of mission schools during colonialism (Page 1980; Vail and White 1989), and strategic conversions to Islam (Thorold 1995).⁸ Malawi is divided into three administrative regions. As in many other Sub-Saharan African countries, Malawi is home to different ethnic groups, the largest being the Chewa, the Yao and the Lomwe. Strong ethnic identities emerged where the British strengthened the power of chiefs and where educated Malawian elites acted as ‘culture brokers’ by creating a tribal history and communicated this through the mission education system (Vail and White 1989). In the Northern region, both preconditions were created and certain (less powerful) tribes saw a benefit in participating in the mission education system in order to bolster their position. In the South, where Mangochi is located, the population defended their agricultural land from governmental and mission interference; hence fewer mission schools were built. To illustrate the difference; in 1904 the pupil-primary school rate in the North was 1:800; in Mangochi it was 1:5000 (Platas 2018:14-15). In 1915, there was opposition to the colonial

⁸ I limit myself to describing the parts of Yao history that are most relevant for my study, but see Thorold (1995) and Dicks (2012) for reviews that are more comprehensive.

regime in the Southern region. Vail and White (1989) relate that, as a result, the British enforce Indirect Rule; they chose the most conservative, traditional chiefs in the region – the Yao – to enforce the indirect rule. The tribal order they imposed placed the Yao chiefs at the top of the classification system. Although the position of the chiefs was strengthened, there was no tradition of mission education that provided a means to widely reinforce ethnic identity, as happened in the North (Vail and White 1989).

Photos 3.1. Boys doing 'piece work' for fishermen; and Mosque.

Today, most Yao in Mangochi and Malawi as a whole are Muslim. With 11.6% of the population, Muslims are a minority in a largely Christian (87%) country (NSO and ICF 2017). According to the stereotypes, this was the reason Yao did not value education. Why did the Yao convert to Islam and what was their relation to the education system? Arriving from what now is Mozambique in the early 19th century, the Yao quickly occupied the area and became active in trade, including ivory and slave trade, and found partners in the Swahili and Arab traders from the East coast. In 1891, the British established the protectorate and in 1896, they prohibited trade in slaves. According to Thorold (1995) this resulted in a decline of power for the Yao chiefs. Whereas conversions had been occasional prior to this, this now became a strategy for the chiefs to maintain their power. Thorold argues that the chiefs made a strategic decision to continue the alliance with the Swahili and the Arabs, which resulted in mass conversions to Islam between 1921 and 1931, mainly through the Islamisation of Yao initiation ceremonies (called *jando* for boys and *nsondo* for girls). For instance, instead of partial circumcision, boys were fully circumcised in the Islamic way, and initiation thus became a rite of passage not only into adulthood, but also to becoming a Muslim. Islam and Yao traditions were easily united (Thorold 1995). According to Arnfred (2011), Islam did not

condemn initiation ceremonies as Christian missions in the region often did, because Islam recognises the importance of female sexuality.

As mentioned, Christian mission health care and western education was unequally distributed among the different regions. In the Yao areas Islamic schools were established instead, which taught the Quran and basic Arabic literacy. Furthermore, parents feared – not unjustifiably – that mission schools would convert their children to Christianity (Bone 1982). Therefore, many Yao did not take part in mission education, which later became the blueprint for the current education system. As a result, Thorold (1995) argues, the Yao's superior position as traders further deteriorated when western education became more important after Malawi's independence in 1964. Mostly people from other districts (non-Yao) filled positions in the civil service.

These historical events play a role in Yao's lower education attendance today. Currently, 28% of Christians compared with 49% of Muslims in Malawi have had no formal education (Pew Research Center 2016). This resembles a wider Christian-Muslim educational attainment gap in the whole of Sub-Saharan Africa. Examining why this gap continues to persist in Malawi – and particularly in Muslim majority districts such as Mangochi – Platas (2018) suggests that Christians and Muslims in Malawi voiced similar demands for education, but historical patterns of school attendance originating in mission education have produced different social norms between the groups. Yet, these norms are not values inherent to characteristics of the group.

Interestingly, there seems to be no difference in the use of maternal health services between Mangochi and Malawi at large. Currently the same proportion of women in Mangochi as in Malawi as a whole – 91% – give birth in health facilities (NSO and ICF 2017). There are few differences between regions over time. An increasing trend for giving birth in health centres started in 2004 (Figure 3.3). Yet, the Yao do have specific rituals around childbirth, such as an initiation rite associated with the birth of the first child (*litiwo*), in which other women advise the expectant mother on her responsibilities, restrictions on sexual and social contact, food taboos and preparing for delivery (Dicks 2012:152-154). Furthermore, midwives and a Yao woman explained to me that women use traditional medicine to ensure a quick delivery and counter any effects of possible witchcraft. Modern contraceptive use among married women between 15-49 years is lower in Mangochi: 30.9% compared to 58.1% nationally (NSO and ICF 2017).

Figure 3.3. Deliveries at health centres over time (NSO and ICF 2011, 2017; NSO and Macro International Inc. 1994; NSO and ORC Macro 2005, 2001).

Examining the local implementation of RTP in Mangochi

Throughout my fieldwork, I interrogated these stereotypes about Mangochi and the Yao through participant observation within the RTP project activities. For the first few months of fieldwork, I resided in Mangochi town (first with research assistant Beatrice Chibayo and later with Gertrude Finyiza) to familiarise myself with the district, the project, and the implementation of a joint NGOMA/Save the Children activity. I collected and read several district documents. Mangochi town is one of two urban areas in the district and has 50,000 inhabitants. The rest of the 1 million population live in numerous villages, with the highest concentration in the touristic area of Monkey Bay and near the lakeshores (Mangochi District Assembly unpublished document). Throughout the fieldwork, we joined the two RTP team members responsible for implementing the project in the district on several project activities at various locations. These two men – one in his 30s and new to the NGO sector and the other in his 40s and highly experienced – were crucial to this research. I was interested in how these intermediary actors implemented the project, how they took local ideas and practices into account, how they interacted with local actors, and in the tensions that emerged during the implementation process at various local sites.

The activities we observed varied from safe space mapping, child protection committee training, discussions with communities on the root causes of school dropout, and open days at primary schools, to donor visits, BLM youth friendly outreach services, interviews with journalists and visits to health centres. I also participated in two annual RTP meetings with the partner NGOs and senior government officials, engaged in conversations with staff members from the Save Malawi head office and other projects in Mangochi, and joined the launch of Save Malawi's Inclusive Education (IE) project funded by the Norwegian

Embassy. In addition, I analysed project documents; the proposal, baseline, annual reports, the evaluation report and several other documents such as case study reports of success stories.

On the way to and from activities, I often had fruitful conversations with district RTP staff about the project, the larger aid sector and how they experienced their work, and I asked questions related to my observations. I asked them reflexive questions related to their role, relationships to others and their views on implementation, which, as Erasmus and Gilson (2008) suggest, can illuminate power relations. Whenever we were in town, we visited the Save the Children office for a chat. Occasionally the staff paid us a visit in the village. They also helped us out with various practicalities. Over time, we developed a professional friendship. My methods were characterised by informal conversations and discussions rather than formal interviews. The staff appeared extremely busy and worked around the clock to implement the project, communicate with partners and public servants, and fulfil their monitoring and evaluation requirements by writing progress reports. Sometimes they were in a talking mood, while at other times conversations were more difficult due to the pressure of work. I noticed that it worked best to go along with their flow, rather than forcing conversations.

I also assisted with some practicalities, such as analysing data on distributed contraceptives by BLM, driving to activities and taking notes during the annual meeting. But I did not play a role in project implementation or in giving direction to the project. The activity plan was pre-designed, and had very little room for adjustment. However, our conversations might have influenced the staff's knowledge of the district and the way in which they perceived things. During our discussions, I did not only ask questions but also shared some of our experiences from the village. Not doing this would have seemed strange, considering that learning was part of the collaboration with Save the Children.

RTP as one of many NGO projects

It was nearly impossible not to notice the enormous presence of NGOs in the district. Especially around town and along the main road on the west side of the lake, billboards pointed to NGO and CBO offices, and cars with NGO logos drove around frequently. Moreover, because of the many tourist lodges with conference halls, the district was popular for hosting NGO-organised meetings. In September 2015, Save the Children was one of 69 organizations (INGOs, NGOs, Faith-based Organizations (FBOs)) registered with the Mangochi CSO network. However, at a full council meeting in August 2016, the number 78 was mentioned, indicating an increase in the number of registered organizations. The role of

the Mangochi CSO network is similar to that of CONGOMA nationally: coordinating the work of the vast number of organizations. However, as the chair explained, not all organizations were members. ICEIDA, for example, is a development agency and not part of the network. Furthermore, only one of the many Islamic development organizations was a member, whereas many of these organizations were active in the district through building secular and religious schools, mosques, health centres, a teacher training college for girls and other development projects. Islamic reformism gained more prominence from 1994 onwards, after President Bakili Muluzi attracted development funds from donors, including Islamic countries (Van Kol 2008).

I observed a trend among NGOs to focus on girls: specifically reducing teenage pregnancies and early marriages and keeping girls in school. The focus on girls was visible in the newspapers – which I read every day – where numerous articles described the work of NGO projects and responses from local leaders who “hailed” a particular NGO for their excellent work. This appeared to be matched with a comparable number of vacancies for new projects. During the RTP 2015 annual meeting, one of the staff members said *“Every day you see articles on girls’ education in the newspaper. That is what I call commitment.”*

Within Save Malawi in Mangochi, there were three projects that focused on girls (RTP, Keeping Girls in School – KGIS, Inclusive Education – IE), each collaborating with different national NGOs, and funded by different donors (Norad, DfID, and the Norwegian Embassy respectively). As described in the RTP proposal and mentioned during the IE project kick-off meeting, the projects were intentionally implemented in some of the same education zones, because they were intended to be complementary: one project filled a gap ‘discovered’ in another project. RTP was implemented in 7 out of 17 education zones in Mangochi, four of which were start-up zones and 3 scale-up zones where implementation started a year later. Other NGOs also implemented projects focused on girls and some of these had overlapping implementation zones (see article 1). However, one of the larger, also multi-sectoral initiatives (combining education and adolescent sexual and reproductive health) – the UN Joint Programme on Adolescent Girls (JPAG) together with its follow-up Improving Access and Quality of Education for Girls in Malawi (UNJPGA) – was implemented in other zones than RTP. According to the RTP proposal, in spite of many similarities this UN initiative did not have a component focusing on sociocultural norms. RTP thus filled a gap.

Senior officials from the district health and education offices explained they played a role in distributing the NGOs evenly so that the whole district was covered. However, in reality, certain areas had more NGO projects than others. One of the reasons was that local

NGOs often had a smaller reach and tended to target villages nearby their offices. Another reason was that certain areas had a higher population and therefore had greater needs. Furthermore, (I)NGOs based in town tended to favour implementation close to their offices, rather than in remote areas. Within Mangochi, my fieldwork area was known to be popular among NGOs. But I am confident that my research site is not unique and that the identified processes are also found in other localities.

Community-level fieldwork

I intended to follow the implementation of the RTP project in one locality. I chose a village on the more vibrant and densely populated side of the lake, with many shops, bicycle taxis and pick-up trucks moving people and merchandise between markets. Contrary to the stereotypical depiction discussed above, Mangochi was ethnically diverse, and each area had different characteristics; this one was ethnically mixed. Yet despite this mixed nature, many senior public servants and RTP staff encouraged me to do research there, as they argued there were many teenage pregnancies and many girls dropped out of school. Another reason for choosing this location was that it was relatively easy to travel to town where Save Malawi's office was located.

Accessing the village

In Mangochi, my colleague and I visited the District Commissioner, the District Health Officer, the District Education Manager, and the District Planning Officer to introduce the NGOMA project. Following local ethical procedures, the District commissioner wrote a letter for me to hand over to the Traditional Authority (a higher-level chief who is in charge of a geographical area in a district), whom I interviewed and who then gave permission for me to talk to the group village head of the area I was interested in.

The area can be described as semi-rural. It was located near a market and there appeared to be no clear visible boundaries between villages. Despite the presence of poverty and food insecurity – characteristics almost universal in rural Malawi – the area had developed exponentially during the last couple of years. The market had grown, and more shops and bars had opened. Less poor households could get electricity and piped water. There were some employment opportunities with local companies and tourist lodges. These developments had attracted people from all over Malawi to migrate to the area, increasing the population in our village – according to one of the chief's advisors who kept the village registration book – from 1,860 to 2,589 between 2014 and 2015 alone. People had sold parts

of their land to village elites who constructed iron sheet houses for rent. Consequently, people rented fields for subsistence farming further away from the village. There were many female-headed households in this largely matrilineal society. This was either because the husband had left, had multiple wives, or worked in South Africa.

The group village head was in charge of his own village – comprising 9,000 people – and the village heads of seven other villages had to answer to him. He was relatively young, had attended school in the Northern region, and had become chief only recently. He assisted me with finding a house in the village on the other side of the tarmac road from where he lived. The iron sheet house had a veranda, living room, kitchen, and two bedrooms. Gertrude was at the time 30 years old, as was I, and she has ample experience with conducting anthropological research under similar living conditions. She therefore suggested sharing one bedroom for safety reasons; there were burglaries during the night and only one bedroom had a door. For these reasons, we had also employed a 20-year old boy as a night-guard. In addition, the house had an outdoor latrine, unreliable electricity, and an equally unreliable shared water tap.

Photos 3.2. Our pink/blue house in the village; and Health Surveillance Assistant meeting at chief's house

The head of our village was an older man, had been chief since 1990, and lived in town. He came to the village for meetings and farming. He left the daily governance of the village to the assistant chief and to his advisors. In 2016, a new village head was elected. It was the responsibility of the village head to introduce Gertrude and me to the community. Whereas the group village head introduced us during a community meeting in his village, the head of our village did not do this despite our request. Gertrude suspected the reason for this was that he did not see a benefit to our presence. We did not bring any project or resources.

Because we had to respect the authority of the village head, we decided to relinquish the idea of an introduction during a village meeting, and instead visited individual households at different places in the village. Our somewhat problematic introduction in the village was corrected later, when the Health Surveillance Assistant (community health worker) introduced us to the women during a village meeting in February 2016.

Participant observation in the community

Participant observation in the village was a time consuming exercise, especially because of our struggles with gaining access and building trust. Community members seemed not so fond of us initially, which might have been related to our poor introduction in the village and my positionality. Initially, many women asked “so you just want to know what it is like to live here...how does that benefit me?” and some seemed reluctant to talk to us. People might have associated me with the development sector, and responded accordingly. Biruk (2017) describes how Malawian villagers have grown accustomed to receiving soap in exchange for answering survey questions. Nevertheless, as we participated in daily village life and had many informal conversations, over time people got used to our presence and we managed to build trust relationships.

Our specific data collection strategy was co-produced by Gertrude. She knew from experience that asking direct interview-style questions and bringing a notebook often did not work and could produce social desirable answers because people would associate us with a NGO (see Verheijen (2013) where this is described at length). At the start of fieldwork, I sometimes tried this approach, but it was not very fruitful, as it did not match the conversation standards in rural Malawi. People lost interest, got tired, felt uncomfortable, or enquired why we were asking so many difficult questions. Rather, I began to notice that people talked whenever they felt like it and that they started to share more stories with us over time. This reflects that, rather than fixed entities, fields are relational, temporal and spatial (Gupta and Ferguson 1997). Research assistants are often integral to the creation of networks within fields (Gupta 2014).

We therefore used a largely informal approach; sitting on our own or on a family’s veranda, observing what was happening around us, and chatting about everyday topics with people who passed by. Our house was built along the road to a water pump, where girls and women passed by to fill their buckets and do dishes. They also came to our house to sell vegetables, chickens, or occasionally clay pots. Boys and men tried to sell items someone had brought from South Africa, such as clothing, radios and DVD players. During the day, the

village was quiet, as most people were working in the formal or informal sector, or on their own land. Towards the end of the day, the village came back to life; women returned from the market and started preparing food, children came back from school, and youth were hanging around with their friends. This allowed us to visit the school and the health centre, schedule interviews and transcribe notes during the day, while most conversations in the village took place towards the end of the afternoon.

We spoke with mothers, grandmothers, and their teenage children, and occasionally fathers. People shared personal stories, stories about friends and relatives, or village gossip, though we tried to steer conversations towards topics of interest, such as experiences at school, sexual and reproductive health, relationships, ambitions, interactions with relatives, development and NGOs. This loosely structured approach was key to contextualising teenage pregnancies and school dropout, and understanding the (changing) perceptions over time of different relatives.

As time passed we grew acquainted with an increasing number of adolescents, both girls and boys. Some lived nearby and we interacted with them on a daily basis. Others we met during our visits to the primary school, when visiting households in the village, or from the youth club at a local NGO⁹ – whose members regularly paid us a visit to chat. We observed how teenagers – both in and out of school and from different grade levels – spent their time, interacted with their peers, spoke about each other and dealt with livelihood insecurity.

The local NGO was situated at the market and had a good relationship with the surrounding communities. We interviewed and thereafter regularly interacted with the director and other employees. The director was an active member of the Mangochi CSO network and invited us to participate in a CSO-network meeting and a full council meeting at district level where the collaboration with NGOs was discussed. Furthermore, Gertrude assisted the local NGO in the implementation of their programmes when I was away from the field. I also interviewed the staff of another nearby local NGO, and a member of a CBO in the village.

We interviewed and regularly spoke with the group village head and village head, village elders or advisors, and the councillor. These conversations focused on interactions with NGOs, governing the village, maternity services, bylaws, education, teenage pregnancies, and initiation ceremonies. The group village headman or his advisor participated in NGO or other development meetings and communicated those messages to the village

⁹ I anonymised this local NGO, in order not to reveal the fieldwork location. I refer to it as ‘the local NGO’.

heads under him. The village head of our village did not participate in such meetings but was supposed to communicate the messages he received from the group village head during village meetings at his house. Furthermore, there were mosques and churches of various denominations located in the area. The Catholic Church owned the health centre and the public primary school.

As I describe in article 2, Muslims were divided into the Sufi order *Quadriyya* and the anti-Sufi *Sukuti*; the latter generally distinguished themselves by means of closely adhering to the Quran, performing a different number of prayers on Friday, a commitment to education, and opposing practices that are un-Islamic, such as traditional initiation ceremonies, dancing at funerals and witchcraft (Dicks 2012; Thorold 1995; Van Kol 2008). I investigated the differences between the more traditional Quadriyya Muslims and the more recent wave of reformist Islam/Islamic development. We interviewed a village imam and visited an Islamic development organization nearby. In town, we interviewed leaders of the Mangochi Quadriyya Organization and the leader of the Islamic Information Bureau. He was a former member of the Muslim Association of Malawi and currently TA in Mangochi. We also spoke with villagers about religion.

Photo 3.3. Girls beating drums and dancing in initiation camp; Taking notes in initiation camp.

Because initiation was such a central factor in the explanations of RTP staff for the high rates of teenage pregnancy in Mangochi, I wished to conduct participant observation in a girls' initiation camp to acquire knowledge on the content and meaning of this ritual and transitions to adulthood. Moreover, due to its secretive nature it was difficult to ask questions about initiation. Gertrude agreed, as she had always been curious about the content. The director of the local NGO put us in touch with an initiator in a nearby village, who after a

conversation and an interview granted us permission to participate in her camp in July 2016. Participating in initiation provided us with the opportunity to speak with women and girls who visited the camp to greet the two girls of four and six who were being initiated. Even though we learned a lot through this participant observation, unfortunately the initiator limited our access to information by not answering questions and cutting off our conversations with others. As the director of the local NGO told us later, several village elders did not agree with our presence in the camp despite our conversation with them beforehand. Furthermore, many women visited the camp because of rumours regarding our presence, resulting in an uncomfortable situation for the initiator. On the sixth day, we decided to leave, because the situation had become unbearable for us as we feared her witchcraft. Nevertheless, the experience gave me important insights into what initiation is like, its central importance in transferring local knowledge and norms, as well as a personal appreciation of the power and fear of witchcraft.

The primary school as RTP implementation site

My experiences and observations in Mangochi town made me realise the importance of mapping the different NGO activities in one locality. I interviewed the chair of the Mangochi CSO network who had a good overview of current NGO activities. I also asked about the spread of NGO work in Mangochi when I spoke to the traditional authority, the group village headman, the village head, the councillor, the NGO-contact person of the area development committee, staff at two health centres, and the head teacher at the primary school. In keeping with the seemingly messy development realities on the ground, every person named different NGOs, projects, and voluntary community groups that were active.

The primary school in the area became an important ethnographic site because many development activities targeted the school or took place there (article 1). The school had 13 classrooms for more than 3,000 students and served the surrounding villages. In the absence of a public secondary school in the area, several private secondary schools, as well as nurseries and primary schools, had been constructed. According to a senior official at the District Education Office, there were 265 primary schools in the district, which was in sharp contrast to the limited number of secondary schools (Figure 3.4). Overall the education system in Mangochi district comprised a single National grant-aided Secondary School, two District Boarding Secondary Schools and three District Day Secondary Schools, 27 Community Day Secondary Schools, 13 Private Secondary Schools, and four special needs primary schools (Mangochi District Assembly). Although fees for primary education had

been abolished in 1994, secondary schools – at the time of fieldwork – required the payment of fees. For private schools, tuition fees were often higher and the schools were of varying quality (Grant 2015). By the time I left Mangochi, the MP and councillor were working on plans to construct a public secondary school in the area, funded by the MP's development budget.

RTP trained Primary Education Advisors (PEAs) and two primary school teachers at each school in implementing project activities, such as life skills education and youth club activities. RTP also engaged with community groups connected to the school, such as mother support groups, school management committees and parent teacher associations, all of which were composed of volunteers from the surrounding villages.

NGO activities at the primary school

During NGO organized activities, various local representatives were present, but the composition of the group was always different and depended on the design of the project. Sometimes there were 30 actors consisting of a combination of (head) teachers and community representatives of our 'group village'; or adolescent girls from the surrounding villages. Other times there were three representatives of every group village in the education zone; or female teachers from different schools in the zone. Apart from valuable participant observations, these activities enabled informal conversations with a variety of actors from different villages. While we struggled in the beginning to find a way to be invited to development activities, the head teacher increasingly invited us to participate and became an important gatekeeper, as well as a key source of information.

I observed that most activities followed a similar format, which suggests that they are a highly ritualised set of practices irrespective of the topic (Watkins and Swidler 2012). Apart from participating in such activities, I examined the roles and practices of actors in the primary education sector. I interviewed and had informal conversations with the Primary Education Advisor (PEA), the head teacher and a group of five teachers who were particularly involved in development activities. I asked them about the interaction with NGOs, the content of the projects (including RTP's aim to strengthen sexual and reproductive health information), their opinions regarding NGOs' and the schools' priorities and needs, and how the NGO activities affected their work and the school. In addition, we had informal conversations with the deputy head teacher, the former head teacher, and several teachers throughout the year, during activities or when we paid a visit to the school. We also undertook classroom observations at different grade levels, and attended a youth club session during

which we also introduced ourselves to the girls in grade 7 and 8. We participated in donor visits, and a RTP project review meeting at the school. We also spoke with teachers employed at other schools who lived in our village or when they were visiting their relatives. I interviewed a senior officer at the District Education Office about the collaboration with NGOs, and collected statistics on enrolment, dropout, school characteristics etc. We interviewed the chair of the mother support group, and had informal conversations with other members of the group. Gertrude attended a training session for several mother support groups and village heads, organised as part of another Save Malawi project. Gertrude also attended a joint open day organised at the neighbouring school as part of RTP. I accompanied the PEA on a tour visiting the different schools in the zone during which I spoke with head teachers and several teenage mothers who had returned to school. At ‘our’ school, we interviewed a teenage mother and a girl who had ‘escaped marriage’, who were often put forward as examples during donor visits. We used the head teacher’s request for us to teach as a way of introducing our research to 150 girls and boys in grade 8 and ask them to write a truth-based story about the life of a boy or girl who had either completed education or had dropped out of school. This deepened our understanding of how poverty affected teenagers, the different reasons for dropping out, strongly framed (im)moral behaviour and the struggles involved in becoming ‘successful’.

Photos 3.4. Donor visit at the primary school; and Merged classroom grade 8.

Figures 3.4 Distribution of health and education facilities in Mangochi (Mangochi District Assembly unpublished document)

Health centres

In the area, there was a health centre operated by the Catholic Church, which fell under the auspices of the Christian Health Association of Malawi (CHAM). Originating in mission hospitals, CHAM has a long-standing collaboration with the government and currently provides 75 % of health services in rural Malawi (CHAM 2016). CHAM is the largest non-governmental service provider, though not considered a NGO in Malawi. There was also a small private clinic belonging to a local company. Both required user-fees, however, the CHAM health centre had a user-fee exemption policy (service level agreement – SLA) for maternal and neonatal health services and the private clinic had a SLA for contraception and essential drugs.

The nearest public health facility with maternity ward was the district hospital, at 20 km distance. The district counted two public hospitals, 10 public dispensaries, and 13 public health centres (Mangochi District Assembly). In addition, there were 15 CHAM health centres (four had a SLA), of which two were hospitals and a further two private clinics (Figure 3.4). The nurse/patient ratio was 1:4301 (Mangochi District Assembly). In 2016, ICEIDA was in the process of constructing a new maternity ward in town. The MP and

councillor were in negotiations with a nearby tourist lodge regarding financing the construction of a public hospital in the area.

BLM was responsible for the reproductive health component of RTP. Their task was to organize reproductive health outreach activities, train health providers in Youth Friendly Health Service (YFHS) provision and train Youth Community Based Distribution Agents. The CHAM facility near the village was Catholic and did not provide contraceptives. Therefore, RTP trained two Health Surveillance Assistants (community health workers) and two nurses at the private clinic. RTP also encouraged health centres to start youth clubs to discuss SRHR issues.

Youth friendly health services

I interviewed health personnel at the two local health centres, the Catholic Health Commission (CHC), which was in charge of the CHAM health centre, and at BLM's clinic in town. I also interviewed two health surveillance assistants in charge of the surrounding villages. I asked these actors about teenage pregnancies, youth sexuality, contraceptive use among youth, and community responses to the services. We visited three BLM outreach centres in the district (one near the primary school), where we spoke with staff and observed how they provided information and services. I also interviewed staff at Malawian NGO Youth Net and Counselling (YONECO) about their activities, and a sex worker who was in charge of activities at one of their local village offices. When I was away from the field the local NGO's youth club became active, and Gertrude participated in their activities during which, among other things, sexual and reproductive health and rights issues were discussed. During this period, she also participated in the training of a local youth CBO in peer YFHS provision, as part of YONECO's programme.

Because in my articles I only touch upon this component of RTP, I elaborate on some findings here. As part of the RTP project, BLM had one outreach team, which served three districts. This meant they spent approximately one week in every district, in which they had to cover seven education zones, with each comprising between 10 to 15 primary schools. This meant it was not possible to visit every site once every three months, the ideal frequency according to the staff. Prior to their outreach, BLM gave health talks at a nearby primary school. They informed both boys and girls about the offered services. Staff explained they emphasized the importance of working hard in school and that the best thing to do is to abstain from sex. They had to emphasize this in order to be accepted at the school and in the community, as many people worried that providing knowledge on contraceptives would

encourage youth to start having sex. BLM's common phrase, "It is best to abstain, but for the ones who cannot abstain, please use a condom" was echoed repeatedly. BLM also discussed "misconceptions" around contraceptive use and promoted HIV testing. After school hours, young people could visit the outreach tent where they received information and watched a demonstration of different contraceptives and condoms. Again, the message to abstain was prominent. BLM staff explained the outreach activities were often well visited. Out-of-school youth and adults from the community were also able to receive free contraceptives and HIV testing. Despite some initial struggles, staff explained that after revisiting the same sites repeatedly, the chiefs and the communities became more accepting. Unfortunately, in our group village, their visit was not sufficiently announced and only few young people had the opportunity to make use of the services. During their health talks, BLM encouraged youth to visit the nearest health facility for family planning and advised them how to address the health worker in order to receive what they needed. According to BLM staff, there was a huge demand for contraceptives; however, there is structural underfunding. Since RTP only funds the team for three years, continuity of their services is not guaranteed.

There were some problems with the YFHS training. First, the RTP district team explained that some health workers had walked out of the training because BLM did not provide allowances. The training had to be repeated later. During the RTP annual meeting another problem was discussed. Some health providers had already received training in YFHS as part of other NGO projects, but had pretended to lack the knowledge in order to receive new training and thus the allowances. The HSA in our village explained she had been trained, but due to contraceptive shortages, only the other HSA actually provided them. Despite their training and willingness to provide services, the nurses at the private clinic related that only a few young people accessed the services out of fear of meeting their relatives or neighbours at the clinic. The same youth CBO who was trained by YONECO was supposed to be trained as part of RTP, but by the time the project was reaching an end in 2016, they still had not been trained, because of problems with BLM's allowance policies. Nor had they received contraceptives. Although CHAM did not provide contraceptives and knowledge on SRHR, the health centre did start a club for HIV positive youth in the spring of 2016. The local NGO started providing free condoms towards the end of fieldwork. Condoms could also be bought in various shops.

Actors at the local level perceived teenage pregnancies and education as closely interlinked. The midwives at the CHAM health centre in the village were in agreement that promoting the importance of education was the best way to curb the many teenage

pregnancies. According to them, the low interest in education among the Yao led to early marriages and teenage pregnancies. By keeping girls in school, child bearing could be delayed they argued. At the same time, they worried about the lack of access to contraceptives. However, the midwives had other worries, as they faced the consequences of a health system that was in a service delivery crisis (article 3).

Photos 3.5. BLM youth friendly outreach service; and Traditional dance during organised donor visit

Health service crisis

During interviews with various actors, a full council meeting, and from newspapers, I repeatedly noticed the state of crisis of the Malawian health system. There was a lack of funding, a lack of medication, of fuel and food for patients, a lack of capacity including closed health centres, poor quality of services including overcrowded maternity wards, delays in the payment of salaries, and suspension of outreach clinics. District Health Officers were banned from speaking to the media. The Malawian newspaper, *The Nation*, had introduced a “health systems crisis” logo.

One problem in particular caught my attention; problems with the payments of service Level Agreements and the consequences this had for the quality of maternity care. As I discuss in article 3, the user-fee exemption policy at the CHAM facility was ‘falling apart’ as a result of suspension of donor funding, shifting priorities at the national level, and unstable service contracts between the government and CHAM. In January 2016, the health centre reintroduced user-fees for maternal health services. These problems were in sharp contrast to the focus on Safe motherhood and skilled birth attendance that were so central between 2012 and 2014. I therefore decided to follow the unfolding of events; how the health centre dealt with financial setbacks and how this influenced patient care. I interviewed and had follow-up conversations with a project manager of the Catholic Health Commission, the nuns and

midwives at the health centre, and Health Surveillance Assistants. We also collected statistics on the number of births, antenatal and postnatal care registrations at the health centre over several years. We examined the village birth registration book.

We observed the health centre during our visits, noticing for example that midwives were assisting in other wards when institutionalised births decreased. But we did not conduct participant observation at the labour ward for a sustained time. I requested this multiple times, but never received an answer. Neither did I get permission to interview or observe at the maternity wing at the district hospital. The District Health Officer (DHO) was non-responsive when I approached him for an interview. I did interview the then Minister of Health about the situation with the service contract, the crisis in the health sector, and relations with donors and NGOs. I approached the Minister for this interview, after my supervisor, Katerini Storeng, and I had unexpectedly met him at a lodge on the way to Mangochi.

Photos 3.6. User-fee announcement; and Bed in CHAM's maternity ward (photo credit: Katerini Storeng)

NGOs	Community	Health sector	Education sector
RTP (district staff, head office staff, project activities)	Traditional Authority	Minister of Health	District Education Office (senior officer)
Other Save Malawi projects	Group village head	CHAM health centre (nuns, midwives)	Primary Education Advisor
BLM (director, nurses and outreach)	Village head	Private Clinic (nurses)	Primary school management
Local NGO 1 (director, staff, youth club, training youth CBO, various other activities)	Elders/advisors	Health Surveillance Assistants	Teachers
SEED Malawi (chair Mangochi CSO network)	Mother Support Group	Statistics on uptake of maternal health services at CHAM	Students grade 7 and 8
Catholic Health Commission (project manager)	Councillor	Village birth register book	Statistics on school enrolment and dropout
Local NGO 2 (project manager)	Villagers		Visit to other schools in the education zone
Mangochi Quadriyya organization	Community Based Organization		NGO and government organized meetings and trainings (incl. teacher training and mother support group training)
Islamic information bureau	Imam		
YONECO	Initiator (interview and participant observation)		

Table 3.2. Overview data

4. Positionality, ethics and analysis

Veracity (how well does the study succeed in its depiction?) and objectivity (how well does the study transcend the perspectives of the researcher and of the informants?) are important for judging the quality of ethnographies (Stewart 1998). In the previous chapter, I created a trail of my ethnographic path and specified the research context, which contributes to objectivity, as it sets out how I collected my data and what I base my claims on. Reflexivity is also of key importance in ethnographic research (Hammersley and Atkinson 2007). In this chapter, I describe how the apparently complex context of development projects provided specific challenges for data collection and analysis, and raised particular ethical challenges. Due to these challenges related to my positionality, creating trust relationships required intensive effort, and prolongation of fieldwork was necessary to achieve veracity (Stewart 1998). I also describe how my positionality affected the statements of informants and how I dealt with this analytically. This allows for making larger claims and contributes to objectivity (Stewart 1998).

Positionality

My positionality in the field has shaped my relationships with informants, the methods I used and the data I collected. In general, I strongly relied on informal conversations and participant observation, and less on formal interviewing. I will discuss my reasons for this approach through a discussion of positionality in relation to power.

Power is a core feature of health policies and systems (Freedman and Schaaf 2013; Sriram et al. 2018) and NGO development projects (Hilhorst 2003). In the case of health systems, Freedman and Schaaf (2013) argue that power is present at each actor interface, shaping actions, processes and outcomes. Therefore, I suggest conducting research in the realm of INGO health development projects, especially when undertaking a multi-layered ethnography since such a project inevitably places the ethnographer within a web of power relations. There are power relations between and within sites, and sites have diverging and sometimes similar goals which shape interactions between actors. While attempting to maintain a neutral position by behaving with understanding towards various perspectives and respectful towards all sites, a researcher is never perceived as neutral. In Malawi, I had various experiences whereby actors ostensibly perceived me to be part of the aid structure; as a donor or a staff member of a Northern INGO. For example, during a RTP organised meeting members of a mother support group asked me to include the distribution of umbrellas in the

project so they could use those during household visits. Verheijen (2013) and Dionne (2018) have also described these experiences in Malawi. Dionne employed research assistants for data collection to circumvent social desirable answers related to development discourses. Verheijen strongly relied on data derived from a whole year of naturalistic participant observation.

One of the development-related practices that seemed to relate to my positionality was what Olivier de Sardan (2015), in the context of donor-dependent health systems, refers to as “doublespeak”¹⁰. There seemed to be double discourses at all sites: an official one communicated to donors, NGOs and initially to me, and one that reflected local realities more accurately and at first remained hidden, but which we could access by emerging ourselves in the field and establishing trust. For example, at the school I realised there were two discourses. At the start of fieldwork, the head teacher and one of the female teachers staged a youth club activity to show us how they aimed to reduce teenage pregnancies. Afterwards I asked if we could participate again next time. The teacher mentioned that they organised the club once a week. When I asked about the day, she seemed to hesitate, answered “Wednesday”, and said she would call me to let me know. However, I never received a phone call. We later learned that youth clubs do not take place in this form, but that teachers integrated messages in their daily teaching routine. We also learned that, during donor visits, teachers presented the youth clubs as if they took place in their official form. Similarly, among RTP staff, there was a public discourse in which they praised the project and a private discourse in which they were critical of it. Village representatives also applied different discourses. For example, the group village headman told us over the phone – not realising he was talking to my research assistant – that he had no choice but to accept BLM’s Youth Friendly Health Services (YFHS) outreach in the village (implying he was not too keen on their presence). The next day he told us in person that he thought BLM’s presence was a good thing. Another example is a representative from the area development committee who conveyed to us that the community had stopped practicing initiation ceremonies because NGOs had told them these were bad practices. However, in several villages we observed the ceremonies were hugely celebrated, and we even participated in one.

These double discourses around the work of NGOs became important in my analysis, but also made fieldwork challenging. Especially in the beginning, I often had the feeling that actors were hiding things, and I struggled to understand what was really going on. Examining

¹⁰ See also Scott (1990) who refers to the “performance of compliance” and public and private scripts, and Goffman’s (1959) conceptualisation of frontstage and backstage behaviour.

power, as Erasmus and Gilson (2008) suggest, requires spending considerable time at a site, soaking up all information, and purposefully selecting actors to focus on. Furthermore, through interviews, the researcher can ask actors to reflect on their role, relationships to others, and their views on implementation. Furthermore, power can also be examined through reviewing documents, analysing discourse and language. However, Erasmus and Gilson suggest, direct questions about power are best avoided. I observed patiently, asked questions mostly through informal conversations, spoke with key local actors who participated in multiple NGO activities, listened to their reflections on the development sector and their ideas about other actors, and attempted to make sense of it from each actor's perspective. Throughout, I tried to understand what actors had to gain from communicating double discourses to me or to other actors in the web of power relations.

Positionality of research assistant

When we work with research assistants, reflecting on their positionality is also important. During the first fieldwork period, I had assistance from Beatrice Chibayo, a 20-year-old girl with a secondary school diploma who was waiting for admission to tertiary education. She assisted me with translating from Chichewa to English in daily life, and with numerous practicalities in Mangochi town. Being a Muslim, she familiarised me with the different versions of Islamic practice in Malawi (Quadriyya and Sukuti).

Photo 3.7. Hanneke with research assistants Gertrude and Beatrice

Gertrude Finyiza assisted me from the moment I moved from Mangochi town into the village. Gertrude grew up in Mangochi, is fluent in both Chichewa and Chiyao, and has good proficiency in English. Since 2007, she has assisted several anthropologists. Gertrude was of crucial importance to this research; she strengthened my understanding and analysis in ways I could not have achieved on my own. She helped with translating, as my vocabulary

of Chichewa grew over time but remained mostly limited to commonly used words and phrases. At times, she was also a 'cultural translator'. I would, for example, enthusiastically greet women during initiation camp, but Gertrude explained it was more appropriate to show modesty and wait until the women approached me. Gertrude was respected in the village for her ability to speak three different languages and for living and working with an *azungu*

(white person). She was respectful and friendly towards everyone. The head teacher or the director of the local NGO sometimes presented her as a role model to other girls. When we had completed fieldwork and moved back to Lilongwe, several people commented they had enjoyed our presence and thanked us for being friendly and for not disturbing anything.

In the village, both Gertrude and I adopted the identity of students, because it seemed easier for people to understand our positionality. Although people found it strange that we were not married and did not have any children at age 30 (according to local gender norms we were still girls), at the same time they seemed to accept this because of our student status. Women commented and joked that Gertrude was copying the behaviour of the *azungu* to have children at an older age. Many people asked how we had met and when I explained she had assisted one of my lecturers – Janneke Verheijen – from my Master's degree at the University of Amsterdam, they said they were happy, because they were sure that Gertrude would translate everything they might say to me. I informed them that the research was for the University of Oslo, but that my family lives in the Netherlands. People were curious and often asked me questions about what kind of food I ate back home, how many siblings I had, or if there was malaria and HIV in my country.

It was not always the case that both of us were present during conversations. Sometimes I would be transcribing interviews inside, while Gertrude chatted with girls on the veranda. She then transcribed those conversations during the evening. At other times, I joined them and Gertrude would translate. Because Gertrude had worked independently before, I felt comfortable with her collecting data for four and a half months while I was in Oslo. During my absence from the field, Gertrude sent me weekly reports of what had happened in the village. She mostly wrote about conversations she had had with people we already knew. Her reports contained rich material, often consisting of the exact words people had said, her follow up question or comment and the person's answer to it. This enriched the material on the village level. A difficulty with this arrangement was that I could not immediately ask follow up questions, because I read the texts a week later. We discussed the data during our weekly phone calls and decided on follow up questions and topics. I have included Gertrude as co-author on one of my articles.

Research ethics

The NGOMA research project obtained ethical approval from the Norwegian Social Science Data Service (NSD) and the National Committee on Research in the Social Sciences and Humanities in Malawi. Following local ethics approval, I obtained permission from the

District Commissioner, the Traditional Authority, the Group Village Head and the Village Head to conduct research in the area. Furthermore, NGOMA signed a Memorandum of Understanding with Save the Children (see appendix for all approvals). Applying ethical guidelines in the context of participant observation is not straightforward, as I discuss below. Furthermore, multi-layered frameworks bring specific challenges.

Informed consent

Ethical guidelines are cultural and reflect ideas of appropriate research behaviour (Hammersley and Atkinson 2007). Informed consent, originating from biomedical science, means informing participants about the full aims of the study, possible harms, and asking them to give written or verbal consent to participate in the study (Duncan and Watson 2010). During interviews, informed consent took this form. I informed people about the research, my background, and whether I could ask them some questions in relation to this. I asked them for oral consent (in accordance with NSD guidelines) to use the interview for my study, which everyone agreed to. I gave interviewees my business card and some of them asked if I could share the articles with them after publication, which I did.

However, in ethnographic research informed consent is not a box that can be ticked off, but should rather be seen as an ongoing process (AAA 2012; Duncan and Watson 2010; Miller and Bell 2002). This was, for example, the case with RTP staff. I explained my sub-project to the Mangochi district staff and asked if I could use our conversations and observations for the analysis, which they agreed to.

However, complex power dynamics might be at play around access and consent (Miller and Bell 2002). When conducting research within an INGO, the anthropologist can potentially move along the aid chain: from the village to the district office, to the national office and all the way to the donor. Depending on the situation, I suggest, INGO staff can perceive this as an ‘asset’ or as a ‘risk’. This complex positionality can open up or foreclose access to sites and events and thus consent to participate in activities. This implies that access is something that has to be continuously negotiated. For example, the RTP project manager invited me to the annual meeting and presented me to participants, saying “we even have a researcher in the village to better understand the communities”. In this situation, I became an asset.

Similarly, the RTP project coordinator and community facilitator were, at times, eager to show us how they implemented the project, as well as to share their frustrations. They could not always voice these frustrations to the head office (because of the hierarchy) and

regularly expressed the desire for me to write about them so that maybe things would change in the aid structure. This mostly related to work pressure, reporting, experienced gaps in the project, short-term funding, and struggles they experienced during implementation (e.g. with allowance and ‘culture’). On the other hand, they asked if my research could contribute to getting a new round of funding, because they lamented that three years was not long enough to achieve a real impact. I often answered that I understood those frustrations and would try to incorporate them in my analysis, but that I could not help them make the project more successful. Sometimes RTP staff pointed out that certain information was confidential, for example, by saying “between you and me...” or “don’t include this, but...” I have respected their wishes by not including references to this in my articles. However, it did provide background information. I suggest that an ethnographer can embody an asset when she is able to communicate upwards what actors cannot express themselves.

On the other hand, ethnographers can pose a risk. This was apparent, for example, during an orchestrated donor visit when the ‘production of success’ was central. This put me in a difficult position – the head teacher had invited Gertrude and me to a donor visit with Save Norway, but the RTP team had not informed us about the activity. It is likely that they perceived me as a risk factor at that moment. I decided to attend, but this required some ethical reflection. To what extent was there consent from all parties involved? During the donor visit, I tried to minimise my influence as much as possible. While we waited for ‘the visitors’ to come out of the classroom, a RTP staff member told me he was so happy that all the youth clubs were functioning the way they were supposed to and that the project was so successful. He ‘performed success’ in this setting, and also to me, whereas during private conversations he was more critical. Such a donor visit is an example of how I reflected on my positionality and how this influenced the data I collected.

Furthermore, pressure to consent might have been applied from above; obviously, there are power relations within the organization. Save Norway granted the NGOMA team access to the RTP project, and Save Malawi staff might have felt pressured to agree to our presence. Although it is difficult to assess the influence of internal power dynamics and how this played a role in consent, that a certain pressure was being applied from ‘above’ became apparent when a district staff member told me that the Save Malawi country director had asked how I was doing and if they were taking good care of their guest. District staff members seemed to assume a certain responsibility for my wellbeing. They insisted on helping with buying furniture and other things for the house and with finding someone to fix the car when it broke down. And although they agreed to my presence in the project, they had the power to

include or exclude me from certain activities throughout my fieldwork.

That informed consent is an ongoing process (AAA 2012; Duncan and Watson 2010; Miller and Bell 2002) also became apparent in the village. The fact that the village head, who can be considered a gatekeeper, did not make an effort to introduce us during a community meeting made informed consent challenging. The ethical choice I had to make was either to bypass the village head and introduce myself and Gertrude during the village meeting without his announcement, or start the research without an official introduction (as he suggested we should do). After careful consideration, I decided it would be more unethical – considering local rules – to bypass the chief. However, this had consequences for consent from villagers.

Our initial experience with explaining the research at households, and women asking how they would benefit or girls not seeming keen to talk to us, cannot be considered informed consent. Rather, perhaps, it was a form of refusal. As Tyldum (2012) argues, researchers often apply subtle forms of pressure to recruit respondents, yet this is often not acknowledged as such. Examples of this are financial incentives, but also the use of gatekeepers who can have certain power over the respondents, or the building of trust after which respondents feel they cannot refuse to participate (Tyldum 2012). If pressure is applied, Tyldum argues, it is important to ensure respondents are not at risk of any harm. Although I do not necessarily agree that building trust – a key component in ethnographic research – is a form of pressure, Tyldum's arguments do provide some guidance for reflection.

Even though some women and girls showed some initial resistance, we continued interacting with these villagers and took notes of conversations and observations. Over time, we developed good relationships with them and they disclosed more. Our informal approach to a certain extent ensured that people themselves took the lead in conversations and disclosed what they felt comfortable with. However, if we asked follow-up questions, people sometimes avoided answering – for example, when girls did not want to reveal how they had earned money, implying they received it from a man. Because of the problematic interactions at the start of this research, I wanted to explain once more – before we moved out of the village – what we would use their stories for. We visited the village heads, elders, families and teenagers we had talked with throughout the year and asked them explicitly if we could use what they had told us for the research and that we would not use their names. This also applied to the conversations Gertrude had had without me. Everyone agreed to this. We gave a piece of clothing to everyone involved in our research as a way of thanking them for their participation. The group village head and his advisor asked us to share the findings with them. In accordance with the African Studies Association (ASA 2005) guidelines, I promised I

would do my best to give them a copy of my ‘book’.

Asking for informed consent in development activities was more complex, because this involved a gatekeeper who might apply pressure (Tyldum 2012). Therefore, when the head teacher or Save Malawi staff invited us to join development activities, I also asked permission from the facilitator – either an NGO staff member or a mid-level public servant – to participate. Each activity started with a round of introductions during which we introduced ourselves, stated the village where we lived, disclosed that we were conducting research, and expressed that we wished to learn from the meeting about how they engaged with development. However, it should be borne in mind that the researcher and the gatekeeper still hold considerable power. Even if people wanted to object to our presence, they probably would not have done so in a group. On the other hand, these meetings can be considered semi-public, and so would not require informed consent.

Open and full disclosure of objectives is one of the principles related to informed consent. However, I deliberately did not disclose the exact topic of the research. Rather than stating my specific interest in the RTP project, I explained I was interested in development and NGOs in general. Considering the “performance of compliance”, I was worried that disclosing my interest in the project might influence actors’ efforts to implement the project as intended. As (Hammersley and Atkinson 2007) argue, revealing the exact topic of interest can produce unreliable conclusions. Instead, I asked questions about NGOs and development in general, and about RTP as one of the projects in that sphere.

I was also interested in understanding the broader context in which teenage pregnancies and school dropout occur, which justified a broad approach. I explained to people that I was interested in how they lived their lives and what it was like to grow up in a Malawian village, and stated my broader interest in development initiatives. We assured people that they were free to talk about anything they wanted, that we would keep this information to ourselves, and that I would eventually write about our findings without mentioning their names. Because we considered teenage pregnancies a potentially sensitive topic, I decided not to specifically state my interest in this issue.

In this case, two ethical principles that are stated in the ASA (2005) and AAA (2012) guidelines – “open and full disclosure of objectives” and “do no harm” – are conflicting. According to the American Anthropological Association’s (AAA 2012) code of ethics, it is the researcher’s responsibility to make sound judgements when such conflicts occur. I considered the implications of full disclosure of the research topic as possibly doing harm to participants and I decided it would be ethically justified not to disclose our interest in teenage

pregnancies. As Frye (2017) argues, girls' sexuality and education are considered contentious issues in Malawi, and parents and teachers might punish girls for sexual activity. If we had fully disclosed the topic, girls might have experienced harm when talking to us.

Hammersley and Atkinson (2007) argue that "while ethical considerations are important, they cannot be satisfactorily resolved by appeal to absolute rules, [...] the effective pursuit of research should be the ethnographer's main concern. It is the responsibility of the ethnographer to try to act in ways that are ethically appropriate, taking due account of his or her goals and values, the situation in which the research is being carried out, and the values and interests of the people involved" (p.228). I have tried to adhere to this throughout.

Confidentiality and anonymity in multi-layered ethnography

In multi-layered ethnographies that involve NGOs, confidentiality and anonymity are challenging issues. In today's global health landscape, especially when researchers extend their ethnographic gaze beyond local communities to also include experts, there are no clear boundaries between research participants and the audience; people can be both (Pigg 2013). This holds special challenges, particularly when research involves hiding certain practices and perspectives (Pigg 2013), such as "private speak" (Olivier de Sardan 2015). This also raises the ethical question of what informants have consented to (Miller and Bell 2002), since I did not know in advance what my analysis would be.

A way of rethinking participant observation in the light of this complex ethical and political landscape, Pigg (2013:132) suggests, is to be mindful of context, socially differentiated points of view, social structure, practice, accountability and intersubjectivity, and theoretical propositions. As Fassin (2013) argues, the important thing is to shift between perspectives and provide a nuanced analysis. Therefore, for every article, I have paid particular attention to my wording, to how I portray the actors that are involved, and to explaining what actors do while being mindful of their positionality and context. I refrained from using data that could harm participants or that would sensationalise the analysis. I intended to provide a realistic representation of local conditions and to do justice to the perspectives of multiple actors.

I became particularly aware of the politicised field after I had written a blog post with preliminary research findings on the webpage of my research institute (Pot 2016b). This was picked up by Norwegian media, published in a newspaper (Pot 2016a), and subsequently a Save the Children staff member voiced that this damaged trust, because I had not first presented my findings to them. As a result, I sent all subsequent publications to them first.

Indeed, as Sherry Ortner points out in an interview, studying NGOs and writing critically about them might harm established rapport, but not writing critically would be morally problematic because the ethnographer would be complying with power (Shryock 2017). Social science has a role to play in public accountability (Hammersley and Atkinson 2007). As Olivier de Sardan (2015) contends, it is the task of anthropologists to reveal private speak and engage in expert and public debates.

Another question that arises from this is how to ensure confidentiality when the sites are interconnected and when informants become the audience. Writing in-depth about an INGO project with two district implementers, one primary school and one health centre, potentially makes it easy to trace opinions and revelations back to individual persons. In such cases, confidentiality and anonymity might be jeopardised. In each article, I have attempted to ensure confidentiality as much as possible. In article 1, I decided to anonymise the names of two local NGOs, so it would be more difficult for the reader to trace the school. I did decide to name the other NGOs and projects, as it was a crucial part of the ethnography. I anonymised RTP staff by referring to them as Save the Children staff members, and since I had also spoken with staff at a national level and from other projects, it would not be possible to link quotes directly to RTP district staff. Before the article was published, I double-checked if the way I had referred to them as Save Malawi staff was acceptable. The district coordinator laughed about my worries regarding anonymity, just as the head teacher did. “It is ok”, they said, “because you have written the truth”. For article 2, naming the district was crucial for the argument and naming the RTP project would make it easy to link quotes and descriptions to the two project implementers. I therefore decided to send the final draft to the RTP district coordinator and ask his advice regarding his anonymity. He mentioned that naming the project – as I had done in the first article – would “carry weight” in the district and that both articles reflected realities on the ground. He even asked me to mention him by name, as he seemed to feel proud to be associated with it. In article 3, I anonymised the local NGO that was involved in trying to ‘fix’ the situation, so it would be more difficult to pinpoint the health centre and the village. People who can be identified in their professional capacity – such as the Minister of Health – have given permission for me to do so. I refrained from mentioning the specific location of the village in any of the articles so as to guarantee the anonymity of villagers. However, for people with local knowledge it might be possible to identify the village.

Analysis: Taking notes, critical thinking, and developing concepts

Ethnographic fieldwork is an iterative and inductive process, which builds up to a rich contextualised analysis. Recording notes and observations in a field journal, having analytical conversations with research assistants, and writing analytical notes are an important part of this process. Here I discuss how we recorded our data, the opportunities and challenges for critical thinking while conducting fieldwork, the blurred boundaries of the field itself, and how the development of concepts has helped me attain distance and analyse the data.

Most of our data consisted of elaborate field notes. During conversations with villagers, Gertrude often translated to me verbally and took short notes on her phone. However, when we spoke with village heads or their advisors we sometimes did bring a notebook when we had many detailed questions. Interviewees often waited patiently until Gertrude had written down the answer. She transcribed the notes at home, or dictated to me while I typed and she prepared lunch or dinner. This became our ritual twice a day. During these moments, I also transcribed detailed notes from interviews, and informal conversations we had conducted in English. Conversations with public servants or NGO workers were in English, and also a few villagers could speak English.

Gertrude transcribed notes from NGO or village meetings herself. When an interview or meeting was in Chichewa or Chiyao, Gertrude took notes in English so I could read along. Apart from the literal translation, she wrote down comments, such as *people do not look interested* or *they complain about allowances*. I also wrote down my observations. Obviously, she missed out on some verbal information, but because the meetings often seemed quite tense with few active participants and complaints about allowances, I did not want to draw attention away from the facilitator by asking permission to record. Similarly, because of the prevailing double discourses, I felt interviews and conversations would flow more naturally without recording them. There were a few exceptions: I recorded the focus group discussion with teachers, the interview with the minister of health and the initiator.

During our evenings, we often had interesting analytical discussions where I also took notes. These were important because Gertrude's interpretations (as a partial insider) were sometimes different from mine (as an outsider). I then used these conversations to ask follow-up questions. I also kept analytical notes during fieldwork, tried to answer my research questions and identified gaps. However, these analytical reflections were not always easy due to the extreme heat, power cuts, children playing on the veranda, or people visiting us during the evening.

Even though conducting this research was extremely fascinating and an invaluable experience, living in a village in one of the poorest countries in the world was at times emotionally and physically tough. People constantly asked me for money for all sorts of things – they struggled to make ends meet and women were giving birth at home because they could not afford the user-fees. Furthermore, my own health failed me at times and I became a real participant observer in several local health centres. Unfortunately, Gertrude and I were involved in a car accident near the village as a result of which a three-year-old girl ended up in the district hospital. We also experienced the fear of witchcraft during initiation and an attempted burglary during the night. Although I also learned from these difficult experiences, breaks from the field have been important to be able to take analytical distance.

However, ‘the field’ and ‘home’ are not separated spatialities, but interconnected places that are negotiated and constructed (Gupta and Ferguson 1997). Technology, in my opinion, blurs these boundaries even further. Fields and data continue to enter our lives even though we have physically left. WhatsApp is an important communication medium in Malawi, because it is relatively cheap and an easy way to communicate. During fieldwork, I communicated via WhatsApp with a range of informants, who sent me good morning GIFs, jokes, videos, but also invitations to meetings. For example, when the head teacher had installed WhatsApp on his phone he invited us to more meetings than before. The director of the local NGO sometimes invited us to meetings using WhatsApp, and occasionally we discussed the meeting afterwards partly face-to-face and partly on WhatsApp. These interactions continued when I was in Oslo. Participants kept sending me updates and I used the opportunity to ask follow-up questions.

The WhatsApp conversations sometimes enriched my understanding. For example at the school and with regard to the head teacher’s role in NGO project implementation. He would text me that he was at an NGO training of trainers in Blantyre, that he was training teachers somewhere else in Mangochi, or that he and the teachers had prepared for a donor visit but the donors had cancelled. The RTP district coordinator sent me information about RTP phasing out, or reports of a fire at the district hospital, or asked me if I could assist him with analysing data from BLM on the number of distributed contraceptives. Some of the text messages I have included as data, for which I specifically asked permission. In fact, Gertrude and I are still in touch with some teenagers from the village who sometimes send us jokes and updates.

Although ethnographic fieldwork is an iterative and inductive process that builds up to a rich contextualised analysis, analysis at a higher level can take place when the

anthropologist acquires distance from the field. I started by closely reading and organizing the hundreds of pages of field notes in broad categories – such as ‘stereotypes’, ‘NGO activities’, ‘contraceptives’, ‘village governance’ and ‘RTP’ – using NVivo Pro. I read literature and searched for concepts that could open up my data and allow me to analyse what was going on. This way of working, in preference to relying on pre-defined theories, characterises the ethnographic method (Hammersley and Atkinson 2007). Just as projects are reshaped and translated up and down the aid chain, as I will show, so anthropologists are involved in interpreting and translating their data into written text (Fassin 2017). Analysis starts with identifying interesting patterns, puzzles or contradictions between views or groups (Hammersley and Atkinson 2007). However, preliminary ideas are also shaped during fieldwork. Very early on – and keeping the overall research question on dynamic interactions in mind – I became particularly interested in the reshaping of NGO projects along the aid chain, the overlapping initiatives on girls, the centrality of the school as a venue for development activities, the strong stereotypical ideas about the Yao, and the crisis that emerged in the health sector. I chose to focus on these topics and puzzles in my analysis and approached them from different actor perspectives.

As Hammersley and Atkinson (2007:163) put it, “ethnographers collect data of various kinds from different sources [...] and they seek relationships across the whole corpus. Here the aim is to compare and relate what happens at various places and times in order to identify stable features [...] that transcend immediate contexts”. As such, Mangochi can illuminate broader trends about the changing role of (I)NGOs in today’s development landscape. I therefore paid particular attention to the triangulation of my data across multiple sources, times, and techniques, which, according to Erasmus and Gilson (2008), is important, alongside context and nuance, when dealing with issues of power. I aimed, following Fassin (2017:23), “to confront the various discourses with each other, to relate them to the social position of the agents, to compare them with facts observed in the field, and to interpret them in light of other sorts of knowledge – historical, sociological, and philosophical, in particular”. In the next chapter, I will discuss the analytical concepts I used and provide further details about the questions I asked of my data.

5. Analytical concepts: global to local project implementation

Although rich descriptions of actors and context are of key importance, ethnography also needs to engage with, and contribute to developing, theory and concepts (Stewart 1998). Concepts should grow out of the context and be used as a lens to look at the data and open up for generating an analytical understanding. Good ethnography also allows for generalisation, which Stewart (1998) refers to as *perspicacity*. When concepts and theory are sufficiently specified to the local context, ethnography can generate insights that are applicable beyond the specific site. This requires exploration and intense consideration of the data – for example searching for reorienting or disconfirming observations. One can also compare findings to ethnographies concerning other times or places (Stewart 1998). Hammersley and Atkinson (2007) argue that theorizing “ought to involve an iterative process in which ideas are used to make sense of data, and data are used to change our ideas. In other words, there should be a movement back and forth between ideas and data.” (p.159)

The nature of my research required developing an interdisciplinary perspective to analysis. After intense reviewing of literature in the fields of medical anthropology, public health and the anthropology of development, I landed on three main concepts that I found particularly useful in analysing my data: 1) *Travelling models*, which allowed me to conceptualise the implementation of globally designed health development initiatives and their gaps with the local context. 2) *Brokerage*, which allowed me to analyse the role, agency and practices of differently positioned actors involved in project implementation and how they reshaped travelling models locally. 3) The concept of *culturalism* allowed me to place travelling models within a behaviour change focus in a broader context of critical medical anthropological research and analyse how brokers blame culture. I will discuss each of these concepts in this chapter and specify the questions I asked of my data.

Travelling models: Health interventions and global norms

Differently situated actors deal with multiple policy ideas and initiatives that originate from the Global North. This implies that donor-driven health and development initiatives – implemented by (I)NGOs – are often highly uniform (Olivier de Sardan et al. 2017), for example based on a set of global guidelines to improve maternal health or adolescent health and wellbeing. The idea is that certain approaches work everywhere, regardless of context. Context is thus considered background noise, rather than crucial in developing successful interventions (Adams et al. 2014). Medical anthropologists have associated uniform policies

that are less tailored to local specificities, ethnic and national identities with the potential failure to improve health (Adams et al. 2014; Biehl and Petryna 2013:8; Whiteford and Manderson 2000:2). Although public health is beginning to understand the importance of context, the idea of uniform interventions itself seems to be “untouchable” (Olivier de Sardan et al. 2017:72).

Olivier de Sardan et al. (2017) term such policies, interventions and protocols “travelling models” based on “miracle mechanisms”. Such models are founded on a success story in one context, and then simplified to a mechanism stripped from context that is believed to be responsible for its success. Complexity thus is reduced to simplicity. These models can be both vertical (disease specific, narrow, technocratic) and horizontal (broader system strengthening), but always contain a core component of social engineering – e.g. changing health worker behaviour. The wider health and development field is full of such travelling models. Travelling models discussed in this dissertation are skilled birth attendance and user-fee exemption policies (article 3), and ‘the girl effect’ underpinning many girl-focused initiatives (article 1 and 2). The RTP project is built on multiple travelling models.

As Olivier de Sardan et al. (2017) argue, travelling models often fail to work as intended. Local actors selectively adopt or resist the models, because they do not match with the context. Furthermore, they are stacked on top of one another. ‘Implementation gaps’ emerge because health workers’ behaviour is often shaped by practical norms and professional cultures, rather than official norms. Their routine practices often remain hidden and are not examined in public health literature. That travelling models are designed globally makes their success or failure an outcome of the behaviour of all actors in the aid chain (Olivier de Sardan et al. 2017). In my articles, I show what happens to these travelling models in the local context. I do this by making use of the concept of brokerage.

Brokerage: Agents and agency in the health development landscape

The analytical concept of brokerage used in the anthropology and sociology of development proved useful in making sense of my observations in Mangochi. Multiple actors were involved in implementing donor-driven initiatives: NGO district staff, teachers, health workers, CSOs, chiefs, and village committees. As Roalkvam, McNeill, and Blume (2013) argue, different actors relate to one another in various ways and have unequal power and different values and interests. The concept of brokerage aligns well with actor-oriented approaches in development while also accounting for structures of power (Lewis and Mosse 2006). The concept allowed me to analyse the role, agency and practices of differently

positioned actors in project implementation within webs of power relations, and to elucidate how project implementers were positioned differently in the aid hierarchy. Each particular position came with opportunities and constraints. In order to make the most of the situation, both for themselves, their environment (e.g. families, the school), and the beneficiaries, and adapt global norms to the local context, they mediated and reshaped development projects. This resulted in a transformation of projects on the ground.

Brokers and translators have been theorised as intermediary actors positioned between donors and beneficiaries – the beginning and end of the policy chain – who play a key role in development initiatives (Bierschenk, Chauveau, and Olivier de Sardan 2002; Lewis and Mosse 2006; Merry 2006; Watkins et al. 2012). Generally, these intermediaries tie together different interests through acts of translation and organize development interfaces, but also pursue their own ambitions. The actors who embody these positions and their particular roles have changed over time, largely in accordance with changes in the ‘aid landscape’ and approaches to development. The changing role of NGOs – as described in chapter 2 – is reflected in the roles and positions of local development brokers.

One of the first analyses of brokerage is Clyde Mitchell’s description of the intermediary role of Yao village chiefs in Malawi, who brokered between the colonial administration and kinship structures (Bierschenk et al. 2002; Gluckman, Mitchell, and Barnes 1949). On behalf of the British, Yao chiefs collected hut taxes for example (Vail and White 1989). Gluckman et al. (1949) conceptualise chiefs as passive agents, caught between two value systems (not a plurality of actors), and furthermore as receiving no gains from their broker role (Bierschenk et al. 2002). Boissevain (1974) was the first scholar to describe brokers as active intermediaries who benefit from their position (Bierschenk et al. 2002). In the late 1970s, anthropological engagement with the concept of brokering largely disappeared, because of shifting trends within anthropological theory from cultural essentialism to Marxist and Foucauldian inspired analyses that engaged with issues of power from a more distant perspective (Lindquist 2015; see also Ortner 2016).

Neoliberal reforms in developing countries brought the broker back in focus. Bierschenk et al. (2002) coined the term “local development broker” and described its emergence in relation to neoliberal policies, political democratization and the emergence of NGOs who increasingly acquired development funds. This is intimately linked with the implementation of Structural Adjustment Programmes in the 1980s, and the emergence of NGOs as service providers in the health and education sector, as described in the introduction. Bierschenk et al. (2002) conceptualize local development brokers as representatives of local

communities; crucial in mobilizing resources and communicating needs to donors, but also in “respond(ing) to the dynamics of ‘project availability’ in the development world” (p.24).

As noted in the previous chapter, Malawi historically has a weak civil society (Robinson 2017). NGOs largely emerged after the turn to a multi-party democracy in 1994 and played a crucial role in implementing donor-funded initiatives and Western development discourses (Thornton et al. 2014), and service provision in reproductive health (Robinson 2017) and education (Kadzamira and Kunje 2002). Currently, NGOs play an increasingly large role in co-shaping policy and in implementing global priorities, rather than representing the grassroots. The role of the state is increasingly ‘hollowed out’; donors suspend budget support and channel funding to NGOs. The changing role of the state and NGOs translates into the role of local development brokers.

Indeed, Lewis and Mosse (2006) argue that with new forms of transnational connections between people, information and ideas, the roles of local development brokers have diversified. Therefore, they advance the analytical use of the concept of brokerage by building on actor-oriented approaches and ‘translation’. They examine interactions between differently positioned actors in the aid chain, and their production of interpretations and scripts in which others can be temporarily engaged. Lewis and Mosse argue that brokers’ interpretations are performative: they enrol others in their version of the world (2006:13). This means, for example, that actors ‘perform’ project success during donor visits to schools because they want the projects to continue. This also explains the existence of the double discourses I described in Chapter 4.

Thus, development projects become real through acts of translations, the linking of interests of different situated actors, and the sustaining of interpretations (Lewis and Mosse 2006:13). Based on their subject positions, actors might have diverse ideas of what a project does and should achieve, which might be different from the stated goals of the project. However, brokers are also vulnerable actors who often occupy unstable positions. Studying the role of brokers is crucial to examining what happens to policies and projects on the ground (Lewis and Mosse 2006) and can illuminate broader contexts and processes (Lindquist 2015). Such an ethnographic approach to brokerage can thus open up ‘the black box’ of development aid and public health projects.

As articles 1 and 2 show, brokerage is particularly useful in analysing actors’ increasing role as ‘norm entrepreneurs’ aiming to modify the conduct of beneficiaries, in tandem with the increased importance given to the promotion of global norms (Bierschenk 2014a; Fichtner 2012). In this context, Merry’s (2006) conceptualisation of the term

“knowledge broker” is useful to describe individuals who translate discourses and practices operating in fields of unequal power, channelling the flow of information from one space to another. Because they often have greater knowledge of, and commitment to, one side rather than the other, knowledge brokers determine this process of translation (Merry, 2006).

Koster and van Leynseele (2018) take this a step further and analyse the role of brokers in relation to the proliferation of actors, organisations and institutions involved in development, which are dynamic and thus never stable. They argue that in such “messy” settings on the ground, brokers become assemblers: “they bring together different sites and actors, and, at an analytical level, they are a means of demonstrating coherence among seemingly fragmented or decoupled fields” (Koster and van Leynseele 2018:5). “The broker” they argue, “is an analytical starting point for tracing the assembling and reassembling of local practices in relation to supra-local drivers and global forces” (ibid:3). As I will show, this is the case for local actors in Malawi.

In all three articles, I analyse actors’ practices in relation to power. I characterise them as brokers who enact various roles in health development initiatives. I explain why they act in the way they do based on the webs of power relations they find themselves in, and based on their particular context. How do they broker? What do they broker? What are their perceptions on the issues at stake? How do they reshape global norms and why? What, how, when, and why do they communicate? How do they benefit from their role? What are the consequences of their actions? I analyse how Malawian INGO staff, health workers, teachers, and village heads reshape travelling models to align them with their own ideas, context constraints and to optimise the opportunities these models offer. How can their practices explain what happens to these travelling models in the local context?

Culturalism: Blaming culture

Brokers translate and bring travelling models to life, within the limitations set by the health development landscape. As I learned during fieldwork, INGO staff and senior public officials often spoke about the cultural practices of villagers as the main explanation for teenage pregnancies, school dropout and lack of development. Villagers had to be “sensitized”, which then should lead to altered behaviour. In my attempt to understand where this approach came from, I resorted to the rich medical anthropological literature on the underpinnings of such models, which may result in blaming culture.

Donors formulate interventions based on western cultural ideas (Justice 1986). Much of the policy work is shaped by ideology, especially in the field of maternal and child health

(Whiteford and Manderson 2000). Even though they are often framed as morally neutral due to their evidence-based underpinnings, travelling models in the area of sexual and reproductive health carry with them particular ideas regarding ‘correct’ behaviour (Pigg and Adams 2005). For example, women are supposed to give birth in health facilities, or attend a certain number of antenatal care appointments, and adolescent girls should delay pregnancy and remain in school. Such global norms often have particular neoliberal underpinnings stemming from the ideal of the rational, freely choosing, self-managing individual (Brown 2003; Swidler 2013). Within these dominant neoliberal framings of health, failure to comply with such norms is often labelled as an individual moral shortcoming rather than being attributed to the institutional, political and economic context (Marsland and Prince 2012). Individuals are thus held accountable and responsible for improving their own situation. Implemented in non-western settings, such as Malawi, the notion of ‘culture’ as behavioural determinant can easily take precedence over structural explanations; a process referred to as “culturalism” (Fassin 2001). Such ideologies risk labelling fixed and homogenous cultural stereotypes as the main explanation for behaviour that deviates from intervention aims (Fassin 2001; Ryan 1972). Culturalism can result in “victim blaming” (Ryan 1972) or “community blaming” (Yadavendu 2013), holding individuals or communities responsible for their behaviour that results from cultural norms.

Concerns about health of ‘the Other’ in what we now term developing countries dates back to colonial times, when the aim was to produce healthy work populations (Lock and Nguyen 2010). Christian missions often played a key role in providing health care to rural populations. Maternal and child health in particular were of key concern and comprised a morally charged field and object of reform according to ‘modern’ Christian institutionalised birth (Vaughan 2013). Although much has changed since colonial times, some argue that dichotomies between ‘tradition’ and ‘modernity’ continue to play a role in today’s health policies (Sarelin 2014; Vaughan 2013).

This dichotomy between traditional and modern is reflected in the field of sexual and reproductive health more broadly. Pigg and Adams (2005) argue that international discourses on sexual and reproductive health have been increasingly objectified and medicalized as a consequence of the hegemonic position of science, biomedicine and risk reduction in Euro-American modern societies. This process has contributed to moralization. Dominated by a modernist epistemology that aims to reveal the ‘truth’ about nature, ‘modern’ sexuality is shaped by assumed universal ‘facts’ about the human body and attempts to create a ‘normal’ sexuality. According to this modernist view ‘local misconceptions’ about sexuality will in

time be replaced by ‘modern’ perceptions which, due to their scientific underpinnings, appear morally neutral. However, promoting ‘normal’ sexual behaviour does often have a moralizing character, especially when framed in terms of life and death (Pigg and Adams 2005). These underpinnings often mean that (global) health professionals and authorities perceive ‘local’ knowledge, beliefs, behaviours, values and practices as inferior, to ideally be replaced by ‘global’ evidence-based knowledge and behaviour (Lock and Nguyen 2010:8; Whiteford and Manderson 2000). Lock and Nichter (2002:9) suggest that NGOs take part in this process by trying to re-socialize communities through teaching them health development terminologies aimed at influencing their thinking and behaviour.

Yet, as Brada (2011) argues, ‘local’ and ‘global’ do not necessarily represent specific geographic localities, but are rather associated with distinct actors, discourses and practices. The ‘global’ is associated with claims to expertise and moral stances, whereas the ‘local’ is constructed in opposition to this as resource-limited, backwards, or inferior (Brada 2011); the ‘local’ thus inhabits an ‘Other’ position (Rieder 2016:56). As my research shows, Malawian INGO staff, who can be considered educated elites, both draw on ‘global’ expertise and morality while being rooted in the ‘local’ village (Swidler and Watkins 2017). This dual position takes particular forms in project implementation, often resulting in culturalism through reinforcing ethnic stereotypes. As I analysed my data I asked, what makes RTP staff blame culture? What form does it take? When do they employ such discourses? How does the design of the project relate to culturalism? How does all this relate to local realities?

6. Summary

In this chapter, I provide a summary of three peer-reviewed articles that each deal with aspects of dynamic interactions between NGOs and local actors, and the theoretical concepts outlined in the previous chapter.

Article 1: Public servants as development brokers: the shaping of INGOs' reducing teenage pregnancy projects in Malawi's primary education sector

Author: Hanneke Pot

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This article draws on anthropological theorising on brokerage and translation within development practise (Lewis and Mosse 2006; Merry 2006; Rossi 2006). I argue that shifting donor priorities and the ambition of NGOs to strengthen existing public structures through training workshops has created new possibilities for junior public servants – Primary Education Advisors (PEAs), head teachers and teachers – in Malawi's primary education sector to take on supplementary roles as development brokers. As such, the article contributes a new perspective to the literature on development brokers which has largely focused on brokers employed by NGOs. Drawing on one school as a case study, I show how these brokers – in various roles – actively co-construct a multiplicity of girl-focused development projects (including the RTP project) in relation to their socio-material realities. Brokers shape and translate projects up and down the aid chain in order to tie together different interests, strategically position themselves and adapt development rationales to benefit the school, students and themselves.

PEAs and head teachers strategically operate to accrue resources from NGO projects in an under-resourced education sector. Organizing development activities and facilitating NGOs' and donors' access to the school, teachers, students, and community groups, enabled these brokers to amass benefits for the school, the students, and themselves. The NGO activities became part of the school's economy, but brokers also benefitted personally in the form of allowances, which formed an important element of their livelihoods. Successful brokers received more requests from NGOs to implement project activities and gained recognition from the community.

Brokering also has unintended consequences, as it increases public servants' workload, forces them to delegate duties to subordinates and displaces classroom teaching to

make room for NGO activities. Giving priority to a multiplicity of NGO activities can, therefore, undermine broader educational goals. Furthermore, brokering reinforces existing hierarchical relationships within state bureaucracies, as more senior public servants benefit more from allowances.

Teachers operated as ‘knowledge brokers’, translating global norms on girls’ education and sexual and reproductive health and rights. Teachers carefully balanced between replicating project content and communicating a message that was acceptable when considering prevailing community norms, their positionality in the community, and their ideas related to motivating girls to focus on school. As a result, they downplayed reproductive health information in favour of encouraging sexual abstinence. Furthermore, teachers struggled to perform extra tasks in an under-resourced school and were demotivated by the lack of compensation from NGOs to perform activities on their behalf. Therefore, they did not organize the youth clubs as intended.

Good brokers are valuable to NGOs, as project implementation and anticipated continuation depend on their enthusiasm and ability to translate success upwards. As I show, public sector brokers and NGO staff collaborated to do this by being selective in the content and framing of upward translation of outcomes. The aim was to secure the continuation of NGO projects and sustaining the benefits they – and their school – received from such projects, even though these did not necessarily cover the broader needs of the students and the under-resourced school. This drive for success, I argue, prevents critical reflections from travelling up the aid chain and limits donors’ understanding of the broader unintended implications of their development initiatives.

Article 2: INGO behaviour change projects: Culturalism and teenage pregnancies in Malawi

Author: Hanneke Pot

In press: Medical Anthropology

Perceived as the greatest investment for economic development, adolescent girls currently are at the centre of many multisector health and development initiatives. As I show in my second article, it is important to examine how such initiatives are implemented in local realities. Seemingly morally neutral, they are reinvested with moral meaning during implementation. Drawing on Fassin’s (2001) theorization of culturalism as ideology, this article analyses the design, implementation and reception of the RTP project. I analyse how culturalism – in the form of ethnic stereotypes and harmful cultural practices – flows through the project and how

implementers employ such discourses for their own purposes.

A tendency to overemphasize culture is inherent to the project's behaviour change approach that aims to modify sociocultural norms on contraceptive use and girls' education in order to increase girls' 'self-efficacy' so they can remain in school and avoid pregnancy. This is underpinned by a more generalised tendency among INGOs to hold communities responsible for development while largely ignoring structural, economic and political inequalities.

During implementation, project staff – who can be considered elites in Malawi – reinforced class-shaped notions of development intertwined with education, and overemphasized a static 'culture' as a behavioural determinant of frequent teenage pregnancy and school dropout. In community meetings, behavioural and cultural factors were overemphasized to prompt community representatives to take action in line with project aims, thereby depoliticizing the issue. Staff branded initiation ceremonies of the Yao as harmful cultural practices, because they supposedly contributed to promiscuous behaviour, lack of parental interest, and early marriages and teenage pregnancies. Staff regarded ethnicity conflated with religious orientation as a causal factor for lack of interest in western education. Although staff acknowledged the Yao stereotypes were oversimplified, at times they reinforced them. Culturalism strategically served to advocate for the necessity of the project in a landscape of similar initiatives, and to explain the project's contrasting success and failure in different parts of the district. Culturalism, thus, also relates to precarious donor funding.

As such, culturalism played a role in concealing complexities and identifying the main locus of change to be in communities, in line with the project. Overemphasizing "culture" as an explanation for high rates of teenage pregnancies and school dropout denies local communities their rationale for different livelihood strategies, ignores differences within local communities and downplays socioeconomic circumstances and everyday uncertainties (cf. Fassin 2001). Furthermore, the project's design denies the complex way in which girls' multiple aspirations are shaped, which is not linear as the project suggests. I argue that an analytical shift is necessary to think about teenage pregnancies and girls' education in terms of structural inequalities rather than "culture." Most likely, improvements require long-term investment, rather than implementing a three year project that, although holistic in its aims, had a questionable impact on strengthening the public sector.

Stereotypes are widespread in Malawi, and also circulated within the village in which I conducted fieldwork. They originate in historical inequalities, but have been reinforced in

previous health and development initiatives in Malawi in the context of HIV prevention and human rights campaigns. Therefore, I argue that culturalism is a product of an ongoing series of health and development initiatives that dichotomize modernity and tradition, and is reinforced by short-term donor-funded activities targeting individuals and communities. This illustrates how culturalism, through ethnic stereotypes and harmful cultural practices, becomes a ‘cultural product’ of health development initiatives (Swidler and Watkins 2017) and part of a country’s development ideology (Pigg 1993).

Article 3: When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi

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My third article places the aim to reduce teenage pregnancies within a broader context of maternal health and the Malawian health system. The article, which is co-authored with Bregje de Kok (University of Amsterdam) and Gertrude Finyiza (research assistant), focuses on the power dynamics at play in the local implementation of policies related to the presidential Safe Motherhood campaign that was so prominent during Joyce Banda’s Presidency (2012-2014). The article contributes to the literature, marginal in public health, which places globally designed “travelling models”, such as user-fee exemption policies and skilled birth attendance, in the broader context of the day-to-day functioning of health systems and public health policy. The analysis shows how dynamic responses and accountability relationships can help explain problems with the implementation of policy and their inequitable effects when confronted with broader malfunctions of health systems.

Banda’s initiative encouraged women to give birth in health facilities, banned traditional birth attendants, constructed maternity waiting homes, and trained community midwife assistants. Furthermore, Banda mobilised traditional leaders to promote institutional deliveries. The article discusses NGOs’ role in adapting the Safe Motherhood initiative to the local context. In Mangochi, NGOs linked homebirths to maternal mortality, initiated an upward accountability system for maternal deaths following the chiefs’ hierarchy, and encouraged chiefs to enforce bylaws and instigate home-birth fines in order to spur women to give birth in health facilities.

The suspension of donor funding, a shift in political leadership and priorities, and unstable service contracts between the government and its implementing partner, the Christian

Health Association of Malawi, jeopardised the sustainability of these policies. Starting in July 2015, the health centre experienced financial problems because of delayed government payments. This financial situation resulted from complex webs of accountability between donors, national and district government, and CHAM, intertwined with actors' different priorities in under-resourced settings. At the start of 2016 the health centre reintroduced user-fees for maternal health services in order to cope with the funding problems. User-fees were suspended again at the end of 2016.

The article describes the perceptions and experiences of policy implementation among health workers, village heads and women. The way in which maternity services 'fall apart' and are 'fixed' is the result of dynamic interactions between policy and webs of accountability. This highlights issues of trust between health workers and women, which were negatively influenced by the local implementation of "travelling models", but also the attempt by a village head to maintain the trust relationship with the health centre. Furthermore, it brings out issues of intersectionality: the poorest rural women struggle most to access care.

Policies are met with a cascade of dynamic responses, informed by actors' different priorities and constrained by limited power within a constantly under-resourced health system. This ultimately resulted in the exclusion of the most vulnerable rural women from maternity care services, contrary to the aims of global and national safe motherhood policies. We argue that to understand widely acknowledged inequities and policy-to-practice gaps in maternal health, the workings of global-to-local power relations in policy and health systems must be critically analysed.

7. Discussion and conclusion: shifting priorities, similar practices

In this thesis, I analysed the dynamics around INGO project implementation in Malawi, within the broader context of overlapping development initiatives, shifting priorities, conditions of scarcity and donor dependence, and poor health outcomes. I asked, *how do dynamic interactions between INGOs and local actors shape the implementation of donor-funded health development projects, and what does this tell us about the changing role of INGOs within today's aid landscape?* I examined this question through an analysis of Save the Children's *More Educated Girls – Reducing Teenage Pregnancies in Malawi* (RTP) project, designed to prevent adolescent pregnancies by keeping girls in school and increasing the use of Sexual Reproductive Health and Rights services. As I set out in chapter 2, in Malawi and globally, reducing teenage pregnancies is framed within the larger aim of reducing maternal mortality, but also underpinned by economic arguments aligned with global goals like the UN Sustainable Development Goals. In this chapter, I will first reflect on my methodological approach, before discussing and drawing connections between the three articles that each address aspects of my overall research question.

Methodological reflections

As I set out in chapter 3, my analysis departed from a methodological stance in order to focus on the interactions between different social 'sites' or 'layers' in one locality (Fassin 2013) and on things that happen in the social spaces created by global health activities – occurrences which are not accounted for by the intervention itself and therefore often remain 'invisible' (Pigg 2013). As such, my research is not an evaluation of the RTP project itself, but an ethnography of the workings of the system of global health and development (Pigg 2013), using the RTP project as a lens to examine the practices of various brokers and to reveal the persistence of gaps between policies and outcomes (Lewis and Mosse 2006).

This methodological stance implies that I did not cover all aspects of the project, such as its goal of increasing contraceptive use among Malawian youth, which I briefly touched upon in chapter 3.¹¹ Rather, I have decided to place the project's aim of reducing teenage pregnancies in the context of Malawi's weak health and education system and the broader socio-cultural context in which NGO interventions are implemented. The story I tell in article 3 about the 'falling apart' of maternal health services is one that would probably have

¹¹ Malawian scholars have examined youth's perceptions on sexuality and contraceptive use and their engagement with YFHS (Munthali and Zakeyo 2011; Munthali et al. 2006).

remained ‘invisible’ otherwise. This story illustrates the continuous struggles and uncertainties people in rural Malawi have to deal with, and the inadequacy of NGOs’ plea that they change their behaviour and socio-cultural norms. Furthermore, the health service crisis I describe in that paper strongly brought to the fore actors’ agency within webs of power relations. The practices of community representatives in response to the service crisis arguably were not related to ‘performance’ in the context of NGO projects, as discussed in article 1.

Another point I would like to raise here is my reliance on informal conversations rather than formal in-depth interviews in order to gather ethnographic data or evidence. As described in chapters 3 and 4, this decision emerged from the complex conditions of aid dependency. Because actors exercised “dependent agency” through the “performance of success”, the highlighting of poverty and small acts of resistance (Anderson and Paterson 2017), in-depth interviews and focus group discussions would have yielded more systematic and structured, yet not necessarily more accurate, data. My approach to data collection has provided me with very broad information on livelihoods, and the tensions between global norms and the aspects of lives that people value themselves (Marsland and Prince 2012). This approach resonates with arguments geographers have made recently in favour of foregrounding “place” in critical debates on global health, rather than the dominant medical anthropological focus on health centres and single interventions, as this is crucial for understanding the broader impact of global health initiatives (see also Herrick 2017; Neely and Nading 2017).

Measuring intended outcomes?

Whether RTP actually achieved its intended outcomes of reducing teenage pregnancies in its target districts, including Mangochi, is difficult to analyse. One of the main arguments of the official evaluation report is that the quantifiable indicators – a percentage reduction in teenage pregnancies, school dropout and school re-entry – were not useful in measuring complex social change (Millard et al. 2016). Nevertheless, the evaluators listed several positive results: strengthened skills for mother support groups and child protection committees, improvements in the safe school environment and more awareness of the risks girl face at school, greater knowledge on SRH issues and teachers’ skills to teach these topics, more equal gender relations for boys and girls who participate in youth clubs, and a reduction in sexually transmitted infections.

However, a major point of critique the report makes is that the project lacked sustainability. Both teenage pregnancies and keeping girls in school are very complex issues, not linear as suggested by the project's theory of change, and require long-term investment. Such investment should take the form of sustainable service provision and integration of the developed curricula in teachers' and health workers' education, rather than on-the-job training whereby trained civil servants monopolise knowledge (Millard et al. 2016). Additionally, the report points to aid dependency ideas in communities that might inhibit local social change, arguing that Save the Children "should consider focusing on communities which believe in [and] accept the provision of knowledge as a valuable form of assistance" (p.ix).

I would argue that RTP's evaluation report was critical and accurate in describing some of the local complexities. However, what my ethnographic research contributes is a deeper understanding of context – the environment the project confronts, how it is received by and affects local actors, and the unintended consequences it might have. After all, development projects are implemented in complex dynamic systems (Bierschenk 2014), which can transform interventions in surprising ways (Penn-Kekana, McPake, and Parkhurst 2007). This is not only the case for brokers but also for the very beneficiaries the projects are meant to target. My findings transcend individual projects, and could be considered as a type of evidence that is generally not taken into account in project design.

Dynamic interactions and unintended consequences

Each of the articles that make up the thesis examines different aspects of the interactions between INGO staff and local actors. As discussed in chapter 5, I have conceptualised INGO staff, teachers, health workers, village heads and other community representatives as *brokers*. I found the concept of brokerage to be a fruitful way of examining how dynamic interactions between these different actors shape the implementation of NGO health development projects. For every actor something else is at stake. I have shown how brokers transform projects and travelling models infused with global norms in ways that make sense in their context and give them particular meanings. The brokers work to maintain their positionality and derive personal benefits, but are also constrained by the aid system and power relations. In this discussion chapter, I elaborate on some of these aspects.

In my articles, I have documented several unintended consequences of NGO initiatives and shifting aid modalities more broadly which emerge through the practices of various brokers. I describe and analyse these in various ways – as "culturalism", the weakening of health and education sectors, a growing allowance culture, double discourses and the selective

implementation of policies and projects, lack of sustainability, and upward communication of project results that emphasizes success while downplaying limitations or failures. Here, I elaborate on two important unintended consequences of the design of travelling models and how they play out in dynamic systems. First, what I call the paradox of aiming to strengthen existing public structures through non-governmental action and second, the way in which the reshaping of global norms results in culturalism. I argue that these factors, in combination with the non-linearity of development, help to explain why it is so difficult to reduce teenage pregnancies within a three-year INGO project.

‘Strengthening’ existing structures: the production of an “allowance culture”

As discussed in chapter 2, Malawi’s public sector is historically weak. As my analysis in article 1 and 3 shows, the education and health sectors continue to be severely under-resourced, dependent on donor funding and therefore vulnerable to service provision crises when donors suspend budget support and aid modalities shift. My work shows that donors, and international NGOs in partnership with Malawian NGOs, intended to strengthen the health and education sectors and community structures to achieve their intended goals. Working “through existing structures” meant the capacity building of the public service in question, as opposed to “creating parallel structures” through NGO service provision. They did so largely through interventions such as training and “sensitization”, which I argue, contrary to their intentions, are unlikely to result in sustainable improvements. Moreover they create a parallel system in a different way: one of training workshops and accompanied allowances. Such paradoxical outcomes of the intention to strengthen existing structures have been described in an USAID commissioned report on the role of NGOs in Malawi’s education sector (Kadzamira and Kunje 2002). Furthermore, research in Malawi also indicates problems with an allowance culture in the health sector (Vian et al. 2013). Pfeiffer has documented similar findings concerning the health sector in Mozambique, as described in chapter 2.

Article 1 shows how multiple overlapping international, national and local NGO initiatives can unintentionally weaken the education sector by displacing core activities, increasing workload, and delegating project tasks to teachers. In a weak education system like the one I observed in Mangochi, it became difficult to implement NGO activities as intended. And over time it is quite likely that these activities – such as youth clubs – stop altogether (see also Swidler and Watkins 2009:1183). Similarly, article 3 shows that midwives stopped implementing the fine-and-letter system concerning home-births as intended because they realised that, as a result, women were losing trust in the health centre. Some chiefs also

stopped implementing these by-laws related to home births. My findings show gaps between how policies and projects are intended to play out and the way in which they are actually implemented in local realities: in thinned form, or ceasing, over time, to be implemented at all. These findings resonate with the literature on street-level bureaucracy (Lipsky 1980), which explains why frontline workers or junior public servants often rely on routine practices that make it possible to deal with the under-resourced context. Junior public servants or street level bureaucrats have the power to reshape policies or stop implementing them. The actions of these street-level bureaucrats actually become the policy (Lipsky 1980, cited in Erasmus 2014)

My analyses of junior public servants as brokers (article 1) and the practices of various actors involved in the maternal health service crisis (article 3) contribute to street-level bureaucrat theory, because they deal with their practices of power, a dimension which is mostly lacking in street-level bureaucracy theory (Lehmann and Gilson 2013). Article 3 explicitly contributes to redressing the dearth of detailed and nuanced analysis of actors' practices of power (Lehmann and Gilson 2013; Sriram et al. 2018). A focus on power relations between different actors illuminates the different ways in which services 'fall apart' and are attempted to be fixed; actors keep in mind the interests of the common good but also their own priorities. As I have shown in article 1, the concept of brokerage in the context of NGO projects also has potential to contribute to an analysis of power and ground level dynamics in the public sector. Article 1 clearly shows how public servants also pursue their own ambitions within the context of overlapping NGO projects, while at the same time being concerned about the school and the students. It is not one or the other; brokers pursue various goals simultaneously – a multi-pronged strategy made possible by NGO projects. To this end, they largely communicate success to donors and obfuscate critical reflections about NGO projects.

However, as I argue in article 1, short-term NGO projects – including RTP – might create perverse incentives and alter brokers' motivations, resulting in what Malawians refer to as an "allowance culture": having an unproductive interest in monetary compensation for participating in NGO activities. According to my own observations during NGO-community interactions in Mangochi – and argued by Chinsinga and Mvula (personal communication, January 9, 2018) – the same goes for chiefs. Swidler (2009) argues that chiefs' accountability to their people might be altered by NGO initiatives, as they increasingly turn their gaze upwards to the NGOs and their donors, rather than to the villagers. Yet, article 3 also

demonstrates that the leaders in ‘our’ village turned their gaze downwards by abandoning the home-birth fine when user-fees for maternal health services were re-introduced.

Various brokers – including street-level bureaucrats or junior public servants and chiefs – thus selectively implemented projects and policy. Yet, brokers also reshaped the norms that underpinned many of these initiatives, which I will now turn to.

Reshaping ‘global norms’: Culturalism as cultural product

All three articles consider the way in which different brokers ‘translate’ or reshape ‘travelling models’. They adapt these models’ supposedly ‘morally neutral’ evidence-based underpinnings to their particular context. As I describe in article 1, teachers reshaped broader information about “sexual and reproductive health” into a message focusing solely on abstinence. In chapter 3, I discuss how partner NGO, BLM, apart from demonstrating and distributing contraceptives, also recommended abstinence. As I have shown in article 2, RTP staff also tweaked the design of the project. They mainly tried to convince community members to keep their children – both girls and boys – in school to achieve development and eradicate poverty, and did not emphasize the adverse health outcomes of teenage pregnancies. Some of the Mother Support Group members, as one of the RTP staff members told me, reinforced information provided during initiation ceremonies. Yet, RTP staff saw initiation as a harmful traditional practice that was working against the aims of reducing teenage pregnancies and keeping girls in school. In article 3, I show that NGOs and village heads contributed to reshaping the global norm of skilled birth attendance to the Malawian context, resulting in by-laws stipulating home-birth fines. According to Long (2004) this reshaping of intervention content is inherent to knowledge dissemination, and thus can always be expected to a certain degree.

One particular way in which global norms were reshaped pertains to ‘culture’. Article 2, shows that, two-and-a-half decades after Paul Farmer (1992) wrote *AIDS and Accusation: Haiti and the Geography of Blame*, “blaming the victim” (Ryan 1972) or “community blaming” (Yadavendu 2013) is still common. In Mangochi, I observed that project staff, senior civil servants, but also villagers themselves, blamed ‘culture’ or ethnic stereotypes of the Yao – initiation ceremonies and Islam in particular – as a static behavioural determinant for high rates of teenage pregnancy and school dropout in the district. Fassin (2001) terms this process culturalism: labelling fixed and homogenous cultural stereotypes as the main explanation for behaviour that deviates from intervention aims.

By examining the processes through which culturalism plays out as a practice in

project activities, I showed that it is important to examine who casts blame and why in order to understand the particular form it takes and when it is deployed. RTP's project design made it easy to blame culture. Cultural stereotypes were evident in meetings with community representatives, but also in explanations of project successes and failures, reflecting an aid landscape characterised by short-term projects and uncertainty over funding (Rajkotia 2018). This points to a need to examine the logic behind "strategic simplification", rather than simply claiming that implementers overlook social and cultural complexities (Yarrow 2008).

Culturalism in Malawi takes the form of reinforcing ethnic stereotypes that – as I showed in article 2 and more elaborately in chapter 3 – originate in historical inequalities. However, another important finding is that the culturalism I observed builds upon previous health and development initiatives that blamed harmful cultural practices. INGO staff, senior civil servants and villagers alike, seem to have internalised – at least discursively – a form of 'development idealism' associated with western cultural models that have been implemented in Malawi since 1994 and have been placed in opposition to tradition (Thornton et al. 2014). Malawi's development ideology and accumulated development interventions seem to have an impact on how people think about 'local' knowledge and practices, as Pigg (1992; 1993) has demonstrated in the case of Nepal. Pigg (1992) argues that blaming traditional villagers for lack of development is part of local identity politics that operates between different social classes and fashions ideologies of national progress that is informed by international development projects. What Watkins and Swidler (2012:201) argue for NGO staff can be extended to villagers: people evoke culturalism in the form of harmful cultural practices to distinguish themselves from 'Others' in the presence of a foreigner. They perform their knowledge of development discourses, which they have learned during other NGO activities (Anderson and Paterson 2017). In this sense, they perform a "ritualised modernity" (Swidler 2013). As such, blaming harmful cultural practices has become, affirm Swidler and Watkins (2017:58), a "cultural practice" in itself.

I thus agree with Hilhorst (2003), who argues that – even though there are always multiple discourses at play – when certain NGO discourses become dominant they can have profound effects on what can and cannot be said and done. Lieberman's research is interesting in this respect. Comparing cross-national HIV responses, Lieberman argues that countries burdened with sets of rules that regulate racial and ethnic group categories and intergroup behaviour (such as Kamuzu Banda's quotas that favoured the central region in accessing education, or political parties which were divided along ethnic lines) had weaker national responses to HIV. These countries were more likely to frame policy responses along ethnic

lines, and to blame minority groups for AIDS (Gauri and Lieberman 2006; Lieberman 2007). In the Malawian context this is shown not only by the common practice of blaming of harmful cultural practices associated with specific ethnic groups and located in the village (Page 2015; Swidler and Watkins 2017), but also by government's resistance to adopting a medical male circumcision policy as recommended by global guidelines. Chewa Christian policymakers associated male circumcision with the 'traditional practice' of Yao Muslims and therefore resisted implementing this as a HIV prevention strategy (Parkhurst, Chilongozi, and Hutchinson 2015). The RTP project unintentionally feeds into this "habit of framing social problems in terms of ethnic groups" (Lieberman 2007:1414). The danger with culturalism is thus that it reinforces ethnic and class inequalities and divisions within societies, rather than holding powerful actors, such as the government and donors, to account for Malawi's many health and development problems such as weak public services, unemployment and poverty.

The complexity of teenage pregnancies

The unintended consequences of the paradox of aiming to strengthen existing public structures through non-governmental action, and the way in which reshaping of global norms results in culturalism, help to explain the difficulty of reducing teenage pregnancies within a three-year INGO project. It is also important to critically examine the idea that a reduction of teenage pregnancies obeys a rational, linear 'theory of change' (see chapter 2). The relationship between schooling and fertility – which underpins RTP – is not necessarily causal or linear, and it does not hold at the country level (Johnson-Hanks 2006). In order to reduce teenage pregnancies we should first understand why and how they occur. In article 2, I show the complexity in which girls' multiple aspirations are shaped. Rather than being negatively influenced by fixed cultural norms, as appears from the project proposal, girls exercise agency – though constrained by structural factors, such as poverty, weak public services, and unequal gender relations – in various ways towards different and multiple ends. They variably, though not mutually exclusively, aspire to completing education, dropping out of school and enjoying their free time, being fashionable, or getting married and becoming a mother. Relatives also have various ideas as to what girls (and boys) should do and achieve which sometimes conflict with girls' own desires. Interestingly, self-efficacy might unintentionally emerge as *ufulu*; a notion of human rights that is locally interpreted as pursuing individual freedoms, such as the right *not* to go to school, or to stay out late, in opposition to community representatives' ideas. Development does not follow a linear path. I agree with Mkhwanazi (2006) who, based on ethnographic research in South Africa, argues that we should shift our

understanding of teenage pregnancies in line with the numerous ways in which girls exercise agency in various subject-positions. There are always multiple, competing, and hierarchically-positioned gender discourses. And these are always subject to change, differing between generations.

When considering the Malawian structural context, for some girls and their relatives, teenage pregnancies and early marriages can be understood as a form of livelihood security, which is confirmed by ethnographic research from South Africa (Swartz, Colvin, and Harrison 2018). Thus, whereas from a ‘global’ public health and development perspective, teenage pregnancies and school dropout is undesirable, from a ‘local’ perspective, they might be, depending on the circumstances, preferable. Van Der Sijpt (2013) conceptualizes reproductive complexities and contingencies not as individual rational choices, but as emerging from social configurations that shape possibilities and constraints of reproductive aspirations and choices.

The changing role of NGOs in the current health development landscape

The RTP project does not, of course, stand-alone, but is one example of a larger aid landscape that shapes what (I)NGOs do. The second part of the research question is what my local ethnographic research can contribute to scholarship on the changing role of NGOs in the global health and development landscape. To briefly recapitulate from chapter 2: currently many INGOs play an increasingly prominent and many-sided role in the field of global health – as policy advocates, stakeholders in the development of global policies, recipients of donor funds, and implementers of donor-funded programmes. As a result, policies are designed far away from the local realities on which they impact, a feature which medical anthropologists have associated with their failure to work as intended, because they become less tailored to the local context (Adams et al. 2014; Biehl and Petryna 2013:8; Olivier de Sardan et al. 2017; Whiteford and Manderson 2000:2). These long implementation chains create complexity and uncertainty in the NGO organizational landscape and environments are unpredictable and poorly understood; goals are ambitious, vague and unrealisable; technologies are ineffective and unrealistic (Watkins et al. 2012). This long aid chain turns northern NGOs into “managers of funding” (Sridhar 2010:465). Their counterparts in the Global South, in ‘partnership’ with national NGOs, seem to become implementers of donor-driven policy. They follow the shifting priorities set by donors and adhere to global best practices and discourses. The prominent role of NGOs induces constant innovation, short-term projects, and shifting priorities (Adams et al. 2014).

RTP is a classic example of this aid structure, as is the rapid relative shift in priorities from skilled birth attendance to reducing teenage pregnancies. In this section, I reflect on what upholds this system, a system which produces travelling models, short-term INGO projects, behaviour change interventions, and the ‘strengthening’ of existing structures through training. Such reflection is necessary to arrive at the argument that certain unintended consequences repeatedly occur because of the way in which projects are designed and responded to by local brokers. Their underlying mentalities and practices persist even though priorities change (Beck 2017).

This dissertation described several ‘travelling models’ based on universal “miracle mechanisms” that are stripped from context (Olivier de Sardan et al. 2017). Skilled birth attendance and user-fee exemption policies, for example, were intended to reduce maternal mortality. The RTP project consisted of a combination of mechanisms or building blocks to reduce teenage pregnancies: changing sociocultural norms, improving access to contraceptives, and providing sexuality education through the education sector. This was underpinned by a ‘girl effect’ logic that couples girls’ education and individual empowerment with economic development (Hickel 2014).

Olivier de Sardan and colleagues (2017) argue that despite long-term social science criticism, the number of travelling models in global public health and development continues to rise. The authors list several reasons: 1) the models create employment for experts designing and implementing them; 2) The design and implementation of travelling models has become a routine practice for many institutions involved, including NGOs; 3) The field is largely supply driven from the Global North with little pressure from recipient governments to alter the models; 4) Funding prioritizes scalable travelling models; and 5) there is a strong *belief* in mechanisms that work everywhere. I find this analysis insightful, though, I have also shown that various brokers adapt and reinterpret such travelling models to the Malawian context. When the models arrive at the local level, they are already transformed. For example, to my knowledge, no travelling model prescribes home-birth fines.

Multilateral organizations actively frame issues and shape how they are viewed and addressed, often in a neoliberal, economic-technocratic, depoliticized manner (Bøås and McNeill 2004). Furthermore, Roalkvam and McNeill (2016) argue that the current global public health landscape takes a ‘global’ perspective for granted and includes a growing variety of stakeholders in health policy design and implementation. It also focuses on the greatest value for money in terms of lives saved and offers clear, measurable, and potentially profitable, technological solutions to complex problems. Monitoring and evaluation strategies

that measure quantifiable targets have become a key feature of health and development especially since the start of the MDG era (Gardner and Lewis 2015; Roalkvam and McNeill 2016).

The SDGs somewhat shifted the ‘vertical’ or issue-specific focus of the MDGs to promote broader, multi-sector approaches, as exemplified in a stronger focus on quality of care to improve maternal health and multi-sector approaches to adolescent health and wellbeing. Nevertheless, we are still in a climate where reaching targets is given crucial importance. Global health policies remain stubbornly vertical or disease specific and focused on quantifiable targets (Roalkvam and McNeill 2016). Although RTP had a multi-sectoral approach to teenage pregnancies, the built-in monitoring and evaluation strategy was based on numerical indicators. Yet, the evaluation stated that these could not measure complex social change (Millard et al. 2016). Nonetheless, brokers’ practices were shaped by the experienced need to demonstrate project success, as I address in article 1 and 2. As becomes clear in article 1, brokers uphold representations of a successful project (Mosse 2005a), and convey public and official discourses to more powerful others, including researchers (see also Anderson and Patterson 2017), hoping NGO projects will continue. In the current aid system, attributing success to individual projects seems to be more important than learning from failure and conveying critical reflection to donors (see also Rajkotia 2018). In article 2, I show that the need to explain project success and failure reinforces culturalism. According to Watkins et al. (2012), reporting and creating success is one of the core practices of development NGOs. Kloster (under review) shows that RTP project staff at various levels were concerned with “chasing success stories” in order to communicate the project’s success up the aid chain. This reduced the complexity of unequal gender relations to counting girls who were ‘saved’ by the project. This is a typical case of quantification “at the expense of understanding the complex interplay between politics, economics, culture, and history” (Robinson 2017:212).

Furthermore, RTP’s targeting of individual girls and communities, and the strong focus on encouraging women to give birth in health facilities in Malawi, align with a larger depoliticization of development goals since the MDGs, in the sense that broader structural drivers of reproductive health remain under-addressed. NGOs contribute to this process. Because of their short-term and narrow projects, they do not have the same reach as the state and the focus of development thus becomes the community instead of society as a whole (Prince 2014:26). This is especially clear in the area of reproductive health and HIV prevention, where the focus of public health specialists on “intimate interventions” has contributed to a stress on the individual rather than social, political, and structural factors

(Robinson 2017:206). In the case of Mangochi, concentrating on community and behaviour change, rather than seeking changes in Malawian society in general, resulted in culturalism.

Against the trend towards oversimplified, short-term projects addressing very complex issues, Cleland and Watkins (2006) call for greater realization of the fact that behaviour change, whether in relation to uptake of contraceptives or HIV prevention, takes several decades, because information has to be evaluated and adopted within local social networks. Yet, both the global population movement and the HIV/AIDS control programmes have known periods when ‘global’ actors became impatient with the lack of progress despite the provision of services and information. They targeted contextual obstacles to behaviour change, such as poverty, gender inequality and traditional cultural practices, but to little effect (Cleland and Watkins 2006). Translating this to reducing teenage pregnancies, this implies that donors and implementers should be patient, and that – at a minimum – sustained provision of, and access to, basic information and services (including youth friendly and maternal health services and education) are crucial.

Although donors and NGOs play a large role in service provision, such as delivering contraceptives to health facilities in Malawi, my research shows that NGOs also play a large role in training public servants. Indeed, Prince (2014) notes that “public health institutions are crisscrossed with ‘public private partnerships’ and non-governmental projects”; public institutions are “partners” and health personnel participate in training workshops (p.24). Training is one of the most common practices among development NGOs – a practice that satisfies all the actors in the aid chain in one way or another. Donors can count the numbers of participants, NGO staff build professional networks, and local actors receive allowances or per diems (Watkins et al 2012; Swidler and Watkins 2009; Watkins and Swidler 2012). Smith (2003) argues that “apparent alterations in donor priorities, such as from ‘family planning’ to ‘reproductive health’, do not affect the underlying donor model of social change. The workshop mentality survives these shifts,” (p.713). This is because, according to Scherz (2014), donors commonly believe in teaching people skills. The “sustainability doctrine” – as Swidler and Watkins (2009) call it – thus also translates to the public sector, though, they argue, “the ideal of sustainability [through training workshops] is a convenient self-delusion for funders” (p.1192).

I suggest that the characteristics of the aid landscape, discussed in this section, contradict the aim of long-term strengthening of the health and education sectors, which is crucial for improving many health and development outcomes – including teenage pregnancies and maternal health. My research indicates that, within this aid system, there is

little space for INGOs to represent the grassroots or to convey to donors what is really needed. Rather, various brokers attribute success to individual projects and translate ‘global norms’ into the local context by trying to convince the ‘local’ to adhere to these norms, blaming culture along the way. There is a tension between being global, but wanting to appear local, which Storeng et al. (2018) show, can lead to donor driven ‘locally-led’ change, whereby INGOs obfuscate their role in national policymaking processes. Rather than strengthening the grassroots, INGOs reinforce the position of elite brokers.

Reflections on INGOs’ role

The question that inevitably arises is what should the role of INGOs in global health and development be? Banks et al. (2015) advocate for a radical restructuring of the aid sector whereby INGOs can act as bridges between small and fragmented CSOs, and local, national government and international actors; not as implementers of donor-driven policy, but as mediums to convey the needs and agendas of local CSOs to more powerful actors. Banks and colleagues argue that INGOs should reflect on their own role, shift away from rational linear models of development, show greater interest in the political economy of social change and be more accountable to the grassroots. Although this could be a way to strengthen civil society, the fact that INGOs themselves very often depend on donor funding complicates the matter. Half of the ‘civil society’ seats on major Public Private Partnership boards are filled by INGOs; however, review of documents suggests that their main role is to support the partnership through programme implementation and advocacy rather than challenging decision-making and representing the grassroots (Storeng and de Bengy Puyvallée 2018).

A key point for reflection, I suggest, is which harmful practices should be the focus of change: harmful cultural practices in communities, harmful organizational practices in public services (and the ‘allowance culture’), harmful INGO practices of blaming culture and widespread culturalism, or – as Pfeiffer and Chapman (2015) suggest – harmful donor practices that shape the aid structure? Changing the last is most likely to result in improved health and development outcomes, as the practices of powerful global actors are often more influential in moulding health outcomes and inequities than are practices in local communities (Lock and Nguyen 2010:10; Ottersen et al. 2014). The case of the maternal health service delivery crisis I described in article 3 is a clear illustration of this argument.

Donors and INGOs should also reflect on and change the modalities through which aid is distributed. In Malawi, donors’ shift back and forth between supporting the government’s budget directly and channelling funding through NGOs; a vacillation that has resulted in

public service crises (article 3; Anderson and Patterson 2017). Pfeiffer et al. (2017) argue that the SDG health system goal will not be achieved if donor-funded vertical or off-budget initiatives, and Poverty Reduction Strategies (PRSPs) that limit public spending, continue to distort the government's ability to invest in the health system, finance workforce expansion, and coordinate donors and NGOs. On the other hand, I also acknowledge that donors are in a difficult position when it comes to corruption scandals. Political scientist David Booth (2012) argues that the problem with the aid alignment principle is that it centres on what donors should avoid (project-based aid), not on what they should do to achieve "country-owned development programming" with a development oriented political leadership. When budget support fails because of recipient governments' clientelist practices, as is the case in Malawi, there are no guidelines for how to effectively deal with this.

To participate in these debates, I have disseminated my research findings in several ways throughout the PhD process to Norad, Save the Children Norway and Malawi, and to various NGOs and senior civil servants in Mangochi district. Senior policy makers in Norad responded with interest to the preliminary research findings on overlapping NGO initiatives in the education sector. Staff at Save the Children Norway were surprised to learn that INGO district staff are not necessarily "locals" and also explained they are constrained by requirements set by Norad. The RTP district coordinator responded enthusiastically to the articles and claimed they accurately represented the challenges and realities on the ground. Especially from NGOs and senior civil servants in Mangochi district, I have received positive responses.

Conclusion

A main contribution of my research is to demonstrate how ethnographic analysis of the practices of variously positioned actors (brokers) within webs of power relations brings to the fore 'hidden' characteristics of donor-funded projects, including how they are often underpinned by travelling models. Brokers deal with and reshape health and development projects in ways that make sense within their context. Brokers derive benefits from them, maintain their positionality, pursue their own ambitions, but also keep in mind the interests of the common good. Apart from illustrating a disconnect between global policies and local realities, a major contribution of my research thus lies in its focus on practices that are created by global health and development activities, but that often remain 'invisible' in formal project evaluations, and are generally therefore not considered in project design. These practices are crucial in explaining why projects and policies might fail to achieve their goals, lack

sustainability, or have unintended consequences.

My research showed that even though policy priorities and aid paradigms shift, some unintended consequences are recurrent and might even be strengthened over time. This aligns with Beck's (2017) description of development projects as an ongoing series of interactions between global and local actors – the underlying mentalities and practices of development often remain the same even though priorities alter. The practices of brokers lead to a reproduction of unintended consequences that relate to the aid structure. Local actors therefore not only respond to the content of interventions, but also to historical and present interactions with more powerful actors (Adams et al. 2014). 'Evidence-based' policies and projects thus not only become more uniform and overlook the context, but – perhaps more importantly – disregard the practices of brokers within these contexts; practices that result from the accumulation of health and development projects. As such, global health and development projects reproduce unintended consequences and lack sustainability of intended outcomes.

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Papers

II

INGO BEHAVIOR CHANGE PROJECTS: CULTURALISM AND TEENAGE PREGNANCIES IN MALAWI

Hanneke Pot

Adolescent girls are at the center of health development initiatives. Based on ethnographic research in rural Malawi, I analyze the design, implementation, and reception of an INGO (international non-government organization) project aiming to reduce teenage pregnancies by keeping girls in school. Drawing on Fassin's theorization of culturalism as ideology, I analyze how a tendency to overemphasize culture is inherent to the project's behavior change approach, but is reinforced locally by class-shaped notions of development, and play out through reinforcing ethnic stereotypes. I argue that culturalism builds upon previous health development initiatives that dichotomized modernity and tradition, and is strengthened by short-term donor funding.

Keywords: Malawi, behavioral change, culturalism, harmful cultural practices, teenage pregnancies

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Bionote

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Currently, adolescent girls are a major target group of global health and development interventions. In line with the interconnected nature of the Sustainable Development Goals, the *Global Strategy on Women's, Children's and Adolescents' Health* and a *Lancet Commission on Adolescent Health and Wellbeing* suggest multisectoral policies with a strong link between adolescent (reproductive) health and education, including comprehensive sexuality education (Patton et al. 2016; WHO 2015). The prevailing development discourse depicts girls as the greatest investment for economic development; an empowerment discourse which, according to Hickel (2014:1355), “has become popular because it taps into ideals of individual freedom that are central to the Western liberal tradition.” In the case of maternal health, this pairing of health and economic arguments resulted in part from a deliberate rebranding by advocates who felt that the message “saving women's lives” did not resonate with neoliberal or business-oriented donors (Storeng and Behague 2014). The framing of teenage pregnancies is related not only to adverse health outcomes, but also to the interruption of schooling and girls' developmental potential (Patton et al. 2016). In wider development discourse, education, gender equality, human rights, delaying marriage and reducing fertility are constructed as reciprocal causal aims, characteristic of modern societies and capable of catalyzing economic development (Thornton, Dorius, and Swindle 2015).

The focus on girls has been criticized for its neoliberal underpinnings. Girls are simultaneously constructed as vulnerable and responsible for development, presented as culturally constrained and sexually oppressed; individual personhood and kinship are overemphasized as drivers of poverty, whereas structural factors at communal, national and global levels are ignored (Hickel 2014; Shain 2013; Switzer 2013; Switzer, Bent, and Endsley 2016). Empirical research shows that “empowered” girls struggle to overcome structural barriers (Hayhurst 2013) and draws attention to the creation of new subjectivities and relationships (Classen 2013). Interventions that appear to be morally neutral and evidence-based are implemented in target communities, where they are “reinvested with moral meaning in the course of social practice” (Pigg and Adams 2005:2-3).

In this article, I examine ethnographically the design, implementation, and reception of an INGO project aiming to reduce teenage pregnancies by keeping girls in school. I do not intend to evaluate the project in terms of achieving its goals, nor to make value judgments regarding the INGO staff who passionately implemented the project on temporary contracts with limited human resources. Rather, I focus on analyzing practices that are created in the name of global health, but often remain ‘invisible’ (Pigg 2013): in this case, the overemphasis

of culture as a behavioral determinant of high teenage pregnancy rates and school dropout rates. This plays out through ethnic stereotypes, not only between elites and villagers, but also within the village. This overemphasis on culture results from numerous development initiatives that dichotomize modernity and tradition, and is reinforced by short-term global health and development activities targeting individuals and communities.

BLAMING CULTURE

Individualized behavior change approaches and technological fixes remain at the core of many public health and development interventions (Swidler 2013; Yadavendu 2013). Many – though not all – reproductive health interventions aim at replacing local views and practices with expert knowledge, behavior and technologies (Pigg and Adams 2005). “Culture” or norms are often conceptualized as behavioral determinants, although this understanding lacks empirical observations, renders individuals without agency, and leads to homogenizing, stereotyping, and victim blaming (see De Kok 2009).

Blame, moralization and discrimination of target groups plays out in local realities. The dominant colonial medical discourse blamed uncontrolled African female sexuality for the spread of syphilis (Vaughan 1992). In prevention campaigns, individuals or “African sexualities” were blamed for the spread of HIV (Schoepf 2001); traditional practices as the primary barrier in relation to girls’ education (Vavrus 2002). The Human Rights agenda has facilitated blaming “harmful cultural practices” for women’s subordinate position in society, despite the complex intersectionality of gender, age, class, race and ethnicity (Longman and Bradley 2015). Yet, structural, socioeconomic and political inequalities severely limit individuals’ options for behavior change (Farmer 1992).

Fassin terms this process “culturalism as ideology,” which he defines as “the *intellectual figure* that reduces culture to mere essence and that makes culture the ultimate interpretation of human behaviour” (2001:302, italics in original). Culturalism does not refer to “culture and personality” theory, but to ordinary representations and practices. Culturalism can result in “victim blaming” (Ryan 1972) or “community blaming” (Yadavendu 2013), holding individuals or communities responsible for behaviors that result from cultural norms. By overdetermining the role of an ahistorical static culture and limiting the analytical focus to target communities, without analyzing the content of interventions, and the culture of the intervention developer and implementers, culturalism is “doubly deceptive” (Fassin 2001:306).

I draw on Fassin's (2001) four dimensions of symbolic violence produced by culturalism, which he illustrates with the example of an HIV positive woman of African origin in France who, contrary to medical advice, desires to get pregnant. Fassin argues that, first, interpreting the desire for motherhood as "African" denies the universality of the aspiration. Second, thinking that all African women have similar desires to motherhood denies their different representations, practices, and strategies. Third, the need to avoid all risk labels the woman's behavior irrational. Lastly, exclusively speaking about culture takes a woman out of her context, when socioeconomic and sociopolitical factors may be stronger determinants for behavior. Fassin calls for politicizing culture by examining the purpose culturalism serves more powerful actors.

I will show how overemphasizing "culture" for high rates of teenage pregnancies and school dropout denies local communities their rationale for differences in livelihood strategies, socioeconomic circumstances and everyday uncertainties. Furthermore, the project's design denies the complex way in which girls' multiple aspirations are shaped. Implementers were aware of socioeconomic and sociopolitical constraints, but overemphasized "culture" as explanatory, in line with the projects' behavior change approach, its embedded notions of development, and the need to demonstrate project success.

NGOS' role in culturalism

In implementing global policies, NGOs propagate new moralities in the name of development (Lock and Nichter 2002:9). Donors, implementers and villagers often have competing moral visions, priorities and discourses (Swidler and Watkins 2017). In Malawi, national NGO staff embody an ambivalent position. As elites, they distinguish themselves from poor, uneducated, tradition adhering and "morally deficient" villagers, by overemphasizing harmful cultural practices associated with health and development problems such as HIV, or as oppositional to human rights (Page 2015; Ribhon 2002; Swidler and Watkins 2017). This self-interest in maintaining their status, combined with the desire to help poor populations, unintentionally results in victim blaming (Ryan 1972). "Othering" – discovering the ways in which a target group differs from "the Self" – forms an essential part of this process. In sexual and reproductive health interventions, these differences are often identified around sexual practices (Pigg and Adams 2005:6). In Malawi the notion of harmful cultural practices has played a role in constructing "the Other." Since the end of the dictatorship in 1994, INGO development initiatives that passed on messages to Malawian elites working for government and NGOs have juxtaposed tradition with democratic freedom, modernity and change

(Ribhon 2002; Thornton et al. 2014). Through national campaigns, radio broadcasts, and newspaper banners, traditional practices and values such as those supporting early marriage were challenged in favor of modern Western family ideals, and HIV prevention campaigns targeted specific traditional (sexual) practices (Swidler and Watkins 2017).

ETHNOGRAPHIC CONTEXT AND METHOD

I conducted ethnographic fieldwork in Mangochi, a district in Malawi's southern region, between May 2015 and August 2016, as part of a study of the dynamic interactions between INGOs and local communities (Pot 2018). The INGO project focused on reducing teenage pregnancies. The prevailing discourse, observable in Malawian newspapers, linked girls' education to various issues, from teenage pregnancies and early marriages, to economic development and combating climate change through declining fertility rates. Mangochi district is a popular choice for NGO interventions because of its relatively lower indicators in health and education (see Table 1), and according to the chair of the Mangochi civil society organization network, there were 69 registered organizations in 2015.

Indicators 2015-16	Mangochi	National
Girls (15-19) who have begun child bearing (%)	36.7	29.0
Fertility rate per woman	5.3	4.4
Median years of completed education – women (15-49)	3.7	5.6
Median years of completed education – men (15-49)	5.1	6.6
Median age at first marriage women (20-49)	17.7	18.3

Table 1: Indicators Mangochi and Malawi. Source: (NSO and ICF 2017).

With my Malawian research assistant, Gertrude Finyiza, I observed various project activities at different locations in Mangochi district. I had regular discussions with the two implementing staff members, participated in national project meetings, had conversations with head office staff, and read project documents. I critically analyzed the project proposal, focusing on its framing of teenage pregnancies and girls' education; the underpinnings of the design; the intervention strategy; and – based on my analysis of local realities - what was *not* discussed.

Fieldwork was concentrated in a semirural village, where Gertrude and I rented a house. Although currently ethnically mixed, the fieldwork area traditionally belonged to the Yao, a matrilineal group with origins in northern Mozambique. Close ties with Swahili trading partners and chiefs' fear of losing power after being defeated by British colonizers led to conversion to Islam in the late nineteenth century (see Van Kol 2008). *Madrassa* (Islamic

education) competed with Christian mission education, the latter being the blueprint for the current secular education system, and this historical disadvantage, Van Kol argues (2008), has contributed to Yao's lower education levels. Since 1994, Islamic reformist organizations have attempted to improve the position of Muslims by providing scholarships, and have built secular and Islamic schools, and mosques. In addition, the first democratic government – after years of dictatorship – failed to fulfil its promises on livelihood security following free primary education policies (Kendall 2007). The quality of education declined, in the southern region, resulting, Kendall (2007) argues, in education becoming a “hollow process.”

Poverty, food insecurity, and weak public services characterize rural Malawi (Pot 2018; Pot, de Kok and Finyiza 2018). With high inflation and limited formal employment opportunities, people struggle to secure their livelihoods, fishing was once a lucrative business, but has become challenging due to overfishing. Temporary labor migration to South Africa has continued. Nevertheless, the village and surroundings have developed. The market has grown, more businesses, shops and bars owned by Yao and non-Yao have opened, and bicycle taxis transport villagers and merchandise between markets, where a sexual economy has developed. Wealthier households have access to electricity and piped water. Tourist lodges and an industrial farm provide employment, the latter requiring no education. These developments attracted people from other districts to the area, increasing the population in the village from 1860 to 2589 between 2014 and 2015 alone. People sold parts of their land to village elites who constructed iron sheet houses for rent. Consequently, people began to rent fields for subsistence farming further away from the village.

During fieldwork, Gertrude and I interacted with several families of different ethnic groups. We spoke with grandmothers, mothers, occasionally fathers, and their teenage children about daily life and what it was like to grow up or raise (grand) children in a Malawian village. We spoke regularly with teenage girls and boys about their experiences at school, reproductive health, relationships, ambitions and interactions with relatives. We observed how teenagers – both in and out of school and from different grade levels – spent their time, interacted with their peers, spoke about each other and dealt with livelihood insecurity. Furthermore, we participated in NGO development activities and village meetings, and interviewed traditional and religious leaders, and village elders. We interviewed staff from several NGOs, teachers, and health workers. We also interviewed an initiator and conducted participant observation in her girls' initiation camp for one week to acquire knowledge on the content and meaning of this ritual, and transitions to adulthood.¹

UNDERPINNINGS OF A BEHAVIOR CHANGE PROJECT

The studied project *More Educated Girls - Reducing Teenage Pregnancies in Malawi* (RTP) was funded by the Norwegian Agency for Development Cooperation (Norad), with US \$3.8 million assigned to Save the Children Norway (Save Norway). The project was a response to shifting priorities in Norwegian foreign policy from maternal health to girls' education. Save Norway tasked Save the Children International Malawi (Save Malawi) with designing the project. Save Malawi implemented the project in partnership with two national NGOs, Forum for African Women Educationalists in Malawi (FAWEMA) and Banja La Mtsogolo (BLM) (Marie Stopes International's national affiliate). The project ran from January 2014 to December 2016 in six administrative districts, selected partly because of relatively high rates of teenage pregnancy.

A situation analysis of programs, partners, and donors identified the need to address environmental (family, friends and institutions) and individual (risk perception, vulnerability, opportunity) barriers for the use of youth friendly health services, with emphasis on sociocultural factors (Save the Children 2013:5). Another identified gap was the need to improve the primary school environment (2013: 5-6). The approach was based on data from the Malawi Demographic and Health Survey (DHS), government policies and strategies, WHO guidelines, psychological theory, and existing Save the Children strategies intended to be adapted to the Malawian context. The proposal adopted the Population Council's conclusion that "early childbearing (was) both a cause and a consequence of dropping out of school" (2013: 4). By proposing a multisector approach, the project viewed "the adolescent girl holistically, addressing her health and education needs and the sociocultural environment in which she lives" (2013: 6). Concretely, the project aimed to reduce teenage pregnancies by increasing girl's use of key sexual and reproductive health (SRH) practices and services; reducing girls' school dropout rate; and increasing school re-entry after pregnancy. The project's "theory of change" assumed that lack of access and utilization of SRH information and services, lack of quality learning environment and self-efficacy, and lack of community and social support towards girls' education were causes of teenage pregnancy, and that improving these would result in achieving the project aims (Millard, Msowoya, Sigvadsen 2016: 5-6).

Self-efficacy and Sociocultural Norms

The proposal defined "self-efficacy," derived from psychological theory, as "believing in better future opportunities and one's ability to successfully prevent pregnancy." Low self-

efficacy was described as a key determinant of teenage pregnancies and school dropout, and a “theoretical” component in “creating a climate for behavioral change” (Save the Children 2013:9). Therefore, “strengthen[ing] adolescent girls’ self-efficacy” in order to “strengthen and support their confidence, negotiation skills, empowerment and build peer support” was perceived as crucial (2013:9). The proposal characterized the social context as influential in shaping girls’ beliefs and aspirations. The “opinion and perception of parents and community members” was considered the “most frequently cited barrier to adolescents’ use of SRH services,” and “parental support for and belief in the importance of a girls education is a protective factor for keeping girls in school” (Save the Children 2013:17). The proposal suggested the need for “changed behavioural and social norms” and strengthening community capacity to support girls’ educational aspirations by engaging traditional and religious leaders, community committees, and other local stakeholders, through village meetings, to create “community based solutions” (2013:17). Lastly, the project aimed to strengthen the learning environment and life skills education through participatory mapping exercises and teacher training (Pot 2018). Youth friendly health services were intended to be strengthened by training health workers, peer educators, and providing outreach services for the duration of the project.

In this article, I focus on project staff and local communities. By focusing on sociocultural norms and behavior change, the project facilitated culturalism in its design. Communities and individual girls were encouraged to conform to “global” norms of education and delaying childbearing, which in the proposal appeared to be morally neutral due to public health language and references to policy documents. By advocating for “sensitization” and “community wide normative change” (Save the Children 2013:17), lack of knowledge and sociocultural norms were assumed as a main reasons for teenage pregnancies and school dropout. This focus on changing individual behavior and community norms resembled early approaches in HIV prevention (Parker 2001). Girls were assumed to lack agency, and the project aimed to strengthen their self-efficacy to achieve educational aspirations. This results in an oppositional construction of education and teenage pregnancies, and raises the question of the benefit of education in the context of rural Malawi. Furthermore, “teenage pregnancies” - defined as childbearing in girls between 15 and 19 years of age - is extremely common in Malawi where the median age at first birth is 19 (NSO and ICF 2017).

The problem of school dropout might be structural. Social mobilization campaigns, as part of the 1992 USAID-initiated Girls' Attainment in Basic Literacy and Education (GABLE)

program, had intended to change communities' attitudes towards girls' education to reduce fertility. Yet, when free primary education was implemented in 1994 as part of new democratic entitlements, school enrolment doubled, indicating that communities' unfavorable attitudes towards girls' education were likely overstated (see Mundy 2002:31). The DHS revealed a link not only between teenage pregnancy (and early marriage) and level of education, but also to wealth (NSO and ICF 2017). The project's baseline study found that poverty was a major cause of school dropout (Kadzandira 2014), suggesting that teenage pregnancies and early marriages associated with low levels of education might be adaptive responses to economic conditions. This is especially pertinent given the contradiction that Malawian girls expressed high levels of self-efficacy in relation to achieving educational success, whereas an estimated 40 percent of girls and boys complete primary school and only four percent complete secondary school (Frye 2012). Frye argues that girls' educational aspirations should be understood as "assertions of a virtuous identity," rather than rational calculations to a bright future.

PROJECT IMPLEMENTATION

Project staff framed the main contribution of the project in relation to other NGO initiatives. During the 2015 annual meeting, Save Malawi staff stressed the multisectoral focus and behavior change approach as key, because other approaches – such as providing uniforms – had been unsuccessful.

This view also related to Malawian INGO staff's complex subject positions. As university educated Malawians, staff members were elites, in status far removed from local communities. The two male staff members in Mangochi were non-Yao, Christian, and did not speak the local language *Chiyao*, which was challenging during some of the community meetings. Whereas one, Edson, had lived in Mangochi town as a child and teenager, the other, Tonthozo, had grown up in a village in another district². In community meetings, he shared his personal story, "I didn't rely on parents, I helped myself, they didn't have interest ... I went to secondary school without shoes." To me he added, "poverty is no excuse, because I also managed. You just have to work hard." Both men strongly believed in individual motivation and capacity, though being male they had not experienced the same struggles as girls.

The perceived need for behavior change also related to specificities of Mangochi district. Project staff considered the short duration of the project and limited time for behavior

change the main obstacle to implementation. Tonthozo noted: “The Yao strongly hold on to their culture. They don’t want to accept any knowledge. They say ‘yes’, but then go back to their own practices. This also happens with other groups, but not as strong as with the Yao.” Generally, there were strong stereotypical perceptions of the Yao as an ethnic group that valued initiation ceremonies, early marriages, madrassa, and large families, that they did not value western education and resisted development discourses because they were Muslims and protected their culture. At the 2015 annual meeting, I noted that many project staff members and senior civil servants referred to these stereotypes to explain why teenage pregnancies were relatively high, pinpointing Mangochi’s low indicators of a static culture that pertained throughout the district.

The district staff acknowledged these stereotypes were oversimplifications, and during implementation, they tried to do justice to differences within Mangochi. Thereby they constructed “identities” for each area. For example, they characterized my fieldwork site by “civilized Yao” and “mixed;” across the lake there were “traditional Yao;” in other zones there were other ethnic groups. Each zone had specific causes for school dropout and teenage pregnancies, predominantly framed in behavioral and cultural terms.

Dynamic interactions

During community meetings, staff adapted the project to the social environment. They emphasized the importance of education for girls and boys – as opposed to teenage pregnancies and early marriages – to achieve development and end poverty, and related this to climate change and xenophobia:

This project is to encourage girls to go further with education and trying to prevent school dropouts. There were 172 school dropouts and the reasons for these dropouts were pregnancies. If we live like that then people will be making bricks and children are getting married while young. Let’s work together. Farming didn’t go well, the weather changed. Before Christmas, we had rain, but as of now, the weather is changing [climate change]. In South Africa, they are cutting our neck [xenophobia]. (Edson)

Throughout the project, the staff also challenged culture and behavior. As one participant expressed during the 2015 annual meeting, the project’s baseline had identified that “strong cultural activities” contributed to teenage pregnancies and dropout. This, with staff members’ own notions of development, community members’ expectations of material

benefits, the limitations of the project, and likely the need for achieving success, all shaped the dynamics during community meetings.

One aspect of “sensitization meetings” was, as mentioned by Tonthozo, “to understand not the obvious, but the underlying reasons” for school dropout and teenage pregnancies. We drove to an area predominantly inhabited by the Mang’anja ethnic group. Tonthozo had invited the 50 participants -- initiators, teachers, village heads, and other community representatives -- to share their thoughts. Most people looked at him passively, possibly slightly annoyed because we had arrived two hours late and Tonthozo had just explained they would not receive lunch allowances. Inactive participants and complaints about allowances were almost routine, and complicated project implementation. From villagers’ perspective, allowances were one of the few ways in which tangibles from numerous donor-funded projects reached them.

A few participants responded to Tonthozo’s question, raising issues such as poor education quality, lack of money for school fees and other necessities, and too few teachers. Participants also brought up parental behavior: “after puberty stage they encourage the child to get married,” and “kids are not being encouraged [to go to school] by parents.” When a participant raised the issue of unemployment, everyone applauded. Participants also mentioned that girls’ dressing style evoked proposals from men and that “students are getting engaged to men” because of poverty.

From this point onwards, Tonthozo changed his tone: “You are running away from the points that we want,” he said, steering the discussion away from structural issues. The initiator responded: “The problem is *ufulu* [human rights, locally translated as “freedoms” – see Englund 2006].” This issue was frequently raised by community members and referred to youth not listening to their parents because they claimed to have “freedoms” in the country’s contemporary democracy. Before asking about *ufulu*, Tonthozo asked about the content of initiation. The initiator responded that she tells girls to “continue school, it’s your future, ignore the men. But the kids don’t listen.” Tonthozo asked: “You mean you don’t teach them styles of sex?” Many participants confirmed this was the case, but the initiator commented: “We are different initiators.” Clearly aiming for further discussion, Tonthozo said, “I was also initiated; can you mention what you tell them?” A man commented: “*Kusasa fumbi* (removing the dust) was done in the past, but not now.” This referred to a practice whereby girls and boys are encouraged to have sexual intercourse after initiation. Tonthozo: “It is happening a bit, right?” A participant confirmed this. Tonthozo linked initiation to teenage pregnancies:

“If the kids try having sex they fall pregnant. You always tell the kids that they should not be afraid of men.” The initiator disagreed: “We don’t tell them like that. We tell them to respect parents and not to play with men.” Tonthozo challenged the participants on other consequences of initiation:

Don’t you change the names of your kids? When you change their names, they feel like they are big enough. At school, they are called by their real names, while at home you respect them a lot after being initiated. We always have good norms, but you always add bad things. You can’t tell them to go and sleep with men.

Tonthozo asked the teachers to explain why kids fail to continue with their education, and was told: “They are rude, they don’t listen to the teachers, they have ufulu, the freedom we have in our country.” One participant explained ufulu:

Students don’t use ufulu properly. Teachers have responsibility to teach about ufulu, but most ... don’t know what ufulu is ... the NGOs have more power than we do.

The participants linked what they saw as the misuse of ufulu to previous NGO initiatives implemented since the turn to democracy. Tonthozo interrupted and brought the issue back to parents’ responsibilities:

If the child comes late from school you just leave them, that’s the problem and I am satisfied. ... You don’t use ufulu clearly, and that is making kids not go far with education. Parents, you keep going to school to stop the teacher from punishing your kids, kids go to video shows, but you just look at them. Girls are bringing phones, but you don’t ask where they got it.

Tonthozo used various strategies to encourage community representatives to express issues in terms of behavior and motivate them to change. He shared his own background, made jokes, and had a preaching communication style. Although he acknowledged structural problems, he aimed to change attitudes: “It is true that there is poverty, but where is the NGO that can come and help you end poverty?” Instead, he argued that parents should “give guidance” and use ufulu “not only emphasize “rights” but also “responsibilities.” He asked: “What can we do to change ufulu?” Participants responded they would organize a meeting to talk to other parents. Afterwards he explained his strategy:

Provoke and then make jokes as a band-aid [to make up for the provocations]. You have to let them know that you know what is going on. Otherwise, they will only mention positive things. Like for example they mentioned that they tell kids about the importance of education during initiation rituals, but they don't tell that they teach them about sex.

In this meeting, Tonthozo tried to activate community members to change their own situation in line with the project, thereby holding initiators, teachers, and parents responsible while depoliticizing problems. Staff described structural constraints as “gaps in the project.” However, by overemphasizing behavior rooted in “culture,” staff members denied rural communities their social conditions.

LOCAL REALITIES

Discordance with local realities is inherent to any behavior change approach, as the “Other” has to change in accordance with project aims. There were various discrepancies between this project and local realities. Yao initiation, notions of development, and girls' aspirations, stereotypes about the Yao and culturalism, all played a role in concealing complexities and identifying the main locus of change to be in communities.

Initiation

To many Yao, initiation was a crucial moral injunction, symbolizing the transition to a different life stage and gender roles. Intimately linked with ancestors, funeral practices, the power of chiefs and witchcraft, initiation is a core element related to collective clan, kin and village obligations that are central to everyday life. It also collides with NGO moralities of individualism, human rights and pursuing educational aspirations (Swidler 2013).

During one month of seclusion (*jando*), boys between the ages of 5 and 10 were circumcized and received moral instructions about their new life stage. The initiator in charge of girls' initiation (*nsondo*) explained that girls were initiated twice: at the age of approximately 6 to 10 and “when the breasts start to come out.” One woman explained, “initiation is important to learn about the culture, follow what people were doing in the past, respect elders, and knock before you enter the bedroom of your parents. If they don't answer, don't enter.” Girls learn how to behave towards elders and men in the second initiation, but instructions on “how to treat the man in the bedroom” are provided only when “a man comes to propose.” This is “when the breasts are big.” However, playful references to sexuality were made during the first initiation: older visiting girls beat drums, and practiced songs and skills

with the younger ones, including how to perform a specific dance, which – presumably – mimicked how to move during sexual intercourse. Many songs and symbols cryptically referred to fertility and sexuality, and were accompanied by moral instructions, which older girls explained to us. Based on interviews with Malawian youth, Munthali and Zulu (2007:166) argue that “while issues of respect and new roles in society are discussed, a key focus of initiation or puberty rites for both girls and boys is to advise them on the transition to a sexual world,” either by avoiding or encouraging intercourse. Although girls’ initiation has been linked to perpetuating unequal gender norms (Ribhon 2002), Arnfred (2011) argues that (in Mozambique) initiation – especially of sexual skills – is an important source of female power and strongly protected in matrilineal societies.

Harmful Cultural Practices

Project staff and several villagers explained that Mangochi was famous for sex. Because of initiation, Yao women supposedly had distinct sexual skills, for which men from other ethnic groups praised them. Although Save Malawi has no official stance on initiation, project staff perceived initiation as important for transferring positive cultural values, but also argued it “should be adapted a bit.” Based on pre-existing stereotypes, rumors and information learned during community meetings, but without observing them, project staff had constructed an image of Yao initiation. Girls were said to receive instructions to never deny a man, and “remove the dust” with a *fisi* (literally hyena; a man with whom to have first sexual intercourse, marking the end of initiation). They also heard rumors of a naked woman lying on top of a girl to practice having intercourse, and the insertion of an egg so that a young girl would get used to the size of a penis. Project staff linked such instructions to girls exchanging sex for money, teenage pregnancies and early marriages. Due to its secrecy, initiation often fuels rumors about sexual content. Such rumors might have implications for how people act in their social context. Munthali and Zulu (2007) argue that Malawian youth perceive initiation as a license to have sex.

Although these are generalized ideas about initiation, project staff connected them to a distinct “static” Yao identity when speaking about Mangochi. Through information derived from community meetings, they constructed initiation as the *source* of other “cultural” behaviors that contributed to school dropout and teenage pregnancies. When a journalist of a national newspaper asked project staff about the main reasons for dropout in Mangochi, Edson explained:

During initiation, the children get a new name and are getting responsibility to look after themselves and their family. They will not receive any support from their parents and are treated with respect [like adults]. They are supposed to find money themselves, so the boys go to the lake to fish and the girls get money by having transactional sex. At school they are not addressed in this respectful way – baba, mama – this is the reason they drop out.

Initiation therefore was seen as responsible for problematic parent-child interactions, whereby the child had an adult status and responsibilities, and so was rude towards teachers; this in turn resulted in school dropout. The intention of this conversation was to promote the project and the staff member strategically provided an explanation in line with the behavior change focus, so reinforcing existing stereotypes. However, initiation as a static practice did not exist; it is in constant dialogue with context (Grimes 2000; Salomonsen and Roalkvam 2010). For example, several girls explained that the “fisi” practice was in the past, and that nowadays they could choose if they wanted to “remove the dust.” The duration of the camps varied, and ceremonies have shifted to the school holidays. Several people also claimed that the age for the initiation had decreased, because girls started puberty at a younger age. However, Yao who practised Islamic reformism, usually a younger generation (Van Kol 2008), condemned initiation ceremonies practiced by Quadriya Muslims as “un-Islamic.” A reformist imam (religious leader) explained that he promoted medical male circumcision, religious instruction and sexual abstinence before marriage.

Educated modern villagers

The discourse that education leads to a better future reflects a specific notion of development. During the 2016 project review meeting, Save Malawi staff, and partners from the government and one of the national NGOs, discussed how to convince people of the importance of education, especially in areas where things “are not improving very much.” The participants concluded that they needed “to sensitize the communities [because] there is a lack of knowledge” and that communities lacked role models to convince girls and families of the importance of education rather than early marriage to a man working in South Africa. Edson attributed the lack of improvement to “migration and culture,” while attributing positive changes elsewhere to a mixed population in which it was “easier for people to understand the importance of education.” Culturalism served to explain project success and failure, reinforcing stereotypes about the Yao. This denied the “Other’s” rationale that education

might be less beneficial where there were few formal employment opportunities or where schools were inaccessible.

Everyday life and development

Swidler (2013) argues that NGOs' focus on the autonomous rational individual through, for example, education is discordant with local realities of poverty, uncertainty, kinship obligations and lack of options to formal employment. This was the case in Mangochi, although there were differences among villagers. Teachers and community representatives argued that poverty was the main reason for school dropout (Pot 2018). A Yao woman explained: "Some parents encourage their children more than others. It is not that they find education unimportant, but it is because of poverty they drop out. They want the kids to help in the business." To many, development was linked with tangibles, such as having electricity, piped water, and iron-sheet houses, eating different food, sleeping on a mattress, having braided hair, nice clothes, mobile phones, televisions, and bicycles. People explained they could develop through small businesses, fishing, and working in South Africa. Dropping out of school and working in South Africa was more directly beneficial for boys than pursuing an education; for girls and their kin, marriage could be more beneficial. A Yao woman mentioned "there is no benefit in going to school" and had told her youngest daughter to drop out and take care of the grandchildren, so she (the mother) could work on an industrial farm. After a while, she encouraged her daughter to get married, so a man could provide for her. The girl explained that "going to school will take a long time for me to get what I want, because what I need most is some clothes."

For other villagers, education provided hopes for a better future, including better jobs. A divorced teenage mother explained: "I decided to go back to school because I am not happy with poverty." However, many families struggled to pay for secondary school fees in the face of uncertain livelihoods. Kin obligations and relationships in South Africa were instrumental. A girl mentioned: "My father is in South Africa and is able to send money for school fees and even nice clothes." A few lucky girls received assistance from NGOs and several girls relied on a PTM (Promise to Marriage) with a man working in South Africa, whereby they were engaged to be married and he assisted in paying their school fees. Some girls mentioned that these men did not always keep their promises to remit money, leading them to drop out. Meanwhile, because of the PTM, in-laws could ask girls to help with household chores, making it more difficult for them to focus on school.

The development discourse on the importance of education resulted in culturalism within the village. Several women from other ethnic groups spontaneously mentioned they disapproved of Yao girls and boys dropping out of school and they, to the contrary, did value education. They pointed to the bad influence of initiation ceremonies, and that Yao girls were “prostitutes.” Non-Yao villagers talked in a moralizing tone about a group of girls who had dropped out of school, and one woman mocked one girl for not being able to count money when selling vegetables. Reformist Muslims strongly advocated for knowledge acquisition as one of the central pillars of Islam. For example, a 19-year-old boy, following tertiary education, mentioned that the Quadriya Yao were “ignorant” and “still followed the old [traditional] way.”

The complexity of aspirations

Aspirations and agency are dialectically related to one another and to imaginations of alternative futures affected by constantly changing social, economic, and cultural structures (Dejaeghere 2016:5-6). The emphasis on schooling increases available options and imaginations, yet as already indicated, it can collide with the cultural expectations of moving from initiation into marriage and motherhood, and may be constrained by economic realities. The result is that “for many young women, the conflict between schoolgirl/mother roles becomes an embodied reality” (Kendall and Kaunda 2015:35).

When pursuing an education, girls delayed entry into adulthood “traditionally” following initiation, therefore claiming the status of girl for a longer period of time (Kendall and Kaunda 2015) and trying to pursue their dreams of becoming nurses, teachers, or managers at the industrial farm or at a tourist lodge. Girls mentioned that they appreciated encouragements from teachers, relatives, and peers. One girl (age 11, 5th grade) explained that she wanted to get married at 19, but wanted to finish secondary education first. She also conveyed that “when a girl is not married after 19 she becomes a ‘prostitute’.” However, girls in their late teens were sometimes still in primary school due to grade repetition. Girls dropped out of school, sometimes against their relatives’ advice, to marry and have children, or to pursue other aspirations, such as selling vegetables and enjoying their time at video showings. They also delayed adulthood, as they often refused men’s proposals by claiming that they were “still young.” For some, selling vegetables provided a daily income, and one girl aimed at being successful at this as a precondition for marriage to ensure she was financially independent.

Girls' reproductive actions were often informed by their aspirations and whether a man claimed responsibility. Some girls used condoms or hormonal contraception, often without parental knowledge, and therefore they feared attending the youth friendly health services at the local clinic and preferred traveling to town. Others monitored their menstrual cycle, advised each other on ways to abort (e.g. using aloe vera, drinking washing powder, or visiting the traditional healer). Girls talked about their friends' unsafe abortions when the man "denied the pregnancy" or the friend wanted to continue school. These abortions were not always successful and could have disastrous consequences. Thus, although many teenage pregnancies were unplanned, girls did exert some – constrained – agency in whether or not to take action, just as they chose or refused a partner for marriage. The construct of "teenage pregnancy" is, therefore, extremely complex.

Undesired pregnancies relate to age, marital and school going status, with aspirations that are not mutually exclusive and are shaped in various ways by dynamic sociocultural norms, but also by economic development, employment opportunities, and the entanglement of human rights with democratic freedoms. Mojola has shown how Kenyan school-girls aspire to modern consuming womanhood, which they achieve through sexual relationships, and suggests that "(m)ultiple femininities are always on offer for young women" (2015:218). Many Malawian girls pursued an education and had boyfriends. Through sexual relationships with peers and/or "big men," they were able to "be in fashion" and buy snacks. Several secondary school girls explained that sexual relationships provides them with money to buy second hand clothes. Community representatives saw this behavior and parents' inability to control their children as the result of *ufulu* as well as structural factors. A health surveillance assistant (community health worker), who was trained by the project, described poverty, the desire for material goods, and lack of contraceptive use as the main reasons for teenage pregnancies, suggesting that the project's presentation of linear development is discordant with the complexity of girls' aspirations. To some girls, self-efficacy is the belief in better future opportunities through education and preventing pregnancy, to others self-efficacy manifests as *ufulu*. Yet, a focus on "changing *ufulu*" – as staff suggested - still placed responsibility on individual girls and their individual behavior.

CONCLUSION

I have analyzed the design, implementation and reception of an INGO project aiming to reduce teenage pregnancies through keeping girls in school in Malawi, and have shown how

“culturalism” (Fassin 2001) flows through the project in the spaces created by global health development activities (Pigg 2013).

The project’s focus on behavior change and sociocultural norms, reinforced by class-shaped notions of development, positions “culture” as a behavioral determinant to explain high teenage pregnancy rates and school dropout. In community meetings, behavioral and cultural factors were overemphasized to activate community representatives to take action in line with project aims. At other times culturalism strategically served to explain project success and failure. Culturalism plays out through ethnic stereotypes, not only between elites and villagers, but also within the village. I argue that culturalism is a product of an ongoing series of development initiatives that dichotomized modernity and tradition, reinforced by short-term global health and development activities targeting individuals and communities.

Beck argues that “(e)ven when international discourses shift, underlying mentalities and practices may persist, allowing development projects to endure in repackaged forms” (2017:7). In Malawi, government and NGOs have blamed the same cultural practices, such as *fisi*, for different health and development issues (Page 2015; Ribhon 2002; Swidler and Watkins 2017). Initiation is now held responsible for fueling teenage pregnancies and school dropout. This illustrates how culturalism, through ethnic stereotypes and harmful cultural practices, becomes a “cultural product” of health development initiatives (Swidler and Watkins 2017) and part of a country’s development ideology (Pigg 1993). The pressure to secure donor funding and explain project failure reinforces culturalism (see also Lock and Nichter 2002:12; Page 2015), suggesting the value of examining and changing the harmful cultural practices of donors (Pfeiffer 2015) that facilitate these short-term projects.

Despite the projects’ design to fill a gap and be “holistic,” and staff attempts to better understand the reasons for teenage pregnancies and school dropout, the project is discordant with local realities. The reasons for teenage pregnancies and school dropout are complex, as are the ways in which girls’ aspirations are shaped. By overemphasizing “culture,” lack of attention is given to the fact that teenage pregnancies (and early marriages) are adaptive responses to socioeconomic and sociopolitical circumstances. Despite increased enrollment since 1994, teenage pregnancy rates and the median age of 19 at first birth have not substantially changed (NSO and ICF 2017). Comparing four successive DHSs, Grant (2015) found that although age at first birth has increased with the level of education, Malawian secondary school graduates continue to give birth at young ages. Grant suggests that limited employment opportunities leave girls with few options but marriage. Although the project

attempted to strengthen the education and health sector, sustainable improvements are questionable in under-resourced settings dependent on multiple short-term NGO initiatives (Pot 2018). As Schoepf (2001) described in relation to AIDS, anthropologists can contribute to an analytical shift in thinking about teenage pregnancies and girls' education in terms of structural inequalities rather than "culture." Otherwise, girls' self-efficacy might continue to be an unrealistic *belief* in a bright future (Frye 2012).

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Notes

¹ In practice, the initiator limited our access to information. She postponed answering questions and interrupted our conversations with visiting girls and women. I believe our presence and the unusual number of visitors who came to verify the rumors of a white woman in the camp made her uncomfortable as it jeopardized her authority and ability to protect the camp.

² Edson and Tonthozo are pseudonyms.

III

When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi

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Abstract: *Despite the strong global focus on improving maternal health during past decades, there is still a long way to go to ensure equitable access to services and quality of care for women and girls around the world. To understand widely acknowledged inequities and policy-to-practice gaps in maternal health, we must critically analyse the workings of power in policy and health systems. This paper analyses power dynamics at play in the implementation of maternal health policies in rural Malawi, a country with one of the world's highest burdens of maternal mortality. Specifically, we analyse Malawi's recent experience with the temporary reintroduction of user-fees for maternity services as a response to the suspension of donor funding, a shift in political leadership and priorities, and unstable service contracts between the government and its implementing partner, the Christian Health Association of Malawi. Based on ethnographic research conducted in 2015/16, the article describes the perceptions and experiences of policy implementation among various local actors (health workers, village heads and women). The way in which maternity services "fall apart" and are "fixed" is the result of dynamic interactions between policy and webs of accountability. Policies meet with a cascade of dynamic responses, which ultimately result in the exclusion of the most vulnerable rural women from maternity care services, against the aims of global and national safe motherhood policies. DOI: 10.1080/09688080.2018.1535688*

Keywords: accountability, power, health systems, traveling models, maternal health policy, user-fees, home-birth fines, inequity Malawi

Introduction

In December 2015, a group of village heads marched into the office of a local non-governmental organisation (NGO) which worked to enhance communities' self-reliance in the areas of health, education, environment and advocacy. The village heads had just received news that from January 2016, women needed to pay for maternity services in the nearby health centre, run by the Christian Health Association of Malawi (CHAM). This reintroduction of user-fees contradicted Malawi's Presidential Safe Motherhood campaign of 2012–2014, launched by former president Joyce Banda and underpinned with substantial donor funding and political legitimacy.¹ Banda's renewed attention to an existing policy^{2,3} intended to reduce

Malawi's high maternal mortality ratio (497 deaths per 100,000 live births)⁴ by encouraging women to give birth in health facilities, banning traditional birth attendants (TBAs), constructing maternity waiting homes, and training community midwife assistants.⁵ Banda mobilised traditional leaders to promote institutional deliveries,⁶ which were free at the point of care in public and certain CHAM facilities. The user-fee reintroduction also contradicted service delivery contracts between the Malawian government and CHAM that were supposed to guarantee user-fee exemptions. The group village headman, leader of several other village heads in the area, asked the NGO's director for assistance to get the free services back and expressed his worries:

“It is a big problem, because women don’t have the money to pay for delivery, so they will give birth at home. Many women will die! The TBAs [Traditional Birth Attendants] will have to help them, but there is no clean room where they can give birth.”

In this article, we examine the reintroduction of user-fees, after several years of exemption policies, and its impact on service access through an analysis of the perceptions, experiences and actions of various local actors: health workers, village heads, and women. We situate this in the changing funding landscape, namely the withdrawal of donor funds, and relate it to two relevant policies, the Presidential Safe Motherhood Campaign and the Service Level Agreements (SLAs). We analyse how dynamic relationships of power and accountability at various interfaces interact with these policies and show how in a donor-dependent and under-resourced setting, different actors apply their limited agency to manage and “fix” services that are “falling apart” in relation to their own priorities. This generates a cascade of dynamic responses – behaviours and relationships arising from within and outside the health system – in relation to policies,⁷ which ultimately result in the exclusion of the most vulnerable rural women from maternity care services, against the aim of global and national safe motherhood policies. This ethnographic study supports a growing body of evidence regarding the inequitable effects of user-fees,^{8,9,10} problems in relation to “traveling models” (uniform interventions which “travel” from global to local levels) such as skilled birth attendance and user-fee exemption policies,^{11,12,13} and the role of multiple actors in the generation and mitigation of problematic policies and their effects. In this way, we illuminate processes leading to inequity, a central challenge to achieving the Global Strategy for Women’s, Children’s and Adolescents’ Health and the Sustainable Development Goals (SDGs).¹⁴

Power and accountability

Financing mechanisms, shaped by nation states, as well as non-state actors and donors, are a key determinant of health care access. After structural adjustment programmes were implemented, anthropologists¹⁵ and other scholars⁸ demonstrated how user-fees undermined public sector services for the poor. A review of the empirical literature shows an adverse effect on maternal and

child health, especially among the poor.¹⁰ In recent years, user-fee exemption policies have been widely implemented. A quasi-experimental analysis comparing three Sub-Saharan African countries with user-fee exemption policies, and seven without, has shown a modestly higher skilled birth attendance and lower neonatal mortality rate¹⁶ where fee exemption was implemented. Other reviews show that user-fees are an important source of facility revenue, and if not replaced, can negatively affect provider behaviour and quality of care.^{9,17}

An analysis of power is necessary to understand the events leading up to the temporary reintroduction of user-fees and its effects. Power dynamics are an under-examined but key feature of health policies and systems.^{18,19} Power manifests implicitly or explicitly at the global, national and local level, and is present at each actor interface, shaping actions, processes and outcomes.¹⁸ “Traveling models” are adapted or resisted by health providers, whose behaviour is strongly shaped by practical matters, informal norms, professional culture,¹¹ and power dynamics.¹⁹ Examining how policy works out “on the ground” requires a multi-level analysis of power relations and the reflexive, complex and dynamic responses of health system actors.⁷ Since health systems are deeply political and a core social institution, functioning “at the interface between people and the structures of power that shape their broader society”,²⁰ analysing power in health policy and systems improves our understanding of the underlying causes of inequity.¹⁸

Power is conceptually fluid, and often discussed in the context of closely related concepts, such as accountability.¹⁸ Accountability has three dimensions: *responsibility* (holding responsible, taking responsibility), *answerability* (providing information, justifying actions), and *enforceability* (sanctioning inappropriate actions).^{21,22} Just as sources of power are always relational and context-dependent,²³ so is accountability. Actors are involved in multiple accountability relationships or “webs of accountability”, which are uneven. The moral landscape that forms, enacted in a context of risk and under-resourced systems, affects behaviours, interactions, health systems functioning and the quality of maternity care,²⁴ as discussed below.

Methods

The analysis draws on the first (HP) and second (BdK) authors’ research on maternal health in

Malawi, and, specifically, HP's ethnographic fieldwork in Mangochi district between May 2015 and August 2016. This was part of a broader project looking at interactions between international NGOs and local communities in attempts to reduce teenage pregnancies. Problems related to payments of service contracts and their consequences on the quality of maternity care overall emerged as an important theme. Between October 2015 to February 2016 and July to August 2016, HP conducted participant observation in the semi-rural area where she lived with her experienced research assistant and third author (GF) and where the health centre referred to in the introduction section was located. HP and GF investigated what happened over time, how the health centre dealt with financial setbacks, and how midwives, village heads and women responded to events and each other's actions. HP, accompanied by GF, interviewed and had follow-up conversations with a programme officer of the Catholic Health Commission (CHC), the director of the local NGO, the chair of the civil society organisation (CSO) network, nuns and midwives at the health centre, the local councillor, community health workers known as Health Surveillance Assistants (HSAs), and village heads and their advisors in two villages. HP also interviewed the then Minister of Health, examined the village birth register book, collected statistics on the uptake of services at the health centre and discussed patterns with the head midwife.

Core to the ethnographic method was the informal conversations and observations, which emerged from daily participation in the village, long-term interactions with families, and repeated visits to the health centre. HP and GF asked whether women and girls in the village had heard about the reintroduction of user-fees. Worries or stories they had heard were shared with the researchers. HP and GF also asked women with new-borns where they had given birth and why. Observations in the village, for example during meetings at the chief's house, or discussions between women, were informative in understanding general discourses. Observations during visits at the health centre before and after the reintroduction of user-fees confirmed a reduced uptake of services. GF continued data collection between late February and June 2016 while HP was away from the field and had weekly phone conversations with HP to discuss findings.

The National Committee on Research in the Social Sciences and Humanities in Malawi and

the Norwegian Social Science Data Service provided ethical approval. Following local ethics approval, HP obtained permission from the District Commissioner, the Traditional Authority, the Group Village Head and the Village Head to conduct research in the area. She obtained oral informed consent for interviews and household visits and introduced the research aims during a village meeting. The interview with the Minister of Health was recorded. HP and GF took detailed notes during all other interviews and transcribed them as soon as possible thereafter. They registered informal conversations and observations in digital field journals. Interviews were conducted in English. GF translated informal conversations and interviews in the village from *Chiyao* and *Chichewa* into English. NVivo Pro was later used to organise data in a database.

Data collection and analysis were part of an iterative and inductive ethnographic process, which built up to a rich contextualised analysis. HP and BdK analysed actors' perceptions and dynamic responses to the unfolding events and each other's actions. Discussions between the authors, BdK's knowledge on Safe Motherhood policies in Malawi and her work on power and accountability,²⁴ as well as data triangulation across multiple sources and perspectives, facilitated a nuanced analysis that considers multiple perspectives. Study limitations are the absence of data on the number of women who gave birth at the district hospital and at home, and the limited geographical scope as actors in other villages might have responded differently.

Findings and discussion

Global-national: dynamics around policies and funding

Presidential safe motherhood campaign

A key strategy of Banda's campaign was to "empower" and "sensitize" traditional leaders on the importance of improving maternal health.⁶ Consequently village heads developed various strategies,¹ in Mangochi together with NGOs, as explained by the chair of the CSO network:

"We showed statistics -morbidity reports- to communities. We started recording maternal deaths. Because we made this public, people got scared to give birth at home. And we gave regular updates to the communities."

I was one of the people who were involved in developing by-laws [local rules enforced by village heads]. NGOs discussed with the chiefs [village heads] what to do. They said that the women should pay a goat when delivering at home [...]

The other rule is that village heads should report deaths to the group village head, who reports to the TA [Traditional Authority]. The TA holds the chief accountable, and the chief has to pay money to the TA for every death.”

In Mangochi, local implementation and monitoring of the Safe Motherhood campaign thus entailed the following: NGOs linking homebirths to mortality; initiation of an upward accountability system for maternal deaths, following the chiefs' hierarchy; and encouraging women to give birth in health facilities through by-laws and home-birth fines (including a letter confirming the home birth and paid fine). Several actors were involved in implementing these by-laws, as explained by a midwife:

“The rule is that the women who deliver at home are supposed to pay 1000 kwacha [US\$1.5] to the chief, and the chief should give 500 [US\$0.75] to the hospital. [...] The chief should also write a letter, which the woman should bring to the hospital.”*

In 2015–16, 91% of women gave birth in health facilities.⁴ However, when Banda lost the presidency, the Safe Motherhood Campaign went back into “invisibility” at the national level, NGOs stopped focusing on the issue, there were no headlines in the newspapers anymore, and the continuation of local enforcement depended on individual village heads who had their own motivations to enforce the bylaws or not (B Chinsinga and P Mvula, professor and senior researcher, personal communication, January 9, 2018).

Service level agreements

The temporary reintroduction of user-fees contradicted SLAs between the government of Malawi and CHAM, which provides 75% of health services in rural areas.²⁵ In Mangochi, four out of fifteen CHAM facilities had a SLA,²⁶ where CHAM provides maternal and newborn health services free of charge and the government reimburses the costs. The government pays staff salaries and essential medication. District councils and CHAM signed

SLAs for geographical areas where needs were greatest.²⁷ Targets (based on expected user numbers) are reviewed and adjusted annually. The SLAs have substantially increased access to services.²⁸ Nationally, CHAM and the government were in ongoing negotiations over a new memorandum of understanding.²⁵

Starting in July 2015, “our” health centre was experiencing financial problems because of delayed government payments. According to the Minister of Health and the CHC programme officer (operating ten CHAM facilities in Mangochi, two with a SLA), several other health centres encountered similar problems. This is supported by a newspaper article.²⁹ This financial situation resulted from complex webs of accountability between donors, national and district government, and CHAM, intertwined with actors' different priorities in under-resourced settings. Malawi depends in large part on donor funding. Donors financed 63% of the health budget in 2013/14 and 54% in 2014/15.³¹ This drop in donor funding was due to corruption. In 2013, Banda's administration was involved in the “Cashgate” scandal and subsequently lost the elections. Donors have suspended budget support during every Presidency.³² Through the Health Sector Joint Fund, several donors earmarked money to safeguard the payment of the SLA and utility bills of hospitals, but the suspension of budget support indirectly influenced the payment of SLAs.

Our study found that the government and CHAM accused each other of respectively over-invoicing and delaying payments, which has been noted by others.³³ The then Minister of Health commented:

“There has always been a disparity between what is claimed and what is owed. [...] There are two problems that normally come with that. Let me say this that on average we are corrupt. [...] That normally happens even at facility level. [...] So then, the problem becomes that the government ends up spending a lot more money on reduced service delivery. [...] On the other side, we are not particularly good as government on ring-fencing monies. [...] You find that DCs [District Commissioners] have run out of money for [e.g.] education and they go and take from the SLA money. [...] I cannot say with certainty that the DC took money from the SLA. But I will be surprised if it has never happened in Malawi.”

According to the CHC programme officer, the result was that the District Health Officer (DHO) received less money than planned for and had to choose which issues to prioritise:

*According to the exchange rate on January 1, 2016

“They [DHO and District Council] were unable to pay the private clinics and meet their part of the contract. They prioritized operational costs at the district hospital and argued they can’t pay for the SLA while patients in the district hospital don’t have food.”

This ultimately resulted in the health centre reintroducing user-fees to cope with the financial setback. We will now discuss how health workers, village heads and women dealt with this “falling apart” of the SLA.

At the health centre: balancing institutional viability and maternity care

The primary health centre served a population of 50,000 in a large geographical area. The nearest public hospital with a maternity ward was 20 km away. The relationship between the surrounding villages and the CHAM facility appeared good: village advisors and women mentioned its good quality of care. The maternity ward included a four-bed pre-delivery room, a two-bed delivery room, a ten-bed post-delivery room, a private room for those who paid extra, the HSAs’ office, and a separate building for antenatal care (ANC). The health centre offered only basic obstetric care (including post-abortion care): there was no surgical theatre and they could not perform caesarean sections. Most complications required referral to the district hospital.

Midwives and HSAs implemented the Safe Motherhood policies. They encouraged women to give birth in health facilities and registered the place of delivery, thus enacting accountability through monitoring and evaluation. According to the midwives and HSAs, policies and interventions (awareness campaigns, SLA, by-laws with associated home-birth fines) were initially successful, with more women delivering at the health centre. However, multiple developments converged and conspired against trust and service use – including the way in which by-laws were implemented, financial shortages reducing the quality of care and ultimately the reintroduction of user-fees.

The midwives explained that by-laws were no longer “effective”:

“The laws are no longer effective [...] the way in which the letter [from the chief] is written implies that the rule is coming from the hospital. So women think that the hospital is punishing them for home delivery. [...] We think a lot of chiefs don’t follow up on the women who delivered at

home. So we stopped asking for the letters. [...] Because the chiefs don’t care, the women think that the hospital wants money.”

According to the midwife, the way in which chiefs implemented the by-laws appeared to affect women’s trust in the facility, so they stopped enforcing the policy.

Furthermore, the deteriorating financial situation resulting from funding problems with the SLA influenced the quality of maternity services. Midwives complained they had to use examination gloves instead of surgical gloves and they could not test haemoglobin levels. The government had not provided folic acid and iron tablets, so women had to pay to obtain these. They now also had to pay for services not directly related to pregnancy, but that used to be free to pregnant women. The midwives seemed to fear that the declining quality of care and payments for certain services affected their relationship with women and might stop them from coming to the health centre. A midwife complained:

“Women are used to free services. Even if they can afford to pay, they still refuse to come, because they expect a free service.”

In balancing its mission to provide health care to the poor and the financial situation, the health centre continued to offer most services free of charge for a while. In addition, as the nun in charge explained, they wrote a monthly letter to the DHO, thus holding him accountable for the situation, because: “The DHO is supposed to supervise the SLA”.

The programme officer at the CHC said they had regular meetings with the DHO, set ultimatums and threatened to terminate the SLA. However, these attempts to regain government funding were unsuccessful. In December 2015, the health centre announced the termination of free services, hand-written in *Chiyao* on posters in the ANC room:

“Notice: From January 16, all women who are going to start antenatal care and those who are going to deliver will be paying money”

The other CHAM facility under the CHC in Mangochi did the same. Women had to pay MK7500 [Malawi Kwacha] (US\$11) for delivery, MK1000 (US\$1.5) for ANC registration, and MK1000 (US\$1.5) for a post-delivery check-up. In case of complications, they paid extra and MK10,000 (US\$15) for ambulance

transport to the district hospital. Yet, the health centre's management intentionally asked less than their actual expenses, according to the nun in charge:

"150 women give birth in our facility every month. It is a disaster. We were no longer able to provide good services. We ask women to pay 10,000 kwacha [US\$15], so we can buy medication and gloves. But this 10,000 is not enough for us. But for the women here it is probably too much."

During ANC, the midwives and HSAs advised women to save money for delivery or for transport to the district hospital. Yet this was challenging, as the changes were announced only a few weeks in advance and it was in the midst of the "hunger season". Women went to great lengths to access the free services, sometimes tricking nurses into helping them. One of the midwives described:

"Women pretend to have money, but after helping them it turns out, they don't have it. Or the case is so urgent (at point of delivery) that we can't refuse to help the women and can't even ask about money until after delivery."

Four women jointly "escaped" from the maternity ward during night-time. A village advisor and one of the midwives explained they had put their babies in food baskets and walked out without paying. Because of the false payment promises, the management had decided there would be a strict "paying-up-front" policy. The interaction between women's and midwives' actions and dynamic responses to sharpen the health centre's policy could have contributed to critical situations and possibly maternal deaths.

Unless they were in labour or in critical condition, midwives had to refer women to the district hospital if they were not able to pay up front. Village heads, advisors and women told us about women giving birth on the side of the road, in the maize field, or at home. Others could not reach the referral hospital, or reached it too late. A midwife told us how a woman delivered at home, because she could not afford to pay the fee. As she was bleeding, she came to the health centre. Although she was referred to the district hospital, she died. A village advisor mentioned another situation:

"There was a woman and child who had to be transported to the district hospital by ambulance. The child was born premature at 6 months. The midwife

said they had been calling to the hospital the whole night to request an ambulance, but it didn't arrive in time. It arrived in the morning. The woman couldn't manage to pay 10000 [US\$15] to use the health centre's ambulance. There are two ambulances, which have been donated. But there is no fuel."

The Minister of Health gave instructions to the Ministry to settle all payments accumulated between July and December 2015 by January 31, 2016 to facilities who had their finances in order. This was secured through the African Development Bank.²⁵ On January 18, 2016, CHAM and the government signed a new memorandum of understanding, which was effected on July 1.²⁵ According to the CHC, the government still owed the health centre MK9 million (US\$14,000) in July 2016. Nationally, unpaid invoices had accumulated to MK400 million (US\$614,000) by March 2016.³⁴ In total, 16 out of 69 CHAM facilities with a SLA suspended the agreement in 2015.²⁵ In December 2016, a year after the reintroduction of user-fees, HP received a message from a midwife that services were offered free of charge again.

Village heads: local enforcement of policies and fines

As mentioned, village heads were key in the local enforcement of by-laws. They had the power to ask for fines, or not. The group village headman said:

"Women who deliver at home are charged 4000-5000 [US\$6-7.5], the equivalent of four/five chickens. Because the hospital is near and women are supposed to be ready all the time [to reach the hospital]. [...] My job is to guide the chiefs who are under me. [...] They are supposed to tell their people, but not all of them do. [...] That is why some who live close to the hospital still deliver at home."

Just as with the by-laws, the reintroduction of user-fees generated various responses amongst chiefs. The group village head went to "Mr. [NGO]" because he had helped them before and he said,

"I know that when they have money they will spend it to help the communities. The other organizations don't do that."

There was, thus, a relationship of trust. The group village head followed up on the NGO's advice to involve the councillor, who then wrote a letter to

the DHO. He tried to seek help from more powerful actors who could help him to get the free services back, but his power was constrained:

“It is a decision from the government, and I don’t have enough power. But I hope we can do something by talking to the radio. We have to tell others what is going on.”

The NGO had experience with using the media to hold the government accountable.

One of the village advisors, who was a HSA volunteer, explained they had lifted the MK1000 (US \$1.5) fine for home deliveries:

“Because we understand why it is complicated for women to pay for the hospital or travel to the district hospital.”

Considering it unreasonable to expect women to travel 20 km to the district hospital, and understanding financial struggles, the village leadership was responsive towards the situation of women. Another village advisor responded to the reintroduction of user-fees by emphasising women’s responsibility to use family planning during a public speech:

“They [the government] said [...] you should be using family planning methods, [...] but you don’t use it, that’s why there is not enough land to cultivate and also a lot of hunger. [...] Now giving birth [at CHAM] is 7500 [US\$11]. Are you going to manage? [...] From the past, the hospital was not free, but after helping you, they were giving the expenses to the government to pay for you. So don’t say that the Catholics have started bad things, no, but the government doesn’t have money to pay for you and it will take time to be sorted out. So be careful and tell each other.”

Village heads and advisors thus responded in various ways. Despite the midwives’ experiences of village heads “not caring about hospital deliveries”, in these two villages they did appear to care about women’s health and access to maternity services. According to one of the village’s registration books, which was updated to June 2015, nearly all women had given birth at CHAM. Village leadership tried to manage and “fix” the situation and hold the government accountable through the following means: involving more powerful actors (the NGO and councillor); social accountability initiatives (radio); holding women accountable by promoting family planning methods; or refusing to do so by lifting the fines. In the meantime, some

tried to maintain the trust relationship with the health centre by telling women that it was the responsibility of the government and not of “the Catholics”.

Women: accessing services and inequity

How did the reintroduction of user-fees affect women and their experiences of exclusion and inequity? Data from the health centre indicated that the number of skilled deliveries and ANC visits decreased by approximately 50% immediately after the reintroduction of user-fees. A midwife commented:

“We used to have eight-ten deliveries a day. Nowadays there is only one, two or three a day. Most women stopped coming. The same goes for ante-natal care. Today there were less than 20, while previously the number was close to 70.”

The programme officer at the CHC mentioned:

“There is some sort of ‘natural selection’, the ones who can’t afford it go to the district hospital.”

A midwife thought more women delivered at home because of worse quality of care:

“Reasons I have heard are that many people deliver there, they are not attended properly, they deliver on the floor, and they are not being assessed until delivery.”

Some women married to “businessmen” for example, could afford deliveries at the CHAM health facility. Others could not save enough money. A woman explained:

“I didn’t have money and I couldn’t do anything but give birth at home. There is no food in the house, no door at the other side of the house, not enough clothes, even torn blankets. How can I pay 7500 [US\$11] to the hospital?”

According to a midwife, multigravida women, in particular, stayed away, whereas younger women and girls still came to the health centre. She said that parents tend to help their teenage daughters. For example, the mother of a pregnant 15-year-old conveyed her worries regarding her daughter’s delivery. She was making mats and started saving money to pay at the CHAM facility; since they lived nearby, they could come and provide their daughter with food and other support.

From information in the postnatal register, one of the midwives inferred that women who had given birth at home returned less often for

postnatal care than women who had given birth at the CHAM facility or the district hospital. The woman described above who gave birth at home had decided not to take the baby to the health centre for postnatal care, afraid that the nurses would shout at her and hold her responsible and accountable for not complying with the advice to travel to the district hospital. Instead, her mother had protected the baby with traditional medicine. For other women seeking postnatal care after home delivery, they would still need to pay user-fees, as explained by a midwife:

“The ones who give birth at home and then come in for check-up still have to pay 7500 [US\$11]. This is because we check a lot of things: vital signs, checking the baby, weighing the baby, iron, blood pressure, temperature, the uterus, tears etc. The women who [do] come in after home birth are the ones who experience problems. Like losing a lot of blood or tears etc. We are still charging this 7500, because we are afraid if we reduce it, we will encourage home delivery.”

This practice of the health centre, partly based on continued enforcement of the Safe Motherhood policies, affected poor women’s access to services even further.

Conclusion

This article contributes to literature, marginal in public health, that places globally designed “traveling models”, such as user-fee exemption policies and skilled birth attendance, in the broader context of the day-to-day functioning of health systems and public health policy.^{11,35,36} Our analysis shows how dynamic responses and accountability relationships²⁴ can help explain problems with the implementation of policy^{36,37} and their inequitable effects when confronted with broader malfunctions of health systems.^{12,13,35} This article contributes to understanding processes leading to inequity, which is a central challenge to achieving the Global Strategy for Women’s, Children’s and Adolescents’ health and the SDGs.¹⁴

Global attention to maternal health has contributed to holding governments responsible for maternal mortality and improving health systems’ capacity to provide services. This and other research from Malawi shows that Safe Motherhood policies can affect women through punitive means.^{5,6,30,38†} Both home-birth fines and user-fees place the burden on poor women and increase

health system inequity, as confirmed by a long-standing and growing body of evidence on the negative implications of user-fees,^{8,9} and the recent studies on home-birth fines.⁴⁰ We showed that different actors are frustrated about user-fees and their impact on the poor, especially because in Malawi non-institutional deliveries have become strongly associated with maternal deaths.⁶

Our analysis highlights issues of intersectionality, with different social locations, power relations and experiences converging to shape inequity.⁴¹ The falling apart of SLAs especially affects women in rural areas, where access to care is already minimal. In addition, the poorest rural women struggle most to pay user-fees, and would have to travel to the district hospital. If village heads did not suspend the home-birth fine, women would end up in an impasse, having to pay the fine or user-fees.

Actors’ dynamic responses highlight issues of trust between health workers and women, which were negatively influenced by the local implementation of “traveling models”.⁴² Damage of trust seemed to be the reason midwives stopped enforcing the fine and letter system. User-fees eroded trust between women and health workers. Some women “escaped” without paying or were afraid of being shouted at when accessing postnatal care after home delivery. A village advisor tried to maintain the trust relationship by telling women not to blame CHAM for the situation, placing the responsibility with the government. Reduced trust in health workers and the government might have broader consequences of trust in public services and society more generally.⁴³

Our analysis has shown the need for considering aspects of power, health systems functioning and financing at the global, national and local level⁴⁴ to understand how health policies are implemented and what the consequences may be. We have shown how actors’ priorities play a role in the “falling apart” of services, starting with the discontinuation of donor funding and the (de)prioritisation of Safe Motherhood at the national level. In attempts to manage and “fix” the “falling apart” of services, dynamic responses are informed by actors’ different priorities and constrained by limited power within a constantly

[†]See also ³⁹ for how financial incentives as part of results-based financing for maternal and newborn health affect Malawian women.

under-resourced health system. This draws parallels with research on “street-level bureaucrats”, who manage policy implementation and “broker” project demands in the context of resource constraints.^{45,46} Local actors’ inability to hold powerful actors to account demonstrates that webs of accountability are uneven. Only when we analyse power relations from the global to the local level, and how these dynamically interact with policies, can we understand how inequities are shaped. Following other scholars,^{7,11,36,43,44} we make a couple of suggestions towards more equitable health systems. First, utilising ethnography can generate a better understanding of the complex interactions between policy and dynamic power relations. Second, policy reforms can start from the frontline, and should strengthen trust between women and health providers. Lastly, policy implementation should be monitored long-term, while being attentive to a possible cascade of dynamic responses and unintended consequences. This evaluative learning can feed back into improving policies.

Acknowledgements

We would like to thank all informants in Malawi for sharing their experiences and reflections with us, especially the women, village heads and midwives who were directly affected by the “falling apart” of services. We hope this article contributes to making their voices heard to a Malawian and a global audience. We would like to thank the NGOMA research team in Oslo and Malawi for valuable discussions and Katerini Storeng in particular for commenting on earlier drafts. Thanks to colleagues from the Department of Anthropology at the University of Amsterdam for their comments during a seminar.

Funding

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Résumé

En dépit d'une forte priorité accordée à l'amélioration de la santé maternelle ces dernières décennies, il reste encore beaucoup à faire pour garantir aux femmes et aux filles de par le monde un accès équitable aux services et à la qualité des soins. Pour comprendre les inégalités largement reconnues et les lacunes dans l'application des politiques de santé maternelle, nous devons analyser de manière critique les rouages du pouvoir dans les systèmes politiques et sanitaires. Cet article examine les dynamiques de pouvoir en jeu dans la mise en œuvre des politiques de santé maternelle dans le Malawi rural, un pays qui enregistre l'une des charges les plus élevées de mortalité maternelle du monde. Plus précisément, nous analysons l'expérience récente du Malawi avec la réintroduction temporaire des frais d'utilisation des services de maternité en réponse à la suspension du financement des donateurs, une réorientation dans le leadership et les priorités politiques, et des contrats de service instables entre le Gouvernement et son partenaire d'exécution, l'Association chrétienne de santé du Malawi. Sur la base d'une recherche ethnographique réalisée en 2015/2016, l'article décrit les perceptions et les expériences de la mise en œuvre des politiques parmi différents acteurs locaux (agents de santé, chefs de village et femmes). La manière dont les services de maternité « s'effondrent » et sont « réparés » est le résultat d'interactions dynamiques, qui aboutissent en dernier ressort à l'exclusion des femmes rurales les plus vulnérables des services de soins de maternité, à l'encontre des objectifs des politiques nationales et internationales de maternité sans risques.

Resumen

A pesar de un importante enfoque mundial en mejorar la salud materna durante las últimas décadas, aun falta mucho por hacer para asegurar acceso equitativo a los servicios y calidad de la atención para las mujeres y niñas del mundo. Para entender las inequidades ampliamente reconocidas y las brechas entre las políticas y la práctica en salud materna, debemos analizar críticamente el funcionamiento del poder en las políticas y sistemas de salud. Este artículo analiza las dinámicas de poder en juego en la aplicación de políticas sobre salud materna en las zonas rurales de Malaui, país con una de las cargas más altas de mortalidad materna del mundo. En particular, analizamos la reciente experiencia de Malaui con la reintroducción temporal de tarifas de usuaria para servicios de maternidad como respuesta a la suspensión de financiamiento de donantes, cambio de liderazgo político y de prioridades, y contratos inestables de servicio entre el gobierno y su socio ejecutor, la Asociación de Salud Cristiana de Malaui. Basado en investigaciones etnográficas realizadas en 2015/16, el artículo describe las percepciones y experiencias de la aplicación de políticas entre diversos actores locales (trabajadores de salud, jefes de poblados y mujeres). La manera en que los servicios de maternidad “se derrumban” y se “arreglan” es el resultado de interacciones dinámicas entre políticas y redes de responsabilidad. Las políticas se encuentran con una cascada de respuestas dinámicas, que a la larga causan que las mujeres rurales más vulnerables sean excluidas de los servicios de maternidad, lo cual va en contra de los objetivos de las políticas internacionales y nacionales a favor de una maternidad segura.

Appendix

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Vår dato: 30.06.2015

Vår ref: 43124 / 3 / HIT

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 14.04.2015. All nødvendig informasjon om prosjektet forelå i sin helhet 29.06.2015. Meldingen gjelder prosjektet:

43124	<i>NGOs and the transfer of global maternal health policies</i>
Behandlingsansvarlig	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Sidsel Roalkvam</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.07.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54

Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

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Prosjektvurdering - Kommentar

Prosjektnr: 43124

Prosjektet er en internasjonal samarbeidsstudie. Universitetet i Oslo er behandlingsansvarlig institusjon for den norske delen. Personvernombudet forutsetter at ansvaret for behandlingen av personopplysninger er avklart mellom institusjonene. Vi anbefaler at det inngås en avtale som omfatter ansvarsfordeling, ansvarsstruktur, hvem som initierer prosjektet, bruk av data og eventuelt eierskap.

Formålet med prosjektet er å undersøke og forstå hvordan ikke-statlige aktører bidrar til å overføre policyideer og kunnskap mellom globalt, nasjonalt og lokalt nivå. Prosjektet består av tre understudier: 1) en etnografisk studie av diskurser og praksiser rundt reproduktiv helse i en landsby i Malawi; 2) en etnografisk studie av en internasjonal NGO og dens arbeid med reproduktiv helse på flere nivåer (globalt, nasjonal og lokalt i Malawi) 3) en studie av den Malawiske staten og hvordan den arbeider med andre aktører innen reproduktiv helse.

Forskerteamet ved Senter for utvikling og miljø består av to PhD kandidater og en seniorforsker. I tillegg samarbeides det med en seniorforsker ved Chancellor College, University of Malawi.

Ifølge prosjektmeldingen skal utvalget informeres muntlig om prosjektet og samtykke til deltakelse. For å tilfredsstille kravet om et informert samtykke etter loven, må utvalget informeres om følgende:

- hvilken institusjon som er ansvarlig
- prosjektets formål / problemstilling
- hvilke metoder som skal benyttes for datainnsamling
- hvilke typer opplysninger som samles inn
- at opplysningene behandles konfidensielt og hvem som vil ha tilgang
- at det er frivillig å delta og at man kan trekke seg når som helst uten begrunnelse
- dato for forventet prosjektslutt
- at data anonymiseres ved prosjektslutt
- hvorvidt enkeltpersoner vil kunne gjenkjennes i den ferdige oppgaven
- kontaktopplysninger til forsker, eller student/veileder.

Det behandles sensitive personopplysninger om helseforhold.

Det behandles enkelte opplysninger om tredjeperson. Det skal kun registreres opplysninger som er nødvendig for formålet med prosjektet. Opplysningene skal være av mindre omfang og ikke sensitive, og skal anonymiseres i publikasjon. Så fremt personvernulempen for tredjeperson reduseres på denne måten, kan prosjektleder unntas fra informasjonsplikten overfor tredjeperson, fordi det anses uforholdsmessig vanskelig å informere.

Personvernombudet legger til grunn at forsker etterfølger Universitetet i Oslo sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc/mobile enheter, bør opplysningene krypteres

tilstrekkelig.

Det oppgis at personopplysninger skal publiseres. Personvernombudet legger til grunn at det foreligger eksplisitt samtykke fra den enkelte til dette. Vi anbefaler at deltakerne gis anledning til å lese igjennom egne opplysninger og godkjenne disse før publisering.

Forventet prosjektslutt er 31.07.2018. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:

- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lyd-/bilde- og videoopptak

Jf. epost fra prosjektleder 29.6.2015 vil det ikke bli innhentet personopplysninger om barn under 16 år i prosjektet. Personvernombudet minner om at forskningsetiske retningslinjer likvel vil gjelde. Lenke: <http://www.etikkom.no/Forskningsetikk/Etiske-retningslinjer/Samfunnsvitenskap-jus-og-humaniora/> (se spesielt del B, pkt. 12).

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY

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Ref No: NCST/RTT/2/6

19 October, 2015

Dr Sidsel Roalkvam
Chancellor College
University of Malawi
P.O Box 280
Zomba

Dear Sidsel Roalkvam,

RE: RESEARCH ETHICS APPROVAL OF PROTOCOL NO. P.09/15/58: NGOS AND THE TRANSFER OF GLOBAL MATERNAL HEALTH POLICIES (NGOMA)

Having satisfied all the ethical, scientific and regulatory requirements, procedures and guidelines for the conduct of research in the social sciences sector in Malawi, I am pleased to inform you that the above referred research study has officially been approved. You may now proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this letter. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research in the Social Sciences and Humanities in a format that is available at the secretariat. Once the study is finished, you are required to furnish the Committee and the Commission with a final report of the study.

Wishing you a successful implementation of your study.

Yours Sincerely

Martina Chimzimu
NCRSH ADMINISTRATOR AND RESEARCH OFFICER
HEALTH, SOCIAL SCIENCES AND HUMANITIES
For: CHAIRMAN OF NCRSH

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21 October, 2016

The Principal Investigator
Centre for Social Research
University of Malawi
P.O Box 281
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Dear Dr Mvula,

APPLICATION FOR CONTINUING REVIEW OF PROTOCOL P.09/15/58 NGOS AND THE TRANSFER OF GLOBAL MATERNAL HEALTH POLICIES (NGOMA)

We acknowledge receipt of your application in which you are requesting the National Committee for Research in Social Sciences and Humanities (NCRSH) to grant you permission to continue with your study Protocol P.09/15/58 NGOs and the Transfer of Global Maternal Health Policies (NGOMA)

The National Committee for Research in Social Sciences and Humanities (NCRSH) has reviewed the application and its study annual report. Having considered all the necessary documentation, NCRSH hereby grants you permission to continue with another one year. In case of modifications and amendments to the **approved protocol**, implementation of such amendments should not be effected before NCRSH approval of the same. With this letter, the ethical approval for annual continuation, effective the date of this letter is duly granted.

Your Sincerely,

Martina Chimzimu
NCRSH ADMINISTRATOR AND RESEARCH OFFICER
HEALTH, SOCIAL SCIENCES AND HUMANITIES
For: CHAIRMAN OF NCRSH

Memorandum of Understanding

between Center for Development and Environment, University of Oslo, Save the Children Norway and Save the Children in Malawi to analyze public health policies, opportunities and challenges related to Save the Children's test and invest project on Reducing teenage pregnancies by Keeping girls in Schools in Malawi

1. Background

Twenty six per cent of Malawian teenagers between 15-19 years have started childbearing (MDHS, 2010). Early child bearing has many consequences both for the mother and the baby. Young girls have higher health risks during pregnancy, during delivery and post natal both for themselves and their babies. Young mothers often drop out of school when expecting a child. Most of these girls do not reenter the education system after giving birth; consequently will not develop the educational skills that all young girls have a right to achieve to reach their full potential.

In a response to address this particular public health phenomenon and concern in Malawi, Save the Children Norway (SCN) with the financial support from Norwegian Ministry of Foreign Affairs /Norad has been implementing, in partnership with Save the children Malawi, a project called ***"More educated girls – Reducing teenage pregnancies in Malawi"***. This project has been designed based on situation analysis of programs, partners, and donors working to address Adolescent Sexual and Reproductive Health (ASRH) in Malawi. Various stakeholders including Ministry of Health, development partners, and NGOs were participated in the design phase of the project. While service delivery strategies implemented and proposed by partners varied, a gap identified was the need to address environmental and individual barriers to the use of youth friendly sexual Health Services. The situation analysis also sought to explore the link between teenage pregnancy, education, and keeping the girls in school. The connections between keeping girls in school and teenage pregnancy, reinforced by data from the MDHS, stressed the importance of a strong focus on improving the learning environment for girls to facilitate keeping them in school and advocating to young mothers to return to school.

The project goal is to reduce teenage pregnancies in Malawi. Building on synergies between our health and education programming, the project will achieve this by (1) increasing use of key sexual and reproductive health practices and services, (2) reducing girls' school dropout rate, and (3) increasing school re-entry rate after pregnancy.

To reach our goal, the following outcomes are proposed:

- Improved learning environment and self-efficacy of adolescent girls.
- Improved access to high quality Sexual Reproductive Health services for youths.
- Improved social environment to support adolescents' Sexual Reproductive Health Rights and educational achievement.
- Improved operationalization of policies to support adolescents' Sexual Reproductive Health Rights and educational achievement.

This project will be implemented in six administrative districts (Mangochi, Machinga, Ntcheu, Mchinji, Balaka & Phalombe) where the incidences of teenage pregnancies are highest. As a leading Child rights organization Save the Children will seek to yield improved results, for and with young people, by holding government as the primary duty-bearers to account, using existing structures to create an environment in which adolescent girls can thrive in and out of school, support government-led programs and policies for increased sustainability, scalability and accountability and promote a culture of quality and learning.

Currently, the project has been in the process of conducting baseline survey in order to set benchmarks of key project outcome indicators. As these is a test and invest area in the current strategy, SCN wishes to complement and enhance learning gained through research and assessment by partnering with universities and research institutions. In these regard, UiO/SUM has showed an interest to work in partnership and examine the underlying SRH/ASRH policy and related aspect favorable in order to implement the test and invest project. This document is prepared to clarify, purpose, roles and responsibilities and deliverables of the partnership.

2. Purpose

The ultimate purpose of this collaboration is to advise on the background of rigorous research those contextual factors that can enhance, influence or improve this test and invest project. This study examines SC's work on SRH policy at all levels (global, donor country, national office, community level) and questions the degree to which local knowledge and realities can enhance or improve SC's work on SRH policy on all these levels.

Health plays a role in the social empowerment, agency and capabilities needed to improve well-being; however, it is not merely a matter of making services, personnel and commodities available. It relates to how systems organize public information and participation in decision making, and invest in relationships, communication, knowledge, leadership and capacities to support these roles and functions. In order to explore these processes the research team will use participatory techniques as a methodological tool. Participatory research recognizes the wealth of assets that community members bring to the processes of knowing, creating knowledge and act upon that knowledge to bring about change.

By applying participatory techniques in the beginning, mid-way, and towards the end of the project period we will be able to explore/understand how values, norms, action, needs and desires are shaped and changed. We will apply participatory techniques on different groups in the community, e.g. adolescent girls and community leaders.

The key questions are highlighted as follows:

- What are the existing SRH/ASRH polices in Malawi? How are these policies implemented? Who are the key actors towards implementing ASRH/SRH policies in Malawi?
- How do those policies enhance or influence the test and invest project?
- How does the project engage community members and other influential leaders? What are their roles? How is the policy related to them?
- How does the project involve young people in the implementation of project and SRH/ASRH policies in general?
- How does Save the Children work with different partners including governmental agencies and local communities to advocate for their view on implementation of existing policies and how it leads to the drafting of new policies?

- Create a contextual framework for what works, does not work and why both on the health aspect and education. (eg attitude towards teachers in communities, teacher plans, classrooms settings).
- Through participatory techniques we will be able to get to know the community leaders attitudes (as the need to have data and study how we can influence the attitudes of the community leaders through the placement of the Researcher in the community)

On the other hand, the proposed study will contribute to SUM's research on global governance for sustainable development and its emerging global health portfolio. It will be affiliated with the LEVE network and with the NORHED project Strengthening Capacity for Democratic and Economic Governance.

3. Methodology

The aforementioned questions will be addressed using a multi-sited qualitative (ethnographic) approach, including observations and in-depth interviews at local, national, and global levels to understand how policy is being framed and negotiated at the interfaces between these levels. Moreover, the study will do in-depth interviews with local SC staff, international/Norwegian SC staff, and local counterpart in addition to focus group interviews and discussions with Save the Children's target groups within the selected two districts. This will focus on who the actors engaging in these encounters are (e.g. health workers, health seekers, teachers, chiefs, district commissioner, community based organisations), who they represent, what they bring to the encounter and the power dynamics between these actors.

4. Roles and responsibilities

SCN, SCM and SUM will take part in conducting the study. The roles and responsibilities of SCN, SCM and SUM are presented as follow.

Save the Children Norway (SCN)

- Provide inputs on the TOR, study protocols and tools
- Coordinate and facilitate the implementation of the study
- Organize regular meetings with SCM and SUM to discuss the implementation and challenges encountered
- Provide inputs and feedback on the study report

UiO/SUM

- Assign principal investigator of the study (point of contact)
- Select and inform the potential collaborators of the study in Malawi
- Develop protocols and standard procedures for the study
- Carry out the study as per agreed standards and ToR
- Prepare, share and discuss research findings with SCN, SUM and stakeholders. Details around how this can be done will be discussed and agreed upon during 2014
- Responsible for all financial matters related to the study
- Share and agree upon a actively plan/timeline on the study
- Develop ToR of the study in collaboration with SCN

Save the Children Malawi

- Assign key person to coordinate and collaborate with SUM to carry out the study
- Select districts (in consultation with SUM) for the study
- Facilitate and arrange all the necessary conditions for the smooth implementation of the study
- Organize meetings with government, stakeholders, community members and young people whenever necessary

Deliverables

- Terms of Reference (TOR)
- Detailed work plan for the study will be developed
- Study protocols and tools will be developed
- Final report of the study with findings, recommendations and lessons learned
- Presentations slides for workshops, meetings and conferences prepared

Budget

Save the Children and SUM have separate budgets from different back donors. The budgets should stay separate and if there happened to be any cross funding a formal application needs to be written for approval for both parties. (e.g. Save the Children expect SUM to pay their own transport to the program areas).

Timeline

The study will takes place during the project implementation period. The study will be expected to be launched in the last quarter of 2014. A timeline will be developed in collaboration with SUM, SCN as well as SCiM.

Ethical guidelines for SCN (attached to this document) also need to be sign by SUM.

Sign

Save the Children

Sign

Center for Development and Environment,
University of Oslo

Ethical Guidelines for Save the Children Norway

Document name:	Ethical Guidelines
DOCS No. and version:	274965
Approved date:	11.6.2014
Approved by:	Save the Children Norway Leader Group
Author:	Georg Mork
Next revision:	2016

This document has status as an attachment to the individual Employment Contract with Save the Children Norway and applies to employees, elected or appointed officers and voluntary personnel who represent the organisation (hereafter called representatives of the organisation). The document shall be signed by the individual and binds the signee in the same way as the contract. (The guidelines are based on the International Save the Children Norway Child Safeguarding Protocol, which was adopted by the International Board Trustees of Save the Children in March 2010).

Governing guidelines

Save the Children Norway is a human rights organisation that has no political or religious affiliations. The organisation's values are based on the United Nations Convention of Children's Rights and the Declaration of Human Rights. Save the Children Norway is an organisation working for and dedicated to the rights of children and the defence of the best interests of children in Norway and abroad. Our relationship to children shall be positive, dignified and respectful. The objective of the guidelines is to set the standard for personal conduct and the execution of tasks carried out on behalf of Save the Children Norway. Save the Children Norway's representatives shall spare no effort in striving to attain good and well considered choices where "the best interests of the child" shall be the overriding aim. The guidelines are split into two parts, 1) mandatory requirements and 2) guidelines for individual co-workers in situations that may present ethical challenges.

Representatives of the organisation cannot hold additional posts, secondary posts, positions of boards of directors or other tasks or commissions that are incompatible with the interests of Save the Children Norway, or may impair confidence in the organisation. Full disclosure is required with regard to any such posts and commissions as described herein that may influence the individual's role in Save the Children Norway.

All Save the Children Norway's representatives have the right and obligation to report any breach of these guidelines, in particular if there is suspicion of child abuse, misappropriation of funds/financial infidelity and similar acts and corruption. The manner in which reporting shall be carried out is described in the guidelines for reporting.

1. Mandatory requirements

Representatives of the organisation must clearly and unequivocally distance themselves from:

- misappropriation of funds/financial infidelity perpetrated against Save the Children Norway or organisations with which Save the Children Norway co-operates with.
- careless or negligent handling of confidential information that may result in substantial harm to the organisation, co-operating partners or individuals.

We shall never

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- strike or by other means expose children to physical or mental violence, bullying or demeaning behaviour
- expose children to any form of force or exploitation
- initiate sexual contact, or practice any kind of sexual conduct¹ of any kind with any person under the age of 18, regardless of the local legal age of consent. Failure to estimate a child's age *is not* considered to be or accepted as a redeeming circumstance
- produce, keep, store, have, distribute or by any other means be in contact with images of or representing the sexual exploitation of children
- violate a child's integrity by accusing, demeaning, dishonouring or by other means expose children to emotional abuse
- initiate or attempt to initiate any relationship with a child or any person in a child's family with the objective of committing any form of assault against the child (grooming)
- help a child with intimate tasks the child can do for itself
- discriminate against, give unfair advantage to or favour or treat children in an unfair or unjust manner
- encourage children to participate, either alone or with other children, in unlawful, dangerous or similar activities
- expose children to unnecessary risk of both physical or psychological/emotional nature

Save the Children Norway has a policy of zero tolerance with regard to the above-mentioned points. This means that any person who represents Save the Children Norway and who is in breach of any of the above-mentioned points must be prepared that there will be immediate consequences for the employment or affiliation relationship. The above-mentioned points apply both within and outside working hours unless specifically exempted.

2. Guidelines for ethical standards in the workplace

Representatives of Save the Children Norway shall

- adhere to the laws of the individual countries and show appropriate respect for customs and traditions. In cases where local customs and traditions are in breach of the UN Convention on Children's Rights and the UN Declaration of Human Rights the representative shall respect the international conventions.
- avoid discrimination with regard to race, religion, social and/or ethnic origins, gender, age and disability of all kinds.
- aspire to achieve neutrality in relation to religion and party politics.
- manage the organisation's resources in a sensible and proper manner.
- not subject colleagues to harassment, bullying or other forms for improper conduct.
- never attend the work place when under the influence of inebriants or intoxicants.
- show respect for the child's integrity and avoid embarrassing or mortifying exposure through photographic / video records and other documentation of the child's situation.
- combat corruption by
 - a) not accepting, either for oneself or others, gifts, travel, hotel accommodation, services, discounts, loans or other befits or advantages that can (or that the giver intends to) influence their role or their work in/for Save the Children Norway to own advantage.
 - b) not to offer gifts or other benefits that can, or are intended to, influence the recipient's actions in providing products and/or services.²

¹ Cf. The Criminal Code Section 19

² Gifts (of minor value) such as flowers, confectionaries and similar are not deemed to be such influence. If you are in doubt consult your immediate superior. In doing this you will also be able to have an assessment made of whether the gift is of such character that it should be handed to Save the Children Norway.

The ban on accepting gifts also applies when employees are engaged in external service tasks or carrying out tasks abroad. If special cultural circumstances indicate that to refuse a gift will be offensive to the giver, a gift can nonetheless be accepted but must be passed on to Save the Children Norway on returning home.

Ref: Save the Children Norway personnel handbook. DOCS-#121146-Personalhåndboka Retningslinjer for mottak av gaver - oppdatert 2010

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Consequences

I hereby confirm that I have read and understood Save the Children Norway's ethical guidelines, and hereby commit to adhering to these for as long as I am employed by or in any other way represent the organisation. I understand that each and any breach of the said guidelines can have consequences for my employment/affiliation with Save the Children Norway (typically discharge, suspension, summary dismissal). In breaches of a minor nature the consequences can include verbal or written warnings.

Oslø 23/2-15
Place/date

Sidsele Roalkvam
Signature

SIDSELE ROALKVAM
Capital letters

AV