Global Health Governance – Global Agendas, Local Realities

Expressions of Donor Influence in the Malawian Health System

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Master Thesis, Institute of Sociology and Human Geography

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Global Health Governance – Global Agendas, Local Realities

*Expressions of Donor Influence in the Malawian Health System*
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Abstract

This thesis has sought to illuminate how the operations of a national health system can be understood using a theoretical global health governance (GHG) lens. A national health system usually operates within the parameters of the government and the state. So how does it affect the operation of a national health system to receive financial and technical support from external actors?

This thesis uses the Malawian health system as a case study of how ideas of global health are interpreted in a national health system. Malawi was chosen as a case because the country’s health system is largely financed by external actors, as the government is unable to finance the operation of the health system. This qualitative study is based on textual analysis of the Health Sector Strategic Plan [2011-2016] and interviews with important actors in the Malawian health sector. The aim of this is to gain deeper understanding of the mechanisms that are happening in the health system as a result of external influences.

The main findings from this study are that external actors and partners in the Malawian health system have two main influences. The first is the enforcement of parallel systems of health care delivery in the decentralised health system. The second finding is that the external actors exert resource-based power over priorities in the health sector, through their access to financial resources.
Preface

Talk about being ‘out of place’. I was a blonde Norwegian girl, with a couple of dirty Birkenstock sandals, an ankle bracelet and a white embroidered bomber jacket. I didn’t fit in. I stood at the entrance of Crossroads Hotel and had no idea what I was doing there.

Crossroads Hotel is the largest conference hotel close to the old town in Lilongwe. Today it was the place hosting the Annual Review for the Health Sector 2015. The conference started at 7.45am. I was there at 7.55am since I overslept my alarm. Around me were maybe thirty other people in suits, fancy dresses and posher outfits than I could manage to pack in my 75-litre backpack. I registered my name at the registry. I had been invited, but yet I was so scared of being thrown out that my hand shook and I wasn’t able to sign properly. But they let me into the conference room and I found a seat. They even gave me a copy of the Annual Review Report. When I sat down, a lady gave me a copy of the programme. I was in. I had fooled them properly. At least that was what it felt like.

Lilongwe, 18.09.15

I want to thank a number of people for making this thesis happen. Thank you to the informants who took the time in a hectic month to talk to me. Without you, this thesis would not have been possible. I also want to say ‘zikomo’ to Boniface and James, who took great care of a lost and luggage-free Norwegian in Malawi. You are lifesavers. Caroline; thank you for keeping me sane in so many ways.

I want to extend the highest gratitude to my patient supervisor, Kristian Stokke. Thank you for helping me finding clear-cut arguments in a cluttered head that is full of thoughts. I also want to thank the Centre for Development and Environment (SUM) for inviting me to the centre, and for offering me a place to work and think. Thanks to the Institute of Sociology and Human Geography for making the trip to Malawi possible.

I want to thank my family for filling the role of being my very own health development partners (providing both financial and technical support). My mother; for the unlimited guidance and support in writing, but also for teaching me and always reminding me to have a critical mind, but more importantly; an open heart. Pappa and Torgrim, thank you for reminding me why I’m doing this, and for providing the best bear hugs. Thank you Cas, for not being afraid to tell me when you can’t understand shit of my writing. Thank you Solveig, for not letting me slaughter the English language. But also thank you for being great friends. Oda Lykke, Axel and Maren, thank you for your kindness in telling me when I could use a break.

I am forever grateful for the two past years with the greatest fellow students on the third floor of Harriet Holter’s House. Thank you for dealing with my pathos. You are true friends.

Marie out

Oslo, May 2016
## List of Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
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<tr>
<td>CSO</td>
<td>Civil-Society Organisation</td>
</tr>
<tr>
<td>DFID</td>
<td>Department of International Development (United Kingdom)</td>
</tr>
<tr>
<td>FICA</td>
<td>Flemish International Cooperation Agency</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccine and Immunization</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GHG</td>
<td>Global Health Governance</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>GHP</td>
<td>Global Health Partnership</td>
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<td>GTZ</td>
<td>German Technical Cooperation</td>
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<tr>
<td>HDP</td>
<td>Health Development Partner</td>
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<tr>
<td>HSSP</td>
<td>Health Sector Strategic Plan [2011-2016]</td>
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<td>MHEN</td>
<td>Malawi Health Equity Network</td>
</tr>
<tr>
<td>MHS</td>
<td>Malawi Health System</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCA</td>
<td>Norwegian Church Aid</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
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<tr>
<td>NORAD</td>
<td>The Norwegian Agency for Development Cooperation</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The U.S. President's Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PoW</td>
<td>Programme of Work [2004-2010]</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector-Wide Approach</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nation’s Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
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1 Introduction

The conducting of health policy has changed after the Second World War. Processes of globalisation have in many ways intensified this transformation through fundamental changes in how we relate to global health (Buse, Drager, Hein, Dal, & Lee, 2009, p. 1). Moving from health as a matter of disease and border control to the investment in health care as a human right marks a shift in the way health policies are being conducted on a global scale. The objective of global health is to address the prevalent health inequity that exists across the globe, in terms of access to medicines and health care that can contribute to better health for more people.

Yet, the actors involved in the field of global health have not found consensus on how global health governance (GHG) is best conducted. Global health, and especially GHG, has become a contested area where policy and innovations in health are governed in a relatively uncoordinated manner. The result is a complex ad hoc oriented system where pledged commitments and objectives are confused by the multitude of different and overlapping policy documents, strategies and abbreviations. The scope for practical policy implementations has as such been limited. This thesis seeks to clarify some aspects concerning the interface between global health and national health system operation. The rationale for choosing this aspect of global health lies in understanding the bigger picture and thus being able to contribute to understanding the broader strokes of how global health policies are being conducted globally, and what the influences are on the national and local scale.

Health within the parameters of the state is largely delivered by national health systems. National health systems face a diversity of structural conditions which impact on the efficiency and quality of health care provision, such as the political environment and the macroeconomic situation. Especially in the Global South, health systems are vulnerable to the effects of such structural conditions, in addition to other social elements such as poverty (Chant & McIlwaine, 2009). The Global South will in this regard be considered as a uniting term for the countries united by their commitment towards ‘development’ (Turner & Hulme, 1997; Chant & McIlwaine, 2009). In the aim towards health equity, however, national health systems are an important instrument in delivering health care to different populations. Thus, the inefficiency of health systems has become an important obstacle to increasing health equity.
This study has therefore sought to illuminate aspects concerning the operation of a national health system and how this can be influenced by external forces, such as ideas of global health. The point of departure in this regard is to evaluate these aspects in relation to developments in global health policy, because the ‘architecture’ of global health has shifted in the last few decades. Health as an integral part of countries’ governmental set-up where the state is the main deliverer of health services has lost supremacy in the last years, and global health is now faced with a situation where multiple actors and their respective interests have taken a central position.

1.1 Problem statement

To pin down local realities of health and the functioning of a health system, this thesis will centre on a case study of a national health system in Sub-Saharan Africa. While being a small country in terms of actual size, Malawi is highly involved in global health. The country is facing many challenges in relation to poverty, generally low economic growth and low levels of infrastructural development, as well as underperformance on health indicators such as child mortality and life-expectancy (NORAD, 2013). However, the country has adopted many health innovations, and has made some significant relative gains in health since the transition to multiparty democracy in 1994. Malawi is a highly donor-dependent country that receives significant amounts of donor funding from multiple partners and organisations. In the health sector some of these actors are identified as the Department for International Development (DFID), the German Technical Cooperation (GTZ), the Flemish International Cooperation Agency (FICA), United States Agency for International Development (USAID) and United Nations Population Fund (UNFPA) (Ministry of Health, 2011, p. 85).

The massive influx of expatriate actors in development and health can cause challenges in terms of national governance of health and the operation of the national health system. Eggen and Sending (2012) points to how global agendas on health can cause national health systems to be undermined by more resource-powerful actors: “They can be reduced to gatekeepers without mentionable influence on strategies and priorities, and low capability to channel foreign resources into health related fields that are not identified in the Millennium Development Goals” (Eggen & Sending, 2012, p. 212, own translation, italics original). The Malawian health system is an illustration of how a comprehensive health system responds to external influences, in terms of resources and support.
Earlier research on global health, GHG and the relationship with national health systems has been largely focused on globally committed targets on health and the scope of international collaboration in global forums (Dodgson, Lee, & Drager, 2002; David P Fidler, 2005; Kickbusch, Silberschmidt, & Buss, 2007; D. Fidler & Drager, 2009; Feldbaum, Lee, & Michaud, 2010; David P. Fidler, 2010; Labonte & Gagnon, 2010). Largely, the issue pertaining to studying the interface between national health systems and global ideas on health concerns who or what is thought of as the supreme actor in the conveyor of health. The literature on GHG is diverse on how it relates to such supremacy. Some argue strongly that the state holds a primary role in the formulation and provision of health care (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHO MPSCG), 2009). In contrast, others claim that national health systems have no choice but to adhere to the global influences on global health strategies, and the variety of actors that are involved in the spread of these (McKee, Gilmore, & Schwalbe, 2005).

Calls have been made to meet the need for research on what effect expatriate actors in national health systems have on policy formulation and priorities in developing countries (Buse & Harmer, 2009, p. 250). Whilst efforts have been made to adequately analyse the effect of donor-biases on HIV/AIDS to the detriment of other priorities in the operations of local NGOs (Morfit, 2011), it is somewhat more elusive what the effect is on more qualitative measures of the national health policy environment. Following the arguments of Sylvia Chant and Cathy McIlwaine (2009, p. 255), there is need to strengthen the understanding of health as more than quantitative measures, and that health system strengthening should not be mainly based on quantitative measurements of progress in health.

The gaps in research have inspired the shape and objective of this thesis. The objective of this study is to further understand the effects of global ideas on health governance on the Malawian health system. Following the arguments of George and Bennett (2005, pp. 266-267), the Malawian case study can contribute to middle-range theory; the aim is to explain certain aspects of a general phenomenon, and the case study is consequentially rather limited in its scope. The goal of this contribution is to further develop the aspects of global health governance conceptualisations relating to health systems.
1.1.1 Research questions

The structure of this thesis has been guided by two research questions based on the objective of this study. The questions that this thesis aims to answer are:

(1) *What characterises the Malawian Health System (MHS) as formulated in the Health Sector Strategic Plan (HSSP) [2011-2016]?*

(2) *How does the agenda of the Health Development Partners (HDPs) influence the implementation of the HSSP, and what are the consequences for the priorities and organisation in the MHS?*

These questions have been articulated with the aim of understanding the processes that happen in the Malawian health system as continuous and non-static. It is not my prerogative to investigate and explain the full relationship between the Malawian government and the development partners and organisations that are present in the country, but rather to shed light on the mechanisms that have emerged in the government system through influences from global agendas on health. To gain insight to these two questions, the thesis will benefit from the responses shared by the informants interviewed during a qualitative fieldwork in Lilongwe, Malawi in the months of August and September 2015. Their perceptions have shaped the theoretical scope for this thesis, and their thoughts have been invaluable in the pursuit of gaining knowledge on how processes of governance are happening in the Malawian health system.

1.1.2 Scope and limitations

To address all aspects of the relationship between GHG, HDPs and the Malawian government and national health system is outside the scope of any master thesis. Some limitations are thus necessary.

First of all, this thesis will focus on the existing theoretical scope of global governance and its relation to health. The different approaches that will be discussed will draw inspiration from classical and modern governance theory and their applicability to notions of global governance. This thesis thus assumes the existence of globalisation as a global phenomenon. The leading argument for this is that globalisation processes are evident in terms of the
increased establishment and importance of transnational organisations, foundations and partnerships that unite in their fellow commitment towards curing disease, as well as alleviating inequities in health (Buse et al., 2009). The thesis will however not expand on aspects of globalisation other than the challenges this poses pertaining to the governing of health. In relation to the assumption of globalisation, the thesis will assume that development partners that are distributing financial support for development are aligned to the Paris Declaration of 2005. This means that they are committed to notions of ownership, alignment, harmonisation and mutual accountability in donor relations: “[...] support partner country efforts to strengthen governance and improve development performance” (OECD, 2005, p. 3).

Secondly, the thesis will make use of a timeline which doesn’t necessarily ‘exist’ in conventional terms, but is inspired by the timeline described by Walt, Spicer, and Buse (2009). The three epochs are the era of primary health care (1970s-1980s), the era of health reforms (1980s), and the era of health partnerships (1990s-2008). This means that these three epochs will frame the discussions in the following chapters, but that they are not underpinned historically by dramatic shifts brought forward by events or global commitments. The timeframe rather reflects the tendencies that emerged in the area of global health in the decades after the Second World War, and is meant to provide a historical context to the thesis.

Lastly, in studying Malawi from a governance point of view, it is important to recognise that the country operates with a parallel political system. The country did not remove the traditional authorities in the creation of the state, and these traditional authorities still play an important role for policy implementation. When policy is legislated in government, it is also run by the traditional leaders. This has created a dynamic relationship between old and new systems of governance, which makes the Malawian political context unique in its own right. However, as the traditional authorities do not play in on the decision-making process within the governance and policy levels in the Malawian health system, their role will not be addressed further.

1.2 Case in point: Malawi as national and global

What makes it reasonable to think that it will be more beneficial to examine global impacts in the Malawian health system in contrast to any other system? Will it be transferable to understanding the general interaction between global influences on health and national health systems? The rationale for choosing the topic of analysis for this thesis is based on
interpreting and explaining the tendencies of how health policies are being conducted globally and what the influence is on the local scale. Choosing Malawi as an area relevant for the choice of case study was related to the economic and political contexts that characterises the country. In order to amply identify the contextual aspects of this case study, the following paragraphs will provide a brief account of the economic and political landscape in Malawi, in order to understand the policy environment in which the national health system operates today.

Expatriate influences have played an important role for many of the social developments in Malawi for a long time. David Livingstone visited Malawi first in the middle of the 19th century, establishing the linkages between Great Britain and Malawi for the years to come. Following the declaration of Malawi as a British Protectorate after the Berlin Conference in 1884, the British influence in Malawi was a fact. Early on, the British established laws that would ensure ownership of land to the colonisers. This was founded on the idea that Africa would provide cheap and abundant labour, while the British could provide capital for production (McCracken, 2012, p. 77). After the Second World War, this became a prominent feature in what is known as the ‘second colonial occupation’, where the restructuring of African economies across the continent was prepared in order to satisfy the British consumer back in Europe. This became the starting point of a national economy specialised on producing raw materials for export, including tea, cotton, and tobacco (McCracken, 2012, p. 238). To this day, most Malawian production is within these three sectors with the rest of the economy operating small-scale. Small-scale peasantry represents 80 percent of the occupation in Malawi, and most families are reliant on producing their own food (World Bank, 2015). This economic system is vulnerable to natural risks such as drought and floods, which has led to famine and famine-related crisis for many decades.

The involvement of the British and various colonial heads also influenced how health was treated and organised in Malawi. Before the colonial period, most Malawians sought traditional medicine provided by healers with responsibilities within two main categories: witchcraft specialists and herbalists. Many serious diseases were prevalent in Malawi, and the British did not respond well to the disease environment. Malaria was the most prominent disease, and many of the British missionaries died few months after their arrival. Western medicine was not familiar with the new infectious diseases, and could not offer any treatment for the ailments (McCracken, 2012, p. 116). However, the involvement of missionaries also introduced new bacteria and disease to the African continent. In Malawi this meant the spread
of tuberculosis, smallpox and bilharzia. The first and the latter of these diseases are prominent and cause significant fatalities to this day. The organisation of health care into a health system was important for the colonising powers, and today components of the Malawian health system largely reflects the health system which was established by the British (McCracken, 2012). Western medicine has played a significant role in Malawi also after decolonisation, and the country eagerly adapts to new innovations in medicine and vaccine technology.

The economic situation in Malawi today is one of complexity. Expatriate development partners and donors have been present in the country also after decolonisation, and some argue that Malawi’s donor dependency poses a challenge to the development of Malawian society (Nyirenda, 2014). Malawi transitioned into a multiparty democracy after revolts in the population after thirty years of autocratic rule under Dr. Hastings Kamuzu Banda. Dr. Banda ruled Malawi as the undisputed leader and ‘Father’ of the country after decolonisation in 1964. Even though his rule was repressive, he was in large part allowed to rule the country without much interference from Western countries (O Ihonvbere, 1997). According to Julius O Ihonvbere (1997, p. 225) Dr Banda owned half the Malawian economy during his rule, and the majority of this was distorted through large scale private expenses and transactions. Dr. Banda was pro-Western, and through his years as leader the donors looked past Banda’s political regime, as he was lenient to follow their conditions in exchange for receiving more funding. However, this funding increased the personal accumulation of wealth for Banda, reinforcing the Big Man Rule. Big Man Rule is a form of personal rule; a political concept which has been rather widespread on the African continent, pointing to how autocratic leaders blur the private and public spheres of political reality (Hyden, 2013, p. 98). The consequences of such rule in Malawi were the severe underdevelopment of the national economy and a non-accountable and inefficient government.

After Dr. Banda was overthrown in 1994, hopes were high in Malawi for a democratic transformation that would better the lives of the people in the country, and open up the political system for civic participation (Lwanda, 2006). However, the last twenty years have shown that this has been a challenge on many levels. Ten years after the democratic shift away from Banda and his regime, the economic situation had not much improved in the country. However, O Ihonvbere points to how those attempts were made to challenge the large transaction costs that were eating away at the already small national budget (O Ihonvbere, 1997, p. 240).
The role of the donor partners present in the country has also shifted after Malawi’s transition to democracy in 1994, in terms of becoming more involved politically and economically. However, the relationship between Malawi and its donors has been challenged more times than once in the last few years. An increase in political unrest in society led to a dramatic confrontation in 2011, when several protesters were killed by police forces in Lilongwe, Blantyre and Mzuzu during a peaceful protesting of the worsening economic situation and the increasing political oppression (Human Rights Watch, 22.07.2011). The incident led to the freezing of donor funding from the key donors present in Malawi. The following March, in 2012, Malawi’s President Bingu wa Mutharika made international headlines when he told the expatriate donors to ‘go to hell’, following the cuts in foreign aid to Malawi as a result of its political and economic practices (Nyasatimes, 03.2012). The President was concerned that the donors were supporting his political opposition, and damned their presence in the country. He said that if the donors did not believe that Malawi was a democracy, they could very well leave the country.

President Bingu wa Mutharika died shortly after his outburst on the expatriate donors in 2012, leading his vice president Joyce Banda to become the first female President in Southern Africa. A wind of change seemed to blow over Malawi, and hopes were again high. She stayed on as President until the term ended, and mended many of the ties with development partners and key donors during her time in office. Her efforts largely repaired many of the donor relationships with key development partners, which helped Malawi out of an economic crisis at that time by unfreezing funding from various Western partners (Guardian Africa Network, 17.12.2012). Joyce Banda was superseded by Bingu wa Mutharika’s younger brother Peter Mutharika, who still functions as Malawi’s President at the time of writing this thesis [May 2016].

Health has for a long time held the centre stage as an important segment of aid for development, and the health sector has been of great importance for the development partners present in Malawi. This is evident through the many partnerships, commitments and agreements on health care delivery that are present in the country. The aim of these commitments is to increase the level of health in Malawi, and the different actors are united by their commitment to global targets on health such as many of the Millennium Development Goals, and the newly established goal three of the Sustainable Development Goals (SDGs); Good Health and Well-being (UN, 2016). Such goals also engage with the sustainability issue of aid for development, and many actors in health have as a result become
more focused on ‘good governance’ in the attempt to make aid more efficient. In many
countries that receive aid, the result has been a direct link between efficiency and measured
results in the health sector: “[…] the protection and promotion of health has become an
independent marker of ‘good governance’ at national and international levels in the early 21st
century” (David P Fidler, 2005, p. 11).

However, during President Bingu wa Mutharika’s term, China came in as a strong
financial actor, especially in terms of financial support for infrastructure. The emergence of
China as a financial supporter in African countries is outside the scope of this thesis, but has
been discussed heavily elsewhere (Rotberg, 2009; Kilama, 2016). However, the importance of
the introduction of Chinese finances in Malawi for this thesis is that it opened up perspectives
on the efficiency of ‘traditional’ aid from Western countries. President Banda stated in 2012:

“China doesn't keep us waiting for two years. China will decide today and will go ahead. The
next day you sign, and work starts … so, the choice for Africa is: do I want to have a road next
year, or do I want to stay for two years discussing about human rights and governance before
we can even talk about the road?” (Guardian Africa Network, 17.12.2012).

President Banda’s quote shows how dealing with Western development partners often
includes conditions on governance structures. However, the largest portion of Malawi’s key
donors is tied to such conditions, because of conditions on accountability and transparency ‘at
home’. Malawi’s situation is thus influenced by governance conditions that circumvent their
own system of governance, using financial resources as a means for ensuring elements of
‘good governance’ in the Malawian government system.

These elements of the economic and political climate in Malawi help with the process
of situating the parameters of this study. Studying the processes of organisation and
implementation in the Malawian health system can contribute to bridging the gap between
theoretical assumptions and practical experiences with the implications global health
governance ideas have on national health systems (George & Bennett, 2005, p. 265).

1.3 Structure of thesis

The first chapter introduces the research questions for the following thesis, and elaborates on
why these questions are relevant in a study of global health governance in Malawi. This
chapter has also elaborated on the key elements of the Malawian society that are necessary in
order to situate the parameters of the case study
The second chapter will conceptualise the theoretical assumptions for the research project. This chapter will theorise how global health governance functions as a tool for analysing situations relating to governance in health. Two models of governance are conceptualised in this chapter in order to establish an analytical framework for the research project. This chapter also forms the conceptualisations of health systems.

The third chapter will explain the methodological framework posited for this thesis, as well as elaborate on what happened during the fieldwork in Malawi in the months of August and September 2015. The last section of the chapter will also introduce the approach used in the analysis of the produced data.

The fourth and fifth chapter represents the analytical contributions of this thesis. These two chapters will aim at using the theoretical conceptualisations as a backdrop to answer the research questions posed earlier in this chapter. The fourth chapter will conceptualise the Malawian health model, and ground the Malawian idea of health, which constitutes the priorities and organisation of the Malawian health system as formulated in the HSSP. A discussion on the informant’s experiences with the priorities and organisation of the health system will help constitute the Malawian health model based on the two conceptual models of governance established in the second chapter. The fifth chapter will identify in what ways the expatriate HDPs influence the implementation of the HSSP, and how this affects the priorities and organisation of the MHS. This chapter will embed this discussion in the conceptualisations of power within health governance, as established in chapter three.

The sixth chapter will draw together the summaries and conclusions from all the chapters of this thesis, and draw the lines for the concluding remarks and the recommendations for further study.
2 Theoretical Assumptions

Health is of instrumental and intrinsic value to everyone. Good health or the lack thereof, is highly personal and private, but does at the same time inflict on the society as a whole. Global health governance (Abbreviated as GHG, which it will be referred to as from this point) does in many regards represent a paradigm shift in how we understand and conceptualise health and health care, but within this understanding lies different approaches to practical health care delivery. These different approaches also entail consequences for the implementation of health care on the national and local scale. The aim of this chapter is to present and evaluate two conceptual models for governance within the theoretical scope of GHG. The Malawian health system does not operate in vacuum. It is contextual and situated in multiple instances. In order to offer a new perspective on health system development within a GHG system, it is critical to understand how different stories collide, constituting the makings of a unique context.

This chapter will thus expand on the influences that have had, and still have, impact on the policy formulation of organisation within the global health scene generally and health systems specifically. The chapter will first account for the theoretical framework in which ideas of GHG is grounded, namely global governance thought as established in International Relations theory. The chapter will then account for the historical developments in the governing of health, to contextualise the developments that have happened in the international versus global understanding of health from the end of the 19th century and up till today. This will be inspired by the same analytical timeframe used by Walt et al. (2009), which was introduced in chapter one, Introduction: the era of primary health care [1970s-mid-1980s], the era of health reforms [mid- 1980s] and the era of global partnerships [1990s-2008]. This is in order to hold on to the chronological order of developments in the global health field, and to portray the historical timeline for this chapter. This timeframe also hold value in the conceptualisation of the two models of governance conceptualised in this chapter: The Primary Health Care Approach (PHC) and Global Health Partnerships (GHPs).

Lastly, the chapter will draw linkages between these two governance models and the conceptualisation of health systems. The main argument of this chapter is that notions and ideas of GHG mark a radically different understanding of how health is dealt with on the national scale.
2.1 Why govern health?

In the pursuit of understanding what governance for health means, and for whom it is meant, it is important to clarify the definition of health. The widely known definition by the World Health Organisation (WHO) is “[…] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organisation (WHO), 22.07.1946). The definition grounds a belief that health is much more than the “lack of” health – health is rather the capabilities of a person, which must be protected and ensured. Words do not, however, easily translate into action. The WHO’s definition of health does not make the job of policy formulation for health an easy task, as it is wide in scope, and thus rather diffuse in its explicit meaning. This means that conceptualisations at policy level are necessary for governments to translate ideas about health and health care into comprehensive action. Different nations understand health differently, but the consensus across the globe has come to understand health as a basic human right, which requires efforts at the highest level to uphold for all persons (World Health Organisation (WHO) & United Nations Children's Fund (UNICEF), 1978). This implies that health is not something that just happens; it is achieved through the active provision of health.

In the world today, large and expanding inequities in health persists (World Health Organisation (WHO), 2008). Different nations face different issues and problems in achieving health for their population, and matters such as climate, economic and political situation, and lifestyle affect the level of health in a population. The trend thus far has been that the negative effects of such matters adversely affect populations in what can be called the Global South. The term Global South frames as mentioned the countries united by their commitment to ‘development’ and are most commonly referred to as developing countries, the Third World, or (most recently) the Global South (Turner & Hulme, 1997; Chant & McIlwaine, 2009).

But how does one operationalise inequity in health? Firstly, inequity in health is something different from inequality in health. Inequality assumes that people have different opportunities in health. However, inequality in health cannot be fully eliminated, as differences between people at micro-level will imply that opportunities are different. For example, men are more prone to some diseases in contrast to women, and other genetic factors can mean that some people are much more at risk of being affected by certain diseases. Inequity in health however, implies a degree of fairness in opportunities for health: “Equity in health could be interpreted as consisting of equality in outcomes among groups or individuals who are similar from a genetic/age/sex perspective” (Committee for Development Policy
health equity can thus mean the internal factors such as genes and gender, and geographic location. It also encircles external factors such as food, living environments and political processes (Blaxter, 2004, p. 104). Emphasis has also been placed on how structural factors play the biggest part in the continuation of inequity in health, especially in terms of how health system development is strongly correlated with the quality and distribution of health care (Chant & McIlwaine, 2009). Inequity in health has become one of the most important objectives for the pursuit of governing for health, as inequity is perceived as unfair and unnecessary (Committee for Development Policy (CDP), 2009).

This is especially evident in health system development and strengthening in the Global South. It is widely recognised that system development in the South is confronted with multi-scalar issues concerning political and economic factors (Chant & McIlwaine, 2009). In order to define health in such a vulnerable environment, emphasis is often put upon quantitative measures of health. One of the objectives of this thesis, following the arguments of Sylvia Chant and Cathy McIlwaine (2009, p. 255) is to strengthen the understanding that health must be understood as more than quantitative measures, and that health system strengthening should not be mainly based on quantitative measurements of progress in health. It is just as important to recognise how ideas, perceptions and thoughts on health in society is decisive to how health care service delivery is idealised, planned and executed.

Health is a multi-dimensional phenomenon which requires a multi-faceted response that recognises its complexity on all levels of society (Chant & McIlwaine, 2009, p. 256). Health of the individual affects the health of the society, and the level of health care in society affects the individual in terms of what level of health one can aim to aspire. According to Mildred Blaxter (2004, p. 91) the relationship between the individual and the society is of a reciprocal nature. As health acts most vigorously on the personal level, it is the sick in relation to society that express how we perceive health as a social phenomenon. However, to change health in terms of gaining health or curing disease, efforts must be made on the social structure. Efforts of an individual will not impact change in a society based on economic imperatives where economically dominant groups hold hegemonic status (Blaxter, 2004, p. 95). This imbalance in reciprocity between the individual and the society as a whole, where progress is conditioned on social structures, is arguably linked to the inequity in health on a global scale (MacLachlan, 2006).

Inequities in health across the world have demanded coordinated responses to ensure an increase in health equity for everybody, independent of nationality, gender, income or...
religion. However, as argued in this section, responses to inequities in health across the globe cannot be adequately responsive before the multi-dimensional scale is recognised. However, as this is being increasingly recognised, attempts have been made towards a fellow understanding of health on a global level, and this is where global governance for health has come to play a crucial role.

2.2 Conceptual landscapes of governance for health

In order to expand on the attempts made to govern health on the global scale in the aim of reducing inequities in health, it is necessary to explore how global governance for health came to be relevant, as well as the inspiration behind its emergence.

The timeframe established for this chapter follows the developments that happened in the international community; the era of primary health care coincided with the post-war period, largely characterised by the uprisings of the nation-state and international collaboration; the era of health reforms followed new ideas about the position of economic development and the rise of capitalist markets in the mid-1980s, and; the era of global partnerships was largely a response to the processes of globalisation that emerged after the fall of the Soviet Union and the end of the Cold War in 1991. This historical backdrop has been important in the conceptualisations of governance, and especially global governance. The next paragraphs will expand on the theoretical assumptions for global governance.

2.2.1 Conceptualising governance

What does governance mean? It’s a rather vague concept in that it can hold several different meanings depending on the context, concept and issue at hand. At the same time, it can be understood as reformation of the public sector (as argued by Rod Rhodes), or the fragmentation of the public sector and the changing role of the state in international relations (as advocated by James Rosenau). Another approach is that governance is simply the mechanisms employed by a government in order to endeavour in social regulation (Shirlow, 2009, p. 41). Anne Mette Kjær (2004, p. 3) makes a distinction between the dictionary concepts governance and to govern (“the act or manner of governing; the office or function to govern” and “to rule and control with authority; to be in government), and the meaning of governance as political organisation as understood in the political sciences. The difference between the two is made of their belonging to government. The dictionary definitions of
governance/to govern is largely synonymous with government, while governance as a political system involves a much more complex organisation of actors at all levels of human activity.

There is agreement on the argument that the emergence of governance as a concept is fairly new, and for many scholars it truly emerged from the changing patterns of policy practices that happened within the state and across states after the end of the Cold War (Kjær, 2004, p. 6). Peter Shirlow (2009, p. 43) argues that the concept of governance after 1990 aims to study the relationship between governance and the practice of power, and the mechanisms employed in negotiating this relationship. Relating to this development in the governance concept is the development of the *global* governance concept.

Concerning the theoretical scope of global governance, it is necessary to clarify how the concept of global governance is being related to. Drawing on the models most commonly known from studies of international relations, there are mainly three schools of global governance thought; neo-realist, neo-Marxist and liberalist. These three are different in how they approach the governance concept, especially on the role of the state. These three schools traditionally relate to the issue of international relations, but for the sake of this discussion the focus will be directed towards how they relate to *global governance*.

Neo-realist thoughts on global governance build on the thoughts of scholars who engage in governance theory from the starting point that the world consists only of nation-states, and there is no global governance, only cooperation within the international system. According to Anne Mette Kjær (2004, p. 60) this model of international relations is often referred to as the ‘billiard ball model’, where states constitute the most important unit in composing the international system. Defining the parameters of a nation-state is important in this regard. The nation-state is usually regarded as an ideal-type, consisting of the nation (community of people perceived of as linked together in one group) and the state (political and legal entity of control), merging together the community and territory into a modern socio-spatial organisation of a society (Gilmartin, 2009). However, as an ideal-type, there is no ‘one’ nation-state that fulfils the ideal of what a nation-state should be. The different nation-states that exist around the world are rather complex entities that differ from each other, but are united as a group in effect of being nation-states.

The international system is anarchic, as supported by John Mearsheimer and his offensive realism. Offensive realism in this regard holds the view that the anarchic situation in the international system is the mechanism which causes change in the *balance of power* that
exists between states (Mearsheimer, 1995). The leading thought of the neo-realists is that there essentially is no global governance, despite the processes of globalisation that are happening at an increasingly faster pace. The international community must rather aspire to build a strong international system through alliances between nation-states, as proposed by the most recognised neo-realist thinker Kenneth Waltz (Kjær, 2004, p. 83).

The neo-realist model has been criticised for the implications their view of the international system has for the decision-making process between states. The model implies that the issue of trust between states will always be troublesome, because decisions of each state will be based on notions of self-interest. If a state feels threatened, the decision will be based on minimizing the threat, and the effect will be that the international system and the balance of power is jeopardized. Others voice out a concern for the models inadequate appraisal of power outside the parameters of the nation-state in the international system, proposing that the model is inadequate to answer to the challenges in a globalised world order (for example Guzzini, 1993).

The neo-realist model builds on the structuralist views concerning how states collaborate on issues of foreign policy. Structuralist views on global governance are however epitomized in the neo-Marxist approach. The neo-Marxists hold strongly that the world is dominated by a hegemonic idea about organisation which forms the basis, while the overbuild draws on the ideas that are proposed in the basis. In the case of international relations, this base is the capitalist system, which supersedes all else in matters of foreign policy. Even though this view is very important in understanding the theoretical evaluations of the structural adjustment programmes initiated in the Global South in the 1980s, this view will not be emphasised further in this thesis, as it largely coincides with the neo-realist view on global governance. The main contribution of the structuralist developments in the global governance arena is the rise of non-governmental organisations (NGO) as a response to the state-led development planning that preceded in the 1960s and 70s (Turner & Hulme, 1997, p. 200). The approach also holds explanatory power as to how the structural adjustment programmes were acts of hegemonic power; the hegemon being the capitalist system, and the exertion of power by more dominant actors in international health (Bartsch, Huckel Schneider, & Kohlmorgen, 2009, p. 114).

Contrasting the neo-realist model of international relations is the liberalist model of global governance. Emerging in international relation’s theory, and largely invoked by the theorist James Rosenau in the early 1990s, the liberalist model suggests that global
governance must engage in networks and partnerships to establish a peaceful global community, in juxtaposition to the neo-realist belief that there is no global community. Those who support the liberalist view on international relations believe that the global governance processes that are happening go beyond the scope of collaboration between states. Within the liberalist view, all transnational activities are recognised as issues of global governance, but the scope of international relations theory concerns the political sphere of transnational activities (in contrary to the economic sphere): “[…] not as government but as a minimum framework for rules necessary to tackle global problems, guaranteed by a set of institutions including both international organisations and national governments” (Kjær, 2004, p. 86).

Critiques of the liberalist bulk within international relations are often centred on its “idealistic” scope of the approach that does not fully appreciate the role of the state in international decision-making. Especially neo-Marxist structuralists point out how liberalist global governance does not take into account the power differences that exists between different actors on the global scale. Also development theorists point out how inequalities between the more developed world and the Global South must be addressed in order to avoid hegemonic power abuse by the more powerful actors within the global community (Turner & Hulme, 1997; Kjær, 2004). However, the liberalist approach to global governance basically raises legitimate questions concerning the paramount role that the state holds in neo-realist thinking, which have been important in assessing the authority of the state. By including the role of NGOs, global assemblages and other networks of collaboration on the international scale, liberalist global governance theory questions the high position of states, without denying their continued role in the global community (Kjær, 2004, p. 97).

This account of the three models of global governance in international relations provides a brief introduction to each approach. The different schools on global governance and their different suggestions to the current system of global governance will frame the conceptualisations of governance models for health. This makes sense in multiple ways, especially as much of the literature on GHG draws inspiration from international relation’s theory to corroborate the claims for how the theoretical assumptions of GHG are developing. However, even though it is important to see the linkages between the two fields, I will ultimately underpin that the conceptual models for GHG are elusive in the sense that they are theoretical constructs, and the reality of global governance for health is a much more complex field.
2.3 Conceptualising Global Health Governance

The foregoing section illustrates the broad strokes of thought in global governance. The establishment of GHG conceptualisations largely builds on international relations theory of global governance, because of the multi-dimensional characteristic of the phenomenon (Fidler, 2005). This section will aim to establish the GHG agenda, in order to situate how global governance has come to play such an important role for health. A brief account of the historical backdrop of GHG, as well as illustrating how power has become an important aspect of the GHG arena are important aspects in this regard.

International health governance vs. global health governance

The first traces of governance of health as matters of foreign policy on an international scale emerged as a result of expanding trade traffic between the continents in the late 19th century (Youde, 2012, p. 14). The increase of trade spread the fear of diseases such as plague and cholera, which invoked many ports to enforce quarantine on ships. However, the implementation of quarantines, especially in Europe, was incoherent. Because nation-states represented separate economic and political units, it meant that they employed different standards for quarantine as a response to the fact that implementation of quarantines both slowed down, and increased the cost of trade. This had an effect on the national economy and political setting. The first calls for coordinated action on an international scale to set quarantine standards followed. This story tells us how the coordination of public health measures has had an international character for quite a few years already. However, this coordination was characterised by significant disagreements concerning strategies for handling disease across borders (Youde, 2012, p. 25). The international health governance was based on an understanding of health care as an area of national concern. It only became international when the threat of infectious disease hampered trade, and economic factors.

The character of international health governance changed after the Second World War. Together with the humanitarian move towards the expansion of human rights and international collaboration for peace as manifesting through the foundation of the United Nations (UN), the understanding of health was altered in the restructuration of the world. Moving from concern for matters connected to international trade, caring about health for the sake of health changed the name of the game. Governance of health as a response to understanding health as intrinsically and instrumentally important, in addition to the wider
recognition of the large scale inequity in health, brought forward new international commitments to attaining health for the world population. These commitments culminated in the WHO slogan “health for all by 2000”, which was introduced in 1977 (World Health Organisation (WHO) & United Nations Children’s Fund (UNICEF), 1978). This marked in many ways the first changes in policy towards introducing health policies recognising that good health would have beneficiary effects on the society as a whole, having spill over-effects that would increase productivity in other sectors. Following the timeframe established in the introduction of this chapter, this phase is what is called the era of primary health care. This period in global health was more similar to international health governance, focusing on the potential of the world’s nation-states in providing health for their citizens, largely defined by national borders (Berridge, Loughlin, & Herring, 2009).

Succeeding this period, came a response in the shape of massive structural adjustment programmes during the era of health reforms in the 1980s. This period was largely governed by the thought that economic development would produce health, and thus led to the massive uptake of expensive loans across the Global South in an attempt to access the global economic market. This had devastating effect on health systems in the Global South, and this period is known as a time of regression in the area of health, where structural inequities increased (Berridge et al., 2009). However, this time also saw developments in terms of increased numbers of actors in global health. The mushrooming of NGOs and philanthropic organisations in health developed the field of global health to become more multipolar.

After the era of health reforms in the 1980s, there was a new tide as the world neared the new millennium. During the 1990s there was a larger focus on how health needed increased attention as a global issue, which was guided by mainly two arguments.

The first was that health needed to be treated in response to the continuing inequities in health that persisted in the world. This represents the humanitarian and solidarity approach to health as a fundamental human right, and the newfound belief in that this could be more efficiently addressed on the global level. David Fidler (2002, 2005; 2006; 2008; 2010) argues that issues of health on a global scale bring together normative values and material politics of interests, and that global health has become an important issue for international affairs. The global political agenda has become increasingly occupied with issues of health in terms of political, social and economic interests. Recognising that priorities in health differs between states, he argues that the processes of prioritisation in international relations have great impact
on how states choose to conduct business in terms of wanting to preserve one’s own interests (David P. Fidler, 2010, p. 12).

Secondly, global health security took stronger hold as a policy issue for the international system. “Old” diseases such as polio and tuberculosis still kill millions every year, while “new” diseases such as HIV/AIDS have had enormous impact on many countries, in addition to the resurging influenza pandemics that spread with wider ferocity each time a new influenza pathogen took hold (Cooper et al. 2007: 228). There have been many examples in the last twenty years of how global health is influencing policy mechanism, especially through epidemics and pandemics such as SARS and Ebola which have been presented as “[…] a clear threat to global health security” (Editorial, 11.10.2014). These two arguments are strong explanatory factors to the development of GHG in the last twenty years.

**Framing the geographies of global health governance**

GHG is a conceptualisation, as well as an analytical tool, to understanding the ways the global community, national governments and local offices relate to and deal with health. But how does one go about to define a concept such as GHG? The literature on GHG and global health policy is wide in scope and complex in nature. Ranging from tobacco control and biomedicine security, to global information management, vaccines and family planning, health as an area of study embraces many branches, which intertwine in their interrelatedness between subjective and objective perceptions of health. In the search for the “good life” and optimized health, researchers and academics, as well as politicians and philanthropists are putting an increased amount of time and effort into health research (MacLachlan, 2006).

However, as the expiration date of the WHO’s “Health for all by the year 2000” neared without being achieved substantially, the global community sought new answers to solve the health inequity puzzle. Much of the literature does however concern the fragmentation and disagreements on how one should conceptualise GHG (Dodgson et al., 2002; Lee, Fustukian, & Buse, 2002; Kickbusch et al., 2007; Ronald Labonte, 2008; Feldbaum et al., 2010; David P. Fidler, 2010; Loewenson, Modisenyane, & Pearcey, 2014; McInnes & Lee, 2015). Different approaches to GHG emphasise different elements as most important. Yet, after twenty years of conceptualising GHG, there is an emerging consensus on the agenda of GHG. This agenda emphasises that the role of GHG should be to address the inequities in health on a global scale. This is to be done through two strategic objectives: recognising health as a global public good that requires unified collaboration to provide, and
the important role of health systems in providing health (Buse et al., 2009, p. 9). GHG as an umbrella term for these developments in policy and institutional responses to health has experienced an increase in legitimacy. Thus, ideas of GHG have gained authority as a solution towards combatting inequity in health, as it aims to heighten the level of health for the globe as a whole.

Emerging from GHG is the concept of global health diplomacy, which constitutes the policy arena for transnational issues on health policy: “It is a world to which outsiders find it difficult to relate, where the art of diplomacy juggles with the science of public health and concrete national interest balances with the abstract collective concern of the larger international community in the face of intensive lobbying and advocacy” (Kickbusch et al., 2007, p. 30). Global health and the governing thereof constitute a complex web of policy mechanisms, economic factors and collaboration strategies. These mechanisms can further be understood by applying concepts of power.

Conceptualising power in health governance

Drawing on the meaning of global governance as established by Anne Mette Kjær (2004) and Peter Shirlow (2009), it becomes evident that a further examination of the concept of GHG must include an understanding of the concept of power. The discursive developments happening in global health, such as negotiations of global commitments and the influence of international health institutions on national health systems are largely influenced by notions of power. Such notions are traceable both on the structural plane and between actors in global health, constituting a complex web of power mechanisms (Bartsch et al., 2009). Power can in the widest sense be recognised as “distinct hierarchy between those who hold power and those who do not” (Gallaher, 2009, p. 63). Along the geographic tradition, the interesting aspects of power in relation to health, is the where’s and why’s of the spatial distribution of power. It is seminal to seek further understanding of how power plays a role in the organisation and implementation of health policies. In this thesis, power will be understood in a constructivist manner in order to understand how different modes of governance within global health engage differently with modes of power, implying differing impacts on health.

Conceptualisations of power in health policy are largely inspired by macro theory on power within political systems. Gill Walt (1994) discusses how policy making processes in health are influenced by power. She argues that power in health policy can be conceptualised in two camps: pluralist view of power, and elitist view of power. These two camps illustrate
how structural (pluralist) versus actor-based (elitist) power is exercised in decision-making in health.

The pluralist view poses that the state, or the government is the “unbiased arbiter between many competing interests” (Walt, 1994, p. 36). Thus, the government is a neutral, but pluralist entity that mediates interests on behalf of the different actors in society. The government as a mediator translates power on behalf of the population, acting as an impartial institution. However, questions are raised to the plausibility of the government as a neutral actor, because governments in fact have considerable power, which can override the plurality of decision-making.

The elitist view on power builds on the understanding of hegemony, which poses a structuralist approach to power; health policy is directed by dominant social classes, and the role of the state is to uphold these structures of power (Walt, 1994, p. 37). Essentially, this suggests that a few actors hold the power to implement their views on policy, in this case health policy. This power is to a larger degree explained by the financial status of the elite. However, the elitist notion of power has been criticized for overestimating the ability of the few and small to exert power over the many. However, there have been empirical examples underpinning how such elites often play an important role in the exertion of power, especially in the Global South (Walt, 1994, p. 38).

Walt’s conceptualisations of power are concerned with how policy is being negotiated within a political system, such as the state. However, it is possible to translate these notions of power from the parameters of a closed political system to the complex architecture of global health. Looking back to the neo-realist and liberalist school of thought of global governance in international relations, lines can be drawn between these and the pluralist and elitist notions of power. The neo-realists engage with balance of power between states, implying that states act on self-interest in the international system. The exertion of hard and soft power can result in the changing balance of power between the actors (nation-states) in the anarchic international system. However, the nation-state does in this regard engage in acts of self-interest on behalf of the population in their respective state. As such, nation-states represent a plurality of actors in the international system, where not one holds total power over another.

Contrarily, the liberalist thought argues strongly for the interdependency theory of power. The interdependency theory suggests that all actors on a global scale are engaged in collaboration and institutions to achieve legitimate peace in the international system. The liberalist interdependency theory also strongly relates to the pluralist notions of power, as
many actors and institutions are mediating power relations as neutral entities. Global governance and power in health policy is in liberalist thought marked by how no one group holds total power over other groups (Walt, 1994, p. 36). One critique of the liberalist approach to power is however that it neglects the difference of power between actors, thus undermining how different sources of power have different impacts on policy mechanisms in the field of global health.

Notions of elitist power do occur within the global community of health, and has largely been traced to resource-based power. According to Bartsch et al. (2009, pp. 115-116), modes of power in health are categorised by four categories of power in global governance: discursive, decision-making, legal/regulatory, and resource-based. These four categories are equally important to grasping the full extent of power in policy mechanisms in global health. However, especially one of these categories lie at the centre of power relations, and is experiencing increased legitimacy in the global health field; resource-based power. The field of global health is characterised by being extremely expensive, especially in terms of Research & Development and innovation in medicine and vaccines (Buse et al., 2009). In addition, and in special interest for this discussion is how financial issues are hampering health equity in countries of the Global South. This is largely due to structural factors such as weak government systems and low economic development and poverty, but is however a reality for many states. The mobilisation of developmental financial support for health in such countries has been remarkable for many years. Some argue that this is due to the fact that aid for health is viewed as ‘soft’ politics, in contrary to ‘hard’ politics such as war and peace. However, health as an increasingly important issue of foreign policy is a de facto development, and involvement in the area of health can be viewed as increasing the scope of power for states in matters of foreign policy (D. Fidler & Drager, 2009). Thus, actors whom have access to resources hold greater influence in the global health field than other authorities such a decision-making power and legal or regulatory power (such as the WHO) (Bartsch et al., 2009).

In terms of power within states and national health systems, one can approach it through a constructivist lens. Hegemonic notions of power can be employed to conceptualise how nation-states and national health systems interact. Hegemonic situations are in this regard thought of as characterised by a dominant party seeking to induce subordinate parties to accept its moral, political and cultural values as the “natural order” (Gesler, 1991, p. 141). Emerging from this relationship is a power balance characterised by control and resistance, or
contestation, leading to competing interests between groups in society. In the sphere of GHG and national health system development, acts of power can be informed by an understanding of hegemony as a concept that influences the system of governance.

The next sections will attempt to construct two theoretical models for governance for the analysis of GHG generally, and the situation in the Malawian health system specifically. Inspired by the international relation’s models for global governance, neo-realism and liberalist suggestions will shape the two following models. This is in order to draw clearer lines between the two main models of governance that has emerged in GHG. However, caution is pleaded to view these two models as theoretical constructs, which hold many limitations in the face of the complexity of GHG. They are however useful for the sake of conceptualisation.

2.3.1 The Primary Health Care Approach

If we take a step back to consider the understanding of health at the personal level, GHG in itself doesn’t mean too much to the person on the ground. Health care must be translated through local health services, which are provided directly to people. And in this lies the fundamental argument of the Primary Health Care’s (PHC from this point on) approach to health – health is first and foremost personal, and health care must be about valuing the person.

The PHC approach was established by the WHO after the Second World War, and especially during the 1970s. The PHC as a policy agenda was pledged during the 1978 International Conference on Primary Health Care, organised by the WHO. It is a comprehensive approach to essential health care, built upon the principle that all persons have the same right to health. The Report, jointly constructed after the Conference by the WHO and UNICEF state that the PHC agenda constitutes a holistic approach to health care at the local level, with the mandate to achieve the highest level of health for all persons (World Health Organisation (WHO) & United Nations Children's Fund (UNICEF), 1978, p. 2). The WHO acts as a matron of global health, and provides the guiding principles for the PHC approach. Their mandate is built on a human rights-based approach to health, which is held in high regard in effect of the legitimacy that the WHO hold in the global health field.

Held in Alma-Ata, now known as Almaty the capital of Kazakhstan, the geographical location of the Conference bordered East and West – the communist block and liberal capitalism. The bridging of two strong political ideologies that marked a gap in the world
organisation after the Second World War, showed how “Health for all by the year 2000” truly meant for all persons in the world, independent from political ideology, nationality or political or economic background. The Conference also marks a shift in the way the international community related to health – moving from the isolation of health as the presence of infirmity, to treating health as a fundamental human right in which governments held responsibility in attaining the highest level of health for their citizens.

The fifth declaration of Alma-Ata explicitly announces that governments hold responsibility for the health of their people, and that this is understood as a responsibility to provision health. The conference forced the international community to acknowledge the growing inequity in health across the globe, and to reconsider the way national governments allocated their resources towards military interests and warfare (World Health Organisation (WHO) & United Nations Children's Fund (UNICEF), 1978, pp. 2-4). Thus, the Alma-Ata Declaration does in many ways represent the turn towards a more inclusive, human-centred conceptualisation of health. Health became valued as an asset in itself that could contribute to a more developed and prosperous world, and not merely as a consequence of economic development.

The heyday of the PHC approach was during the 1970s and the early onset of the 1980s. However, at implementation level, it did not become as popular as was foresighted. The impact of the PHC approach has been debated widely, and the main criticism lies in the approach’s lack of policy adaptation. The idea is easy enough to grasp for policy makers, but the implementation of sustainable health care programmes was extremely wide. In some instances, this led to the development of Selective PHC, where elements of the PHC agenda were extracted to adapt the PHC approach to more fragile states. The PHC approach insisted that each country had a task in adapting the health care to fit within the national context, but in many countries the agenda was difficult to implement and issues relating to quality and satisfaction were compromised, evident in countries such as Tanzania (Gilson, Alilio, & Heggenhougen, 1994; Gilson, 1995). The following section will conceptualise the core principles grounding the PHC model, taking into consideration the possibilities and limitations of the approach.

**Framing the PHC governance model**

The essential message of PHC as a governance tool is that the approach should be different between countries based on their underlying economic, political and socio-cultural conditions.
This is to ensure that all countries can construct a model that is manageable within the possibilities and limitations of each country. Essential health care was perceived of as being the most reasonable starting-point for many of the countries that did not have established comprehensive health systems, and which at the time were categorised as Third World countries. Many of these countries were suffering with disease that were reasonably easy to treat, but were left undertreated because of issues relating to health care delivery and coordination. These countries represented the poorer nations in the post-war world order, where the world’s nations in rapid speed were adhering to different political ideologies and ideas about state administration (Turner & Hulme, 1997). Whether the fact that these nations were poorer played an important role in the establishment of administration practices is outside the scope of this thesis. However, the different development of state administration practices between countries in the Third World and countries of Europe and North-America, represent an explanatory factor in why poorer nations were encouraged to embrace the PHC approach. Acknowledging the new social reality of health care, PHC was a way for national governments to set up a thorough plan for the provision of essential health care. The original PHC approach embedded the responsibilities of health care within the parameters of the nation-state.

Because the PHC agenda has shaped so many of the health systems in the Global South, it is crucial to recognise it as a governance model for health with certain characteristics that differ from other approaches to governance for health. As such, an elaboration on the main characteristics of the PHC approach constituting the governance implications of the health care model is necessary; access, equity and community.

**Ideas of equity**

Essentially, the bedrock of the PHC approach lies within an understanding of health as a human right, and the belief that health equity serves as the guiding principle (Chant & McIlwaine, 2009). However, the concept of equity in the PHC here will not be a normative evaluation on whether a human rights-based approach to health is right or wrong. In many ways, this is a given when talking about health. The issue at hand is how ideas of equity are translated into policy mechanisms for governing health.

The PHC approach is clear on that matters of equity are best treated in achieving access to health care for all people, and that these persons should be met with respect at point of entry to the health system (World Health Organisation (WHO) & United Nations
However, notions of equity hold rather vague connotations in terms of implementing it effectively in health care services.

In order to increase health equity, the PHC approach embodies strategies of decentralisation to reach the person on the ground. Even though the PHC approach is embedded in the thought that essential health care comes first, the attraction of the PHC lies in its person-centred approach to health care. The focus on the person infiltrates all aspects of health, which also transcends the “essentialist” approach to health care as represented by the earlier treatment of health as the absence of disease historically (Youde, 2012). The person-centred approach values that one must see what kind of patient has a disease, instead of focusing on what kind of disease the patient has (World Health Organisation (WHO), 2008, p. 42).

Access to health care is essential to equity in health. In the PHC approach, this is manifested through the idea that PHC is best provisioned through community health workers. Underlying the identification of community health workers as key actors in the provision of health is the thought that these health workers also know the needs on the ground. As governments are responsible for the coordination and provision of health services, states must employ decentralisation policies to achieve equity and access in health for their population.

The PHC approach encourages cross-sectoral collaboration within the government, emphasising the multi-dimensionality of health equity. As such, attributes of health are perceived of as being conditioned upon all aspects of life. Coordination between government sectors is thus believed to have beneficiary consequences for the health of the nation, by seeking the maximum attainment of health in all aspects of society, such as in the education sector, agriculture and food sectors, and the industry sector.

**Community and access – ideas of decentralisation**

The idea is that the person should have access to PHC wherever they might live. Thus, the PHC approach is dependent on the local and community as entities of implementation, because the health worker constitutes the meeting point between the person and the health system. This implies a dedication to decentralisation of health care delivery and services in terms of deconcentration or complete devolution.

Deconcentration, according to Kjær (2004, p. 29) means that the local authorities still hold accountability towards the central government. When decentralisation is read in terms of devolution, all authority is devolved, and accountability is held by the local authorities to the
local population. Deconcentration or devolution of health service delivery encourages the central government to push more resources to the districts, and that the responsibility for these resources is adopted by the district authorities.

This person-oriented point of departure was strengthened in the World Health Report 2008, when the PHC approach was reintroduced as the core method for achieving health for all. The Report was an attempt to reintroduce PHC to national health systems, in the pursuit of eliminating inequity in health. The issue in relation to accessing health care is, however, that even though a population can access PHC services, it is not necessarily the case that the persons in the communities are in viable distance to the places where PHC are delivered (Crooks & Andrews, 2009). This leads to the issue of whether access to health care, in terms of definitional standards, directly causes equality and equity in health (Culyer & Wagstaff, 1993).

The PHC model of governance for health embodies a neo-realist approach to global governance. Under the GHG umbrella, the PHC approach appoints the nation-state and national governments the spearhead position for the provision of health care. Notions of equity and access through community participation and decentralisation grounds the PHC approach to the neo-realist view on how consequences of globalisation must be addressed with initiatives within the parameters of the nation-state. Whilst acknowledging the global aspect of health and commitment to global objectives on health care, the essential governance aspect of the PHC approach is linked to how health care is perceived of as a national concern. Decision-making must be based on cooperation within and between states, and the local level constitutes the most important level of health care policy implementation.

The PHC approach to health equity and GHG is however not the only governance model for dealing with issues of health in a globalised world. Notions of partnerships for health have become increasingly important in the last twenty years, and the existence of global health partnerships (GHPs) has mushroomed. As such, the next section will concern the conceptual framework for GHPs as a contrasting model of governance to the PHC approach.

2.3.2 Global Health Partnerships and Initiatives

The scope of GHG as concept is inevitably large and complex, covering all activities that can relate to health, including political, social, and economic processes. From the GHG approach to deal with issues of health on a global scale, the international community established certain
innovations in order to deal with them more efficiently across national borders. This has especially blossomed after international commitment towards the Millennium Development Goals in 2000, which represents one of the largest pledges to tackle global health issues in recent times. The following segment of this chapter will elaborate on the emergence of GHPs and their mode of operation. This is in order to conceptualise a governance model of global health which is based on partnership between, first and foremost, public and private sector organisations (Buse & Harmer, 2009, p. 247).

Conceptualising global health partnerships
Towards the end of the 20th century, a new kind of global organisation of health care emerged, focusing efforts on partnerships between health actors globally. Even though these are rather new in scope and operation, much attention has been given to this phenomenon of transnational partnerships in health. Some argue that the new focus on partnerships was inspired by the “new world”, as it was organised after the end of the Cold War, which opened up the “blocks” giving way to collaboration across nations and continents (Buse & Harmer, 2009). However, the complex landscape of global health partnerships often leaves the reader confused with abbreviations and diffuse studies on how to measure their scope and operation. Defining GHPs is a troublesome task. Ruckert and Labonte (2014) approach the concept of GHPs as “relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making” (Buse and Harmer in Ruckert & Labonte, 2014, p. 1602). The result is that the literature on global health partnerships as a mode of global governance is rather vague. However, many academics have defined at least two core objectives of GHG that are manifested in GHPs.

First there is the concept of multi-actor collaboration, which emphasises the actor-oriented view of GHPs. In order to exist, GHP as a model of governance is dependent on partnership between multiple actors. David Fidler (2010, p. 3), in his conceptualisation of GHG, emphasises the global characteristic of multi-actor collaboration on issues that require cross-border attention: “the use of formal and informal institutions, rules, and processes by states, intergovernmental organisation, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively”. This definition entrenches the idea behind the concept of GHP as multi-actor oriented. This is in contrast to the PHC approach, where the state serves as the primary actor who provides health services to their population. As mentioned in the previous paragraph, global partnerships on health are often
ascribed to public-private partnerships in health. However, this is being circumvented in Fidler’s definition, where also intergovernmental and non-state actors are put into the GHP mix.

Secondly, GHPs exists on the basis of alleviating the consequences of globalisation processes. The spirit of global partnerships for health was inspired by the thought that inequity in health across the world could be better relieved through the collective action of actors. Richard Dodgson, Kelley Lee and Nick Drager (2002) approach the idea of GHG as one of promotion and protection of public health in a new globalised world order, where ideas hold power in shaping policy. They conceptualize the term GHG as both formal and informal; it operates at multiple scales, and has both public and private characteristics, often in combination: “Health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population” (Dodgson et al., 2002, p. 6). Dodgson et al. here points to a crucial element of GHG which has been essential to the development of GHPs – globalisation. Thus, the transnationality of health as a consequence of the process of globalisation, takes the centre-stage in the conceptualisation of GHPs (Dodgson et al., 2002). GHPs as tools of governance are thus possible to link to liberalist views on global governance. The liberalist approach emphasises the role of partnerships in order to address the consequences of globalisation, which is also prominent in the establishment of GHPs. Processes of globalisation have increased the complexity of the world, which includes the complexity of health issues, and health inequity. The argument for the establishment of GHPs is thus that they should be the overriding model of governance when relating to health (Buse & Harmer, 2009, p. 245).

The scope of GHPs is largely concentrated to four main areas; research and development (for the development of medicine and vaccines), technical assistance and service support (towards defining the policies directed to the access of drugs), advocacy (developing the response capacity towards combatting specific diseases), and financial support (allocation of resources for specific programmes) (Committee for Development Policy (CDP), 2009, p. 38). GHPs often focus on at least one of these areas, if not multiple.

Building on the discussion on equality, equity and access in the foregoing paragraph on conceptualising the PHC approach, the GHP relates to equity in health as an issue to be solved through partnerships that unite for project-specific or programme-based action (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG),
Global partnerships are viewed as the rightful response to global challenges in health, sharing the power that exists amongst the partners (Owen, Lister, & Stansfield, 2009, p. 239). One of the contributions of GHP emergence is that they put pressure on the need to address health issues that often have been neglected. An example in this regard is how the Global Alliance for Vaccine and Immunisation (GAVI), a large GHP, have provided drugs and vaccines free-of-charge, or at a heavily reduced cost to alleviate inequities in health (Ruckert & Labonte, 2014, p. 1601). Initiatives such as these have been successful and important in terms of stimulating Research & Development on diseases that have not been prioritised, such as neglected tropical diseases. Ideas of equity and access is thus very important within the GHP framework, but these are accomplished through mobilisation of funding towards projects and programmes directed at specific diseases.

However, issues of equity in health can easily be skewed by the various interests of partners involved in GHPs (Ruckert & Labonte, 2014, p. 1609). It has been pointed out that many of the partners involved have strong philanthropic interests, which can divert attention away from important issues of health. One example in this regard is the Bill and Melinda Gates Foundation, which have strong beliefs in technological solutions to health care. In addition, their budget is in a different league than other important actors in health (such as the WHO). Their elite role in terms of economic resources means that they exert hegemonic notions of power in advocating bio-medical solutions to global health. The legitimacy of their operation is enforced in their massive economic influence, which diverts attention away from the holistic and social determinant approach to health.

Yet, GHPs are recognised for their contribution to establishing general norms for technical management and financial strategies for the delivery of health, which has “[…] improved national health policy making through institutional reforms and health system strengthening” (Ruckert & Labonte, 2014, pp. 1601-1602). However, concerns have been uttered on the long-term effects of GHP initiatives. GHPs are largely ad-hoc oriented and mandated for certain projects. Thus, what the space is for GHP interaction with long-term national health system development represents an issue concerning the sustainability of GHP initiatives in terms of impact on health equity and access. Another concern is the programme-orientation of GHPs, which does not take into consideration the wider implications for national health systems. GHPs most often engage in vertical health interventions, which have led to the materialization of silos in global health. The impact of disease-oriented silos in
global health has led to the distortion of funding and organisation of national health systems, especially in the Global South (Ruckert & Labonte, 2014, p. 1603).

2.3.3 Interactions Between National Health Systems and Models of Governance

While ideas on health care have become increasingly global in character, national health systems still translate global policies on health (Sandberg & Justice, 2013, p. 93). The following section will aim at untangling the meaning and parameters of a health system within the two models of governance outlined above. Even though the international community now more than ever are bypassing national governments in the pursuit of effective health governance, most health care delivery happen through health system mechanisms. The next section will introduce and discuss the conceptualisation and development of health systems, especially in the Global South. This discussion will be centred on how health systems can be understood as national entities, and as belonging to a global network of health care delivery. These two distinctions build upon the conceptualisations of health governance as state-centred in the PHC model, and as networks or partnerships, as established in the GHP model.

All health systems operate within differing contexts. Definitions of what a health system should be differ widely between states, politicians and academics. The definitions differ in terms of vision, objectives, organisation, and outcomes. However, the different approaches to health systems are united in that they form a system. According to Wilbert M. Gesler (1991, p. 15), one must first aim to understand what a system is in order to grasp how a system of health emerges. A health system per se is a concept that includes almost every notion of what constitutes the society – culture, politics, and economics – in the pursuit of “bringing health” to the population. The societal conception of health is meticulously systematised in an aim to enhance public health of a given societal space. The system is a pattern that is made up of many different components (Gesler, 1991, p. 21). In terms of what a health care delivery system is composed of, Gesler points to illness, people, environment, resource, cultural system, economic system, system of government and barriers to care (Gesler, 1991, p. 22). These elements are interlinked and relates to each other, constituting a pattern. This pattern results in a system that also reflects the wider societal system in which it operates (Gesler, 1991, p. 31).
Health systems as national vs. health systems as global networks

The different health systems which emerge in the world today are, however, built upon the founding definition given by the WHO on what a health system embraces: “all organizations, people and actions whose primary intent is to promote, restore and maintain health” (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG), 2009, p. 2140). This definition does not focus on the scale of health systems, but rather on the components of action and organisation that happens within the formation of the health system. However, in order to conceptualise the impact of PHC and GHP in health systems, it is necessary to contrast how health systems most commonly are characterised in the GHG literature: as national entities, and as part of global networks.

The definition of the WHO on what constitutes a health system is definitely a very broad definition of an inherently complex situation. A more nation-focused conceptualisation of a health system could be to treat it as such activities which are under the partial or full control of national governments: “As core social institutions, health systems also need to be responsive to the needs and demands of the population. For example, in a democratic society claims to health services and conditions that promote health can be seen as assets of citizenship” (Kruk & Freedman, 2008, p. 264) This conceptualisation underpins the sovereigntist ‘way of thinking’ about health systems, and that the nation-state conceptualisation of a health system shapes the system through the social belonging of the citizens within the state. The objectives of this kind of health system are as mentioned, to provide health for their population, which is done by three forms of input: policies, funding, and organisation. Investing in these inputs will consequentially produce effective, equitable and efficient health systems both nationally and globally (Kruk & Freedman, 2008, p. 265).

Another approach to health system understanding is to understand health systems as public goods. This has evolved through especially one kind of advancement within the area of global health cooperation – global health initiatives (GHIs). The scope of GHIs are inevitable large, as it contains most initiatives pertaining to health. There are however some characteristics which are identified in most GHIs. GHIs are most commonly vertically oriented, meaning that they are concerned with battling some specific disease burdens that characterize many of the health systems across the global south, but do not aim at delivering a comprehensive long-term solution to health system weaknesses in delivering these services themselves. GHIs are in addition most commonly funded by external sources and not by the nation-state where the GHI is being implemented. GHIs are characterised by being inherently
international in terms of the number and different origins of involved actors, which can be local, regional and national, as well as intergovernmental or global in terms of originating from international organisation (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG), 2009, pp. 2139-2140).

The functions of a health system as listed in the foregoing paragraph, have changed in the last two decades due to the increased involvement of global networks, and their implementation of GHIs. As argued earlier in this chapter, the emergence of GHPs and networks has been largely ascribed to responses to the challenges in health posed by globalisation. GHIs have become a tool for implementing ‘fast-track’ solutions to pressing health problems that are causing inequities in health, which means that GHIs are distinctly concentrated to the Global South. This fact is challenging if one considers the issue of power within global health, in terms of hegemonic power where some actors hold power over others.

In order to address the interface between national health systems and GHIs, it is necessary to understand the space where the two entities meet. The World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG) authored a review of the interaction between national health systems and GHIs to address the effects of such a relationship on health service delivery. Among their findings, they point to the fact that in many areas where GHIs are involved, both geographically and conceptually, there are distortions in service access, service equity and service quality (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG), 2009, pp. 2139-2140).

Their analysis of this interaction across countries in both the African continent and South-east Asia concludes that GHIs have had positive impact on many different areas, but that there is room for enhancement in terms of the emerging divide between GHI-targeted services and non-GHI targeted services. Their findings thus underpin the argument that global focus and priorities do not necessarily match national objectives, and the intersection between the global and the national contribute to GHG being a contested space of interaction (World Health Organisation Maximizing Positive Synergies Collaborative Group (WHOMPSCG), 2009, p. 2147).

The relationship between the governing of inherently national health systems and the involvement of GHIs sheds light on an interesting aspect. While national health systems, according to conformist conceptualisations, work for the enhancement of public health for their populations, GHIs epitomize globally committed understandings of health as a global
public good. Thus, this interface between national health systems and GHIs offers a starting point for understanding how the two entities and conceptualisations relate to each other.

### 2.4 Summary

The starting point of this chapter was that the Malawian health system does not operate in a vacuum. It is impacted by a number of different processes at multiple scales. It is necessary to pin down some theoretical assumptions in pursuit of a model where one can further understand the relational processes that impact on the Malawian health system.

First, the chapter engaged in the basis of why governance for health has become a relevant subject of study, and how it is connected to the larger concept of global governance. The models most commonly used in international relations theory in discussing global governance are neo-realist, neo-Marxist and liberalist. Focusing on the neo-realist approach in contrast to the liberalist approach, the chapter developed two governance models that can help explain especially two divergent governance approaches in GHG: the primary health care (PHC) model and the global health partnership (GHP) model. Lastly, the chapter engaged in a discussion on the possibilities and limitations of combining these two models of governance with the mechanisms of health systems.

The interesting aspect of this reality in the Malawi health system is that PHC did not become the most popular establishment across the African continent. Many countries attempted to follow up the requirements for PHC, but the cost attached to it meant that it fell short to the privatisation of health care which was introduced in the 1980s (Chant & McIlwaine, 2009, p. 276). Chapter four and five will seek to expand on the role of the PHC and GHP model in Malawi, and its impact on the articulation and implementation of the Health Sector Strategic Plan [2011-2016]. First, however, follows a chapter concerned with shedding light on the methods employed during the fieldwork in Malawi, and the possibilities and limitations concerning how the production of data can contribute to a deeper understanding of the policy process on different scales within GHG.
3 Methodology and Methods

At the base of any research project lays a solid aspiration to understand more about the topic chosen, and the wish to contribute to the existing knowledge. This process is also characterised by striving for this contribution to be thoroughly and rigorously executed. In addition, as a researcher of social sciences, one often has to do this on the basis of qualitative data, which is traditionally more open for interpretation than quantitative data. This chapter will explain and discuss the methods that have inspired and guided the data production for this research project.

The driving forces behind conducting the research for this thesis were twofold. First of all, I wanted to gain a deeper understanding of the views that existed within a national health system regarding the process of articulating and implementing priorities and organisation. Secondly, I wanted to do this in a way that could contribute to middle-range theory developed from an inductive grounded theory approach to data analysis. This chapter will expand on the methodological perspective that informed the methods employed in this study. The methodological perspective was in this regard inspired by grounded theory approached through a constructivist lens. The methods employed in the production of data is in this regard thought of as the process I engaged in in order to gather informants, conduct interviews, conversations and observations, and the basis on which I analysed these data.

The chapter will thus elaborate on (1) the choice of qualitative methodology; (2) the execution of the fieldwork in Lilongwe, Malawi, and the production of data, and; (3) grounded theory as tool for analysis and method of theory development.

3.1 Qualitative Research and Methodology

One of the key elements of conducting social research, is to remember that the researcher herself is a subjective part of social reality whilst aiming to view it from an objective point of view (Bradshaw & Stratford, 2010). What is important in this regard is how the researcher makes the choice of what kind of objective position she takes on. As methodology serves as a tool for the mind to choose a way of thinking about social reality, it serves a purpose in terms of defining the way one wants to analyse the data gathered. However, choosing just one “box” of methodology is in many ways crude and limited seeing as there are always possibilities as
well as limitations in every method. However, the aim for this study was to explore meaning and perceptions within the governance structures of a health system, and the choice of a qualitative approach seemed the most rewarding in order to gain an understanding within these two concepts.

As discussed in the first chapter, the purpose of the thesis is to answer two research questions pertaining to the study to understand and further examine the individual experiences among the different actors in the politics of organisation in the health system in Malawi. After some consideration on the possible contribution of qualitative data production versus quantitative data collection, it became clear that a qualitative approach could help define and develop the nuances of complexity which the research questions search for (Silverman, 2010, p. 118). When a researcher thinks about gathering and producing data in a way that is most fruitful for the research, she must also consider the methodological mind-set in which the data is collected. Long before the start date of the fieldwork in Malawi, the research proposal was focused on examining how the data could speak for itself and how the informants could bring individual insights. By employing this strategy in the planning and the production of data, the research took on a constructivist mind set. Keeping this in mind, the research aimed at producing data that would be conscious on the effect individuals have on the way answers and meanings are being uttered and delivered (Jørgensen & Phillips, 2002).

The objectives of the study and the choice of how to produce and analyse data was on many levels inspired by grounded theory. Grounded theory is largely based on movement from the systematic and rigorous characteristics of producing and analysing data, to the development of theory which are grounded upon that analysis (Strauss & Corbin, 1998, p. 8). Its strength lies in its provision of tangible techniques to approach qualitative data analysis. In addition, it provides a set of tools to ably let the data speak on its own, and be the base of theory development. The study was designed to be a qualitative probe with a single case to illustrate how the agents in the MHS experience and wage their capabilities and agency within the health system. Approaching the MHS as a case study opened up many possibilities in terms of flexibility in the data production.

However, the legitimacy and rigour of theory developed from data can be questioned on the basis of the ability of the researcher, in terms of bias, perspective and earlier experience. Drawing on the arguments first established by Barney G. Glaser and Anselm L. Strauss in their 1967 book The Discovery of Grounded Theory: Strategies for Qualitative Research, the following chapter will thus treat grounded theory in a constructivist manner.
This is based on the arguments of Kathy Charmaz (2014), who emphasizes how the flexibility of the method can be increased by viewing the data through a constructivist lens. Grounded theory was, according to Charmaz (2014, p. 5), a challenge to the positivist methods in social science, at a time when qualitative methods in sociology were losing legitimacy, by equipping the researcher with standardised and systematic tools to handle such data. Constructivist grounded theory takes into account the different positions and background of the researcher, and treats it as part of the contextuality and situation of the data at hand (Charmaz, 2014, p. 13).

3.2 Structuring and Executing a Qualitative Fieldwork

Conducting a fieldwork in Lilongwe, Malawi was a rich experience. This section will discuss the experiences with the chosen research method in producing data, emphasising the methodological choices done by the researcher. The reflections in this section will be based on the personal experiences, which will be at the centre for justifying the process of collecting the data, and the methods and choices used in collecting them. This part will especially aim to establish the trustworthiness of the researcher and her role during the fieldwork, as trust became instrumental to the interviews. This section will also evaluate the process of producing the data, and the quality of these data.

3.2.1 Defining the parameters of the case

My initial interest for conducting a fieldwork lay in gaining understanding on how national health systems are impacted by developments in GHG. GHG as a theoretical construct is mostly debated in a post-structuralist manner. Thus, ideas and perceptions on the subject can also be treated as contributions to the formulation of GHG. In this aim, it seemed beneficiary to focus on one single case to gain deeper insights. The choice to focus on Malawi in this regard came from two issues: an interest, and prior academic experience with countries located on the African continent, and a personal understanding that development in these countries are often unjustly framed in Western countries.

These two elements meant that I sought out African health systems from the start. Considering I do not speak French, I mainly focused on Anglophone countries. The choice of English-speaking informants was grounded on the fact that I wanted to avoid situations where the meaning shared by the informant would be cluttered by my language skills, resulting in
possibly vital information being lost. However, I recognise the fact that the inadequacy of my language skills in French have possibly limited the field of investigation, as practically half of the African continent is Francophone. Thus, the geographical scope for the study focused on Southern Africa. However, many of the Anglophone countries in Africa are concededly the largest receivers of financial support for development.

Further, I wanted to examine a country which was classified as low-income and which receives financial support for development (World Bank, 2016). This effectively limited the pool of countries to look at to Zimbabwe, Malawi, Tanzania, Ethiopia, Uganda, South Sudan and Somalia. South Sudan was not considered an ideal country for conducting the study, because of the turbulent political situation. I scoped the health situation between the countries to see if trends emerged, measured in standardised health indicators. Figure 3.1 illustrates the trends in life expectancy from birth, created from the World Bank database.¹

![Graph: Life expectancy at birth trends in contrast to mean for low income countries](http://data.worldbank.org/indicator/SP.DYN.LE00.IN/countries/XM-MW-ET-SO-ZW-TZ-UG?display=graph&cid=DEC_SS_WBGDataEmail_EXT)

Figure 3.1 provides a coarse indication of the level of health within each country, measured in life expectancy, which is one of the indicators for the Human Development Index (HDI). The graph illustrates to some extent the positive developments happening in health in these countries.

¹ Screen dump retrieved from: [http://data.worldbank.org/indicator/SP.DYN.LE00.IN/countries/XM-MW-ET-SO-ZW-TZ-UG?display=graph&cid=DEC_SS_WBGDataEmail_EXT](http://data.worldbank.org/indicator/SP.DYN.LE00.IN/countries/XM-MW-ET-SO-ZW-TZ-UG?display=graph&cid=DEC_SS_WBGDataEmail_EXT) [Accessed originally 10.03.15, new model created 03.05.16]
Malawi stands out in this regard (dark grey graph). Increasing the life-expectancy years from around 50 years to over 60 years in the period 2006-2014 essentially places the country above the mean for life-expectancy in low income countries. Some further research told me that Malawi has been committed to increasing the national level of health, and induced partnerships with various HDPs in order to achieve this increase. Evidently, something was happening in Malawi concerning the development of health indicators, and I became curious as to what this was. Some further research enlightened me on the involvement of the Norwegian state in Malawi, and the relevance in choosing Malawi as case increased. The study was supported financially by the Institute for Sociology and Human Geography at the University of Oslo, and the objectives of the research was approved by the Norwegian Centre for Research Data (NSD).

3.2.2 Case: the MHS as place

Prior to the fieldwork in Lilongwe, Malawi, there were many practicalities that needed to be addressed. A friendly researcher at the Centre for Development and the Environment at the University of Oslo had given me a telephone number, which would put me in contact with a driver in Lilongwe. In addition, I had booked accommodation through “Airbnb”, a personalised booking site, which meant I was in contact with my landlord. Apart from that, I depended on the kindness of strangers in a country located on a continent I had never visited when I arrived in the beginning of August 2015.

This was, however, also a part of attaining a contextual understanding of the field – I needed to be in it. In the pursuit of understanding the Malawian health system as place, I needed to gain the understanding of how the work takes place in the health system (Hastrup, 2010). According to Kirsten Halstrup (2010) one must understand place in order to properly engage in fieldwork as method. Even though I tried to gather as much information as possible prior to departure, I soon realised that I had to start from scratch when I arrived. This was partly due to the lack of relevant information that was available in published works and online, concerning who would be most relevant to speak to when I was there. Thus, entering the field at arrival opened up an understanding of “how things were done” in Malawi, contrasting Norway in many ways. This method of “diving in” unprepared left me with a tool to help me in many situations that arose during the fieldwork. According to Richie Howitt and Stan Stevens (2010, p. 55) one of the greatest vulnerabilities in doing research in a different context than the one that one is familiar with, especially in countries which traditionally were
colonised nations, is the risk of not being critical to one’s own role subjectively and objectively as researcher. Being unfamiliar with the context in which the case for the study was located in, I became much aware of my role as a foreign researcher and felt humble because I didn’t know the ‘rhythm-of-things’ happening around me.

Yet, I had established an inclination of what I wanted to figure out during the fieldwork, and had written an interview guide for use during the interviews based on the research questions. I wanted to conduct semi-structured interviews, to be able to compare the answers between the informants (George & Bennett, 2005, p. 67). In choosing semi-structured interviews, I could allow for the fluency and openness in the interviews, so that the informants could elaborate on issues they thought were important.

The aim for the next segment of this chapter is to emphasise the methodological choices that were made in the pursuit of producing qualitative data in the Malawian context. The section will explain how I entered the field, how I went about choosing the informants and what methods I chose in order to address them in a way that would provide deeper understanding.

3.2.3 Sources of data – interviews, text and observation

Hoping to explore the different dimensions of organisation within the health system, I wished to interview persons with employment and involvement at different levels within the health system. The nature of the study implied that I would have to conduct elite interviews, with people that were dealing with policy implementation and operation through their career or involvement. The goal of conducting such interviews was to extract rich data from the informants on how they perceived the situation in the Malawian health sector, and the perceptions on their own role within that situation.

Drawing inspiration from a scoping study on climate change in Malawi (Jumbe, Wiyo, Njewa, & Msiska, 08.2008, p. 5), I aimed at interviewing informants from seven different segments that operate within the MHS: research institutions, government ministries, development partners, civil society, NGOs, academia and the private sector. These categories would provide some width to the study, and contribute different perceptions and experiences with the MHS generally, and the planning and implementation within the health system more specifically. I did not interview any development partners with expatriate belonging, as I wanted to gain insight into the Malawian perceptions of the situation in the MHS. I conducted interviews with some development partner organisations, such as the United Nations
Children’s Fund (UNICEF) or Norwegian Church Aid (NCA). However, at these organisations I interviewed employees originating from Malawi to emphasise the Malawian experience in these organizations.

During my fieldwork in Malawi, I conducted eleven in-depth interviews with twelve informants, one informal conversation, and observation. The informants represent most of the segments introduced above, and some informants overlapped these groups as well. The informants that were interviewed are all key actors within planning and implementation in the MHS. These informants were chosen on the background of their professional position in the MHS, and they have spoken on behalf of this position. The experiences and thoughts shared in the interview are thus treated as statements made valid through their position, and not as their personal utterances. Even though the sample was random at best, they do tell stories about their roles and capabilities within the health system. Their insights and openness towards me as a researcher, and the research project also lies at the core of the following analysis.

I interviewed five government officials, belonging to the Ministry of Health (MoH), but including two informants representing the District Administration segment of the Ministry. One of the informants from MoH was at the time of my stay in Lilongwe a PhD candidate in South Africa, thus providing academic perceptions on the MHS. In addition, I interviewed one lecturer at the College of Medicine. I also interviewed a manager at the Public Health Institute of Malawi, which is a research institute connected to the MoH, committed to providing evidence-base for health care. I interviewed a high authority employee from the Christian Health Association of Malawi (CHAM), a private sector agent working parallel to the MoH, representing the faith based organisations in the MHS. CHAM represents an actor of importance in the MHS, on account of delivering almost 40 percent of the health services in the country. Malawi is a very religious country, and faith-based organisations are held in high regard amongst the population. I interviewed two informants employed at the NCA together, representing both an NGO and a Health Development Partner (HDP). However, they mainly engage directly with CHAM because they are both faith-based organisations. I spoke with an informant representing the CSO segment, from the Malawi Health Equity Network (MHEN). I also interviewed one high authority employee at UNICEF, which is an important HDP in Malawi.

2 See appendix I for anonymised list of informants
Early in the interview process, I also had a path-changing informal conversation with an international worker I got to know through a friend. Our conversation lasted for a couple of hours over dinner, and was not structured in any way. Rather, I told her about the topic of my study and let her tell me about her experiences, and thus gained deeper insight into the dynamics of the MHS. I reckon the conversation as part of the produced data, because it led me to rethink some fundamental aspects of the interview guide, such as focusing stronger on the allocation of resources as a governance indicator. In addition, her experiences opened up an ‘outsider’ aspect of the MHS, as she was working with the MoH through the Clinton Foundation.

To gain a broader understanding of the principles guiding the day-to-day operation of the informants, I used the Health Sector Strategic Plan (HSSP) [2011-2016] actively. The document works as a leading vision for the MHS as a whole, and also cultivates norms on how HDPs should engage with the national health system. It also outlines the priorities and organisation of the health sector, which has provided a baseline for the construction of the Malawian health governance model. The HSSP also provided a baseline that I could use to compare the experiences of the informants.

In addition to interviews and text analysis, I was invited to the Annual Review for the health sector for the fiscal year 2014/15. This is an annual conference, which was held at the end of my stay, on the 18th of September 2015. To be invited to observe the Review broadened my perspectives on how policies on health were being conducted and negotiated in the MHS. As many of my informants were present at the conference, I was able to observe how their experiences were from the back of the room where the conference was held, and observed how opinions were uttered, what the speeches focused on, and how the speakers related to the audience.

### 3.2.4 Methods used in producing the data

The timeline for the conducting of interviews lasted for mainly seven weeks, concentrating the interviews with informants between the 24th of August and the Annual Review on the 18th of September. Looking back on this period, it becomes clear that this was anything but a clean process, which in many instances led to insecurities about the quality of the data in terms of how the interview process could affect the outcome. According to Strauss and Corbin, however, research does in most cases deviate from the ideal setting of designing the research and carrying out according to plan (Strauss & Corbin, 1998).
Access: gatekeepers and recruitment

Gaining access to the field was made possible mainly through two separate events. The first strategic move for gaining access to the field was the choice of accommodation. It was somewhat out of my price range, but the compound turned out to be filled with people who worked for the World Bank, NGOs and research institutions worldwide. One of these became very interested in helping me, and gave me the contact information to one of his business partners in Malawi. Even though this business partner did not work in the health sector or within the area of health in any way, he still knew a lot of influential people that did. This business partner thus became one of my gatekeepers, and gave me the personal telephone numbers and email-addresses of three informants in my study. He also gave me tips on how best to approach each possible informant by giving me some information on their background.

In Malawi they do not operate with a telephone book – telephone numbers are largely arbitrary, and most people operate with pay-as-you-go sim-cards. Accessing a person’s telephone number does in many ways mean that you have been granted access by a friend, relative, co-worker and business partner, which I felt increased the possible informants trust in me on a personal level. Contrarily, this feeling of trust was not established through other methods used in gathering informants, which was through email to organisations and their employees. Extremely few responded to these, and the ones who replied did not want to be interviewed.

The other gatekeeper during my fieldwork was a Norwegian country representative at Norwegian Church Aid (NCA). There are many Norwegian people located in Malawi and especially in Lilongwe due to the presence of both a Norwegian embassy and different organisations that collaborate with Norwegian actors. Thus, once a month the Norwegian embassy coordinates a social gathering at a local restaurant, which they call “Nordic Gathering”. I was introduced to my gatekeeper by the student intern at the embassy, and I asked him if he might know somebody whom would be relevant for me to talk to. He invited me to come to the office of NCA to introduce my project. In addition, he forwarded my project to his contact at the MoH, who then put me in contact with possible informants working for the Ministry.

Sampling: choosing informants

The largest problem I faced in terms of legitimacy was in sampling the informants for the interview. As I was hoping to better understand how the policies of organisation was being
implemented and how the Malawian health system acted in relation to external influences, I was aiming at speaking to persons who in some way acted on and had influence within the national health system. This focus on interviewing persons who have and use power, and researching their impact has become more prominent within the social sciences in the last decades. This is in contrast to the more traditional way of conducting qualitative research on entities whom power is subjected on: “social scientists (including educational researchers) commonly acknowledge elites in their research, they less frequently use them, opting instead to investigate those without influence, over whom power is exercised” (Nudzor, 2013, p. 607).

My gatekeepers provided me with useful information such as telephone numbers to get in contact with possible informants. However, I felt rather uncertain as to how I should reach out to these possible informants whom I had the telephone numbers to. This led to some postponement in starting the interview process, as I felt uncomfortable calling the informants personally without any prior introduction. This kind of “cold-calling” could lead to problems in gaining trust between me as a researcher and the informant, because of the intrusive nature of the recruitment process (Valentine, 2005, p. 116). Prior experience told me that the “proper” way of reaching out to possible interview objects would start by email, and be followed up by a telephone call. However, this was not possible as email addresses were nearly impossible to locate. After the first few telephone calls, I gained confidence in the fact that this was the most successful approach to introducing the project to the informant, gaining trust, and booking an interview.

During this process of contacting possible informants, I operated with an excel sheet in order to organise who I had been in contact with, whom of which responded, and whom did not. Through the use of colour coding, the excel sheet gave an overview on whom had denied me access, and whom had granted me an interview. In addition, the excel sheet helped control who had set me in contact with whom. In speaking to many of my informants, the mentioning of who had referred me to them helped me gain access.

In the end, I booked eight of the interviews through telephone contact. I also developed an alternative system to get in contact with organisations and people whom I wanted to interview without having a gatekeeper. This system involved emailing the official contact email in the morning, and approaching the work place a few hours later, before lunch hour. I reached out to five such workplaces, and booked interviews at two of them. The last
interview was booked by email, but I was introduced to this informant through one of my gatekeepers.

I found it rather difficult to get interviews with informants. As an example I was in direct contact with eight more possible informants, but these did not grant me an interview. In addition, I reached out to multiple other organisations and institutions without being granted an interview. The reasons for this were diverse: I had booked interviews with two of them, but they didn’t show up or respond to my follow-up calls; some didn’t have time to fit me in, but replied in a polite manner; some didn’t respond at all, which I believe was because I used email in lack of telephone number; and some of whom I sought out in person simply did not follow up on my request for an interview.

In addition, geographical issues restrained the sample of informants. I attained contact information to possible informants, but these were located in the Malawian cities Zumba and Blantyre. Strain on time, and resources, effectively excluded contact with these. This means that my informants represent a geographically small area of the MHS. The government health system is devolved into 28 districts, which means that talking to informants outside of Lilongwe could possibly contribute different experiences with the implementation of health policies on different levels. I tried to compensate this issue by interviewing informants representing the Lilongwe district, to attain experience from district level as well as the central and policy-making level. The result was that the study is based on fewer interviews than I would have wished, and uncertainties in terms of reaching the ‘saturation point’ prevailed. However, as the intention of the interviews was to gain insight rather than establish truths, the eleven interviews conducted proved themselves to be beneficiary.

The interview situation

The interviews followed the same pattern. On the phone I introduced myself and mentioned who had given me their number, introduced the research project, and proposed an interview. If they said yes, I followed up by requesting their email to send them the consent form. All of the interviews were booked to, and held at, the offices or workplace of the informants. As Gill Valentine points out, when one wants to interview persons based on their employment or official involvement which is relevant for the project the interview is usually in the person’s office (Valentine, 2005, p. 118). However, to interview an informant at their place of work can also put strains on what they want to tell me. Even though I was not conducting
controversial interviews, the openness of the informants could be influenced by being in their place of employment.

Before the interview, the informant would sign a consent form. This was done in order to ‘sign’ a contract between the research project and the informant, so that both parties were ensured of what was the agreement. This consent form also explained that I would use a tape recorder to tape the interviews, in order to accurately transcribe what was being said in the interviews. This helped the data analysis at a later stage, as I go back to the interviews and identify patterns that I missed during the interviews.

The interview guide consisted of approximately 11 questions, or rather aspects that were to be discussed. I revised the interview guide four times after I constructed the original one. As reflected in the consent form, the original interview guide focused on the establishment of the Public Health Institute of Malawi, which is a new institute that collaborates with the Norwegian Public Health Institute. However, this focus was changed, and I took care to explain this to the informants when they signed the consent form. The revisions were made before the first interview, and then after the second, third and fourth interview. The only big revision was after the second and before the third interview (third revision). In this revision I chose to focus the questions more towards the allocation of resources within the MHS to shed light on financial management as a tool for attaining legitimacy in the governance structure. The fourth revision was made to open up the flexibility of the interview guide, and to make it more adaptable to the different positions of the informants.

The questions were categorised into three groups: The Malawian health system and organisation and the national strategies on health care delivery; the economic situation in the Malawian health system; and the relationship with externally originating actors such as development partners and donors. The choice of these categories was informed by their applicability to answer the research questions, but was also enforced after the first interviews in term of their relevance for the situation in the MHS.

The first bulk topic is the MHS as experienced by the informants. This includes identifying main actors, core functions, priorities, and outcomes. I addition it included experiences with changes in the health system, and their thoughts on the PoW and the HSSP.

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3 See appendix IV for consent form
4 See appendix II for full interview guide
The second bulk concerned the economic situation in the health sector, and the allocation of funding. This bulk focused especially on the problematic financial situation in the health sector. One important aspect of this bulk concerned the effects of the corruption scandal known as Cashgate on the situation in the health system.

The last category touched upon the relationship between the MHS and the external partners such as development partners and donors. These questions were asked in order to illustrate how the informants experienced the interface between the health system as a national entity and the health system as belonging to the global community as a global public good. Another aspect of this bulk was to understand how the informant related to GHG strategies on a national scale.

3.2.5 What claims do I make about the data – assessing quality

This section will deliberate on what claims that can be made on the basis of the production of data. Qualitative data production is always contingent, and vulnerable to the interpretation of the researcher. According to Tove Thagaard (1998) the stories that are told in an interview situation, from a social constructivist perspective, is constructed within the situation that they are told. She explains that the data that is created in the interview situation has developed through the relation between the informant and the researcher. In the Malawian context, I experienced that the interview situation was to a large part informed by the degree of trust that was established through initial contact and the first few minutes into the meeting. Trust was however established in different manners. As mentioned, trust was for example established through contact to the informant’s personal cell phone. Trust was also established through the mentioning of whom it was that referred me to the informant. In the interviews where trust was not established, the ‘quality’ of the experiences shared seemed to be hampered, largely due to the interviewee not being comfortable.

What influenced all the interviews was the pressed time. None of my informants really had the time to talk to me, but luckily they could squeeze me in for approximately thirty to forty minutes. However, this meant that the interviews became rather rushed, and not all questions were answered by all informants. In addition, some of the informants were rather stressed, and did not quite ease into the interview situation. In the interview situation, I did however consider the aspects of critical reflexivity, in order to critically assess the interview situation and the data produced in this setting. Critical reflexivity is in this regard thought of as the act of self-critical ethical conduct happening in qualitative research, meaning the
constant consideration of the “[…] self as researcher and of the research process” (Dowling, 2010, pp. 30-31). In Malawi, this was largely done through the keeping of a fieldwork journal, and constant reflection on the implications of my research. In addition, the use of a tape recorder helped me accurately reflect on the interviews after they were conducted, as it provided me with the possibility to go back to what had been said.

My position as a white, female researcher was somewhat of an issue during the fieldwork. One the one hand, the different cultural context meant that some of my personal characteristics were focused upon in a different manner than they would be at home. On the other, my status as ‘white girl’ opened up some possibilities that could have been closed if the researcher was someone else. Gill Valentine (2005) points out that a researcher’s gender, age and marital status can affect the accessibility to the field.

Malawi is rather liberal in its judicial opportunities for women, and the traditional political system is both matrilineal and patrilineal. Today many women are in government, and Joyce Banda became the first female president in Southern Africa in 2012. However, the role of women in the rural areas are not held in high regard, and the country does struggle with abuse and poverty disproportionately affecting women (UNICEF, n/d). The informants were both male (8) and female (4, in three interviews), with an over-representation of males.

These associations, in addition to being a ‘foreigner’ meant that I became anxious to learn how my role as a female researcher would be perceived, especially from the male informants. However, I felt that I was taken seriously and respected for my research on a general basis. To my surprise I felt more resistance from the female informants than from the males. Yet, this resistance also coincided with their feelings of meeting ‘unprepared’ to the interview, and wishes that I would have sent out a questionnaire beforehand. Thus, it may not be related to my gender. The male informants were in many ways more impulsive in the interviews, and spoke more freely than the female participants.

On the issue of validity and reliability, it is sensible to go back to the critical perspectives of Richie Howitt and Stan Stevens (2010, p. 46) on colonial research. This is because the data produced through my fieldwork was situated in a different context than what I am known with, and thus problems relating to the quality of the data can occur. They address the tricky case of transmission of cross-cultural research, where much of colonial research traditionally has been deemed as objective and valid by fellow researchers, while the objects and areas of study feels misunderstood. The resulting research can in some cases go as far as being deemed ethnocentric, fostering on Orientalism. In interviewing actors in the MHS
about their personal perceptions and thoughts, biases can occur. The informants work within parameters which are rather different than from Western countries. This is largely connected to how the government system is donor funded, and the informants can be cautious to say something that can risk the relationship between development partners and the government, also accounting for anonymity. During the fieldwork, this aspect took an interesting turn. I interviewed people above me in social ‘rank’, and explicitly explained how I was eager to learn more about the Malawian context in health. However, I experienced that some of the informants viewed me as ‘Norwegian’. In Malawi, the implication of being ‘Norwegian’ in the policy-making field holds connotations relating to financial support. This is related to Norway being an important development partner for Malawi, and Norwegians are generally held in high regard as the two countries share similarities (both small democratic countries committed to peace). Some of the interviewees hoped that I would mediate the experiences from Malawi to policy-makers in Norway. As such, I felt subordinate to my informants and their position in the MHS, but some of them believed I was ‘above’ them in effect of being ‘Norwegian’.

3.3 Analysis: processing the produced data

As a qualitative researcher, one enters the field with the hope that one can gather insights, observations, conversations and thoughts that can contribute to the meaningful production of data. By *production* of data is meant how qualitative data is never “gathered” as a constant, already existing set of data awaiting discovery. Qualitative data is rather the result of interpretation – interpretation of one’s role as a researcher, interpretation of contexts and relationships that inform and shape the informant’s experiences, and interpretation of how the data that is produced from this process is contextual and not finite (Fossåskaret, Fuglestad, & Aase, 1997, p. 35).

The choice of grounded theory as mode of qualitative data analysis is, as discussed earlier in this chapter, justified by two guiding principles of the research: (1) to gain deeper understanding of the organisation of the health sector in Malawi through the accounts of actors involved in the implementation of the HSSP [2011-2016] and; (2) perform effective and efficient analysis of the produced data to ably develop theory on GHG grounded in the Malawian data. The third and last section of this chapter will explain the methodology in analysis of the data that were collected, of which key findings will be introduced and
discussed in chapter four, *Building the Malawian Health Model*, and chapter five, *Implementation Realities*. The arguments concerning grounded theory will be built upon the conceptualisations of Anselm Strauss (1987), and his collaboration with Juliet Corbin (Strauss & Corbin, 1998).

Barney Gibson and Jan Hartman (2014, p. 33) argue that the core objective of grounded theory lies in the task of the researcher to enter the research without preconceived ideas. However, Kathy Charmaz (2014) emphasise that the core objective of the researcher is to not bring in any predated theoretical ideas, but that the earlier conceptualisations of the researcher can bring insights to developing theory. Through the production of data and the initial analysis, the aim has been to not let earlier conceptualisations colour what was being told in the field and in interviews, but to understand these same stories parallel to assumptions of the GHG as an overarching theme.

The analysis of data for this thesis started whilst in the field. Initial analysis took the shape of categorising and explaining the concepts that emerged in the interviews and what the informants shared with me in terms of phenomenons and experiences, and through the observations that were made. If one informant in the interview situation told me something that I grasped as “interesting” for the study, I would try to contrast their experience with the experiences in the following interviews. The aim of this activity was to establish a network of concepts and categories that could help trigger patterns between the different interviews. If one considers the activity of categorising, it really is a pursuit to organise phenomena to find meaning in them. This meaning is often established based on the associations which we have with prototypes (Fossåskaret et al., 1997, p. 39). A prototype in this regard can be understood as the idealised version that is accumulated through many different versions of a phenomenon. This understanding is based on Max Weber’s ideal types. The prototype is deductively selected by the researcher, based on the researcher’s perceptions and epistemological worldview. Thus, the categorisation, and the analysis of data, is highly contingent on the researcher.

To employ grounded theory as method for the systematic gathering and analysis of data, Anselm Strauss and Juliet Corbin (1998, p. 12) argues that it is important to let theory building emerge from the data itself through a to-and-fro movement between data and analysis. Much of the value of this method lies in its ability to ground theory from data, in a systematic and reflexive manner, which can offer insight into areas of study that are not typically accessible. Grounded theory is a method that emphasises the ability of the researcher
to move between what is heard and experienced, and elevate this to the abstract level – and from there move back to the data: “The value of the methodology […] lies in its ability not only to generate theory but also to ground that theory in data” (Strauss & Corbin, 1998, p. 8). According to Anselm Strauss and Juliet Corbin (1998, p. 13) the process of coding one’s data must be grounded in flexibility and creative interpretation which moves between the data itself and the researcher, with her or his built-up abilities and understandings in undertaking research. The grounding of theory in data thus becomes a process where interpretations of data build theory rather than testing theory against hypotheses.

Initiation of the coding was inspired by Anselm L. Strauss’ (1987, pp. 27-28) coding paradigm, a set of elements to look for in the data: (1) conditions, (2) interaction among the actors, (3) strategies and tactics, and (4) consequences. I followed this set of concepts in coding and interpreting the data, following the three bulks of topics from the interview guide. Approaching the data analysis in terms of open and axial coding encourages the researcher to make use of memos; writing ideas and patterns that emerge from the reading of data, which helps the researcher to categorise the different codes and to more ably detect patterns and relationships between the codes. The risky business of analysing data through the use of codes is that it is possible to disintegrate and reintegrate the data, which is highly actor oriented on all levels, to a degree where one ends up articulating a theory which is just a retelling of what is already known.

Parallel to the researcher actively categorising phenomena, the informant also classifies their experiences. One of the most important tasks of the researcher is to be able to put herself in the realities of the informant (Fossåskaret et al., 1997, p. 39). This part of analysis handles the complexities of meaning – experienced, appropriated, unconscious and internalised. The interpretation of meaning draws on semiotic and hermeneutic perspectives.

The analysis of data involved writing memos while sifting, reading and coding the interviews, in order to follow up on thought processes that emerged from the reading process. This follows Mats Alvesson and Kaj Sköldberg’s understanding of Anselm Strauss’ emphasis on rigorous interpretation of the data: “Through the writing of memos, the theory emerges successively […]” (Alvesson & Sköldberg, 1994, pp. 86, [own translation, emphasis added]). Thus, the analysis of the produced data from Malawi helped me structure the two following chapters of this thesis. The experiences and thoughts of the interviewees constituted patterns connected to the influence of external forces of global health on the national health system.
Thus, the telling of the Malawian story was largely shaped by the categories and patterns that emerged in the interview situation.

3.4 Summary

This chapter has sought to shed light on the methods employed in the production of data for this thesis. The overall aim of these methods has been to approach the data production process with caution concerning my own role as a researcher and interpretation of data. When dealing with personal perceptions and thoughts on issues relating to the MHS, the informants bring their own associations and feelings, which can be biased. In the Malawian context, the informants work within parameters that are rather different than in Western countries. The government system is heavily donor-funded, and biases can emerge from a personal connection to HDPs. Thus, the method employed in approaching the views shared by the informants has sought to take this context into consideration.

First, the chapter emphasised the rationale of choosing to conduct a qualitative fieldwork to produce data on the Malawian context. Secondly, an account was provided of the methods employed in producing these data, especially focusing on semi-structured interviews with Malawian actors. Lastly, the chapter introduced the techniques used in order to analyse the produced data, making use of coding and memo-writing in order to categorise the data to look for emerging patterns. The main argument of this chapter has been that the use of a qualitative methodology and a grounded theory approach to the data production and analysis provide a constructivist interpretation of the situation in the Malawian health system.

The next two chapters will outline the analytical contributions based on the data production methods explained in this chapter.
4 Building the Malawian Health Model

Following the arguments posed in chapter two, theoretical assumptions, and chapter three, methods, this chapter will aim to answer the first research question for this thesis based on the data produced from the fieldwork in Malawi. The first research question is: What characterises the Malawian health system (MHS) as formulated in the Health Sector Strategic Plan (HSSP) 2011-2016? The research question implies an examination of the strategic document currently being implemented in Malawi, the Health Sector Strategic Plan (HSSP). This will be done through an evaluation of the objectives stated as priorities in the HSSP, and how these are related to by the informants that participated in the study conducted in Malawi. The combination of textual analysis and the perceptions of the informants will contribute to the construction of what constitutes the Malawian health system (MHS). In addition, the discussion will untangle the organisational structures by which the MHS is organised, to give an idea of how national decentralisation policies are influencing the governing of the health sector. However, the ideas of the HSSP are also being processed by the actors in the MHS on a daily basis. The analytical approach of this chapter is based on constructivist ideas on how data can help ground theoretical aspects of the MHS.

The guiding argument for this chapter is that the ideas and principles presented in the HSSP [2011-2016] represent the construction of the MHS, and that these ideas and principles are derived from a PHC approach to health. The argument of the following section is that the stated mission, goals and principles of the HSSP draw inspiration from the health system approach advocated by the WHO in general, and employ core elements from the PHC approach specifically (World Health Organisation (WHO), 2007, 2008).

4.1 Health in the Global South: Approaching Malawi

In order to grasp the realities of national health system development in Malawi, it is important to understand the context in which it operates. This is in order to justify how different health systems differ from each other based on locality. The political and economic situation in

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5 From this point on in the text, MHS will refer to the Malawian health system as a concept for the system as a whole. The Malawian health system consists of many different actors, functions and structures (Figure 4.1 and 4.2). When the text refers to one specified entity within the health system, it will be explained explicitly.
Malawi was briefly accounted for in chapter one, introduction, but a reassertion is necessary.

The populations that live in the Global South relate to health in a different way compared to the more “developed” parts of the world. This is because the relationship between health and development is largely intertwined in societies characterised by poverty and vulnerability. In the pursuit of economic development and prosperity, both individually and for the society as a whole, the level of health has direct impact on productivity and efficiency: if you get ill with an infectious disease, for example HIV/AIDS or Tuberculosis, it will directly impact your ability to work for your income, and thus security (Chant & McIlwaine, 2009, p. 256). This effect is part of a negative spiral, where poverty is closely linked to lower standards of health, affecting the productivity level in resource-poor societies with double force, where poverty and poor health are enhancing each other.

Higher standards of health are related to social conditions such as sources of clean water and functional systems of sanitation, good living environments, and more sufficient nutrition. This is recognised as positive spiral, where good health also reinforces the efforts to uphold strong infrastructure that provides good health. This implies that equity in health is disproportionate in different parts of the world, measured in terms of opportunities for elevating one’s own level of health (Committee for Development Policy (CDP), 2009, p. 8).

Chant and McIlwaine (2009, p. 260) argue that public spending on health has great impact on gross domestic product (GDP) levels in a country, suggesting that health on the individual level has positive spill-over effects on the productivity in society as a whole. This provides a strong argument for increasing the amount diverted to health systems in the Global South by national governments. However, the levels of public spending on health and the presence of comprehensive health systems with sustained health care delivery are rather rare, especially on the African continent (Chant & McIlwaine, 2009). In Malawi, however, the situation is characterised by a different trend. The government attempts to increase the public spending on health, and they are the only country among their neighbours that provides a comprehensive health programme ‘free of charge’ to its citizens (Ministry of Health, 2011). However, being a poor country with challenges connected to economic development, building of infrastructure and low levels of education, health standards are generally low. The national government is nonetheless strongly committed to attaining higher health standards, illustrated by their commitments to global health innovations, such as being the first country in the world to implement the WHO Option B+ for HIV-positive pregnant women (UNAIDS, 13.06.2015). This commitment has meant a great deal for the national level, in the aim of attaining equity.
in health and equal opportunities for all Malawians in order to encourage health-seeking behaviour.

4.2 The HSSP: Vision and Mission in the Malawian Health System

The vision of the MHS is largely guided by strategic plans, which are written by different stakeholders in the health system. The MHS has produced and implemented two strategic plans for the health sector since 2004, namely the Programme of Work (PoW) [2004-2010] and the Health Sector Strategic Plan (HSSP) [2011-2016].

Strategic health planning in Malawi is however not a new phenomenon. The PoW followed the fourth National Health Plan, which was the last in a series of striving health plans that was implemented in Malawi until 2004. These were however wide in scope, and were not fully fulfilled due to the too-high ambitions it set out to achieve (Conticini, 2004, p. 17). However, according to the MoH the PoW is essentially a continuation of the National Health Plans, the only difference being in the refocusing of the documents role as a strategy tool: “PoW [is] a strategic document for activity-based health sector planning and operations” (Ministry of Health, 2004, p. 5).

The Joint Programme of Work for a Health Sector Wide Approach (labelled the Programme of Work (PoW)) was the precursor to the HSSP. The plan was implemented between 2004 and 2010, as a strategic tool for the MoH to actively introduce and enforce the Sector-Wide Approach (SWAp) mechanism in Malawi. The SWAp mechanism was developed as an alternative funding mechanism to the traditional project-oriented aid disbursement from donor to a developing country. Noting how the traditional aid mechanisms often led to the national governments having less control over health projects in the country, resulting in fragmentation and duplication, the SWAp mechanisms hoped to steer donor-driven activities towards the control of the government:

“In essence, a SWAp calls for a partnership in which government and development agencies change their relationships (to clearer government leadership). They interact more together in the formulation of policy, and less on the details of its implementation” (World Health Organisation (WHO), n/d).

Thus, donor funding became united in a pooled fund, which was controlled by the government of Malawi. This money became part of the national budget, and was allocated to
different sectors within the national health system. The SWAp became a possibility for the
government of Malawi to coordinate donor funding, which provided possibilities for
improving oversight and control over health projects being implemented on a national basis.
The introduction of the SWAp mechanism benefitted the national health system in its
mandate to provide health for all Malawians, as they could more easily track what purpose the
money were serving (Ministry of Health, 2004; NORAD, 2013; World Health Organisation
(WHO), n/d).

The pooled funding mechanism increased the national budget on health, providing
possibilities for improving health service quality. Gains were made in health indicators during
the implementation of the PoW, both in overall investment in health infrastructure, and
investment in human resource by being capable to train more health personnel (Ministry of
Health, 2011). The achievements in health indicators was globally appreciated through
Malawi’s success in ‘reaching’ Millennium Development Goal four, to reduce child mortality
by half (Save the Children, 10.08.2015).

Malawi’s improving results in health indicators was due to a cross-sectoral
commitment to attaining health. Within the health sector, this was specifically reflected in the
employment of the Essential Health Package (EHP). EHP was a crucial element in Malawi’s
Poverty Reduction Strategy Paper. Originally a World Bank initiative, Poverty Reduction
Strategy Paper's is a widespread tool in many African countries, which can help mobilize
funding for development. The EHP became an important intervention in the aim for
alleviating the most acute sources of poor health in Malawi, in addition to achieving greater
efficiency and equity in the universal coverage of health services: “The EHP refers to a
prioritised but limited package of services that should be available to every individual in
Malawi” (Ministry of Health, 2004, p. 1).

The HSSP was developed as a continuation of the PoW, and is meant to provide a
strategic direction for the MHS between the years 2011 and 2016. The mission of the MHS,
following the vision of the HSSP, is to deliver a comprehensive range of quality, equitable
and efficient health services to all people in Malawi “by creating an enabling environment for
health promoting activities” (Ministry of Health, 2011, p. 47). The aim of the plan is to attain
the highest level of health among Malawian citizens, which is to be gained through the
“combined efforts” between “individuals, communities, organisations, cooperative partners

6 See appendix III for overview of EHP interventions
and the government” (Ministry of Health, 2011, p. xi). The PoW, and the following HSSP, thus represents a new direction for the MHS especially through the new commitment to the SWAp mechanism. Thus, the HSSP enables a historical aspect for the last twelve years as a new era of governance in the MHS (2004-2016).

The leading vision of the HSSP is: “[…] to achieve a state of health for all the people of Malawi that would enable them to lead a quality and productive life” (Ministry of Health, 2011, p. 1). This vision points to how the plan focuses on health as a two-edged concept, which is both important on the individual level (health as quality), and on the level of the society (health as productivity). This provides a basis for understanding how the MHS through the articulation of the HSSP relate to health as multi-dimensional. In terms of health equity, the idea of health as quality weighs heavily. Health as productivity is a concept that can be traced to an economic understanding of health, where health becomes an instrument for efficiency in production. In Malawi’s case, production is read as the further economic development of the country. Health in Malawi, as constituted in the HSSP, is thus viewed as a human right, and as having positive spill-over effects for society as a whole.

4.2.1 Producing the document

The development of the HSSP as a document involved many stakeholders from all levels of the MHS, both national and international actors. At the national level these include the MoH, medical training institutions, research institutes, NGOs and civil society organisations (CSOs). International actors were for instance bilateral aid contributors such as other national governments, multilateral organisations such as the UN, UNICEF and the WHO, NGOs, and other non-state HDPs involved in Malawi. These actors were united in what is called the Core Group, which is the forum responsible for the articulation of the HSSP, from drafts to the finalised product. The role of the international actors, referred to as HDPs collectively throughout the HSSP, is mainly one of technical assistance and support (Ministry of Health, 2011, pp. 38-39). HDPs are in this regard defined as actors in the MHS, as listed above, which contribute to the functioning of the MHS through financial and technical support. The HSSP identifies the DFID, the WHO, GTZ, FICA, USAID and UNFPA as key technical supporters present at the consultative meetings. The financial support contributed by these partners are facilitating the interventions outlined in the HSSP, and the HDPs are thus participants at the health sector review meetings, which are held annually (Ministry of Health, 2011, p. 85). The HSSP does not, however, engage in a further elaboration on the role of the HDPs. When the
HDPs are referred to, they are mentioned largely as belonging to the governance structures of the MHS, and not as separate entities. Thus, the expanded role of HDPs are somewhat understated in the formulation of the HSSP.

The HSSP is structured in 8 chapters with different argumentative points, but these chapters cover mainly four topics: the guiding principles of the HSSP based on a situational analysis of health in Malawi; further implementation of the EHP; governance structures, and; the financial situation for the implementation of the HSSP. The area of interest for this thesis is the chapters concerning the vision and the governance of the health sector. These are namely the chapters on the introduction and priorities of the plan (chapter three), “the guiding principles, goals and objectives of the plan” (chapter four), “strategies, interventions and implementation arrangements for the HSSP” (chapter five), and the chapter “governance of the health sector” (chapter six). The other chapters of the HSSP will in this regard be left out, but it is recognised as being vitally important in the formulation of the HSSP, as these other chapters provide overview and analysis of the current situation of health in Malawi in terms of health indicators. The rationale for choosing mainly these four chapters is because they are, as mentioned, key to understanding the priorities and the organisation of the MHS after the shift towards strategic health planning within the SWAp mechanism in 2004.

4.2.2 Rationale of the document – evaluation of objectives

The purpose of the HSSP is to convey a sound vision for the development of the MHS. The objectives stated in the plan are aligned to achieve this purpose, and are focused upon two segments to make this development possible (Ministry of Health, 2011, pp. 50-52):

1. The continued implementation of the EHP, but in a broader version than established in the PoW.
2. Emphasis on health system strengthening to facilitate the implementation of the EHP.

These two objectives provide an opening in understanding the characteristics of the MHS. Firstly, the objectives strongly reflect the two main elements of the PHC agenda: focus on essential health care and the use of a strong national health system to provide this. Secondly, they also reflect the two core values of the PHC agenda, which is equity in health and universal access to health services.
These two priorities established in the HSSP are first of all built upon the evaluations of the PoW, which were conducted after the expiration of the PoW in 2010. In addition, the priorities are also linked to the recommendations that came from the “Burden of Disease” which was a study conducted by the College of Medicine in Malawi in 2011 to provide a sufficient evidence-base for the priorities of the health sector.

The EHP – conceptualising priorities

First I will consider the first of the two objectives for the MHS, the continued implementation of the EHP. This is an important aspect of what are deemed as health priorities in the MHs, as stated in the eleven core interventions of the EHP. The rationale behind focusing on priorities of the HSSP as an expression of priorities within the MHS is based on how priorities reflect power within decision-making processes within a health system. Establishing what the priorities are, who negotiates them and how they are debated illuminates how relations of decision-making power are being processed in the MHS.

The EHP is enshrined in the HSSP as main priority for delivering of essential health care. The ‘package’ originally consisted of eleven diseases and conditions that are easily treated, but also widespread in Malawi. The choice to compromise health services for these issues into one comprehensive package was built upon the idea that if the health system can alleviate the basic causes of ill health in the population, then the general standards of health will increase. The second idea was to simplify the training for Health Surveillance Assistants in the communities, which deliver health care at the primary level. Health Surveillance Assistants are medical personnel with basic medical training given over a two-month period. The objective of training such Assistants is to have persons with basic medical knowledge in the communities, whom will be able to refer patients to health centres and hospitals. By providing training and equipment for the EHP, resources could be more efficiently and equally distributed across the country to increase health equity. By ‘package’ is meant a set of priorities that are consulted first in meeting with the patients.

Concerning who makes the priorities for the HSSP and the health sector as a whole, the idea is that these should be negotiated between the actors of the MHS. The question becomes if this is so, and to what extent the Malawian actors experience this negotiation. The HSSP indicate that the priorities are negotiated between the government health system, and

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7 See appendix III for full list of interventions.
the HDP stakeholders in the MHS. The informants were asked whether they had any thoughts on how the priorities in the HSSP were articulated, apart from the technical process described in the plan. One of the lecturers at the College of Medicine observed that the negotiation process is a continuous process, combining efforts at the global level and the national level, all the way to the district level:

“[…] obviously, the MDGs and now the SDGs – they come out of prioritisation, a stiff competition as to what should make it in there and the wording and so forth. It’s obviously a high level policy setting staging those. By the end of the day, the MDGs are translated through the HSSP, then the HSSP is translated through these information plans [District Health Implementation Plans]. […] But districts are allowed some autonomous decision making in prioritisation based on their own epidemiological data” (Academic informant, interview 01.09.15)

This perspective suggests that the priorities formulated through the EHP constitute a combination of global agendas and local needs. Reflecting the visions in the PHC agenda, national ownership to health is of crucial importance. The EHP is in many ways prioritised based on the needs of the country, in alignment with the vision of the PHC. Priorities are also adapted to district level strategies on health, to suit each individual district.

For the informants whom did not belong to any government ministry or the MoH, this question sought views on whether they felt that their organisation participated in any way to the priorities of the plan. While representing different segments of the MHS (NGO informant 1 (31.08.15), CSO informant (03.09.15a), and NGO informant 2 (17.09.15)), they united on their perception of the HSSP as a collaborative document, where the MoH and stakeholders can draw on each other’s experiences. These informants all trusted that they contributed to the priorities, and the guiding principles of the HSSP. These experiences of the informants support the argument that the articulated priorities are collaborative between the different actors in the MHS.

There were views amongst some of the government informants that the EHP is basic, but instrumental to the MHS (MoH informant 1, interview 02.09.16a. MoH informant 2, interview 07.09.15. MoH informant 3, interview 17.09.15b). The EHP was expanded for the articulation of the HSSP, and emphasis was put on the need for broadening the scope of the package, so that it would be adaptable to emerging diseases. This was emphasised by one of the informants who worked directly with developing the HSSP: “The strategic plan [HSSP] learnt a lot from the PoW, but becoming a little bit wider. The EHP was being extended, hoping that sooner or later we’ll not even have the emerging issues. But the way it was defined, to me I found it to be more research based” (MoH informant 3, interview 17.09.15b).
This experience underpins how the EHP is based on health indicators from Malawi, thus supporting the claim that the priorities are adjusted to fit local realities.

Yet, there were views amongst the informants suggesting that the expansion of the EHP was superfluous because the essence of the EHP is misjudged, meaning that the package does not represent an adequate response to the health challenges facing Malawi (CSO informant, interview 03.09.15a. Private sector informant, interview 28.08.15).

The EHP represent a kind of health intervention which is most concerned with lifting the most basic health indicators in the population. Yet, the cost of the EHP has been challenging to cover. This challenge is also the reason for the simplicity of the package, in order to deliver at least the minimum amount of care as a human right (Academic informant, interview 01.09.15). According to one of the planners at MoH, the situation characterising the EHP is doubled; whilst representing a very basic form of health care, the MHS is not able to finance it:

“The challenge is that the system doesn’t have enough money to finance that package. But, that doesn’t take away the fact that it’s very basic, this package of services. It just points to the weak health-financing situation we currently have. But in general I think the interventions in the EHP – they’re basic!” (MoH informant 2, interview 07.09.15)

The priorities of the MHS as articulated in the HSSP are thus primary in nature, and are focused on addressing the main disease burden in the country. One of the large challenges facing these priorities is, as pointed out, the issue of health financing. However, as one of the NGO informants points out, the health priorities in Malawi are also dependent on being heard and seen by the HDPs to receive funding: “If a programme isn’t focused, they’ll lose it. Because nobody is talking about it.” (NGO informant 2, interview 17.09.15). Her experiences illustrate how priorities are of fragile nature, and easily bypassed if they are not constantly in focus.

The HSSP also recognises a range of issues connected to implementing the EHP equally for all Malawians. The EHP was reconstructed for the HSSP, to account for the different levels of health service delivery under decentralisation in the MHS. As such, the EHP is under the HSSP defined by the level of delivery rather than by the specific conditions it applies to. This was a development done in order to recognise how different levels of the MHS can contribute differently to the delivery of the EHP, so that some of the deliverance responsibilities would be lifted off the Health Surveillance Assistants in the communities. Even though the health system became technically decentralised during the implementation of
the PoW, the geography of Malawi is characterised by many hard-to-reach areas. These have been hard to cover in terms of employing Health Surveillance Assistants that are willing to live in these areas. In addition, there have been issues connected to covering the geographical challenges in terms of distance between communities and health centres. Also, difficulties in monitoring and oversight mechanisms in such areas has proved challenging in terms of avoiding duplication of activities between government health system institutions and NGOs implementing activities in communities. In the pursuit of better deliverance of the EHP, the HSSP wants to enable this through more thorough routines for health data and hospital monitoring and statistics, as well as securing a strengthening of incentives for human resource to stay within the government system, to secure that institutional memory is not lost (Ministry of Health, 2011, pp. 39-40). Thus, there is a shift from the PoW approach to the HSSP approach in terms of how the EHP is defined. This is important in regards to the role of the second objective of the HSSP; *strengthening the performance of the health system to support the delivery of the EHP services*.

**Organisation – Decentralisation as strategy for equity**

The second segment of the objectives actually constitutes the core feature for the implementation of the first objective, *implementation of the EHP*. The second objective concerns the strengthening of the capacities of the national health institutions MHS. These capacities are guided by the national decentralisation strategies, which mean that the national health system has been decentralised to district level, or secondary level. Decentralisation is an important strategy in the PHC approach to the governing of health, in order to close the gap between communities and the government health system.

Figure 4.1 provides a map of the government structures at district level that is presented in the HSSP. The following paragraph will use this institutional map as guidance when explaining the idea of decentralisation in the MHS.

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8 Secondary level and district level refer to the same, and will be used interchangeably.
The aim for health system strengthening in the MHS is grounded in the idea that national health systems are the primary provider of comprehensive health services. This is advocated by the WHO, and was the focus of the organisation’s re-introduction of the PHC agenda in 2008 (World Health Organisation (WHO), 2008). Health System strengthening is a concept legitimized by the WHO, which has become a favourable term used by donors in their funding agendas directed towards countries in the Global South (for example see Braquehais, 19.10.2015; USAID, 2016; GAVI, n/d; NORAD, n/d).

Health system strengthening is in essence the pursuit of strengthening the six building blocks of a health system, as defined by the WHO: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship) (World Health Organisation (WHO), 2007, p. vi). These six principles were established in response to the arguments that most countries would not be able to reach the Millennium Development Goals if resources were not directed towards health system functions, instead of only aiming resources towards specific diseases and programmes. The six building blocks are however rather vague, and are not necessarily easily translated into effective health systems. This has been the case for Malawi, even though there is commitment to health system strengthening practices in the (Ministry of Health, 2015).

The MHS is decentralised at district level to comply with the National Decentralisation Act, which was approved in 1998. The overall aim of national decentralisation is to enhance the participatory democratic environment, which the country has been enforcing since transition to multi-party democracy in 1994. With higher degree of community participation in decision-making, it is believed that public services can operate more efficiently and with more accountability to promote ‘good governance’ (The Hunger Project, n/d). The aim of this is to reduce poverty and increase development in Malawi.

The health sector is categorised into central, tertiary, secondary, and primary level. The MoH constitutes the highest level of governance within the MHS, and is called the central level under decentralisation. The different elements of the health system branch out from the leadership of the MoH. The MoH, as a government agency, holds responsibility for setting the agenda for the system as a whole. It is emphasised in the HSSP that this responsibility is followed through in collaboration with different stakeholders. Its main leadership responsibility relates to “[…] developing, reviewing and enforcing health and related policies for the health sector” (Ministry of Health, 2011, p. 79).

![Map of government health system governance structures at national level](source)

Figure 4.2: Map of government health system governance structures at national level

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10 Source: Health Sector Strategic Plan (Annex 10, Ministry of Health, 2011, p. 132)
The organisation within the MoH agencies is highly complex, and it does not contribute anything to this analysis to go into detail on each government agency. Rather, a short introduction is sufficient: above the MoH is the Cabinet Committee on Health, overseeing that the health agenda fulfils objectives established in the overarching development strategy for the country, the Malawi Growth and Development Strategy, in addition to the National Health Policy. There is also a Parliamentary Committee on Health responsible for the lobbying and mediation of the interests in the health sector to the Parliament. Another establishment within the MoH is what is called the Health Sector Working Groups, which works for better coordination of the health sector, both in the sector itself and between the health sector and other departments of the government. The Health Sector Working Groups consist of multiple stakeholders in society, including governmental, non-governmental and civil society organisations in addition to many others. The technical assistance is established by the Technical Working Groups, who include multiple partners from both within and outside the government system (Ministry of Health, 2011, p. 80).

The Cabinet Committee on Health, the Parliamentary Committee on Health, the Health Sector Working Groups and the Technical Working groups make up the health sector on the national level, and hold responsibilities for developing and enforcing policies for the health sector as a whole. These entities were established as a part of the commitment to the SWAp in 2004. Different HDPs are largely represented in the multitude of Working Groups (Technical and Sector). The intention of transcending into the SWAp mechanism was to ensure national ownership to the health programming in Malawi, but the representation of HDPs in these central groups ensures their continued influence over national matters of health (Sandberg & Justice, 2013, p. 103).

In tandem with decentralisation, the responsibilities for implementation of the HSSP have changed. The decentralisation of the government health sector involved devolving the administration and political authority to district level, shifting the implementation responsibilities of the MoH towards district level. The decentralisation policy was an attempt at government reform which would distribute responsibilities to multiple actors within the government system, in the pursuit of efficiency, accountability and transparency. The intention for the health sector was to only decentralise the health centres at primary level, in the communities. However, for the MoH this was perceived as incomplete, and they were worried it would create confusion in terms of distribution of responsibilities in the organisation of the health system. As one of the planners at MoH expresses it:
“[…] if we devolved only the health centres, then the responsibility for the secondary level would be a bit confusing. Like, in the referral system in terms of the management of health care workers […]. So, the MoH decided to devolve their whole district health care system to the districts [secondary level]” (MoH informant 1, interview 02.09.15a

In order to have oversight of the different districts and their implementation, the MoH established five zonal offices. Branching out directly from the MoH, these provide technical support to the District Health Management Teams in their planning, delivery and monitoring of health service delivery at district level. The five zonal offices represent the regions North, Central East, Central West, South East and South. Coincidently, these zones also facilitate the tertiary level of the MHS under decentralisation, as Malawi’s five central hospitals are located in each zone.

Within the parameter of each zone you find the different districts, which constitute the secondary level under decentralisation. In Malawi there are a total of 28 districts, and each of these has their own District Health Management Team working towards the implementation of the HSSP, which are managed by District Administration. The different District Health Management Teams have responsibility for the primary level of health care, at community and health centre level. The primary level consists of Health Surveillance Assistants in all the communities, including the ones defined as hard-to-reach. These are managed by the Village Health Committees. Above the primary level there are health centres spread out between the different communities, which are managed by the Health Centre Management Committees. The health centres are covered by medical personnel that have higher medical competence than the Health Surveillance Assistants. The district level and primary level work closely together, as these two levels are also the closest ones to the different communities in Malawi. The main task of the primary health centres is to focus on delivering health services aligned to the EHP. They also have the ability to refer patients from the communities to the secondary level, which are the district hospitals. These hospitals are small, but spread around the country to deliver health care for those who need treatment that is beyond the staff at health centres.

The HSSP was constructed with the decentralised health system in mind, planning for how different segments of the health system hold different responsibilities, which has effect on the organisation of the MHS. However, one of the informants (District Administration informant 1, interview 02.09.15b) illustrated how not all responsibilities concerning the organisation and operation of the health sector were decentralised. One of the responsibilities that still lie with the MoH is the posting of health personnel between the districts:
“[…] We’re supposed to be decentralised by now, but we’re not. So, if I have let’s say HR problems, I can’t go headhunting […]. It’s posted from the MoH. Now, depending on how good they’re doing on postings, I’ll get the numbers I need. But it doesn’t work that way. If 28 people [wants to be employed], they [MoH] just go one one one one. Because it’s 28 districts, and 28 people. So, some districts are doing way better than other districts” (District Administration informant 1, interview 02.09.15b)

As such, the devolution of the health system does not entail the decentralisation of all responsibilities from the MoH, which in the case of this informant is being perceived of as inefficient. According to this informant, the inefficiency lies with how different districts need different resources, including human resources. Thus, when responsibility for distributing human resource lies with the MoH, the districts have little authority to contrast these decisions.

In addition, decentralisation policies have led to a shifting of authority within the government in terms of the responsibilities for allocating resources. Before the move towards decentralisation, it was the MoH who allocated the budget from the Ministry of Finance to each district. Now, the responsibility of allocating resources to the districts lies entirely with the Ministry of Finance, bypassing the MoH:

“[…] what used to happen before [the Decentralisation act] was that they [Ministry of Finance] would give us the district budget, and then the MoH would have to allocate these resources to the districts. So now it’s them [Ministry of Finance] who allocate district resources. I think regardless of whether the PoW or the current HSSP or the one we are developing; I think this is how things happen.” (MoH informant 1, interview 02.09.15a)

Decentralisation has moved the allocation responsibilities towards district level. This had led to the creation of District Implementation Plans, stating the priorities for each district in terms of what they want to achieve within a year. These papers are aligned with the goals of the HSSP, but are also based on indicators that are relevant for each district (District Administration informant 1, interview 02.09.15b). As such, the objective of health system strengthening through strategies of decentralisation in the MHS has entailed a shifting of responsibilities within the MHS in terms of implementation of services and allocation of resources. This means that the implementation of the EHP under the HSSP is largely governed by the district administration units.

4.2.3 Grounding Governance in the Malawian Health System

The foregoing elaboration concerned the two objectives of the HSSP: the implementation of the EHP, and the emphasis on health system strengthening in order to facilitate the
implementation of the EHP. These two objectives have two main consequences. First, the EHP represents a PHC approach to health. Secondly, the two objectives are based on the idea of the MHS as a mainly national entity.

Firstly, The HSSP is largely inspired by the PHC approach in its formulation. In example, the HSSP lists twelve guiding principles for the health sector. These guiding principles are: (1) National ownership and government leadership, (2) Human rights based approach and equity, (3) Gender sensitivity, (4) Ethical Considerations, (5) Efficiency, (6) Accountability, (7) Inter-Sectoral collaboration, (8) Community Participation, (9) Evidence-based decision making, (10) Partnership, (11) Decentralisation, and (12) Appropriate technology (Ministry of Health, 2011, pp. 47-48). Using these guiding principles as a baseline for grounding the ideas that inform the governance structures in Malawi, it becomes evident that many of these guiding principles of the HSSP are also drawn directly from the principles guiding the PHC approach from 1978. Especially the principles concerning (1) national ownership, (2) human rights based approach and equity, (4) ethical considerations, (8) community participation, and (11) decentralisation are more or less directly derived from the leading vision of the PHC agenda (World Health Organisation (WHO) & United Nations Children's Fund (UNICEF), 1978, pp. 2-3). These principles also draw on the six building blocks of health systems as established by the WHO (2007). Essentially, the HSSP is to a larger degree based on the approaches of the WHO, and the PHC agenda especially, in stating its mission and guiding principles for the health sector.

In contrast, very few of the guiding principles of the HSSP can be linked to principles guiding the GHP approach. Of course, the realm of GHPs is rather airy and government systems do not necessarily operate according to ideas of GHP specifically. However, ideas of GHG and GHPs are apparent in globally committed targets on health, and are evidently inspiring health service implementers through the power of discourse. Some of these principles are also evident in the guiding principles of the HSSP, such as (5) efficiency, (6) accountability, (9) Evidence-based decision making, and (10) partnership (Buse & Harmer, 2009; Owen, Lister, & Stansfield, 2009; Walt, Spicer, & Buse, 2009). The guiding principles of the Malawian health model thus builds largely on health care delivery being state-oriented. The MHS is as such mainly a governmental unit, where responsibilities of health equity and geographical access lie within the government.
4.3 Summary

The aim of this chapter has been to illustrate how the idea of the MHS is expressed in the HSSP, and how this is perceived amongst the informants. The chapter has been structured into two main segments in order to reflect the two main objectives of the HSSP. The experiences of the informants and the challenges they shared, has largely shaped the character of this chapter as their thoughts on what constitutes the MHS have guided the discussion.

The first segment concerned *priorities* of the MHS. This was illustrated by how the idea of the EHP was being formulated both in the HSSP and by the informants. Some of the arguments that emerged from the informants concerning the priorities were that they are first and foremost negotiated between the different stakeholders in the MHS before they are stipulated in the HSSP. A second argument was that priorities are fragile subjects, which are easily bypassed if they do not have strong actors advocating on their behalf.

The second segment concerned the *organisation* of the MHS, in terms of health system strengthening. In this section, the structure was built on especially two concepts that kept emerging from the interviews, namely *decentralisation* and the *allocation of resources*. The main argument of this segment was that the organisation of the health sector has changed because of the move towards decentralisation policies, where the power of allocation and implementation has shifted from the MoH to the districts.

The overall mission of this chapter has been to illuminate how the strategic planning on health in Malawi, and especially the HSSP, can be understood as a PHC model of health governance. The guiding principles, priorities, interventions and organisations of the HSSP are shaped by an ideological belonging to the PHC agenda, as defined in the chapter three, *theoretical assumptions*. However, in order to address the issues relating to health financing, the MHS is largely involved with HDPs. The HDPs provide financial and technical support to the government system, but the question becomes what this relationship entails for the government model of health in Malawi. The MHS and the government health system are faced with a network model of governance where HDPs bring influences to the government system. The question becomes not only how the MHS is organised in terms of priorities and organisation, but also how this is influenced by the presence of HDPs in the health system. The contribution of this chapter has been to chart out the ideas that inform the governance model for health that is established in the MHS through the articulation of the HSSP. The following chapter will concern the influences brought on these ideas by the HDPs.
5 Implementation Realities: Identifying HDP influence

“We're very good at making policy documents and strategies and so on. But, converting those documents into tangible, you know, things that actually happen is very bad. There are so many examples of policy documents which have been taken from Malawi, gone to another country and they've worked and the countries are doing much better. But for us, I think we've been very happy with the status of being constantly donor dependent.” (Private sector informant, interview 28.08.15)

The last chapter explained the characterisation of the MHS in light of the formulations in the HSSP. That chapter outlined the conceptual idea of health and health care in the MHS. However, the chapter did not engage in the practical implementation of the HSSP between 2011 and 2015. The aim of this chapter is to approach the implementation processes of the HSSP, and thus answer the second research question posed for this thesis: How does the agenda of the Health Development Partners (HDPs) influence the implementation of the HSSP, and what are the consequences for the priorities and organisation in the MHS?

The two main objectives of the HSSP outlined in chapter four, Building the Malawian health model, will provide the analytical baseline for this chapter. These objectives are the priorities of the MHS and the organisation of the MHS. The views of the informants have largely formed the basis for this chapter, as their thoughts and experiences have guided the understanding of HDP influence in the MHS. The mission for this chapter is thus to contrast the informants’ experiences concerning the implementation of the HSSP with the theoretical assumptions outlined in chapter two in order to operationalise the implementation of the HSSP. The experiences of the informants problematize the implementation of the HSSP in the MHS, which raise critical arguments concerning the governance structures that have emerged in the MHS through HDP influences.

The main argument of this chapter is that the MHS has become an arena where external influences impact the development of health service delivery. The influences are coming from HDPs, who hold considerable power in the MHS due to their access to resources and their involvement in core Working Groups within the government. The argument will draw inspiration from Norman Long’s analytical conceptualization of interfaces, as discussed by Hein, Burris, and Shearing (2009). Interfaces can be useful in approaching the interaction between multiple actors within a social system: “A social interface [is] acritical point of
interaction or linkage between different social systems, fields or levels of social order where structural discontinuities based upon differences of normative value and social interest, are most likely to be found” (Long 1989 in Hein et al., 2009, p. 80).

### 5.1 Implementation of the HSSP

“The HSSP is another document which is very good, but the commitment to get funding, to fund the whole strategy, was not there. It was always working in a deficit in terms of how much funding should have gone into that. And during the implementation there were two things: first, the older brother of the current president [the former President Bingu wa Mutharika, authors note] started having bad relationships with donor partners, so they withheld financial support to the country. And then there was Cashgate as well. That really didn’t help. So, the health sector was not properly funded. And so the strategies haven’t quite worked” (private sector informant, interview 28.08.15).

After five years of HSSP implementation activities, it has been acknowledged that there have been challenges connected to various aspects of the implementation (NORAD, 15.09.2015, 2013). After the initial commitment to the HSSP in 2011, the plan was to continue implementation of the interventions under the SWAp mechanism, which was introduced through the implementation of PoW. However, this plan faced many obstacles, and proved to be a difficult task after 2012. This was especially due to two incidents, which had large consequences for the MHS even though they were not directly linked to the operation of the health sector. First of all, former President Bingu wa Mutharika damaged the relationship with the key donors supporting Malawi, by denouncing their presence in the country (Nyasatimes, 03.2012). Secondly, in 2013 there was a huge financial scandal under the presidency of Joyce Banda, labelled the Cashgate scandal (CSMONITOR, 03.12.2013). These two incidents show how matters of health are interconnected to the political and economic dynamics in society, and point to the vulnerability of donor-dependent developing countries.

However, these two incidents cannot alone explain the challenges connected to the implementation of the HSSP. Also fundamental challenges connected to the financial and technical aspects of implementation hold explanatory power. Especially the challenges concerning inadequate infrastructure and human resource have been expanded on elsewhere (NORAD, 15.09.2015, 2013). Still, the argument of this chapter is that HDP influence, especially when induced and magnified by these two political events, has had significant impact on the implementation of the HSSP. The role of governance structures and its development through HDP influences has not been largely addressed. The following discussion on the implementation processes characterising the MHS will be guided by the
governance map on district level as presented in the HSSP (Figure 4.1). This is in order to provide an overview of how the implementation activities in health service delivery have deviated from the intended plan.

5.1.1 Prospects for implementation: Translating policy into practice

The translation of policy into health service practice in Malawi has involved many stakeholders and committees, whom have collaborated to administer and manage health services across the country. The steward of health in Malawi is as explained the MoH, who guides the policy formulation and the strategic vision for the health sector. In responsibility of the implementation processes of the HSSP are the individual districts, which work closely with the District Council and the zonal offices. As presented earlier, the governance structures within the government health system revolve around the National Decentralisation Policy (1998), where authority is devolved away from central level to district level (Figure 4.1). This is represented by the establishment of District Councils, which are the administrative organs that hold authority besides the MoH in delivering health services. Both the District Council and the MoH are accountable to the Ministry of Local Government and Rural Development. The main role of the District Council is to manage the District Health Management Teams (DHMTs) in the operation of health service delivery in Malawi’s 28 districts. The DHMTs are also assisted by the five zonal offices in the annual implementation plans, which are national plans based on the objectives of the HSSP.

Within the government

At district level, the HSSP and the annual implementation plans are translated into District Implementation Plans. These plans are aligned to the objectives of the HSSP, and outline the priority areas for each district annually. These are evaluated each year within the district health system, and are changed according to the needs in the different districts (Ministry of Health, 2011, p. 81).

As devolution is the goal of the national decentralisation policy, the different District Health Management Teams hold autonomous power in deciding the priorities for health service delivery in their respective district. However, this autonomy is largely blurred, which is arguably linked to the weak implementation of devolution strategies in the government as a whole. One high authority employee of the District Administration in Lilongwe believed that
the problems experienced in the districts concerning coordination of priorities, and the channelling of funding were because of the weak implementation of decentralisation policies. The District Administration acts as coordination and implementation manager, and holds authority over the District Health Management Teams, linking the District Council and the MoH to the implementation of health care services at the district level. As discussed in chapter four, the MHS is supposed to be decentralised at district level, which entails a different distribution of responsibilities than under a centralised system where the government holds full decision-making power. However, the high authority informant from the District Administration believed that the tentative decentralisation is causing challenges in terms of the legitimacy of district decision-making power. Authority between the different segments of the government health system becomes imprecise:

“Ideally if we were decentralized, my masters are the [District] Council. So, I'm supposed to be answerable to the councillors of the district who are in the communities and so on. But yet, if you go to MoH you go to all these directors who want me answerable to them also. Depending on whatever vested interest individual directors have, they'll try to influence that on me. Yet, the Council will also try to influence their community needs, so it becomes a pulling game. So, yeah, it does get a little bit confusing. Because it becomes "who is your boss."” (District Administration informant 1, interview 02.09.15b).

Here, it is pointed to how responsibilities technically are distributed between MoH, the District Council and the District Health Management Teams. Yet, his experience is that the different actors within the government health system are mixing accountabilities, leading to a situation where the limits of responsibility are not fully clarified between the government agencies in the MHS. The lack of clarity between the segments of the government health system leads to a setting where responsibilities are distorted, and the result is that district level decision-making power is negotiated. This is especially evident in how budgets are being worked through the government system:

“Looking at the indicators and the trends and everything, we prioritize which activities we'd like to carry out for that year. Having done that we get a budget ceiling. Now, the budget ceiling comes from - well, it's worked through the MoH, but then the funding comes from treasury to local government finance committee. And then local government finance committee to the District Council, so we source our funds from the Council. Ideally MoH is supposed to be directing policy, and local government is supposed to monitor the finances in an ideal setting of decentralization. But, it's a grey area so you never get to… So, we get the funding - it's not ideal, it's not what we want. So we end up with an ideal budget, then we get funding which is below the ideal budget - so we have to go back and redo the strategies according to the money that's available.” (District Administration informant 1, interview 02.09.15b).
One of the elements that hold the largest explanatory factor in terms of the blurred lines of responsibility is the financial situation. Decentralisation policies have moved the budgeting responsibilities from central level to the Ministry of Finance, implying that central level should only administer policy implication. The district level holds responsibility for the management of implementation and allocation of funding within the given budget from the Ministry of Finance.

The financial situation in the health sector is characterised by insufficient funding towards both objectives of the HSSP; the comprehensive delivery of the EHP, and health system strengthening. One of the informants representing NCA, a Norwegian NGO expressed concern for the scope of the HSSP, and the precursor PoW: “Implementation of these hasn’t been successful, because of issues of funding. The HSSP tried to capture some of the areas that were not in the other document [PoW]. But, because of funding challenges, I think some of the targets within the strategic plan may not be met” (NGO informant 1, interview 31.08.15). The challenge is that the districts must find ways to implement health services in accordance with the HSSP while not accessing adequate resources. The distribution of responsibilities is squeezed between the central and district level, resulting in a situation where decentralisation policies are weak and resources are minimal. This dynamic is also evident in the lack of implementation of key committees on the primary level of health care delivery. This was pointed out as a worrisome development from an informant representing a CSO:

“I think, pertaining to community health there's a lot to be desired. For example, the only link between the health facilities and the community itself are the health facility advisory committees. However, according to the findings of our service delivery satisfaction survey, it was the case in most health facilities these committees are either non-existent or ineffective. Except in areas where some NGOs are implementing an intervention that were for the strengthening of these committees” (CSO informant, interview 03.09.15a)

The experience of this informant sheds light on how weak implementation of decentralisation policies also has consequences for the people on the ground in terms of accountability and transparency upwards in the MHS.

In regards to the effects of the strained financial situation, the EHP was brought in as a measure to distribute health services more effectively. As also touched upon in chapter four, the views amongst the informants regarding the implementation of the EHP were relatively tepid. Opinions on the EHP being too basic were uttered, especially amongst the informants representing the MoH (MoH informant 2, interview 07.09.15. MoH informant 3, interview
At district level, the informants viewed the EHP as not much more than an idea, rather than a comprehensive package of health service delivery (District Administration informant 1, interview 02.09.15b. District Administration informant 2, interview 03.09.15b). In facing everyday challenges in the pursuit to treat the patients, the focus of the district level informants was directed towards isolating the most essential health care, in order to match the negotiated budget. An employee with high authority at one of Malawi’s central hospitals focused on how the prioritisation within the hospital is mostly based on the need of the patients. However, the financial situation is causing challenges in terms of providing services adequate to meet those needs. In meeting the needs of the patients, the priorities at district level are not necessarily the same as the priorities of the EHP, as established by the MoH and other stakeholders who provide crucial funding. This hospital authority informant pointed to how:

“We are failing to match our resources with those needs. As a hospital we are supposed to provide all the services [...], somebody comes in with ANYTHING it’s our responsibility. [...] You know, it’s politics. What is the political philosophy? Like now, there are non-communicable diseases. They’re not getting the resources they need, but they are getting more and more” (District Administration informant 2, interview 03.09.15b, emphasis added).

The informant representing a CSO agrees with the hospital authority informant in that financial gaps are hampering the implementation of the HSSP: “We have a lot of gaps. Starting with the allocation – it’s not adequate, because some activities that are within the district implementation plan are not well supported. And this creates issues when implementing” (CSO informant, interview 03.09.15a). The aspect pointed to by the CSO informant is the challenge for efficiency in implementing the HSSP, which is often linked to resources such as adequate health workers and access to drugs. In Malawi, there are very few sufficiently trained health workers in proportion to the huge population, which counts to approximately 17 million people at the present time of writing this thesis [May 2016]. The issue of inadequate numbers of health workers was also emphasised from the CSO point of view, as a challenge to meeting the needs in the communities, thus challenging health equity at the local scale (CSO informant, interview 03.09.15a.). The country has increased the resources focused at health training since 2004, and the number of doctors have increased from 43 doctors in 2004 to 265 doctors in 2009 (NORAD, 15.09.2015), suggesting an improvement in human resources for the implementation of the HSSP.
However, a lingering issue of inefficiency in the MHS is the brain drain in the health sector, where trained health workers are being picked up by more well-paying organisations (Research Institution informant, interview 16.09.15). This is largely due to the low wages and possibilities for promotions in the government health system. This means that they leave the government-led facilities, which are already experiencing lack of adequately trained health workers. This has come to create a larger gap between the services provided by the private health facilities, which demand a fee, and the government health facilities. Another issue which is mentioned frequently is the challenges connected to drug pilferage, as a cause of inefficient communication between central and district level and also as an issue of financial strain, because of the challenges in providing sufficient drugs to meet the needs of the country (MoH informant 1, interview 02.09.15a. MoH informant 2).

These two examples of inefficiency in the MHS translate into a tough environment to conduct implementation in. This has led the government to seek out alternative measures to provide health for the population. MoH thus collaborates with private actors through the establishment of Service Level Agreements in order to relieve the pressured financial strain on delivering the basic health service, as compromised in the EHP.

**Bringing in the private sector**

“At community level, numerous NGOs, FBOs and CBOs deliver promotive health services but the majority of the providers and the services they offer are unknown to MoH and stakeholders” (Ministry of Health, 2011, p. 90)

The main partner to the government health system in health care delivery in Malawi is the Christian Health Association of Malawi (CHAM), which is a faith-based organisation (FBO). CHAM represents around 37 percent of health care delivery in Malawi, accounted for in services, and to some extent accounted for in facilities. However, the government system represents the largest proportion of the health care delivery, in terms of services and facilities. This accumulates to about 60 percent. The last few percent are represented by smaller private actors, which will not be debated further. CHAM provides the same services as the government, but the users must pay a nominal fee to benefit from their services. As expressed by one of the informants who work for the organisation: “CHAM is an alternative. I would say that our situation is that our facilities are slightly better than the government facilities. […] There is a user fee, but in most cases it’s not cost recovery. It’s more of a nominal fee.” (Private sector informant, interview 28.08.15).
Both actors do however mainly provide services to account for the conditions that have been established in the EHP, meaning that they provide health care that pertains to the same priority areas. As such, they deliver complimentary health services, and not overlapping or competing health services. The relationship between the government system and CHAM is thus characterised by collaboration to meet the health needs of the country together: “[…] largely the population is covered by CHAM and government as complimentary providers” (MoH informant 2, interview 07.09.15). CHAM has especially played a role in health service delivery in Malawi’s hard-to-reach areas, because they establish facilities and service delivery in the areas where the government facilities are too far away for the communities to reach. This is made possible because CHAM is also largely donor-funded, but the donors that work with CHAM fund outside of the government system. This means that the funding available to CHAM does not go by the government before they are employed by CHAM, and can thus be utilized differently than government resources.

The government system and CHAM is in many ways united by their fellow goal to attain a higher standard of health for the Malawian people. However, as their governance structures are different, especially in terms of management and funding they work with different imperatives to reach the goal. The challenge in this is that the level of accountability between the two health service deliverers can be unclear, and the perceptions on responsibilities between them can be blurred, as expressed by one of the informants:

“There is again level of awareness of responsibility to me, because CHAM has no mandate of health. The steward of health in Malawi is the Ministry of Health. CHAM seems to forget that they’re not autonomous. […] I think the whole point is that the steward of health is the Ministry of health, the one that decides the minimum care Malawians should receive is the Ministry, it’s not CHAM. Then in this, to make sure that people access these services the Ministry wants to use CHAM as a conveyor of the services” (Academic informant, interview 01.09.15)

Malawi is thus in a situation whereby they have two dominant actors delivering health services complimentarily, but at governance level the lines between who holds authority is blurred. However, the management structures between the two are fundamentally different, as CHAM collects a nominal fee from their patients while the government facilities provide health services free of charge. However, the financial situation in the country and the health sector has led the government to not be able to deliver health services sufficiently, because it is delivered ‘free-of-charge’. Health services in Malawi are not paid for out-of-pocket, but are funded through taxation. The Malawian population pay around 5 percent tax for everything
they buy, which means that they are, to some extent indirectly paying for the health services they receive. As one of the informants put it: “it’s not free, it’s disempowering propaganda to use the word free. We already provide 5-10 percent of health care funding.” (Academic informant, interview 01.09.15).

One private sector informant currently employed by CHAM (interview 28.08.15) pointed to how the organisation of the health system is built on the principle “health for all”, and this was translated into health services being free of charge for all. He considered this to be a large shortfall in the health system because the system cannot afford to be free of charge. His argument was that the financial situation to a large degree was caused by the thought that the health system should be free for all, which impacts on the practical organisation of the health sector because the government doesn’t have enough money to fund it properly. This informant expresses how the government system is crumbling as a result:

“In terms of the governance structures, I think we're doing badly as a country in the health system. We could do a lot better. But I think the biggest problem is the political will. I give you an example - the fact that health services are free, everybody knows that it's not cost effective, but the political will is just not there to ensure that people start paying” (private sector informant, interview 28.08.15).

As such, the scope of the MHS as provided by the national health system and CHAM has been struggling to implement the HSSP. This has been largely due to two factors: weak decentralisation is enforcing inefficiency in the government health sector, and inadequate funding is hampering the implementation further. In order to reach all areas of Malawi with the interventions stated in the HSSP, the government has thus brought in the private sector through Service Level Agreements. As such, CHAM provides over one third of the health services in Malawi.

Overarching the implementation has been issues of funding. As such, HDPs are very present in the MHS as providers of financial support, in addition to technical support as outlined in chapter four. Yet, the involvement of external partners into a predominantly national health system has surfaced challenges concerning the governance structures and power in the MHS, especially when faced with a national financial scandal.

5.2 Continuity versus Change: The Cashgate scandal

The HSSP lists a number of challenges concerning the implementation of the HSSP. Topping the list is the concern for poor alignment between the Malawian government health sector,
and the HDPs: “[...] compromised national ownership through parallel processes and uncoordinated oversight” (Annex 5, Ministry of Health, 2011, p. 118). There has been an increase in uncoordinated oversight following the financial scandal that has had undeniable impact on the Malawian health sector, especially impacting the governance structures of the MHS.

In the third year of implementation of the HSSP, in 2013, Malawi was struck by a financial scandal that shook the bedrock of the Malawian governance model (CSMONITOR, 03.12.2013). During Joyce Banda’s second year in office, looting and fraud in the public sector was uncovered to a massive extent. This was after President Banda had repaired the relationships with some of Malawi’s key donors after the death of President Mutharika in 2012. The fraud started to unravel after the shooting of the government Budget Director Paul Mphwiyo outside his home, allegedly as a move to try and stop him from announcing that he had found large-scale looting in the government. September 2013 was characterised by an unravelling of financial fraud amongst top government officials, and it has been claimed that tens of millions of US dollars had disappeared after Joyce Banda took office (Fortin, 19.11.2013).

The Capitol Hill Cashgate Scandal, as it was initially called, had enormous impact on donor relations, and the responses from most of the HDPs were also grave for the MHS (Nyirenda, 02.12.14). Health financing and allocation of resources within the health sector had been an issue for a long time. However, the initial successes linked to the implementation of the EHP during the PoW period was eliminated during the implementation of the HSSP. This can largely be ascribed to the changes in governance structures that happened as a response to the Cashgate scandal. A conversation with an international worker, currently based in Lilongwe to work with health system strengthening, shed light on how Cashgate became directly linked to the allocation of resources in the MHS. She followed up on how this has increased the discrepancies in health system funding:

“Before, there were pooled-based funding, but after Cashgate that changed. Most partners became scared of not being accountable to their own countries and governments, and therefore either pulled out entirely or chose to find other ways of funding. The biggest challenge in the health system is lack of funding” (Conversation, 01.09.15)

Frightened of issues of accountability, most HDPs withdrew from the SWAp pooled funding mechanism that they were committed to. Even though commitment to the SWAp was signed, and thus pledged till at least the end of the HSSP, the HDPs pulled out:
“In 2013 there was this Cashgate scandal. The Ministry of Health wasn’t necessarily at the head of it. I don’t think there were any issues in the Ministry of Health, but because these donors are obviously also financing the other sectors as well, they said ‘We’re pulling out of the government as a whole’. But there was an agreement which was signed between the donors and government in 2004 for the SWAp and the Programme of Work that they were going to commit their resources for this period. But when this scandal came up, they pulled out regardless of whether there was an agreement. So, you already see that there isn’t like, control there” (MoH informant 1, interview 02.09.15a).

Thus, the role of the HDPs changed in light of the Cashgate scandal. Moving from technical and financial support responsibilities as stated in the HSSP, the HDPs broke out of agreement with the government health system. The reasons behind the decision are not necessarily blameworthy; donors are required to be accountable to the taxpayers and supporters from their country of origin to uphold legitimacy, and they are faced with tough decisions when met with issues that question the relationships concerning accountability and trust. The point to be made here is that the actions of the HDPs have had unplanned consequences for the implementation of the HSSP, suggesting that the HDPs hold power in the operation of the MHS.

As pointed out, the resources that the HDPs bring to the MHS are invaluable to health service delivery, because there is so little money in government as a whole. However, the Cashgate scandal illuminated some serious challenges concerning the efficiency of resource utilization in the government, which ultimately shows that the MHS is operating in an environment which undermines efficiency: “the government [revenue] we raise in the country is enough to run health care; we’d need just very little financial help from donors if we were as efficient as possible, but because of corruption… It’s such a worrisome development.” (MoH informant 1, interview 02.09.15a).

Thus, the MHS and especially the government health system are operating within a challenging environment, which became epitomised through Cashgate. However, the HDPs did not leave Malawi entirely after the scandal. Even though the funds were frozen for a period of time in 2013 and 2014, they did not entirely leave the health sector. Rather, they were just channelled outside of the government system. The resources were instead coordinated by the HDPs that contributed them, and were channelled towards NGOs, which utilized the resources on local and district level. Thus, the government system, MoH and national health institutions and health care deliverers largely lost the control of the coordination mechanism within the MHS.
5.3 Identifying HDP influence

“Malawi as a country is basically dancing to the tune of everybody” (private sector informant, interview 28.08.15)

The Cashgate Scandal holds illustrative power in terms of outlining the influence of HDPs in the MHS. Cashgate can in this regard be treated as a ‘shock’ that fundamentally changed the role of HDPs in the MHS, moving towards greater independence from the government health system. As mentioned in chapter four, the role of the HDPs is somewhat understated in the formulation of the HSSP. They are pointed to as being part of the national governance structures, but are not explicitly defined in terms of their financial and technical influence. The realities of health service implementation has rather identified that the role of the HDPs divert from their stated role in the HSSP. The influence of many of these HDPs has largely been based on their resources, which has become evident during the implementation of the HSSP.

Tracing back to chapter two, theoretical assumptions, power in global health governance can according to Bartsch et al. (2009, pp. 115-116) be categorised into four groups: discursive power, decision-making power, legal and regulatory power, and resource-based power. In the global health scene, resource-based power has come to play a more significant role than before, illustrated by the influence and impact of resource-rich organisations such as the Bill and Melinda Gates Foundation and GAVI (Buse et al., 2009). Traditional actors such as the WHO weigh heavily in terms of discursive power, and legal and regulatory power and have claimed legitimacy through exerting authority concerning decisions in international health. One example of this is the global commitment to the International Health Regulations [2005], even though this is voluntary for sovereign states (WHO, 2008). However, such authority has not held supremacy in the last twenty years. Global agendas on health, as manifested through the Millennium Development Goals and Goal Three of the Sustainable Development Goals, have shifted the weight towards result-orientated measures of health. More attention is thus being paid to investment in health for the purpose of enhancing health indicators. The consequence has been that resource-rich actors have taken a bigger stage in health affairs, and resource-based power has gained legitimacy in global health.

In Malawi, the HDPs represent a diverse range of actors. They are states providing bilateral support (i.e. DFID, USAID, NORAD, FICA and GTZ), inter-governmental
organisations providing multilateral financial and technical support (the WHO, UN, UNAIDS, UNICEF, World Bank), public-private partnership organisations (PPPs) (such as the Global Fund and GAVI), and non-state actors (i.e. Clinton Foundation, Bill and Melinda Gates Foundation, Doctors without Borders, Oxfam). Some of these actors have worked more intimately with the government of Malawi and the MoH, whilst others are smaller and are thus more present in the communities. Especially the NGOs are working at local and district level for implementing health initiatives parallel to the government health system. The key donors to the government and the MoH are outlined in the HSSP as the bilateral donors, and some of the multilateral and public-private partnership donors (Ministry of Health, 2011).

These donors are also pointed out by a multitude of the informants as being key financial supporters, and thus capable of exerting influence in the MHS. The point to be made in regards to this is to illustrate that the HDPs constitute a range of different actors whom fulfil different roles in the MHS. The bilateral donors are the ones that cancelled the financial support and left the SWAp mechanism after Cashgate. Actors such as the WHO and the UN do not provide financial support directly to the government, but have held stronger discursive power in terms of technical expertise and support.

The HDPs hold power in the operation of the MHS. This power is being exerted through access to resources, which is decisive to the national government system. As established in chapter four, Building the Malawian Health Model, the MHS is mainly a national health system ascribed to the parameters of the nation-state and thus the government of Malawi. Health is perceived as a national issue, and it is the responsibility of the government to deliver health care to all Malawians. However, as Malawi is classified as a low-income country based on GDP, the country is struggling to establish a self-sustained national economy.

The country does recognise a strong link between a healthy national population and prospects for economic growth, which means that they are committed to delivering quality health services to everyone. In order to make this possible, the government of Malawi and the MoH has been dependent on foreign financial support to be able to manage the health system. Malawi has been a darling for international donors for many years, as the country has largely committed to the standards and conditions posed by the donors. After decolonisation, Malawi became known as a pro-Western country which more than gladly implemented Western innovations, especially in the health sector, with measures such as vaccines and new drugs. The donor climate in Malawi is thus a very open one, where multiple donors and development
partners can enter the country and contribute in most sectors. On top of this, development aid for health has become increasingly popular, meaning that there has been plenty of money available for health. At times this has meant that almost 60 percent of the government budget for health care has been provided by donors (MoH informant 2, interview 07.09.15). The financial support provided by HDPs have been crucial in order to provide basic health care to the population, but the country is still unable to deliver sufficient health care accounting for the HDP support (Ministry of Health, 2011, p. 96) However, the increasing amount of actors has meant that issues relating to coordination and allocation have become important.

During the implementation of the HSSP, the MoH were committed to including the HDPs into the planning processes of the government through presence in the different Working Groups, in order to gain oversight and control over the organisation, input and outputs in the sector. This attempt was especially successful through the years 2004-2013; during the implantation of PoW, and the initial implementation of the HSSP. The success can in large part be ascribed to the SWAp pooled funding mechanism, meaning that the HDPs would unite their resources into a government controlled ‘pool’, and leave responsibilities of allocation, priorities and operation of the MHS to the government. This approach is largely compatible with the PHC-agenda, where the national government holds responsibilities for providing health for the nation. Yet, the influence of the HDPs during the implementation of the HSSP and after Cashgate has changed. The main issue in this regard is that the national plan of health system delivery is hampered by the lack of resources to implement it properly. Resources in this regard are mainly financial resources, but also technical and human resources.

5.3.1 How is the power of the HDPs expressed?

The power and the influence of the HDPs are largely manifested in two ways. Firstly, the HDPs push resources towards district and local level, thus enforcing parallel systems within the MHS. Secondly, with resource power HDPs are able to push priorities towards what they deem important. The following paragraphs will expand on these two interfaces where HDPs decree influence.
**Enforcement of parallel systems**

The first aspect of HDP influence concerns duplication of health service activities in the MHS. The effect of HDP influence is not a new thing. Largely due to global commitments on serious diseases such as HIV/AIDS, Tuberculosis and Malaria, MHS has created own agencies to deal with the prevalence of these diseases in Malawi. These agencies are largely funded by initiatives such as PEPFAR and UNAIDS, and the effect is often that these diseases receive a disproportionate amount of funding in contrast to other areas in health. However, these disparities have been accounted for in the HSSP, and the government structures are well-integrated with the specialised government agencies. What was not planned for in the HSSP was the collapse of the SWAp funding mechanism.

Even though different health initiatives have operated in the MHS for many years, the HDP influence has been especially evident after Cashgate. The main evidence is as explained the pulling out of the SWAp mechanism, leading to challenges in health financing for the government health system. However, the money has not left the country. They are rather directed through different channels, which have implications for the organisation of the MHS.

One of the channels is local NGOs and small-scale health service implementers (NGO informant 2, interview 17.09.15a). The second channel is through the district level health management, and the primary level of health care (Figure 4.1). This response from HDPs has led to the enforcing of parallel systems of health governance in the MHS, where the government health system is directly targeted by the HDPs at district level. Because the districts are devolved, they effectively hold implementation authority on the HSSP. The influences of HDPs are important in regard to the coordination between the central level represented by the MoH and the District Administration and Health Management Teams:

“We ensured that their plans [District Implementation Plans] were aligned to the HSSP. [...] So, you have the districts that have priorities, which they implement using government resources. But there are a lot of different donors who have their priorities. And districts have to implement those irrespective of whether the districts feel that there are other areas which are higher priorities” (MoH informant 1, interview 02.09.15a)

The issue is that the weak implementation of decentralisation, as discussed in paragraph 5.1.1, has left the districts unprepared for dealing with HDPs coming directly to the districts. This is largely due to the blurred levels of responsibilities between the different levels of the government health system, where some duties lie with the MoH (human resource), some lie with districts (implementation of the HSSP through District Implementation Plans) and some
lie with the Ministry of Finance (budgeting). Within this fragile system of government, space has opened up for HDPs to govern health parallel to the government system. The aim of the HDPs is to increase the level of health for Malawians, so their actions are not questioned on the normative level. It rather becomes an issue of how the power of HDPs is influencing the development of the MHS within a framework of poor decentralisation, and what consequences this has for the organisation of the MHS.

Amongst the informants the relationship with expatriate donors is largely perceived of as ‘good’ or ‘fine’ in terms of their presence in Malawi. However, the different informants perceive different challenges concerning how the HDPs assume responsibilities within the MHS. The aspect that unites the different perceptions, however, is that the HDPs now more than before are directing their support toward the district level and through NGOs at primary level. The different informants perceive differently whether the roles that the HDPs fulfil are useful or not, especially in terms of efficiency and possibilities for coordination in the health sector. The informants seemed to disagree on what possibilities there were for efficient collaboration between the government system and the donors, leading some of the informants to suggest that the fragile national health system benefits from donors doing parallel activities. One of the academic informants viewed the pull-back of donors from the government as useful for efficiency, because of the challenges concerning effective governance in the government system:

“We have seen a phase whereby the donor funds were buying drugs, and they ship them themselves all the way to the health centre. So, in those contexts it’s useful. When the system says OK, this is the support we want, and then the donors themselves or the system they’ve hired [NGOs] implement the activities. In a system, if you pour water into a tin that’s failing to hold its own water, I don’t think it would be able to hold that of its friend.” (Academic informant, interview 01.09.15).

This informant suggests that the MHS as a health system is so fragile in its operation that it makes more sense for financial support to bypass the government system in order to sustain efficacy. However, his point conveys an underlying assumption that the donors are fitting in to the national agenda on health, thus fulfilling a complementary role to the government health system much like the role of CHAM. This is, however, an assumption that can easily be taken for granted, considering that the HDPs represent foreign donors with their own agendas and demands for accountability and results. Within the government system, the informants conveyed a different assumption – that the donors would rather implement health services based on their own motivations:
“The collaboration is, well, it really depends. With some donors my opinion is that the collaboration is excellent [...]. They are not particular where they want their resources to go, but other donors have their target districts, so that’s not good for us. There are so many donors who want to do specific things in specific places. There are some who align with what the government wants to do, but there are some others who want to do what they want to do.” (MoH informant 1, interview 02.09.15a)

The view from the MoH highlights how the relationship between government health institutions and the HDPs differ between different donors. This means that while some collaborate with the MoH, others are more specific about what they want to contribute where. This experience is supported by one of the informants representing UNICEF in Malawi, which is an important HDP in the country, both in terms of support to the government and as local implementers of health services. Her view was that the organisation had intentions to comply with the government priorities in order to align with national ownership in the health sector, but that at the end of the day they just had to forge on with their agenda to reach the beneficiaries (NGO informant 2, interview 17.09.15a). This illustrates how HDPs can choose to override existing government structures in order to achieve health for the intended beneficiaries.

At district level, collaboration with the HDPs was viewed as complicated because of the lack of communication structures between the MoH and the district level. It was pointed out how the need for health financing is leading to a situation where the influence of the HDPs are overriding the HSSP and thus the district implementation plans, leading to duplication of activities and verticality in district programming:

“The biggest challenge is that first you have districts that don't really know what the Ministry is doing. Because they have a lot of partners coming in, so you don't... Today you are promoting short-term family planning methods basically. So now the Ministry will say ‘Oh, now we're promoting [...]’. They swing to the tune of the highest bidder basically. So, with that swinging, it's difficult for you to know where they stand. So you also start swinging! So now we're all swinging! For example, if UNICEF is the flavour of the month, we're all going UNICEF, UNICEF - And UNICEF will say ‘No, I want ORS only’, and we go ‘OK’, and nobody will say ‘sorry, we don't need ORS training because we already did them’. We all go and do them, AGAIN. Become massive ORS-guys. Things like those - whole strategies not being kept. [...] If you're swinging nothing changes. You're still the same, that's not what was essential for you” (District Administration informant 1, interview 02.09.15b)

From the point of view of one of the NGO implementers present in Malawi, the duplication of work in the health sector was viewed as the fault of the MoH. This is because the MoH holds the coordinating role in the MHS, where they have mandate to steer health implementation
activities in line with the priorities and objectives of the HSSP. The informant expressed how this responsibility of the MoH was not being fulfilled in terms of coordination of resources available to the health system:

“Different actors have different roles, but the only hick-up that is there is the duplication of work. You find that what we are doing as [an NGO] in the area of maternal health or in improved health chain, you find that another actor is also doing the same within the same geographical area, so looking at it from that angle, I would say as one of the major players in the country, we haven't been ... The MoH hasn't done quite a very good job on that one in terms of resource allocation, to say "You can go to this side, you can go to this side"” (NGO informant 1, interview 31.08.15)

Duplication is an unfortunate, but ironic feature of the MHS, as one of the employees at the Public Health Institute of Malawi pointed out. He shed light on how the health system is struggling to pay for adequate health service delivery, but at the same time lacking oversight routines to monitor that activities are not being duplicated: “[…] it's like you don't have enough resources to implement things, but also within the same system things are being duplicated. So it's a big problem.” (Research institute informant, interview 16.09.15).

**Exertion of power in priorities**

The expressions of donor influence in the MHS illustrate that the HDPs hold power over the government health system and other national health institutions because of their access to resources. This is not a normative suggestion, but a reflection on how different modes of power in governance relate in a balance of power. This balance of power is being contested by the HDPs exertion of power over what priorities are deemed important in the MHS.

Drawing on the conceptualisations of neo-realist and liberalist thought of governance, the MHS as a governmental national health system is facing elements of different governance structures in meeting with the HDPs. In relation to power theory, the relationship between the national health system and the HDPs reflects how resource-based power in global health holds greater authority than other sources of power. This skewed balance of power has consequences for the implementation of the HSSP in terms of national ownership and principles of a nationally governed health system:

“[… ] power balance is an issue. Sometimes we want to fall into what they [the donors] want, because they are the ones giving us the money. And it complicates the whole SWAp principle, because we’re supposed to take the lead […] Because we are begging, we want to handle them with care. We feel like they’ll go away” (MoH informant 3, interview 17.09.15b).
The argument that the HDP influence is largely a consequence of the lack of overruling power in the MoH, is supported by one of the high authority hospital informant: “What basically happens is that the donors – they will come, and tell you the areas they are interested in. And, as you know, beggars must not be choosers” (District Administration informant 2, interview 03.09.15b). The informant points out here a contrasting aspect to the resource-based power exercised by the HDPs – Malawi, and the health sector, has few other choices than to adjust to the will of the HDPs. Being a very poor country, they are limited in economic freedom, suggesting that resource-rich actors hold greater power in the MHS than actors with other sources of authority such as regulatory or decision-making power. The result is that the health priorities stated in the HSSP can easily be forgotten when faced with the possibility of financial support: “On the other hand as well, there are certain diseases burdens or priorities that maybe will not be areas of interest for the donors, but maybe as a country we see them as priorities. But if the donors comes, that is interested in a certain area, I think at times it’s difficult to say no” (Research institute informant, interview 16.09.15).

The effect of the power relationship that exists between the MHS and the HDPs leads to some priorities being neglected whilst others are receiving more funding than necessary. One example in this regard is the distribution of mosquito nets in the district, as a prophylactic to prevent Malaria. While this is a part of the District Implementation Plan, you also find NGOs distributing nets financed by HDPs. This is causing misuse of nets, because households receive more nets that they actually need (District Administration informant 1, interview 02.09.15b). In contrast, minimal amounts of funding are provided for the treatment of cancer, as this is not viewed as cost-effective (private sector informant, interview 28.08.15). Previous studies on the impact of external influences on national health systems has also pointed out how long-term and high-risk treatment for diseases such as cancer attracts little attention and funding in countries located within the parameters of the Global South (Caines et al., 2004; Committee for Development Policy (CDP), 2009; World Health Organisation Maximizing Positive Synergies Collaborative Group (WHO-MPSCG), 2009). Yet, cancer and similar diseases are important areas of investment in global health in the ‘developed world’. It was pointed out by many of the informants that the scope of health in Malawi was largely concentrated to ‘treatable’ diseases, neglecting other important indicators of health because it is not perceived of as ‘efficient’ to fund such initiatives. Finance is thus skewed towards other priorities, which will provide faster and more tangible results (Private
sector informant, interview 28.08.15. Academic informant, interview 01.09.15. District Administration informant 1, interview 02.09.15b. District Administration informant 2, interview 02.09.15b. Research Institution informant, interview 16.09.15.

In this regard, the collaboration with HDPs in terms of allocation of resources towards different priorities was viewed as being complicated at district level. The high authority District Administration informant shared how HDPs should relate to the MHS:

“It could be better, yeah. Ideally, the partners just looked at the health system itself, and worked around that. But you see, partners like to play politics in the government. So, today they like you, so they give this [money]. Tomorrow, just because they’re upset with what somebody said or what the President did or the Minister did, they change their minds, turn around and the whole rest of us suffer” (District Administration informant 1, interview 02.09.15b)

The point in this regard is that HDPs hold influential power over how Malawi and the government system must act in order to receive financing. This means that the national health system must comply with the conditions and rules applied by external partners. The nature of these relationships shares similarities with GHP, where health equity is sought through collaboration with different partners. The exertion of power by the HDPs in this regard also reflect elitist notions of power as argued by Walt (1994). This is because the influences employed by the HDPs represent a small number of actors in the MHS, where decisions are made by the few (HDPs) that undermines the priorities of the many (the Malawian population).

Of course, this does not necessarily mean that the MHS would be an example of a neutral pluralist power if the HDPs had not been present in the country. The Malawian government has, as discussed, faced issues of accountability and transparency for a long time. However, the point to be made here is that the HDPs have influence over the MHS which is not necessarily intended, but has come about as an effect of the resource-based power that the HDPs hold. In the Malawian case, one of the main obstacles for health equity, as perceived by the informants, is the challenge of funding health services so that they can benefit all Malawians. The collaboration with HDPs is thus mainly of a financial and technical nature, and a strategy to achieve health equity.
5.3.2 So what? – Challenges for health equity

The openness of the donor climate in Malawi is causing the PHC-agenda as established in the HSSP to face challenges in terms of equity and equal access in health for the population. However, this is not a contrast that can simply be answered as a PHC model of health governance versus a GHP oriented approach to health governance. As explained in chapter two, theoretical assumptions, GHPs constitute a specific kind of partnership where focus is directed to the mobilization of funding towards specific health programmes and diseases. The HDPs present in Malawi represent a large variety of donors, which have not been explicitly separated for the sake of this discussion. However, the key donors in the MHS represent largely traditional donors, such as the bilateral donors present in the MHS.

However, it can be argued that the influence of these HDPs in MHS brings in notions of GHP mode of health governance. This is because the influence of the HDPs largely pursues efficiency over equity, thus pushing economic measures above social processes. Chapter four, Building the Malawian Health Model argued that the HSSP values health equity as quality and productivity. However, the influences of the HDPs are pushing the weight towards matters of productivity over matters of quality. Linkages can be drawn between the two main aspects of HDP influence (enforcement of parallel systems and exertion of power in priorities) and challenges these together pose for health equity in Malawi.

Challenges of geographic equality

The first challenge is represented by how the resource-based power of the donors has had an influence on the geographic implementation of the HSSP. This is because the HSSP was designed with the condition that donors would support health financing, and when this mechanism failed after the ‘shock’ of Cashgate the HSSP was not prepared for health financing moving outside the government health system:

“Much of our programming is premised on donors supporting the sector. And almost 60 percent of the sector is donor financed. So, when that window collapses and the effectiveness of the implementation becomes conditioned [on the donor funding]. […] So I think the main obstacle is donors pulling out of direct support. Probably, now depending on our discussion with partners, we could be in a better position to plan for resources that don’t go through the government system. In the current strategic plan, I think much of the planning assumed that the resources would go through either the government system or within the MoH system” (MoH informant 2, interview 07.09.15).

Thus, moving outside the government system entails moving outside of comprehensive
service delivery in the districts. As pointed out, Malawi has many geographic regions and communities that are hard-to-reach. Within the government health system, these areas have been largely been covered by CHAM facilities, which provide the EHP to the hard-to-reach communities. However, as pointed out by the MoH, this is leading to gross inequities in health between the populations living within the CHAM catchment areas and populations living within government facility areas because the CHAM facilities charges a user fee (Ministry of Health, 2011, p. 91). The government and MoH are trying to compensate for this imbalance by signing Service Level Agreements with CHAM in order to remove the fee for the poorest populations. Lack of equity in health service delivery between districts is thus already a problem in implementing the HSSP within the SWAp mechanism at national level. However, when HDPs in addition target their resources to specific districts, other districts are consequently not supported with the equal amount of funding or interventions, re-enforcing mechanisms of inequity that already persist in Malawi. One of the planners at MoH supports this argument by pointing to the extent of resources in the MHS that are not coordinated by the MoH:

“The from the current round of the resource mapping, it’s around $US577 million coming into the health sector NOT through the MoH, but various donors who are in the health sector in Malawi. That’s just a lot of uncoordinated support. […] If every donor was supposed to report to the MoH, or maybe subscribe to the priorities of the MoH, that $US577 million could have a lot of impact. But because people can go anywhere and do what they want, the impact is really so limited.” (MoH informant 1, interview 02.09.15a)

Thus, the movement from a dominantly government based system of health governance towards a network governance between the government and various actors is causing challenges in terms of geographic equality in access to health services between different districts. This is because the resources which now flow into the MHS are not centrally coordinated, which is causing duplication of work and uncoordinated implementation of health activities (District Administration informant 1, interview 02.09.15b. District Administration informant 2, interview 03.09.15b).

The assumed consequence in this regard is that different areas have different possibilities for health care as a result of uncoordinated HDP influence. Firstly, the enforcement of parallel systems of health care impacts the implementation of health services at district level, as some districts are receiving more funding than others, and duplication of health service is happening in some districts. Secondly, the negotiation of priorities due to resource-based power held by the HDPs has consequences for what are deemed priority areas
of health in Malawi, which does not necessarily coincide with health needs on the ground. One example of this is the argument posed on the lack of ‘cost-effectiveness’ of establishing centres for the treatment of cancer (private sector informant, interview 28.08.15).

**Challenges of sustainability**

The second challenge in regard to health equity is the issue of sustainability. The MHS is in need of externally funded support, as government revenue is not utilized efficiently enough to fund the national health system. However, the long-term effect of HDP influence on the governing of health in Malawi faces issues in regards to the governing and development of the health system. This is because the influence of the HDPs enforces parallel systems of health service delivery and exerts power over priorities in the MHS. A study conducted by the DFID (2004) on the impact of GHPs within the parameters of the national health system, points to how issues of sustainability pose a worrisome issue for health systems, especially in low-income countries:

“There is little, if any, chance that many low-income countries will be able to meet ongoing costs themselves if GHPs funding for current activities ends as planned after a 5 year period [...] there is a risk that country spending patterns will be dictated by the GHPs, and the need to sustain the activities and services provided by them, rather than by national priorities” (Caines et al., 2004, p. 30)

The situation regarding health service delivery in the MHS is one of complexity. As advocated by the WHO, it is the mandate of the state to protect and enhance the public health of its nation. However, as pointed out by Lawrence Gostin (2007) it is often the case that the poorest countries in the world lack the capacity to do so. In the Malawian case, health financing has caused difficulties in implementation of the HSSP. Following the definitions in chapter three, *theoretical assumptions*, the Malawian government system and the MHS is dominantly a governmental system. The government revenues used for funding the health sector is extracted from taxes payed by the Malawi citizens, and the MoH operates as the policy director of health, taking on the national responsibility for answering to the health needs of the country in order to increase the health of the nation. The districts do in this regard play an important role in designing District Implementation Plans that answer to the local epidemiological needs of the population. However, the troubled financial situation in the country is causing challenges in terms of utilizing government revenue efficiently, leaving the beneficiaries on the ground to pull the shortest straw. Issues of corruption and low degree of accountability in the government system have led to a situation where the different
government agencies are underperforming (MoH informant 1, interview 02.09.15a). This poses challenges for health equity on a national scale, as the government is not able to sufficiently deliver health care services as mandated in the HSSP.

Equity in health concerns the individual. As the link between health and all other aspects of life is so close in countries such as Malawi, challenges in health services delivery have direct consequences for the service beneficiaries. In the pursuit of increasing equity in health, the MHS must address how issues of government systems versus governance networks can best work together, because all interventions ultimately should benefit the person on the ground:

“Pressure is there; I mean they [the HDPs] are also under pressure – they have to be accountable. And whatever is coming to us also has to be accountable in their country. But, I mean, if you’re going to record things like good governance – what does the person in the village understand about good governance?” (District Administration informant 1, interview 02.09.15b)

5.4 Summary

This chapter has sought to answer the second research question posed for this thesis: *How does the agenda of the Health Development Partners (HDPs) influence the implementation of the HSSP, and what are the consequences for the priorities and organisation in the MHS?*

The first section of the chapter concerned the practical process of HSSP implementation within the government system, and how the indistinct implementation of decentralisation policies is leading to a complementary health delivery system with the private sector in the different districts. These implementation activities are also happening within the SWAp mechanism, which means that the MHS is faced with challenges connected to inefficiency.

The second section of this chapter explained how a ‘shock’ during the implementation of the HSSP meant that the financial support from most of the donors in the MHS was pulled out of the government system. As the donor support for the MHS accounts to approximately 60 percent of the entire budget, the government health system coordinating role within the MHS lost authority. The meaning of the Cashgate scandal in this regard is that it changed the role of donor interaction in the MHS. The third section engaged in identifying in what ways the HDPs and their response to the Cashgate scandal influences the MHS. The influences of HDPs are largely constituted in two ways: through the enforcement of parallel systems of health care delivery, and the exertion of power in priorities. These two elements of influence
pose challenges for health equity in two ways; challenge of geographic inequity in health service delivery between districts, and the challenge of sustaining the interventions of the HSSP specifically, and for the MHS generally, if donor-support is withdrawn.
6 Summaries and Reflections

This thesis has sought to illuminate how the operations of a national health system can be understood using a theoretical GHG lens. Theoretical aspects of GHG are in this regard understood as different modes of governance for health. This thesis has focused on two such models of governance, namely the PHC approach to health and the GHP approach. These two conceptual models formed the backdrop of the analysis of health formulation and HDP influence in the Malawian health system.

GHG as a theoretical frame was chosen on the basis of its scope for understanding the developments in health policy that have been happening in the decades after the Second World War, when health became recognised as a basic human right. Constituting a set of new ideas about how health should be addressed and dealt with, GHG has taken a centre stage in terms of informing national strategies on health as well as global commitments to health. Examples of such global commitments are the Millennium Development Goals (MDGs) and goal 3 of the new Sustainable Development Goals (SDGs). The operation of national health systems must to a larger extent address issues of foreign policy and international relations, which can influence their operation in unforeseen ways.

This is especially the case in the Global South, were many national health systems are dependent on financial aid from external actors in order to operate properly. For this thesis, the Malawian health system was chosen as a case study. The two research questions posed in this regard were:

(1) What characterises the Malawian Health System (MHS) as formulated in the Health Sector Strategic Plan (HSSP) [2011-2016]?

(2) How does the agenda of the Health Development Partners (HDPs) influence the implementation of the HSSP, and what are the consequences for the priorities and organisation in the MHS?

These two questions have guided the theoretical assumptions for this thesis, as well as the data production during the fieldwork in Malawi, and the final analysis of these data as formulated in chapter four and five. Basing the production and analysis of data on methodological elements drawn from grounded theory, the case study of Malawi was
approached and analysed on its own terms. Recognising the contextual distinctiveness of the situation in Malawi, emphasis was put on the importance of letting the information gathered in the field structure the analysis for this project. In doing so, the informants whom participated in the study have contributed to the further theoretical stance of GHG influence.

Summary and main findings

The assumptions of global health governance accounted for in chapter two outlined the theoretical framework that has been employed for this project. The conceptualisations of global governance in terms of neo-realist and liberalist ideas from international relations theory formed the foundation for conceptualising the two models for health governance; PHC and GHP. This chapter also conceptualised how notions of power are applicable to global health and the operation of national health systems.

Chapter three outlined the methodological starting point for conducting research for this thesis, and argued how the methods employed in the production of data could be beneficiary in order to gain a deeper understanding of the Malawian case. The chapter largely expanded on the process of data production during the fieldwork in Malawi August and September 2015. At the core of the conducted interviews was a desire to understand what priorities were being made, which were left out, and what the result was for the organisation and operation of the MHS. However, the interviews opened up for the informant to go into detail on what (s)he found important, which meant that I ended up with a different kind of material than I had envisioned. However, from these emerged multiple thematic categories that brought new insights to the field. This distinction emerged from the grounded theory approach to the produced data, where the researcher interprets data through the movement between the produced data and theoretical assumptions.

Chapter four and five constitute the presentation of the main findings for this study as they aim to answer the two research questions. Chapter four, Building the Malawian Health Model aimed at defining the parameters of the MHS. This was done through a textual analysis of the HSSP, the current strategic plan for the health sector in Malawi. The textual analysis was complemented by comparing the goals and objectives stated in the plan with the experiences shared by the informants. Chapter four discussed how the MHS as constituted in the HSSP is fundamentally characterised by elements which are found in the PHC agenda. In this case, the PHC agenda was operationalised using the governance elements posed by the WHO originally in 1978, as formulated after the Alma-Ata Conference. The HSSP, and the
perceptions of the informants, explained how the MHS is largely focused on two elements for operation: the implementation of the EHP as part of increasing equity in health, and decentralisation policies in order to increase universal access to the national health system. These two objectives guide the planned development for the health sector in Malawi, which is predominantly a government-oriented national system.

Chapter five aimed at defining and explaining the scope of HDP influence within the parameters of the MHS as defined in chapter four. The rationale behind choosing this focus was that the issue of donor-influence was reoccurring in the interviews, whilst being largely understated in the HSSP. The main findings in this regard was that HDPs influence the MHS in principally two ways; through the enforcement of parallel systems of health care, and through the exertion of power in priorities for health.

The presence of parallel systems in the health sector has been prevalent for some years as a result of inefficiency in the government health sector, leading to private sector and NGO activities at district and primary level. However, in response to pulling out of the SWAp mechanism, the HDPs also started channelling their funding directly to the district level, enforcing the parallel health system delivery.

The exertion of power in priorities is largely based on the resource-based power held by the HDPs through their access to resources. As exemplified in chapter five, HDPs often follow their own agendas on what health priorities are deemed important, which don’t necessarily match the priorities of the MHS. As explained, HDPs now allocate their resources to the government system at district and primary level, and also to NGOs operating in the communities. These actors at district level are not necessarily prepared to deal with this resource flow. In addition, the HDPs can largely influence what priorities they want their resources to be directed towards, as the MHS is dependent on the funding. In effect, other priorities are not focused upon, creating disparities between national priorities and ‘global’ priorities formulated in global policies on health. The influences brought forward by the HDPs are largely inspired by elements from the GHP agenda and ideas of GHG. As such, the MHS is faced with two modes of governance in the pursuit of implementing the HSSP.

This thesis has argued that the challenge of HDP influence is the possible effect it has on health equity. Firstly, the parallel operation of health services and the exertion of power over priorities can effectively lead to the inequity of health service delivery between different districts in Malawi. Secondly, in this influence there arises a question of sustainability. The question becomes what will be the consequence for the operation of the MHS if financing
from HDPs stops, and what the future holds for the Malawian health model in meeting with external influences. These two effects combined can possibly have devastating effect on the prospect for fully implementing the objectives of the HSSP, and thus have negative consequences for health equity in Malawi.

Caveats, thoughts and remaining questions

This thesis has assumed one theoretical (GHG) and methodological (qualitative) perspective. This has led to a certain view on the development of the MHS, which could have been different if a different perspective had been employed. The operationalisations of the influences are largely based on the perceptions and experiences of the informants, and on observation of the challenges and issues addressed at the Annual Review in September 2015. This means that the data produced and analysed for this thesis has largely sought to tell the story of the Malawian health system on its own terms, instead of focusing on the counter arguments posed by HDPs. The motivation behind this choice was informed by a wish to explore the perceptions ‘bottom-up’ from the national level to the global level, and this thesis has thus benefitted from a constructivist perspective on GHG and national health systems. Concerning the question of whether the case of Malawi is transferable to other cases, I would pose that it is in some ways. The context of Malawi is of course unique, but the manifestations of donor influence is not necessarily so. As such, in the aim for identifying donor influence in national health systems, one can make use of similar tools as employed in this thesis.

The fundamental issue for Malawi, however, is that it is a poor country which at this point in time is unable to fund its own health system. Issues of economic development have consequences for all aspects of social life, including health and the provision of health services. This thesis has not engaged in discussions of why Malawi is poor, or what strategies can be employed to reduce poverty. Yet, economic development is of crucial development to Malawi, and perhaps the most important indicator for the further development of the health sector, with or without the presence of external partners in health.

“I don't see where we'll get the money as a nation, but I don't think… I wouldn't have had a headache if I had enough funds to buy a paracetamol myself.” (Academic informant, interview 01.09.15)
Literature


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Appendix I: Interviews and informants

Academic informant
*Lecturer employed at the College of Medicine, interview conducted 01.09.15.*

CSO (Civil society organization) informant
*Employee at the Malawian civil society organisation Malawi Health Equity Network (MHEN), interview conducted 03.09.15a.*

District Administration informant 1
*High authority employee within the District Administration, interview conducted 02.09.15b.*

District Administration informant 2
*High authority employee at one of Malawi’s central hospitals, interview conducted 03.09.15b.*

MoH informant 1
*Planner at the Ministry of Health, interview conducted 02.09.15a.*

MoH informant 2
*Planner at the Ministry of Health, interview conducted 07.09.15.*

MoH informant 3
*Former planner at the Ministry of Health, interview conducted 17.09.15b.*

NGO (Non-governmental organization) informant 1
*Two-person interview with two employees at NCA, interview conducted 31.08.15.*

NGO (Non-governmental organization) informant 2
*High authority employee at UNICEF, interview conducted 17.09.15a.*

Private sector informant
*High authority employee at the Christian Health Association of Malawi (CHAM), interview conducted 28.08.15.*

Research institute informant
*Employee at the Public Health Institute of Malawi, a Ministry of Health agency, interview conducted 16.09.15.*

Conversation with international worker
*Guiding conversation with employee at the Clinton Foundation, 01.09.15*

Observation from the Annual Health Sector Review Conference “Population and Health”, 2014-2015
*Personal reflections, 18.09.15*
Appendix II: Interview Guide

1. Malawian Health Sector
   - Please describe the health system in terms of: Main actors, Core functions, and Outcomes
   - What are your thoughts on the national strategies: Programme of Work and the Health Sector Strategic Plan? How are they being implemented?
   - How are the national strategies on health influencing allocation of resources, priorities, governance structures, outcomes?
   - How are priorities being articulated?
   - How important is accountability and transparency?
   - What are the main challenges in the health sector?

2. Economic situation in the Health Sector
   - Please describe the economic situation: Resources, governance, priorities, and outcomes.
   - Is the current allocation efficient? Cost-effective?

3. Relationship between the Malawian health sector and expatriate actors in the Malawian health system
   - Please describe relationship with: External actors / Donors / Implementers?
   - Do you think the collaboration between the Malawian health system and expatriate actors are impacting the development of the health system right now?

   - What do you hope the health system will look like in ten years?
Appendix III: The EHP

The Malawi Essential Health Package as defined in the Programme of Work (PoW) (Ministry of Health, 2004, p. 23)

Interventions:

- Prevention and Treatment of vaccine preventable diseases.
- Malaria Prevention and Treatment – ITN promotion, IPT and Case Management.
- Reproductive Health Interventions – including Safe Motherhood Initiatives, Essential Obstetric Care and PMTCT.
- Prevention, control and treatment of Tuberculosis and related complications.
- Prevention and treatment of Schistosomiasis and related complications.
- Management of Acute Respiratory Infections and related complications.
- Prevention, treatment and care for Acute Diarrhoeal Diseases (including cholera).
- Prevention and management of HIV/AIDS, Sexually Transmitted Infections and related complications including VCT and the provision of ARVT.
- Prevention and management of Malnutrition, Nutrition deficiencies- (iodine, Vitamin A, Iron) and related complications, especially those associated with HIV/AIDS.
- Management of eye, ear and skin infections and related complications.
- Treatment of common injuries – including emergency care for accidents and trauma and their complications.

Support systems:

- Essential laboratory services.
- Drug procurement, distribution and management.
- Information, Education and Communication - Behaviour Change Interventions.
- Pre- and in-service training.
- Planning, budgeting and management systems.
- Monitoring and Evaluation – including enhancing integrated disease surveillance activities.
- Patient management systems.

Essential Non-EHP Health Interventions:

- Prevention and control of hazards from environmental factors – water and sanitation.
- Prevention, control and treatment of African Trypanosomiasis.
- Provision of dental services.
- Provision of specialist eye services.
- Mental health services.
- Prevention and control of epidemics.
- Emergency care.
Appendix IV: Consent form

CONSENT FORM

“Global Health Governance– expressions of development in the Malawian Health System”

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August 2015

I am a master level student in Human Geography at the University of Oslo. I am writing my master thesis on the theme of global health. My focus is to map out how local politicians and health personnel experience the development of the Malawian health system as a part of the 2011-2016 Malawi Health Sector Strategic Plan. I am studying the debate on how health service delivery is conducted on a national and local level in Malawi, and how different perspectives impact the way health services are being organised and delivered.

In order to approach and answer my research questions, I aim at interviewing approximately 10-15 key actors in the Malawian health sector - official employees, politicians and health service workers. I wish to ask about their opinion of the organisation and actors of the health sector in Malawi, and more generally about the political process on the development of a Public Health Institute. To explore the drivers of this new institute, I will also ask questions regarding changes in health service delivery and organisation during the last ten years.

The interview will last for about 45 minutes to an hour. To be able to correctly reconstruct the conversation, a tape recorder will be used in addition to note taking during the interview. Time and place is decided in unison between the researcher and the participant. The interview is voluntary, meaning that the participant can choose to withdraw from the interview and the research project at any time. All data will then be deleted and not pursued further. All data collection for the research project will be handled confidentially, and anonymity is guaranteed in the process and the finalised master thesis (unless otherwise wished). The gathered data will be coded anonymously, and will be deleted at the end of the master project, within the year of 2016. Questions can be directed at me, Ms. Marie Johanne Talleraas, or at my supervisor Prof. Kristian Stokke.

Declaration of consent:
I have received information about the research project, am correctly informed about the handling of collected data, and am willing to participate

Date and Place:…………………………

Signature:……………………………………………………… Phone:………………………