

**AN INSTITUTIONAL ANALYSIS OF COMMUNITY AND HOME BASED  
CARE AND SUPPORT FOR HIV/AIDS SUFFERERS IN RURAL HOUSEHOLDS  
IN MALAWI**

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**SPY MBIRIYAWAKA MUNTHALI**

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## **Abstract**

Standard economic models often emphasize inputs, outputs and an examination of the structures in order to conduct an economic performance evaluation. This study applies the Institutional and Development Framework (IAD) in the broader context of New Institutional Economics (NIE) in order to examine the transaction costs of delivering Community and Home Based Care and Support (CHBC) to HIV/AIDS sufferers. For purposes of unveiling the empirical reality guiding decision making processes in the CHBC service delivery, comparative qualitative research techniques of normative variable and concept formation have been adopted to draw out the relative institutional influences from the HIV/AIDS national response partnerships. The study identifies the conflict between the predominantly standardized and more rigid formal management techniques adopted by key members of the national response and the informal cultural techniques familiar to the rural communities, and a lack of motivational incentives in the CHBC structures as the key factors against CHBC capacities to draw external funding for service delivery. CHBCs are also weakened by incoherent governance structures at the district level for facilitation of funding and information flow exacerbating the community vulnerability. Rationalization of the institutional arrangements and a clarification of roles from district to community levels, a shift of focus to facilitation of informal techniques and an integration of performance enhancing incentives are the critical policy insights envisaged to spur CHBCs to work better.

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## List of Acronyms Used

ADB	African Development Bank
ADC	Area Development Committee
ADF	African Development Fund
ADMARC	Agriculture Development and Marketing Corporation
ADRA	Adventist Development and Relief Assistance International
AEC	Area Executive Committee
ART	Antiretroviral Therapy
ARVs	Antiretroviral
BCI	Behaviour Change Initiative
CADECOM	Catholic Development Commission
CBOs	Community Based Organizations
CDC	Centers for Disease Control
CESCR	International Covenant for Economic, Social and Cultural Rights
CHAM	Christian Health Association of Malawi
CHBC	Community Home Based Care
CIDA	Canadian International Development Agency
CSOs	Civil Society Organizations
DAC	District AIDS Coordinator
DACC	District AIDS Coordination Committee
DEC	District Executive Committee
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DEVPOL	Statement of Development Policy
DFID	Department for International Development of the UK
EHP	Essential Health Package
FBOs	Faith Based Organizations
FEWS	Famine Early Warning Systems
FMA	Financial Management Agency

GBS	General Budget Support
GF	Global Fund
GOM	Government of Malawi
HRW	Human Rights Watch
HSA	Health Surveillance Assistant
IAD	Institutional and Development Framework
IGA	Income Generating Activity
IDAs	International Development Agencies
IEC	Information Education and Communication
IHS	Integrated Household Survey
IMF	International Monetary Fund
INGOs	International NGOs
LGRD	Local Government and Rural Development
MANASO	The Malawi Network of AIDS Service Organizations
MANET+	Malawi Network of People Living with HIV/AIDS
MARDEF	Malawi Rural Development Fund
MDGs	Millennium Development Goals of the United Nations
MEJN	Malawi Economic Justice Network
MGDS	Malawi Growth and Development Strategy
MOF	Ministry of Finance
MOH	Ministry of Health
MoU	Memorandum of Understanding
MSF	Medicines San Frontier
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NAF	National Action Framework
NAPHAM	National Association of People living with HIV/AIDS in Malawi
NGO	Non-governmental Organization
NHA	National Health Accounts
NIE	New Institutional Economics

NIT	New Institutional Theory
NORAD	Norwegian Development Assistance
NSF	National Strategic Framework
NSO	National Statistical Office
OECD	Organization of Economic Cooperation and Development
OIs	Opportunistic Infections
OPC	Office of the President and Cabinet
OVC	Orphans and Vulnerable Children
PAP	Poverty Alleviation Programme
PER	Public Expenditure Review
PLHAs	People living with HIV and AIDS
PMTCT	Prevention of Mothers to Child Transmission of HIV/AIDS
POW	Programme of Work
PPE	Pro-poor Public Expenditure
PRS	Poverty Reduction Strategy
PWP	Public Works Programme
STD	Sexuality Transmitted Diseases
SWAP	Sector Wide Approach
TAs	Traditional Authorities
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TIP	Targeted Input Programme
UNAIDS	United Nations AIDS Organization
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Education Fund
USAID	United States Agency for International Development
VACC	Village AIDS Coordination Committee
VCT	Voluntary Counseling and Testing
WB	World Bank
WFP	World Food Programme

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## Introduction

This study evaluates the community and home based care organizations (CHBCs) giving health care and support for acquired immunodeficiency syndrome (AIDS) patients in Thyolo and Ntcheu districts in Malawi. It is premised on background socio-economic factors that constrain the communities' capacities to respond to the AIDS pandemic. It also explores what influences the organizational arrangements of the national response to the HIV/AIDS pandemic has delivery of home based care and support. The need for this arises because the poverty situation in Malawi, particularly in rural areas, leaves a significant toll on those responding to the HIV/AIDS situation. Secondly, due to the nature of the HIV/AIDS problem, the economy and in particular, the health sector, has been reorganized into new multiple partnerships and roles. Furthermore, the slow pace in the decentralization process of the public sector has implications for the coordination of the community development agenda including health and HIV/AIDS service delivery.

The foregoing implies that community organizations shoulder the bulk of the burden of delivering health care and support for HIV/AIDS sufferers against a background of their own inadequacies. Besides, their informal techniques embedded in cultural practices and community norms have to come face to face with different approaches from their formal counterparts, and this is a possible source of institutional frictions that need to be understood. They need to be understood because they impact on the performance of the CHBCs hence this institutional evaluation.

The study adopts a normative approach to examine aspects of transaction costs of operating CHBCs within the branch of New Institutional Economics (NIE). The rest of the research output is presented in the following order; Chapter One outlines the background socioeconomic conditions and the health sector in Malawi; Chapter Two is the literature review; Chapter Three presents stakeholder analysis in the health sector and HIV/AIDS matrix; Chapter Four gives the methodology; results are presented in Chapters Five and Six, whereas Chapter Seven covers the analysis; and the conclusions and policy insights can be found in Chapter Eight.

## Chapter One

### **Introduction to the Malawi Poverty and HIV/AIDS Situation**

#### **1.0 Introduction**

The primary purpose of this chapter is to highlight the context of the research. The context covers the geographical locations of the study and their socio-economic conditions, the HIV/AIDS situation and also locating the CHBC dimension within the national response to the HIV/AIDS pandemic. Specifically, the chapter begins with a short description of the whole country of Malawi before narrowing down to a brief of the characteristics specific to the two study sites of Thyolo and Ntcheu. An overview of Malawi's poverty and development indicators, organization of the health sector, the HIV/AIDS sector with specific highlights in the CHBC dimension are provided. The chapter ends with a statement of the problem and the research questions on which the overall study is premised.

#### **1.1 Descriptive Geographical, Administrative and Economic Characteristics**

Malawi is a small landlocked country located in south-east Africa bordering with Mozambique, Zambia, and Tanzania. Out of the total geographical area of 118,480 square kilometers, about 94,079 square kilometers are covered by land and the remainder is taken by Lake Malawi occupying the eastern border.<sup>1</sup> The population of the country currently estimated at 13,603,181 is reported to be growing at about 2.4% per annum. The country has an elongated shape that follows the Great Rift Valley stretching over 855km in length and ranging from 10 to 250 km in width (GOM, 2007).

Malawi is divided into three main geographical regions, which coincided with former regional administrative borders. Each of the three regions has its own unique topographical, ethnic diversity, and socio-economic characteristics. The Northern Region

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<sup>1</sup> Maps of Malawi and the two study districts are in the appendices

is mostly hilly and extensively covered by forests. The Central Region is relatively more flat and warmer with forested areas fast giving way to extensive tobacco farming. On the other hand the South is dominated by mountainous highlands but also accommodates the Lower Shire Valley at the bottom end of the country bordering with Mozambique.

As a consequence of the former regional administrative arrangements, there is one major city in each region to cater to the needs of the rest of the districts. The Southern Region has 12 districts and has the highest population. The major city anchoring this region is Blantyre with a population of about 600, 000 and where the main industrial sites for the country are situated. Lilongwe, the capital city, is pivotal to the central region's ten districts, the central government administration as well as most foreign missions. Northern Region is the smallest with six districts; the least developed in terms of infrastructure and is anchored by Mzuzu City.

The country has a tropical continental climate which exhibits three distinct seasons. From November to April Malawi experiences the rainy season, which is followed by the cool season starting May to July and then the dry season runs from August to October. The majority of the population is located in the rural areas and depends on subsistence farming as the source of their livelihoods. The major crops that are grown are maize mainly for domestic consumption, and tobacco for the export market. Due to reliance on agricultural activities and a dismal industrial sector the country's economy has often exhibited signs of vulnerability to hunger and other socio-economic deprivation due to erratic rainfall, adverse market conditions and perpetual shortages of inputs amongst the farming communities.

Malawi's Gross Domestic Product (GDP) is estimated at about US\$ 2.1 billion, and the average annual growth rate has been estimated at below 2% between 2000 and 2005 when it peaked to about 5% before falling again to 1.9% in 2006. These growth rates are not adequate for reducing the widespread poverty whereby 52 percent of the population (6.4 million people) are said to live below the poverty line and 22 percent (2.7 million

people) are in ultra-poverty, meaning that they cannot even afford to meet their recommended daily food needs (WB, 2007:11).

The country is also reported to have some of the worst demographic and health related indicators in the developing world. The United Nations Children's Fund (UNICEF) reports a mortality rate of 125 out every 1000 live births in the under five year age group and an adult life expectancy of just above 39 years by 2006 (Reuters, 2007). An overall human development index compiled by United Nations Development Programme (UNDP) is reported at 166 and is one of the lowest. About 18 percent of the population live in urban centres while the rest are in rural areas where infrastructure and basic services are underdeveloped.

With regard to incidences of diseases, Malaria, Tuberculosis (TB) and the HIV/AIDS situation have been responsible for major setbacks in Malawi's development efforts. Malaria has been the number one health problem in Malawi for decades. The climatic conditions coupled with poor sanitation make it very favourable for malaria borne mosquitoes to breed. Owing to major weaknesses in the organization of the health sector such as a weak system of inputs, as well as poor environmental conditions, major diseases such as TB have not been adequately handled. Owing to the many complications and vulnerabilities cited above Malawi is also faced with the worst case of the HIV/AIDS situation in the developing world. The infection rate for the population aged 15 to 49 has been estimated at 14% for a long time and is reported to have fallen only by 2% by 2007 due to the national response (GOM, 2007). It is envisaged that addressing economic growth and sorting out inefficiencies in reaching out to the poor masses in the rural areas are critical steps to addressing the country's economic ills enumerated above.

### **1.1.1 A Brief on Thyolo and Ntcheu Districts**

The study focused on communities in the two districts of Thyolo and Ntcheu. Thyolo district is in the southern region and was the main study site. The district covers an area



of 1715 km.<sup>2</sup> and has a population of 458,976. It has a population density of 267 people per Km<sup>2</sup> owing to the vast commercial tea estates that have taken up most of the land (Zachariah, 2006). The district is divided into seven traditional authorities headed by a traditional chief. The altitude varies between 300 and 3500 m above sea level. The District receives rainfall ranging from 800 to 1200 mm per annum. The majority of households are farmers who earn about 80% of all their income from the agricultural sector. The main crops produced in this district are maize, tea and bananas. The farmers also keep livestock. In Thyolo average land holding per household is estimated at 0.6 ha. This is low in comparison with the national average of about 1.5 hectares per household. In a normal year 63% of the households experience from 5 to 6 months of food shortages as a consequence of the inadequate land for growing crops, erratic rainfall and lack of access to farm inputs. Due to the agricultural activities Thyolo district also has the lowest forest cover in the entire country estimated at about 2%. The structural factors in this district have also been responsible for adverse economic conditions such as the highest average annual food inflation in the rural markets (FEWS, 2007).

The complications in the economic conditions have also resulted in Thyolo being one of the districts recording the highest incidence of HIV/AIDS in the country. Currently it is estimated that 20% of the population are testing positive for the HIV virus (MSF, 2007). This explains the strong presence of the NGOs such as Medicines San Frontier (MSF) who have been providing care and support to the communities and two formal hospitals and 17 health center facilities since 1997 (MSF, 2006). The MSF reported that by the end of 2006 at least 7,216 individuals had been placed on Antiretroviral Therapy (ARVs) out of the 11,500 estimated to be in need of them (MSF, 2006). Although there are significant impediments to the delivery of the care and support services, such as the shortages in qualified medical staff and inadequate medical supplies, the involvement of CHBC volunteers has yielded tremendous results in the national response.

Ntcheu is a district in the Central Region bordering the southern region as well as with Mozambique. This district was the secondary study site. The district is situated between the two major cities of Blantyre and Lilongwe and it covers an estimated 3,424 km.<sup>2</sup> with

a population of 370,757 (GOM, 2002:12). The occupants of Ntcheu are mostly descendants of the South African Zulu people and have maintained their traditional structures led by the paramount chief Inkosi yamakosi Gomani overlooking seven traditional authorities (TAs). The location of the district along the main routes between the south and the central region on one side, and the route to the north and the lake on the other, makes it more economically active. Farmers produce and sell vegetables like cabbages, tomatoes, potatoes and carrots, among others, almost all year round. They also benefit from the roving system of weekly or bi-weekly markets whereby other wares besides the agricultural outputs are also sold.

Due to the location, demand for commodities sold on the markets as well as in the small grocery shops is assured. In this regard Ntcheu has better economic opportunities than their Thyolo counterparts. However, the economic activities following the mobile markets have also been noted to have negative effects for the communities. A study conducted in Ntcheu indicated that the district had the highest rate of sexually transmitted diseases such as syphilis. After day time transactions in the markets the peak of activities relocates to drinking joints and rest houses (Munthali, *et al.*, 2002).

The agricultural activities in Ntcheu also extend to growing maize as the staple and tobacco as the main cash crop. On account of this and infrastructure developments the district has a low forest cover of 10% compared to other districts which range from 38% to 69%. While Ntcheu appears to have all the economic opportunities owing to the location of the district, the population remains in severe poverty with a high prevalence of health problems. Health problems range from a lack of staff in the public health facilities to a stagnating behavioral change process. For example, UNAIDS reports that in Ntcheu only about 621,182 condoms were distributed in a district with an estimated population of 371,000 compared to 1,122,431 in Thyolo in 2005 to a population of approximately 459,000 (GOM, 2005: 28). Ntcheu is far more accessible, and more urbanized than Thyolo. But Thyolo district which has a higher incidence and prevalence rate for HIV/AIDS also has a relatively more effective drive, through the role of NGOs and CBOs such as MSF and NAPHAM, to contain the pandemic.

It is also reported that on average households in Ntcheu only managed 1910 community and home based care visits as compared to 72006 in Thyolo (GOM, 2005: 33). While it is known that there is no scientific number of sufficient CHBC visits to the people living with HIV/AIDS and that visits cannot be used as a proxy for the quality of health care service to the sufferers, the frequency of visits, however, can be a good institutional indicator of effort towards community level initiatives. It is also a good indicator of the gravity of the pandemic in a given area, that is, the more serious the situation the more visits will be expected. Ntcheu has a much lower record of people registered to be living with HIV/AIDS, estimated at 248, while Thyolo has registered up to 1421. This means that the efforts for the partnerships in the national response go beyond addressing community needs, such as those of physical access to facilities, by also playing an important role of getting the communities organized. This situation shows that interventions in Ntcheu have not had any major impacts in fostering coordination in the HIV/AIDS sector, despite the advantageous geographical and socio-economic position of the district.

## **1.2 The Malawi Poverty and Vulnerability Profile**

Malawi remains one of the poorest countries in the world with an annual per capita GDP estimated to have been slowly growing from about US\$160 in the 1990s to about US\$250 in 2007 (GOM, 2008). The country ranks 166 out of 177 countries on the UNDP Human Development Index (HDI) calculated for 2004 (UNDP, 2007). The most recent measure of the prevalence of poverty available is one estimated from the 1998 Integrated Household Survey (IHS) which found that 65.3% of the Malawi population are poor in that they live on less than \$1 a day; worsening from a World Bank measure of 60% in 1995 and 55% further back in 1992. With a Gini Coefficient of 0.62, Malawi has one of the highest income distribution inequalities in the world. The economy is very small, undiversified and largely survives on a narrow base of economic activity concentrated in agriculture. The economy exhibits an enormous amount of dependency on external borrowing and grants to fill in the gaps in budgetary requirements; as such the country is

perpetually overburdened with loan repayments. Growth opportunities have been stifled due to the immense government appetite for borrowing.

Poverty is worse in rural areas where about 76% of the population are trapped, and as a result of the pervasive poverty situation, most social indicators are very low compared to the rest of Africa. In 2003 the National Statistical Office reported that only 34% of the rural households consumed above the daily recommended calorific requirements, and 63.7% of the overall consumption came from own production. Life expectancy at birth is reported at 39.8 years by the UNDP (2007). There is a decline from 40.2 years that was estimated in 1997 and along the same lines the UNDP reports that Malawi was ten times poorer in 2001 than it was a decade back. Growing population, increased effects of the HIV/AIDS pandemic, and the inability of the Malawi Government to deliver health care and other related socio-economic requirements in the public sector do account for some of the declining living conditions among the majority of Malawians that consequently tend to compare unfavourably with other developing countries. For example, delivery of the Essential Health Package (EHP) which is the core of the health policy is undermined by various bottlenecks including procurement and inconsistent delivery of medical supplies to the rural health facilities (GOM, 2008). It has also been set back by erratic government allocation of resources often below the required minimum of US\$22 per capita expenditure on health over the year 2003-2007 (GOM, 2008). Consequently, some of the human development indicators have either deteriorated or have shown only slight improvements. For example, infant mortality was 114 per 1,000 live births by the year 2001. Although this represents an improvement from 126 in 1997, it is still high when compared to other African countries (World Bank, 2001).

A high proportion of Malawi's population still does not have access to safe water as Table 1.1 below will show. In 2000, only 57% of the population had access to safe water, and by 2007 approximately 30% were still consuming unsafe water, and about 61% had sustainable access to sanitation facilities. This means that the rest of the population moves in and out of usage of such facilities rendering them vulnerable to the transmission of diseases. The proportion of people living below the poverty line has also grown

between the periods 2003 and 2007 due to increasing population while the general economic conditions are declining.

The inadequacies of the dependency on public sector provisioning of health care are also manifest in the significance of out-of-pocket household expenditure on health care. For example, household spending as a proportion of HIV/AIDS health spending has changed from 7% in 2003 to about 4% 2007. Considering that the majority involved here are the poor masses, these are significant contributions towards health financing they have to make. The change from to 7% to 4% does not reflect an absolute decline in the out-of-pocket expenditure, rather it shows the impact that the increase in HIV/AIDS spending, in particular for procurement of ARVs, from the Global Fund has had on the national response level.

**Table 1.1: Selected Development Indicators**

<b>Indicator</b>		<b>2003</b>	<b>2007</b>
1	GDP per capita (US\$)	195.3	257
2	Population growth rate (%)	1.9	2.2
3	Population below poverty line (%)	65.3	76.1
4	HIV/AIDS Expenditure as % of Total Health spending	17.5	29.8
5	Rural population with chronic food insecurity (%)	55	18
6	Per Capita Expenditure on Health (US\$)	16	22
7	Life expectancy at birth (years)	39	39.8
8	Out-of-Pocket spending as (%) of Total HIV/AIDS Spending	7	4
9	Population with access to safe water (%)	57	73
10	Population with access to sanitation facilities (%)	77	61
11	HIV/AIDS prevalence rate (% of 15-49 age group)	14.4	12

Source: GOM (2005d), GOM (2006), UNDP (2007), GOM (2008)

Other social indicators are equally poor. In education, for example, 39.9% of the adult population could not read or write as of 2000. The pupil-teacher ratio, at 71 in 1998 is also quite high compared to other African countries. This has been exacerbated by the increase in gross enrolment rates in primary school following the introduction of free primary education in 1994. The implication of these indicators is that the health sector continues to compete for resources with the education sector. There is growing consensus that poverty is influenced by literacy levels, land holding sizes, farm productivity and asset distribution. It is, however, worth noting that the picture is not universally gloomy.

For example, there is a slight improvement in the life expectancy perhaps as a response to increased per capita spending on health among other efforts. There is also a noticeable decline in the overall HIV/AIDS prevalence rate from 14.4 per cent in 2003 to about 12 per cent in 2007 as Table 1.1 shows.

The impacts of poverty and other vulnerabilities which are manifested through the widening income disparities, malnutrition, falling asset levels, falling productivity levels and consequently worsening food shortages affect various groups differently. These indicators have been observed to worsen in the face of the HIV/AIDS pandemic. The incidence of HIV/AIDS creates destitution and this drives individuals into risky livelihood behaviour and coping strategies, which ultimately increases their vulnerability (Masanjala, 2006:1).

In a nutshell, the vulnerability compounds the Poverty-AIDS nexus into a vicious cycle. HIV/AIDS accompanies poverty, is spread by poverty and produces poverty in its turn. Individuals, households and communities living with HIV/AIDS find that lost earnings, lost crops and missing treatment make them weaker, make their poverty deeper and push the vulnerable into poverty. In turn, desperation raises the propensity for risky behavior. Therefore, the cycle intensifies. For example, FANR (2002) reports that sales of chickens, goats and cattle are classic coping strategies households all over sub-Saharan Africa engage in every year. Selling of livestock is a normal practice and does not result in increased poverty; however, at a certain point livestock levels will reduce to where they are no longer sustainable.

In Malawi in particular, households with a high level of demographic morbidity or mortality have been reported to be consistently likely to reduce consumption and switch to less preferred foods and wild foods while others actually go for entire days without meals to deal with an ill adult situation. Such is the extent of their vulnerability and hopelessness. Surely this can only underscore the fact that the households' capacities to undertake CHBC are ill-placed and indeed, as a development agenda, these deserve more attention. Furthermore, interventions to address the needs for CHBC at community level

create new ties amongst the actors. While these ties have a clear agenda to pursue development, the action arena tends to become turfs for misunderstandings, delays and frustrations that will negatively affect service delivery.

### **1.3 The HIV/AIDS Situation in Malawi**

Malawi is ranked the 9<sup>th</sup> worst affected country with regard to HIV/AIDS pandemic where about 850,000 individuals are estimated to have died of HIV/AIDS in Malawi since the first case was reported in 1985 (PANOS, 2007:11). As an epidemic, it was prioritized from 1994 by the new regime that took over from the long term dictatorship of Dr Kamuzu Banda. A call was made for a unified response at a time when AIDS had already disrupted a number of socio-economic trends in Malawi (AVERT, 2008:1). From 2004 the National AIDS Commission estimates that almost 110,000 new infections, which get fuelled by the poverty situation and gender inequality, occur each year (Conroy *et al*, 2006:49). This places emphasis on the sexual behaviour of Malawians by connoting that a lack of opportunities for earning income leads to commercialized sexual behaviour which involves multiple partners. On the other hand absence of negotiating power on the part of women makes them vulnerable to unprotected sex that puts them at risk. Recent evidence suggests that high incomes from sales of tobacco is equally to blame for the spread of HIV/AIDS in rural areas since it is used to lure sexual partners who are not necessarily driven by needs associated with poverty (PANOS, 2007:15).

The HIV/AIDS pandemic affects more women than men at ages below 30 and the scenario is reversed thereafter (AVERT, 2008:8). To this effect almost 60% living with HIV are reported to be women. The situation has equally hit children with an estimation of over 91,000 orphans by 2005. The infections are also predominantly urban biased, with those occurring in the rural areas constituting half of the urban rates. The geographical distribution of those living with an infection in the age bracket of 15-49 in Malawi is estimated to be 475,000 in the south, 216,000 in the center, while 75,000 are said to be found in the northern region (Conroy *et al* 2006: 52). The most recent National Health Accounts data on the prevalence of HIV/AIDS in Malawi indicate that the rate has

stabilized around 12% due to the efforts in the national response to the pandemic. The strategic organizational arrangements for responding to the pandemic are discussed in section 1.4.1.6 below.

#### **1.4 Responding to Poverty and Vulnerabilities**

From around 1990 a number of policy frameworks anchored by the second Statement of Development Policies (DEVPOL-II) have been tested in Malawi. A number of policy framework papers were generated to guide specific areas of interest. These were augmented by other similar blue prints instituted to respond to international agreements and conventions such as Education for All (EFA) and the Convention for the Rights of the Child (CRC) among others. Like all its predecessors the DEVPOL-II and related initiatives did not reverse the trend of economic indicators that had come to be associated with the country.

Since the return of a democratic environment in Malawi, the Poverty Reduction Strategy was adopted and was placed at the centre of development efforts. In 1994 the Poverty Alleviation Programme (PAP) was launched. Sectoral policy frameworks such as a Medium Term Expenditure Framework (MTEF), Sector Investment Programmes (SIPs) and Sector Wide Approach (SWAP) had all been worked out to support the PAP initiative. This took place against a background of a lack of proper evaluations of the previous efforts. During the period 1994 to 1998 government implemented programmes that were not necessarily based on the PAP blue print. The PAP remained largely unused beyond being a campaign tool.

By 2002 the Malawi Poverty Reduction Strategy (MPRS), popularly referred to as PRSP, was developed as an offshoot of the World Bank's highly indebted poor countries development initiative (PANOS, 2007:19). Beside the merits of addressing the deep rooted poverty, this initiative was also motivated by possibilities of drawing upon the resources targeting the Highly Indebted Countries (HIPC) for the development agenda, for which Malawi qualified. This strategy is still in use to this day.



The Malawi PRSP is a multi-sectoral strategy developed through a participatory process that involved government, civil society, the private sector and donors. It is a comprehensive and policy focused framework designed to reduce poverty. The overall goals are: to promote growth and diversification of the economy, improve the delivery of social services, create social safety nets, improve governance and integrate policies on HIV/AIDS, gender, environment and science and technology across the main sectors. The strategy seeks to address key components of the development process which are: (i) to provide a balanced approach to fiscal policy designed to create the necessary conditions to generate growth, improve social outcomes, protect the vulnerable and improve governance, and (ii) to provide an appropriate macroeconomic framework and financing plan, (iii) a detailed action plan linked to strategic goals and (iv) an adequate institutional structure for monitoring the PRSP. It also sought to focus on reducing the incidence of HIV/AIDS and improve lives of those living with HIV/AIDS (IMF, 2002).

These targets are being pursued in the broader international context of eradicating poverty as part of the Millennium Development Goals (MDGs). The major goal is one of halving the incidence of poverty by 2015. The implication of this is that poverty must decline by about 2% every year. In line with this philosophy the Malawi poverty reduction strategy had proposed to allocate more resources to rural areas, rural infrastructure and support for micro and small-enterprises (IMF, 2002). It was expected to enhance productivity and growth. It states that particular attention would go to the development of micro-finance institutions and access to land and land tenure with the objective of increasing opportunities for the sections of the population likely to effect short and medium term economic growth. However, reform issues of land and land tenure have always been of a long term nature and often construed to have political connotations. Thus, fears of over-optimism in achieving the desired goals have featured highly. The hope for the success of the PRSP has always rested on the effectiveness of activities in the agricultural sector. Over the years agricultural production has been known to suffer serious setbacks from natural phenomena such as droughts and floods, again suggesting a high degree of uncertainty in achieving the desired results. For

example, Malawi has had various experiences with droughts and famine since a major Southern African Region drought of 1991/92 which affected over 6 million people (UNDP, 2007:2). Then there was another famine in 2001/02 and the 2003 flooding among various weather related disasters. The point is that the need for a comprehensive programme of action has been an imperative for a long time.

In particular, the PRSP has been undermined by other factors such as the 2001 removal of agricultural targeted inputs by the aid partners. The effect of implementing this policy was country wide deterioration in food security which spilled over to the subsequent years (Chinsinga, 2007: 3). By 2004/05 a universal subsidy was worked out and approved by the Parliamentary Committee on Agriculture and was brought into effect in the growing season of 2005 because there was need for a pro-poor tool to reverse this situation. This resulted in a huge boost in agricultural output. At the same time government also introduced the Public Works Programme (PWP), a type of social security, which targeted to increase the purchasing power of poor people. In this initiative those working on the PWPs were paid an equivalent of US\$1.5 per day in a bid to afford them an opportunity for earning cash. Such sources of livelihoods have remained irregular and abysmal such that they have not been able to lift the poor out of their predicament.

There has been a growing concern that the well known critical areas that might revitalize the development process and consequently make an impact on poverty levels have not received the right amount of attention. For example, the IMF reviews of PRSP noted that capacity building programmes to redress the impacts of HIV/AIDS, which was rapidly affecting both private and public sectors, was lacking and yet HIV/AIDS was supposedly an important component of the PRSP (IMF/IDA, 2002: 9). It has been observed that HIV/AIDS had been classified as just one of the many cross-cutting issues in the PRSP, and not a central pillar such that the commitment to deal with the pandemic as one way of addressing the vulnerabilities is clearly undermined (PANOS, 2007:20). On the other hand, the much acclaimed pro-poor targets in the national budget being articulated in the PRSP were allocated resources considered to be too inadequate to effect any meaningful

changes on the very poor sections of the population (Chirwa, 2004:159). Furthermore, Conroy *et al* (2006:104-222) posit that there is need to push more aid into infrastructure development in order to begin to make an impact on poverty and other vulnerabilities. What all these observation show is that there are numerous bottlenecks behind the deep rooted poverty, whose cycle will continue as long as insufficient funding and strategizing of the PRSP and similar frameworks remains. Clearly, the dimensions of the Community and Home Based Care ought to be seen to be undermined by factors from both the policy implementation side and those from the socio-economic status of the households participating in service delivery.

By 2007 the government introduced another blue print which benefited from the evaluation of the PRSP. The Malawi Growth and Development Strategy (MGDS) aims to create wealth through sustainable economic growth and infrastructure development. This strategy attempts to place emphasis on growth as a means of dealing with poverty and rightly places emphasis on addressing the impacts of HIV/AIDS by drawing out specific priority targets. Targets for HIV/AIDS are duly linked to issues of food security which are in turn central to the delivery of the CHBC agenda. However, concerns regarding the need for clarifying coordination and implementation roles and procedures, and envisaged capacity voids in key areas are still lingering (PANOS, 2007:21).

#### **1.4.1 Overview of the Malawi Health Sector**

The main health agenda for Malawi was guided by the National Health Plans which spanned 1986-1995, and then for 1999 to 2004, when they gave way to the EHP which is the implementation tool of the Sector-Wide Approaches (SWAP). The National Health Plan was augmented by disease, or program specific policy or implementation frameworks, for example the strategic framework for HIV/AIDS, and the Malaria Policy, among others. Over these planning phases the burden of disease remained high fostering the need to increase the delivery of quality health care, so the EHP was conceptualised on these premises.

The EHP is also an offspring of implementation experience owing to resource constraints and the realisation that the Ministry of Health is not making sufficient impact by attempting to deliver all types of interventions on a very limited budget. One of the critical targets of the EHP is to provide community level health services. At village level there are three approaches to health service delivery, namely; promotive (education, mobilization and behaviour change, etc.); preventive (immunization, family planning and supplementary feeding, etc.) and thirdly clinical services (outpatient and home based care). By design the EHP, introduced in 2002, focuses on areas of highest priority. These are areas defined by major sources of morbidity and mortality among Malawians, especially those that disproportionately affect the poor in rural areas. The EHP is costed at per capita expenditure of \$17 and the government is expected to contribute \$4 while the balance is externally financed (GOM, 2002). This is what directs operations in the public health domain as it replaces the previous frameworks.

For almost a decade, Ministry of Health and Population has focussed on implementation plans which rendered the overall formal policy framework almost obsolete. Although the Ministry was aware this had negative implications on some of the Ministry's regulatory roles, it continued to operate on that path presumably because the programme specific frameworks have attracted the most handsome donor funding. A lot of critical health needs have been relegated from the priority list because of the narrow base on which the recurrent Health Sector budget is built. Domestically sourced health expenditure is estimated at a low average of \$4 per person and delivery is weakened further by lack of a proper resource allocation formula across the vector of diseases and the geographical distribution of health facilities (GOM, 1999: 17). The sector has also been beset with problems of weak inter-sectoral linkages as highlighted by the first NHA study (2000). Many important functions of the MOHP have been overshadowed by operations of the disease specific programmes, notably the Malaria, HIV/AIDS and TB programmes that are still attracting immense resources.

#### **1.4.1.1 Functional Organisation of the Health Sector**

Health service providers in Malawi fall into two sectoral categories: traditional (informal) and modern (formal) sectors. Within the modern health sector we have three main categories of health service providers namely; the public sector, non-profit private sector and the private-for-profit sector. In the informal sector there are traditional healers –those dealing with diseases and spirits, and the traditional birth attendants (TBAs). TBAs were recognised in 1992 and have maintained their established links with the modern health sector (GOM, 2004: 13)

#### **1.4.1.2 Mainstream Public Sector Approach**

The Ministry of Health and Population (MOHP) is the largest provider of public health services, which are currently provided free of charge in all government facilities (only Lilongwe Central Hospital has an optional paying facility) apart from maternity care, private wards at central and district hospitals, and paying outpatient departments. There are 27 District Health Offices in the MOHP. These are responsible for the dissemination of national policies, overall coordination of health services and programmes, and provision of public services at district level. The current health service delivery system is district-based and is in line with local government administrative boundaries, and managed by the District Health Management Team (DHMT) which is led by the District Health Officer (DHO).

#### **1.4.1.3 The Public-Private Mix**

This is a quasi-public or non profit private mission sector grouped under the Christian Health Association of Malawi (CHAM), which provide a large proportion of services at variable charges. The CHAM is made up of independent church-related and other private voluntary agency facilities. This is a semi public arrangement because the government assists CHAM by providing it with some annual grants that are used to maintain personnel in the facilities and these personnel are drawn from government training

institutions. Further to this, CHAM facilities charge user fees that are not profit oriented for some selected services while the rest, such as growth monitoring, immunization, and community based preventive services, including treatment of specific communicable diseases such as TB, STD and leprosy, are free. The sector also has some selected firms (e.g. agricultural estates, large companies, and parastatals), that also provide health services to their employees and people in their catchments either at concessionary rates or for free. There are also international and national NGOs, which support scattered small-scale community-based vertical health projects, but these rarely provide facility-based services.

#### **1.4.1.4 The private-for-profit sector**

The private-for-profit component is a rapidly growing arm of the Malawi health sector. The growth impetus has arisen from initiatives generated by doctors and paramedics retiring from or leaving the public health sector to fill the opportunistic gap arising from the service deficiencies in the public sector. According to the latest National Health Accounts for Malawi, lack of health workers, supply stock-outs, and lack of basic utilities such as water, electricity, telephones or radio communication in the government facilities have rendered the public outlets unattractive, thus creating a niche for private facilities purportedly with better quality services (GOM, 2007:10). The latest facility survey available conducted by the Ministry of Health shows that the private-for-profit sector is the fourth largest provider of health services with 11.7% of the total health facilities in the country (GOM, 2007:10). Growth of these private practitioners, however, is mostly skewed towards urban and peri-urban centres for obvious business motives.

#### **1.4.1.5 Distribution of Health Care Facilities**

Malawi's network of health facilities belonging to different ministries and agencies is fairly widespread geographically but the Ministry would prefer to have every community living within a 5km radius of a facility. Currently it is estimated that 85% of the population live within 10km of a health facility. The facilities range from small dispensaries on estates to large hospitals in cities. Table 1.2 below shows that there were

878 health facilities in the country in 2003, about 71% of them being primary centres (health centres, dispensary/maternity)

**Table 1.2: Distribution of Health Facilities in Malawi by Ownership, 2004**

	<b>MOHP</b>	<b>Local Govt.</b>	<b>Other Govt.</b>	<b>CHAM</b>	<b>Firms</b>	<b>Private</b>	<b>Total</b>
Central hospitals	4	0	0	0	0	0	4
District hospitals	22	0	0	0	0	0	22
Hospitals	19	0	0	27	7	3	56
Mental hospitals	1	0	0	1	0	0	2
Rural hospitals	16	0	0	18	0	0	34
Urban Health Centers	8	0	0	0	0	0	8
Health Centers	288	12	33	115	36	10	494
Maternity Units	2	12		1	0	11	26
Dispensaries	54	4	5	8	83	76	230
Non-functional	2	0		0	0	0	2
Total	416	28	38	170	126	100	878
<b>Percentage share (%)</b>	<b>47.4</b>	<b>3.2</b>	<b>4.3</b>	<b>19.4</b>	<b>14.4</b>	<b>11.4</b>	<b>100</b>

Source: GOM (2007)

According to WHO Commission for Macroeconomics and Health, one of the priorities of developing countries is to create or strengthen health service delivery systems at the level closest to an individual. The EHP is consistent with this. Thus, the MOHP is trying hard to keep all these facilities operative in the wake of implementing the EHP. It will be understood that the Essential Health Package largely built on a medical approach is dominated by treatment and hospital referral matters whereas CHBC and its nuances are likely to find focus outside the hospital setting and involving a wider cross-section of stakeholders.

#### **1.4.1.6 Organization of the National AIDS Response**

The national response is conceptualized within the precincts of the international efforts for reaching the Millennium Development Goals. These seek to contribute significantly to the reduction of the burden of poverty and HIV/AIDS in the developing nations. Operational strategies are governed by the UNAIDS concept of the ‘Three Ones’ which has been explained in detail under organizational inter-relations in Chapter Six. The national response is located within the SWAP framework of the Malawi Health Sector,

and is specifically guided by the National AIDS Commission National Action Framework (NAF) which runs from 2005 to 2009. Within this setting, an Integrated Annual Workplan that stipulates the yearly targets to be reached by the NAC along with its implementation partners is formulated. The NAC reaches the lower level implementation partners through international NGOs, normally referred to as Umbrella Organizations, through whom the communities can request for the NAC coordinated project grants. Other NGOs, CSOs, private and public agents, then the community agents in the form of CBOs, and individuals are direct partners of the NAC in terms of taking part in various dimensions of the response. Responses in terms of funding have been thoroughly addressed in Chapter Three. Further discussion on district arrangements can be found in Chapter Seven. A brief on the AIDS Policy Framework is described below.

#### **1.4.1.7 The HIV/AIDS Policy Framework**

Since 1985 when the first case of HIV/AIDS was diagnosed, a lot of effort has been put into framing a response to deal with the disease. One of the major milestones included the setting up of the National Aids Control Programme (NACP) which was equivalent to a sub department in the Ministry of Health in 1988. The NACP was established to coordinate all the initiatives against the disease. This was done through campaigns aimed at disseminating HIV/AIDS information to promote knowledge of issues such as, the symptoms of AIDS, reducing and preventing transmission, prolonging lives, managing its impact and negative consequences and furthermore, strengthening institutional capacity for a more effective response to the situation.

Realizing how enormous the challenge was, in consultation with donors and other international and local stakeholders, the NACP was then restructured as the NAC, which has more or less the same functions albeit with a little more autonomy and a wider scope in which to coordinate responses. While the NAC has a full mandate for dealing with the problem, its major role is in coordinating efforts by a multitude of actors. The coordination is in both giving technical guidance and acting as a conduit through which externally sourced resources for the cause are channeled to the battle fronts. While at the



outset the NACP was more preoccupied with disseminating information about the incidence of HIV and AIDS and prevention of infections, the experience gained has led to a switch of focus to *behaviour change* and a scaling up of various forms of successful interventions by the NAC in recent years. There are various sources of funds applied towards these interventions, such as the Global Fund and assistance from multilateral and bilateral donors. In a global village, Malawi is now expanding the provisioning of the ART by building on the then WHO 3x5 which targeted to put about 3 million people world-wide on ARVs by the end of 2005. The central tenet of this initiative is to make the ARVs available free of charge to the AIDS sufferers.

Implementation experience from the past led to the drafting of a policy guide. Hitherto, issues of HIV/AIDS had been guided by the National HIV/AIDS Strategic Framework (2000-2004). This policy document was drawn on the basis of collective action. It focused on capacity building by identifying gaps in various forms of responses and directing interventions through those existing structures. The framework was built on initial efforts by government such as a blood screening policy in the two major referral hospitals in Lilongwe and Blantyre, and the later added dimension of public education on HIV/AIDS in the Medium Term Plan which was in place from 1989 to 1993. Then from 1993 to 1998 a multi-sectoral approach was adopted to deal with all socioeconomic dimensions of the epidemic, which later incorporated other issues such as counseling, home based care, surveillance and research among others. Evaluation of these initiatives led to the birth of the strategic plan. The Goal of the strategic plan was to '*reduce the incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS*' (NAC, 2003:1) The framework targeted culture, youth and social change, socio economic status, management of People Living With HIV/AIDS (PLHAs), prevention, information and education, and voluntary testing and counseling in an attempt to address the growing problem among Malawians. Already at this point one can almost sense that the level of priority accorded to CHBC was minimal, particularly because the NAC did not have clearly constructed guidelines as to what the CHBC package might entail. Most of the CHBC tasks were undertaken by stakeholders in the way they saw fit. The NAC was left to encourage or assist different

groupings with required funding for their activities. To date the CHBC approach still suffers glaring gaps in conceptualization and functionality both from the NAC and poverty reduction strategy perspectives.

#### **1.4.1.8 Strategies of the National AIDS Response**

Focus on dimensions of dealing with the HIV/AIDS pandemic has been changing over the years since the first infection was reported. The initial efforts concentrated on prevention of new infections by emphasizing blood screening and promoting awareness as an important ingredient for behaviour change (Conroy *et al.* 2006:139). This entailed putting up VCT centers and reorientation of health staff to the new roles of counseling and testing. The strategy was altered in the late 1990s to include the important dimension of care and support for People Living with HIV/AIDS (PLHAs). Since then more effort has gone into the implementation of the VCT dimension, and the Information, education and communication (IEC) which was also prioritized in the National Strategic Framework (NSF) to tackle background bottlenecks in the progression of the response. By 2006 about 60 VCT facilities were reported across the country, up from about 20 sites that existed in 2003 (PANOS, 2007:12).

Following the Global Fund initiative to fund the treatment of AIDS patients, the dimension of care and support has become central to the national response. The provisioning of the antiretroviral therapy (ART) is tied to the need for nutritious foods to be supplied to the patients. This has led to food security and nutrition strategy also occupying a central position in the response. To date the care and support dimensions include, targeted nutrition programmes for pregnant women and breastfeeding mothers, providing food to those on ARVs, and a food security policy that is pursuing sustainable access to food by those in need. Additionally, community organizations have access to small project grants designed to help in the delivery of care and support to the PLHAs and the growing population of orphans. The dimension of community care and support, which is central to this study, is presented in the next section.

#### **1.4.1.9 The Community and Home Based Care Dimension**

The WHO defines Community and Home Based Care (CHBC) as any form of care given to sick people in their homes, which includes physical, psychosocial, palliative, and spiritual activities (Ncama, 2005). The continuation of the HIV/AIDS crisis has led a switch in the focus of development policy from a situation of managing hospital cases to care giving and support in homes or community the world over. According to Spier and Edwards (in Ncama, 2005) home care programs for people living with HIV/AIDS (PLHAs) were mainly initiated in North America and Europe in the late 1980s. In Malawi AIDS cases receive care from their households, members of the extended family and the wider community who sometimes work as an organized CHBC.

The idea of CHBC appears to have been documented around the mid 1990s in Malawi as the signs of getting overwhelmed by the burden of HIV/AIDS began to show in the government hospitals and the need for alternative strategies was becoming evident. It is not clear who was responsible for the first CHBC initiatives in Malawi, however it is known that NGOs such as the Light House at the Lilongwe Central Hospital and other Community Based Organizations were instrumental to the conceptualization and development of the idea. The idea has evolved through counseling, teaching of approaches to care and support and making ARVs accessible to members who operate within their communities. Concerted efforts involving donors, NGOs, Government of Malawi, Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) led to the widespread evolution of the CHBC dimension in the national response to HIV/AIDS in Malawi.

In 2002 the Malawi National AIDS Commission documented that care and support for AIDS sufferers had been on the decline particularly due to the worsening condition of poverty in the country in recent years. The HIV/AIDS pandemic undermined socio-cultural structures making it difficult for families and traditional institutions to cope. This problem is compounded by the inequitable distribution of gender roles in African society, where sourcing of food and direct care for the sick is largely a responsibility for women.

It, therefore, becomes apparent that the current system of health care and support is immensely constrained and unsustainable, and hence worth serious investigation.

The specific policy statement for CHBC is said to be; *to promote the delivery of quality CHBC as an essential component on the continuum of care for PLHAs* (NAC, 2003:10). At the moment the promotion is mainly done through the practice of capacity building in Community and Home Based Care in the form of small grants that groups of caregivers receive from the NAC. The proliferation of orphan care centers has taken center stage over the years mainly because communities are left with children that have no where to turn to when their households go through dissolution. It is not known what it costs to run these care centers at the moment, let alone how well they are performing since no known evaluation of the institutions has come to the fore. One can almost conclude that the emerging picture is one where orphan care is more of a community problem while caring for the sick is largely a specific household matter. Other forms of interventions to foster the needs arising from the effects of the disease include, but are not limited to, work by NGOs and CBOs and some specific projects in Malawi such as Project Hope and Care Malawi. However, with specific reference to these highly influential NGOs, their work is limited by geographical bias because they are not evenly distributed by both their physical location and programme operations. This bias is compounded by the fact that most of the NGOs do not have HIV/AIDS as their core business and the immediate effect of this is that there will be varied degrees of focus on AIDS activities.

As a strategy in the plan, Community and Home Based Care features as an important component of HIV/AIDS Management in the overall National Strategic Framework (NSF) developed and coordinated by the NAC. Major actions under home based care include; (i) developing positive attitudes among clinicians and home based care providers, (ii) ensuring availability of drugs and other facilities, (iii) building capacity for hospital care and for home based caregivers and health care givers in coordination of their services, and (iv) reviewing the home based care guidelines and clinical management, among others (NAC, 2003:10).

At household level where the bulk of ministering to the sick takes place home based care is largely a responsibility of women who look after the sick members. They are responsible for feeding and general sanitary needs. Documented types of care include providing funds for buying medicines, food and other essential needs. These needs are funded through decumulation of assets or doing piece work (ganyu) and the burden is bigger for households headed by women and/or where the bread winner is not in formal employment or in stable business (Munthali, 1998:7). Take note that the general form the care takes depends on the nature and conditions of the household.

Because of the many dimensions to, and the complicated nature of the notion of Community and Home Based Care, that is backward and forward linkages to measures of poverty, agricultural productivity and production, exchange markets, employment; infrastructure among several key dimensions, a clear and well integrated plan of CHBC is a necessity. The development and conceptualization of the NSF for HIV/AIDS was done independently of the Community Social Action Matrix of the Poverty Reduction Strategy. The implication is that there is a clear need of a systematic integration of the two strategies.

### **1.5 Statement of the Problem**

In concert with international evidence, research conducted in Malawi by Munthali (1998:7-8) reveals that household impact of AIDS was being felt at various levels. For instance, AIDS affected agricultural production and earnings. In Zambia Serpell (1999) showed that two-thirds of families with paternal death experienced an 80% reduction in income while in Zimbabwe research by Stover and Bollinger (1999) reported that AIDS deaths were associated with up to 61 % reduction in maize production due to reallocation of labor and land resources. One of the implications of the AIDS pandemic is that changes in household consumption and investment behavior have become a necessary way to cope. In Tanzania following death of an adult, household expenditure dropped by 11 % while for the poorer half of the population food expenditure fell by 32 and consumption by 15 % (Over *et al.*, 1995). In Malawi 43% of households were reported to

spend more than five hours per day caring for the sick members of their families, clearly this has a corresponding impact on food production and consumption (Arrehag, 2006). Clearly, the conditions associated with HIV/AIDS have social consequences on the households concerned, especially changes in household health and composition. While illness may lead to a reduction in health maintaining activities, loss of a bread winner may result in dissolution of an entire household. In Zambia, for urban families with paternal death, 61 % moved to cheaper housing, 39 % lost piped water, while 21% and 17 % of girls and boys respectively, dropped out of school (Serpell, 1999). Lastly, in Malawi there were psychological costs, especially social stigma, grief and uncertainty about the future among caregivers and survivors (Munthali, 1998) and vacancy levels were reported to have risen up to 58% between 1990 and 2000 in the education sector alone (UNDP, 2002). All these indicators signal how difficult it is for households and communities to cope and respond to the pressures created by HIV and AIDS.

On account of the complicated situation, households find themselves in partnerships that emerge to make an impact on the HIV/AIDS pandemic. For example, the NAC and other NGOs enter into relationships with the community groups by making available some grants for income generating purposes. While the idea of IGAs is an important step towards addressing the needs for CHBC, the process of acquiring these grants is mired with procedural bottlenecks which render them relatively inaccessible to the rural poor. Secondly, these interventions have resulted in multiple organizations descending on these communities to work with the villagers. One of the implications of this development is that, differential working methods and standards are passed on to the communities and in the process alter how they conduct themselves. The inter-relations involve making critical decisions such as planning for activities, resource allocations and accounting for externally injected resources. Relating with numerous partners whose nature and methods are varied can be a source of frictions that have a bearing on the way the CHBCs perform. It is on the basis of these aspects, the communities' own difficult conditions to cope with the HIV/AIDS demands and the growing influence emerging from the multiple partnerships, that this institutional evaluation research is conceived.

## **1.6 The need for an Institutional Analysis Evaluation**

There is growing evidence of governments which fail to provide adequate health care to their citizens. On the other hand there is acknowledgment of the NGO sector playing a key role in filling the gap albeit with efforts that are not as evenly spread as those of the public sector. The resultant advent of significant out-of-pocket costs associated with the failures of formal health services impact particularly on the poor on two fronts. First is that the government has the responsibility to provide the social amenities such as health care to the poor, so if this does not happen there is need to understand why. Secondly, in a country like Malawi where health care is supposed to be free, paying for health care must be seen as a negative signal because it entails huge opportunity costs on the part of the households. For example, households tend to prioritize food security year in year out, so diverting cash to pay medical bills indicates government policy failure that needs to be explored.

The need to find ways of facilitating the communities' agency, such as the CHBCs, is underscored by two factors. First, the communities are known to be struggling with the adopted critical roles of administering health care services at home. This is done within the difficult economic conditions they face and the need to support them has been clearly endorsed by international partners. Second is the observation in the New Institutional Economics that inter-relations in a complementary mode with the recipients of health services have side-effects of generating frictions. Frictions have their origins in the different capacities, interests and working methods between the formal and informal systems that are coming together. The inertia generated by the sticking points, which translate into transaction costs of that economic system, has implications for the overall performance of these organizations. Since the operational arrangements of the national response to the HIV/AIDS are structured in a governance mode, an institutional analysis type of evaluation reflecting the sources of the transaction costs faced by these organizations is warranted. It is thus envisaged that the following questions should be central to this evaluation.

How does the presence of external agents influence CHBCs? What transaction costs or economising transaction arrangements arise from relating with external organizations? How do these factors impact on the operating methods of the community based organizations? Are there new working methods adopted by the community agents to reduce transaction costs? Are there conflicts or tensions between working methods of the CHBC groups and their external partners that raise transaction costs? What resources and services do the actors bring to the care continuum? How are the perceptions and consequent working arrangements of the community actors altered by the partnerships? Are these alterations reducing or raising transaction costs of delivering care? What are the motivational factors generated by the framework? These questions are explored within the context of the New Institutional Economics, and in particular with respect to the concept of transaction costs that explain CHBCs conduct themselves the way they do.

## **1.7 Summary and Conclusions**

The Chapter introduced dimensions of Malawi as a country, the socio-economic conditions prevailing and in particular, the circumstances of the health sector and the situation regarding the HIV/AIDS pandemic. This was done with the view of showing the terrain in which the dimension of community and home based care, which is central to this study, takes place. The terrain is made of the background conditions of poverty and food insecurity on the one hand, and a growing influx of different organizations into the HIV/AIDS sector influencing the way the CHBCs conduct their business. The chapter has drawn research questions based on these conditions and motivates for an institutional analysis evaluation of the governance structures that are resulting from the national HIV/AIDS response. The analysis focuses on identifying transaction costs hampering the operations of community agency by assimilating the normative factors, which are normally unquantifiable, to capture standards in use and mental constructs of the actors.



## Chapter Two

### **Theoretical Background to Economic Development and New Institutionalism**

#### **2.1 Introduction**

This chapter analyses theoretical approaches to the process of socio-economic development. While the literature survey has as its main focus an analysis of the theories underpinning the concept of new institutionalism as it applies to the organization of Community and Home Based Care (CHBC), the chapter starts with an examination of the development theories which have been the bedrock of economic organization in so far as individual choice and welfare are concerned. The brief analysis of development theory finds its importance in the notable shift of focus in 'development concerns' among developing nations over a number of decades.

The broad aim of the first section is to illustrate the empirical application of theory in addressing development and the associated socio-economic ills faced by humans. It is well known that development policy has close links with the role of the state in providing an environment that ensures exchange which broadens the horizons of consumer choice and, therefore, widens the scope for individual welfare in the first instance. Secondly, these policies and strategies go a long way to prescribe the conditions that determine the general standards of living and the ability of households to respond and cushion themselves during shock events such as the HIV/AIDS pandemic. It is in this light that Development Theory and its various forms of strategic application are reviewed.

Section two will then analyze the insights that emerge through the advent of institutional economic theory which has, hitherto, added another dimension to how economic development ought to be perceived and evaluated. Analysis of the theories of new institutionalism is central to the whole study. The importance of institutional arrangement and indeed the importance of institutional analysis are well documented in the literature.

North (1990:1) shows that institutions are the underlying determinants of the long run performance of economies. Institutions are a guide to human interaction or they can also be seen as constraints which shape human interaction. Copestake (2003:9) shows that social development such as promoting good governance or mobilizing movements in support of an extension of social and economic rights becomes a precondition for economic development. Thirdly, Topouzis (1998:13) also observes that enhancing sustainable human development and social participation are prerequisites for the revitalisation of the rural economy and thus, for effective responses to HIV/AIDS. It is therefore imperative that the theories that form the background to the interplay between actors in the response to the HIV/AIDS pandemic in Malawi, in particular the Community and Home Based Care and Support dimensions, should be discussed.

The rest of the chapter presents the background to economic development policy and some examples of the various forms of its application strategies. Then the chapter presents a general introduction to institutional theories before narrowing down to the concept of new institutional economics, thematic approaches to institutional analysis and a justification for its application in this study, before finally ending with a summary and conclusions.

## **2.2 Background to Development Policy**

It is an obvious fact that a majority of nations have for a long time been grappling with a myriad of socio-economic problems by applying various policies and strategic policy actions. The emergence of the study of economics has everything to do with these efforts of trying to understand and deal with the problems faced by humans. By definition, economics is the study of how individuals and societies make choices about the use of scarce resources to maximize overall well being (Rudd, 2003:21). The methods of resolving economic problems have been changing over the years just as have the nature and magnitudes of the fundamental socio-economic problems. The changes and shifts in economic thinking, with changing times, led to what are called paradigms in the economic theories of development. A paradigm is defined as a constellation of values,

beliefs and perceptions of empirical reality, which together with a body of theory is used by a group of scientists by applying distinctive methodologies to interpret the nature of some aspect of the universe we inhabit (Hunt, 1989:2). Developing countries in particular, such as Malawi, have for many years provided ample conditions for experimenting with economic development ideas by many scholars and development oriented institutes.

An identifiable trend path taken by Malawi and many other developing countries, *albeit* with external influence, constitutes policy frameworks that have contextualized growth, growth with redistribution, rural livelihoods and diversity, poverty eradication and/or poverty reduction through structural adjustments and more recently intensifying a firm grip on notions of governance. With due recognition that development policy is guided by development theory this section will merely serve to shed light on the aforementioned along with the theoretical underpinnings and then quickly move on to the more recent appeal of economic concerns and organization under the subject matter of New Institutional Economics.

### **2.2.1 Definition of Development**

According to Sen (1999) “Development consists of the removal of various types of unfreedoms that leave people with little choice and little opportunity of exercising their reasoned agency.” Sen points out the fact that “indeed, the origin of economics was significantly motivated by the need to study the assessment of, and causal influences on, the opportunities that people have for good living.” Reed (1996) defines sustainable development as improving the quality of human life while living within the carrying capacity of supporting ecosystems. This definition has economic, social and environmental dimensions, and includes factors such as labour intensive growth, distributional equity, gender equity, provision of social services, and ensuring that consumption of natural resources does not compromise the needs of future generations.

This study will be built on the definition as suggested by Sen particularly because the study is all about rural people's participation on the one hand and recognition of the role of government and other bodies in providing an enabling environment for individuals and groups such as those involved in Community and Home Based Care to contribute to economic development and, in particular, providing care and support for HIV/AIDS cases within their localities. Clearly, this definition considers development as a process of removing unfreedoms in the form of a lack of public facilities and social care, such as absence of epidemiological programmes, organized arrangements for health care, or educational facilities, and indeed limitations in the people's participation in social, economic and political life of the community. This study will, therefore, conceptualize development in light of the extent to which free and sustainable agency from the unfreedoms is enhanced amongst the populations under study, particularly through their involvement in home care and support responses to the HIV/AIDS pandemic.

### **2.2.2 Development as Freedom: The Capabilities Deprivation Approach**

The capabilities deprivation approach developed by Amartya Sen (1999) recognizes that lack of sustainable freedoms relates directly to economic poverty, which robs people of freedom to satisfy hunger, or achieve sufficient nutrition, obtain remedies for treatable (diseases) illnesses among other accessories of life. This method draws its strength from its attribute of enabling an evaluation of the effectiveness of a given policy.

The approach enables an evaluation of the extent to which people's unfreedoms have been enhanced. It also points out the effectiveness derived from a development effort on account of the free agency of people. It recognizes that the people's freedom to participate in economic interchange has a basic role in their social living. In this context, if a person is considered poor it must be understood as a deprivation of basic capabilities and not as low income as is usually the case under the economic growth strategy. Thus, an expansion of real freedoms that people enjoy is not limited to economic growth, such as the growth of GNP, even though this is an important means to the expansion. It means there are other factors influencing the expansion of these real freedoms, some of which

encompass the removal of poverty, tyranny, poor economic opportunities, as well as systematic deprivation, and the removal of the neglect of public facilities, as well as intolerance.

In discussing the state and provision of economic facilities and social opportunities, Sen (1999) refers to these as instrumental freedoms. Social opportunities encompass the arrangements societies make for education and health care for individuals to live better lives. It is argued that these facilities are important not only for the conduct of private lives (e.g. healthy life of individual households) but for a more effective participation in economic and political activities (Sen, 1999:39). Here, the fundamental point is one of developing human capital and is supported by the observation that Japan's development was clearly helped by the human resources development related to the social opportunities that were generated through a higher rate of literacy than European countries enjoyed at a similar stage of development. The Japanese among other Asian countries went comparatively early for massive expansion of education and later health care even before they broke the restraints of general poverty, and they have reaped accordingly.

Their freedoms are influenced by substantive public support in the provision of those facilities such as basic health. Another example is given of China which gained massively by moving into a market economy, with the background of higher prioritization of health care and education. On the other hand India only concentrated on higher levels of education with a substantial neglect of basic health care which left the country poorly prepared for widely shared economic expansion. Clearly the case for developing countries to primarily tackle the shackles of the social problems such as poor health indicators such as HIV/AIDS among others, cannot be emphasized enough. This theory makes a case for provisioning of appropriate structures and an enabling environment deemed as paramount for the success of other forms of potential economic development. The approach draws some similarities with the notion of 'growth with redistribution' in that it recognizes the role of the state in providing an enabling environment (i.e. reducing inequities and providing social infrastructures) which foster choice and, therefore,

prepares the peoples to tackle economic development. Such a form of investment by the state is expected to unlock returns for the entire economy enabling people more effectively to engage in development work. This sort of relationship is crucial for development to take place as neither government nor the population can do it alone (Dasgupta, 1993:536-538). This kind of theoretical thinking is very relevant today as the burden of disease has taken a new dimension with the prevalence of HIV/AIDS. This problem has severely compromised the peoples' well being and in effect has gone a long way to cut back the economic prospects for a majority of developing countries. It is this phenomenon that makes this study of institutional organization in Malawi imperative.

### **2.2.3 Growth Oriented Development Approaches**

In its early stages, the notion of development was tied to industrial policy designed for boosting and coordination of investment. Industrial investment was idealized to provide a 'big-push' to inter-sectoral externalities, that is to say that growth benefits from one industrialized sector would spill over to generate increased demand in other sectors (Shapiro, 2005:1-2). Notable works in the study of development economics included Rosenstein-Rodan (1943), Nurske (1953) and Lewis (1954). The orthodoxy regularly found in the macroeconomic literature mainly draws our attention to notions of savings, formation and flow of capital, investment incentives and wealth effects as the fundamental instruments of an individual's welfare, i.e. that an individual will largely need to spend and expenditure is enhanced by wealth and income which are themselves a function of savings or capital formation. Orthodox economics thus pointed towards policies that maximized the growth of income (GNP) if individual's or household welfare is to improve over time.

Growth maximizing economics has been applied by economists in developing countries such as Malawi for many decades. For example, Malawi adopted an agricultural system which specialized in cash crop production in the estate sector with the view to enhance economic growth and export performance. Cash crops also provide the highest returns to the farmers' productive resources, with the realised cash being used to buy consumption

goods (Masanjala, 2005:1). The large scale estate sector received preferential treatment as an anchor for the economy. By way of feedback effects this sector was meant to help in the domestic fight against the core economic problems, in the manner of unbalanced growth as argued by Hirschman (1958, 1977 in Dutt and Ros, 2003:4), of promoting and taking advantage of linkages between sectors as a development strategy. Masanjala (2005:1) points to the underlying assumption that as the farm households earned more income, the market would broaden the scope for its welfare maximisation; obviously the multiplier effects were envisaged to be at play as the consumers interacted with other agents in the wider market. Unfortunately, this chain of events never proved to work as expected, and the literature suggests that in many developing countries there have been cases of imperfect or missing markets so that the trickle down economics of the growth strategies have failed. Cases of such failures are commonplace due to what Chenery and Bruno (1962 in Dutt and Ros, 2003:4) call supply rigidities in agricultural sectors of developing countries, which breed inflation on the one hand and that attempts to increase exports on the other, were likely to be met with inelastic demand on world markets and hence deteriorating terms of trade. Perhaps this is the major weakness of applying the growth strategies in such complicated and difficult conditions.

Specifically, all indicators of development in Malawi showed signs of deterioration over long periods, for example over the years the real growth rate of the GDP for Malawi has fallen from 5% in 1997 to almost 2.6% in 2005 (WB, 2006). During the same period per capita GDP has fallen from above US\$200 to about \$160 while about 65% of the population is estimated to live below \$1 per day. The World Bank also reported that the total HIV/AIDS prevalence rate amongst adults was estimated at 14.1% at the end of 2005. The Malawi Demographic and Health Survey of 2000 reported that indicators of wellbeing were very low, for example the proportions of value of food and cash crop production to total production by households remained at 96.1% for food crops and only 3.1% for cash crops (NSO, 2000:2), implying that the cash crops were not in a position to contribute to other household consumption needs. By 2005 the total share of agriculture to GDP had fallen to 34.7% from about 40% in 2000 while the share of industry remained stagnant at about 19% (WB, 2006). The child mortality rate is as high as 122

per 1000 live births and life expectancy has dropped to almost 37 years, while the literacy rate is estimated at an average of 43% (World Press, 2006). Thus, gains from the intended growth have remained elusive. Such failures led to the birthing of other adjunct notions such as the Basic Needs Approach and Redistributive Strategies which are discussed in the next section. Observers have placed the blame for the failings on development policy, especially as these policies seem to be applied across many countries such as Tanzania, Mozambique and Malawi in a one size fits all fashion under the guidance of the IMF and the World Bank, neglecting the special characteristics of a particular country in the process (SARPN, 2003:9). It is in light of this that the New Institutional Economics approach gains ascendancy by explaining the detail of a specific object of study (institution) to bring out its special characteristics and analyzing the effects and effectiveness of policy design. In particular the focus of the development theory is seen to be on a macro level where formal structures, rules and regulations are the subject of policy and no issues of economic organization or institutions of a normative nature are accorded the attention modern literature seems to suggest.

### **2.2.3.1 Basic Needs Approach**

The Basic Needs (BN) Approach has the Marxist concept of 'use-value' incorporated by asserting that production has to be oriented towards meeting basic needs of the people, that is, production for use-value and not production to maximize aggregate incomes which implies production for exchange value. The Basic Needs Approach to development is one which gives priority to meeting the basic needs of all people (Stewart, 1985:1). This approach stemmed from the development ideas of the 1950s where the focus was on growth maximization and industrialization as the mutually supportive development objectives. This approach was mainly championed by researchers at the International Labour Organization (ILO). At a time when experiences with growth were associated with unemployment, underemployment, income distribution problems and poverty the view of a growth-only orientation to development increasingly gave way to the Basic Needs (BN) Approach.



The break-away move from the growth approach first concentrated on dealing with unemployment which was perceived to be relatively too high in most poor countries, and thus employment became a development objective in its own right. Even that proved to be unsatisfactory as more issues arose regarding numbers of people unemployed *viz a vis* the low productivity originating from short and long hours of work respectively. The ILO championed raising incomes for the poor as the focal point of development. The strategy followed was one of maximizing growth but with redistributing the results by investing benefits in favor of the poor. This perception of strengthening the incomes of the poor as a focus of development essentially targeted the elimination of poverty and deprivation. It is on account of this that the BN approach sees incomes as important in enabling individuals to acquire certain basic goods and services but not as an end in themselves (Stewart, 1985:2-3).

While the conventional schools of economics use incomes as a basic indicator of welfare, the BN approach uses it to discriminate between different types of goods. It departs from the standard assumptions about consumer sovereignty, revealed preference and welfare optimality by selecting certain types of goods for households for special attention by regarding them as unsubstitutable in certain respects with others. The BN Approach is consistent with redistribution of income in accordance with social welfare functions. Again, an example of the application of such thinking was observed in Malawi, when it was found that the estate sector spin-offs were inadequate to drive all other sectors, especially, the poverty and food security patterns the government sought. It was thus logical to invigorate the smallholder farming activities by offering them incentives in the form of guaranteed producer prices through a state marketing agency, a socially administered credit input system, along with the promotion of favorable technologies and subsidies on key agricultural inputs (Chirwa, 2004:4-5), among other strategies.

A number of other social dimensions were also being tackled at the same time to boost the welfare of households, especially in areas of food security, nutrition and rural markets. All these were being pursued due to evidence of the failure of rapid growth and increasing social inequality. Thus the development strategy had to change focus to more

direct methods of dealing with poverty and inequality. At this point it might have appeared logical to apply redistributive strategies to bring up some balance between distributional inequity and the promotion of growth. At the same time it must be recognized that growth strategies met with more or less similar application problems in most other developing economies where inequality was commonplace, coupled with the fact that by nature economic problems also tend to be dynamic so that changing the theoretical thinking was imperative. The background and examples of application of the consequent redistributive strategies, that aimed to fix the background problems first, is discussed in the next section.

### **2.2.3.2 Growth with Redistributive Strategies**

While modern resource allocation theory remains central for the purposes of locating optimal public policy, Partha Dasgupta (1993) observes that there are compelling reasons for resource allocation not based on Pareto efficiency, i.e. elevating regard for aggregate well-being. He points out that the state has an agenda in this respect (Dasgupta, 1993:336-337). In what formed an important critique to orthodox conclusions of 'trickle-down' economics, evidence from East Asian countries showed that growth alone was not sufficient to achieve macroeconomic targets. Making sure there are no huge inequalities offered appropriate complimentary impetus to reaching macro-goals. From this perspective, governments were encouraged to foster development with redistributive strategies due to the inequities bestowed on economies by inefficient markets (Stiglitz, 2001:16). For instance, the case of a support-led process which works through a programme of skillful social support for health care, among other relevant social arrangements, and does not necessarily work through growth, proved its worth in both Sri Lanka and pre-reform China. These resulted in rapid reductions in mortality rates and enhancement of living conditions without much economic growth. So even though growth has remained paramount on the agendas of many developing nations, those states have also sought to reduce the social inequalities that were particularly manifest in rural economies.

In Malawi, with funding from the World Bank, the Malawi Social Action Fund (MASAF) was established in 1995 as a key poverty alleviation instrument for the government to address community social needs. Among its goals are to improve communities' access to assets that would enable them to provide CHBC and support services among others, make cash transfers to the very poor and vulnerable households through public works, enhance community savings and investment promotion and the provision of social infrastructures such as roads and bridges, which would revitalize the rural economies and reduce destitution. It is believed that this twelve year programme will contribute to the attainment of the selected Millennium Development Goals (MDGs) (MASAF, 2006). These types of programmes have been implemented in many countries in the Sub-Saharan region. Griffin (1989) observes that although there were different configurations of the redistributive strategies, they all had one thing in common, that being the specific objective of eliminating poverty, illiteracy and disease, in order to increase the range of human choice, to give man-kind greater control over the natural environment and thereby to increase freedom. Those who advocated this idea of faster growth presupposed that all the subjects would benefit and the effects would greatly increase both the material and cultural standards of the people (Griffin, 1989:164).

It will be noted that support-led programmes have the advantage that they are labour intensive and therefore, relatively cheaper to implement than other forms of investment in developing countries and that the participatory spirit clearly leaves the constituents feeling better endowed. Obviously, as Rudd puts it, 'a prerequisite for implementing a given policy should be that its benefits outweigh its costs' (Rudd, 2003:22). However, in the absence of proper analysis of rural institutions, higher and lower organizational inter-relatedness in these strategies mean that some of the key policy targets are misplaced because they do not incorporate the fundamental factors that drive the target populations to act. Most notable in this case is the set of incentives that motivate the rural population to engage in socio-economic activity and what constitutes tangible benefits to the actors.

### **2.2.3.3 Poverty Reduction Strategy (PRSP) Frameworks**

Recent frameworks adopted by most developing nations have been straddling structural adjustment, liberalization of the markets to enhance the sectoral productivity and equity on the one hand, and poverty reduction strategies on the other. Policy debates have indeed been distorted by overemphasis on income poverty and income inequality, to the neglect of deprivations that relate to other variables such as unemployment, ill health, lack of education and social exclusion, especially because it is generally perceived that economic inequality is synonymous with an income distribution malaise.

The Poverty Reduction Strategy (PRSP) is a comprehensive framework designed to reduce poverty. The overall approach remains to promote growth and diversification of the economy, the delivery of social services, create safety nets, improve governance and integrate policies on HIV/AIDS, gender, environment, and science and technology across the main sectors (IMF, 2002:3). Comments from observers appear to indicate that HIV/AIDS concerns have not been comprehensively addressed by the PRSP framework, and what this means is that planners have not fully embraced HIV/AIDS as a development problem, as has been the case with the traditional economic problems of poverty and inequality.

HIV/AIDS has brought up a new (adverse) dimension to a series of economic problems faced by many developing countries, especially in sub-Saharan Africa. The IMF describes HIV/AIDS as the main challenge to Malawi's development efforts in the foreseeable future and they also motivate for an improvement in maintenance of a good economic database that will result in good policy decisions (IMF, 2002:9). So far, studies on HIV/AIDS in Malawi have concentrated in looking at the socio-economic impacts or demographic impacts of HIV/AIDS (Munthali, 1998:11) and in recent times have also investigated issues of financial flows in the health sector with regard to HIV/AIDS in particular. Many local and international organizations have teamed up in a concerted effort to deal with the effects of HIV and AIDS. This entails formal and informal contractual arrangements amongst the vast array of organizations in the network. The

inter and intra-relationships amongst the groups such as community and home based care, partner organizations such as NGOs and local authorities, and other central as well as donor organizations, have not been subjected to an institutional analysis. The next section highlights the approaches to the configuration of the responses to the pandemic in the southern Africa region.

#### **2.2.3.4 Conceptualizing the fight against HIV/AIDS**

This research is aimed at studying the way these organizations and institutions are related. The National AIDS Commission's Strategic Plan indicates that one of the critical processes is to strengthen partnerships between non governmental organizations (NGOs) and formal and informal community based organizations (CBOs) and that CBOs will play a significant role in implementing this strategic framework (NAC, 2003:19). In the early stages of the pandemic, according to Douglas Webb, the conceptual models of the epidemic increasingly stressed the structural aspects at the expense of the role of agency (Webb, 1997:194). He observes that this was one reason short term programmes failed. In terms of the interaction between development processes and the HIV/AIDS pandemic, the dominant conceptual model had been the adverse impact of disturbing the socio-demographics and economic growth. On account of this focus was placed on blood screening to detect the presence of the virus and find means to curtail further infections in those who were found negative. Ideally sustaining an infection free population was viewed as a way of limiting the damaging effects of the disease on the socio-economic strands of the nations.

There is evidence that government responses did not yield the results they expected. In particular the epidemic continued to devastate and the response appeared to be getting more and more overstretched. But what was responsible for this outcome?

Webb posits that an explanation of the failures of the national response at the early stages must be explored with limitations placed on the organizations to react in an adequate way and the political and economic climate that contextualize the responses in mind (Webb,

1997:71). For example in Malawi, the response was institutionalized as a department within the Ministry of Health. This presupposes that the pandemic should be dealt with as any other disease that runs on the ministry's budget. The implications of assuming that AIDS is all but a health problem have back fired significantly, because all other dimensions such as cultural factors went ignored for long periods giving rise to a deepening crisis. Second to that is that the resource implications of dealing with the pandemic were underestimated by far. At that level the need for capacity building from across sectors and international communities went unnoticed; therefore, the financial allocations to the response were too meager to make a dent in combating the effects.

With time and experience it came to be understood that HIV/AIDS is a bigger development problem than had been envisaged hitherto. More importantly, it is now understood that that the pandemic is closely related to states of poverty and food insecurity and that the people most at risk of infection are those who are socio-economically marginalized, this means that they are the same people with the least capacity to respond. It, thus, needed fashioning of an integrated response that includes international donor communities and other sectoral players to take it head on.

With the knowledge of the wider scope of the implementation arrangements needed, the United Nations General Assembly Special Session (UNGASS) made a declaration of commitment which proposes the leadership and human rights aspects to be the core of the strategies for facilitating the effective management of HIV and AIDS. That is emphasizing implementation and realization of the rights as the point of departure (IDASA, 2003:30). This is a general shift to conceptualizing the pandemic as a governance issue. In that regard, the concept introduces pluralism in the response. That is a realization of the multi-sectoralism in the approach to include NGOs, CSOs, and CBOs among various agents. The governance approach must, therefore play the role of ensuring that viable relationships upholding human rights emerge. The approach also recognizes that human beings, especially at the grassroots level, are affected by other conditions such as, droughts and increased insecurity all of which culminate in the human rights reasoning.

Now the changing terrain of the response to the pandemic raises one major concern. Managing many institutions from many sectors can be a challenge (IDASA, 2003:30). In particular governance structures require that roles are defined, an identification of who leads certain aspects of the response must be undertaken, and then there are accountability issues which have often been at the centre of inter-organizational relationships. Although the governance approach is more appropriate for this challenge because it is inclusive of all social welfare aspects of the pandemic, the needs for rationalizing the inter-relational concerns cannot be over-emphasized. It is on account of this observation that this study undertakes this institutional analysis.

To this effect, Conroy *et al* (2006:208) suggest that a governance framework for the implementation of all policies is likely to be more effective. This framework must put human rights at the center of the development policies and implementation. The merit of this is that a governance structure has better chances of ensuring the effectiveness of donor aid from outside the country. This would already be reducing the potential sticking points of inter-relations between funding agents and the recipient organizations. Along these lines of thought, they also posit that roles of CSOs and NGOs can flourish in a decentralized state. Decentralization can only be meaningful if major efforts go into building additional capacity to implement activities (Conroy, *et al.*, 2006:209). This idea brings the strategies of responding to the HIV/AIDS pandemic closer to the communities by cutting out the bureaucratic processes that delay implementation.

It also recognizes the importance of the community ideas in planning and implementation of the programmes by ensuring that programme content is not entirely decided by the aid agents. They say that the local specialists bring local knowledge, cultural understanding and a sense of ownership and commitment. This contrasts with the manner in which national capacity can be undermined when programmes and policy conditionality are imposed by donors without proper consideration of local constraints and needs (Conroy, *et al.*, 2006:213). This has been a subject of contracting between external agents and the local community level actors. Of essence in this study is that formulation of the CHBCs

has a fundamental weakness in that it did not take into account certain aspects of the communities that are likely to have effects on the performance of the actors. For example, the role of incentives, which is a central subject matter for institutional economists that study performance, was not central to the packaging of the CHBC arrangement in Malawi. Secondly there are matters of feeling and perception amongst the actors that cannot be quantified, but are vital to the actions on the CHBC grouping, that need to be understood along with other forms of limits to participation. It is on these grounds that this study seeks to understand the inter-organizational relations and other factors which spell the needs and aspirations of the community people, towards a performance enhancing process. Performance is contextualized within institutionalism, hence the institutional theories presented in the next section.

### **2.3 Institutional Theories**

Prior to the birth of Institutional Economics, economic theory had for decades relied on the concept of firms as production functions, an umbrella to the technologically determined combination of inputs. The present day concept of institutional theory was largely influenced by the paper on ‘The Nature of the Firm’ by Ronald Coase in 1937. There are now several alternative theories of organization in economics with ‘transaction cost economics’, ‘agency theory’, ‘property rights theory’, and a mix of resource-based and evolutionary perspectives as the leading approaches (Menard and Shirley, 2005:281). However, it is worth mentioning that other scholars had already laid the conceptual foundation for institutionalism prior to the Coase paper, some of the notable ones being Thorstein Veblen and John R. Commons.

In its initial stages institutionalism was held to be more scientific than orthodox economics because it was both more empirical and more in line with the latest research in other related disciplines. The scientific nature of institutionalism was more open to empirical testing than orthodox theory (Rutherford, 2001:177), it could include case studies and documentary evidence and did not need to be limited to quantitative or qualitative statistical methods. At this stage the need for economics to come closer to



reality was clearly evident. According to Rutherford ‘what was being held out was an approach to economics that claimed to be modern and scientific, that focused on the critical examination of the existing institutional structures, that was in line with the empirical methods of the exact sciences,.. and that was connected to important and pressing issues of economic and social reform’ (Rutherford, 2001:178).

While the institutional kind of thinking continued to be sidelined by mainstream economic theory, Shubik (1975) points out that the lack of institutional content in the core of neoclassical theory eventually became an issue both on a theoretical level, particularly as new concepts and analytical tools were developed, and on a more applied level of the comparison of market outcomes with regulatory alternatives (Shubik, 1975:545 in Rutherford, 2005:186). Over the years there have been many developments to the conceptualization of institutional thinking. The most prominent offshoot of these developments is the birth of what has come to be known as the New Institutional Theory (NIT), the New Institutional Approach, or the New Institutional Economics (NIE) on which most recent studies are premised. An important component of this approach is the concept of Transaction Costs which was championed by Oliver Williamson beginning with his work in 1971 and has been further developed to-date (Williamson, 1971). The beauty of the approach is that it leaves wide open the number of scopes in which the notion can be applied to empirical work. Unlike the orthodox neoclassical economics it has not developed very specific tools and modes of application and testing of outcomes. Tolbert and Zucker (1994:1) put that argument in summary as follows; “The Institutional approach is not highly institutionalized, as institutional theory has developed no central set of standard variables, nor is it associated with a standard research methodology and has relied on a variety of techniques.” One of the main reasons there appears to be divergence in how the institutional terms are coined and used is that there are many definitions for what institutions are (Tolbert and Zucker, 1994:1). So obviously, depending on the definition, the applicability of the terms will vary across the whole range of the nature of institutions thus perceived, i.e. from formal to informal and from rules and regulations to norms and heuristics that are only culturally based. Before moving into the analysis of the different perspectives of the NIE, in the section that

follows below we need to explore some of the definitions to be regularly found in the institutionalists' literature.

### **2.3.1 Defining Institutions**

North (1990:1) describes institutions as the 'rules of the game' that set limits on human behaviour. This definition emphasizes the widely accepted view of institutions as mechanisms that guide behaviour when selecting among alternative choices of action whereby the mechanisms may include rules, norms, strategies and heuristics. In most cases collective choice is likely to require explicit agreement among a group on a calculated choice and also a process of informal social acceptance for legitimacy of the choice made (Heikkila and Isett, 2004:11). According to Coleman (1990:243), social norms specify what actions are regarded by a set of persons as proper or correct, or improper and incorrect. Norms and their accompanying potential rewards for compliance, or punishments for non-compliance, are not the sole determinants of decisions by rational actors, but they affect the costs and benefits which individuals take into account when exercising choice (Keefer and Knack, 2005:702).

Other scholars such as Hodgson describe institutions as 'durable systems of established and embedded social rules and conventions that structure social interactions' (Hodgson, 2001:295). Another definition in the new institutional literature, describes institutions as taking for granted actions that are reinforced subconsciously by rewards and sanctions (Zucker, 1991: cited in Heikkila and Isett, 2004:8). The taken for granted nature of norms reflects realistic human behavior but emphasizes hidden motivations for acting, whilst acknowledging these normative and heuristic influences sheds light on decision outcomes that may not account for exogenous incentive structures imposed on the actor. New Institutional Economics (NIE) has helped scholars to understand how institutions shape choices by organizations that do not conform to efficiency maximizing outcomes and for explaining the role of institutions among organizations with indeterminate technologies (i.e. organizations within which their products have unknown transformation and

production functions such as the Community and Home Based Care and Support Services (CHBC)).

North's definition allows room for the economic agents to reason about their situations and learn by doing over time, which means that the norms should be able to change with relative ease as situations change (adaptive capacity), whereas in the Hodgson's definition there appears to be more rigidity facing institutional change. In other words once formed the rules and norms will create some sort of structure that will remain stable and economic decisions would have to be fashioned from within these for some time. This view is also widely held and perhaps the disparities between the two perspectives will persist because 'change' also remains an ambiguous point of reference.

But there is general consensus that institutions are defined as helping to form stable expectations; hence institutions can only be changed infrequently if they are to fulfill this function. Institutions operate at a deeper level. Institutions are in effect constitutional; they establish the framework of rules within which more routine decisions take place (Wiggins and Davis, 2006:2)

### **2.3.2 The New Institutional Economics Theory (NIE)**

The New Institutional Economics is a branch of economics that consists of the transaction costs analysis of property rights, contracts and organizations. It was identified as an attempt to extend the range of neoclassical theory by explaining the institutional factors traditionally taken as givens, such as property rights and governance structures, and unlike the old institutionalism, it is not an attempt to replace the standard theory (Rutherford, 2001:187). Principal-Agent theory, Transaction Costs and Public Choice theory all describe issues of contracts in service delivery: i.e. relationships that exist within firms or organizations and between organizations. Where it is duly accepted that societal participation in service delivery is vital, and that the society enters into some contractual agreement with higher level organizations, the NIE attempts to analyze the contractual arrangements and therefore, the impacts this has on the participation and

welfare of the households involved (Williamson, 1985:16). By recognizing the role of organizational arrangements and relational contracting as a strong complement to the widely accepted role played by production arrangements in neoclassical economics, NIE brings to the fore the critical role of the ‘governance paradigm’ in discussing development concerns in recent times.

### **2.3.2.1 Justification for the application of the NIE**

Use of the New Institutional Economics (NIE) is justified in this study. Firstly, the study is about multi-tiered contractual relationships among institutions and organizations. These institutions and organizations are not organized in the standard mode of the mainstream economic models of the market and, therefore, need a different approach that does not focus on production costs. Rudolf Richter in his paper on the meaning of the New Institutional Economics, while commenting on the work of Cheung (1992), singles out the fact that this branch of economics enables us to explain why observed institutional arrangements are as they are as critical. On the empirical front, on the other hand, practitioners are more interested in the constraints of the real world (Richter, 2003:7). One reality of the real world which in which many developing countries, such as Malawi, is the overwhelming HIV/AIDS pandemic giving rise to a consequent multiple inter-relations of institutions and organizations, which is the subject of this research.

Secondly, the NIE is an approach that enables use of both standard economic tools and the normative standards of measurement, such as the application of norms or rules of the game. The NIE extends economic theory by incorporating ideas and ideologies (mental modes) into the analysis, modeling the political process as a critical factor in the performance of economies (Richter, 2003:8). For example, the NIE uses agency theory, to understand the institutional arrangements between an organization such as National AIDS Commission (NAC) and a community group. Similarly, the relationship between an NGO and a given CBO can be analyzed in an agency chain. NIE attempts to analyze the contractual arrangements and therefore, the impacts this relationship has on the participation and welfare of the households involved. According to Oliver Williamson

(1985), governance structures are evaluated by comparing patterns of costs generated for planning, adapting and monitoring production and exchange. It is these costs that are central to the application of NIE. The questions underlying the analysis are; ‘do parties to the exchange operate harmoniously, or are there frequent misunderstandings and conflicts that lead to delays, breakdowns and other malfunctions?’ (Williamson, 1985:2).

The next section will shed light on the concept of transaction costs economics as it applies to the application of the New Institutional Economics. The NIE not only considers institutional arrangements but also deals with the institutional environment as the environment also impacts on the performance of the individual institution by the provision of opportunities and constraints that have a direct bearing on the decision-making process. This is also critical for the arrangements and operations of the CHBC. Tolbert and Zucker (1994:27) point out the usefulness of applying the New Institutional Theory to analyses where the material benefits associated with a given structure are not readily calculable. So as we try to assess how social institutions, such as CHBC, work towards their goals the NIE provides a more appropriate framework than efficiency oriented approaches would.

### **2.3.2.2 The Concept of Transaction Costs**

The remarkable properties of neoclassical markets, where prices serve as sufficient indicators, are widely conceded but opinions differ in assessing transactions that are organized within quasi-market and non-market modes of organization. What this new line of research does is to move away from the concept of the firm as production function and replace it with the concept of firm as governance structure (Williamson, 1985:16). Governance has to do with cooperation, organization modes and coordination. Transaction costs economics seeks to analyze behaviour of agents with diverse goals in terms of how they efficiently complement each other (Menard, 2005:284). Transaction cost economics is part of the New Institutional Economics research tradition which largely applies to relational contracting in economic institutions, in particular the changing character of economic organization over time is of interest.

‘Transaction costs economics attempts to understand economic organization, taking economic transactions as the unit of analysis. Economic transactions are characterized by a number of dimensions or attributes such as the specificity of the investments required to conduct the transaction, the frequency with which similar transactions occur and the duration or period of time over which they are repeated, the complexity of the transaction and uncertainty about what performance will be required, and the difficulty in measuring performance, among other attributes’ (Spiller *et al*, 2003:15). Transactions with different characteristics call for different ways of organizing, and this micro analytical approach endogenizes and explains the governance structures (distribution of ownership, contracts, etc) chosen to support the different transactions. For this reason evaluation of characteristics found within one institutional setting need not be generalized to other groups involved with similar activities even if the exogenous factors contributing to the institutional environment might appear to be the same.

By definition, transaction costs are the costs of running the economic system (Williamson, 1985:18). Williamson likens the transaction costs to friction in the mechanical systems by asking whether the gears mesh, and whether the parts are lubricated. In economic terms this translates to harmonious operations between contracting parties and would like to recognize and analyze any misunderstandings or conflicts that might delay processes. North’s literature on new institutionalism (1990:45-47) shows that institutions have three frictional dimensions, namely ‘informal constraints’ which come from socially transmitted information and are part of the culture, ‘formal constraints’ which are formal rules which do interface with the informal rules and thirdly, ‘enforcement’ of the contracts where costs arise. He notes that the inability of societies to develop effective, low cost enforcement of contracts is the source of economic stagnation. Transaction costs arise from costliness of acquiring the information needed for measurement and enforcement of the exchange (North, 1990:27).

### **2.3.2.3 Properties of Transaction Costs Economics**

Theories of economic organization are mainly built on two behavioural assumptions. First is the assumption of bounded rationality of human beings as economic agents. That is to say that transaction economics recognizes that behaviour of a decision maker is intendedly rational but only to a limited extent, largely because of information asymmetries on the one hand and that humans are naturally imperfect in processing information on the other. Second, is the self-interest seeking behaviour, commonly known as opportunism (Williamson, 1985:30).

According to Williamson, application of transaction costs economics acknowledges that rationality is bounded and maintains that an economizing orientation is elicited by the intended rationality part of the definition, while the study of institutions is encouraged by conceding that cognitive competence is limited. While economizing on bounded rationality takes two forms, i.e. one concerns the decision process and the other involves governance structures, transaction costs economics mainly focuses on the economizing outcomes arising from assigning transactions to governance structures in a discriminating way (Williamson, 1985:46). That is to ask why transactions are assigned in one way and not another? Transaction costs economics also takes strong interest in appeals to self-seeking behaviour because this behaviour rests on incentives brought about by the institutional arrangements and will obviously influence the conduct of the economic agents. For example, in the Community and Home Based Care and Support system, members of the society join and exit the groups on account of the existing incentives or lack of them, which is precisely what the approach must unveil.

Another property of transaction cost economics in posing the problem of economic organization is that it would like to recognize both costs of *ex ante* and *ex post* contracting. Williamson refers to costs of drafting; negotiating and safeguarding an agreement where safeguarding will naturally take effect after the agreement has been effected. Transaction costs economics maintains that it is impossible to concentrate all of the relevant bargaining action at the *ex ante* contracting stage, instead bargaining is

pervasive, on which account institutions of private ordering and the study of contracting in its entirety take on a critical economic significance. The behavioural attributes of human agents described as the condition of bounded rationality and opportunism are brought together and get reflected upon within the same framework. Richter (2003:3) notes that the notion of opportunism is influenced by economic organization, and it is the joining of this attribute with factors of bounded rationality that give rise to exchange difficulties. It, therefore, makes sense to analyze these attributes of institutions together.

Essentially what this means is that when actors, such as the members of CHBCs, engage in their routine service delivery they will be able to learn new ideas or meet some impediments that might not have been foreseen at the beginning and might require reorganizing methods of achieving their objectives. On the other hand they might just discover other opportunities which arise as a result of interaction within institutions. These might not be reflected in the agreement with the partner organizations. Such deviations from the standard agreement need to be incorporated in the agreements for more than one reason, for example, to reduce the costs of operating, to keep the agents motivated and make them remain in the service delivery and indeed to make sure that the goals of the principal organization, (and therefore overall economic goals) remain on track, among other reasons. What this attribute emphasizes is that contracts should be continually negotiated and in case of differences court orders should not be the way forward, but rather the partnering institutions should have mechanisms for negotiating lasting solutions to enable them to adapt to any change and this process also has a cost.

In his article on “Economic Performance Through Time,” Douglass North (1994:359-360) emphasizes the importance of change through time that individuals, groups, and societies have to go through and refers to this change as a consequence of learning by doing. This change transforms institutions and the institutional transformation clearly relates to economic development. The same idea is postulated in his new institutionalism. He writes ‘the incentives embedded in the institutional framework direct the process of learning by doing and the development of tacit knowledge that will lead individuals in decision making processes to evolve systems gradually that are different from the ones



they had begun with. Adaptive efficiency, therefore, provides the incentives to encourage the development of decentralized decision making processes that will allow societies to maximize the efforts required to explore alternative ways of solving problems. We must also learn from failures so that change will consist of the generation of organizational trials and the elimination of organizational errors' (North, 1990 in Picciotto: 3)

The need for evaluation arises because in both closed contractual arrangements as illuminated by agency theory and the relational linkages of open contracts, which is the domain of transaction cost economics, parties seek results and compliance with agreed standards or expected behavioural norms. But because information available to the two parties to the contract differs, i.e. due to information asymmetry, there is always a need for evaluation which would relate results observed from the behaviour of the two agents. Evaluation should be seen as a means to effect appropriate change, or recasting of contractual ideas from which both parties would gain.

Williamson (1985) summarizes the properties that make transaction cost economics a handy approach as follows; 'Transaction cost economics is; more micro analytic, more self conscious about its behavioural assumptions, introduces and develops the economic importance of asset specificity, relies more on comparative institutional analysis, regards the business firm as a governance structure rather than a production function and places greater weight on the ex post institutions of contract, with special emphasis on private ordering as compared with court ordering.' (Williamson, 1985:18)

#### **2.4 Approaches to New Institutional Economic Analysis**

The NIE analytical approach has well developed frameworks that are flexible for the application of a wide range of theoretical concepts suitable for such social situations. Most of the frameworks recognize that structures of importance in any given situation where individuals make resource allocations and other decisions are located at various levels or domains. As such institutions are amenable to multi-level analysis as exemplified by Williamson's (2000) framework. All frameworks seem to agree that

analysis will more often conveniently be undertaken by separating components of the problems which can eventually be reconfigured. Proceeding with this perspective and considering that this study is focused on unpacking the way of life for CHBC groups in terms of their goals, beliefs, power relations and cultural traditions that shape their processes, choice of an evaluative analytical approach for their performance is deemed suitable. This study also opts to do a detailed analysis at one level, using other levels only as sources of influence exerted on this chosen action arena. In this regard the Institutional and Development Framework developed by Ostrom *et al* (1994) is considered most suitable for the configural analysis of the CHBCs, especially for how it handles the relationships amongst rules, attributes of the world and cultural phenomenon that are relevant in this study.

#### **2.4.1 The Institutional Analysis and Development Framework (IAD)**

The IAD Framework developed by Ostrom *et al* (1994) is applied to capture the transaction costs of information, coordination, structural arrangements, informal rules and norms, and the formal governance contractual relations in a social analysis of the CHBCs. The IAD is a multi-tier conceptual map that allows an integration of various theories of action across domains to be applied together and is particularly important for doing comparisons and evaluations (Ostrom, *et al* 1994 in Koontz, 2003:2). Since this study is concerned with evaluating the performance of institutions faced with exogenous and endogenous factors such as rules, materials and internal conditions, the IAD is deemed to be a more suitable framework for analyzing the CHBC activities for the various reasons outlined below.

Firstly, because it enables the researcher to use the exogenous and endogenous factors mentioned above as variables impacting the chosen action situation of interest and, therefore, making it possible to identify a case for any outcome of the action. According to Sobeck (2003:363) the IAD framework emphasizes the structure of the *situations* in which individuals find themselves and how they work to overcome their problems collectively. The framework requires that an action arena be identified to understand the

individual behaviour in the institutional context and since this study focuses on the CHBC institutions as a unit of analysis, it then follows that action situations at that level will be the focal point. Unlike the actor centered approach, this method recognizes that a situation extends beyond the actors, which means factors or roles played by external agents affecting the said actors should easily be incorporated in the analysis. The specifics of the action situations of the CHBCs in this case include their interpretive behavioral responses in view of their capacities and the available information, rules in use, materials and conditions they are faced with, from within as well as externally in their social situation.

Secondly, the approach recognizes that group behaviour is amenable to pursuit of self-interested goals by the members who seek certain incentives and thus, the group structures must have mechanisms to monitor such behaviour. Owing to the fact that CHBCs exist in communities that are in a situation of extreme poverty, and are faced with potential access to funding from various sources for their activities, itself a potential source of self interest and conflict, so that an examination of the incentive structures and costs of participating calls for a situational analysis to reflect on how the participants weigh their benefits and costs of participation.

Lastly, Sobek (2003:368) notes that the IAD framework can be used to illuminate why a group of individuals came together to work on a project whose benefits are not limited to only those participating. Considering that CHBCs are a construct of social activities for a wider community, benefits of their initiatives will obviously accrue to non-members, especially benefits accruing from avoiding collective risks of a deepening AIDS crisis in the community. So while this notion does unveil insights into the creation of the groups, it also creates an opportunity to reflect on the free-rider problem in a situation where it is clear that collective action is important. Against this background the entry and exit of the members in the CHBC groups is reflected upon. While this section highlights the models and selected variables associated with the application of the IAD framework, a detailed IAD framework is discussed in chapter four which presents the methodology.

Three models that link clusters of variables are analysed as follows according to the feed-forward relations indicated by the arrows in Figure 2.1 as follows;

### **Figure 2.1: Specific Models Applied in the IAD Framework**

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Model 1: (**Materials** e.g. food items, time, clothing etc) → (**ACTION**) → (**Outcomes**)

Model 2: (**Attributes** e.g. social networks, infrastructure etc.) → (**ACTION**) → (**Outcomes**)

Model 3: (External and internal **rules/norms** in use) → (**ACTION**) → (**Outcomes**)

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Adapted: (Ostrom, 2006)

For specific purposes of addressing the objectives of this study, the above models are used in the framework to isolate variables that fall into three categories. According to Ostrom (2005:829), to use this framework to analyze a social problem one should first identify a conceptual unit called an *action arena*, where an action arena includes an action situation and actors. An action situation has characteristics that make grouping of variables in the following; participants, positions, outcomes, action-outcome linkages, control that participants exercise, information and costs and benefits assigned to outcomes (Ostrom, 2005:828). For this reason, the action situation and actors form the central part of the framework as shown in figure 2.1 above.

First is an outline of variables that are classified as *Physical or material conditions* as reflected in the first column of figure one that are brought into the action arena for purposes of supporting or affecting care and support for HIV/AIDS cases. The study analyses how initiatives and decisions pertaining to various assets, endowments, and other resources are generated or are passed around with the intent of enabling care and support. Care and support is thus the outcome of the decisions and activities and this is only reflected in the transaction cost terms as already defined.

Second, the framework shows how *attributes of the community*, which is the state of the environment in which the community live, such as the distances from markets and from hospitals, transport and communication facilities and general state of deprivation, impact on the action arena.

And lastly, the framework allows the researcher to analyze the role of *rules* that emerge from the everyday exchanges within groups and those imposed from higher level organizations such as the NGOs and government to which these institutions are answerable. Attributes and rules of each CHBC group put together with the characteristics of the actors yield a unique pattern of interacting methods, and thus, a unique pattern of outcomes is expected for each set of the causal combination.

#### **2.4.2 Insights for Analysis from New Institutional Economics (NIE)**

The first important insight arising from NIE is the relationship between the institutional environment, institutional arrangements, and people's activities. NIE provides the framework for examining the importance and effects of policies, institutions, and processes that make up the formal and informal institutional environment, from international and national institutions to those operating within communities and households. This gives insights into the pressures for, constraints on and possible effects of institutional change (on resource access, utilization and productivity; on opportunities for and constraints on trade based activities; and on livelihood outcomes for different people).

More specifically NIE provides a framework for:

- Examining the institutional interactions between assets, activities and outcomes
- Analyzing the effects of power and processes of (and incentives for) institutional and livelihood change and
- Understanding the reasons for and effects of different institutional arrangements

NIE emphasizes that institutions (the institutional environment and arrangements) are a very important part of social capital. While the institutional environment is an asset that tends to be emphasized at larger scales of analysis (community, national, or international for example) access to particular institutional arrangement is an important part of an individual's social capital, together with a culture of trust between transacting or

cooperating parties. Along these lines Welzel *et al* (2005:124) observe that individuals invest in social contacts so that they can gain access to socially embedded resources. Bourdieu (1986) cited in Welzel *et al* (2005) in this regard defines social capital as the connections individuals use to pursue their personal goals. The convergence of these notions suggests that institutional arrangements such as the Community and Home Based Care (CHBCs) enable people participating to individually and collectively benefit from access to assets other than their own due to the connections they have.

Secondly, NIE emphasizes and gives insights into the importance that is anchored in access to assets. Access to and benefits from assets through institutional interconnectedness have an inherent characteristic of offering incentives for their development. These are consequent upon institutional development, which is in turn dependent on the institutional environment, information flows, asset characteristics, and the vulnerability and power of different actors. Therefore, where NIE attempts to evaluate the physical and economic characteristics of assets in use, it must be done with due reference to the institutional arrangements which constrain or promote their use. The importance of this aspect to this study is that in the delivery of CHBC service, members of the communities and other partners involved engage in the creation, development and promotion of the use of a wide range of assets. The range of assets should, therefore, be analyzed using the NIE framework in order to understand how decisions pertaining to these assets are made, the incentives and constraints at play, and how the overall institutional arrangements or environment impacts on these assets and their use because this is what essentially translates into care and support for HIV/AIDS sufferers, especially as the households and communities under study operate in conditions of severe poverty.

A third insight concerns the importance of information as a source. This has implications for the valuation of human and physical capital. Effective information flow and use are pre-requisites for the development of the institutional environment. Productive and equitable arrangements are not only an important part of social capital as a livelihood base, but also as a livelihood outcome in themselves, enhancing dignity and freedom in

what Sen refers to as the ‘removal of unfreedoms’ for an effective participation in economic and political activities (Sen, 1999:39). Where an analysis of existing institutions determines that they are not functioning as well as they might, for example because the flow of information between partners is not smooth and this emerges as a bottleneck in how they shape their behavior, it is then appropriate to look for institutional innovations that will reduce transaction costs. In this study information flow between the home based care groups and the partner organizations is very important. If the flow is good (i.e. consistent and timely) then it must be seen to be reinforcing the service delivery by providing support to the human resource capacities in their decision making processes. The information flow is obviously a function of institutional arrangements apart from other factors, and this is what the NIE analysis in this study will focus on.

### **2.4.3 Potential Analytical Factors**

The New Institutional Economics rests on a firm conceptual and theoretical basis, thus allowing for rigorous analysis of the efficiency of resource use. NIE shares with neo-classical economics the assumptions of rational, maximizing, self-interested economic agents. However, it relaxes some of the more restrictive assumptions of neo-classical perfect competition to reflect more common, real world situations (Williamson, 1985:17).

Williamson (1985:13) concedes that it can be difficult to determine the most appropriate approach for analyzing institutions since there are a wide variety of transaction activities that are amenable to analysis by NIE. A useful starting point in the analysis of existing institutions is to consider the *characteristics of the assets* that are affected by the institutions in question. For example, in delivering the CHBC services what assets are being used, or changed? In other words, what assets are influencing the running of the care delivery and what assets are being influenced by the existence of the care and support arrangement?

The analysis is concerned with the ‘*transactions*’ by the group and also with the make up of the group itself and its interaction with the characteristics of the range of assets they

are managing. Transactions are the economizing habits exhibited by the routinized fashion of decision making regarding the creation and use of assets they have access to. This borders on property rights and literature reveals that exercising of such rights will reflect the objectives of the legitimate owners of the assets. Williamson points out that 'ownership matters,' i.e. the right to use the asset, the right to appropriate returns of the asset and the right to change the form or substance of an asset (utilization) will track the purposes of its owners (Williamson, 1985:27). Therefore, it follows that we can evaluate these decisions to get an insight into the attainment of the social goals and aspirations of a particular group or community.

The notion of property rights and the exercising of such rights also suggests that the make up of the group matters. This idea recognizes the fact that a group will have various characteristics that identify it. For instance we must be interested to know how the group started, i.e. by whom, when and why, the composition of the group (membership mix and size) and their beliefs among other things. These ideas will help to track the purposes either of the group members or that external agents might have had in the making of the group, and will also track its overarching influence in the decision arena. The idea also provides good grounds for investigating the influence external (formal) rules have on the structures against those socially couched (endogenous) by the membership. Richter's (2003:6) commentary highlights the importance of collective outcomes resulting from collective action in a situation where members are individually motivated. Obviously members will join the groups willfully as individuals, so we need to know what keeps them in the CHBC or lets them exit. Is it due to internal misunderstandings or pressure from other organizations? Institutions do not simply evolve to increase efficiency, but also to increase their own well being, and above all they must first be created and reasons behind the entire process must be explained. The importance of these attributes is also a subject of emphasis by Williamson in what is described as *ex ante* incentive alignments, that is to say that institutions emerge because of the various incentives which they proffer on the individuals' involvement with them (Williamson, 1985:29).



#### **2.4.4 Examples of Empirical Application of NIE**

This brief section aims to show selected cases where NIE has been applied empirically in order to explain behavioural patterns using tools of analysis adapted from pure economic theory combined with theories and analytical tools from other disciplines of the social sciences. This is the combination which other approaches are not able to achieve.

Using the theoretical framework of the New Institutional Economics (NIE) and working within its typical 'rational choice framework' Manchanda (2003) applied NIE to analyze the incentive system (formal and informal rules) in the provision of social infrastructure (education and health) in three different states in India. Manchanda applies the institutional framework (as above) to explain performance of different institutional arrangements in two parts. First is the explanation of performance through the lenses of transaction costs and agency chains. Second was the application of the framework of institutional incentives to the individuals that directly affect performance (field management and implementation levels). The process identifies better and weaker institutional arrangements, thus, the method is helpful to explain institutional failure. He found empirical support for the insights of institutional theorists who argue that inefficient institutional arrangements can get locked in. By so doing the study was able to identify factors that explain why some institutional arrangements perform better than others (Manchanda, 2003:2). In other words his paper demonstrates clearly the importance of institutional arrangements as they affect the social outcomes. Two important analytical perspectives seem to emerge in this case that can be applied to the CHBC in this study. First is the importance of institutional arrangements. HIV/AIDS is already well known to have brought together a multi-tiered form of institutional contractual relations, and these institutions are subjected to different types of environments owing to policy, for example decentralization, financing needs and capacities and the provision of other resources. New Institutional Economics principles will come in handy to explain how well suited these arrangements and conditions are for the attainment of the HIV/AIDS and CHBC goals in particular.

Second is the importance of studying the incentive structures in the existing institutional arrangements towards the creation and persistence of the institutions. Literature suggests that individuals will continue to engage with others in structures created by the rules, norms and culture, for instance in CHBC service delivery, if there are incentives that improve their welfare. Such incentives have been the subject matter of the principal-agent theory of economics and also form an important part of the contractual relations branch of institutional economics where bargaining is considered. NIE will be used in this study to explicate details of incentives in the formation, reinforcement and indeed efforts to change institutions amongst the economic agents involved, as these attributes are important for reaching goals for CHBC and overall economic development.

In a study based on a survey undertaken in India on rural household incomes and interaction with the local institutional environment, Ghandi (2003) examined the role of local institutions on households' resources and development. He found that decisions that households make on how to allocate resources and generate income often depend not only on the household's resources but also on the local institutional environment. In other words, membership in local institutions plays a significant role in explaining variations in incomes and growth of assets and therefore the overall contribution to development goals. The relevance of these findings to this study is that households are institutions by themselves and work hand in hand with the institutions of CHBC by making decisions regarding membership of these groups (for example who out of the household should be a member of CHBC and why), making use of household assets for CHBC, and providing human resources for service delivery, among others. To do all these things the households and communities must face an attractive array of incentives and must also be cognizant of the constraints involved. Thus this study would like to understand the influence by and on households and the entire community reflected in CHBC service delivery.

The question of collective action has been studied widely, for example Ostrom *et al* (1993) effectively used NIE to analyze the problem of collective action in a particular case of rural infrastructure. Leonard (2000) applied the analysis to a case of the provision

of health and veterinary services in Africa while Heikkila and Isett (2004) applied it to a case of mental health care provision in Arizona in USA. The case studies show that NIE analysis provides advanced tools for analyzing socio-economic issues at macro and micro levels. For example, Heikkila and Isett, following their analysis argue that an institutional model of decision making that accounts for exogenous factors that influence costs and benefits of different strategies and endogenous institutional factors that limit or enhance the ability of individuals or groups to make certain choices, provides a more accurate picture of the real world (Heikkila and Isett, 2004:10). The study looked at the failures of the fee policy regime changing to a new Community Partnership of Southern Arizona (CPSA) arrangement. This was not just a change from a centralized to a decentralized policy environment; it also involved a network of actors in a partnership which earmarked reducing the 'transaction costs' of service delivery. Using the Institutional Analysis and Development (IAD) framework, two observations from the analysis are particularly significant for this study. First is that understanding 'operational-level dynamics' is crucial to explaining collective outcomes, that is to say a synchronization of incentives and norms was a strong driving factor towards effecting necessary operational changes and thus, cooperation in the network. Secondly, while actors made sure to cooperate they also sought to maximize their individual benefits by lobbying for further funding for themselves (a case of self-interest) and thus showing that while incentives existed the culture of trust was not adequate amongst the partners. Since, for example CHBC and, in particular, the issue of norms and cultural contracting is a crucial socio economic asset at a micro level, application of NIE is deemed relevant and justified for understanding the embeddedness of these rules and norms, and how they change with changing situations. Perhaps one key criticism that the literature brings to the fore is that while NIE is mostly useful in explaining change, it does not have the capability to predict such change. The goal of this analysis, however, is not to forecast change; rather it is to identify the existing institutional arrangements and explain their performance for purposes of policy formulation.

Examples of key relevant relational arrangements in the Community and Home Based Care environment to be analyzed include those between these groups and partner Non

Governmental Organizations, such as Medicines San Frontier (MSF) which is an international NGO. A second example is given by the relationship between CHBC groups and the National Association of People Living with HIV and AIDS in Malawi (NAPHAM), a local NGO that is represented in Thyolo District, among others. The application of NIE will draw upon tools of agency theory to study how the partnerships in CHBC work (feedback and feed forward) and explain the accountability issues making the core of the governance relationships. Resource dependency theory will extend the analysis to show how the CHBC depend on financial contributions from NAC and other external partners, and how this impacts on their decision making processes. An understanding of the impact of exogenous factors (such as rules and constitutional laws) from higher level organizations and endogenous factors (incentives and sanctions) offered by the internal arrangements is critical for the maintenance or alteration of the institutions.

#### **2.4.5 Thematic Approaches to Institutional Analysis**

Four main analytical branches of institutional analysis are found in the literature. These areas can be used separately to classify institutional issues or they can be used collectively to guide the analysis. However, two of these approaches are more popularly used in empirical testing of the New Institutional Theory. These classifications will be discussed next and a justification of using the selected approaches is given below;

##### **2.4.5.1 The Normative Approach**

This approach to institutional analysis was mainly advocated by March and Olsen (1984, 1989 and 1996). They argue that the best way to understand political behaviour (individual and collective) is through the logic of '*appropriateness*' that individuals acquire by virtue of their membership in institutions. In other words, an individual's behaviour will be shaped by what is deemed appropriate by the group he belongs to, so by joining the group an individual is almost expressing his preference to identify with the goals and standards of that group. They also argue that preferences are endogenous. They

contrast this with the logic of ‘consequentiality’ that is central to rational choice theories. That is, people functioning within institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities. Furthermore, these standards of behavior are acquired through involvement with one or more institutions and the institutions are the major repositories of values (Peters, 2000:2).

The notion of appropriateness corresponds well with North’s (1990) idea that institutions shape people despite the fact that people create these institutions (North, 1990:3-4). The approach emphasizes the importance of rules and norms which are not necessarily formal in nature but depend on mutual understanding, trust and reciprocity. Other scholars, such as Coleman (1987) and Ostrom (1999) have also shown that social relationships can constitute resources which individuals can appropriate to assist them in increasing their well being. So, in summary, the social context which is the core of the normative approach matters. The normative approach tends to focus on the individual institution and the way in which it develops its internal, common ‘logic of appropriateness’. This version is mostly concerned with change and it does have a very clear concern with institutional development (Peters, 2000:7). Perhaps institutional development, in this regard, is expected to translate into better welfare among its constituents, thereby impacting on overall economic development of a particular society and of the entire economy.

#### **2.4.5.2 The Rational Choice Approach**

The Rational Choice version of institutionalism emphasizes institutional arrangements of rules and incentives. Members of the institutions behave in response to those basic components of institutional structure. Unlike individuals in normative institutionalism the preferences of the occupants of these structures do not get modified by membership of the institutions. Rather, the individuals who interact with the institutions have their own well ordered sets of preferences that remain largely unchanged by any institutional involvement they may have (Peters, 2000:3). The critical assumption under this theoretical position is that individuals have access to incentives provided by the structures but they retain their individual cognitive capacities to make their own decisions

independent of their involvement with the structures. So, even if the rational choice approach depends primarily on individual utility functions and rational calculations based on those utilities, the presence of on-going institutions enables the external researcher to predict behaviours and to test hypotheses that might not be possible without the presence of the structures. On the one hand the rational choice approach sees change as quite easy; all you have to do is change the incentives (e.g. the pay-off matrix of the game) and behaviour will change almost immediately.

#### **2.4.5.3 The Historical Institutional Approach**

The argument of this approach is that the policy and structural choices made at the inception of the institution will have a persistent influence over its behaviour for the remainder of its existence (Steinmo, Thelen and Longstreth, 1992). The idea of '*path dependency*' is the central explanatory principle for the historical institutionalists, although they are also interested in ideas that help to shape and to sustain the directions of policy (Hall, 1986; King, 1996). The approach is more suited to explaining the persistence of policies and much less so in explaining change in policies or structures according to Peters (2000:4). The historical institutionalists assume that change is difficult at best, and likewise that change is difficult to plan and design. In their view change comes about primarily through 'punctuations' in the equilibrium that characterizes institutions, hence institutional design, given the uncontrollability of change, is a virtual impossibility.

#### **2.4.5.4 The Empirical Institutionalism**

This approach is used to describe literature that asks the question of whether institutions make any difference in policy choices. The definition of institutions utilized in this literature is rather a common sense one, emphasizing the formal structures of government. Perhaps this is its weakness as it shifts away from the fundamental definition of the new institutionalism which is built around norms and cultural beliefs as stated by North (1990), even though the formal linkages must also be analyzed because

they do influence the informal institutions. In some ways the empirical version shares similarities with the rational choice approach. Institutions are conceptualized as exogenous to the values of the individuals functioning within them. This statement means that it is assumed that individual values will not be altered by involvement with the institution. Behaviour will change in response to the assortment of opportunities and constraints presented by the structure, but the values that condition that behaviour are assumed to be unaffected by the institution. (Peters, 2000:4)

What this means is that there are various ways of approaching institutional analysis but as Peters (2000:4) points out while there are important differences there are also some features to unify the approach to institutionalism, by way of expanding the normative approach by bringing in a more explicit theoretical core. The important point binding all these various approaches is that structures, however defined, do matter.

Peters (2000) also points out that the second factor that tends to unify institutional analysis is that structures persist while individuals come and go. Thus, even though individuals are argued to be the primary animators in the rational choice version of institutionalism, the institutions in question appear to enjoy some existence outside of or beyond those individuals. The normative approach also recognizes that structures persist and that they attempt to replicate themselves by socializing new members into the values that define the institution. The important point to be understood is ‘what motivates behaviour over time as well as understanding the more immediate pressures for action and change’ (Peters, 2000:4-5).

#### **2.4.5.5 Measuring the Extent of Institutionalization**

Institutions can also be assessed in terms of the degree of institutionalization using the following four criteria advanced by Peters (2000:8).

- 1) *Autonomy* represents a concern with the capacity of institutions to make and implement their own decisions. Arguably, the extent to which they are not dependent upon another organization or institution, determines whether they can be said to be

institutionalized. This concept might be operationalized in terms of budgets and autonomous sources of revenue. Clearly this is a pertinent question to ask about Community and Home Based Care and Support institutions given the conditions in which they operate in rural economies.

2) *Adaptability* taps the extent to which an institution is capable of adapting to changes in the environment, or more importantly, capable of molding that environment. As with open systems approaches to social life, the institution should be able to continue to import needed resources despite changes in the relevant environment. In respect of the CHBC adaptability should reflect on how the methods of delivering the care and support have been changing as the socio-economic conditions of the communities have also been changing. Of particular interest are the deterioration of economic conditions faced by the households due to poverty and deprivation on the one hand, and the changing demands of the HIV/AIDS situation on these households due to implementation of policy actions and the pressure exerted by the coming in of multiple aid organizations.

3) *Complexity* demonstrates the capacity of the institution to construct internal structures to fulfill its goals and cope with the environment. Again this conception is analogous to thinking in systems theory and structural-functionalism that discussed the importance of structural differentiation. Due to the complex demands placed by HIV/AIDS and other socio-economic problems on the households, it will be important to find out how the groups are able to plan, schedule and assign the CHBC activities and follow them without disruptions from competing tasks or from external agents' demands.

4) *Coherence* represents the capacity of the institution to manage its own workload and to develop procedures to process tasks in a timely and reasonable manner. This also represents a capacity of the institution to make decisions about its core tasks and beliefs and to filter out diversions from those. In CHBC this needs to be weighed against the idea of waiting for initiatives that originate from the higher level NGO or government agents, and ties in with the analysis of the incentive matrix.

Not all institutions will be fully formed and institutionalized. In fact some of them might actually deinstitutionalize and become less autonomous or less coherent. Their attributes



may predict something of their own behaviour as well as the influence they pose on their environment and on policy (Peters, 2000:8). The effects of an institutional environment will also be manifested through these attributes, for example, if a group largely depends on external help to make decisions and retains its shape on account of the external assistance, the analysis is supposed to shed light on what is not going right in this kind of institutional arrangement. Institutions are expected to enjoy a high level of autonomy despite the fact that they benefit from resource and technical contributions of their external partner institutions. Institutions are also supposed to be flexible enough, that is, to be able to change their working methods as conditions change. Analysis of the concept of adaptability reflects on the groups' ability to learning new and more efficient methods that make them more effective under the new circumstances. Finally, the groups should be in a position to handle the complex tasks and resource demands on their hands due to the complex nature of the HIV/AIDS pandemic. The complexity arises from the socio-economic demands as well as from the complex matrix of partnerships. This requires that the groups which are usually at the bottom end of the hierarchy need to re-examine their own coherence regularly so that their agenda does not get replaced by that of the influential external agents.

## **2.5 Summary and Conclusions**

The literature survey set out to analyze the theoretical thinking behind development paradigms that have been adopted by developing economies. The broad aim was to show that development concerns have been changing over time and different schools of thought have contributed immensely by crafting theoretical ideas that support a wide range of strategies being applied to address the socio-economic ills of developing countries. From a perspective of poverty and deprivation in its latest form, the core socio-economic development problem has been compounded by the burden of disease, in particular, the HIV/AIDS pandemic which has resulted in the creation of new institutions and a new institutional environment in affected economies. A multi-tiered organizational arrangement is now working in a decentralized policy environment to combat the HIV/AIDS pandemic. From a theoretical standpoint, it makes sense to move away from

the core business of neoclassical economic models to analyze the performance of the institutions emerging to deal with the crisis. This favours a governance approach, especially as transactions are not only organized in the markets, but in various other modes of arrangements such as hybrids and hierarchy chains. On account of this the literature has discussed the advantages of the New Institutional Approach in enabling the analysis of transaction costs and incentive structures to be at the center of relational contracting, which moves beyond the costs portrayed by the neoclassical economics in the standard mode of the market.

Essentially the literature survey has tried to evaluate the importance of economic organization in dealing with the modern economic problems and motivates for the application of the New Institutional Economics to analyze the contractual relations amongst the many organizations and institutions that are engaged in development, in particular the institutions involved in Community and Home Based Care (CHBC) and support. Within the NIE a number of analytical building blocks will be applied to cater for a wide range of issues (e.g. transaction costs of incentives and constraints) that explain contracts, rules, norms, strategies and the impact of the concept of culture on the performance of institutions. These will include, but not be limited to, a combination of the rational choice, the normative, historical and empirical approaches. The study will draw upon the strengths of each approach in explaining elements of institutionalism in Community and Home Based Care service delivery in Malawi. Specifically the study has adopted the application of the Institutional Analysis and Development framework for the advantages it offers, firstly for enabling the choice of an action arena of interest to be studied at one level and secondly, for making it possible to break the units of study into smaller components such as is outlined in figure 2.1.

## Chapter Three

### **Institutional Linkages and Stakeholder Analysis of the HIV/AIDS Sub-Sector**

#### **3.1 Introduction**

This chapter applies the tools of situation and stakeholder analysis in the New Institutionalism to elucidate the institutional, financial and structural linkages of stakeholders in Community and Home Based Care and Support for HIV/AIDS sufferers in Malawi. This is done within the broad spectrum of the wider government decentralization policy as it applies to health, in terms of the health Sector Wide Approach (SWAP) and the HIV/AIDS policy framework, funding mechanisms, key implementation arrangements that highlight roles of key partner organizations in the national response to the HIV/AIDS epidemic in Malawi, and analysis of outcomes of the institutional arrangements.

This chapter lends itself to the application of the New Institutionalism paradigm which emphasizes good governance or appropriateness of institutions in economic development. Much attention is being given to improving governance in developing countries with the objective of improving the productivity of international assistance and the country's economic performance. No behavioural theory underlying the relationship between governance and economic growth has yet been formalized but there is a great deal of literature on the costs of poor governance; so much so that improving institutions and enforcement of appropriate institutions appears to be the best way forward for improving governance and economic performance (Duncan, 2003:1). In that context this chapter, therefore, recognizes the fact that governance processes can be affected by many background factors such as the level of poverty, the flow of aid resources, and availability or lack of complimentary labour resources amongst the Community and Home Based Care (CHBC) service delivery groups, and indeed in the way organizations relate in the entire stakeholder matrix.

The national response to HIV/AIDS involves multiple layers of role players. Hence advancement in transparency and efficiency of information flow is critical for the success of the response and to development as a whole. In the HIV/AIDS response, the multiple organizations involved are both diverse in nature and by geographical dispersion, allowing for wide variations in operational standards and, thus, their economic performance. Such organizations may have very different socio-economic background conditions and, more importantly, widely varied access to information. Information asymmetry is a critical component of the inter-organization and intra-organization decision making processes and the ultimate outcomes. Thus, while focusing on institutional economics of governance, this study recognizes that effective channels of communication in the national response to the HIV/AIDS epidemic are of paramount importance.

The rest of this chapter covers an ‘overview of the situation’, that is, briefly highlighting the developments in the HIV/AIDS epidemic and relevant indicators for Malawi. This is followed by a discussion of the policy environment from global, national and health sector perspectives, to highlight the inter-relatedness of organizations, especially with respect to channels of funding and the organizing of implementation strategies. The chapter then analyzes the systemic outcomes of the policy and structural linkages as they apply to stakeholder categories of government, non-governmental organizations and community based organizations, including the CHBC which is the focus of this study.

### **3.2 An overview of the situation**

According to the General Comment 14 (cited in Jones, 2004:389) of the International Covenant on Economic, Social and Cultural Rights (CESCR), health is a fundamental human right indispensable for the exercise of other human rights. Globally, the health and epidemiological transitions continue their advance and so do the demands on health systems in countries at all levels of development (Berman and Bossert, 2000:12). Health care systems in developing countries, such as Malawi, suffer from serious deficiencies in financing, efficiency, equity, and quality. These are often compounded by lapses in

policy and implementation strategies making countries ill-prepared to meet their health and overall development challenges (Berman and Bossert, 2000:12). A review of the Malawi Poverty Reduction Strategy (PRS) commenting on the overarching policy framework observes that government policies have not yet made a significant impact on poverty. High prevalence of HIV/AIDS and weak institutional capacity are some of the key reasons for the deepening situation of poverty and deprivation (IMF, 2002:3). The foregoing highlights the complicated situation of global development involvement. Due to the HIV/AIDS epidemic development concerns and the consequent goals of many countries have taken on a new dimension and the state of deprivation has acquired new meaning. HIV/AIDS is known to undercut productivity as well as stocks of wealth, and thus clearly exacerbates poverty in developing countries. The devastating burden of HIV/AIDS not only reinforces global geographical inequality, but also reverberates across all development initiatives (Jones, 2004:386). The complex causes of and manifestations associated with the HIV/AIDS epidemic seemingly invite commensurate comprehensive and multi-layered policy responses (Jones, 2004:390).

Many international and local organizations have come together to deal with the epidemic in unified strategies. More recently, the Paris Declaration of 2005 provides the background to the need for a concerted effort for enhancing aid effectiveness. This entails linking funding efforts from donors to the national development strategy of the partner country in a single framework of conditions and/or a manageable set of indicators that seeks to achieve lasting results (OECD, 2005:1). At the same time, there have been notable shifts in roles from central government to semi-autonomous public sector agents, such as the National AIDS Commission, and an increasing involvement of non-governmental organizations within the developing countries such as Malawi. This comes about against the background of realization of the inappropriateness of the existing health care delivery system along with widespread criticisms aimed at institutions and processes for their increased inappropriateness in performing tasks expected of them. Specifically, government failures have been used many times, even before the advent of the HIV/AIDS pandemic, to justify a series of reforms aimed at reducing costs in the provision of public health services and cutting down the size of bureaucratic processes,

particularly evident in public sector organizations, and enhancing the role of NGOs who are reputed to be more adept in reaching out to the communities.

Clearly, the existence of the new development concerns and the obvious inadequacies of the public sector have led to new approaches, attitudes, and implementation of some radical solutions in an attempt to stop the downward spiraling of the development process (Berman and Bossert, 2000:1) In particular, the health sectors of many developing countries have seen governments relinquishing what used to be their strong-holds in service delivery and encouraging its devolution to more decentralized systems that are inclusive of the once peripheral non-public organizations. These aforementioned dynamics in the system, the need to reaffirm, and the overall need to improve the policy framework, to address the attendant weaknesses in the system, are obvious. Thus, it is on these grounds that this situational analysis of the HIV/AIDS pandemic and its institutional arrangements in Malawi is premised. Thus, partnership commitments and effectiveness of relational linkages in finance and communication, and their outcomes are the center piece of this analysis.

### **3.3 Relevant indicators specific to Malawi**

Malawi's economic indicators remain too poor to promise a reversal of the health and demographic downturn. For instance, annual per capita income is currently estimated to be \$160 (WB, 2007:11). The average annual economic growth rate between 2000 and 2005 was only 1.5 percent (WB, 2007:11). The United Nations Development Project (UNDP) poverty index for 2005 ranks Malawi among the 12 poorest countries in the world and the Integrated Household Survey (IHS) of 2005 revealed that about 52 percent of Malawians live below the poverty line (GOM, 2005:139). Severe food shortages are an ongoing phenomenon. The IHS also reported that 22 percent of the population do not meet their nutritional requirements (GOM, 2005:139) while 12 percent of people in the age bracket (15-49) years are living with HIV and AIDS (GOM, 2007:6). About 70 percent of the beds taken in hospitals are occupied by people with HIV/AIDS related infections according to the National AIDS Commission (NAC) and less than 2000 people

who live with AIDS had actually registered with the People living with HIV and AIDS (PLHA) association. The 118 Voluntary Testing and Counseling Centers (VCT) records show that less than 5 percent of the population expected to be infected has actually voluntarily used the VCT centers, and only half of these centers operate according to the stipulated standards (NAC, 2004: 16-30).

Until mid 2004, the ARV drugs for people living with HIV and AIDS were being obtained at an equivalent of US\$23 per month. Since majority of Malawians could not even afford to access food, considering that 22% were reported to be below the ultra-poverty line during this period, the numbers on Anti-Retroviral Therapy (ART) remained as low as 5 558 in 2004. Malawi Government's recognition of this constraint on many potential beneficiaries of the ART led to a change of policy, by introducing free ARVs and this resulted in a dramatic rise in the number of beneficiaries to about 80 000 by end of 2005 (NAC, 2004:17). The progress in administering ART was partly hampered by lack of appropriate personnel in the health clinics for dissemination of the medication across the country. Nevertheless, government made strides in enabling 54 new health facilities to administer ART including central hospitals, district and mission hospitals, private clinics and the Malawi Defense Force and the Police Service. It also assisted in training 336 doctors, clinical officers and nurses to provide ART. ARV guidelines were also made available (NAC, 2004:17). The socio-economic problem of orphans is also a well known phenomenon in Malawi. Currently it is estimated that 1 055 889 orphans exist of whom 527 381 are attributed to the AIDS epidemic<sup>1</sup>. Delivery of care for orphans and vulnerable children is mostly done within their own communities by the CHBC and similar support groups.

Life expectancy at birth has decreased from 44 to almost 38 years; the maternal mortality rate is very high while education levels continue to decline (GOM, 2005:1). Access to health services remains modest with only 54 percent of the rural population having access to formal health services within a radius of 5 km (DFID, 2006:1). The National Health Accounts (NHA, 2001) revealed that above 20 percent of total health costs were out-of-

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<sup>1</sup> Figures were interpolated from NAC estimates of 2001 and the projected orphan population of 2010

pocket household expenditures and these relate to households already classified as very poor. Therefore, in this way the need for improved delivery of health services is well articulated. This picture also shows that households and communities have already become key partners in development efforts, including financing health services and delivery of community and home based care and support. However, it is also well known that Community Based Organizations (CBOs) are poorly funded, and are beset by numerous other challenges as they pursue their health and other livelihood goals and they are dependent on other key partners to enhance the community's capacities. For instance, the government undertook to supply the CHBCs with home based care and support kits to serve people living with AIDS but it has not been able to develop a proper system of coordinating supplies and replenishing mechanisms for the CHBC care kits issued. Thus, in its present form the CHBC's arrangement is not well suited to meet the challenges of service delivery and support to people living with HIV/AIDS (PLHAs) (NAC, 2004:18). The NAC developed a curriculum for CHBC groups to be trained and training has been offered to most of the groups across the country, *albeit*, with a lot of inconsistency. This will be highlighted in chapter six. There are specific sectoral policies to guide the critical intervention areas such as the behaviour change initiative (BCI), voluntary counseling and testing (VCT), PLHAs, Orphans and vulnerable children (OVC), Antiretroviral (ARVs) and CHBCs among others. All these interventions fall under The National HIV/AIDS Framework 2005-2009.

Malawi being a poor country has to rely heavily on international development assistance to deal with most of the development problems notable in the health sector. Policy and implementing strategies of the International Development Agencies (IDAs) are, thus, crucial to the success of the implementation of the Malawi Poverty Reduction Strategy and reaching the MDGs. This is premised on the fact that developing countries have very limited resources available to invest in public sector and NGO institutions.

The need to rationalize resource allocation is obvious. Therefore, institutions that are publicly supported should have a clear programme focus and mandate and each set of institutions should capitalize on their comparative advantages while reducing overlaps



and inter-organizational conflicts (Swanson and Samy, 2002:6). It is for this reason that institutions in developing countries are under increasing pressure to deal with a range of policy issues, including accountability, relevance, responsiveness and cost effectiveness. International and bilateral organizations involved also have an agenda to foster modernization of these local institutions but only seek to do so with fewer resources (Swanson and Samy, 2002:6).

The subsequent sections, therefore, endeavor to shed light on the role played by the IDAs in organizing the Malawi Health Sector in a complimentary role to the national policies and, in particular, the role of financing SWAP in health and the HIV/AIDS epidemic. Discussion will also focus on the decentralized governance setting recently adopted by the Malawi Government in an attempt to harness the response to the HIV/AIDS epidemic with particular emphasis on Community and Home Based Care and Support among other development concerns needed to make an immediate impact on the rural communities.

### **3.4 Global Policy and the role of the IDAs in Health**

The global response to HIV/AIDS has been uneven. Some of the reasons responsible for this situation include, the huge costs required for prevention programmes as well as the cost of treatment and care for HIV/AIDS cases (Jones, 2004:390). Malawi, like many other Sub-Saharan African countries where HIV/AIDS has taken a toll, has struggled to cope with the needs for human and financial costs of dealing with HIV/AIDS in the last few years (Bellows and Dowswell, 2002:4). Support from the International Development Agencies (IDAs) has been critical in dealing with not only the HIV/AIDS epidemic but also ensuring availability of the bulk of all health sector needs such as making drugs and equipment available in health facilities. In a complementary mode the bulk of government's contribution goes towards maintaining human resources, coordination and ensuring a favorable policy environment while the IDAs seek to plug the financial gaps.

IDAs have had a long history of supporting development in Sub-Saharan countries and their roles have been changing due to the altering terrain of development problems. In its

current form, assistance is guided by the development agenda embodied in the MDGs of the United Nations and the Poverty Reduction Strategies of the developing world countries, such as Malawi. The MDGs represent a new consensus that embodies a new notion that poverty reduction is multidimensional and that progress depends on simultaneous actions across sectors (Bradford, 2004:2). Of the eight MDGs three are health goals; reducing mortality in the under five age group, reducing maternal mortality, and reversing the spread of communicable diseases, specifically HIV/AIDS, malaria, TB and others. Bradford (2004) notes that for the first time, the dominant development paradigm recognizes a comprehensive set of interconnected imperatives as critical to progress, abandoning the notion that a selective set of financial keys are exclusively crucial to sustainable development. This is a global agenda because it seeks to integrate synergies from international approaches with local responses by strengthening the latter.

There are two most notable ways in which international organizations have fostered development in the health sector of Malawi. First, and most important, is by financing the health development initiatives through country programmes or projects. Secondly, by providing technical expertise that builds capacity in technically lacking areas of development need. A crucial example of this aspect is the development of the SWAP in the Malawi health sector, a process which was initiated by the Canadian International Development Agency (CIDA) in early 2000 and was further developed in the form of a Joint Programme of Work in 2003 by a wider group of IDAs, government and other public sector agents. The Programme of Work (POW) is key in guiding the projection and operationalization of financial flows in the health sector. Nevertheless, this does not give a complete picture of what is happening in the sector because evidence of parallel methods of funding project-based activities and other uncoordinated health development efforts outside the SWAP have been documented a number of times (Birdsall and Kelly, 2007:35). The implementation of the Joint Programme of Work is anchored by the component of Essential Health Package (EHP) to be discussed in Section 3.6 of this chapter which highlights sectoral policies and implementation strategies. The SWAP entails untied general sector-wide assistance going into the government budgeting

process either to be part of the normal government funding in treasury or some sector specific budgets (Birdsall and Kelly, 2007:36).

Apart from the endemic problems faced by governments in developing nations in organizing service delivery, the increasing number of the international organizations involved with assistance and the ever increasing size of assistance has translated into some institutional and governance concerns. For instance, it has been documented that the IDAs are faced with a series of interlocking constraints that limit the effectiveness of development cooperation. Some of these constraints are a proliferation of uncoordinated project efforts, lack of country ownership, cost and time overruns and a disappointing record of sustainability, all of which work against the development performance they are designed to enhance (Baser and Morgan, 2001:14). In pursuit of more effective reforms, the SWAPs were designed to harmonize policy and operational procedures that change focus from IDAs to country ownership of development initiatives. Specific to HIV/AIDS, the response strategies in Malawi are being developed within the rhetoric of the ‘Three Ones’ which is an understanding reached by officials from African nations, multilateral and bilateral agencies, NGOs and the private sectors to have one agreed framework for coordinating action among partners, one coordinating authority and one agreed country level monitoring and evaluation system (Birdsall and Kelly, 2007:34). Malawi’s National Framework was developed to run from 2005 to 2009 on the basis of the end-of-term review for the previous National Strategic Framework and national level consultations. Along with the international efforts to harmonize the coordination of country level efforts in the fight against HIV/AIDS, The Malawi HIV/AIDS National Action Framework has eight priorities; prevention and behavior change, treatment, care and support, mitigating socio-economic and psychosocial impacts, mainstreaming partnerships and capacity building, research and development, monitoring and evaluation, resource mobilization, tracking and utilization; and national policy coordination and programming (GOM, 2005: 16). Working within and being guided by one framework is an easy way for all partners to move towards optimizing resource allocations and make the inter-organization linkages more effective (UNAIDS, 2004: 1).

The second “One” was an agreement to make sure that there is only one coordinating body for all efforts and multiple partners. Thus, the National AIDS Commission has been given the authority and legal mandate to oversee the processes from resources mobilization, implementation roles of various partners and the ultimate evaluation processes for programmes. In this regard, there also had to be a single unifying monitoring and evaluation framework for all partner efforts in the fight against HIV/AIDS giving rise to the third “One”. According to the UNAIDS an improvement in this area would lead to gains in use of quality M&E data for policy adaptation, this would also ensure that M&E functions are linked to the National Framework and serve to ease the process of national oversight (UNAIDS, 2004: 4). One can easily see from this scenario that once these steps are taken at country level, it becomes much easier to make understand and make comparisons at international level for various indicators of inputs and outputs relating to the fight against HIV/AIDS.

The reorganization the HIV/AIDS sector took place within the wider efforts of harmonizing the health sector for similar reasons because the NAC falls within the SWAPs. As a process the development of SWAPs in Malawi met with hitches as the initial understanding by the IDAs of the SWAP arrangement was not nearly the same as that of government, especially in the areas of fund disbursement and requirements for accountability (Bellows and Dowswell, 2002:11). That misunderstanding was a clear manifestation that the government and NAC had not been fully involved at the crucial birthing stage of the Malawi SWAP initiative. This was reminiscent of many past development initiatives implemented in developing countries, whereby the implementation ideas are hatched during exchanges that involve the IDAs with research institutes and universities in developed countries, only to transfer the technologies and initiate local involvement of the developing world at the implementation stage. This has often contributed to the IDAs questioning capacities of the latter and it creates a situation whereby local partners act from a subordinate position throughout the implementation stages. The local partners often end up not fully owning the development process. The NAC’s report of too much IDA intervention in the implementation of its activities over the period 2002 to 2004 was clearly a result of misunderstandings based on such grounds

(NAC, 2004). This must certainly be seen as a weakness in what should be a process of developing a single institution to spearhead health service delivery. A sound institution is built on a culture of trust, confidence and common goals that embody collective ownership.

Clearly, the arrangement is now seen to be effective in helping to mobilize resources and guide implementation procedures (reduction of transaction costs) among the partner organizations with special reference to programme design, planning of activities, procurement procedures, reporting and financial controls among other related core objectives (Baser and Morgan, 2001:19). On another level, IDAs' procedures have been substantially harmonized to an extent that there is now a highly coordinated funding mechanism in place, *albeit* with its own constraints. The next section considers the funding arrangements as guided by the SWAP and the Memorandum of Understanding (MoU) between the IDAs and the Malawi Government.

### **3.5 The funding mechanisms by the IDAs**

The largest part of international and local public sector funding for health is determined through the Joint Programme of Work (POW) within the Sector Wide Approaches. The POW is a six year outline of a shared and preferred future for the health sector that is specified in the form of strategic options for bringing about the desired health goals. It also highlights priority health activities to be implemented by the MOH, Development Partners and Non-Governmental Organizations and their prioritized resource implications (ADF, 2005:13).

However, there are still considerable amounts of resources from the IDAs that are channeled outside this programme into the health care system. The SWAP Joint Programme of Work 2004-2010, the National AIDS Commission End of Term Review of the National HIV/AIDS Strategic Framework (NSF 2000-2004) and the GOM National Health Accounts of 2006 confirm this and affirm the fact that incomplete integration of resource mobilization poses significant challenges for planning and implementation of

the national response (MOH, 2004; NAC, 2004, GOM, 2006). The core component of the SWAP is the EHP which endeavors to prioritize the critical basic health services to be administered in the closest proximity of the communities. The essence of this EHP is to recognize the scarcity of resources in the sector and that government cannot do everything. Thus, the package seeks to promote efficient allocation of the resources by tackling only key components while reducing management and other transaction costs (GOM, 2005:3). As prioritization takes place, it should be clear that there are significant resource gaps in the health sector that remain unattended either from within or efforts outside these structures.

The Joint Programme of Work under the SWAP entails pooling of resources by the international agencies, Malawi Government and non-government organizations. An estimation process and prioritization of the requisite resource envelope to implement the POW shows the available funding from donors and the government over the programme period 2004 through 2010. The total funding for the POW for the period is estimated at US\$735 million as reflected in Table 3.1. Caution, however, must be heeded as most figures for later years, shown in Table 3.1 below, are only indicative estimates since not all partners are able to predict their own resource envelopes for longer than a year according to the Malawi Government (GOM, 2005:5). The summary of the anticipated resource flows and their distribution by source are presented in Table 3.1 below.

**Table 3.1: Financing Flow of the Joint Programme of Work (US\$ mn)**

Source	Period						Total
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	
<b>GOM</b>	33.4	35.9	36.3	35.7	35.7	35.5	212.5
<b>IDAs</b>	56.9	79.9	80.7	91.8	101.5	112.4	523.2
<b>TOTAL</b>	<b>90.3</b>	<b>115.8</b>	<b>117.0</b>	<b>127.5</b>	<b>137.2</b>	<b>147.9</b>	<b>735.7</b>

Source: GOM (2005)

Table 3.1 above is an attempt to show the resources that are either channeled to or are committed by the Government of Malawi and the international partners for the

implementation of the POW of the SWAPs. There is a steady increase in the level of funding for the POW, and this is clearly due to the flows from the development partners whereas the government contribution is expected to remain steady in absolute terms. In relative terms the government contribution is noted to be declining from about 36% in 2004 to about 26% in 2008. One of the critical requirements for implementation of this programme is that it must be owned by the national government which entails that government contribution is a prerequisite in order to attract external resources into the SWAPs. So while government remains committed to this requirement, it is clear that the budgetary constraints do not allow for a steady increase that will match the adjustment in externally sources finances, and this is in no way to suggest a declining level of commitment to addressing health problems in Malawi.

The POW aims to increase the per capita (government and donor inclusive) health spending from US\$7.70 in 2004/05 to an annual per capita spending of US\$12.60 by 2009/10. On the other hand, the Commission on Macroeconomics and Health estimated a minimum requirement of per capita health expenditure of US\$34. Thus, the POW is also largely under-funded (GOM, 2005:17). The Government of Malawi Survey of donor partner expenditures in the health sector revealed that there are no less than 17 international sources of funding, with the African Development Fund (ADF), Department for International Development (DFID), Norwegian Embassy and Swedish Government, UNICEF and USAID being the prominent contributors. This, however, does not include the Global Fund which is the major source of funding for HIV/AIDS, especially for the delivery of ART at the moment. By and large the system has witnessed a steady increase in assistance to the sector. However, most of the assistance is routed through parallel approaches and this makes planning and monitoring difficult. The Government contributes an average of 29 percent of the total POW funding, which is an average of about US\$35 million per year through the annual budget.

Government signed a memorandum of understanding with the IDAs to ensure their continued contribution. Government's commitment is now assured by including 70 percent of the Health Budget in what is classified as Pro-Poor Expenditure (PPE) which

means that the government undertakes to protect that expenditure in the event that budgets have to be cut (GOM, 2005:5).

With regard to HIV/AIDS, during the dissemination of the NSF Review in 2005, the National AIDS Commission reported a satisfactory resource mobilization and continued goodwill from the international community which had already committed about US\$275 million to the NAC. Of this amount, 71.39 percent was from the Global Fund, 26 percent from the pooled resources which included the World Bank, NORAD, DFID and the Government's contribution, while the remainder came from UNDP, ADB and CDC (NAC, 2004:35). The significance of the Global Fund increased from 25.8 percent of the total POW finances in 2004/05 year to about 30 percent in 2005/06 and is expected to rise further to 31 percent by 2007.

**Table 3.2: Sources of HIV/AIDS Funds (US\$<sup>2</sup>)**

Source	Period					
	2002-03	%	2003-04	%	2004-05	%
Donors	10,755,533	46%	43,714,530	75%	46,230,713	73%
MOF	9,414,530	40%	10,516,901	18%	12,560,116	20%
LGRD	-	-	112,698	0.2%	68,605	0.1%
Firms	1,600,233	7%	1,471,037	2.5%	1,505,571	2.4%
Households	1,595,907	7%	1,908,860	3.3%	2,868,560	4.5%
Other Private	-	-	41,904	0.1%	-	-
Total HIV/AIDS	23,366,204	100%	57,765,929	100%	63,233,564	100%

Source: GOM (2006)

On the other hand, to give a more comprehensive picture of resource flows into HIV/AIDS alleviation in Malawi is given by the National Health Accounts (NHA) for Malawi for the period of 2005 to 2006. Table 3.2 gives a partial picture of the sources of funds and amounts expended on HIV/AIDS during the study period of 2002 through 2005.

<sup>2</sup> Figures were converted from Malawi Kwacha equivalents at average annual exchange rates of US\$1=MK108.57, US\$1=MK109 and US\$119.04 for the three consecutive fiscal periods given in the table



It can be seen that overall the resources available for the national response have been growing from 2002 to 2005. Changes in shares of contribution by source of funding reflect the policy shifts in the health care system. Donors' contribution which includes all international partners, that is multilateral, bilateral and international NGOs made a significant jump from 2002 to the latter years. The drastic changes can be explained in two ways, firstly as a consequence of the mobilization efforts for more resources needed as the entire system was being revamped, and thus more funds were realized as reflected in the increase from 46 percent to above 70 percent.

Secondly, the system changes entailed recasting of mandates including shifting some of the responsibilities of the central government to a semi-autonomous NAC, hence the drop in the percentage of the financial contribution by the Ministry of Finance. The NAC largely runs on externally sourced funding and not government funding for recurrent costs as was the case with the former National AIDS Control Programme (NACP). At the same time a number of funding harmonization processes including the construction of the SWAP, creation of capacity for coordination and fund disbursement to beneficiary organizations, and drawing up the frameworks within which NAC and partners would operate, among other strategic concerns, were undertaken. Multiple types of benefits have been realized from these changes. First, the NACP arrangement entailed both a coordination and implementation government unit. By its nature, a government unit is severely constrained on financial and human resources to carry out the sort of mandate that HIV/AIDS and its demands place on the entire economy. As a government department not only lacks the technical expertise in various facets of the fight against HIV/AIDS, but it also precludes the involvement of potential partners from playing a critical supporting role.

Clearly, there are efficiency gains in the NAC coordination role from both a resource mobilization as well as accountability perspective. The NAC reports to have successfully coordinated the preparation of sectoral action plans; for example the bio-medical roll out, Orphans and Vulnerable Children (OVC), the strengthening of financial, procurement

and monitoring systems, formation of networks that work on specific themes, such as the OVC and PLHAs, and the formation of coalitions for advocacy such as the faith-based and business sector coalitions (NAC, 2004:10).

Secondly, the semi-autonomous status of NAC has clearly reduced transaction costs by streamlining programme procedures while there is an increase in number of partners and sources of funds involved. For example, under conventional funding arrangements various sources of funds would entail multiple accounting requirements, various progress reports, and assorted procurement or grant-making systems. Under the NAC harmonized funding arrangements were adopted so that a single accounting documentation, progress reporting, 2 grant-making, and 4 procurement systems are followed and above all there is increased transparency in the coordination system while the implementation responsibilities are left to various partner organizations better placed to carry out such roles. The diversity of the implementing partner organizations means that many sectors of the economy are duly touched by the SWAP arrangement.

**Table 3.3: Financing Agents for HIV/AIDS Funds (US\$<sup>3</sup>)**

Agent	Period					
	2002/03	%	2003/04	%	2004/05	%
MOH	9,382,356	40	9,426,415	16	11,100,911	18
NAC	2,614,542	11	14,227,923	25	35,991,296	57
Other Public	183,243	1	753,952	1	554,452	1
Households	1,560,015	7	1,858,400	3	2,806,575	4
Firms/Insurance	1,636,126	7	1,521,498	3	1,567,556	2
Donors	5,674,594	24	26,867,238	47	7,480,722	12
NGOs	2,315,329	10	3,110,503	5	3,732,052	6
<b>TOTAL</b>	<b>23,366,204</b>	<b>100</b>	<b>57,765,929</b>	<b>100</b>	<b>63,233,564</b>	<b>100</b>

Source: GOM (2006)

Further benefit of this recasting of policy and implementation procedures is clearly manifest in Table 3.3. The table shows resources that were previously routed through central government and/or were being disbursed directly by donors that now go through

<sup>3</sup> Figures were converted from Malawi Kwacha equivalents at average annual exchange rates of US\$1=MK108.57, US\$1=MK109 and US\$119.04 for the three consecutive fiscal periods given in the table

NAC as the spending agent. Financing agents are organizations that receive and disburse funds to end-users on behalf of the source of the funds.

Table 3.3 also gives a reflection of institutional changes effected from the overall SWAP arrangement, including the strengthening the role of the NAC as a financing agent for HIV/AIDS funding and thus, underscoring the importance of the presence of an appropriate institutional environment. Not only did the harmonization lead to mobilization of more resources as seen in this section above, but it also shows the amount of confidence this arrangement bred among partners leading to improvements in financing mechanisms.

The crucial coordination role accorded to NAC, taking over responsibilities that were previously in the hands of the IDAs and the Ministry of Health, reveals the fact that a semi-autonomous body is likely to operate more efficiently and more transparently than the NACP which preceded it in the form of a government department. Clearly the shift of the percentage share of funding through the Ministry of Health drops from 40 percent in 2002 to about 18 percent in 2005 and the proportion of funding that went through the donor community also dropped from 24 percent in 2002 to 12 percent in 2005 because of the new role of the NAC. At the same time it can be seen that funding routed through the NAC goes up to 57 percent in 2005 from 11 percent in 2002. This arrangement also created new capacity which enabled drawing upon resources that would otherwise not have been accessed within the usual government system.

The need for an appropriate environment, more efficient financing mechanisms and a well integrated approach is well known amongst all partner institutions. However, cases of discrete funding with community project orientation remain commonplace in the sector. The presence of discretely funded projects reveals two positive pictures that should be of benefit to the entire national response. First, is the growing realization by stakeholders of the need for more resources to be injected into the system, especially to reach grassroots institutions, than is presently the case. Secondly, and more refreshing is that there is a lot more absorption capacity at lower levels that is currently blocked by

bureaucratic and capacity bottlenecks at higher institutional levels, particularly so within the public sector, and clearly evident through the IDAs limited placement of funding of the basket for HIV/AIDS in the harmonized arrangement. To this effect, there is evidence that resources are not reaching the intended targets as desired. Latest concerns of this are raised in the NHA (GOM, 2006:56) indicating that resource gaps are still wide at the grassroots organizations level. It can therefore, be concluded that there is room for further rationalization of procedures in order to reach and assist the communities more effectively.

The picture, however, is darkened by the widespread notions of failure to use aid effectively in Africa and this has bred some degree of resistance by financing agents in releasing more resources. The gloomy picture of developing economies is worsened by the widespread belief that more donor resources will not add to growth (McPherson, 2003:2). Scholars and practitioners often point to a lot of money that western governments and international institutions have poured into developing nations' programmes in the past without tangible results. We can, however, draw some strength from the emerging picture, particularly from the presence of unexploited capacity in the rural communities as we seek more integration of the governance structures surrounding HIV/AIDS and other health issues and the fact that aid has, hitherto, been passed down to recipient organizations sporadically without such systematic programming and harmonization as is taking place now, a factor likely to enhance aid effectiveness, thus a reason to stimulate increased funding.

Essentially, what is alluded to is that the major concerns about capacity largely lie at higher public sector institutional levels rather than those at the community level, because localized institutions remain the target of both the integrated system and the discrete projects, implying that there are unexploited gaps. Besides, it is clear that there is capacity for the communities to absorb a lot more funding than hitherto acknowledged. The communities are clearly in a state of deprivation and are struggling to cope with the effects of HIV/AIDS and poverty, so the case for more funding should be an obvious one. Often it is the mechanisms for getting the resources to the communities that are mired

with bottlenecks, and effectively, only limited amounts of financial assistance reach the targeted populations. A case in point is the requirements for proposal writing placed by the NAC for the communities to obtain funding for their activities, the bureaucratic delays and frustrations to those who have the technical expertise to draw up proposals, while others are completely cut off from benefits. Secondly, while the rest of government procedures are being decentralized, NAC structures, procedures and funding channels at district level are sporadically implemented. As such the much needed completion of harmonization at the district level which would bring resources closer to the communities remains rhetorical.

Streamlining procedures at NAC, ministry and donor levels, therefore, should be the issue needing attention and by themselves they will go a long way to sort out the capacity issues at all levels. These must include harmonization of district level procedures, more simplified and broader standards for communities to access funds are needed. These must focus beyond the formal channels of the government systems and NGOs as is the case now, thus expanding representation of grassroots organizations at higher levels should enhance the absorption capacities of the communities. Clearly, benefits from reduced transaction costs would accrue to the communities if further integration among all approaches was achieved in the first place, and higher level organizations would also benefit by smoothening out procedural matters as they all work from a common structure.

We can learn from the success stories of other community health delivery services such as the distribution of anti-malaria bed nets, which was based on a roving support system conducted by teams that made regular visits to the communities to fill in gaps left by permanent staff known to be averse to poor working conditions in rural areas. The advantage of such a system is that it will arrest the problem of lack of community nursing and health surveillance assistants faced at any point in time due to avoidance of poor working conditions in rural areas.

Another advantage is that there is a strong will of international donor assistance to support the cause, so the country needs to work fast to invest in building community

economic, human and social capacities on the basis of the available external assistance with the view that the need for external assistance should gradually be scaled down over the years. This calls for proper organization of the relevant institutions, especially those that look to promote communities. While this process remains slow or non-existent the potential community beneficiaries continue to reel beneath the heavy weight of the epidemic as they struggle to engage in CHBC and support for those infected and affected by HIV/AIDS. Simultaneously, further damage is being done to the communities' integrity. The NIE emphasizes the fact that "a viable national economic system needs robust, flexible and open institutions and multi-level governance systems that allow for learning and increase adaptive capacity without foreclosing future development options" (Aligica, 2005:164). Thus, learning fast and creating these adaptive capacities is imperative.

### **3.6 National Organizational Arrangements**

The Malawi Poverty Reduction Strategy is an overarching development policy framework operating in the country. This Macroeconomic Framework seeks to provide a balanced design to public policy that will create conditions for economic growth, improve social sector outcomes and protect the vulnerable sections of the population. It also seeks to improve institutional governance (IMF, 2002:1). The sector goals and strategies are linked to this national policy. All efforts seeking to improve the alignment of the governance structures, behaviour and performance of organizations in the HIV/AIDS response must remain cognizant of this higher level policy. The Poverty Reduction Strategy is guiding the economy-wide resource allocation and institutional organization among other development issues. In return, effective institutional organization must have attributes that help to build a sound policy environment. The Poverty Reduction Strategy recognizes the deep rooted poverty amongst Malawians and its attendant consequences on the health status of the population, especially with respect to HIV/AIDS prevalence. The policy works on the principle of allocating scarce resources, most of which are externally sourced, to priority sectors such as health and the treatment of HIV/AIDS epidemic.

At the sectoral level, health development is guided by the SWAP. A Sector-wide Approach is a method of working between and amongst government, IDAs and some NGOs in which significant funding for a sector is provided to support that sector's policy and expenditure programme under government leadership, using common approaches across the sectors (Baser and Morgan, 2001:19). The Malawi Health Sector Policy is reflected in the Programme of Work and the core implementation component of this is the Essential Health Package (EHP) which is offered to all Malawians. The EHP refers to a prioritized but limited package of services that should be available to every individual in Malawi at all times and reflects eleven key interventions that address major causes of death and diseases in the country and the supporting structures of the health system (GOM, 2004:1). The mandate of the EHP is to bring basic priority health services closest to the community while also providing a systematic referral system for patients from the front-line facilities to higher levels. This is clearly in keeping with the national policy and the priority setting over resources into areas of extreme deprivation. It is also consistent with the general principle of targeting health outcomes, primarily a healthy population, to get economic development right.

The current policy guiding the national response to HIV/AIDS was drawn up in 2003. Prior to that, the policy response was largely based on National Strategic Frameworks. 'National HIV/AIDS Policy; a call to renewed action' has two main goals. First, is to prevent further spread of HIV infections and secondly, to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation. Its key objectives seek to foster provision and delivery of prevention, treatment, care and support services for AIDS cases, to reduce individual and societal vulnerability to HIV/AIDS, and to strengthen the multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programmes (GOM, 2003:4). A broadening of the horizon of actors is duly acknowledged as a key component of the response. This is in line with the government stand on decentralization of its delivery of public services, but at the same time the policy recognizes that the background institutional issues affecting HIV/AIDS are multidimensional. Therefore,

these require a concerted effort from various players. Owing to this multiple nature of discrete issues that are associated with addressing the HIV/AIDS epidemic, some specific sectoral policies have been duly put in place to guide the widely varied organizations involved. Examples of the guiding principles are found in the Behaviour Change Policy, the policy for promoting PLHAs, impact mitigation, treatment, care and support, Voluntary Testing and Counseling, Prevention of Mother to Child Transmission (PMTCT) and the policy for protecting Orphans and Vulnerable Children (OVC), among others. This wide array of specific policy notions shows that there is ample recognition that the concerns are more than just a mere health problem.

At the national level central government provides the policy guidelines, prioritized implementation strategies and the entire organizational arrangements, including the NAC, which fit within the overall government goals of poverty reduction. On the other hand the IDAs mainly contribute to the SWAP by mobilizing resources from external sources and providing technical expertise in selected areas of management and leadership such as programme planning and governance. The focal point of the IDAs is at the national level, engaging with government and the NAC for policy and implementation progress. To a lesser extent the IDAs also interact with NGOs and civil society organizations, some of which they support outside the SWAP framework.

At a lower level, the NAC coordinates the sector specific policy and implementation strategy. The NAC is the government's implementation arm and, therefore, it is responsible to the Secretary for Health at the higher level. It is responsible for coordinating all implementing (Public and non-public) partners across the country. Public facilities are health clinics and hospitals, district assemblies and District AIDS Coordinating Units. Non-public partners include NGOs, umbrella organizations that work as satellites for the NAC in districts (mainly including international NGOs) and towns and other NGOs that are limited to implementation, and civil society as well as Faith Based Organizations. Civil Society organizations' role is two pronged. First they serve as implementers of some AIDS programmes and provide guidance to communities. Secondly, they engage as watchdogs for policy implementation and governance,



especially at higher levels of the hierarchy where they interact more with government, the NAC and IDAs.

At the grassroots level, there are community based organizations to which households belong. These are often the targets of the higher level organizations for implementation of programmes. They often have their own initiatives to implement with guidance from public and non-public organizations, but occasionally they are also found to implement initiatives originating from higher level organizations to whom they report or look for support. Other partners include public organizations such as District Assemblies, private companies which promote AIDS at work places, international and local NGOs who work closely with community based organizations. It must be noted that linkages amongst these agents are quite distinct from those proposed under the decentralization process set-up. More discussion on these relationships is presented in Chapter Six as part of the analysis.

### **3.7 Decentralization and the structural stakeholder linkages in HIV/AIDS**

The role of the public sector in developing countries has changed substantially over the past three decades (Swanson and Samy, 2002:5). With the decline in government expenditures, public systems are not able to provide adequately for the health needs of their countries (Swanson and Samy, 2002:5). Attempts to rationalize the development agenda and improving the overall macroeconomic performance have revealed that administrative and organizational weaknesses rank highly among factors that undermine public service delivery and overall productivity. Adding to that is the increased complexity and sophistication of the HIV/AIDS epidemic which is overstressing the public sector's resources. Consequent to this is that the private sector, NGOs and civil society organizations have become important alternatives to the public provisioning of technical inputs, information and training, and organizational support services to communities and rural households. The need to invest human resources in health care and poverty reduction, among other things, are emphasized for achieving major improvements in global health institutions (Swanson and Samy, 2002:5).

One of the critical steps undertaken by Malawi is to reorganize health service delivery by increasing the role and capacities of the lower administrative levels by giving them more autonomy regarding implementation and financing decisions in what is called decentralization. It must be clear why decentralization and other reforms, which try to enhance performance by cutting bureaucracy, facilitating speedy flow of information and feedback effects and rooting out numerous bottlenecks such as corruption, have become critical components of today's development paradigm. This is in line with the MDGs which spell out the global agenda and emphasize the need for broad systemic and institutional changes required in the health sector, including international cooperation and strengthening public health systems in developing nations on account of their inherent weaknesses.

In the new public management arena decentralization is one of the processes that seeks to enhance the quality of service delivery. Decentralization takes various forms but the most common one is what is called deconcentration, which involves the transfer of functions and resources to the regional or district level offices of a central government agency such as the Ministry of Health. There is also a blended version which is often applied to include delegating some authority and functions to autonomous and/or semi-autonomous bodies in some form of contractual agreement (Bossert, 2000:1). According to Bossert (1998) the process of decentralization may be seen as one of selectively broadening the decision space or range of choice of local agents within the various spheres of policy, management, finance and governance.

In Malawi, decentralization is being undertaken to encompass the entire macro policy, so the local government agents, namely the District and Town Assemblies, have the authority to make decisions pertaining to planning and utilization of financial resources derived from both their own initiatives and the central government within the overarching government policy framework. The Government of Malawi became one of the pilot cases undertaking to develop a National Decentralization Policy under the recommendations of

the World Bank which saw this process as one way of doing away with bureaucratic processes impeding economic progress (Cross and Kutengule, 2001:8)

The Policy that was approved in 1998 sought to devolve powers and functions of governance and development to elected Local Government Units called Assemblies composed of the following: Councilors, Traditional Authorities (TA), Members of Parliament (MP) and five representatives of special interest groups. The decentralization process also saw a Decentralization Secretariat being set up under the Office of the President and Cabinet in Lilongwe. According to the Malawi Government this process was viewed as critical for the operationalization of the Vision 2020 development blueprint and the Poverty Reduction Strategy which is also mainstreaming the fight against the HIV/AIDS pandemic. Local Assemblies have virtually taken on the responsibilities that were previously concentrated in the then district arms of the central government and adopting the planning and financial responsibilities in process (Kaarhus and Nyirenda, 2006:12). Ministry of Health and the National AIDS Commission are some of the important arms of government policy that have to devolve their responsibilities to local levels for implementation of health care.

With specific reference to the HIV/AIDS response, the local government is expected to set up an office for the District AIDS Coordinator (DAC) who will oversee the technical and administrative services of the response in the district including planning and reporting (NAC, 2004). In short, the whole process of planning and implementing a development agenda is supposed to be location specific.

### **3.8 An analysis of systemic outcomes of the current organizational arrangements**

According to Duncan (2002) the adoption of appropriate institutions should have capital augmenting effects on the economy (such as through the adoption of new property rights), as well as positive effects on the efforts of individuals within the economy. This implies that the existing endogenous growth models can actually be adapted to incorporate the physical and human capital augmenting effects of improved institutions.

In other words improvements in institutions are supposed to translate into improvements in welfare (Duncan, 2002:3).

Furthermore, if extended in this direction, endogenous growth models would account for both the capital and labour augmenting effects that are needed to include the impact of good governance on economic growth (Duncan, 2002:3). Many empirical studies have also looked at the association between good and bad indicators of governance and economic performance indicators, particularly the costs of poor governance or costs of institutional failure. For example, studies have looked at the impact of corruption, policy credibility (or the institutional environment in NIE), rent seeking (opportunism or self interest) and lack of transparency and accountability (moral hazard from information asymmetry) on the economic performance of countries such as economic growth and investment. Either way, it should be understood that an understanding of the institutional configuration, in a given policy context has a lot to say about the balance between the intended and unintended consequences of that policy and is ultimately also necessary for its success (Aligica, 2005:161). In relation to HIV/AIDS funding, Institutional arrangements and the large flows of external capital into AIDS such as the coming in of the Global Fund the term ‘system-wide effects’ has been used in analyzing the outcomes of such initiatives in the health sector. For example, it has been documented that the Global Fund has created an opportunity for public and private agencies to interact and improve partnerships that work against the HIV/AIDS pandemic. Undesirable side-effects such as creation of additional pressure on the limited human resources as well as lack of harmonization and uncoordinated efforts, as well as frictions in partnerships and budgetary implications resulting from the coming of the Global Funding have been noted in several countries including Malawi (Mtonya *et al*, 2005: 31)

Conversely, the observed outcomes must reveal the standing of the institutional configuration and must pave the way for the improvement of the policy in question. Obviously the changing institutional terrain in the Malawi Health Sector with the emergence of new policy guidelines, new roles shared between government and IDAs and alteration of the public sector structures such as the shift from NACP to NAC, as

well as the inclusion of the non-government working partners offers a configuration that must have a complex mixture of health outcomes. These implications are of critical importance for the recasting of the health sector agenda, particularly the fight against HIV/AIDS, as well as the general development strategy. In light of these contextual changes to the Malawi Health Sector reorganization the intended and unintended outcomes of the institutional arrangements and institutional environment as a whole are discussed next.

### **3.8.1 Outcomes associated with the IDAs in HIV/AIDS context**

One important outcome attributable to the IDAs is the SWAP initiative. By organizing the health sector into an integral planning and implementation structure, transaction costs pertaining to the execution of the health sector programmes and in particular HIV/AIDS stakeholder organizations are reduced. Technical and administrative capacities of many partner organizations from national to CHBC initiatives have been created or enhanced. These enable the organizations to function more efficiently than they would otherwise do, and it is now considered unthinkable to have an HIV/AIDS response that doesn't involve the IDAs. For example the Global Fund has enhanced the scope for partnerships, for example the Financial Management Agency (FMA) of the NAC was reported to be working with 1, 042 organizations by March 2006 mainly due to the availability of the grants support and implementation of the ART (NAC, 2006: 2). The Malawi National Health Accounts of 2007 documented that donors contributed 46% in 2003, 76% in 2004 and 73% of total resources for HIV/AIDS spending in Malawi (GOM, 2007:51) This underscores the importance of the IDAs in the fight against the HIV/AIDS pandemic in Malawi. At the same time the donors were also reported to play a critical role of procuring ARVs that were utilized between 2004 and 2005. This is reflected in the rise from 24% of resources being channelled through the IDAs in 2003 to 47% in 2004 and then dropping again to 12% in 2005. Considering that procurement of ARVs is done outside Malawi, the donors have obvious advantages in handling these transactions as compared to Malawi Government; therefore, these synergies were exploited to good effect by the partnership.

Similarly, the public-private interaction has improved a great deal in these structures due to the resources flowing from the IDAs. Ordinarily, donors do not have the technical or administrative capacity to assess, fund and monitor hundreds of thousands of community based organizations around the world, so some type of intermediary is usually employed to take on this role. There has been an increased reliance on governments to do this, but even these governments' capacity to disburse to NGOs and CBOs is limited (Halmshaw and Hawkins, 2004:37). The creation of new structures in Malawi has enabled disbursement to both public and non-public organizations albeit within a process that is mired with bottlenecks. For example, Umbrella Organizations have been used as intermediaries for purposes of funding district and community organizations by the NAC. An application of the NIE interpretation to this scenario suggests that the new arrangements have transaction costs reducing effects due to the certainty and stability of policy processes arising from commitments within the structures. This also suggests that there is some degree of policy credibility which is good for the performance of the stakeholders. However, there are delays involved between the time the CBOs get in contact with the NAC for funding and the time the Umbrella Organization is able to verify and approve each organization's proposal and eventual funding such that cases of proposal withdrawal or redundancy are not rare.

The IDAs have been criticized for delayed funding processes and also for interfering in the implementation process which is supposed to be owned by government and its partners. The IDAs have delayed funding on the pretext that there is no absorption capacity for more funding. Absorption for more funding has been said to be lacking at both higher and community level. However real the absorptive capacity problems might be, there are alternative views against using these limitations against improving funding efforts for HIV/AIDS initiatives. One way is to look at how AIDS funding has progressed so far. In Malawi, as well as other countries with similar needs, AIDS funding has for a longer period been provided on an 'emergency' basis with uncertain and irregular flows targeting activities with short-term goals (Poku, 2006:355). This implies that long term goals of development which are tied to ensuring the existence of appropriate structures

and systems, which manifest operational capacity, have received inadequate attention needed for large scale effectiveness of the financial assistance for foreign technical assistance, information and education campaigns, and provision of condoms and ARV drugs currently flowing in. According to Poku (2006) interventions are more relevant if they address the challenges of building capacity and the needed systems for large-scale implementation of the AIDS response at the country level. Thus, even the already inadequate funding that is currently being channeled down is unlikely to achieve the desired goals in the absence of ample strategic complimentary funding in key areas. Clearly these irregularities and uncertainties have translated into increased transaction costs and thereby holding back progression in the national response initiatives.

Hitherto, HIV/AIDS funding for the communities as well as other levels has been slow, pending the government's rationalization of its governance structures resulting into sustenance of increased transaction costs. Notably, the decentralization process is not seen as an emergency and furthermore it has to rely on a meager government recurrent budget. Consequent to this mismatch are the worsening conditions in the treatment of the pandemic. The examples of this are manifest in the under-funding of the SWAP by the IDAs who also engage in discrete project funding outside the SWAP. This implies that the under-funding of the SWAP is not only a matter of prioritization due to the limited resources it receives, but the IDAs still consider the partner organizations to lack capacity. Secondly, it has been repeatedly documented that much as there are efforts mobilizing resources from various sources, it has been very difficult for many civil society organizations, and CBOs alike, to access these funds because of their lack of capacity to adhere to the rigorous application requirements (UNGASS, 2006:2). Such lack of harmonization amounts to operational obstacles to development.

Clearly, if HIV/AIDS is treated as an emergency, it does not make sense to let funding to the communities remain blocked by such bureaucratic principles and place the blame on the potential recipients of the much needed assistance, particularly if other facets of the development continuum do not receive an equitable level of priority as the basic expenditure for HIV/AIDS does.

Similarly, ART was on the cards for a long time but a lack of implementation capacity was offered as an excuse by IDAs not to promote it in developing countries, Malawi being one of them. In the process a lot of lives were lost. ARVs became available from 2003 and until mid 2004 were obtainable at a cost. Now the ARVs are distributed for free in the health facilities, but some significant wastage has been experienced.

On another level, time and financial wastage was experienced due to the IDAs late inclusion of Government and the NAC into the build up to the development of the SWAP. This led to implementation misunderstandings between the IDAs and government agents and proved very costly. It became the focal point of the interaction between the two partners. These frictions meant that the response towards disbursement was limited. This could have been avoided if the process had been all inclusive from the start.

The NIE emphasizes credible commitments and smooth contractual relations as important aspects for institutions and economic development. Applying these notions to the observation that the involvement of the IDAs seemed to go beyond their mandates suggests the existence of characteristics that are not performance enhancing within the relational matrix. This observation can be attributed to the extent to which the IDAs own the SWAP and the fact that the donors contribute in excess of 76 per cent of the resources in the health sector (GOM, 2006:56) and the results of the NHA synthesis do concede to the fears that the government may not be in the driving seat of the health delivery initiatives. This does not reflect well on the need for promoting local ownership of the development programmes. While it is easy to understand that donors have a keen eye on ensuring transparent and responsible stewardship for the development assistance they manage in Malawi the concept of the SWAP was almost undermined, for example, because of their involvement in providing consultants and setting up of the technical assistance for the grants management of the NAC (Bellows and Dowswell, 2002:11). It is clear that at this early stage only the donor community understood the arrangement and its attendant responsibilities. The mini-SWAP for HIV/AIDS was launched with these



and various other misunderstandings including what, in retrospect, the donors refer to as a huge leap of faith in their partners. Bellows and Dowswell (2002:15) recommended the need for a consultative group to provide a single consensus before engaging in the SWAP. Considering that government was only co-opted to be part of the programme and was initially perceived to misunderstand the whole concept, it is not unexpected for IDAs to keep a keen eye on all developments and to some degree continue to own the process. However, one positive aspect emerging from this developing partnership is that the donors have managed to let go a sizable proportion of the resources they contribute to be managed by the NAC as the discussion on the table for financing agents above indicated. This entailed allowing the NAC and the Malawi Government to assume a central role in overseeing the HIV/AIDS resources.

Now that the SWAP arrangement is up and running reasonably well, however there are fears documented by the donors regarding their government counterpart organizations. One of the critical ones being that donors just need to acknowledge that a partner with low capacity often cannot perceive their own shortcomings, and that there is need to find a way around this problem (Bellows and Dowswell, 2002:10). Obviously this means that their grip on the modalities of the SWAP implementation should go beyond what is normally envisaged as standard practice, which is to let the government run the SWAP agenda. This raises questions about how much confidence the donors have, not only in the government partnership, but similarly with the lower level organizations and institutions they are funding through the SWAP. The SWAP has been fully developed but questions regarding how far the donors will go to entrust their partners with confidence and increasing resources to manage remain.

According to the NIE principles mistrust and tensions, such as those experienced in the Malawi SWAP, have negative effects on the outcomes of the working of institutions. Nevertheless, the DFID reports that collectively these initiatives have strengthened the leadership and accountability of the National Response in Malawi (DFID, 2006:2). At the same time the NHA indicate that expenditures on HIV/AIDS have been on a sharp increase from US\$29 million in 2002/03 to US\$69 million in 2004/05. The rise has

largely been due to a steep increase in donor HIV/AIDS support through the Global Fund (GOM, 2007:56).

### **3.8.2 Outcomes associated with government and NAC in HIV/AIDS partnership**

A start has been made in this regard with the expansion of public/private partnerships to address HIV/AIDS and this kind of cooperation needs to be further expanded to benefit further improvements in the public sector capacity (McPherson, 2003:7). This entails a major shift in economic policy and how it is implemented, especially as it requires a new consolidation of partnerships in organizations engaged in efforts to mitigate the impacts of HIV/AIDS. This is probably the first time that public and non-public organizations have interacted so extensively to deal with a common problem. Hitherto, the solution to poor public governance has often been to go outside of existing structures, either by creating new vertical programmes; however, with the growing of partnerships in recent times working with NGOs and Civil Society Organizations (CSOs) has become a predominant strategy. For example, in Malawi it has been reported that only about 4% of the CSOs currently involved with HIV/AIDS existed around 1985 when the pandemic was just recognized and since then there has been a dramatic increase in the creation of such organizations (Birdsall and Kelly, 2007: 51).

Now there is growing realization that more can be done by bringing together multiple players provided there is improved governance and accountability (Berman and Bossert, 2000:15-16). This has made it possible for the Government to concentrate on providing the rest of the players with incentives and a conducive environment to influence their conduct. Specifically, in Malawi, the health sector and the case for HIV/AIDS has led to a partnership context that comprises nineteen donors who are on record to contribute to the cause for HIV/AIDS and the wider health initiatives, albeit some operating on programmes outside the SWAP, a host of international and local NGOs, public sector organizations such as local governments and the NAC. It also involves private firms which run various initiatives for employees such as HIV/AIDS workplace programmes, contributions to insurance for their employees and dependents, provision of health care

services and goods to HIV/AIDS patients in their on-site facilities, and reimbursements to employees who have spent out-of-pocket resources on opportunistic infections. Then there is the Christian Health Association of Malawi (CHAM) and the Insurance Organizations, and various networks emerging such as The Malawi Network of AIDS Service Organizations (MANASO), Malawi Network of People Living with HIV/AIDS (MANET+) and the PLHAs, all of whom have various roles to play to ensure the sustenance of good health among Malawians. The entire picture has altered the flow of finances and the relative importance of various sections of the health sector in the country.

Firstly, the influence of the government becomes notable through the incentives and disincentives associated with subsidies and transfers. For example, the government is distributing ARVs for free and it is also distributing CHBC kits apart from other welfare transfers and subsidies. The government is also the custodian of the equity and welfare effects that come when market access is provided or denied, and the financial and organizational benefits and costs of complying with laws, regulations, restrictions and prohibitions that individuals and organizations have to conform to (McPherson, 2003:8). Opening up an enabling environment appears to be the way forward to harness the partnerships among all the players in the HIV/AIDS sector to operate more efficiently, and creating smooth interactions among stakeholders has obvious containment of transaction costs synergies according to the NIE literature. It can, therefore, be concluded that the role of Government in promoting this environment has been performance enhancing to the actors even though there is still a lot of work to be done to harmonize the coordination processes further as alluded to in the earlier sections of this chapter.

At the lower levels, NAC recognizes the need to strengthen the community capacities in the National Strategic framework, especially those of PLHAs through training members of CBOs who work as volunteers (NAC, 2004:22). One sticking point has been the perception of incentives associated with this service delivery. This was also voiced by those personally interviewed during field research of CHBCs in Thyolo District. Community members outside the functioning of the CHBC complain that individual

volunteers benefit from programme money and allowances for attendance at workshops. This explains to some degree the movement of individuals in and out of membership of these groups. Some individuals join CHBC in pursuit of the perceived benefits, and they exit the groups when they realize no significant monetary benefits exist in the system. This culture seems to be becoming deep rooted in rural areas as there are many NGOs who often give monetary incentives to those who participate in their meetings and other activities, so that the spirit of volunteerism is negatively affected. Instability of working groups should be seen to be a negative performance attribute because CHBC work is grounded in cohesiveness which can only be developed slowly through a culture of trust. Similar negative systemic effects arising due to the push and pull factors of opportunism from the HIV/AIDS funding and partnership interaction needing retrospective attention have been reported in Swaziland (Kelly and Birdsall, 2005: 12). This shows there is a realization of the drawback of these effects on the health sector development agenda.

Government and the NAC have concentrated efforts on promoting the behavioural change hypothesis. This has been the prevailing public health orthodoxy explaining people's vulnerability to HIV/AIDS not only in Malawi. It is an approach premised upon narrow epidemiological definitions of the individual and certain risk-groups, assuming that people make rational choices based upon information given to them about health risks. This approach tends not to recognize the interplay between broader societal factors, development issues and the HIV/AIDS epidemic (Jones, 2004:399). To this day, not only in Malawi, a number of organizations are still grounded in that notion of an individual requiring behaviour change. While it is not right to absolve individuals from all responsibilities, the vulnerability of specific individuals and groups and regions to HIV/AIDS must be situated within a more thorough analysis of the interaction of institutional, cultural, social, economic and historical contingencies of place without underplaying complex social dynamics (Jones, 2004:399-400). There are negative implications of such misplaced focus on the success of the entire response.

On account of the above behavioural change hypothesis, for example, the NAC review found that there are communities that still do not accept the reality of HIV/AIDS as they

attribute mortality and morbidity to witchcraft and not AIDS (NAC, 2004:21). In the NAC analysis it was blamed on the culture of not revealing the cause of death when a death is AIDS related. In most cases communities get HIV/AIDS education through the radio, and it is unlikely that such channels would take culture into account. It is made worse for some communities who do not have access to radio. Furthermore, radio represents a highly standardized mode of communicating AIDS information, thus limiting its applicability to the majority of poor rural based communities resulting into an explicit example of moral hazard from information asymmetries across the various groups. Notions of institutional theory would call for Information, Education and Communication (IEC) modes that are culturally crafted or society specific for them to make sense. To do this the incorporation of the target population's own constructs of what is applicable to them need to be applied, and not the straight jacket methods that are largely practiced. An opportunity should be created where the communities will find it easier to adapt those techniques they find most appropriate to integrate with their efforts such as CHBC while also ensuring they remain on course to deliver the wider HIV/AIDS partnership agenda.

Lastly, government systems usually work better in promoting a roll-out of standardized approaches rather than supporting innovation and diversity. All of this makes it more difficult for government and the NAC to disburse funding for HIV/AIDS and has been a cause of stagnation where grassroots structures are concerned (Halmshaw and Hawkins, 2004:37). In this regard the system has focused on the application of a standardized approach in the facilitation of ART and related services to alleviate mortality and morbidity associated with AIDS. This is almost a standard health practice, with procedures well laid out, and administered at selected health facilities. The alleviation of mortality and morbidity in this regard enhances community action and community sector capacity to produce for their needs. Prolonging lives of PLHAs through the administration of ART has the positive effects of revitalizing rural livelihoods and other development activity. There is documented evidence from other countries, such as Brazil, that increased spending on health commodities and access to treatment has helped relieve systems that were formerly overstretched by HIV/AIDS and acted as an important first

step in capacity maintenance (Halmshaw and Hawkins, 2004:36). So the present efforts in delivering ART should be seen to significantly go a long way to produce positive feedback effects on the communities, government and on the entire national development agenda. On the other hand it has also been documented that various organizations at the grassroots level have missed out on the opportunity to draw upon AIDS funding due to factors such as lack of knowledge of the working of Umbrella Organizations, lack of resources to hire consultants to write project proposals and formal registration bureaucratic procedures among others (Birdsall and Kelly, 2007: 141).

With particular reference to the administration of the ART a number of negative effects are worth noting. Firstly, it brings back focus of HIV/AIDS to the hospital setting. Initially the government sought to place the focus of the pandemic in the communities and homes owing to its massive cost implications on the public sector. Due to its technical nature, the administration of the ART has resulted in pulling of resources and energies to health facilities where ARVs are accessed. ARVs can only be distributed by technically trained personnel and these can only be found in certain health facilities. For this reason the health facility becomes the focal point of the health care delivery again at the time that partnerships in the fight against the HIV/AIDS pandemic have been seeking to shift the same towards the communities.

Administration of the ART also has implications for human resources at the health facility level. Shortage of human resources in the Malawi health facilities is a well known problem and this has been reported to affect all health care delivery avenues (Mtonya *et al*, 2005: 41). Considering that the administration of ARVs is a fairly new avenue, personnel from within the health sector are being orientated. In light of its significance, the ART is often times the focal point of the health workers while other health problems are relegated to secondary importance. For example, there are reports that there has been a severe shortage of human resources which not only hamper the roll-up of the ART but also affected other avenues of health care delivery in Malawi The quick-fix approach taken has resulted in many government staff previously in clinical services getting trained to handle Anti-Retroviral Therapy (ART). This is due to availability of more resources

associated with ARVs and the lack of the same in other services. One of the effects of this is that other health services suffer. There are general reports of insufficient staff being available to administer the rest of clinical services. The implications of this on communities are obviously devastating. Hypothetically, the other health problems that are implicitly being tolerated can always act as catalysts for the Opportunistic Infections (OIs) associated with HIV/AIDS, potentially resulting in an undesirable vicious cycle. This has necessitated the inclusion of the Human Resources Development Plan in the Global Fund Budget to address the short fall and enhance the delivery of the ART as well as other complementary services (Mtonya *et al*, 2005: 42)

### **3.8.3 Outcomes associated with the NGOs in the HIV/AIDS context**

NGOs together with the private sector and civil society organizations have become important alternatives to public provisioning of technical inputs, information and training, and organizational support services, to communities and rural households (Swanson and Samy, 2002:5). The HIV/AIDS epidemic has not only brought together existing local and international NGOs to partner government, it has also seen the birth of numerous NGOs which aim to fill the gaps in the collective response. Malawi has witnessed creation of numerous civil society organizations involved in the fight against HIV/AIDS. For example, in Malawi CSOs reported to engage in AIDS activities have been increasing at the highest rate compared to other countries in the region between 1995 and 2005 (Birdsall and Kelly, 2007: 51). Some of the key organizations the National Association of People Living with HIV and AIDS in Malawi (NAPHAM), The Malawi Network of AIDS Service Organizations (MANASO), Malawi Network of People Living with HIV/AIDS (MANET+) to which other agents are affiliated, and then there is a Faith Based Organizations' Secretariat formed to coordinate efforts from religious affiliate organizations such as the Catholic Development Commission (CADECOM) and Adventist Development and Relief Assistance International (ADRA). These have obvious livelihood and welfare effects on the wider communities being reached.

NGOs are now closer partners to government than ever before. Previously the Malawian Government did not have a good record of disbursing funds to NGOs to facilitate development. The example of the NAC working through umbrella NGOs means that there is increased capacity to reach the communities simply by enhancing the flow between the two partner organizations' set-ups. NGOs are reputed to exercise comparative advantages in many areas concerning capacities to reach the communities. So from the perspective of absorbing funds and the mushrooming of these NGOs the system must be seen to offer a two-fold performance enhancing benefit.

Organizations such as USAID, UNICEF, WFP, OXFAM and CARE International have been involved in direct welfare transfers, and therefore, mitigating the impact of HIV/AIDS by specifically alleviating food insecurity (NAC, 2004:22). Nevertheless, there is evidence of further fragmentation of these efforts at the community level. The food provisions that are supposed to reach PLHAs and other vulnerable groups, like all other forms of social support, are normally channeled through traditional authorities. The chiefs have been reported to politicize the supplies and infuse corruption into the distribution process; further discussion of this is presented in Chapters Five and Six of the findings of this study. Food provisions are supposed to complement the ARVs and should reach the PLHAs with utmost speed and consistency. While it has been conceived that an NGO working across communities would be direct, reliable and efficient it is envisaged in this study that given the infrastructural and other bottlenecks in Malawian communities under a community based organization would be the most ideal route for reaching the rest of the community. In many instances field research for this study found that chiefs were aware of the working of CHBC groups, but were not working closely with them. Such gaps in some areas are more pronounced than in others. For example, a case of one chief in Ntcheu District who was approached by field researchers to help locate a CHBC group that had been identified within his area for interviews informed them that there were no CHBC groups in his area when in fact they existed. This is one example of existing gaps in the system or organizational arrangements that actually impede progress. At the moment Malawi relies more on the international NGOs who are termed as Umbrella Organizations to carry out roles that should otherwise be undertaken by the District AIDS



Coordination Committees. The district teams are still in the process of being established, and whether they would be able to face up to the challenges of delivering the targets for fighting AIDS in the districts remains to be seen. With current structures, in terms of reaching the community people the NGO sector has the comparative advantage of delivering better services with supplies.

#### **3.8.4 Outcomes associated with the CBOs in the HIV/AIDS context**

Boettke and Coyne cited in Aligica (2005:163), mention the importance of the idea of vulnerability. The main concern is with vulnerability of governance systems to external shocks and their structural or intrinsic capability to overcome them. For instance the vulnerability of those affected by HIV/AIDS reflects the vulnerability of individuals and CBOs. While getting infected reflects the individual's vulnerability due to lack of power to receive adequate care from supporting institutions on the one hand, vulnerability effects are also felt at the CBOs' level. That is, the CBOs vulnerability is reflected in their lack of power to mobilize adequate support and minimize the risk of opportunistic infections among the infected individuals (Jones, 2004:388). These reflections also mirror an area highlighted by the Bloomington scholars on issues of institutional resilience or organizational adaptability and flexibility found in the field of new institutional economics (Aligica, 2005:163-164). CBOs must reflect adaptability and resilience in order to withstand the implications of HIV/AIDS. But to do this the reality of their situation captured in the normative, cognitive and institutional patterns must be reflected in their ability to make pertinent decisions. Given the misgivings regarding grassroots capacities as observed in the developments towards the building of the SWAP arrangement in Malawi, and the stagnation of the decentralization process the question to be asked is 'to what extent are the CBOs the main actors making decisions at that level?' Principles of economics would suggest that allocative efficiency is likely to increase with more decision space accorded to the local actors because they have more information and knowledge on local circumstances such that their decisions regarding service delivery would benefit more than if these decisions were taken at a more central level.

The outcomes of the interplay involving the IDAs, government and NAC do not support the CBOs' capacity to make their own decisions. The CBOs cognitive capacities are considered too inadequate to engage in meaningful development decisions by the NAC and other funding agencies. As such the CBOs are pushed to the bottom of the decision making chain and thus continue to face a situation of deprivation. On the contrary, within their communities, the CBOs are at the pinnacle of decision making processes and this suggests one of the greatest asymmetries and institutional challenges in the national HIV/AIDS response. Obviously lack of power and decision space for CBOs undermines their effectiveness.

From a resource flow point of view, the CBOs have been marginalized by the IDAs and other partners on account of their lack of absorptive capacity. There is evidence of a discrepancy between the increasing resources that are being mobilized or acquired by donors, governments and international organizations for expanded HIV/AIDS responses, and the actual amounts being channeled to affected households and communities (Save the Children, 2005:2). According to Save the Children, there are a number of bottlenecks stopping the smooth flow of funds to support community initiatives not only in Malawi, but also for the rest of the region. Providing actual resources to communities is not taken sufficiently seriously at global and national level, hence current mechanisms do not adequately allow for resource flows to reach community-based organizations as governments and IDAs are not accountable for their spending to support the CBOs initiatives. "It is recognized that increases in funding to community based organizations can, on occasion, lead to bottlenecks. However, there is no reason why this should be accepted as an inevitable outcome and, when it does occur, is used to trumpet the hopelessness of community action on HIV/AIDS" (Halmshaw and Hawkins, 2004:36). Currently an attempt to increase aid uptake has resulted in a shift in aid modalities from project off-budget to budget support for governments which targets to build capacities in resource allocations and use (Birdsall and Kelly, 2007:36). However, with the missing structures at lower levels of the institutional arrangements such as the role of district local assemblies the gaps at community level could only be closed at a very slow pace.

At the planning level the CBOs have equally not been comprehensibly involved. First, the CBOs have not been duly involved because of the underdevelopment of the local government structures. This leaves only the NGOs and FBOs to be the critical links to these grassroots organizations. It is already known that NGOs do not cover all corners of the country, thus only those being targeted by the NGOs stand a chance to get involved in planning the activities. The consequences of these factors are that the massive funding from IDAs has not ended up at the grassroots level where it is most needed. Second is that typical of the higher level organizations, the development agenda is worked out at international or national levels and then transferred to the local level. Often times this has caused implementation problems because of the lack of the local input into the programme agenda. An example of this is the inadequate agenda for Faith Based Organizations (FBOs) in the NAC strategic framework and the weakness of the Information, Education and Communication (IEC) strategy by the NAC to effect behaviour change in respect of HIV/AIDS amongst Malawians as reflected in the NAC, 2004 Strategic Framework Review. The lack of local community ownership of development programmes is a recipe for failure.

Thirdly, and connected to the lack of community ownership is that, once initiatives are perceived to be owned by an external agent, a dependency syndrome evolves such that the communities lack their own initiative. The evidence of this idea, in as far as the CHBCs are concerned, is picked up in detail in the presentation of data in Chapter Five. Suffice to say that the perspective of external support weakens their capacity to make decisions and innovations and aggravates the spirit of hopelessness in a situation where the parent agent (NGO, FBO etc.) are not forthcoming with the support when it is expected. In light of the NIE reasoning when partners are not engaging and interacting smoothly, the transaction costs of delivering the services are heightened. However, obtaining external support appears to be a predominant feature that compliments the most CBOs efforts in Malawi. The NIE suggests that partners need to complement each other in order to reduce transaction costs of operating. In this regard, availability of some funding is strength from the NGOs whereas the same is lacking on the side of CBOs. At the same time the communities have the implementation capacities which the NGOs are

happy to exploit. Nevertheless, as discussed in the findings in Chapters Five and Six (also see Birdsall and Kelly, 2007: 140-141), from an institutional economics and transaction costs perspective it makes more sense for these CBOs to own and have a firm grip of their programmes and agenda.

Equally true from the foregoing, also highlighted by the principles of NIE, is the danger of home-grown responses becoming supplanted with externally sourced solutions. The community sector is the glue that holds together responses to HIV/AIDS, yet it now needs to adapt to new partnerships with government and other emerging HIV/AIDS service providers which have their own solutions and strategies for dealing with HIV/AIDS problems. Cultural norms and the development of social networks have led to society specific ways of doing certain things and it is these approaches that the partner organizations must learn to promote because the informal methods would already have transactions costs minimizing attributes inherently built within them. For example, when households face crises such as illness or death, communities provide monetary gifts, loans, and food, clothing and school fees, enable access to medical care, donate labour and provide employment (Luzze, 2002 in Save the Children, 2005:5) among other initiatives.<sup>4</sup> Other forms of safety net adaptation in the face of the HIV/AIDS impact include the birth and sustenance of savings associations, cooperatives, and loan providers individually or as groups, pooling of community labour to help in the fields, rural revitalisation grain-saving schemes to assist orphan households, as well as other faith based initiatives (Save the Children, 2005:5). The partner organizations need only to come in to foster increased effectiveness of such initiatives already known to be working well.

Most initiatives, such as CHBC, in these communities are self financed and there are programmes that seek to channel resources to that level but the channels are mired with blockages. For example, the provision of CHBC kits extended to communities is done at health facilities, just like the administration of ART. The survey also found that on occasion the CHBC kits would be brought to the communities by the NGOs. The

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<sup>4</sup> More discussion on these aspects is included in the findings of this study in Chapter Five and Six.

inconsistency is a concern for the communities as it breeds uncertainty. Uncertainties tend to raise the transactions costs of making critical decisions. Evidence from focus group discussions (FGDs) in Thyolo District conducted for this research in February 2006 revealed that, even though trained, some CHBC groups were not clear as to what was the recommended method of replenishing the kits. These inconsistencies can be explained in two ways. Firstly, the training sessions given different groups were widely varied in duration ranging from two day training sessions to two weeks training sessions. One immediate consequence of this is that there will be varied and compromised quality among the implementers and therefore, it is likely that these people will produce varied outcomes.

Secondly, in some places where NGOs are operating, they occasionally replenished the stocks of CHBC kits whereas other CHBCs obtained them directly from the health facilities. This would certainly send conflicting signals to communities. Whereas the initial kits were distributed during the training workshops, the system should make it clear how fresh stocks must be obtained with some degree of consistency. While the arrangement has all the good intentions, absence of a follow-up with the community and the tendency to operate on implicit assumptions with rural communities in this case proved to be detrimental. In general, the situation is a reflection of the lack of integrated planning amongst partner organizations, hence increased uncertainty and thus, increased transaction costs. The uncertainty gets amplified by the fact that there are governments', non-governmental and locally based organizations involved in what is normally a two way relationship. On the other hand the multiplicity in the interrelations is what makes integrated planning imperative in order to make the communities more effective.

Partnerships are reported to be a prominent feature at community level, especially involving NGOs and CBOs. But there are gaps in the forms of relationships that exist. NAC reports that larger NGOs such as the Umoyo Network, World Vision, ADRA, Plan International and Action AID do engage with smaller NGOs, which are mostly CBOs, in areas where the larger NGOs have programmes (NAC, 2004:28). CBOs work as agents of the larger NGOs; this implies that what transpires locally is not entirely the

community's agenda because programmes must conform to the agenda of the principal NGOs. While these agency relationships enable the CBOs to access resources, they do so within uncoordinated frameworks. The outcome of efforts like this is duplication and overlaps within some communities increasing the transaction costs that the programmes aim to control.

While there is overlapping in some places other communities remain in isolation with no similar programmes to participate in. This is particularly true because most rural communities extensively rely on the designated umbrella NGO organizations for instituting proposals and the entire capacity to draw upon NAC funds and resources. The alternative would be to work through other NGOs who operate in their areas, without which the communities tend to be generally cut off. At the bottom of the entire picture is that the modern institutional governance paradigm emphasizes local ownership of the development agenda, that is, CBOs just need to be supported as they execute their own agenda which is not the same as working as an agent. The system of obtaining financial assistance from the NAC has created a platform for competition for those resources, as the larger organizations have the capacities to engage a process of drawing upon those resources while the small community based organizations' chances of writing a proposal to get resources are rather limited. Hence the sort of symbiosis that develops between the needy CBO and the larger and more capable organization is not the most ideal.

Further gaps exist at the district level in as far as coordination is concerned. The ineffectual roles of the DACCs and VACCs, among others, limit the extent to which the communities can participate in the response. Potentially, these committees have comparative advantages in representativeness to offer in the districts over their NGO counterparts, but given the current capacities of the district management it is not clear whether creation of the said roles would lead to the full effect being envisaged here. The District Assembly structures are, by design, supposed to be representative. They spread out to communities without exclusion unlike the parallel approaches, so these would offer the best geographical coverage, including the complete integration of traditional chiefs and the Faith Based Organizations (FBOs). Currently the involvement of FBOs appears

to have been undertaken on an ad hoc basis with no clear guidelines. The NAC attests to the fact that the framework does not articulate clearly what is expected of the FBOs. This is clearly a situation of an externally driven agenda and therefore could not have been effective among the FBOs. However, the FBOs came up with structures and set up a secretariat to coordinate their own efforts in the national response, presumably due to the realization that they are not intimately anchored within the communities. Specific to HIV/AIDS the role of district management teams, in particular the roles of DACCs and DAC are well covered by the International NGOs (INGOs) who are the intermediaries between the NAC and the community based organizations in terms of processing and transmitting funding support. While good progress is being made in getting into contact with many local organizations there still are reports indicating that CBOs have missed out on opportunities to get grants because they lack information on the funding arrangements as well as that they cannot manage to get through the procedures adopted by the INGOs and the NAC for grant management (Birdsall and Kelly, 2007: 141)

### **3.9 Summary and Conclusions**

The main aim of this chapter has been to highlight the structural institutional linkages on the one hand, and the financial flows in the HIV/AIDS response in Malawi. In the context of New Institutionalism, the chapter set out to apply a situation analysis to highlight the problems associated with HIV/AIDS in Malawi, the situation regarding funding and implementation arrangements of the national response with particular interest in the CHBCs. A stakeholder analysis was then used to elucidate how the existing structures have been performing in the response, particularly focusing on the stakeholder inter-relational issues and how these have manifested themselves as transaction costs of institutional arrangements.

In evaluating the situation, the analysis suggests that the conditions of HIV/AIDS and the associated poverty among Malawians are still severe. Efforts to contain the situation have been put in place: they range from a poverty reduction policy, to decentralization policy and AIDS specific policies. Implementation arrangements are multi-layered involving

public organizations, international development organizations, non-governmental organizations and community based organizations, with each sub-sector being guided by the health sector policy that creates an enabling institutional environment.

The funding situation has been improving, especially with the introduction of the SWAP arrangement, and the entry of Global Funding to provide ARVs through government facilities. However, the situation regarding funding at community level remains poor. The reservations regarding community capacities by donors and government are responsible for this situation. This is observed through the limited funding of the SWAP by the IDAs and the limits on the sizes of the NAC grants offered to communities, apart from other procedural limitations communities face. Since decentralization of services to lower levels is ongoing, and the DAC positions are being created, implying that the communities would be more involved in the process from planning to running of the development agenda, it remains to be seen whether other district capacities are adequate to support effective transmission of funding and information. Secondly, the district HIV/AIDS guidelines have been developed to clarify roles of the multiple players, their responsibilities and the entire implementation process. The guidelines will ensure harmonization of local activities with the overarching policy agenda in the same vein as the SWAP programme of work guides the higher level organizations. This might just translate into creating the said capacities and therefore, justify more funding at those levels which are likely to result into reduced transaction costs for operating at all levels. The concerns about the capacities and efficiency levels of the district level structures, similar to the rest of the lower level agents, remain a major factor resulting in stalling transition towards their empowerment.

The situation regarding how the stakeholders interrelate is generally considered acceptable as service delivery has been streamlined into the SWAP context. Gaps do exist at all levels, notably the more than firm grip on SWAP by the IDAs which has seen government only being encouraged to get involved from a weaker position. Further gaps within the SWAP exist at lower implementation levels. Structures of SWAP at district and lower levels are not well developed and this needs to be done quickly because



currently the situation limits the involvement of the community level partners, therefore exacerbating the increasing levels of HIV/AIDS and poverty and thus increased transaction costs.

Various intended and unintended outcomes have been discussed in the chapter. Of particular importance are the bottlenecks to the flow of funding to the grassroots level by the entire arrangement, which needs to be corrected as it marginalizes the communities it is intended to serve. The creation and coming together of a variety of organizations and pooling of resources to deal with the epidemic, and rolling out of the ARVs, which have significant positive returns on the economy, are nevertheless performance enhancing outcomes. Lastly, an observation is made that standardized management techniques for funding HIV/AIDS have been partly responsible for limiting absorption of funds at grassroots level. A shift to methods that incorporate society specific or cultural specific methods of working need to be promoted in order to eliminate some of the current asymmetries and thus enable more participation from CHBCs and other CBOs.

## Chapter Four

### Outline of the Research Methodology

#### **4.1 Introduction**

The methods used in this research are located against the background of the concept of the New Institutional Economics. The approaches are being applied in the context of the main goal of this research, which is to conduct an institutional analysis of organizations involved in Community and Home Based Care and support for HIV and AIDS patients. Community and Home Based Care (CHBC) is, thus, the unit of analysis. Primarily, the research agenda recognises that there has been limited institutional economic analysis focussing on the effectiveness of these community based development organizations. In the analysis, the study seeks to recognise the relationships between these institutions and the organisations that influence them as a key component of their performance.

Of secondary importance and closely related is the idea of applying the methodological emphasis to governance principles in rationalizing institutional arrangements. This is in keeping with the growing research agenda in the broad development context and HIV/AIDS in particular. The study adopts a behavioural (normative) approach in an institutional paradigm to explicate the issues of institutional arrangements and the effectiveness of these institutions in delivering CHBC and support in Malawi. In this perspective, the study perceives institutions as a set of guiding norms and interaction procedures, paying particular attention to behavioural responses in the course of institutional participation, communication and adherence to standards. Therefore, the broad aims of the research are to apply a composite method of qualitative and quantitative techniques in order to elicit insights into the perceptions and aspirations of the participating members through their daily routines, and secondly, to analyse how these daily operations reflect on the policy goals. A detailed justification for the application of NIE and the related specific tools of analysis is readily presented in the literature review which is chapter two of the thesis.

This chapter is presented in two main parts. Section 4.2 discusses the specific objectives and broad methods used to collect data. These include sampling of institutions for primary data collection, and a brief highlighting of the complimentary secondary data collection process, as well as a justification for the chosen techniques.

An outline of the survey respondents, data collection instruments and the activity schedule for field-work are attached in the appendices. Section 4.3 looks at the institutional analytical framework.

#### **4.1.1 The study objectives**

The study has the following specific objectives:

- 1) To evaluate institutional performance through ‘transaction costs’ and ‘agency chains’ (contractual standards and coordination)
- 2) To examine the array of incentives (formal and informal) and their impacts on the performance of the institutions (institutional environment)
- 3) To analyse the impacts of actors perceptions of the CHBC partnerships on their performance (costs emerging from information and cognitive capacities).

The three objectives of the study use a combination of qualitative comparative analysis (QCA) and quantitative bivariate regression analysis in the form of cross tables. The following section highlights the procedures followed to collect the information that is analyzed using the aforementioned analytical techniques to make a case for each of the study objectives.

#### **4.2 Sample and Data Collection Methods**

##### **4.2.1 Overview**

According to Malterud during all stages the qualitative research process is systematically influenced by the researcher's preconceptions and theoretical frames of reference. In order to deliver understandable conclusions and knowledge, the researcher must display all vital steps of the transformation and interpretation process (Malterud, 1993:202).

Preconceptions are important for raising the initial questions that the research must address, and as such they do influence subsequent stages of the research process. In this study, one of the most important preconceptions that played a fundamental role to the sampling process is that there is a wide range of organizations, with uneven geographical distribution in the communities, playing varying roles in the lives of CHBCs. For this reason the ‘diversity’ of these organisations must be a factor in how the community based organizations are influenced to

function. This contributed to the sampling of community organizations and households that are affiliated to different types of higher level organizations such as the faith based type, those affiliated to NGOs, and to government agents among others in different locations in order to embrace diversity.

The second important consideration comes from the objective of interpreting the research data using concepts and models that have theoretical background. In the light of this, the application of the New Institutional Economics reasoning aims to explicate the role that the institutional environment plays on the performance of an organization. Application of the IAD Framework and the implied analytical concepts also influenced the sampling procedure adopted in this study.

Specifically, the study uses a multi-layered sample frame of organisations involved in HIV/AIDS responses. Conceptually as organisations at higher levels exercise their policy and implementation mandates through rules and laws that seek to keep the policy targets, they practically exert functional constraints on the lower level organizations such as the CHBC. Owing to the fact that CHBC organisations are autonomous and are involved in making independent decisions as they pursue their organizational targets, the influence generated by organizations at other levels becomes critical for the performance of the CHBC. Thus, the ways in which transactions are organized at the lower level organizations reflect, some what, the influence exerted by the higher level organizations and it is on this basis that a multi-layered sample was chosen for investigation.

The primary data collection process was completed by a team of two co-researchers and four research assistants. Data from the surveys was complemented by information gathered from secondary sources such as documents obtained from relevant organizations during the survey visits. Additional background information was obtained from library and internet sources.

#### **4.2.2 Sampling Technique**

This research process is mainly qualitative. According to Neuman (2006:157) qualitative research looks at social life from multiple points of view and explains how people construct their identities. The research seeks to capture and discover meaning, and rarely does so by using variables or testing hypotheses. Rather it is an examination of motifs, themes, distinctions and

ideas about people being studied within the context of their natural setting. On account of this, qualitative sampling techniques have been adopted in this study.

Specifically a non-probability type of sampling method was deemed suitable for this study of CHBCs. In a step-wise process, a strategy called Maximum-Variation Sampling within the branch of Purposive Sampling was applied for its characteristics of enabling it to capture central themes that are manifest among the various CHBC groups while also ensuring case diversity in group or individual characteristics. Characteristics of the population are used as the basis of the selection (Ritchie and Lewis, 2003:78) It also enables the researcher to sample information rich cases and study them for a deeper understanding of the processes and social inter-relations they engage in. To do this qualitative research does not seek to accomplish a statistically significant sample; rather it seeks to reach a sample that will provide enriched detail for the analysis of the processes and this is explained in the next section. Furthermore, purposive sampling can easily be used to capture quantitative and qualitative data which can then be analysed using mixed methods techniques.

#### **4.2.3 Sample size**

According to Ritchie and Lewis qualitative samples are usually small in size because of the likelihood of repetitiveness of phenomena in the analytical map. Theoretically the statements of incidence or prevalence are not of concern to the researcher as is the case in statistical investigations and also because of the richness of the qualitative data only a small sample can be properly handled (Ritchie and Lewis, 2003:83). They also recommend a rule of thumb for determining sample size; for group discussions 12 to 14 groups suffices beyond which information will become difficult to handle; for single interviews keeping the numbers below 50 is recommended; and for samples the range of 70 to 80 is maximal.

For purposes of this study, a total of 15 groups were sampled for discussions. Of these 10 were from Thyolo District and 5 from Ntcheu District. A total of 100 individuals were interviewed with 50 coming from each of the two districts, and these fifty were purposively targeted in a manner that would generate contrasting and complementary insights. Twenty five individuals were sampled from CHBC volunteers while another twenty five were non-members of the volunteer groups. To add to these interviews key informant interviews were randomly conducted among traditional leaders, political leaders, NGOs and government agents working in the study locations.

#### 4.2.4 Specific Sampling Stages

Within qualitative research sampling, purposive sampling aims to select information rich targets. In a case of institutions, such as those found in CHBC organizations, each study unit is considered to be unique. In light of this, institutions are not amenable to major analytical generalisations or variable oriented comparative analysis. Literature on qualitative research sampling does grant researcher's discretion in terms of how many groups or individuals are considered adequate for meeting the study objectives. The following steps were then followed:

- Step 1. All districts in Malawi were ranked in order of the number of CHBCs. Among the highest ranking, two districts were sampled. The criteria for sampling two districts were, Thyolo District for the highest number of CHBCs and highest number of NGOs working with the communities and Ntcheu District for second highest number of CHBCs but with a very low number of NGOs working there. Secondly, the budgetary limitations dictated that the study be within confines of the selected districts.
- Step 2. Two traditional authority areas were sampled in each district purposefully to capture aspects of transaction costs. One Traditional Authority (TA) is located near the district hospital (about 5 kilometres) whereas the other had to be about or beyond 10 kilometres from the health facility. The distinction based on distance is premised on the definition of the Ministry of Health in Malawi for individuals living near or far from a health facility and it is adopted on account of differentiating transaction costs associated with transport, acquisition of medicinal supplies such as ARVs, health information flow and the ease with which economic agents reach one another to transact.
- Step 3. In Thyolo District 5 groups were then randomly selected in each TA and were informed in advance of the visitation of the research team through the District AIDS Coordination Office. In Ntcheu the 2 groups were sampled from close proximity of the district health facility and then 3 were selected from the TA far from the district health facility.
- Step 4. One Traditional Authority or one political leader from each TA in the proximity of a CHBC group where discussions were taking place was randomly selected for Key Informant Interviews. These were included in order to incorporate the influence of the

political and traditional authority on the running of the CHBCs. In particular, the study recognises that TAs are custodians of the fundamental ethical codes and are instruments of arbitration in cases of contractual misunderstandings, besides being general overseers of all social initiatives within communities.

- Step 5. Within the CHBC group discussions individuals were randomly selected for individual interviews and then additional information was collected from other individuals who were not members of the CHBCs but found within the villages until the number of 25 was reached under each TA.
- Step 6. Following the links from the CHBC group interviews additional interviews were conducted with organizations that they engaged with at a higher level, NGOs (MSF and NAPHAM), or the Local Assembly, District AIDS Coordinators (DACs) for additional Key Informant Interviews. Those specifically interviewed are indicated in Appendix Two.
- Step 7. At national organizational level the research sought insights into policy coordination and oversight of implementation. This was solicited from organizations considered critical for lower level public and non-public delivery of services, such as UNAIDS, the Ministry of Health and the NAC. Those who responded to the survey questions are indicated in the table in Appendix Two.

The following is the summary of respondents to the survey instruments.

- (i) Ministry of Health and the National AIDS Commission.
- (ii) Two districts (Thyolo and Ntcheu), 2 DACs, 2 NGOs, and 1 Town Assembly.
- (iii) At community level, 2 TAs, 2 political leaders, 2 Village Heads, 15 CHBCs and 100 households.

#### **4.2.5 Study locations**

The study was mainly located in the two districts of Thyolo and Ntcheu. Thyolo district is in the southern region and was the main study site. The district covers an area of 1,715 km.<sup>2</sup> and has a population of 458,976. It has a population density of 267 people per Km<sup>2</sup> owing to the vast commercial tea estates that have taken up most of the land (Zachariah, 2006). The district is

divided into seven traditional authorities headed by a traditional chief. The altitude varies between 300 and 3500 m above sea level. Thyolo is one of the districts recording the highest incidence of HIV/AIDS in the country. Currently it is estimated that 20% of the population are testing positive for the HIV virus (MSF, 2007). This explains the strong presence of the NGOs such as Medicines San Frontier (MSF) who have been providing care and support to the communities and two formal hospitals and 17 health centre facilities since 1997 (MSF, 2006). The MSF reported that by the end of 2006 at least 7,216 individuals had been placed on Antiretroviral Therapy (ARVs) out of the 11,500 estimated to be in need of them (MSF, 2006).

Ntcheu is a district in the Central Region bordering the southern region as well as with Mozambique. This district was the secondary study site. The district is situated between the two major cities of Blantyre and Lilongwe and it covers an estimated 3,424 km.<sup>2</sup> with a population of 370,757 (GOM, 2002:12). The National AIDS Commission sentinel surveillance estimated that 11,000 people of the age bracket 15-49 or roughly 3% are infected with the HIV virus in Ntcheu.

#### **4.2.6 Limitations of the Study Sample**

The study sample was achieved on a very limited budget and as such the time spent in the communities was also limited. With this arrangement, it is likely that discussions with the community members were not as deep as they might have been required. The data collection process involved research assistants travelling to different rural settings that are not easy to reach. In the first place it takes a long time to navigate to most of these sites due to the conditions of the roads. Secondly some places are far away from the towns. The major problem with these sites is that in some cases where some required information had not been recorded by the research assistants it was virtually impossible to make call backs for such information.

One research assistant dropped out in the middle of the field work making it difficult to train and deploy a replacement within such a short time. This contributed to the variations in some aspects of data quality.

Lastly, some key informant interviews targeted by the research proved impossible to conduct, for example, at Ministry of Health the key individual who was responsible for CHBC was out on leave for the period for data collection. At UNAIDS the research team was refused consent for the interviews on the premise that all people who were in the office were relatively new. The quality of the data might have been compromised in one way or the other due to the enumerated limitations.



#### **4.2.7 Ethical Considerations**

The study is about HIV/AIDS and organizations involved in the national response. The study, therefore, recognizes the sensitivity which goes with this pandemic. The research approached the Ministry of Health officials who then sensitized the subjects in advance through traditional leaders and leaders of the volunteer groups. A meeting schedule was also worked out at the same time. The data collection team also had to introduce the subject of the meetings and ask for consent from the respondents prior to the interviews. The District AIDS Coordinator (DAC) was always available with the researchers in each community. Lastly the respondents were assured that the research has adopted the principle of non-disclosure of individuals at any time during and after the research process and that the research is for academic purposes and issues arising from these discussions have the purpose of learning from their experiences for the future.

#### **4.2.8 Secondary Data Collection**

To complement the primary data gathered in the preceding steps, data from secondary sources were collected mostly from the Ministry of Health, the National AIDS Commission and internet sources. Use of these has been duly acknowledged in the research output. This bulk of secondary data has been used in the stakeholder analysis which is presented in chapter three with the aim of highlighting the nature and effectiveness of inter-organizational relations through synchronising inputs and outcomes of the said relations.

#### **4.3 The Analytical Approach**

The bulk of this research is of a qualitative nature aiming to make sense of behavioural patterns of rural community groups. Practically this entails creating a description of the unfolding of social processes and not necessarily of the social structures that would be more amenable to quantitative analytical methods. The NIE analytical approach has well developed frameworks that are suitable for the application of a wide range of theoretical concepts depending on social situations of interest and the nature of organizations involved. Considering that this study is focussed on unpacking the way of life for CHBC groups in terms of their goals, beliefs, power relations and the cultural traditions that shape their processes, choice of an evaluative analytical approach for their performance is deemed suitable.

The NIE, and particularly the transaction costs economic theory, asserts that transaction costs aid interpretation of non-standard modes of economic organizational arrangements by focussing on how transactions are assigned in a discriminating way. The relevance of how participants plan, adapt and monitor behaviour, described as the transaction costs of contracting is clearly highlighted in the literature review chapter of this thesis. In light of this, the Institutional Analysis and Development Framework (IAD) by Ostrom *et al* (1994) has been chosen from a host of other frameworks such as the Lamb's Institutional Analysis Model (LIAM, 1980), Actor Centred Framework (ACF) by Sabatier and Jenkins-Smith (1999), Williamson's NIE framework (2000) among others, for the many advantages it offers as discussed in the next section.

#### **4.3.1 Application of the Institutional Analysis and Development Framework (IAD)**

The IAD Framework developed by Ostrom *et al* (1994) is applied to capture the transaction costs of information, coordination, structural arrangements, informal rules and norms, and the formal governance contractual relations in a social analysis of the CHBCs. The IAD is a multi-tier conceptual map that allows an integration of various theories of action across domains to be applied together and is particularly important for doing comparisons and evaluations (Ostrom, *et al* 1994 in Koontz, 2003:2). Since this study is concerned with evaluating the performance of institutions faced with exogenous and endogenous factors such as rules, materials and internal conditions, the IAD is deemed to be a more suitable framework for analysing the CHBC activities for various advantages outlined below.

Firstly, because it enables the researcher to use the exogenous and endogenous factors mentioned above as variables impacting the chosen action situation of interest and, therefore, making it possible to make a case for any outcome of the action. According to Sobeck (2003:363) the IAD framework emphasizes the structure of the *situations* in which individuals find themselves and how they work to overcome their problems collectively. The framework requires that an action arena be identified to understand the individual behaviour in the institutional context. Since this study focuses on the CHBC institutions as a unit of analysis, it follows that action situations at that level are the focal point. Unlike the actor centred approach, this method recognises that a situation extends beyond the actors, which means factors or roles played by external agents affecting the said actors should easily be incorporated into the analysis. The specifics of the action situations of the CHBCs in this case include their interpretive behavioural responses in view of their capacities and the available information, rules

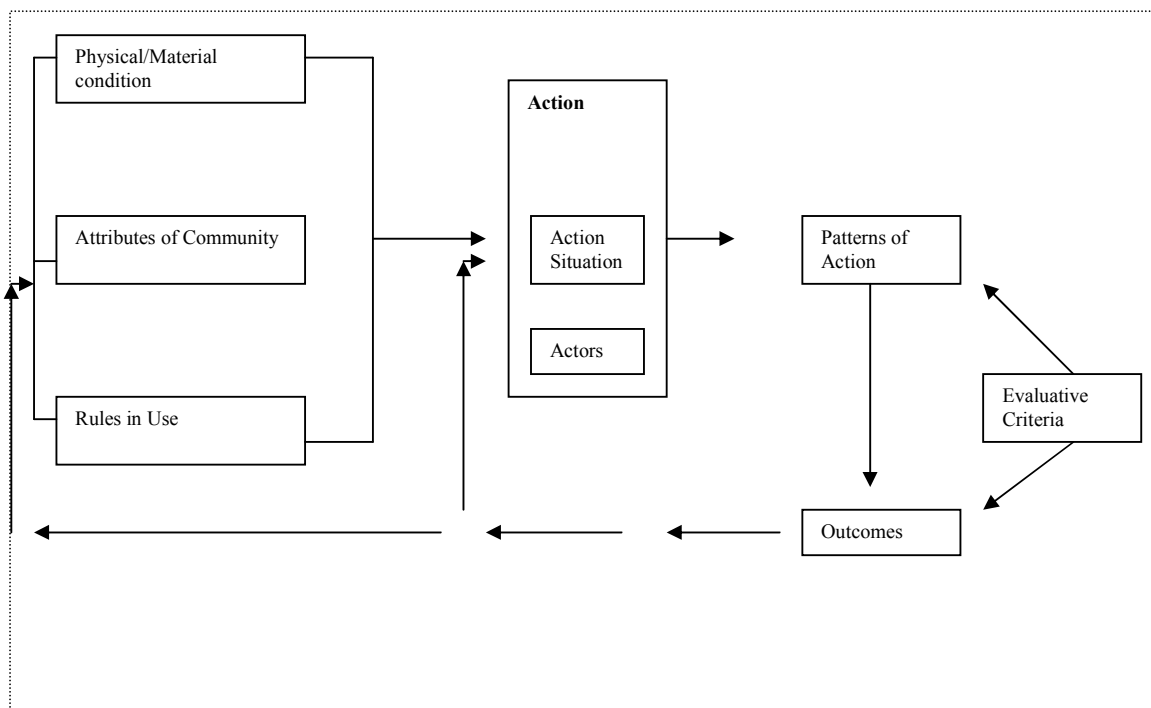
in use, materials and conditions they are faced with from within as well as externally in their social situation.

Secondly, the approach recognises that group behaviour is amenable to pursuit of self-interested goals by the members who seek certain incentives and thus, the group structures must have mechanisms to monitor such behaviour. Owing to the fact that CHBCs exist in communities that are in a situation of extreme poverty, and are faced with potential access to funding from various sources for their activities, a potential source of self interest and conflict, an examination of the incentive structures and costs of participating calls for a situation analysis to reflect on how the participants weigh their benefits and costs of participation. Hence the adopted approach.

Lastly, Sobeck (2003:368) notes that the IAD framework can be used to illuminate why a group of individuals came together to work on a project whose benefits were not limited to only those participating. Considering that CHBCs are a construct of social activities for a wider community, benefits of their initiatives will obviously accrue to non-members, especially benefits derived from avoiding collective risks of a deepening AIDS crisis in the community. So while this notion does unveil insights into the creation of the groups, it also creates an opportunity to reflect on the free-rider problem in a situation where it is clear that collective action is important. Against this background the entry and exit of the members in the CHBC groups is explored. Application of the IAD Framework, the associated models and specific variables included in the analysis are presented next.

For specific purposes of addressing the objectives of this study, the IAD framework is used to isolate variables that fall in three categories. According to Ostrom (2005:829), to use this framework to analyze a social problem one should first identify a conceptual unit called an *action arena*, where an action arena includes an action situation and actors. An action situation has characteristics that make grouping of variables in the following; participants, positions, outcomes, action-outcome linkages, control that participants exercise, information and costs and benefits assigned to outcomes (Ostrom, 2005:828).

**Figure 4.1: The IAD Framework**



Source: Ostrom (2005)

The next section gives an outline of the variables that are applied in the framework.

### 4.3.2 Broad Outline of Variables

First, an outline of variables that are classified as *Physical or material conditions* as reflected in the first column of figure one that are brought into the action arena for purposes of supporting or effecting care and support for HIV/AIDS cases. The study analyses how initiatives and decisions pertaining to various assets, endowments, and other resources are generated or are passed around with the intent of enabling the provision of care and support. Care and support is thus the outcome of the decisions and activities and this is reflected in transaction cost terms as already defined.

Second, the framework shows how *attributes of the community*, which is the physical and environment in which the community live, such as the distances from markets and from hospitals, transport and communication facilities and general state of deprivation, impact the action arena. And lastly, the framework allows the researcher to analyse the role of *rules* that emerge from the everyday exchanges within groups and those dropped down from higher level organizations such as the NGOs and government, to which these institutions are answerable.

Attributes and rules (in the first column of figure one) of each CHBC group put together with the characteristics of the actors yield a unique pattern of interacting methods, and thus, a unique pattern of outcomes is expected for each set of the causal combination.

Thus, three models that link clusters of variables are analysed as follows according to the feed-forward relations indicated by the arrows;

Model 1: (**Assets** e.g. livestock, food items, time, clothing etc) → (**ACTION**) → (**Outcomes**)

Model 2: (**Attributes** e.g. social networks, infrastructure etc.) → (**ACTION**) → (**Outcomes**)

Model 3: (External and internal **rules/norms** in use) → (**ACTION**) → (**Outcomes**)

#### **4.3.3 Specific Analytical Techniques**

In order to reach the goals of this study a number of techniques were applied to process the information collected through the approaches outlined above. The analytical process involved a multi-stage as well as a mixed method process.

#### **4.3.4 Quantitative Techniques**

Stage one involved analysing data collected from structured questionnaires that were administered to households. The essence of these data was to reflect on the background conditions of the communities interacting with the CHBCs. The data were input using the SPSS package and then selected variables reflecting on the relevant conditions were transferred into Lumenaut and Excel software packages.

Simple bivariate regression relationships were run to classify the households by:

*Sources of income, types of employment, land ownership, type of expenditures, number of patients in care, funeral visits, benefits from the CHBCs, and by type of contribution they make to CHBC by district.* This made reflection on background possible by enabling triangulation with the data from focus group discussions and the key informant interviews. It also made distinguishing of peculiar factors in the two locations possible.

### **4.3.5 Qualitative Techniques**

Qualitative techniques involved analysing the information from the focus group discussions and the key informant interviews. This was done in the following three steps.

#### **4.3.5.1 Construction of Categories for Analysis**

On the basis of the broad categories specified in the IAD framework and the principles of NIE the following categories for analysis were constructed and summarised as per focus group.

1. Perspectives held by subjects
2. Strategies and Adaptation
3. Regularly Occurring Behaviour
4. Material and Resources
5. Motivation and Incentives
6. Assets and equipment

#### **4.3.5.2 Relevance of the Categorical Summaries in NIE**

##### ***Perspectives held by subjects***

The category of perspectives was constructed from responses to the questions that sought an understanding of the subjects regarding various aspects of the CHBC arrangements. The varying opinions were then grouped together if they were considered similar.

The NIE is an approach that enables use of the normative standards of measurement. It extends economic theory by incorporating ideas and ideologies (mental modes) into the analysis, modelling the political processes as critical factors in the performance of economies (Richter, 2003:8). In this case the perspectives of the actors are targeting to reveal socio-cultural foundations on which each community is built. According to North (1990) these social and cultural foundations are critical because ethnic ties, social networks and social capital are all important factors that directly affect performance of the actors such as the CHBCs. Williamson refers to this as institutional embeddedness. Welzel *et al* (2005:124) observe that individuals invest in social contacts so that they can gain access to socially embedded resources. It must be clear that the ties do explain a group's level of preparedness

in the event of uncertainties, and therefore must also explain why some transactions are arranged in certain ways. This is what makes this category important for this study.

### ***Strategies and Adaptation***

Strategies and adaptive processes were grouped together based on similarities of responses to working methods. Grouping took into account how many times each was mentioned (frequency) and in order of importance (ranking) for delivery of CHBC services. North (1990:1) describes institutions as the ‘rules of the game’ that set limits on human behaviour. North’s definition allows room for the economic agents to reason about their situations, and provides them with an opportunity to ‘learn by doing over time’. Learning by doing plays an equivalent role as sunk costs in mainstream economics. This means that the agents must be able to strategise in order to achieve their goals with ease. Strategising requires an understanding of the constraints around which decisions must be made, such as contractual obligations and other obstacles. North also shows that the logic of ‘adaptive efficiency’ provides the incentives to encourage the development of decision making processes that will allow societies to maximize the efforts required to explore alternative ways of solving problems, such as who does what and when or role sharing among others. Learning from failures enables the elimination of organizational errors and pave the way for change. From this point of view of the NIE capacity to strategise and adapt clearly has transaction cost implications which is what is being examined in this study.

### ***Regularly Occurring Behaviour***

This category captures what the respondents enumerated as routine activities for their groups. NIE recognises that regularly occurring behaviour is a function of choices made based on governance arrangements, e.g. what is stipulated in the contractual agreements with other agents, or from the social constraints playing at the back of the actor’s mind. Practically, routine behaviour explains what is acceptable or not acceptable within the collective choices. It is the property of enabling to reflect on aspects of compliance or non-compliance in the contractual arrangements and choice decisions from social foundations that help to explain why they do what they do. In other words, transaction arrangements will reflect what transaction cost economising patterns are in use. Rudolf Richter shows that being able to explain why institutional arrangements are as they are is critical, and on the empirical front, this property must draw upon constraints of the real world (Richter, 2003:7).

### ***Material and Resources***

Respondents were asked to enumerate what materials and resources they bring to CHBC. These were classified into categories that reflected the use values or type and frequency. The NIE emphasises the importance of materials and resources brought to the action arena by the actors. In this case, the study analyses how initiatives and decisions pertaining to various assets, endowments, and other resources are generated or are passed around with the intent of enabling care and support. This gives insights into the pressures regarding what constraints and possible effects they are faced with. In other words, there is need to explain what they have or do not have for service delivery, as this becomes the basis for external interventions and the role of complementarities. More importantly, it helps to explain transaction arrangements based on the understanding that Care and Support are outcomes of decisions and activities pertaining to resources, such as how do they generate their own resources to ensure continuity.

### ***Motivation and Incentives***

In this category group discussions sought to find out why they joined and what motivates them to remain in the service. Motivations were categorised by source and type. That is whether they are in the response framework by design to motivate actors or if they are merely perceived as informal motivations associated with the organizational arrangements. The definition in the new institutional literature, describing institutions as ‘taken for granted actions’ that are reinforced subconsciously by rewards and sanctions (Zucker, 1991: cited in Heikkila and Isett, 2004:8) is applicable to this analytical process. The taken for granted nature of norms reflects realistic human behaviour but emphasizes hidden motivations for acting, whilst acknowledging these normative and heuristic influences sheds light on decision outcomes that may not account for exogenous incentive structures imposed on the actor. Tolbert and Zucker (1994:27) point out the usefulness of applying the New Institutional Theory to analyses where the material benefits associated with a given structure are not readily calculable. Second, is the self-interest seeking behaviour, commonly known as opportunism developed by Williamson (1985:30). Transaction costs economics takes strong interest in appeals to self-seeking behaviour because this behaviour rests on incentives brought about by the institutional arrangements and will obviously influence the conduct of the economic agents. In this case, it is applied to explain entry and exit in CHBC structures among other processes.



### ***Assets and equipment***

Assets and equipment were separated from resources in order to understand what arrangements are in place as a fall back position set up within the control of the CHBC. This mainly captured elements of investments that are built to reduce uncertainty by complementing contributions from other network agents.

The NIE emphasizes and gives insights into the importance that is anchored in access to assets. The NIE posits institutional development as a function of the institutional environment, information flows, asset characteristics, and the vulnerability and power of different actors. Therefore, where NIE attempts to evaluate the physical and economic characteristics of assets in use, it must be done with due reference to the institutional arrangements which constrain or promote their use. The importance of this aspect to this study is that in the delivery of CHBC service, members of the communities and other partners are involved in the creation, development and promotion of the use of a wide range of assets. In some cases inadequate investment is undertaken and this must be highlighted.

#### **4.3.5.3 Isolating and Coding for Variable Formation**

In order to make comparison across the CHBC groups possible a further analysis of the data in the categorical summaries was done. This was because each group had varied combinations of observations in a specific category. For example, take the 'Motivation and Incentives' category. Factors prevalent in group three do not exactly match those of group seven. A qualitative analysis technique of isolating and coding the factors within each group was done. Coding enabled the grouping of similar observations so they could be counted as same objects and made their occurrence more comparable across the groups (see Tables in Chapters Five, Six and Seven).

#### **4.3.5.4 Turning Qualitative Observations into numbers**

The essence of applying the above qualitative techniques was to enable us to form concepts that can be analysed comparatively across cases. This stage, therefore, created frequencies of the factors studied under each categorical summary as they occurred per group. The frequencies were compiled into tables indicating factors as variables. The raw frequencies were then aggregated into cumulative frequencies. Ranking was done on the basis of these cumulative frequencies to which symbolic meanings were then attached in as far as the operations of the

CHBCs were concerned. This is the process of concept formation whereby you make sense of the data aided by prior knowledge of the situation under study as well as the possibility of being able to triangulate with information collected through other methods.

#### **4.4 Summary and Conclusion**

The chapter sought to give an outline of the approach and techniques adopted by the study to explicate the issues of institutional arrangements and the effectiveness of the CHBC institutions. The Chapter has been presented in two parts with the first part focusing on sampling and data collection methods and the second part covering the analytical techniques. The study adopts a behavioural (normative) approach in an institutional paradigm. Therefore, mixed methods of qualitative and quantitative techniques of drawing insights from the perceptions and aspirations of the participating members through their daily routines have been highlighted.

## Chapter Five

### **The Role of Community Attributes in CHBC Service Delivery**

#### **5.1 Introduction**

The aim of this chapter is to present the first part of the research findings. The second part is found in Chapter Six. This chapter focuses on attributes of the communities such as their background socio-economic conditions and perceptions of their own situation. According to Keefer and Knack (2006:721) the challenge for development theorists and policy makers is to identify the mechanisms that will create, nurture and sustain types of combinations of social relationships that are conducive to building dynamic participatory societies and sustainable equitable economies. Similarly the application of the Institutional Analysis and Development Framework emphasizes the importance of understanding the role played by community attributes in the form of physical and social conditions, economic opportunities, and contextual socio-cultural attributes prevailing in the communities in building sustainable societies. Based on the foregoing, this chapter specifically aims to identify these community specific conditions at play and evaluate how they influence the arrangement of transactions for delivering community and home based health care. These society specific factors must be distinguished from those associated with other organizations, which are the subject matter of chapter six.

These background conditions pave the way for participation in social initiatives such as CHBC's responses to the pandemic. In other words, what the communities have or do not have in the way of socio-economic conditions and their perceptions of these influences the delivery of care and support for HIV/AIDS sufferers. Edstrom and Samuels (2007:6) contend that effective care and treatment requires livelihood security, freedom from hunger and good sanitation on the part of those providing the care. This idea also suggests that physical conditions as well as social conditions such as geographical features and infrastructures surrounding the economic agents play an important part in the continuum of care and support. In Institutional Economics these are the equivalent of the inputs or raw materials that go into a production function in main stream economics. Institutionalism goes further to look at how agents interact in the process of institution building for purposes of strengthening the responsiveness of each economic agent. In

considering institution building in the wake of HIV/AIDS and community vulnerabilities this chapter seeks to shed light on the role of background community conditions on participation in the care and support for those affected by HIV/AIDS in rural Malawi.

Simply put, the research process endeavors to explain '*why the actors do what they do*' as they face the constraints of the real world, a configurational qualitative analysis which allows for case or concept formation by formulating patterns that can be used in comparative and descriptive analysis in an application of the IAD framework.

The techniques applied here do allow use of mixed methods between qualitative and quantitative data that makes it possible to show the existence of regular patterns as well as unique cases of interest in the subjects' behavior. With this property the phenomena can be broken down into parts or its parts can be aggregated for purposes of description and making inferences relevant to the focal point (action arena in this case) that is critical for the analysis. According to Neuman (2006: 458-459) qualitative analysis is less standardized and is more often inductive in its analytical processes. It centers on showing that an explanation is plausible and tends to be rich in detail that must be organized to show a coherent picture. In this case the picture being illustrated is one of the practical sides to the social lives of the communities responding to the HIV/AIDS pandemic and its demands.

Specifically the following are the issues to be covered in this chapter;

- i) Explaining the situation regarding resource endowments and mobilization efforts
- ii) Investigating general obstacles to participation
- iii) Documenting perceptions and symbols that highlight the members' mind set
- iv) Highlighting the distinct patterns emerging in the two study areas

The evidence of the CHBC actions and processes is presented in this chapter in two main ways. Firstly, quantifiable explanatory variables about the communities gathered through a structured questionnaire are summarized and presented as basic and cross comparative tables with selected indicators showing background community conditions. Secondly, findings designed to draw out and explain non-quantifiable factors of importance such as perceptions and symbols regarding

their own situation and the home based care and support initiatives are presented in terms of thematic or categorical summaries, summary tables and analytical concepts. For purposes of the comparative nature of the analysis, these summaries are designed to reveal the relative operational importance of each factor within a given community group as well as the importance of the same factor across all CHBC groups in the sample.

According to Neuman (2006:459-460) qualitative information can be categorized into themes which can be used for concept formation to examine relationships in the analysis. By its nature, transactions cost economics relies more on comparative institutional analysis (Williamson, 1985:18) thus, these thematic summaries, concepts and summary tables have been constructed to illustrate patterns of similarities and peculiarities that can be comparatively scrutinized. On the other hand, Koontz (2003:1-2) emphasizes that the theoretical literature on the IAD framework being applied in this study is well suited for purposes of comparative evaluation which is premised on transaction costs. Specific descriptions of these classifications and analytical explanations have been duly discussed in Chapter Four which is an outline of the methodology.

## **5.2 Conceptualizing Attributes of the Communities for CHBC**

This section aims to highlight the socio-economic conditions in which the community members exist, with the view that these background conditions have important effects on the day to day running of the CHBC service delivery. In other words factors like poverty levels, facilities at their disposal, and infrastructures among other factors, play a vital role in influencing their decisions and actions and the level of support they can offer.

### **5.2.1 Characteristics of Communities**

Ostrom *et al* (2005:829) in their discussion of the IAD framework show that the background conditions of the communities are an important factor for their actions and consequent attainment of the group goals. Scharpf (2000:8) also emphasizes the importance of ‘characteristics of the institutional setting’ as a variable explaining institutional behaviour. In this study characteristics of the institutions include the background physical and economic conditions

on the one hand and materials on the other. These are duly discussed as they influence the transaction arrangements for CHBC. This section, therefore, gives highlights of the background characteristics of the study areas. A detailed presentation of the background characteristics about rural communities in Malawi is found in Chapter One which is an outline of the Malawi Economy and an overview of the Health Sector initiatives.

The major question to be asked is ‘what *factors influence the important decisions pertaining to CHBC service delivery?*’ i.e. why do they choose to do things in a certain way and not in some other ways? The importance of understanding the context and diversity of local dynamics in such situations is highlighted by a number of scholarly works. For example, Mbiba (2001: 8) and Topouzis (1998:13) both highlight the importance of understanding background factors such as land for such analyses, not only for the support they provide for extension of social and economic rights, but also that even the broader concept of economic development is also preconditioned by these factors. Thus, factors such as land, employment opportunities and major sources of income responsible for the determination of social and economic rights and enabling participation of rural communities in the national response to HIV/AIDS with regard to options and choices are, therefore, scrutinized in table 5.1 below.

Table 5.1 below summarizes selected key community livelihood variables for the two districts from which the CHBCs were sampled. In particular, the table shows the sources of livelihoods and the relative importance of each source within a given category and within a district, making it possible to draw comparisons between variables while also revealing distinct patterns of importance between the two districts.

The percentages given in the table represent the proportion of households in the district sample that has a particular attribute. For example households were asked to rank the first choice sources of income, thus 44% in Ntcheu would have indicated that they rely on crop sales while 16% have small business as the main source of income. The Table also shows the distribution of employment opportunities and land ownership amongst the households.

**Table 5.1: Important Sources of Community Livelihoods**

CATEGORY	VARIABLE	DISTRICTS		AVERAGE
		NTCHEU	THYOLO	
		%	%	%
MSI	Crop sales	44	40	42
	Small business	16	32	24
	Salary <sup>1</sup>	14	16	15
	Other	26	12	19
EMPLOYT	Agric.	31	40	36
	Govt.	18	9	14
	Own Business	38	70	55
LAND	0 - 1	17	33	26
	1 - 1.75	32	41	37
	2 - 2.75	27	19	22
	3+	24	7	14

Source: Munthali (2007).

**Notes:**

*MSI* = the main source of income to the community members

*EMPLOYT* = type of employment for members of households interviewed

*LAND* = a percentage of households owning the stated amount of land in hectares

*TOTALS* = the average percent for the total sample from the two districts.

The table clearly reveals that for both districts of Ntcheu and Thyolo most households depend on crop sales for their incomes. While small businesses also play a major role in the households, the proportion of the households depending on salaries is very low at 14 and 16% for Ntcheu and Thyolo districts respectively, suggesting not only the limited employment opportunities but also emphasizing the absence of infrastructures and various forms of facilities. Absence of infrastructures and formal facilities also means that there is a low demand for skilled labour in these areas hence the emphasis on farm-labour employment and own-small business employment.

<sup>1</sup> Salary is defined as non-farm monthly employment as the main source of income

While it is well known that all rural communities in Malawi are poor, lacking in infrastructure and employment opportunities, the major distinguishing features of the two districts are that Thyolo District which was the main site for the study has its poverty levels exacerbated by land distribution issues. The district is under vast tea plantations that are privately owned such that villages have been squeezed into specific hilly areas making it almost impossible for any realistic chances of farming success. In Thyolo land ownership is skewed towards less than 1.75 hectares per household, clearly insufficient to support an average household estimated at 5 persons, while in Ntcheu most households own at least 1.75 hectares. The significance of this is that the Food and Agricultural Organization of the UN reported that from 1994 there has been a noticeable decline in cultivable land held by a household from an average of about 2 hectares. Thus the indication of an average of 1.75 hectares per household symbolizes a case of worsening poverty amongst the poor people who mostly depend on own-farm production. The limited access to land in Thyolo District due to the vast tea estates owned by various private companies makes the aspect of getting formal employment in agriculture an important avenue for supplementing own crop production, but this only offers limited opportunities because of the seasonal nature of the employment on the tea estates.

Seasonal employment, that is to say employment only available for a short time in each year means resources from this are obviously way below annual requirements for a household. For this reason, most households engage in small businesses, mainly selling small quantities of grocery wares and a range of already prepared food stuffs, often bought at a lower price, to complete the annual livelihood. On account of this, there are more households reported to be in small businesses (70%) in Thyolo. With reference to Table 5.1 above, the fact that the various forms of employment being reflected are complementary explains why the proportions do not add up to 100%. That is to say that, if one household engages in agriculture, that does not preclude the household from engaging in small business and at the same time during certain months they do engage in labor employment in the tea estates, so the forms of employment are not exclusive. The rate of 70% of households involved in small businesses only reflects the incompleteness of livelihoods coming from formal employment and farming, to an extent that most households remain with gaps that call for additional efforts in the form of market exchange. Besides, not all households are located next to tea estates; therefore, some have greater chances



of getting employment on tea estates than others, implying that labor employment should not be expected to be as predominant in Thyolo as small businesses would be. Small businesses can be undertaken virtually from anywhere, from outside the door steps, from the road side and indeed in the formal area markets, thus this automatically becomes reliable avenue for meeting some of their livelihoods.

Communities in Ntcheu are more evenly spread around agricultural employment, own-business and civil service employment indicating a better spread of infrastructure and opportunities. The fact that Ntcheu is situated along the main road connecting the two major cities of Blantyre and Lilongwe accounts for better access to facilities, and besides, the communities are also favoured with better land distribution than is the case in Thyolo. This suggests that the excessive need for own business as a fall back position exhibited by the Thyolo communities is rather suppressed in Ntcheu. However, both districts suffer from inadequate health facilities, especially from a health staff perspective in the government hospitals. For instance it was reported that in Thyolo a medical assistant would treat up to 200 patients per day and it is estimated that 10,000 patients with HIV/AIDS were being attended to (MSF, 2007).

The above section has revealed the importance of household land holding and the consequent production levels. The table below shows production levels for the maize crop in the two areas. The Table categorizes households by district and by level of production for each crop in the growing season prior to this research. The idea is to show that the majority are in the least production category. The ‘bags’ are thus the total output by all households in a given category, for example, 24% of the households have got only about 30 bags at their disposal in Ntcheu district. On the other, much fewer households with better land holding have much more food at their disposal. For example, for production in the category of 26 to 30 bags there are only 7 households, constituting 14% consuming up to 196 bags of maize.

**Table 5.2: Household Maize Production by District<sup>2</sup> (in 50 kg bags)**

District	0.5-5			6-10			11-25			26-30			Total		Mean
	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	Bags	(Bags/H
NTCHEU	12	24	(30)	12	24	(96)	16	33	(272)	7	14	(196)	49	594	12
THYOLO	29	58	(72.5)	13	26	(104)	4	8	(68)	2	4	(56)	50	300.5	6

Source: Munthali (2008)

**Notes:** The quantities are given in estimates of fifty kilogram bags per household.

According to IDASA (2003:29) in consideration of the ‘rights based approach’ which was introduced in the Southern Africa region as a dimension to embrace the responses to the HIV/AIDS pandemic, nutritional standards have a major impact on prevention and care for HIV/AIDS cases. This means that fighting against HIV/AIDS in the Southern Africa Development Coordination (SADC) region recognizes that individuals infected and affected by HIV/AIDS have the right to food. The importance of considering food production not only rests on the critical food shortages that have been reported all too often (AVERT, 2008:8, Conroy *et al.* 2006:79) to affect households nutritional needs. It also has an important dimension of supporting the use of ARVs to those in need because ARVs must be taken with a minimal degree of nutritional cover. Furthermore, productivity levels are also known to get knocked by the AIDS pandemic because HIV/AIDS reduces available labour for farm and household processes. The observed shortfalls in maize production, which is the staple food for Malawi, have more profound consequences for the care and support given by CHBCs.

Table 5.2 clearly exhibits a case of household vulnerability due to inadequacy of agricultural productivity which is so much relied upon. In particular, Thyolo district has an estimated mean productivity of 6 bags per household per annum. Closer scrutiny of the data shows that more than half of the individuals interviewed are reported to produce in the category of less than 10 bags per annum in that district. The significance of this observation is that a typical Malawian household of 5 persons is said to require between 900 and 1100 kilograms of the staple food per year. Thus, there is a glaring shortfall in what these rural families are able to produce, and the

<sup>2</sup> Estimated number of bags in brackets is a product of the median of each category (such as 2.5 bags for those producing less than 5) and the number of households in that category

situation is exacerbated by the observation that there are no meaningful alternative livelihoods (UNDP, 2007:3). It also has an important implication of exacerbating the HIV/AIDS crisis by reducing the families' capacities to cope and thus increasing vulnerabilities even more.

Table 5.2 also reveals the existence of inequalities in the two locations. Far fewer individuals are found in the upper scale producing close to 900 Kg or more in both districts, with families in Ntcheu clearly doing better than their Thyolo counterparts. Clearly productivity in Thyolo is worse than in Ntcheu, making households there less prepared to deal with the crisis. Thus, Thyolo households have a greater need for alternative arrangements for social protection such as public sector transfers or off-farm income and food generating mechanisms. Production of groundnuts, another important crop, also reveals the same situation as presented in Table 5.3 below.

**Table 5.3: Household Production of Groundnuts by District<sup>3</sup> (in 50 kg bags)**

District	0.5-5			6-10			11-25			26-30			Total		Mean (Bags/H
	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	Bags	
NTCHEU	29	76	(72.5)	6	16	(48)	3	8	(51)	0	-	-	38	171.5	4.5
THYOLO	30	79	(75)	7	18	(56)	1	3	(17)	0	-	-	38	148	3.9

Source: Munthali (2008)

The constraints that apply to the production of maize, the staple crop, such as limited land size and limited access to inputs such as fertilizers and seeds also apply to groundnuts. However, some caution is required when studying this table because growing groundnuts is more sensitive to variations in climatic conditions than maize and Thyolo is not as suitable for groundnuts as Ntcheu. Nevertheless groundnuts are an important crop that fetches good returns on the local markets and most households make attempts to grow them.

Table 5.3 suggests that groundnuts are mostly grown on a small scale. Quantities are either consumed or sold. Rural households in Malawi do not have well developed and standardized technologies for storing groundnuts once produced as is the case with maize output. After

<sup>3</sup> Estimated number of bags in brackets is a product of the median of each category (such as 2.5 bags for those producing less than 5) and the number of households in that category

harvesting the farmers are expected to sell the crop in small quantities on the food markets or to the government food purchasing agent -i.e. ADMARC<sup>4</sup> where storage facilities exist. From this outlet farmers have an opportunity to buy food stocks back during lean periods. The most important observation in this table is that for purposes of making an impact on the care and support processes in the realm of HIV/AIDS, the limited stocks of groundnuts cannot facilitate a generation of significant income for these households to fall back on. With the liberalization of food prices it means that farmers would have to buy back stocks from ADMARC at prices they can hardly afford because there is always a mismatch between their own disposal price and what ADMARC charges after factoring in operational costs such as transportation, handling and storage. Furthermore, money generated by the farmers would have been long used up for the numerous competing needs at the households. In this vein groundnuts would not even be considered a crucial basic nutritional requirement if a household is faced with a hunger crisis in Malawi. So this outcome does very little in helping households in escaping from livelihood vulnerabilities and therefore complicating their crisis in the face of HIV/AIDS.

Another crop that ranks highly among households in rural Malawi is beans. Beans are planted together with maize in the upland fields during the rainy season as well as in wetlands during the dry season. So essentially the land size allocated to the main staple crop is the same as that allocated to beans. However this crop does not receive the same attention as maize, such as ensuring an annual supply of improved seed varieties for all farmers on the market. Improved bean varieties coupled with other technological advancements targeted to increase farm produce for the small farmers are available, but in the case of beans they get recycled more often than not and are not favoured with fertilizer inputs as is the case with maize. This explains the low productivity in beans. The production levels for beans, just like for groundnuts, suggest that those with larger land holdings do not bother to cultivate the crop because of limited incentives associated with this kind of effort.

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<sup>4</sup> Stands for Agricultural Development and Marketing Corporation of Malawi

**Table 5.4: Household Production of Beans by District<sup>5</sup> (in 50 kg bags)**

District	0.5-5			6-10			11-25			26-30			Total		Mean (Bags /HH)
	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	%	Bags	HH	Bags	
NTCHEU	17	85	(42.5)	2	10	(16)	1	5	(17)	0	-	-	20	75.5	3.8
THYOLO	14	70	(35)	0	0	-	1	5	(17)	0	-	-	15	52	3.5

Source: Munthali (2008)

Table 5.4 shows that beans are produced in limited amounts by even fewer households than maize and groundnuts already discussed above. Beans also serve two purposes, that is for consumption and for income generation through market sales, the household consumption aspect being the more dominant one because its market value is low since the food product is readily accessible in all local markets. It is for this reason that the majority of households are producing in the range of less than five bags.

For purposes of consumption, typically beans are boiled and taken together with porridge that is prepared from maize flour in most homes in Malawi. This is a very regular dish. Rural households find it quite easy to store beans within their homes. The fact that they are also easy to access in local markets makes it a more plausible option for the households' nutritional cover of healthy individuals. However, for an individual suffering from HIV/AIDS more nutritious foods such as meat and fish are required (Conroy, *et al.* 2006: 144). This means that households have to go out of their way to source more nutritious foods not only for the nutritional contribution but also to deal with the loss of appetite that often goes with any form of illness. The care givers are aware of this need but often times the need has to go unattended because they cannot afford. This is an extra form of pressure on those giving care and support for HIV/AIDS sufferers in the communities as it calls into question what other forms of fall back position might be available at their disposal to deal with such dilemmas.

<sup>5</sup> Estimated number of bags in brackets is a product of the median of each category (such as 2.5 bags for those producing less than 5) and the number of households in that category

### 5.2.1.1 Sources of Assistance at Community level

In light of the above, the research sought to compile the available sources of assistance in the villages in order to document where they turn to in times of need. The following table summarizes the sources of assistance that the households relied upon in the period of one year before the survey to address various domestic deficiencies. Respondents were asked to state where they sought assistance of any kind for livelihoods. Thus the table aggregates the number of household in terms of whether they did seek assistance, and which was their first point of call for any stated form of assistance?

**Table 5.5: Sources of Assistance at Community Level**

Source of Assistance	Ntcheu			Thyolo		
	BC	CON	FS	BC	CON	FS
Immediate Family	1	2	16	1	2	14
Extended Family	-	2	4	-	4	11
Friends	2	17	5	1	8	3
NGO	11	4	0	2	0	2
Money Lenders	2	4	2	6	2	0
Other	3	2	1	6	7	4
None	29	18	20	34	26	16

Source: Munthali (2008)

**Notes**

**BC** = Business Credit

**CON** = borrowing for Consumption

**FS** = seeking assistance to address Food Security needs at own household

The summary in Table 5.5 shows that a wide range of social capital exists in these communities (more on this is discussed in Section 7.2.1.1 in Chapter Seven as an aspect of networking). Some of the communities also have access to commercial capital but the reported indicators show that usage of these facilities is quite varied. By and large there is a clear pattern of dependency on immediate family for food security concerns, obtaining monetary credit from friends for purposes of consumption at home and accessing commercial credit from rural credit schemes for investment purposes particularly evident in Ntcheu district. What is interesting in this outcome is that a complete contrast emerges between the two districts. Households in Thyolo district do not engage in rural finance credit activities. There are a number of rural finance schemes working in Malawi, for example the Malawi Rural Development Fund (MARDEF) one of the government

social protection initiatives, an international private micro credit scheme called FINCA, and the Malawi Union of Savings and Credit Cooperatives (MUSCCO), among others, all of which can be used to access credit either as a group or individual.

One thing that is clear is that households in Ntcheu are able to utilize the credit facilities because of the business opportunities at their disposal. Business opportunities mean that the individuals will be able to repay the loans. Being on the main route between the two major cities households in this area engage in selling various forms of merchandise along the road such as agricultural output. Such opportunities are almost non-existent in Thyolo. So these households have to rely on close family and extended family avenues for help in times of need, and need in Thyolo constitutes food security as Table 5.5 indicates. These are the same families unable to produce output to last them the whole year round, so even the limited output is not only allocated for the consumption of the immediate household but also for the extended family ties. The need to service the extended family is an indication for the amount of pressure placed on the households by the inadequacies of the background conditions which are themselves a function of poverty. More discussion regarding use of NGOs and friends for food security is found in Section 7.2.1.1 under the emerging aspects of social capital in the community.

Poverty levels become more apparent when you look at other household indicators of what the household owns. These indicators are given in Table 5.6 below. The individuals responding to the questionnaire were asked to indicate if they have these basic household assets in their household. The Table categorizes the households into 'haves' and 'have not' in order to underscore the level of deprivation in these communities. But it also serves to make comparison between the two locations possible.

The indicators in Table 5.6 have two fundamental roles in this research. One set of indicators, namely bed with mattresses, sofa set, table with chairs are used to give an indication of affluence at community level. Normally such assets are found and associated with families that are relatively well off. If a household can allocate resources to purchase them, they are considered to have some basic wealth in the Malawian rural community setting. An overview of these data

suggests clear cut disparities between families in Thyolo and Ntcheu districts as the following paragraph explains.

**Table 5.6: Ownership of Basic Household Assets**

Indicator	Ntcheu		Thyolo	
	Yes	No	Yes	No
Bed with mattress	22	27	8	41
Sofa set	11	38	3	47
Table with chairs	34	15	24	26
Paraffin Lamp	30	19	20	30
Radio	34	15	24	26
Mosquito net	37	12	29	21
Solar electricity panel	4	45	0	50
Bicycle	21	28	25	25

Source: Munthali (2008)

Households in Thyolo are under-resourced to the extent that they do not allocate expenditures towards obtaining the basic wealth assets as much as is the case in Ntcheu. The data shows that the majority of people sleep on floor mats in Thyolo where only 8 households were reported to have beds. Even though the question merely aimed to find out if the household had at least one bed and a mattress, it is not hard to imagine that even the households that answered yes to this question have inhabitants who sleep on the floor. This is more common with children and other dependents. In the same area only three households responded that they had sofa sets. These are clearly seen as luxuries and too expensive for these families. A case for their economising behaviour is made stronger when you observe that more households own a table and chairs. This is a cheaper alternative for them. Chairs have a crucial symbolic role when a household receives visitors. In order to show respect to visitors you invite them to sit on the chairs outside the house or welcome them to enter and sit on them inside. If food is offered to the visitors then the table becomes more useful in elevating the stature of the hosts. In the absence of these chairs the host family would normally have to apologize to the visitors that they do not have chairs, which is an embarrassing gesture to make, while asking them to sit on the floor or a mat. So the importance of these assets can not be overemphasized.

The second set of indicators which includes a paraffin lamp, radio, mosquito net, solar panel and a bicycle are considered as key basic needs for every household. These play a vital role in the



day to day life of the family. The Malawi Government has been trying to promote use of solar panels for generation of electricity for more than a decade now. These were considered as cheaper alternatives to the hydro produced electricity which excludes rural areas to this day. Although the infrastructure for a rural electrification project is being put in place now, the communities are yet to get connected, and this will only happen in phases meaning that for the majority this development will take a long time to be realized. Meanwhile the lack of the solar panels suggests that the communities are still cut off from any form of electricity and remain reliant on paraffin lamps or make do with lighting a fire in their homes.

Use or absence of paraffin lamps in the homes should be looked at against the scarcity of paraffin in the rural areas both from prohibitive tendencies due to sustained irregularities in supply as well as the persistent price rises which have taken the price to about MK168 per liter<sup>6</sup>. A household needs about 4 liters of paraffin in a month. This means allocating over MK600 for paraffin in a month constitutes an obvious problem for such households, hence the limited numbers using paraffin lamps when it would have been expected that almost all of them would do so in the absence of electricity. For example, at current prices an allocation of K600 for paraffin constitutes an opportunity cost of about 10 kilograms of maize flour that can serve an average family of five for almost one week.

Ownership of a radio is very important for communication. Radio is the most important channel for passing information to rural people in the absence of other channels such as newspapers. If a household does not have a radio then they are really cut off from vital developmental information. Similarly, a bicycle is so important for transportation because no formal transport system exists in these locations. This explains why there are relatively more households with bicycles at their disposal. On the other hand, those who answered no to the availability of these items (approximately 50% in each district) must be seen to be in extreme deprivation.

Lastly, with the serious prevalence of malaria breeding mosquitoes in Malawi mosquito nets are important household assets. The government and other agents such as the Population Services International (PSI) have been promoting all households acquiring treated bed nets. Nets have

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<sup>6</sup> One United States Dollar is equivalent to about MK140

always been available at a market price, but these were hardly ever acquired by rural communities. This necessitated the free distribution or sell at a token price in the malarial control drive. The Malawi Demographic and Health Survey (DHS) 2004 reported that rural Malawi had an average of 0.6 nets per household. While a lot of these nets have been given as hand outs or subsidized in some other cases, these families still need to purchase the insecticides for treating the nets. The average drops to 0.5 per household when you consider nets that were being treated (GOM, 2004: 251). The household's role is to obtain the insecticides and treat the nets regularly. The drop suggests that households are still unable to cope with the demands of treating the nets regularly at the cost of MK60 per tablet of the insecticides. It is perhaps not as much a priority as the government and other partners would like it to be perceived. However, malaria remains an enormous challenge for the government as it causes up to 40% of deaths among young children and has huge cost implications for the health sector (Conroy, *et al.* 2006: 35). The fact that anti-malaria medicines are accessed freely in hospitals should not be ruled out as one factor working against the drive of investing in bed nets, in which case the two are viewed as alternative solutions.

The anti-malaria roll back policy has been targeting to put about 60% of under five year olds to sleep under these treated nets. It has also been targeting pregnant women in malaria prevention to avoid pregnancy complications in the course of treating malaria infections. The findings in this study, which is 74% usage of nets in Ntcheu and 58% in Thyolo, reaffirms the observation in the DHS 2004 that usage of nets has been advanced more in urban centers and that it grows with the level of wealth. In terms of economic development Ntcheu district is slightly ahead of Thyolo district. The data also reveals the significant role played by the subsidization of the mosquito nets by local and international partners leading to high rates of ownership of nets in the villages.

### **5.2.2 Household Consumption Spending Patterns**

This section serves to present another dimension to welfare indicators. Consumption is one of the key indicators used in social science studies of the welfare state of individuals and households, especially in developing economies. The main reason is that in relatively poor settings consumption takes up the bulk of incomes. In most cases, many rural communities, such as in

Malawi, tend not to produce enough food crops to feed households all year round due to land and climatic constraints and various technological reasons such as those required to boost soil fertility (Conroy, *et al.* 2006:93). Given the inadequacy of farm produce, much attention has gone to studying the broader expenditure patterns of such households in order to explain their priorities.

**Table 5.7: Estimated Household Expenditures (Per Annum)**

VARIABLE	RANGE	DISTRICTS		TOTALS
		NTCHEU % <sup>7</sup>	THYOLO %	
Fertilizer	Up to K2000 <sup>8</sup>	39	60	52
	K2000 - 4000	24	16	19
	Above K4000	24	5	13
Medicines	Up to K500	29	16	21
	Above K500	17	5	10
Clothing	Up to K500	12	31	23
	Above K500	44	28	34

Source: Munthali (2007)

**Notes:**

*Fertilizer* = proportion of households reported to spend on fertilizer

*Medicines* = a percentage of sampled households reported to spend on medicines

*Clothing* = a proportion of households reported to spend on clothing

Table 5.7 gives insight into the most important annual household monetary expenditures estimated for a recall period of one year. The essence of Table 5.7 is not to make inter-household comparisons; rather it serves to make inter-district cases of the level of deprivation by showing the relative levels of expenditure. It is also in keeping with the comparative analysis of important expenditure patterns and household spending priorities. This is done in recognition of the fact

<sup>7</sup> Gives percentage of households that spend in that category

<sup>8</sup> K2000 is equivalent to two 50 kg bags of fertilizer at the government fixed (subsidized) retail price

that spending income is not the most important part of their annual consumption because they rely on own-farm production. Income spending, however, does signal the next important priorities for each household in Malawi.

This table must not only be looked at alongside Table 5.1 above but also with the analytical framework in mind whereby the background conditions of the communities are being considered with the view of the community's capacities to engage in meaningful interaction with other organizations in combating HIV/AIDS and specifically in making day to day decisions on the institutions of CHBC.

In keeping with the importance of own farm production, Table 5.7 shows that spending on fertilizer takes precedence in both districts. It is clear that there is inadequate agricultural production in Thyolo. This is because the majority of households (60%) who were also noted to have insufficient land in Table 5.1 also show very low use of fertilizer. This suggests the cycle of poverty as there is not enough land and low use of fertilizer to grow the crops to lift them out of poverty. Given the inability of the land to generate a self sustaining level of income along with the sporadic nature of employment on the tea plantations, the inhabitants of Thyolo have resorted to small scale businesses (predominantly grocery wares obtained from wholesale outlets sold at a small profit) as the main source of income generation. However, what is not clear is why spending money on actual food items is not one of the important expenditure items, as food does not rank highly in exchange mechanisms within the social networks in this case.

On the other hand Table 5.7 shows that households in Ntcheu are on average able to spend a bit more on fertilizer, presumably due to higher incomes generated from their larger land holdings as shown in Table 5.1. While it is well known that health care demand is a function of numerous factors, on the basis of household expenditures on medicines the majority of the households are found in the categories above K2, 000<sup>9</sup> of expenditure in Ntcheu while in Thyolo most of them are in the lower category which is below K2, 000. Overall expenditures on medicines also suggest that more households in Ntcheu are able to buy medicines than those in Thyolo, 29% against 16% for the lower category of just up to K500 and 17% against 5% in the upper category.

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<sup>9</sup> The latest exchange rate between the US dollar and the Kwacha is about US\$1 = MK140.

Purchasing of medicines includes spending on medicines obtained from traditional healers. Obtaining medicines from the markets is explained by the irregular availability of medicines in health facilities as well as the deterrence of waiting time associated with overcrowded hospitals.

The limitations on purchasing power in Thyolo also become evident when it comes to clothing. Households in Ntcheu are on average grouped in the category that spends more than K500 on clothing, while the majority in Thyolo is spending below K500. This suggests that there is a higher level of social and economic deprivation in Thyolo. For purposes of care and support for HIV/AIDS situation, therefore, it can be concluded that households in Thyolo are more vulnerable and less capable of responding to the demands of CHBC.

### 5.2.3 Indicators of Group and Individual Resources Used for CHBCs

**Table 5.8: Group Ownership of physical Material/Assets for CHBC**

CHBC Group	Protective %	Kitchen Ware %	Bicycle %	Farm Tools %	IGA Equip %	Sanitary Wa %	Office Spa %	Total %
Lizulu	25	25	25	25	0	0	0	100
Sharpevalle	36	9	9	9	0	27	9	100
Matchuana	71	14	14	0	0	0	0	100
Lupiya	71	14	14	0	0	0	0	100
Nansato	0	0	0	100	0	0	0	100
Mpando	0	25	0	0	75	0	0	100
Njolomole	60	20	20	0	0	0	0	100
Nachipere	33	50	17	0	0	0	0	100
Mikombe	29	14	14	0	43	0	0	100
Kwakwanjana	33	33	0	33	0	0	0	100
Goliati	0	25	25	25	25	0	0	100
Senzani	50	13	13	13	0	13	0	100
Manjawira	33	22	11	11	22	0	0	100
Nchiramwera	9	9	55	0	9	9	9	100
Chimaliro	0	0	0	0	0	0	0	0
<b>C Score<sup>10</sup></b>	<b>452</b>	<b>274</b>	<b>217</b>	<b>216</b>	<b>174</b>	<b>49</b>	<b>18</b>	
<b>Rank<sup>11</sup></b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	

Source: Munthali (2007)

**Notes:**

**Protective Wear** = protective assets like umbrellas, raincoats, and boots in possession.

**Kitchen Ware** = group owned kitchen utensils used for CHBC.

<sup>10</sup> Cumulative Score specific to each variable across all cases

<sup>11</sup> Ranking of the predominant strategic working arrangements across all cases

*Bicycles* = a proportion which indicates presence of bicycles owned by each group.

*Farm Tools* = farm implements collectively owned and used by CHBC members.

*IGA Equip* = small items such as carpentry, sewing machines or tinsmith toolkits for income generating.

*Sanitary Ware* = supplies of gloves, bandages and similar items.

*Office Space* = specific office space allocated or being used for CHBC meetings.

Transaction costs analysis focuses on transaction arrangements and not the cause-effect relationship; that is what actions are taken in view of the cognitive abilities, the information available and rule configuration. It also focuses on the attributes of the community, that is what they have and don't have, and what actions are invoked by norms, cultural beliefs, and the relationships and assets they have access to. Table 5.8 indicates that group ownership of materials and assets are quite varied. Most collectively owned assets came to the groups as contributions by external organizations engaging with the CHBC groups, while others are contributions from within the communities or have been bought by the groups. The importance of facilitating compassionate visits to HIV/AIDS sufferers is underscored by donations of protective wear and bicycles to the groups by external organizations such as the Malawi Social Action Fund (MASAF) and the MSF. This is in recognition of the distances covered, as well as the difficult conditions in which the actors work. Partnerships and the background policy environment recognize that the role of CHBC service delivery can be enhanced if traveling within the communities and to the hospitals is made easier.

### **5.2.3.1 Provision of the CHBC Kits**

The Malawi HIV/AIDS National Action Framework for 2005-09 stipulates that the goal of the Community and Home Based Care system in Malawi is to increase access to high quality care for PLHAs (GOM, 2005:26). To achieve this goal the partners have developed an integrated CHBC package which includes capacity building for the community volunteers and a distribution of CHBC kits. The community volunteers are trained in hygiene, nutrition, and psychosocial support. Recognizing that Caregivers require supplies to enable them to serve people living with HIV/AIDS, as well as protect themselves from the infection, the volunteers receive three types of kits. A kit that is provided once to a caregiver in a community, a kit that is given once per quarter to a caregiver in the community and a kit that is given once per quarter to

be kept at a health facility to service the community. Protective wear falls in the category of the items given once through the NGOs and these also include bicycles, basins, and waterproof carry bags among others (WVI, 2008).

Other components of the CHBC kits include quarterly distribution of consumables such as cotton swabs, hand towels, and disposable gloves among other sanitary wears. These are given directly to the community caregivers. Then there is a quarterly distribution of medicinal supplies that is kept at the nearest health facility where the community can access them on a needs basis. During focus group discussions, it was learnt that there was confusion amongst the CHBC members as to how the replenishment of the two types of quarterly supplies was to be operationalized. Some members understood that NGOs would be visiting and distributing them while other thought they were required to travel to health centers to fetch them. More importantly, this confusion among the members arises because they understood these two kits to be one and the same. This is an important institutional factor indicating some shortfalls in how partners are inter-relating and carrying out complementary roles.

The table also shows that there are communities that do not have these assets, indicating the inconsistencies in the facilitation roles played from outside the communities and the internal inadequacies of the actors. At the same time this aspect shows the significance of internal arrangements without focusing on external help, and these are discussed as fall back positions of the communities in times of need in section 5.3.6.2 under the strategic working arrangements.

According to Sobeck (2003:363) the IAD framework emphasizes the structure of the *situations* in which individuals find themselves and how they work to overcome their problems collectively. Obviously here both exogenous and endogenous factors mentioned above have widely varied impacts on the CHBCs' action situation. Transaction costs of coordination for those who have the basic assets of protective ware, transportation and kitchen materials are much lower than those who do not have. For example, in the table it can be seen that Nansato, Goliati, Chimaliro and Mpando CHBCs have do not have protective wear. Kwakwanjana, Mpando and Nansato do not have bicycles. This reflects the irregularity of the facilitation role played by external organizations which distribute these important assets. At the same time it underscores

the inadequacies in these groups to an extent that they cannot afford their own bicycles. What this means is that these groups are faced with much higher transaction costs of delivering the health care as compared to those who have received the assets from NGOs.

#### **5.2.4 Perceptions of Internal Conditions**

Perceptions of internal conditions are presented using tools of Narrative Analysis found within the branch of an interpretive social science approach. According to Neuman (2006:474) this approach merges a theorized description of an event with its explanation. It presents the unfolding of events, interrelationships, or connections within a complex detailed context such as collective action and choices, as well as coherence and the holding together of the whole.

This is a kind of qualitative analysis where people give constructs of their own identity and how they view themselves in the bigger picture of what is happening around them, such as where they position themselves within the stakeholder matrix of the HIV/AIDS response, and in the continuum of community care and support for HIV/AIDS patients in particular. For instance, they are fully aware that the national response has attracted a lot of external resources through HIV/AIDS campaigns in the media and other channels. They have witnessed the establishment of numerous organizations associated with HIV/AIDS apart from various other visible efforts. With knowledge of this kind of environment, where do the community members engaged in CHBC place themselves among other active agents? This should help us to understand why, with specific perceptions emerging; certain decisions and actions are made by the community members.

At another level, using path dependency tools of analysis, which seek to explain a sequence of events as a function of a given unique beginning, this section also endeavors to explain the evolutionary aspects of the CHBC structures and eventual institutions. In other words, some of the outcomes of the CHBC transaction arrangements are a function of constraints and limits that were set by events at the outset of the care and support delivery initiatives.



Table 5.9 aims to show how many groups share a given perception. The idea being to explain the general pattern within which a majority of the members place the specific aspects of care and support within their communities.

**Table 5.9: The Perceptions of CHBC Groups of Themselves and Internal Conditions**

Response	EMR	R_W	GCS	HHS	DDD	SAG	ENC	NPM	IID	SLN
No	7	4	6	5	4	0	7	11	0	6
Yes	5	9	1	7	9	14	8	4	7	9
N <sup>12</sup>	12	13	7	12	13	14	15	15	7	15
% No	58	31	86	42	31	0	47	73	0	40
% Yes	42	69	14	58	69	100	53	27	100	60
% Total	100	100	100	100	100	100	100	100	100	100

Source: Munthali (2007)

**Notes:**

*EMR* = an expectation of monetary rewards expressed by members for CHBCs.

*R\_W* = group members think in their present state they can run CHBC work without external support.

*GCS* = the perception that the general (wider) community is supportive of CHBCs.

*HHS* = own households suffer due to CHBC commitments.

*DDD* = the drop-out rates are due to lack of incentives in CHBC structures.

*SAG* = groups feel they are successfully achieving their goals.

*ENC* = group had or has expectations of an external group business capital injection.

*NPM* = group suffers negative effects for holding parallel memberships on other groupings.

*IID* = internal support is perceived to be irregular and declining.

*SLN* = groups see themselves as stronger with lower membership.

Overall all attributes in the table are present among the CHBCs. The variables were not predetermined before the group discussions; rather they were generated by the discussions. This also explains why the frequency (N) is not consistently 15 for all aspects, as percentages were calculated based on the number of cases where each aspect was mentioned in the course of the

<sup>12</sup> Total number of focus groups that raised and discussed a particular perspective

group discussions. For example, seven groups mentioned that they did not expect to be paid monetary rewards in this charity work, making 58% of those who spoke about it, whereas five groups (42%) indicated that getting monetary rewards was required. This observation is supported by the drop-out rates due to lack of monetary incentives as already discussed above.

About 69% of the CHBCs indicate that they can continue to run the care and support service in the absence of external support. This perception is built on two major pillars. Firstly, some CHBC groups were initiated and engaged with patients well before the flow of external support began, and thus, they see themselves being in a position to be able to continue with their preconceived agendas. Secondly, for some of the groups it is the feeling that they have received CHBC training and some capital injection making them well placed to run the CHBC agenda without further external assistance. Either way, there is a reflection of ample commitment to the cause amongst the communities making CHBC viable.

The wider community is not necessarily supportive towards the groups. For example, the focus group discussions reveal that CHBC groups are perceived to be in gainful ventures by those outside the structures, including some of the traditional leaders. In Thyolo CHBCs were reported to be excluded from the socially beneficial ‘food for work programmes’ designed to augment food supplies for households in need. The reason was that households of CHBC members were considered to be economically well off. On a deeper level, there is an underlying perception that community members in close association with NGOs always reap monetary benefits. NGOs are reputed to offer payments for involving community members in activities such as meetings, training workshops and community development work, for this reason CHBC work is viewed to fall in that category. This perception was voiced and recorded during focus group discussions in Thyolo district. Its significance obtains from the fact that it has a bearing on members’ decisions at CHBC and therefore the idea is also highlighted as an unintended outcome of the roles played by NGOs presented in Chapter Seven. Besides, CHBC members are also subjects of stigma as they are often collectively branded to be HIV positive by virtue of engaging in care and support for the sufferers. Given that the majority of the members feel that the community is not very supportive there is evidence to suggest that misperceptions about how the CHBC structures work are real.

All the groups feel they are somehow successful in meeting their group aspirations as indicated by the SAG indicator. This sheds light on the bigger picture arising from the level of commitment by members of the respective groups, a more general level of effectiveness of the partnerships with other agents and the working methods adopted by the actors. On the other hand, it is interesting to note that the achievements are realized at the expense of the welfare of their own households. About 58% of the groups reported that their households suffer due to CHBC work. Households show their awareness of the economic trade-off as they invest their time and other resources into CHBC service delivery. A contrary indication is observed when members were asked whether being members on other groupings (NPM) such as farmers' clubs had any negative effects on their households. Table 5.9 clearly shows that parallel membership did not have negative effects on the households presumably because the parallel groups are associated with socio-economic benefits to the household members.

Just above half of the groups would have expected an injection of capital for the group to operate on, while there is clear evidence that internally organized support (IID) is perceived to be irregular and declining. Internal support comprises contributions that are made by individuals or organizations that are based within the communities such as churches. Perhaps the smaller number of those expecting a capital injection is explained by the fact that some of the groups are well organized and, thus, capital injection is no longer a critical need for them. Observing those who have received capital injections actually serves as a basis for setting expectations by those who are yet to set up entrepreneurial initiatives to back up care and support initiatives. One positive outcome of the drop outs from membership is that groups appear to become more cohesive and effective by relying on the most committed members. In this case more committed members are expected to be those who value their social values (incentives) such as self-esteem more than the economic benefits of money associated with the presence of NGOs.

### **5.3 Distinct Patterns of Physical and Material Conditions found in the Two Districts**

This section highlights the distinct patterns that emerge from the categorical summary responses obtained from the two districts. It also serves to make some propositions, and not specific

hypotheses, based on the emerging insights about the communities. Qualitative analysis is predominantly concerned about using data to make propositions instead of testing hypotheses as is the case with quantitative approaches. In particular, the section highlights cases that are either peculiar to one district or those predominantly shared between the two study sites. Further interpretation, explanations and analytical insights on the emerging picture of the community background conditions are found in Chapter Seven.

Due to the constraints such as land holding size and its poor quality, and the shortages in farm inputs, among others, Thyolo communities are being left behind in production of the most important crops such as maize which is their staple food. Thyolo is also in a precarious situation because it does not have an effective micro-credit system to use as a fallback in times of need. On account of this situation there are far more households in Thyolo who engage in very small scale sales of merchandise as an alternative for livelihoods than is the case in Ntcheu. This happens when their Ntcheu counterparts are focused on selling their relatively larger scale agricultural produce obtained from more meaningful investment opportunities.

A second distinct feature that separates the two study areas concerns the levels of production that classifies households into categories. In Thyolo up to 84% of the households that took part in this study were reported to produce less than 10 bags of the main staple food per annum. This suggests that households have a lot to do to close the glaring food security gaps in their communities. Only 48% produce less than 10 bags per annum in Ntcheu implying that this area has more families who are better placed to respond to the CHBC needs.

Thirdly, peculiar to Thyolo is that, while getting employment on the farms appears similar in the two study districts, in Thyolo farm employment takes place on tea estates and it is seasonal. This means that there is a short and very specific period when labour is required because tea plantations are perennial crops, that is to say that they do not have to be replanted every year. This observation has the implication that employment opportunities are therefore more limited than is the case on farms in Ntcheu where maize and tobacco are grown and harvested annually. Secondly, Ntcheu also engages in wetland cultivation for green vegetables, potatoes and other crops which are marketed almost the whole year round. These not only offer more steady

demand for labour in Ntcheu, but they also ensure that there is more economic activity in Ntcheu by complementing the rain fed upland agricultural activities. More economic activity, in this case, is a requirement for making effective responses to the demands of care and support for HIV/AIDS at household level.

Ntcheu has displayed the presence of effective micro credit outlets which are accessed by communities. Despite the presence of similar facilities in Thyolo, such as the national MARDEF funds and FINCA International, typical rural households in Thyolo do not access such loans. The mechanisms for accessing and repaying the loans make it virtually impossible for them to participate. With respect to CHBC for HIV/AIDS this is a serious bottleneck to the response as it limits the number of alternatives for responding to the pressure created by the pandemic. This finding also confirms the general observation in economic literature which suggests that the poorer sections of the communities have limited access to credit. In other words poverty is an obstacle to the process of development. These people become marginalized and fall further out of the scope of development because they do not meet the conditions for accessing credit, such as the lack of collateral and a tendency to default on loan repayments.

There are similarities in the two districts in terms of their reliance on immediate families for the exploitation of the stock of social capital for food security. Apart from this observation the households in Ntcheu tend to be more outward looking. In Ntcheu households are clearly able to look outwards to extended family, friends and money lending individuals to get help for other social needs. Such other needs are not strongly considered in Thyolo because to them 'need constitutes food security' and this is what will make them seek assistance, but even that is sought from within the family settings. This is a clear indication of the limits to social capital existing in the Thyolo communities perhaps due to the widespread poverty which requires more informal internal strategies as opposed to wider community ties which become slightly formal. The danger from the inward looking tendencies arises when the entire family is deprived. It renders the task of responding to the crises an impossible one, so with respect to the needs from the HIV/AIDS situation, these families are certainly more vulnerable because they obviously have to rely on inconsistent sources for help.

In studying the presence of basic household assets such as beds, chairs, mosquito nets, radio and bicycles Ntcheu is clearly ahead. Thyolo can only match with their counterparts when it comes to the presence of bicycles within households. The presence of bicycles can be explained by the mountainous terrain in rural Thyolo and the absence of public transport. Ownership of a bicycle has been made even more popular by NGOs who distribute them for community and home based care support. Since Ntcheu has a number of important routes passing through the district, and its the geographical terrain makes transportation with cars, motorcycles and other forms of public transport easier, the need for bicycles is not as pronounced in that area. It is an important feature in Thyolo, but besides that availability of bicycles also gives a reflection of the importance of supportive role played by partners in development work such as the CHBC. This is why the variation in the number of bicycles between the two areas is not significant, because the partners are attempting to make them available to all community volunteer groups.

With regard to expenditure patterns, it has been found that households in Thyolo mostly spend very little. Expenditures mainly constitute bags of fertilizer and medicines. About 60% of the households could only afford up to two bags of fertilizer whereas in Ntcheu only 39% acquired as little as two bags. Two bags of fertilizer are short of the recommended three bags per hectare of cultivable land, and considering that households cultivate an average of 1.75 hectares in Thyolo and close to two hectares in Ntcheu makes this an obvious case of inadequacy. A much bigger proportion of the Ntcheu households were able to acquire more than two bags of fertilizers, more medicines and clothing. From this observation, obviously the vicious cycle of poverty in Thyolo can be seen to be getting compounded and therefore fighting the HIV/AIDS crisis must be a tall order for them.

One other major and explicit finding of this study regarding the CHBC group formation and dynamics is that once groups are formed there is a high tendency of members to drop out. In particular, the drop out rate for Ntcheu district is estimated at 53% while Thyolo has a drop out rate of 42%. Comparative analysis and triangulation of categorical variables suggests that participating members in Ntcheu are relatively wealthier, and therefore, more independent with regard to availability and use of resources, as well as related decision making for CHBC service delivery. Inhabitants of Thyolo, on the other hand, perceive CHBC group membership as a

source of hope not only for the CHBC service delivery but also for opportunities to address their wide spread poverty. In this regard they are more likely to remain members of the CHBC groups than their Ntcheu counterparts. Hence, this study makes the proposition that the poorer members of the community are likely to remain members of the care and support structures for HIV/AIDS organized in their communities than their wealthier counterparts. Along the same lines, Thyolo groups exhibit a predominant desire to receive monetary rewards, to exploit the potential for group capital and reliance on group assets. The following groups from Ntcheu; Njolomole, Manjawira, Sharpevalle, Lizulu and Senzani all share a score of zero indicating absence of the desire to receive monetary rewards. On the contrary, this is a dominant expectation amongst the Thyolo groups. This suggests that the two districts have virtually distinct forces behind their motivation, poverty being one of the major ones in Thyolo. This is supported by the observation that Thyolo is predominant on prevalence of IGA equipment while they lag behind on presence of group bicycles, sanitary ware and farm tools as compared to groups in Ntcheu.

Lastly, the major similarities in the two districts are that all CHBC groups appear to strategically perform similar activities. The most dominant activities include bringing food, medicines and some token money as well as offering labour to the patients' farms and homes. Their activities are always backed by strategic arrangements such as sharing of responsibilities and organization of a fall back position to cover them in times of need.

#### **5.4 Summary and Conclusions**

This chapter undertook to explore four main objectives. These are the situation regarding resource endowments and mobilization; investigating into the general obstacles to participation in the HIV/AIDS response within the communities; documenting perceptions that can give a reflection of the mind-set of the community members; and highlighting distinct patterns emerging between the two study sites. These aspects were studied in the light of the significant role played by community attributes in decision making in institutions such as the CHBC. Community attributes have been approximated by physical and material resources at the disposal of the villagers including infrastructures, asset ownership, production processes from land and farm inputs, economising habits such as in resource allocations and the constraints faced by individuals.

In summary the data pertaining to resources in the two communities shows that Ntcheu is wealthier and more capable of organizing meaningful responses to the pressures of the HIV/AIDS pandemic than households in Thyolo district. However, there are major similarities in the reliance on agricultural output for consumption and generation of income through crop sales in both areas. Due to limited land sizes and the scarcity of farm inputs the majority of households produce less than half the amount of food required for household consumption per year. This is particularly true in Thyolo. The plight of this area is worsened by their inability to utilize the micro credit facilities designed to enable investments in social protection measures. The conditions of the micro credit facilities do not favour them because of the limitations in business opportunities and the demands placed on them by loan repayment.

Employment opportunities in Thyolo district are very limited and confined to agriculture sector, with the large scale tea estates dominating in employing labour for short durations within a season. In Ntcheu there is a wider variety of crops including maize, tobacco, vegetables, and potatoes which are all grown on a relatively larger scale. The labour demand is almost steady throughout the year in Ntcheu in order to complete activities of rain fed and dambo land winter to summer agricultural activities. Thus individuals in Thyolo have to find other sources of livelihoods in the absence of such a comprehensive cycle of events. The most commonly found alternatives are in very small scale businesses. Families also exhibit a strong tendency to depend on close and extended family ties to source extra food security in Thyolo, whereas in Ntcheu households utilize the wider catchment which includes money lenders, friends and the formal micro credit schemes for their own livelihoods.

Ownership of basic household assets has also been found to favour Ntcheu households. The only assets where Thyolo is able to match with Ntcheu are those subsidized or injected for free by development partners such as the bicycles for CHBC work and mosquito nets for malaria control. Beyond these assets, Thyolo looks much poorer and less organized to respond to the pressure created by the HIV/AIDS pandemic. It is for this reason that inhabitants of Thyolo express the need for payment during the CHBC work as they perceive it as formal work for



themselves, and it also shows that the transaction costs of delivering health care are higher in Thyolo to the extent that compensation becomes a necessity for the care givers.

## Chapter Six

### **Institutional Scope for Community and Home Based Care and Support**

#### **6.1 Introduction**

This chapter presents findings regarding the scope of community and home based care. The findings give a reflection of the contextual standards from the international and national frameworks, sectoral policy and institutional linkages at the local government and community levels. The approach is adopted with due recognition that scope for home care and support at community level starts with the critical roles played by international, national and local organizations that invest their scarce resources in the form of human capital, finances and other physical goods and services. These organizations and individuals bring a mixture of efforts to a multi-tiered interactive framework. Both the contextual factors from the framework and the behaviour of individual agents have significant impact on how agents at the grassroots conduct their day to day transactions. It is for this reason that this chapter attempts to analyze how the international and national policy and action environment impacts on the decision making processes of those involved in the care and support at the community level. From the perspective of interactions, the chapter also examines what perceptions have emerged at the community level because these also have an important bearing on decisions made by community members during the delivery of care and support.

The analysis is guided by the following notions of inter and intra-organizational interaction;

- i) Unveiling group dynamics and their evolutionary processes;
- ii) Assessing the extent of CHBC facilitation from a network of partners;
- iii) Examining attitudes and perceptions and their impacts on decision space; and
- iv) Documenting practical responses to the institutional arrangements.

## **6.2 National and Sectoral Policy Frameworks**

The context of the inter-organizational influences is provided by the Malawi Growth and Development Strategy (MGDS) formulated in 2007 as the overarching development policy framework which is gradually replacing the once famous Malawi Poverty Reduction Strategy (PRSP). This Macroeconomic Framework seeks to provide a balanced design to public policy that will create conditions for economic growth, improve social sector outcomes and protect the vulnerable sections of the population. The MGDS has similar goals to the PRSP, which was to improve institutional governance and made sure that sectoral goals and strategies were linked to the national policy (IMF, 2002:1). However, the MGDS emphasizes economic growth and development as the most important avenue for dealing with poverty and other social ills. For example, all efforts seeking to improve the alignment of the governance structures, behaviour and performance of organizations in the HIV/AIDS response must have clear connections with this policy.

The most important and strategic principle is one of allocating scarce resources, most of which are externally sourced, to priority sectors. Allocations into health and the treatment of HIV/AIDS epidemic are but one of such critical strategies because problems arising from this sector have been observed to undercut economic gains from growth oriented sectors. Conversely, positive developments in the well-being of the population have the potential to feed directly into economic growth in Malawi.

In light of this, the study seeks to explore institutional developments in the Malawi Health Sector and, in particular, identifying development participants and the roles played in the continuum of Care and Support for HIV/AIDS patients at community level. Essentially, the chapter will place focus on modes of participation as influenced by inter-organizational relationships.

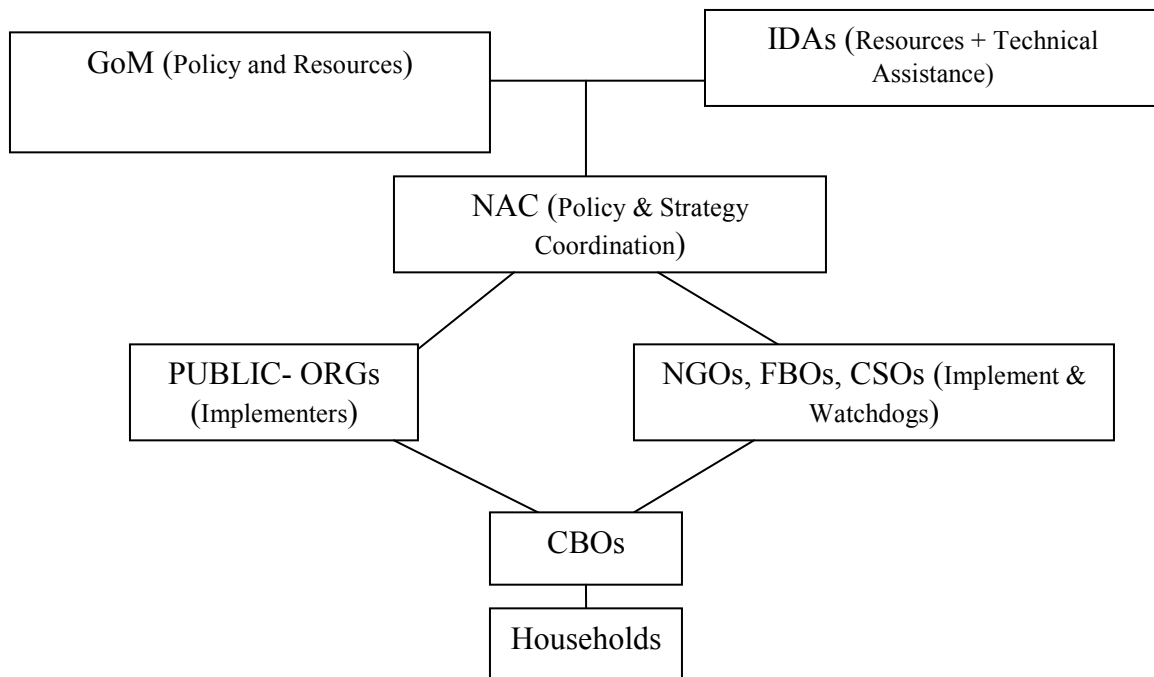
### **6.2.1 The Malawi Health Sector Policy**

At the sectoral level, health development is guided by the SWAP. A Sector-wide Approach is a method of working between and amongst government, IDAs and some NGOs in which significant funding for a sector is provided to support that sector's policy and expenditure programme under government leadership, using common approaches across the sectors (Baser and Morgan, 2001:19). The Malawi Health Sector Policy is reflected in the Programme of Work and the core implementation component of this is the Essential Health Package (EHP) which is offered to all Malawians. The EHP refers to a prioritized but limited package of services that should be available to every individual in Malawi at all times and reflects eleven key interventions that address major causes of death and diseases in the country and the supporting structures of the health system (GOM, 2004:1).

The mandate of the EHP is to bring basic priority health services closest to the community while also providing a systematic referral system for patients from the front-line facilities to higher levels. This is clearly in keeping with the national policy and the priority setting over resources into areas of extreme deprivation. It is also consistent with the general principle of targeting health outcomes, primarily a healthy population, to get economic development right. The Malawi SWAP runs from 2004 to 2010 and has been developed as a primary approach to development support (Birdsall and Kelly, 2007: 98). The SWAP defines procurement, disbursement, management and monitoring systems that all partners must collectively adhere to. These culminate into a harmonious programming and funding environment on the basis of which a lot of international assistance is mobilized.

Figure 6.1 maps out the linkages for communication and operational mandates from the central government level where policy is located, through the technical roles and funding responsibilities of the IDAs, the semi-autonomous coordination role played by the NAC working through the public and non public agents down to the community level. These roles and responsibilities are discussed below.

**Figure 6.1: The Operational HIV/AIDS Policy Transfusion Matrix**



Source: Munthali (2007)

The above figure reveals the important linkages in the policy and implementation of HIV/AIDS strategies in Malawi. From the top, the central government is the custodian of the Health and HIV/AIDS policy. Specifically the Office of the President and Cabinet serves as the highest office for HIV/AIDS such that the NAC is responsible to that office. On the other hand the international partners are critical for most of the inputs into the role of the NAC and they co-own the SWAP with the government. This is the sphere in which all health matters are tackled. Below that level, the NAC is the fulcrum of all efforts going into combating HIV/AIDS in Malawi, including coordination of all implementers of programmes (public and private) most of whom are found at district assembly and town assemblies. However, it is not unusual to find some implementers and civil society watchdogs at national level. By and large, public and private agents such as local assemblies and NGOs tend to work closely with community based organizations in order to reach the individual households at the bottom end of the hierarchy. These channels are not only for transmission of policy, capacity and implementation technicalities but they are also used by the lower levels to draw upon resources for programmes and to send

feedback to upper cadres. It must be noted that this is quite distinct from the linkages proposed under the decentralization process, especially at the lower community levels

### **6.3 Who are the Care givers at International and National Levels?**

Owing to the impacts of the socio-economic and fiscal challenges in Malawi, a lot of effort has gone into resource mobilization for the response to the HIV/AIDS pandemic. Resource mobilization has been the most important area of participation by international partners. International donor institutions, national governments, international and national NGOs, churches, and some private foundations have been heavily relied upon for commitment of funds that are channeled to countries most hit by the HIV/AIDS pandemic (Birdsall and Kelly, 2007:27). The assistance mainly comes in two forms, namely General Budget Support (GBS) and Sector-wide support for the sector wide approaches. The GBS goes to beef up the government budget from where it can reach the government institutions involved in the fight against HIV/AIDS. The sector wide support goes to support the consolidated programme of activities in the health sector and largely includes pooled funds from various sources

The contribution into the SWAP does not only constitute mobilizing resources but also providing technical expertise in selected areas of management and leadership such as programme planning and governance, and procurement of essential goods and services such as ARVs among others. The focal point of the IDAs is at the national level, engaging with government and the NAC for policy and implementation progress. To a lesser extent the IDAs also interact with NGOs and civil society organizations, some of which they support outside the SWAP framework.

The national response to HIV/AIDS in Malawi is largely anchored by funding which comes from a wide range of sources such as the Government of Malawi and the Global Fund. Then there are the UK Department for International Development (DFID), the World Bank, Norwegian Agency for Development Cooperation (NORAD) and the Canadian International Development Agency (CIDA) who contribute to the Pool Fund,

while the United States, Germany, European Union, Canada, Japan, IMF and the African Development Fund are some of the well known sources. The NAC is at the center of the implementation arrangements of the national response. Guidelines for implementation are outlined in the policy for the national response to HIV/AIDS which was drawn up in 2003. The ‘National HIV/AIDS Policy; a call to renewed action’ has two main goals. First, is to prevent further spread of HIV infections and secondly, to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation. Its key objectives seek to foster provision and delivery of prevention, treatment, care and support services for AIDS cases, to reduce individual and societal vulnerability to HIV/AIDS, and to strengthen the multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programmes (GOM, 2003:4).

The NAC has its own Integrated Annual Work Plan which guides implementation among the NAC implementing partners. The NAC partners are widely varied in nature and capacities. Five international NGOs are in partnership with the NAC to oversee the implementation processes at district level in the absence of well resourced and coordinated government departments. In particular the INGOs, normally referred to as Umbrella Organizations, are used as conduits for funding the community level organizations such as FBOs and CBOs. Proposals for obtaining financial grants for community initiatives are routed and funded through these organizations by the NAC. These are Save the Children USA, Canadian Physicians for Aid and Relief; Plan International, Action AID Malawi and the World Vision International.

#### **6.4 Care and Support at Local Government Level**

At a lower level, the NAC coordinates the sector specific policy and implementation strategy. The NAC is the government’s implementation arm and, therefore, it is responsible to the Secretary for Health at the higher level. It is responsible for coordinating all implementing (Public and non-public) partners across the country. The NAC and a consortium of international NGOs discussed above are in an arrangement

whereby the NGOs operate as implementation arms at local district level. These work in consultation with the Financial Management Agency (FMA) which is a private agency hired to handle the NAC grants that go to fund the district and community services. The response involves public facilities, namely, health clinics and hospitals, district assemblies and District AIDS Coordinating Units. The health facilities focus on treatment and care for the patients, in particular the administration of the ART. The District Assemblies play a major role in the public health services which include the planning and executing the public health service in consultation with the communities.

Non-public partners include NGOs, umbrella organizations, such as Youth Council of Malawi, MANET and MANASO that work as satellites for the NAC and at times get grants on behalf of CBOs. Civil society and Faith Based Organizations also are found working at district level. Civil Society organizations' role is two pronged. First they serve as implementers of some AIDS programmes and provide guidance to communities. Secondly, they engage as watchdogs for policy implementation and governance, especially at higher levels of the hierarchy where they interact more with government, the NAC and IDAs. FBOs are mainly involved in giving support to community organizations.

#### **6.4.1 Care Giving in the wake of Public Sector Decentralization Process**

With the decline in government expenditures, public systems are not able to provide adequately for the health needs of their countries (Swanson and Samy, 2002:5). Attempts to rationalize the development agenda and improving the overall macroeconomic performance have revealed that administrative and organizational weaknesses rank highly among factors that undermine public service delivery and overall productivity. Adding to that is the increased complexity and sophistication of the HIV/AIDS epidemic which is overstressing the public sector's resources. Secondly, devolving power from national government to local governments has been hailed as the best way forward. It has been touted as a more inclusive approach which enables communities to be involved in



analyzing their own situation and planning their own development and certainly doing more than just implementation as was often the case in the past.

The Malawi decentralization process is being undertaken to encompass the entire macro policy, so the local government agents, namely the District and Town Assemblies, have the authority to make decisions pertaining to planning and utilization of financial resources derived from both their own initiatives and the central government within the overarching government policy framework. The Government of Malawi became one of the pilot cases undertaking to develop a National Decentralization Policy under the recommendations of the World Bank which saw this process as one way of doing away with bureaucratic processes impeding economic progress (Cross and Kutengule, 2001:8) Although Malawi had a head start in this process, there is evidence that a lot still needs to be done for the District Assemblies to fully embrace their new responsibilities. One of the key problems reported is that decentralization has proceeded on a sector by sector basis instead of District Assembly by District Assembly. The reason is that each line ministry has its own plans and schedule for decentralizing. The District Assemblies have no control on the process. While waiting for the central offices schedules to take effect, the assemblies continue to have coordination and capacity problems because they do not have their own specialist staff to manage sectoral responsibilities such as health, education or transport among others (Cross and Kutengule, 2001:16). In other words, the process is still very much ongoing and there are a lot of gaps in some services such as coordination of HIV/AIDS at that level, as will be noted in the subsequent sections.

It must be clear why decentralization and other reforms, which try to enhance performance by cutting bureaucracy, facilitating speedy flow of information and feedback effects and rooting out numerous bottlenecks such as corruption, have become critical components of today's development paradigm. This is in line with the MDGs which spell out the global agenda and emphasize the need for broad systemic and institutional changes required in the health sector, including international cooperation and strengthening public health systems in developing nations on account of their inherent weaknesses.

The policy that was approved in 1998 sought to devolve powers and functions of governance and development to elected Local Government Units called Assemblies composed of the following: Councilors, Traditional Authorities (TA), Members of Parliament (MP) and five representatives of special interest groups. The decentralization process also saw a Decentralization Secretariat being set up under the Office of the President and Cabinet in Lilongwe. According to the Malawi Government this process was viewed as critical for the operationalization of the Vision 2020 development blueprint and the Poverty Reduction Strategy, and lately the Malawi Growth and Development Strategy (MGDS) which is also mainstreaming the fight against the HIV/AIDS pandemic.

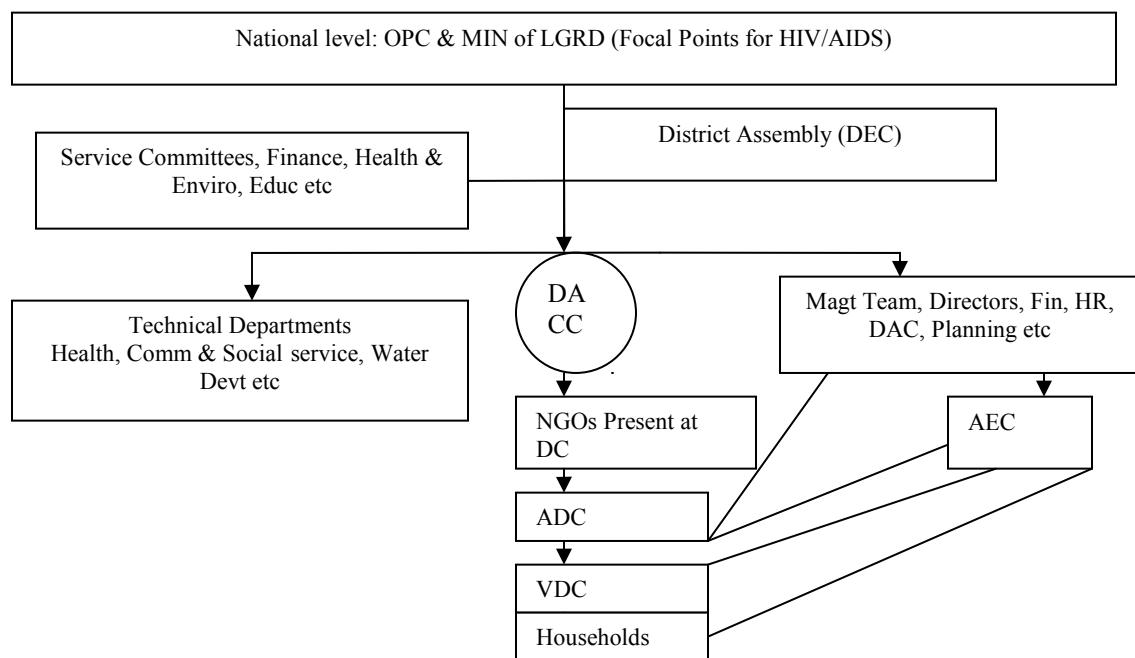
In principle, Local Assemblies have virtually taken on the responsibilities that were previously concentrated in the then district arms of the central government and adopting the planning and financial responsibilities in the process (Kaarhus and Nyirenda, 2006:12). The Ministry of Health and the National AIDS Commission are some of the important arms of government policy that have to devolve their responsibilities to local levels for implementation of health care.

With specific reference to the HIV/AIDS response, the local government is expected to set up an office for the District AIDS Coordinator (DAC) who will oversee the technical and administrative services of the response in the district including planning and reporting (NAC, 2004). In short, the whole process of planning and implementing a development agenda is supposed to be location specific to accommodate unique factors of the areas and the populations that development seeks to assist. With regard to HIV/AIDS a decentralization policy and implementation strategy adopted by the partners in the health sector reveals the structural linkages depicted in figure 6.2 below.

The decentralization process is expected to incorporate the national response for HIV/AIDS in the district planning process. The District Executive Committee will oversee all district development initiatives. This committee has to work through

specialized development service committees which include HIV/AIDS. Specific to HIV/AIDS the District AIDS Coordination Committee (DACC) has the technical mandate to coordinate government departments, NGOs, CSOs, ADCs and VDCs that are working with the communities. The DACC is guided by the District AIDS Coordinator (DAC) who is located under the Director of Planning and Development within the District Commissioner’s management team. The DAC is the representative of the NAC at that level for all technical and policy detail.

**Figure 6.2: HIV/AIDS Stakeholder links under a Decentralization Policy Set-up.**



Source: Adapted from NAC (2004)

Background documents and research reveals that the decentralization process, especially with respect to HIV/AIDS functions is not yet in place for most of the districts. Interviews with the NAC conducted on 2 June, 2006 revealed that the position of DAC was yet to be created, formalized and filled in most districts. The NAC also documented that only two districts out of 28 reported to be well organized (NAC, 2004:34) in this respect. The NAC has, hitherto, been reaching the communities through Umbrella Organizations, these are Save the Children USA, Canadian Physicians for AID and Relief, Plan International, Action Aid Malawi and World Vision, to provide support for

funding community organizations. According to Birdsall and Kelly (2007:101) there is little indication that these District Assemblies are ready to take over from these Umbrella Organizations. Besides, capacity concerns that are the main obstacle at the local assemblies have also bedeviled the umbrella organizations and the recipient community organizations. It has also been observed that even in districts where decentralization has gone ahead, the NAC has not entrusted them with authority to handle funding mechanisms (Birdsall and Kelly, 2007:100). This suggests that there is very little by way of building capacity and the confidence of the public sector structures to take over responsibility.

The following section intends to highlight the key drivers of CHBC work at district level. Respondents to the interviews were asked to rank who were the first and the second main organizations or individuals driving the initiatives of CHBC in their area. Table 6.1 summarizes the response by type of organization and by district.

**Table 6.1 Main Drivers of CHBC (per District)**

District	NGOs	CBOs	MOH	FBOs	DAs	TAs
Ntcheu (1)	19	14	7	1	3	0
Thyolo (1)	28	15	3	0	0	3
Ntcheu (2)	4	6	7	1	5	1
Thyolo (2)	3	15	8	0	0	1

Source: Munthali (2008)

The table ranks the main drivers of the CHBC service in each district. Partners were ranked as most important by each individual respondent on the basis of their knowledge and contacts they have made with each CHBC partner. The figures given in brackets symbolize whether a given partner was mentioned as number one or number two. Of particular interest is the finding that in Ntcheu District the local government (District Assembly) plays an important role. This means that the decentralization process has

taken effect in that district and the Assembly is engaging with other agents in planning and implementation of programmes.

In the discussion on decentralization, it was pointed out that the planning and implementation responsibilities have not been devolved to local government level in Thyolo District. The District has not created and formalized the position of District AIDS Coordinator (DAC). The DAC would be the contact point with the communities. This explains the lack of HIV/AIDS activity under the District Assembly for addressing HIV/AIDS in the communities. The data, however, shows that there are some traditional authority leaders who are contributing to CHBC service delivery. This is not the case in Ntcheu. This suggests that there is unevenness in procedures for reaching and integrating the communities. This is also evident from the perspective of FBOs who are clearly not as visible in Thyolo as is the case in Ntcheu. In other words the unevenness in the approaches at the higher levels such as the district level are mirrored at the community level, and with this in mind questions must be asked about what are the impacts of these variations on operations of CHBC and similar institutions.

## **6.5 The Community and Home Based Care and Support**

Community and Home Based Care organizations are examined on the basis of two types of relations. First is the inter-organizational relations highlighted in the preceding section whereby the community organizations are in contact with other organizations such as the Umbrella Organizations that facilitate the transmission of grants from the NAC to the CHBCs. This chapter recognizes that such relations have profound effects on the CHBCs performance, and therefore, these are highlighted in the form of external influences (exogenous) on care and support delivery.

Secondly, the analysis in this chapter also examines the intra-organizational dynamics which are a function of own rules and heuristics fashioned by the groups (endogenous) and having impact on decision-making at that level. The analysis is presented in these two broad categories of external factors and internal factors at the community level. It

must be noted at this point that although the analysis attempts to separate the external and internal influences, cases of these forces overlapping are not unexpected. Thus, the chapter only endeavors to isolate the sources of the dominant forces.

### **6.5.1 External Factors in Care and Support for HIV/AIDS at Community Level**

External factors that influence the community organizations are looked at from the broader context of the macroeconomic development of the rural communities. Various types of development agents have their presence in these communities to intervene in the vulnerabilities in such locations. For example, in the study sites of Thyolo and Ntcheu, the following organizations were found working on improving livelihoods of the villagers: World Vision International, Africare, Adventist Development and Relief Association (ADRA), Concern Universal, and Medicine San Frontier Belgium, Malawi Social Action Fund (MASAF), among others.

While most of the above organizations have strategies that target the wider concepts of livelihoods and food security, they also tend to incorporate HIV/AIDS components. More broadly, their presence defines the terrain in which the community based organizations, such as the CHBCs, work. From the perspective of institutionalism the CHBC group members will tend to evaluate their own situation against other actors in this broader livelihoods spectrum. Their behaviour is also likely to display an implicit comparison of opportunity sets brought by the different livelihood interventions. In the light of this reasoning, the influences external agents exercise on these community actors must have important implications for care and support decisions, and it is on these grounds that the analysis of external factors is premised.

#### **6.5.1.2 Origins and Evolution of CHBC Groups**

One of the important aspects the IAD framework seeks to explain regarding the life of a group is the transition a group goes through from its inception. For example, capturing of processes of CHBC group formation, group composition, group strategies, motivational

factors, resource use and subjects' perceptions, as well as more outward looking interaction with other agents in the continuum of care and support for HIV/AIDS cases is important for the group's ability to sustain itself. Tracing the origins and the composition of each group is also important for understanding aspirations and motivations that matter. Literature from path dependency tools of analysis, which seeks to explain a sequence of events as a function of a given unique beginning, should also have a role in explaining the evolutionary aspects of the CHBC structures and eventual institutions. In other words some of the outcomes in the CHBC set-up are a function of constraints and limits that were set by events at the outset of the initiative.

In light of this the study seeks to understand and explain how the origins of the groups (*first initiatives*) appear to motivate or place constraints on group progression, and group 'ownership' among other factors. It has been documented that group size may be as much an indicator of institutional success as a precondition for such success (Ostrom and Poteete, 2004:2). The section also highlights the changes in group sizes as an important factor that reveals the underlying realities of the CHBC groups.

### **6.5.1.3 Indicators of Group Formation and Evolution**

Table 6.2 below presents factors of group formation that are important for understanding institutional and transaction arrangements which themselves impact on group performance. The table provides a snapshot of the CHBC groups in terms of how they were formed, and also presents a picture of how they have been progressing in terms of recruitment of human resources and persistence of membership on the one hand, and on the other provides a context for interpretation and analysis of the general behaviour of the participants, also referred to as actions, invoked and explained in terms of inter-relationships.

**Table 6.2: Characteristics of the Origin and Evolution of CHBC Groups**

CHBC	ATT	M	F	G AGE	AIM	IPOP	CPOP	FI	FSI
Lizulu	7	3	4	12	8	16	8	Community	4
Sharpevalle	6	2	4	9	7	75	-	Community	1
Matchuana	10	8	2	10	7	22	10	RC Priest	2
Lupiya	6	3	3	10	8	25	17	RC Priest	1
Nansato	7	4	3	15	9	30	-	CCAP	-
Mpando	8	2	6	10	9	30	15	Community	1
Njolomole	6	4	2	2	2	55	30	NGO	1
Nachipere	7	1	6	9	6	30	7	Govt. Nurse	4
Mikombe	7	0	7	6	4	15	7	NGO	2
Kwakwanjana	10	1	9	9	6	-	-	Govt. Nurse	2
Goliati	5	1	4	8	6	11	6	Govt. Nurse	-
Senzani	7	4	3	6	4	40	19	NGO	4
Manjawira	6	3	3	3	2	40	14	Govt. HSA	4
Nchiramwera	10	3	7	10	6	10	23	RC Priest	1
Chimaliro	6	2	4	11	6	23	11	RC Priest	2
<b>Mean</b>	<b>7</b>	<b>3</b>	<b>5</b>	<b>9</b>	<b>6</b>	<b>30</b>	<b>14</b>		

Source: Munthali (2007)

**Notes:**

*ATT.* = members in attendance at the focus group discussion

*M* = the number of male members that were present during the discussion

*F* = the female members present at the discussion

*G AGE* = the numbers of years the group has been in existence

*AIM* = the average number of years individuals have been members of the group

*IPOP* = the initial population or group size at inception

*CPOP* = the population or group size at the time of research

*FI* = who took the first initiative to compose a given group

*FSI* = the frequency of scheduled meetings or interaction within a group per month

*RC Priest* = A Roman Catholic Priest working in the area

*CCAP* = Church of Central Africa Presbyterian

*HSA* = a government community health surveillance assistant

Table 6.2 shows that CHBC groups have been in existence in Malawi for more than a decade now. Captured in this study are groups with lifespans ranging from two years to



fifteen years. This shows that CHBC has been a growing phenomenon in the response to the HIV/AIDS pandemic. The variation in group ages indicates that over time new groups have been started in an increased rate. Research by Birdsall and Kelly in 2007 shows that civil society organizations in Malawi have been involved in AIDS related activities prior to 1991 but real growth in such organizations has been experienced from 1999. The transition in formation of such organizations has been duly accompanied by the transition in their membership. On average a member spends about six years serving as a volunteer on a CHBC group. This falls short of the average life span of the group which is nine years. This suggests that for every three years that a group exists it loses one year's equivalent of its own volunteerism human capital. Volunteerism comes in many different forms such as time, monetary contributions, and labour, among others, depending on what each group has established as their working modes in the care and support activities.

Table 6.2 also clearly reveals that CHBC work is predominantly undertaken by women in the communities. Men have been noted to join and drop out more rapidly than female members because men are expected to devote their time to household bread winning activities. However, it must be observed that quitting group membership also includes women at a very high rate. The difference between group means of IPOP and CPOP, which are populations at the formation of the group and at time of research respectively, shows that 50% of membership was lost in the average span of the nine years they existed. Such high drop-out rates in group membership are explained primarily by a lack of monetary incentives in the CHBC structures. Individuals tend to quit CHBC in favor of other gainful activities, more evidence of this is discussed under perceptions of internal conditions below.

Nchiramwera, a group found in Thyolo district, is the only group which grew between its formation in 1996 and 2006. Having formed under the auspices of the Catholic Church priest, this group undertook volunteerism as a function of the church's outreach programme. When an NGO called MSF Belgium came into Thyolo communities to start supporting them in fighting against HIV/AIDS, expectations of possible monetary rewards set in and the group grew much bigger before some dropped out again. This

group still remains larger than when it started. This is an example of the importance of socio-cultural perspectives held by the subjects. Monetary considerations which have been observed to have strong influential effects on individuals are found to be weaker than the galvanizing effects of religious beliefs of the community members. This then suggests that the origins of the group do matter when it comes to its persistence.

The national response to HIV/AIDS has obviously provided the drive to start CHBC groups in the villages. The multiple partnerships at higher organizational levels are also manifest at the community level. This is exhibited in the manner these groups started. The study sought to find out who provided the most initial impetus for the group to be created, and the results of this question are summarized as indicator FI. This indicator shows that a variety of individuals have been responsible for initiating CHBC groups in the communities. The range includes government community nurses and health surveillance assistants, church leaders, NGOs and in some respect community members themselves.

Despite the standardized methods documented by the NAC and its partners designed to guide training of CHBC volunteers, variations in channels of passing this information down to the actors have resulted in groups being organized and operating differently. For example one indicator, on the basis of which groups differ, is that despite all of them having steering committees, there is a variation in the composition of the committees and the number of times they are scheduled to have meetings in a period of one month.

Group meetings, to plan and share responsibilities, are scheduled to be conducted on a regular monthly basis, and these range from once in some groups, to two, three and even four times per month in others. This shows how the different forms of training and guidance has influenced the actors, but it also is a reflection of the variations that result from how the same information is amenable to widely varied interpretations due to differences in cognitive capacities and a perception of one's own situation. An aspect of a group's own situation in this case would suggest that groups with fewer meetings per

month are exhibiting economising behaviour in organizing their activities in the most plausible way.

#### **6.5.1.4 Perceptions of Partners External to CHBC Groups**

This section shows that various agents have different roles to play in the continuum of care and support for HIV/AIDS. Roles include facilitating, coordinating, financing and in some cases making critical decisions involving other agents in the matrix. One factor that is important for carrying out roles in such a scenario rests with expectations an agent has of another. In light of this, arguments from resource dependence theories suggest that between two parties who are employing strategic responses to each other, individual behaviour will be manifest in the form of compromise, avoidance, defiance, compliance and manipulation among others.

On the other hand we need to account for institutional incentives and explain what is undergirded by actors' own orientations and perceptions. These orientations and perceptions are a function of access to information and cognitive capacities, what is normally referred to as rational consumerism. To explore these notions we must seek empirical information on the actual preferences and perceptions of those involved which will give a reflection of how they understand the presence and roles played by their partners. This must also unveil misperceptions and normative (ideological) orientations that are responsible for ways in which they tend to do things amongst themselves and how they interface their partners.

Using this sort of logic influential impacts emanating from engaging other partners, such as facilitation, capacity building, and other forms of reinforcements are analyzed. In other words, as CHBCs face their counterpart organizations, which of the elements of these partnerships (institutional factors) manifest themselves in their day to day behaviour? Perceptions of those partners immediate to CHBC groups are summarized in Table 6.3 below.

**Table 6.3: How CHBC Groups Perceive Other Partners and External Conditions**

Response	AES		STL		SFBO		SPL		EID		ECA	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
<b>No</b>	88	(7)	43	(6)	7	(1)	73	(11)	8	(1)	29	(2)
<b>Yes</b>	13	(1)	57	(8)	93	(14)	27	(4)	92	(11)	71	(5)
<b>N<sup>1</sup></b>	<b>100</b>	<b>(8)</b>	<b>100</b>	<b>(14)</b>	<b>100</b>	<b>(15)</b>	<b>100</b>	<b>(15)</b>	<b>100</b>	<b>(12)</b>	<b>100</b>	<b>(7)</b>

Source: Munthali (2007)

**Notes:**

- i) **Yes** = presence of the specified ‘perception’
- ii) **AES** = satisfactory or adequate external support to the group.
- iii) **STL** = satisfactory support from traditional leadership to CHBC activities.
- iv) **SFBO** = satisfactory support from faith-based organizations to the groups.
- v) **SPL** = satisfactory support from political leadership to CHBCs.
- vi) **EID** = external support to CHBCs irregular or declining.
- vii) **ECA** = an indication of the presence of critical external authority or decision making institutions have in the running of the CHBCs (equivalent of property rights, laws and constitutions).

The main finding in this table is that the recipients of external assistance perceive assistance to be irregular and in some cases declining. While this is happening it has also been reported that a lot of these groups do not have the capacities to meet the basic nutritional and hygiene needs of their patients (Conroy *et al*, 2006:144; Birdsall and Kelly, 2007:141). The irregularity of funding has two faces. On the one side, it gives a reflection of the competitive nature of obtaining funding from the NAC via the Umbrella Organizations. CHBCs have to and do write proposals to the NAC and other funding organizations for their care and support services. There is ample evidence that there have been excessive delays in processing these proposals at the NAC (Birdsall and Kelly, 2007:141). The NAC’s ability to disburse is hampered by capacity concerns both at the central office as well as the implementing agents. The capacity is also limited by the inadequacy of resources to meet the increasing demands funding care and treatment. The

<sup>1</sup> Total number of focus groups that raised and discussed a particular perspective

resources going to support households with chronically ill persons were documented by the NAC to have been on the decline (GOM, 2007:51).

The second is that the community members have very limited capacities to write up proposals. When they do, the quality of the proposals is usually below the standards expected by the NAC. This engages the two sides in an exchange process which aims to clarify and improve the technicalities in the proposals. This process has often led to most proposals not getting funded. Failure and delays in getting funding through these channels contribute to the CHBCs claims of irregular and falling funding levels. It must be noted that on occasion villagers have also benefited from sporadic project assistance in the form of relief. However, the negative dependency effects are revealed by projects that are scaling down. For example, the World Vision International has had a massive presence in Thyolo distributing food to households with chronically ill individuals and also implementing food for assets work in the communities called C-SAFE. This project is no longer running in Thyolo, and the negative effects of this phase out are felt by the communities as they appear to be continually on the losing side of the battle against poverty.

Table 6.3 also shows that support for community care from other organizations is considered inadequate as indicated by 88% (AES) of the groups. This also confirms the irregularity of the assistance. Here it is likely that the actors' perception of assistance takes a narrow definition of material and financial support which often comes from external donors. The Table appears to show that support from FBOs and traditional leaders is almost satisfactory. These were observed in the preceding sections to be limited to channeling of information through meetings. But the overall indicator for external support (AES) shows that there is very little coming through, and is thus a cause for dissatisfaction. In essence what the reflections of the actors point to the fact that they do not expect much from the traditional and political leaders, so for that reason they do not see them as a major source of frustration. In other words, these leaderships are outside the structures of CHBC as it were, and whatever form of help they chip in is appreciated. While this is partly a result of some critical bottlenecks existing at higher levels, as

discussed in earlier sections, it is worth noting that there are inherent weaknesses in the coordination structures at the lowest levels as well. In particular there are gaps in human resources and institutional structures crucial for mobilizing resources.

The findings also suggest that there are relatively stronger linkages with faith based organizations, which appear to be working more closely with the groups than traditional leaders. Sidelining of traditional leaders in operations of care giving and support for HIV/AIDS was also observed by Birdsall and Kelly (2007) in a study of Bangwe community in Blantyre district. This brings into question the integrative nature of the approach to development and responding to HIV/AIDS in particular. This situation also applies to perceptions of the political structures in the communities. Just about 27% of the CHBC initiatives indicated that they received supportive contributions from political structures. This is too low considering that there are claims of promoting an all inclusive approach to the National Response.

An all inclusive approach needs to start with the traditional and political figures because these live within the communities, and they often have important social roles to play there. Typically, in situations where there is a serious illness or a funeral, the first point of call is that traditional leader and the political leaders are often expected to contribute resources towards the funeral. The findings, however, suggest that integration of these structures in the communities has been limited to HIV/AIDS information dissemination during meetings. By its nature, CHBC service delivery in these rural areas fits in more with the structures of religious work, than the routine traditional leader's work. For this reason, more effort is needed to get the traditional leaders and political leaders to get more closely involved.

One other important aspect reflecting transaction costs is the extent to which their actions are dictated by external authority or the degree of autonomy exercised by the actors in their day to day decisions. In this regard, the actors were asked to discuss who made the critical decisions regarding their daily routines. While the responses indicate that there is a considerable degree of independence in some areas, the groups still consider that

decisions are made by those who supervise them. This point is strongly tied to the assistance they get from their partners and the semi-formal structures in which they operate. CHBCs see themselves almost as part of the civil structures (hierarchy) that connects government and non government bodies. The groups call themselves names that associate them with the parent organization such as Malawi Social Action Fund (MASAF) group or Medicines' San Frontier (MSF) groups depending on who gives them most of the external assistance. Two concepts found in transaction costs economics, namely 'autonomy' and 'coherence' can be used to interpret this situation.

Peters (2000:8) observes that autonomy shows the degree to which an organization is institutionalized. Autonomy represents a concern with the capacity of institutions to make and implement their own decisions. Arguably, the extent to which they are not dependent upon another organization or institution, determines whether they can be said to be institutionalized. The more institutionalized the better because this implies that the members have experimented and learnt how to work around obstacles to achieve their objectives in the most efficient manner. On the other hand, coherence represents the capacity of the institution to manage its own workload and to develop procedures to process tasks in a timely and reasonable manner. This also represents a capacity of the institution to make decisions about its core tasks and beliefs and to filter out diversions from those. If the CHBC groups have to wait for initiatives that originate from the higher level agents it must be seen to have negative implications on the costs of transacting.

The perceptions discussed in the above paragraph explain why CHBC members ask to be considered for some token allowances because those working for NGOs and government always receive large sums of money in the form of allowances for supervisory visits they make to the communities. The perception portrays that the community members feel the unevenness of the playing field; they consider themselves fully deserving as they are now an integral part of the health delivery structure. At the same time they face high transaction costs on the basis of which they would like to be compensated. In institutional economics literature, this is essentially what Israel (1987: 66) refers to as 'job interpretation' which results from motivational forces that are determined by personal

interests as well as from some automatic inducements of the activities in which you engage. Individuals interpret their own roles alongside others with whom they connect as they perform their activities, and build expectations on such relational linkages.

The influence of other social protection mechanisms also has a part to play in explaining the need for compensation for carrying out CHBC activities. Malawi has been experimenting with various forms of social protection strategies such as the food or farm inputs transfers in the Public Works Programme (PWP) supported by the European Union, Cash transfers tried under the Concern World wide FACT project and the livelihoods augmenting World Bank supported Malawi Social Action Fund (MASAF) are just some of the examples. In these initiatives individuals involved get rewarded for offering offer their labour to public works initiatives. In comparing with these programmes, working on the CHBC appears unattractive and an economically inferior option for time allocation. The NIE reasoning points out those expectations are a function of limitations in cognitive capacities as well as self interested behaviour. Ultimately it is the local people's interpretation of the influx of external organizations and the support they bring that matters because their perceptions determine what decisions they take on the CHBC arena.

## **6.6 How CHBCs Interact with the rest of their Community**

The study recognizes that social inter-relationships between the CHBC actors and the community have profound effects on responding to the HIV/AIDS pandemic. Firstly, as torch bearers CHBC members engage with the wider communities in socio-economic exchanges that underline their value in the community. Secondly, the analysis in this section attempts to evaluate the reciprocal roles played by the CHBC and the wider community. In other words the rest of the community must engage with the CHBCs and do their part in the care and support processes. Table 6.4 below summarizes some of the methods of the prominent modes of interaction.



**Table 6.4: Community’s Contribution and Benefits from CHBC**

VARIABLE	DESCRIPTION	DISTRICT		TOTALS
		NTCHEU	THYOLO	
		%	%	%
Community Contribution	Labour	80	40	57
	Money	41	31	35
Patient Care	1 Patient	15	7	10
	2 Patients	22	5	12
	3+ Patients	32	19	24 <sup>2</sup>
Direct Beneficiaries	CHBC service	44	31	36
Funeral Visits (1 month)	1-3 times	32	57	46
	4-6 times	39	29	33
	7 times or more	22	12	16

Source: Munthali (2007)

**Notes:**

Percentages for districts are derived from the number of sampled households that reported a specific variable while totals give an average for the total sample size which is 100 households.

**Community Contribution** = the proportion of sampled households reported to give either labour or money to the CHBCs in their area.

**Patient Care** = the proportion of households reported to take care of a given number of patients at the time of the study.

**Direct Beneficiaries** = households reported to have directly benefited from CHBC service

**Funeral Visits** = the percentage of households that is estimated to have been to a specified number of funerals in the last month.

Table 6.4 serves to document the pattern of interaction between the community households and the CHBC groups. In trying to study the inter-relations between CHBCs and the community we need to understand the roles played by each side, we need to understand the workloads for example of care givers, and we also need to understand how the communities perceive the role of the caregivers in the community. The table shows that an average of 57% of households contributed labour towards care and support

<sup>2</sup> Caution: Unusually large numbers are most likely inclusive of orphans in the orphan care centers

for HIV/AIDS patients while 35% contributed money. Literature on the IAD framework emphasizes the importance of what the subjects have and what they do not have for purposes of decision making towards determining credible commitments such as care giving. This is the equivalent of inputs into a production function.

In the above example, it is easy to see that labour supply is more abundant and, therefore, it becomes the most plausible option. It also indicates the positive correlation between care giving and level of income. On the evidence of patient care as an indicator for benefits from the CHBCs, far more patients were reported to have been under the direct care of the CHBC groups than is the case in Thyolo during the one year recall period. This observation is also supported by the indicator for households that reported to have received direct assistance from CHBCs whereby more support was given to Ntcheu households than in Thyolo. An average of 36% households in the two districts reported that they had been direct beneficiaries of CHBC services, a factor that underscores the importance of the reciprocal and interdependent nature of the relationships between CHBC groups and the wider communities. From the foregoing it can be inferred that Thyolo communities are too involved in their own survival.

Traditional values and supportive roles that hold the communities together are also revealed by the number of times individuals attend funerals that take place within their areas. In Thyolo communities, more households (98%) indicated to have been in attendance at funerals than about 93% in Ntcheu within the previous month of the survey. Attendance at funerals taking place within your community is almost compulsory by the traditional standards, and often times it costs very little. In the light of this, households in Thyolo tend to commit themselves more to this aspect of community obligations (relative to their Ntcheu counterparts) than is the case in other CHBC activities that require resource contributions. This also points at the state of deprivation in that district.

In the table it is also evident that a majority of the households' responsibilities extend to providing care to more than one patient at a time within their networks, a factor which must clearly introduce stringent competition for their meager resources. Multiple cases of

HIV/AIDS patients mean that care givers must allocate more resources to the cause, but this also underscores the importance of being able to share responsibilities among many members in order to be able to reach out to many patients. This is an important aspect of NIE in terms of how the care givers tend to fashion out their working routines by trying to reach their goals more easily. Further discussion regarding strategic working arrangement is found in Chapter Seven.

One important role of the CHBCs in the community is to combat stigma among individuals. In the table below the presence of the structures for care and support, in particular voluntary counseling and testing (VCT) for HIV/AIDS is examined against the perceptions of the community with regard to presence of stigma. Specifically, the output in the table gives a summary of the response to a question which sought to find out if individuals in the community were comfortable interacting with someone who was tested HIV positive.

**Table 6.5: Indicators for Presence of Stigma in the Communities**

%	Strongly Disagree	Disagree	Agree	Strongly Agree	Total
Ntcheu	10	13	29	48	100
Thyolo	6	10	49	35	100

Source: Munthali (2008)

The table makes an important suggestion that up to 23 % of individuals in Ntcheu and 16% in Thyolo believe that people in their communities are not comfortable around someone who is HIV positive. While the numbers show that a greater proportion of the community are comfortable living and interacting with infected individuals, it still suggests that issues of stigma are very much alive. In this regard, it must be understood that the infected individuals will not be in a position to interact freely with other members of the society due to the existence of stigma. An even bigger proportion of the respondents (54%) in Ntcheu and (50%) in Thyolo reported that the general feeling in the community is that those who got infected through sexual activity got what they deserved. Respondents were asked whether they thought an individual who got HIV infection through sexual contact got what he or she deserved. As reported in Table 6.6 below, the

existence of stigma is well supported. The stigma goes further to characterized infections with the method of infection. Given that it is generally believed that HIV infection is contracted through sexual activity, even those who get infected otherwise must suffer the humiliation that is associated with infection through sex.

**Table 6.6: Perceptions of Stigma for HIV Infection through Sex**

%	Strongly Disagree	Disagree	Agree	Strongly Agree	Total
Ntcheu	17	28	41	13	100
Thyolo	19	31	27	23	100

Source: Munthali (2008)

### **6.7 What Motivates the CHBC Actors?**

This is a summary of factors responsible for motivating members of the CHBC groups to join and participate in the service delivery. Each score signifies how much an aspect was emphasized by the respondents. The section highlights the importance of motivational factors within each group as well as across the groups, thus making comparisons across cases possible through the additive cumulative scores of variables and the subsequent ranking shown in Table 6.7 below.

In studies of human behaviour, incentives and motivations that spur basic processes in which people are involved, it is important to consider the concept of a ‘situation’ (often referred to as stimulus in psychology). According to Hage and Meeker (1988: 75-76) the stimulus is a social definition of a social situation. This is because a particular situation triggers a stimulus which in turn attracts some specific behavioral response. By nature, human beings will work on a situation by responding to reinforcement and feedback mechanisms. More response results if there is positive feedback and reinforcement. Adopting this concept of reinforcement this study seeks to explain how the prevailing situation within the communities, the feedback they get from the community members and leaders as well as partner organizations, play vital roles in determining how CHBC actors organize their transactions.

**Table 6.7: Summary of Incentives and Motivational factors for CHBC**

<b>CHBC Group</b>	<b>Self Esteem</b>	<b>Internal factors</b>	<b>Skills &amp; Training</b>	<b>External Influence</b>	<b>Group Assets</b>	<b>Group Capital</b>	<b>Situation Demands</b>	<b>Monetary Rewards</b>
Lizulu	50	13	13	0	0	0	13	13
Sharpevalle	17	0	17	0	17	0	17	33
Matchuana	13	13	25	0	13	13	13	13
Lupiya	25	25	0	0	13	13	13	13
Nansato	38	13	25	13	0	13	0	0
Mpando	11	11	33	0	11	22	11	0
Njolomole	43	14	14	0	0	0	14	14
Nachipere	17	25	25	0	8	17	0	8
Mikombe	11	33	11	11	11	11	0	11
Kwakwanjana	9	9	18	27	9	9	9	9
Goliati	23	8	15	15	8	15	8	8
Senzani	21	29	0	21	29	0	0	0
Manjawira	27	13	7	20	13	13	7	0
Nchiramwera	18	24	18	12	6	6	12	6
Chimaliro	8	23	8	31	8	8	15	0
<b>C Score</b>	<b>329</b>	<b>252</b>	<b>228</b>	<b>150</b>	<b>144</b>	<b>139</b>	<b>130</b>	<b>127</b>
<b>Rank<sup>3</sup></b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>

Source: Munthali (2008)

**Notes:**

*Self-esteem* = members expressed pride and satisfaction to be recognized and associated with service delivery in the community

*Internal Factors* = impact of other influential factors such as individuals and other groups in the communities

*Skills and Training* = members were motivated by the skills and training gained or expected to accrue within the structures of CHBCs

*External Influences* = the members expressed that the mere presence of external organizations in the HIV/AIDS response is motivating them in this partnership

*Access Group Assets* = gains from group asset ownership plays a role to hold the members together

*Access to Group Capital* = the realization that some form of business capital is obtainable if and when you belong to a group such as CHBC

*Situation-demands* = observations by members of the deteriorating situation due to HIV/AIDS and the need for a response

*Monetary Rewards* = respondents expressed that they were driven by expectations of gaining monetary benefits from engaging in service delivery

<sup>3</sup> Ranking of the predominant strategic working arrangements across all cases

Table 6.7 shows *self-esteem* as being the main driving force among the participants from all groups. Members are motivated because they are recognized as health workers in their areas; they are associated with saving people's lives by giving them counsel towards voluntary testing and consequently introducing those in need to ARVs. According to Israel (1987:61) workers' motivation is affected by characteristics of the activities they perform; this is done by influencing the individual, and therefore, the institutional performance by shaping their personalities and general outlook. In this case, the actors are perceived to bridge the gap between their own communities and hospitals which are often distant from them.

*Internal factors* to the community such as influential individuals, church and other parallel community based groups have played a role, albeit of secondary importance, to motivate the CHBCs. The *training and skills* acquired through CHBC work is rated as the third most influential factor. Training was given to the CHBCs by external agents such as the Ministry of Health (MOH), Medicines' San Frontier (MSF) and the National AIDS Commission (NAC) among others. A critical analysis of the training and skills aspect reveals two dimensions of significance as perceived by the subjects. The first is that training and skills enable them to work and perform better as they face day to day challenges, as well as for purposes of their interaction with other partners. Secondly, and more important is that training is a gateway to obtaining external support, without which they themselves recognize external organizations appear not so keen to provide support. This is a clear cut case of good governance and accountability regarding sourcing and accounting for resources, and is understood that way by the community groups. Above all expectations relating to and attendance of training reflect some degree of strategic thinking on the part of the actors.

The presence of external organizations is found to play a major role largely amongst communities in Thyolo District (CHBCs 9-15) and to a much lesser extent among those in Ntcheu who seem to be relatively more self sufficient. Focus group discussions on perceptions suggest that the presence of external organizations underlies two fundamental lines of thought. First is the recognition that external agents bring resources which must

benefit organized actors such as those in CHBC groups. There are two elements in this reasoning; one is that of exhibiting dependency and the other is a potential for opportunism. As observed by Birdsall and Kelly (2007:141) numerous groups will be born because of the expectations of funding being created by the multiple partnerships and many end up in frustration that they do not get funding.

Second is that community members appreciate the benevolence attributes shown by external agents. The appreciation is shown by committing to do their part in the challenges of HIV/AIDS care and support. It is notable that other factors such as access to group assets, potential group capital, the level of HIV/AIDS infection and its demands, and expectations to be rewarded with money, only have influences that are selectively strong or of secondary importance. However, these must be acknowledged as they are obviously linked to the presence of the external organizations in the areas.

At a more general level, it is clear that these findings add some significant insights on the pressures within which the CHBC actors operate, the limitations they are faced with, and the positive incentives created by the presence of the wider policy environment. The environment generates positive externalities for the actors and in return they respond in ways that are viewed as logical. Since the overall purpose of the analysis is to bring to the fore the critical features of the society and the policy environment responsible for the behaviour of the CHBC actors in a configurational manner, a discussion pertaining to how these subjects perceive the roles played by other actors and their own positions has been given in the earlier sections of this chapter.

## **6.8 What do the Actors bring to Service Delivery?**

The community groups fulfill the role of care giving and support in various capacities. First they realize they have a responsibility because the pandemic is eroding their own community and they have to do something. Secondly, they play a complementary role to the international and national care givers. To do this they have to make a number of sacrifices in the form of inputs into the CHBC activities. The sacrifices, which are often

difficult to quantify, come in the form of human resources, time, financial and material contributions in the course of delivering care and support for HIV/AIDS cases. At the community level the importance of the resources involved in the service delivery is not only found in the economic values but also in the symbolic meanings applicable within the cultural context of the specific location. In community life symbolic gestures are as important as economically valued exchanges; this is why they are discussed as a form of interaction among community members.

This section attempts to only show some of the material resources brought forward to the HIV/AIDS sufferers' households. Resources brought forward have traditional symbolic significance in the eyes of those involved. Table 6.8 below also indicates the importance of the predominant resources that are donated as CHBC service delivery. Hage and Meeker (1988: 75-76) emphasize that meanings must distinguish between ideas as cognates or facts and ideas as symbolic meaning. What are the symbolic meanings attached to visiting the patients? What do they bring to the patients? In other words the importance of these factors is not only grounded in what they do or don't have, but also in how these offerings are perceived in that culture.

By its nature, CHBC involves members making compassionate visits to the patients' homes and this is associated with symbolic gestures such as bringing already prepared food, making monetary contributions towards the patients' needs and supplying them with extra labour. Choices of the strategic gestures chosen have cultural and economic meanings to the actors and the recipients. For example, it's customary to bring food when visiting a patient who is in hospital. With respect to HIV/AIDS the communities have been placed in situations that mimic a 'hospital scenario' where such gestures are expected of them.



**Table 6.8: Summary of Physical and Symbolic Resources brought by Care Givers<sup>4</sup>**

CHBC Group	Food %	Medicine %	Money %	Groceries %	Other %	Fertilizer/Seed %	Firewood %	Total %
Lizulu	50	25	25	0	0	0	0	100
Sharpevalle	25	25	25	25	0	0	0	100
Matchuana	33	33	33	0	0	0	0	100
Lupiya	20	20	20	0	0	40	0	100
Nansato	20	0	20	20	0	40	0	100
Mpando	25	0	25	25	0	0	25	100
Njolomole	43	14	14	14	0	0	14	100
Nachipere	20	20	20	0	20	0	20	100
Mikombe	40	40	20	0	0	0	0	100
Kwakwanjana	50	50	0	0	0	0	0	100
Goliati	14	14	14	29	14	0	14	100
Senzani	50	33	17	0	0	0	0	100
Manjawira	0	0	0	0	0	0	0	0
Nchiramwera	17	17	17	33	17	0	0	100
Chimaliro	33	0	33	0	33	0	0	100
<b>C Score<sup>5</sup></b>	<b>440</b>	<b>292</b>	<b>284</b>	<b>146</b>	<b>84</b>	<b>80</b>	<b>74</b>	
<b>Rank<sup>6</sup></b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	

Source: Munthali (2008)

**Notes:**

*Food* = care givers reported to bring food to patients during compassionate visits.

*Medicine* = medicine bought by group members such as pain killers, anti-malaria tablets (not ARVs).

*Money* = the groups donate money to patients during visits.

*Groceries* = groups reported to supply groceries such as soap, sugar and salt to patients.

*Other* = other assorted items that might have been brought to patients' homes by care givers.

*Fertilizer* = group contributed fertilizer for use in the patients' gardens.

*Firewood* = group fetching and supplying firewood during patient visits.

The same logic applies to provisioning of groceries and medicines that are not readily available to the patient but are crucial for keeping the effects of HIV/AIDS in check. Such requirements are often purchased by the CHBC group members and on occasion they have been supplied by other partners such as the MSF as part of the CHBC kit.

<sup>4</sup> Rows indicate the relative importance of each factor within a group and column ranking does the same across all groups

<sup>5</sup> Cumulative Score specific to each variable across all cases

<sup>6</sup> Ranking of the predominant strategic working arrangements across all cases

However, it was noted that the external supplies remain inconsistent and do not match with the rising numbers of patients. On the other hand, due to economic constraints on the part of the providers, the actors strategically resort to supplying labour for drawing water, bathing patients, sweeping home surroundings and providing firewood as more feasible cost economising options. Clearly, given the nature of the problem of HIV/AIDS illness, actors apply the traditional methods of working around it and reaching their goals.

By tradition a patient is supplied with food during each visit. In particular, there is recognition of the prolonged incapacitation exhibited by HIV/AIDS sufferers, which generates demands for medicines, and financial and labour related contributions. The overriding picture, however, is one of a community providing a gesture of psychological and material support using the traditional methods of paying them a visit and giving them encouragement.

One extreme and peculiar case of inactivity that is striking in the table above is the Manjawira CHBC group. Manjawira CHBC was initiated by a Health Surveillance Assistant (HSA) working for Ministry of Health who gave an idea of coming together to the villagers for purposes of home based care and orphan care. This group grew in size due to injections of funding for a maize mill project, erecting a cattle kraal (but no cattle in it yet) and keeping chickens. However, the group projects have not been able to take off. The focus group discussions revealed that the maize mill was acquired but had not been installed. They also acquired 300 chickens which all died right at the beginning because they could not purchase medicines for them. The group had not had a meeting in about seven months preceding the research. The discussion also revealed that this group was too dependent on the government staff to coordinate their activities instead of their own committee. Due to ensuing frustration some of the members began to pull out of the group citing other engagements as reasons for quitting. The failure of group initiatives in the form of generating resources for CHBC and absence of complementary activities explains the absence of symbolic materials for exchange during care giving activities for this group. But there might be well other non-material symbolic exchange that these people engaged in and are not reflected here. Overall the situation within this group

symbolizes absence of commitment and perhaps a lack of community ownership of the entire initiative. These notions are discussed further in Chapter Seven.

### **6.9 Distinct Patterns of Interaction Emerging from the Two Districts**

This section summarizes the distinct patterns that emerge from the categorized responses obtained from the two districts. In particular, the section highlights cases that are either peculiar to one district or those predominantly shared between the two study sites. Further explanations and analytical and policy insights on these factors are found in Chapter Seven.

One major and explicit finding of this study regarding the CHBC group formation and dynamics is that once groups are formed there is a high tendency of members to drop out. In particular, the drop out rate for Ntcheu district is estimated at 53% while Thyolo has a drop out rate of 42%. Along with this is the observation that no Faith based Organization is observed to have taken a part in formation of these groups in Ntcheu. They all received original influence from the community members, government staff and one from an NGO. On the contrary in Thyolo the church dominated the initial phase of setting up these groups. Perhaps this also contributes to their cohesiveness which leads to a relatively slower rate of drop-outs.

Comparative analysis and triangulation of categorical variables suggests that participating members in Ntcheu are relatively wealthier, and therefore, more independent with regard to availability and use of resources, as well as related decision making for CHBC service delivery. Inhabitants of Thyolo, on the other hand, perceive CHBC group membership as a source of hope not only for the CHBC service delivery but also for opportunities to address their wide spread poverty. In this regard they are more likely to remain members of the CHBC groups than their Ntcheu counterparts. This conclusively suggests that participation at the CHBCs has a positive relationship with poverty and leads to dependency on available external resources.

A second peculiar finding is that community members in Thyolo groups perceive an opportunity set in the existing care and support arrangements that they can exploit to their advantage. The data shows that a predominant desire to receive monetary rewards for giving care and support in the communities, to exploit the potential for acquiring group capital and a show of reliance on group assets exists in Thyolo. A contrasting picture emerges in the following groups from Ntcheu district on the other hand; with Njolomole, Manjawira, Sharpevalle, Lizulu and Senzani all share zero scores in the same factors. This suggests that the two districts have virtually distinct forces behind their motivation, poverty being one of the major ones in Thyolo. This is supported by the observation that Thyolo have focused on acquiring IGA equipment in order to try some income generating activities. Poverty drives their desire to gain as much as possible from the institutional arrangements of CHBC.

Lastly, the major similarities in the two districts are that all groups appear to strategically perform similar activities. The most dominant activities include bringing food, medicines and some token money, as well as offering labour to the patients' farms and homes. Their activities are always backed by strategic arrangements such as sharing of responsibilities and organization of a fall back position to cover them in times of need.

## **6.10 Summary and Conclusions**

This chapter has set out to analyze the impacts that interactions of partners have on the way the members of the Community and Home Based Care (CHBC) groups arrange their transactions. The understanding being that economic behaviour of these members is inherent in the way they strategize on how to carry out their activities. The theoretical background to the transaction costs economics applied here is found in the governance paradigms that have an interest in how inter-organizational arrangements tend to influence the behaviour of actors. In this case it is actors at community level delivering care and support to those infected and affected by the HIV/AIDS pandemic.

The Chapter has shown that there is a strong organizational and policy environment for engaging actors in the care continuum. In particular the SWAP arrangements are critical for bringing international care givers to engage with local agents in harmonized funding mechanisms. This arrangement has resulted in increased funding for HIV/AIDS, even though the funding to the grassroots appears to remain abysmal.

At the local district and community level there still remain major obstacles to funding AIDS related activities. International organizations named as umbrella organizations are working with the NAC to fund the communities owing to delays in the decentralization process of local government structures. This arrangement is working, but with its limitations delays in the decentralization are only perpetuating further inequalities at the community level.

Social capital has been built by the wide range of organizations involved in the care and support. The chapter has found that origins of the CHBC groups have an influence in how they operate and sustain themselves. The origins have an influence on the organizational arrangements in each group and also on the attrition rates observed in these groups. Where the church was key to forming and working with the groups the degree to which members drop out of the groups is rather limited. It is also concluded that poverty is positively correlated with participation in health care and support at the community level.

The poorer communities in the care and support for HIV/AIDS sufferers perceive their position as an opportunity to get paid for delivering health care. They also make efforts to address their long term poverty by strategizing on income generating activities by pursuing group assets that will make this possible. They view the presence of external partners as an ample opportunity for this purpose to undertake such investments, however the short term type of investments organized by the national response do not have the far reaching effects desired by the actors.

## Chapter Seven

### **Application of the New Institutional Economics and the IAD Framework**

#### **7.1 Introduction**

This chapter interprets the factors impacting CHBC service delivery from the perspective of New Institutional Economics (NIE) Theory and the IAD Framework. These factors were presented in Chapter Five as constraints coming from the ‘community attributes’ and in Chapter Six as influences from the inter-organizational relations on the CHBC institutions. The chapter seeks to unveil the performance enhancing factors as well as those constraining it in order to draw some policy insights that might be useful in improving the performance of CHBCs in the national response to the HIV/AIDS pandemic.

The NIE provides the theoretical context for the interpretation, while an IAD Framework is applied as a model that links the input variables to the consequent actions or decisions and to the outcomes. The interpretation follows an examination of the patterns of transactions, and isolating sources of transaction costs that are generated, in the form of friction or resistance, during the course of interaction at the CHBC level. Transaction costs have implications for economic performance of the economic agents, namely the institutions of CHBCs. This is because the pattern of transaction arrangements is based on revealed preference of the methods that constitute economic choice on the part of actors. So essentially, this chapter must explain the determinants of the pattern of choices that are being followed.

The analysis highlights the influences from the inter-organizational relations on the one hand and influences of the community conditions on the other. These are brought together to explain the emergence of new dimensions of social capital (social networks) which cater to the needs of the CHBC groups. Theories of Incomplete Contracts and

Property Rights are used to illuminate some of the various dimensions of the inter-relationships resulting for the partnerships in care and support delivery.

## **7.2 Explaining Transaction Outcomes through Social Capital**

It is well known that social capital explains economic behaviour. Two dimensions of social capital are explored to explain collective action within CHBC service delivery. First, collective action is explored through the interactions that occur to create CHBC groups: the group evolution, group sizes, and ownership and exercise of authority in these groups. Secondly, collective action is examined through the concept of Property Rights and Incomplete Contract Theory which seeks to link the group behaviour to the presence of the external organizations and rules in use.

### **7.2.1 Emergence of New Social Capital**

Application of the IAD framework evaluates economic performance in two ways. It seeks to interpret ‘*outcomes*’ and ‘*processes*’ that result from a mixture of inputs and actions undertaken in the decision making arenas. This section, therefore, makes use of these concepts to explain the performance, i.e. the outcomes of the community and home based care service delivery in respect of social capital. Processes are examined through group behaviour by exploring what they actually do through, for example, regularly occurring behaviour.

One major outcome identified in this analysis is the *extension of social capital* accessible to the actors of the CHBC service. According to Bourdieu (1986 in Morgan and Swann, 2004:2) social capital is defined in terms of social networks and connections. He posits that an individual’s contacts within networks result in an accumulation of exchanges, obligations and shared identities that in turn provide potential support and access to resources. In Putnam’s (1993 in Morgan and Swann, 2004:2) definition, on the other hand, social capital includes people’s sense of belonging to their community, and it constitutes community cooperation, reciprocity and trust, and positive attitudes to community institutions. So beyond being a resource to be tapped, participation in

community activities or civic engagement is a form of social capital. In the light of these definitions, in an exploration of the role of social capital, one of the tasks is to identify the social situation where people can participate in exchanges, examine the relevant actors, and areas of cooperation. This also conforms to the application of Ostrom's IAD framework in that the situation and actors need to be identified and decisions undertaken are examined in the light of given constraints.

Specific to the situation at community level, the sources and nature of exchanges that tend to enhance or inhibit progress need to be explored because in the absence of such arrangements communities must resort to the markets for their needs. In responding to the HIV/AIDS situation the relevant actors that constitute a social network have been identified in Chapter Six at international, national, district and community levels. The analysis of the international and national institutions of care and support reveal that there is a strong presence of support to the structures and funding mechanisms at the policy level.

In Malawi, two main types of social security nets traditionally have been extended to address the needs of the population, those targeting the most vulnerable sections of the communities; these include productivity enhancing interventions such as the agricultural oriented Targeted Input Programme (TIP) for capital-constrained poor households, and the Public Works Programme (PWP) designed to create communal assets for the land-constrained poor. The other type of social security net is direct welfare transfers which include targeted nutrition interventions for malnourished children and mothers, as well as direct transfers to vulnerable groups, such as orphans, the elderly, and chronically ill, or famine stricken families (Arrehag *et al*, 2006:102). In particular, institutional arrangements responding to the HIV/AIDS pandemic have been targeting to widen the scope and provide more effective forms of social support for the communities by creating a more coherent environment to prepare households and institutions at that level to cope better with the effects of the HIV/AIDS pandemic.



The national response to HIV/AIDS in Malawi also receives support from a much wider community which includes international and national agents, such as the Global Fund, DFID, the World Bank, NORAD, CIDA, the governments of the United States, Germany, Canada, Japan, as well as the IMF, European Union, and the African Development Fund at international level. At the national level the Malawi Government is being supported by a host of NGOs, FBOs and other public as well as private agents. The 'National HIV/AIDS Policy is in place to ensure that there are clear coordination and implementation guidelines for the multilevel institutions in the response. The presence of these multiple partnerships entails new relations (transactions) on the part of the CHBC actors. The new relations are, in themselves, an important outcome that increases the adaptive capacities of the community players in the national response. On the basis of the definition of social capital, the interactions mean that participation is also fostered in areas where there would have been none. For example, the administration of the ART, the training of volunteers at the community level, the availability of small grants from the NAC for small community projects, are all transactions that by design tend to facilitate health care while also making up for the already highlighted community inadequacies. Moreover, once created the CHBC institutions tend to persist because of the interactions they make with other partners.

#### **7.2.1.1 Evidence of the Emerging Social Capital for CHBC**

The role of this social capital manifests itself at various levels; in this example, the creation and impacts arising from the evolution of CHBC groups and other forms of community contribution (efforts) are applied to show that social capital is being built. The fact that the outcomes and processes involved have both positive and negative influences on health care delivery have also been picked up in the subsequent sections.

i) *Origins of the groups* is adopted as one of the indicators of social capital in the CHBC context. The national response to HIV/AIDS, which is a collection of multi-sectoral relationships, has obviously provided the drive to start CHBC groups in the villages. Firstly, the multiple partnerships involving organizations at higher levels as

well as those at local level are all found to be present at the community level. Secondly, the wide variation in the driving forces behind the making of these groups is a clear indication of the influence of social networks (See FI in Table 6.2). Those involved in the initial processes of setting up the CHBC groups include government agents such as community nurses and health surveillance assistants, church leaders, international and local NGOs such as World Vision International and NAPHAM, and in some respect community members themselves.

The analysis observes that origins of the group do have an influence on the subsequent stages of its life. For example, grouping the CHBCs by 'source of original initiative' reveals that groups reported to be solely created by the community members had a 50% drop-out rate in membership which is also the average for all groups in the sample. Groups whose origins are found in the church have the lowest drop out rate of 46%, government initiated groups have the highest drop out of 62%, whereas those started by NGOs drop out at 50%.

This suggests that there is a stronger traditional bond between the role of the church and care giving and support for the HIV/AIDS sufferers. This observation also suggests that the churches are better placed to complement groups under their tutelage. Besides, the volunteers' understanding of the nature of CHBC service tallies well with church principles where remuneration is not expected; rather people make contributions based on faith and religious convictions. On the other hand, with the lack of proper follow-ups and supervision associated with most government initiatives in rural locations, a high drop out ratio for government initiated efforts is not surprising. It has been documented on numerous occasions that government struggles to fill staff positions and maintain them in the rural areas.

The promotion of group work at community level mirrors the importance of approaching the fight against HIV/AIDS collectively in international arenas. The merits of the group approach have been documented in various socio-economic disciplines: For example in a discussion of the community decision-making on land

tenure in Kenya, Basset (2007:2) distinguishes between allocating land rights in individual tenures and group tenures and he concludes that a group approach is favoured because it provides for the powerlessness which individual members feel about themselves. This reasoning can be extended to the situation regarding the CHBC actors. Delivery of health care at community level consistently demands allocation of time, labour and other resources which are normally in short supply among the rural poor. Exploitation of externalities of a network is one way of increasing their chances of responding to the burden placed on them by HIV/AIDS.

Secondly, belonging to a group increases the likelihood of accessing external resources. For example, one of the prerequisites for applying for the NAC grants is an identifiable group working in the community. Thus the potential access to funding can only be exploited within that arrangement. This strategy has been vastly used in microfinance credit schemes, such as FINCA International, in developing countries as a process that seeks to bypass collateralization of funding for community level projects. Instead of providing a surety for obtaining a loan, the group is the collateral because it significantly reduces the members' chances of defaulting or misappropriating the funds. The CHBC groups have exploited this to good effect because facilitation of health care delivery has been made possible. External assistance in the form of CHBC kits which contain medical supplies, training for volunteers that equip them with skills for health care, counseling and referral of cases to health facilities, and capacity to draw from the competitive NAC funding for group projects, among others, are now a possibility.

Group membership also creates stability because it reduces uncertainty to both the internal members of the group who develop trust, as well as assuring other concerned partners outside the group. This implies a reduction of transaction costs for both the groups and their partners. One of the key insights from transaction costs economics reasoning is that exchange agreements must be governed. The reason is that the more information is available making planning into the future transactions possible the better the chances of escaping the costs of adapting or redirecting transactions when

costly contingencies arise. A common understanding regarding what the other party is likely to do contribute to foresightedness, which makes it possible for parties to work out fully negotiated contracts for future contingencies. Such contracts keep the costs of monitoring the agreements low. The idea of uncertainty reducing measures is discussed further under strategic working arrangements followed by the CHBC groups. Although the CHBC groups do not have to repay the grants they get from partners, the governance structures of the national response to HIV/AIDS needs to ensure that the funds will be used for the right purposes, and group structures have inbuilt accountability characteristics.

ii) *Participation and volunteerism.* Creation of the group is a form of social capital, but creation is also a result of a process that reveals underlying forces. It is equally true that variations in the group sizes, in particular the falling group populations, must also be explained by some fundamental but not readily observable factors. While it is well documented in the institutional economics literature that group size may be as much an indicator of institutional success as a precondition for such success (Ostrom and Poteete, 2004:2), of concern at this point is the attribute of participation at the level of health care delivery by the community members. With regard to the notion of participation, institutional economic theory points to the importance of responding to incentives as a driving force. The discussion above highlighted the role played by external agents in the creation of the groups, but beyond that the study observes that ‘expectations’ played a key role in the recruitment of group members.

The Rational Choice Theory of institutionalism emphasizes institutional arrangements, that is to say that members of an institution behave in response to those basic components of the institutional structure, some of which are the rules and incentives found in the structures. Applying that reasoning, it is easy to see the argument put forward by Guy Peters (2003:3) which suggests that individual members, in their rational nature, do retain their own well ordered sets of preferences even when they engage with others in a group, unlike the individual perceived through the lenses of normative institutionalism who gets remoulded by the

institutions he is participating in. Those, whose aspirations are not aligned with group goals and are not met, tend to leave. On account of these observations, the idea of participation and fluctuations in group sizes in the CHBCs are examined through the lenses of volunteerism and the notion of bounded rationality.

In CHBCs, responding to incentives takes many forms. Some of the notable examples are the initial formation of the groups as a response to incentives existing in the economy, such as the training and skills acquired from CHBC structures, and community recognition of the roles played, among others. In this regard the study also recognizes that participation in the CHBC groups depends on incentives perceived prior to enrolling on the group (expectations of network externalities). In the absence of these incentives, the 'exit' option is invoked.

In analyzing incentives and motivational aspects, and the perceptions that influence participation at group level, the study concludes that the concept of volunteerism is not understood in the manner other partners promoting it would like. This cannot be wholly blamed on poor information flow, but other forms of bounded rationality in which the villagers interpret the information and set their expectations based on their own background conditions should also explain part of the outcome. Background conditions must include the poverty levels and past history of their involvement with other initiatives that rewarded them for participating in development work. It also explains the lopsided nature of contract negotiations at the ex-ante stage, in particular the absence of bargaining power (voicing interests and expectations) on the part of the community members when the activities are just being initiated. These asymmetries have implications for how the community members make decisions and perform their duties.

Absence of monetary incentives clearly frustrates them and the result is that they quit CHBC to pursue other gainful alternatives. This is not to say that lack of incentives is the only reason for dropping out of these activities. Conroy *et al* (2006:75) show that there is evidence of families nursing chronically ill persons also tend to pull out of

group activities to concentrate on these cases. These individuals become invisible, a factor which puts them at risk of being left out of development initiatives that might have been targeting them. Falling by the way side is just an indicator of failing to cope with the transaction costs associated with responding to the HIV/AIDS pandemic at the two fronts, at the CHBC group level and at the own household level.

However, on a positive note, the falling populations in these groups were reported to have galvanizing effects on the remaining members. The focus group discussions indicated that they work better in smaller numbers, because these constitute only the committed individuals to the volunteer work of the CHBC. The smaller numbers constitute reduced transaction costs of accessing and sharing information. This increases predictability in members' behaviour. The merit of predictability in any transaction is that it eliminates the need to monitor and enforce contracts with others, and thus keep the costs of transacting low. It also reduces the transaction costs associated with the free rider problem that is associated with increasing numbers of individuals interacting to attain collective goals, as opposed to a small group that is well knit together. However, even within the smaller numbers of more committed volunteers, there is evidence of opportunism, as will be noted later on a discussion that sheds light on the lack of space for contract negotiations at both *ex-ante* and *ex-post* stages between the CHBCs and partner organizations.

iii) *Community Contribution to Social Capital*; Social capital at this level is discussed in two forms. The first is made of the transaction costs reducing networks that the communities have adopted amongst themselves as a means of closing their own vulnerability gaps, and in particular benefits the fight against the HIV/AIDS crisis. Second, are the strategic efficiency oriented procedures undertaken in order to work their way to reach their organizational goals. Strategic efficiency arrangements imply economising behaviour on the part of the CHBC actors. These include the methods and approaches such as symbols created in the process of delivering health care. From an evaluation perspective cost economising procedures are viewed to make an important contribution to economic performance of any organization.

The communities in Ntcheu and Thyolo have developed a wide range of social ties they use to fall back on in times of need (Refer to Table 5.5). Usage of these facilities is equally widely varied in these locations. The major concern for which social networks are required in these communities is food security. Food security is not just a concern at the household level, it is also important for health care delivery at the CHBC organizational level. The communities in both Thyolo and Ntcheu rely on the immediate family ties when faced with food insecurity. When the immediate family fails in Thyolo they seek it from the extended family but in Ntcheu it's the circle of friends that is called upon.

The summary to Table 5.5 shows that possibilities of extending social networks vary with one's level of economic status. A contrasting picture emerges in the two locations when we observe social protection mechanisms beyond family and friends. The location that is better off has a wider network they can draw upon while the more deprived individuals from Thyolo are restricted to the family and friends networks that are economically viable. This suggests that the poorer you are the weaker you are in terms of the capacity to organize economic investments that might lift you out of the mire, and indeed to effect a meaningful change in the response to the HIV/AIDS pandemic at your household level. In other words, the finding suggests that transaction costs are likely to be higher where economic status is lacking. In light of this, the role of the state can be enhanced if packaging of interventions such as the NAC grants has an in-built mechanism for deliberate targeting. At the moment the grants have to be competed for and those able to write good proposals stand to benefit.

Secondly, Ntcheu district offers more flexibility in terms of accessing networks with procedures that have a monetary cost attached. In Ntcheu assistance is predominantly sought from friends, private organizations and money lenders besides the immediate family. These are processes that involve a cost of borrowing but they also involve precise contractual agreements. There is very little use of extended family ties for

assistance in that district for the uncertainty this option entails. This means that there is more convenience in borrowing from semi-formal and formal outlets, than the more informal family networks. This highlights the importance of certainty in contractual agreements that are reached by the two parties and also avoidance of search costs, which keeps the transaction costs low. Family borrowing involves uncertainty regarding availability of 'assistance' on the one hand and the possibilities of non-repayment (risk of self-interestedness) tend to reduce the confidence in transactions, therefore creating the need for elaborate safeguards or precise contracts that will ensure absence of exploitation. Formal sources of adaptive capacities deal with this dilemma and tend to keep the costs of transacting on either side of the agreement low. This point also emphasizes the importance of having a wide range of options which increase the possibilities for adaptation in dealing with contingencies, which is itself a cost minimizing outcome. This finding tallies very well with North's (1994) observation in his study for economic performance that 'adaptive efficiency' accounts for the success of institutions, for example, institutions in the western world that replaced the traditional functions of the family induced low cost transacting and succeeded, albeit with some signs of imperfections.

On the other hand, it can be observed that in Thyolo there is reliance on immediate and extended family. Utilization of formal credit facilities is out of their reach because of their levels of deprivation. There is clear absence of flexibility to adapt in the Thyolo communities. The lack of options entails higher transaction costs, exacerbating underdevelopment in the location and specifically at household level, because availability of capital is a crucial ingredient for institutional development, and in turn for overall economic development which prepares communities' responsiveness to HIV/AIDS demands. The idea suggests that these constraints also extend to further rigidities in how the CHBC transactions are arranged in Thyolo. Along these lines, Birdsall and Kelly (2007:140) posit that the scale and scope of what most of the CBOs in home based care are able to achieve is severely limited, given that most of the CHBCs' clients have been reported to suffer malnourishment. Considering that these people are faced with limited farm produce, the next option is



to resort to the costly market transactions, and this is where credit facilities would come handy. In this regard the CHBC organizations resort to offer labour that helps the sufferers in various ways in order to make up for the unavailable resources.

### **7.3 What Do They Actually Do?**

Having looked at the various forms of social capital that are being built within the structures of the national response to the HIV/AIDS, this section sets out to examine what the groups actually do in that context. The IAD framework recognizes that processes, which are a function of power and relations, have a lot to say about the performance of the groups in the action arena. The processes are explored in terms of strategies, regular routines and their own perceptions of the world within and outside their communities.

#### **7.3.1 The Regularly Occurring Behaviour**

Table 7.1 below ranks the most commonly occurring activities of CHBCs. In one of Williamson's (1979: 245) major contributions to the study of transaction costs economics, he shows that transactions have three critical dimensions, uncertainty, the frequency with which the transaction occurs and the degree to which durable transaction-specific investments are incurred. This study is looking at regularly occurring behaviour in this light, because transaction costs economics presupposes that economising habits of agents are inherently exhibited through routinizing of certain transactions. In other words adjustments take place from time to time as a specific transaction is enacted while relegating or modifying processes that tend to raise transaction costs. So for example the regularity with which CHBC activities are observed must align with the transaction costs economics reasoning. In an attempt to answer why they do what they do, the following table looks at regularly occurring behaviour.

**Table 7.1: Indicators of Regularly Occurring Behaviour by CHBC Actors (%)**

GRP	PH LABOR	REP/ RQST	COMM COUNS	SCD MEET	VISIT /FOOD DIST	DRUG DIST.	GP LABOUR	PF LABOUR
Lizulu	40	0	20	20	0	20	0	0
Sharpevalle	38	13	13	0	13	13	0	13
Matchuana	27	9	9	9	27	9	0	9
Lupiya	14	29	14	29	14	0	0	0
Nansato	25	13	25	13	13	13	0	0
Mpando	29	29	14	14	0	0	14	0
Njolomole	50	13	13	13	0	13	0	0
Nachipere	29	14	14	14	14	14	0	0
Mikombe	13	13	0	13	13	13	25	13
Kwakwanjana	14	14	14	14	0	14	29	0
Goliati	56	11	11	0	0	11	11	0
Senzani	33	17	0	0	33	17	0	0
Manjawira	13	13	13	13	25	13	13	0
Nchiramwera	11	33	11	0	11	11	22	0
Chimaliro	38	13	13	13	0	0	25	0
<b>Score<sup>1</sup></b>	<b>428</b>	<b>231</b>	<b>183</b>	<b>165</b>	<b>163</b>	<b>159</b>	<b>139</b>	<b>34</b>
<b>Rank<sup>2</sup></b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>

Source: Munthali (2007)

#### Notes

*P H-LABOUR* = members of CHBC offering labour support at patients' homes.

*REP & REQST* = regularized report writing and placing requests for further assistance.

*COMM COUNS* = members going around the community offering counseling services.

*SCD MEET* = members attending already regularized scheduled meetings.

*VISIT /FOOD DIST* = paying compassionate visits to patients and distributing food supplies.

*DRUG DIST* = the regularized or routine drug distribution exercise.

*GP\_ LABOUR* = attending to group projects for raising incomes.

*P F-LABOUR* = members of CHBC offering labour support on patients' farms.

All the activities listed above are part of the core routines of CHBC groups; however they take place with different intensity which also speaks to the symbolic importance placed on each one of them. From Table 7.1 it is clear that providing labour at the patients' homes is the most regular routine the actors engage in. This includes doing some household chores like cleaning the home for the sick and helping to bathe them among

<sup>1</sup> Cumulative Score specific to each variable across all cases

<sup>2</sup> Ranking of the predominant strategic working arrangements across all cases

other demands as seen fit. This is in recognition that the patients are not able to do much work on their own. Symbolically this gesture also provides hope and encouragement to the entire household faced with the predicament. To the care givers, this gesture is the most plausible option because labour is the most abundant resource at their disposal relative to other resources and can be allocated for CHBC with relative flexibility.

The first ranking also shows that the welfare of their patients takes precedence, and therefore, it commands most of their attention. Apart from the relative ease with which labour is allocated to care and support, as opposed to money and food requirements, it is also supported by the possibilities of division of labour at households. In other words a household which has at least five individuals finds it easier to free one person who can carry out the required CHBC activity while the others engage in different non-altruistic activities. Such divisions and complementary allocations are not possible with food and money which are the other preferred forms of support often given as service by CHBCs. More importantly, this shows where lower transaction costs lie for these households.

The second ranked routine is the combined production of accountability or progress reports and request for funds. This activity shows the importance of external resource injections into the CHBCs' work. Application of the IAD framework requires that we ask what kind of situation the actors are faced with and what decisions they take in accordance with the stimulus of the situation. The situation in this case is made up of the need for care and support for patients and the contractual demands of the donor organizations. Being resource dependent, the actors make sure they meet the demands of their partner organizations by submitting reports and requests for further assistance. The significance of this is evident from the regularity with which the reporting is adhered to. At the same time it is easy to see that monthly meetings which are scheduled with the same pattern are often not adhered to. The communities realize the detrimental consequences of uncooperative behaviour where a sanction such as withdrawal of assistance is a big possibility. In the CHBC arena, two forms of contractual relating are evident. While most contractual relations are informal oral agreements between partner organizations or amongst the role players themselves, there are more formal contracts

signed in respect of financing agreements. Failure to honour these contractual obligations on a regular basis attracts very high transaction costs which the community actors are not prepared to incur.

Strict standards exist and sanctions are applicable in situations of breach of such contracts, such as suspension or withdrawal of funding (as the NAC have done on a number of occasions). The importance of credible commitments is well understood by all players; therefore this activity is always favoured not only from the possible negative consequences but also from the effects of positive reinforcement in form of supplies for CHBC service delivery. Furthermore, it creates and nurtures a sense of predictability regarding the delivery of services at the community in the eyes of the donor organizations, who would otherwise have to incur higher transaction costs for monitoring and reinforcing the delivering the services by the CHBCs .

The groups show a tendency to emphasize activities that are labour intensive, such as counseling and group meetings which are ranked higher than food. This is a sign of inadequacies in the supply of food for patients and the economising habits tend to favour supply of labour. Transaction costs associated with this approach arise from the possibilities of division of labour at household level as discussed above, and comparatively transaction costs of supplying food are higher. In fact supplying of food also involves labour, thus the costliness of that option certainly exceeds the provisioning of labour alone. The supply of food ranks higher than drug distribution only because the latter is scheduled to take place during specific times and is not done as regularly as providing food. Drugs are sourced from other partners in the continuum of care such as the NGOs and government facilities. However, both food and drug distribution also involve application of their labour and time. What is rather surprising is that actors' appropriation of labour to group projects does not appear to feature as one of the most important aspects in these communities. From the point of view of rational choice theory this situation suggests that actors perceive the limited personal benefits do not match the high costs of investing time in group projects. The costs are so high because allocating time and labour to these projects have opportunity costs associated with them. There is

evidence that group projects have been faltering. For example, the case of Manjawira in Ntcheu where all 300 chickens were allowed to get wiped out and a maize mill had been bought but never got to be installed, and similarly NAPHAM in Thyolo reported that some groups began a project to rear pigs and others went into chicken rearing but all their stock died.

Questions must still be asked as to why projects that are likely to have medium to long term effects are neglected in favour of those with most immediate gains such as monetary payments. This is particularly puzzling when it appears that labour is not necessarily in short supply. Failure of small community projects is not limited to this arena in Malawi. Similar failures are observed in other areas such as community water supply projects where villagers appear disinterested to maintaining their own wells and boreholes. Some have blamed the introduction of multi-party politics in which the tendency of touting free hand outs in exchange for votes seems to create and entrench a culture of free riding among Malawians. Whatever the cause for the free rider tendency, transaction costs for delivering CHBC are increased especially that it introduces the need for strict enforcement procedures.

While it is safe to say there is no concrete empirical evidence for these political notions, one thing that is clear is that during the strong rule of one party state which ran for almost thirty years, Malawians were known to work very hard both on their fields and in communal initiatives whether this attracted remuneration or for the purpose of the state. Malawians used to compete to give gifts to the state president in the form of their best agricultural produce; they also used to engage in communal farming practices on a regular basis for reasons ranging from raising money for community causes to helping households that were unable to produce their own food. These are hard to come by nowadays. There is need for a thorough investigation into the causes of this outcome.

### 7.3.2 What are the Strategic Arrangements in Place?

Another form of social capital in the form of investment initiatives and economizing habits targeting smooth operations are summarized below:

**Table 7.2: Ranking of Key Strategic CHBC working arrangements in place (%)**

GRP	FBP	Role	SPT	ESI	Rule	Com	SSI	Reg	Sanc	TP	Cont	HHI
Lizulu	12	12	6	6	6	6	0	6	18	18	6	6
Sharpevalle	30	10	0	10	10	10	10	0	10	0	0	10
Matchuana	21	14	14	7	7	7	0	7	7	7	0	7
Lupiya	9	9	18	0	9	9	9	9	0	18	9	0
Nansato	15	23	15	0	15	8	0	8	0	8	8	0
Mpando	14	21	14	14	7	7	7	7	7	0	0	0
Njolomole	9	9	0	18	9	9	0	18	9	9	9	0
Nachipere	21	7	14	14	7	7	7	7	7	7	0	0
Mikombe	23	8	8	15	8	8	15	0	8	0	8	0
Kwakwanjana	14	21	7	14	7	7	0	7	7	7	7	0
Goliati	13	6	6	13	6	6	25	6	6	0	13	0
Senzani	17	33	8	8	8	8	0	8	8	0	0	0
Manjawira	17	11	17	11	6	6	17	6	6	6	0	0
Nchiramwera	13	13	27	7	7	7	13	7	0	0	7	0
Chimaliro	23	8	15	8	15	8	0	0	0	8	15	0
<b>Score</b>	<b>252</b>	<b>207</b>	<b>170</b>	<b>146</b>	<b>128</b>	<b>113</b>	<b>104</b>	<b>96</b>	<b>93</b>	<b>87</b>	<b>81</b>	<b>23</b>
<b>Rank</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>

Source: Munthali (2007)

**Notes:**

- i) **FBP** = the presence of a short term strategic fallback position.
- ii) **Role** = members strategically share roles to accomplish objectives.
- iii) **SPT** = completion of scheduled periodic tasks.
- iv) **ESI** = presence of an active external sourcing initiative.
- v) **RULE**= group has an effective unwritten rule configuration known by all
- vi) **Com** = presence of an operational structured executive committee.
- vii) **SSI** = presence of special strategic internal initiatives.
- viii) **Reg** = use of an attendance register at meetings to track membership and commitment.
- ix) **SANC** = application of specific sanctions for uncooperative behaviour.
- x) **TP** = indications of task programming.
- xi) **Cont** = regularized monetary contributions made by members.
- xii) **HHI** = getting strategic support from other members of own household.

Table 7.2 reveals that groups value getting prepared for eventualities in case of disruptions in external assistance on which they mostly depend. Hodgson (1993:174) emphasizes the importance of uncertainty reducing measures that foster closer cooperation and shape individual behaviour within a collective setting. This is because uncertainty potentially translates to higher transaction costs for both adaptations when misalignment of contracts is observed at a later point as well as for monitoring progress. Among the important strategic arrangements adopted by the CHBCs are structured committees with designated roles, rule structures, sanctions and maintaining of attendance registers at meetings. This is done by making their own financial contributions that are used only in times of need, and making provisional resource generating mechanisms that become buffers when they are caught short on resources. The significance of this strategy is that it smoothens out the dependency factor on external resources and brings up an element of autonomy with regard to resource use, therefore reducing the costs of transacting. It is clear that fall back positions in the form of group investments are well and truly part of the agenda that the NAC and other partners are promoting. The evidence of such projects failing at the first hurdle is as exasperating as it is difficult to comprehend. In the preceding discussion it was noted that group projects do not receive the attention they deserve despite the potential they have for covering the needs of the CHBCs. Individual benefits as opposed to group benefits appear to be at the center of this crisis together with the tendency to free ride when it comes to group initiatives. These have the impact of increasing costs of transacting.

Other important strategic arrangements include sharing out roles, both by allocating individuals to spearhead some specific strategic responsibilities, as well as by sharing some workloads on demand in order to skirt around time and human resource constraints in the wake of competing demands for labour and time. Through learning by doing, respondents reported that, initially patients were visited in groups but as the processes took a toll, role sharing became a prominently adopted strategy. This behavioral change is clearly in line with what the transaction cost economics would predict. Once this change is adopted the routines remain at the back of their minds such that efficiency oriented principles become part and parcel of the health care delivery processes.

Completion of scheduled routines is also an important aspect towards achieving the group objectives and this supports what is noted in Table 7.1 above in regularly occurring behavior, such as maintaining a routine of sending reports and requests or attending scheduled meetings that ascertain continuity of group life. As a dominant strategy, completion of specific tasks at the right time ensures that groups get the support they need from other partners. It is also an indicator of the importance of maintaining credible commitments among the partners. Credible commitments have a critical role in reducing uncertainty among the actors which then paves the way for smooth continuity of activities, and therefore allows economic progress. Completion of tasks goes hand in hand with, and is a prerequisite for, a strategic measure which ensures that there is an extra effort in place for sourcing more help (ESI) as the transaction costs of neglecting these are too high for them to bear.

The integrity of the group efforts is maintained by group consolidation techniques which place boundaries on what is right and what is not. In so doing there is ample certainty and harmony amongst the members which is a precondition for group performance. This is reflected in the group's rules and reinforcement of their own standards by invoking sanctions by those entrusted with power. Harmony is also ensured by creating special internal initiatives for mobilizing resources intended to augment what is donated by external agents. One such important initiative is the idea of making consistent monetary contributions. Another is obtaining support from other members of a household by enabling them to carry out some occasional roles towards its member's CHBC. Transaction costs are reduced by the adaptive process as well as the complementary roles of the household network.

It is clear that through government and NGO trainings and guidance, the participants have learnt skills and methods of getting themselves organized for effective service delivery. Group training and acquired skills offer the advantages of group organization and survival in the process. The skills make them to be competitive and also to be more flexible to adapt to changing circumstances and therefore keep the costs of transacting



low. On the other hand, the structures borne out of these arrangements reflect the degree of external influence. This is evident in the set-up of committees and leadership styles (roles and designated mandates associated with each position). For example the NAC regulations are very strict with regard to what groups can or cannot do with their funding, so interaction with the NAC spells strict adherence to principles of accountability of funds based on the approved project proposals. On the other hand, procedures for requesting funds must follow specific outlines for the proposals to be considered. Occasionally, some of the external influence has come from other groups in the neighborhood or other developmental groups to which actors hold parallel membership.

All in all the strategies can be grouped into one category. They are all designed to foster stability of the group while limiting the actors to conduct themselves within the perimeter of sanctioned behaviour. Sanctioned behaviour is good because it ascertains that every individual behaves within agreed perimeters, making it easy to predict how every partner is going to react to a situation, thus keeping transaction costs in check. This illustrates what Williamson (2000) refers to as laws, property rights and constitutions from a higher level having influence on institutions that occur at some levels below. These boundaries specify what is right and wrong and they also shape the incentives for actors at the lower level who are expected to play the game within the formal rules.

What is permissible or not can inhibit or distort the effectiveness of organizational methods and interests of participating members both as a group and individually. The distortional attributes have multiplier effects on the outcomes of the institutions. For example permissible modes of interaction in CHBC service require strict adherence to standards of proposal writing and accountability methods for funds obtained from the NAC as well as from NGOs such as the MSF. As a rule structure, this is a disincentive to participation because it regulates participation by excluding those who cannot produce quality proposal documents, and it leads to exclusion for those who cannot manage to handle requisite accounting procedures. Evidence of the NAC suspending 240 community based organizations from all 28 districts and 11 local assembly organs for flouting the NAC procedures was published in the press in Nyasa Times, on 15th

February, 2007. This is clear evidence that the NAC procedural requirements placed on community bodies are too formal and stringent. First, the limited cognitive capacities of the actors pose a challenge for them to assimilate the procedures. Despite the trainings they received adherence remains a difficult task. Second, is that the approach has implications for higher *ex post* transaction costs for both the aid recipients and the donors who have to make extra effort to monitor and enforce the contracts. The obvious implication of this is that the CHBCs' performance is compromised. On account of this, the participating institutions perceive running their own income generating activities with independence as the more realistic and sustainable approach.

### **7.3.3 Group and Individual Resources in Use**

It is not possible to classify which materials and assets are most important for carrying out CHBC service delivery across all cases because the conditions vary from one community to another. It is, however, possible to highlight the materials that are commonly found in use as the members try to accomplish their day to day routines. It is also possible to identify factors that appear to be common to most cases and which ones are uniquely distributed. The idea is to show what they have or what they don't have. Within the IAD framework, Ostrom (1994:837) recognizes attributes of the physical and material world in so far as they determine what actions are physically possible.

Table 5.8 reveals one case of great similarity across groups in the form of the prevalence of protective wear, bicycles for transportation and kitchen wares. Protective wear includes umbrellas, gumboots and rain coats among other items and these together with the bicycles have a crucial role in producing the outcomes of the CHBC service. Obviously the CHBC members value the items so much because they simplify the conditions in which they work. These are good examples of the valuable contributions to the CHBCs made by cooperating partners. North (1995:24) describes such benefits as 'network externalities and complementarities' involving an institutional matrix. They are positive externalities which do not only serve the CHBC purposes, but effectively serve to protect the individuals in their everyday lives outside care giving and support. They

also complement what the individuals have in their homes, thereby taking some pressure off the participants with regard to what they have or do not have. Obviously, owing to the levels of economic deprivation most of the communities cannot afford such wares but the networking has made them available. This is a performance enhancing gesture from the national response partnerships because members are able to work more easily in the difficult and at times near impossible conditions.

The arrangement of the three types of the kits<sup>3</sup> is vital for the performance of the CHBCs. In particular it is important because in light of this arrangement it can be seen that the functioning of the CHBC groups is heavily reliant on how well they are able to coordinate with the NGOs supplying these kits. Apart from reflecting the communities inadequacies in sourcing these by themselves, and thus, making them dependent on external assistance, it also points out how important coordination can be for the delivery of specified activities in a given programme. The NIE conceptualizes uncertainty, for example, such as that resulting from the confusion regarding two different types of CHBC kits (discussed in Section 5.2.3) among the CHBC members and a lack of clarity as to who must take the initiative to replenish stocks of the consumables as well as the medicinal supplies, as an institutional factor undermining performance by raising transaction costs.

By its nature, Home Based Care is supposed to depend on resources owned by households in their homes. Organizational arrangements which straddle between formal and informal techniques have resulted in the acquisition of group assets and resources. This is due to the importance of the routine of preparing and delivering food to the HIV/AIDS sufferers. Considering that most CHBC groups also often tend to orphan care activities in the communities, ownership of group resources becomes imperative. Orphan care has been identified as a niche by these communities because donors are more willing to provide support in this area of need. In Malawi an estimated 950,000 children are classified in the category of orphans and vulnerable children (Conroy *et al*, 2006:145)

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<sup>3</sup> A once off kit includes bicycles, basins, protective wear; a quarterly type includes disposables like cotton, towels, gloves and other sanitary materials and another quarterly type includes medicinal supplies deposited at the nearest health facility.

and government policy has concentrated on capacity development to enable communities and households to offer care, support and protection to these children. While the role of extended families and community is critical for the implementation of the policy, most of the resources for feeding and educating them have to come from external agents. It is documented that a lot of work still needs to be done in this area as the numbers of children in need is growing, raising fears over coordination issues, overstressing resource requirements and information flow amongst all key stakeholders. Obviously, in the case where such arrangements exist there are externalities flowing between the home based care and the orphan care centers.

The CHBCs also have bicycles for transportation during community counseling and visiting the hospitals. External agents such as the Medicines San Frontier in Thyolo have supplied bicycles albeit with an uneven distribution. Some groups benefit from bicycles from their homes or other community groupings they have membership of. The presence of the external agents plays another crucial role of facilitating the CHBC service in this case. The discussion on the background community conditions clearly showed that due to the poor road network in rural areas traveling is one of the major problems experienced by the communities. The facilities such as the health clinics are sparse and individuals have to walk up to 25 km to get to the nearest hospital in some cases. Facilitation of traveling, especially for hospital patients, therefore, has to be one of the most important cost cutting aspects of the partnerships.

The cases of materials and assets presented in the section above revealed the impacts of network complementarities in that CHBCs benefited from the role of external partners. Institutional analysis also takes interest in finding out how actors make attempts to find solutions to impediments against their group goals. The case of the actors' efforts is exhibited by local decisions to invest in small scale equipment for income generating activities. Such equipment includes tools for tinsmith or carpentry that will enable them to generate funds by selling products on demand and farm tools that allow them to work on community gardens for pay. The proceeds go towards the CHBC work. This attribute is more common in Thyolo district. This makes sense because economic opportunities are

more limited in Thyolo than in Ntcheu district as revealed in Section 1.1.1. Generating extra resources is important to cover for the communities' economic inadequacies as well as those associated with aid inputs as they pursue continuity in service delivery. Overall, the aspect of facilitation has the effect of reducing transaction costs of delivering care and support for the patients.

#### **7.3.4 Use of Symbolic Processes for Care and Support**

This section attempts to reveal what each specific group focuses on as important resources used as symbolic gestures for care giving and support for HIV/AIDS sufferers and their households. Thus the importance of these factors lies in how they are perceived by both the care givers and the recipients. While it is recognized that the decisions regarding use of the commodities and gestures discussed in this section have economic values, it is the application of the normative standards of the perceptions embedded in the cultural tradition that is the focus of interpretation in this case.

The study recognizes that visiting the afflicted household and the bearing of a token gift has fundamental cultural significance within communities. Symbols are objects, acts, relationships, or linguistic formations that stand ambiguously for a multiplicity of meanings, evoke emotions, and impel men to action (Pettigrew, 1979: 574). Pettigrew suggests symbol construction serves as a vehicle for group and organizational conception, and therefore, must have significant consequences for the functioning of the organization in question. In light of this definition of symbols and the need to understand the cultural ideas of the CHBC groups Table 6.8 in Section 6.8 highlights the symbolic resources that the communities share with those faced with the HIV/AIDS predicament.

The data from focus group discussion with the CHBC groups revealed food, medicines and groceries as the most important symbolic objects brought to the HIV/AIDS patients. Given in order of importance food, medicines and groceries produce a pattern that is almost consistent across all the CHBC groups in the study.

Bringing food to a patient is a traditional custom that did not start with and is not limited to HIV/AIDS in Malawi. Nevertheless, within the context of the IAD framework this is a unique situation that attracts commensurate actions of the CHBC actors. Symbolically this gesture is extended to anyone who is seriously ill and needs to consume good food to quicken the recovery process. It is in this vein that AIDS sufferers are beneficiaries of this custom. Nevertheless consuming good food with consistency is a primary requirement for AIDS patients. This is not necessarily the case with other ailments. Recognizing this dimension, the community members make it a priority that the patients take good food and medicines in order to keep the opportunistic infections in check. But above all it is a symbol of encouragement to the sufferer from the community expressing their wish for recovery and a longer life. Notably, the discussions with CHBC members in Thyolo revealed that they had to go out of their way to make sure they supplied good food because those are the standards expected of them.

As a social network the groups have developed an understanding that an HIV/AIDS patient has a diminished capacity to produce food or to perform any meaningful activities (Conroy *et al*, 2006:144) and yet the HIV/AIDS patients have higher nutritional food requirements than a normal individual. Research conducted in Malawi showed that a household that has experienced an adult death the area planted with crops was reduced by 32%, and income fell by up to 40%. In general if an individual is infected they tended to resort to planting crops associated with reduced labour demand (Arrehag *et al*. 2005: 8). It is, therefore, imperative for other members of the society to act. Keefer and Knack (2005:707) refer to these as the unwritten commitments that citizens have made to each other because individuals are reliable partners not only in contractual exchange but also to act in the interest of others at some expense to oneself. Considering that the majority of the households do not produce enough food crops to last them even half a year<sup>4</sup> providing food to patients is an enormous challenge. According to the World Bank report for 2007 about 23% of the population has lived in ultra-poverty in Malawi for over a decade now. These families depend on erratic, rain-fed agriculture which leaves them extremely vulnerable such that they have to sell assets to buy food (WB, 2007:3). Their situation is

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<sup>4</sup> (See discussion in Chapters One and Five)

exacerbated by the impacts of HIV/AIDS which also speeds up the depletion of the stock of wealth at household level. The evidence that the members can still show such a strong sense of commitment to the communal goals in general and CHBCs in particular, is indicative of the importance of social capital and social norms in dealing with community development concerns. In particular, the nature of the HIV/AIDS and the attendant CHBC activities benefit from gestures that tend to be reciprocal in nature and, therefore, economical on the aggregate.

CHBCs also benefit considerably from the provision of medicines for patients. In recognition for the need of pain killers, antibiotics and other drugs a community and home based care package was devised. According to the World Vision International the standard practice is that a quarterly distribution of medicinal supplies is made available at the nearest health facility where the community can access them on a need basis (WVI, 2008). However, focus group data shows that accessibility to such drugs is variable in the communities for a number of reasons. One of the reasons is that the communities are not clear on the procedures of obtaining the drugs due to the wide ranging qualities of training the volunteers have received making the procedures well understood in some cases. In respect of this some groups will go for some time without replenishing stocks for supply to patients under their care. These are costs of information on the part of the CHBCs. On the other hand, they also ought to be seen as costs of coordination on the part of the suppliers of the medicine.

One of the implications of the above observation is that volunteers reported not having adequate medicines for patients and thus felt obliged to purchase pain killers for the patients against their own economic inadequacies. Obviously these misunderstandings raise the transaction costs for delivering care. Furthermore, some NGOs, such as the MSF in Thyolo, do occasionally visit the volunteers in their communities and provide medicinal supplies during such visits. This suggests that there is more than one way of getting these supplies. While this flexibility can help the communities who obviously have transport and time constraints to travel to health clinics, the downside of it is that it has resulted in confusion as to who has the responsibility to transport the drugs into the

villages. This misunderstanding has negative implications for the complementary roles of the community agents and the organizations that seek to help them because it raises the costs of transacting due to uncertainties. It is these uncertainties that also make villagers buy medicines that they could easily obtain from public clinics at no cost. It can also be concluded from this observation that those CHBC groups working under the supervision of government HSAs would automatically be disadvantaged because, even where available, government staff do not tend to make supervisory visits on a regular basis. What is worse is that the positions for public health staff are often vacant, implying that the community groups must really be independent.

For purposes of care giving and support, the health of the patients also demands bringing soaps for bathing and washing the patients' clothes. Other forms of groceries supplied by care providers comprise of items such as sugar and salt. The most important observation, in the light of the above, is that community members act as a unit which has inbuilt supporting functions. The tradition recognizes that the family nursing an ailing person, especially with HIV/AIDS which has medium to long term effects, is often challenged in terms of resources. The reason is that the sick person is virtually incapacitated from carrying out any form of responsibility and therefore will not be able to contribute to the family income generating efforts. At the same time there is a perception that a sick person needs attention from the entire family and well wishers. Besides, the effects of maintaining the patient's physical and psychological well-being take a toll on households that are already known to be in a state of deprivation. On account of these cultural traditions of support for individuals faced with a social problem and recognition of the economic constraints, interventions from the wider community are expected and almost guaranteed.

In line with that reasoning, it was observed that there is increased visitation to the households nursing a patient. Thus a visit to a patient is more than bringing food. It is just one function manifesting the importance of social inter-relations and unity involving the community and CHBCs. This is also evident in how attendance at a funeral of a community member is almost an obligation for all in the neighborhood. The frequencies



for such attendance were quite high (See Table 6.4). The normative standards guided by tradition also extend to actively participating in giving encouragement to those less fortunate for various reasons including sickness. This is an aspect of social capital whereby social capital is described as a stock of trust that facilitates provision of public goods (Gabre-Madhin, 2001:4). To this extent it is virtually expected that once a member of the community is down with HIV/AIDS that individual must be encouraged by visitors.

While the system appears to revolve around giving material support, a more important and fundamental dimension is one of giving hope and encouragement to the suffering members of the community. The tradition is also used to control the level of stigma between the sufferers and the rest of community by increasing the level of association. It is the function of creating and sustaining hope and encouragement, with the view that a similar favour will be returned to anyone in a similar situation, which answers ‘why they do what they do.’

The concept of hope and encouragement has an additional dimension in that it cushions not only the afflicted members of the society; it also serves as a form of health insurance for those who are in good health in terms of the unforeseeable circumstances. Suffice to conclude that this is a sequel of a revolving fund in modern economic thinking which individuals can tap into in times of social need. The process has cost economizing effects for the entire community by reducing uncertainty.

To understand and explain the absence of activity in one of the groups as observed in the data in Table 6.8 in Chapter Six, the NIE points to the role of contracts and ownership as critical factors for collective decisions and progress. According to Spiller *et al* (2003:15) we need to understand the micro analytical governance factors such as distribution of ownership and incomplete contracts that raise transaction costs. For example, the exogenous factors contributing to the institutional environment for Manjawira CHBC largely appear to be the same as those applying to other groups. That is, external resourcing of group activities in the form of funds for a maize mill, cattle and chickens

but the inter-relationship between this group and the HSA in their area is unique. It introduces a unique complexity and uncertainties to the transaction arrangements. The group was found to wait for information and guidance from the authorities, and they reported to be receiving conflicting information regarding their projects. This means that the contracts between the group and the sources of funding on the one hand, and the relationship with the health surveillance staff on the other were not clear and therefore they did not know what performance was expected of themselves. The poor information flow and a lack of complementarities highlighted by Williamson (1985) essentially resulted in increased transaction costs that completely stifled project activities.

#### **7.4 Community Level Constraints on CHBCs**

Understanding community background factors for their support in providing social and economic rights and enabling participation of rural communities in the national response to HIV/AIDS with regard to options and choice is fundamental to Sen's (1999:39) definition of development adopted by this study. The definition emphasizes the removal of various types of unfreedoms that leave people with little choice and little opportunity of exercising their reasoned agency. This understanding is also emphasized by various other scholars such as Mbiba (2001:8) and Topouzis (1998:13).

According to Ostrom (2006:837), variables of an action situation are affected by the attributes of the physical and material world. The question to be asked is 'what actions are physically possible?' The findings of this study suggest that the CHBC action arena in the rural areas is considerably influenced by factors such as infrastructure availability and the presence of facilities. For example the difference between the two study districts shows that Ntcheu which is located along the main highway connecting two major cities has better chances of organizing effective responses to the HIV/AIDS situation due to the potential economic activities in that area. First, more households in Ntcheu engage in crop sales (see Table 5.1) such as green vegetables, potatoes, and tomatoes almost all year round. Second, is that the average land size allocated to agriculture also favours Ntcheu with more households farming above 2 hectares, whereas in Thyolo majority are

in the region of 1.75 hectares. Thirdly, more households in Ntcheu can afford more than two bags of fertilizer per annum while in Thyolo the majority can only buy one bag or less (see Table 5.2). On account of all these indicators Ntcheu households are better placed to carry out CHBC activities than in Thyolo.

In Thyolo, which is located farther south on the Shire Highlands, small communities are scattered far apart in the remote areas dominated by tea estates. The situation is also complicated by the difficult terrain and a lack of proper roads and transport resulting in limited levels of interaction. A more severe land constraint for agricultural production in Thyolo indicates higher levels of deprivation and therefore, reduced capacity for responding to CHBC demands.

According to Conroy *et al* (2006:28) in these rural areas the key concern is to produce sufficient quantities of food and to make some income from selling of crops and off-farm employment but due to land pressure these objectives are hardly met. Households are forced to cultivate more marginal land and, thus, worsening the environmental degradation. And this situation is exacerbated by the lack of fertilizers for their agricultural production. With continued hunger, a situation which is complicated by other crises such as poverty and AIDS, these households are in perpetual struggle to survive. This is confirmed by a lower attrition rate of the CHBC membership in Thyolo, in recognition of their situation, where there is a higher level of dependence on external assistance whose influence is perceived as vital. Once members join CHBC groups they are less likely to quit in Thyolo than is the case in Ntcheu where individuals can exercise more economic freedom. More evidence is presented by the tendency to engage in selling of small quantities of grocery wares and food items by the Thyolo households to supplement their livelihoods.

The findings regarding expenditure patterns also show that Thyolo communities are more constrained. They are spending limited amounts on basic goods. Their deprivation means they can hardly spend money on CHBC either. Their situation is compounded by the fact that the only genuine contribution to CHBC, which is labour resources, has to be

redistributed among the many competing needs. Firstly, labour is allocated to employment on tea estates to generate income for survival. Secondly, a household needs to engage in selling basic goods to complement their livelihoods, and thirdly an allocation of labour has to be made to take care of other household demands of which CHBC is but one. It is in this connection that participants suggest that their time allocation to CHBC work negatively affects their households. Decisions to undertake CHBC come at the expense of their own survival mechanisms. In other words it is a high risk activity with commensurate costs. This notion is also connected to the finding that CHBC is predominantly undertaken by women while men devote their time to more gainful activities.

In this case it is clear that the level of deprivation places a wedge in the decision making processes for purposes of CHBC service delivery as the Thyolo community members appear to be so absorbed in trying to survive. Attempts to survive at household level have a negative influence on the institutions of CHBC as the latter depends on decisions made at the household level. These decisions involve allocation of resources within the household, time allocation to the various efforts for survival such as traveling to the markets and hospitals which are at a distance, and thus, clearly, decisions pertaining to allocations for CHBC will come second. This means that CHBC services are compromised. Despite the interventions of external agents in the CHBC, such as distribution of medicines and occasional supply of food stuffs, this form of assistance does not plug the deprivation gaps existing in the communities. These deep rooted problems impose operational bottlenecks in a wider context to which the CHBC institutions are only a component.

In light of the above, this study suggests that efforts to address the performance of the CHBCs need to be directed at plugging the gaps of deprivation at the household level and affecting a sustainable CHBC service delivery system. With this in mind, the interventions will have to be varied depending on the situation in a specific area. In other words CHBCs in Thyolo will not have to compete with their Ntcheu counterparts to draw funds from the National AIDS Commission (NAC); rather there should be deliberate

targeting of resources based on the bottlenecks faced in Thyolo for instance. This is to say that costs of transactions can be made lower and make the Thyolo groups more productive. Furthermore, this suggests that efforts towards boosting CHBCs have to be designed as ‘reinforcement’ rather than ‘assistance’, as is largely the case now. In summary, this suggests that focus must go to designing technologies and systems that seek to integrate CHBCs into poverty reduction strategies since the study reveals that the most critical issues weakening service delivery are tied to community access to facilities, resources and the sustainability thereof.

### **7.5 Community Facilitation through Reciprocity**

Literature on the IAD framework emphasizes the importance of what the subjects have and what they don’t have for purposes of decision making towards making credible commitments such as care giving. According to Rudd (2003:82) there is recognition that social context matters for collective action in that social relationships can constitute resources which individuals can appropriate in order to increase their own well being. The social context for care giving and support for HIV/AIDS has many dimensions which go beyond material support as outlined in the following discussion.

The findings suggest that the communities recognize the two way contributions being made towards and by the CHBCs. First, households make material and moral contributions for the CHBCs to perform their functions. Secondly, households are recipients of the CHBC support. The contributions that are exchanged in the care and support continuum include money, labour, and moral support for both the patients and the rest of the family. The network externalities translate into lower costs of transacting and thus positively influence the CHBCs’ performance. North also refers to these as economies of scope because the complementarities from the network widen the scope of what they can accomplish.

The study found that labour is the most dominant resource supplied by the CHBC groups for care and support (See Table 6.4). This is because labour is more cheaply available

than other alternatives such as money and food material. But equally important from a reciprocal cultural point of view is that CHBC members also collectively make compassionate visits for counseling members of the community against HIV/AIDS infection, and how to live with the infection, as well as attending funerals in the event of death of the AIDS sufferers.

It is the collective nature of action whereby individuals from the wider community exercise cultural trust and reciprocity which creates a stable form of exchange that becomes an asset. The stability embedded in these functions is responsible for keeping transaction costs in check. This is because as these exchanges become systematically established, individuals build expectations and confidences regarding what other community members are likely to do. In so doing there is a reduced element of information asymmetry, fostering increased coordination and access to various forms of resources that become important inputs into the care and support giving for households in need. These functions would otherwise have to be sought from the market if there were no such norms of trust and reciprocity.

Applying Ostrom's (1998) interpretation cited in Rudd (2003:95) with regard to the role of CHBCs, the existence of the groups constitutes social capital that mediates for 'core relationship' between trust and norms of reciprocity. In other words the presence of these groups is a symbol that helps to anchor the community efforts by enforcing both internal contributions and also by providing channels for obtaining resources from outside the community. These result in net benefits accruing to the entire community involved through the process of increased cooperation.

## **7.6 What Incentives Sustain members in Participation?**

North's (1990:135) work emphasizes the importance of paying attention to incentives as a major determinant of economic performance. He suggests that this is important for the analysis of transaction costs. On the other hand Manchanda (2003:40-42) illuminates the categories of incentives that a study of this nature must take into account. In the light of

this, the study makes an account of economic and social incentives being conceptualized by the CHBC actors. The question to be answered is ‘what are the incentives that these agents are actually responding to in this particular institutional set-up?’

Four major factors of importance are found to influence the CHBC actors within this study. They are self esteem, the internal situation in the community, training and skills obtainable through the CHBC structures, and the presence of external partners in the HIV/AIDS response. However, in some cases there is evidence of altruistic motives present amongst the volunteers, some of whom find their involvement as an opportunity to fulfill personal interests as discussed below.

The results in Table 6.7 show self-esteem as the main informal incentive among the participants from all groups. Self esteem arises as an explanatory factor because members are motivated by their recognition as health workers in their areas; they are associated with saving people’s lives by giving them counsel towards voluntary testing and consequently introducing those in need to ARVs. One major distinct pattern emerges: that this factor is stronger in Ntcheu than in Thyolo District. The presence of donors and NGOs in Thyolo has created a strong desire for tangible benefits for the actors’ involvement with efforts of care giving and support. The pursuit of benefits overshadows self esteem as a source of motivation. This is a clear case of opportunism whereby the participants are trying to close the deprivation gaps observed in the background community conditions. The discussion on the impacts of the background community conditions showed that the poorer members from Thyolo were less inclined to quitting their groups than their counterparts in Ntcheu. In this observation the same Thyolo volunteers exhibit altruistic motives. This may well suggest that they perceive their involvement as an opportunity to make up for their economic deprivation. The NIE literature suggests that altruism is a digression which tends to increase the costs of transacting, and therefore, stifling the economic progress of the CHBCs and their partners.

The Thyolo participants also have an increased margin for valuation of ‘training and skills’ which is offered by the national response framework to the CHBC groups. In reality, this appears to be the only notable formal incentive that the structures of HIV/AIDS at community level seem to confer on the participants. Training is particularly stronger in Thyolo than in Ntcheu District. In this case training as a motivational factor is amenable to a number of analytical dimensions. Firstly, training equips members to work better because the participants upgrade or acquire new skills that can be applied directly to their situations. In this regard they become more efficient, and thus, achieve better performance. Secondly, it opens up the participants’ capacities for acquiring external support and for its accountability. This can be interpreted as creation of an opportunity for entering into contractual relations with other partners that would not otherwise have been possible. This point also emphasizes the importance of adherence to standards in such inter relationships. Adherence to standards has merits in maintaining a stable and well coordinated working environment between partners. It also ensures sustainability in resource allocations between the source and the recipient bodies. More broadly, standards regulate human behaviour to desired levels for a smooth pattern of inter-relating. This is what keeps transaction costs low among the CHBCs and therefore, improves their institutional performance.

While training is valued as an incentive in Ntcheu, it does not rank as highly as self esteem in that district, and it is not as important as it is envisaged in Thyolo. The significance of training in Thyolo emphasizes the fact that the presence of external support is fostering the spirit of pursuing tangible benefits from the structures of the national response for HIV/AIDS in Malawi as pointed out already. Training has positive implications for performance by reducing implementation obstacles. Pursuit of training for self interestedness has negative implications for transaction costs. In this case, the presence of both factors compromises the net economic effect obtainable from training, and therefore, limits the performance of the CHBCs.

The internal situation within the communities is observed to be an important factor motivating the villagers working in these groups. This observation is tied to the concept



of self-esteem as well as the presence of external agents in the communities. Firstly, from a cultural perspective community members have an obligation to help those afflicted with HIV/AIDS and the related predicaments. As a consequence of undertaking these obligations and achieving notable positive outcomes members experience pride in what they have done. North's literature suggests that perceptions are the source of actions as they determine what is wrong or right and what ought to be done in a given situation. It is in this connection that the mental constructs regarding the internal situation drives them to perform their activities. Similarly, the internal situation should be understood to be responsible for the presence of the external agents in these communities as facilitators. In this regard it can be interpreted that the more difficult the situation the more the opportunities for engaging these external partners, and the better the opportunities of tapping the available resources. The strong linkage between these two aspects paves way for a smooth inter relationship which is good for economic performance.

The presence of external agents and arrangements to CHBC structures are correctly perceived and associated with transaction cost reducing outcomes for these institutions. However, the findings of this study also suggest that the CHBCs and these related structures do not have adequate incentives designed as part of their frameworks. For example, some dimensions of training as motivational factors are only unforeseen consequences of the design. Training and skills were designed to alter the working methods of the actors in order to bridge the gaps between the informal standards of the communities and those of the formal partners. Nevertheless, these have become a critical formal motivational component towards the performance of the community members. On the other hand the self-esteem that is experienced in the knowledge that the HIV/AIDS situation would have been worse in the communities without the role of CHBC is the most important informal incentive associated with the framework. This explains the actors' quest for the inclusion of monetary rewards, more training and recognition to augment the satisfaction of engaging in the national response.

For purposes of achieving better performance this suggests that the framework needs to change. Using the analogy of the SWAP where the role players clearly know their

responsibilities as they interact with other partners, the CHBC members also understand that at their level they have mandates to accomplish. These mandates feed into the performance indicators of the higher level partners. The higher level partners have economic incentives at their disposal, and for that reason the lower levels carrying out the various roles on behalf of the rest of the tiers must also benefit from similar incentives. This will pave the way for reduced transaction costs and better economic performance.

### **7.7 Impacts from Actors' Perceptions of Internal Conditions**

This is a perceptual analysis where people give constructs of their own identity and how they view themselves in the bigger picture of the continuum of care and support for HIV/AIDS sufferers. The analysis recognizes that transaction arrangements are influenced by where and how the actors position themselves within the stakeholder matrix of the HIV/AIDS response. The literature suggests two inter-relating facets that are being applied to this analysis.

The first is what Williamson (1985) calls the concept of bounded rationality whereby it is construed that two individuals with the same information will behave differently. They will behave differently because no two individuals have the same cognitive capacities. Therefore, they are bound to interpret any information at their disposal differently and this applies to contracts such as is the case between the CHBCs and the organizations they work with. Secondly, is the concept of opportunism which tends to influence economic organization according to Richter (2003:3) and Scharpf (2000:7). Essentially, people have preferences in two dimensions; namely self-interestedness as an individual and group interestedness which constitutes collective normative obligations and aspirations. This is also referred to as a common logic of appropriateness in the normative approach to institutionalism.

Looking at the situation within the communities it is clear that the actors do understand the voluntary nature of the CHBC concept. From a contractual perspective between CHBC groups and their partners, as well as from all the training, and orientation from

media information, it is clear that the role of external agents' is designed to support existing local efforts. From this observation, it makes sense to observe that 58% (see Table 5.9 in Section 5.2.4) of the CHBC groups did not expect to be paid monetary rewards for doing their work. This is a case of each group putting their normative obligations and aspirations to the fore. However, the remaining 42% of those groups expressed the need for monetary rewards, which is not a negligible proportion. This might well suggest that the costs of delivering home based care are so high that they feel compensation is necessary.

Following the above observations it can be inferred that at an individual level, the actors do perceive their work as worthy of remuneration. Even though it is in conflict with the 'logic of appropriateness' anchored by the group interests, the idea is well and truly supported by the membership drop-out rates due to lack of monetary incentives as reflected in Table 6.2. Drawing upon the tools of rational choice theory we can interpret that as members of CHBC institutions interact within the structures, their preferences to maximize utility do not get modified by their membership in those structures. This interpretation of the CHBC actors draws upon their perceptions that the community effort is the only tier that is not remunerated in the entire HIV/AIDS response matrix. This also goes to suggest there is an element of self interestedness from one individual to another. The conflict between individualistic tendencies and the group objectives has negative implications for the coordination processes. Complications arise due to the creation of uncertainty, anxiety, dissatisfaction and an element of withdrawal among actors. These cannot be ignored and must be articulated for policy design.

One of the perspectives that Table 5.9 presents is with regard to the level of independence of the CHBCs vis-à-vis the role of external agents. The study found that 69% of the CHBCs indicate they will be able to run the care and support service in the absence of external support. The study sought to establish the level of commitment amongst the actors but it did not endeavor to measure the change in the quality of care in the event that external assistance was withdrawn. It was found that there is a reflection of ample

commitment for the initiatives amongst the communities making CHBC a viable arrangement. Two perceptions are responsible for this observation.

Firstly, some CHBC groups were initiated and engaged with patients from a cultural and religious perspective (see discussion in Sections 6.5.1.3) well before the coordinated national response came into existence. This suggests that these groups already had their own agendas for care giving and support for HIV/AIDS sufferers. The emergence of the mixture of partners and the resultant coordination mechanisms have only built on the initial community capacities. In the process some of the working and organizational arrangements have been altered but the overall goals largely remain the same. Hence the majority indicate they would continue to pursue such goals. An element of local ownership of the programmes, an important aspect of sustainability, is captured in this perception.

The second observation is that the groups have received the fundamental capital injection either in the form of CHBC training or physical capital. The benefits of this capital investment are perceived to have long term implications for service delivery. The investments put them in a good position to serve the needs of the communities better than before. For example, some groups in Ntcheu district are operating maize mills to generate resources for CHBC work. In Thyolo some groups were reported to be rearing livestock such as pigs for similar reasons. In other words the communities do have the convenience of capital assets that have the potential to feed into their efforts for long periods. In this regard the perception of a medium to long term independence can be classified as a reality. This augurs well with the CHBC work because it increases the possibilities of locally couched decisions regarding daily transactions arrangements without external rules playing a part. This is a true case of facilitating the community development processes.

In their interaction with NGOs and other organizations, the communities tend to associate their partners with opportunities for rewards and benefits. NGOs and other partners are present in the communities in order to facilitate, build capacity and reinforce the locally

existing efforts. However, while these organizations are making good progress regarding their agendas in the communities, their interventions have had other unintended consequences for the community actors. For example, the perceptions that groups directly working with NGOs obtain monetary and material benefits have yielded negative impacts for the CHBC groups as explained in the following section.

Some of the working methods and the general orientation that NGOs have had when engaging the rural communities created misperceptions. For example, discussions with villagers in Thyolo indicated that some of the development programmes run by NGOs within communities rewarded the subjects for attending meetings or engaging in some other types of development work. Therefore, in view of this, any CHBC partnership with NGOs would seem to suggest that there are misperceptions of monetary benefits attached to CHBC service delivery as is the case with attending meetings and working on other types of projects. This explains why CHBC membership grows in the initial stages of partnerships and dwindles with time as expectations are not met. For example, using the same logic, traditional leaders in Thyolo were reported to exclude CHBC members from the list of beneficiaries of 'food for work programmes' designed to augment food supplies for households in need. The understanding was that households who have membership on CHBCs have alternative sources of resources, and therefore could not be classified as needy. This notion was also highlighted in Chapter Three, as one of the unintended outcomes due to the presence of NGOs in the national response at the community level. Perhaps members of CHBC also come to believe that indeed they are deserving payment for their efforts in care giving and support for HIV/AIDS in their communities.

The implications of the above observations are two fold. The first is that if the anticipated incentives in the form of rewards are not forthcoming, as is the case in other NGO-run programmes, the effort level of the participants is negatively affected. Secondly, the amount of segregation due to misplaced perceptions by other community members leads to economic losses as the CHBC participants are excluded from other gainful community initiatives on the premise of their membership. The exclusion from other initiatives

entails social divisions between CHBC and non-CHBC community members. These divisions are exacerbated by the ongoing stigma that suggests all CHBC practitioners are HIV positive. Given all these factors the majority of the CHBC members feel that the wider community is not very supportive. These observations serve to document that misperceptions about how the CHBC structures work are real. The consequences of such perceptions are not performance enhancing on the part of the CHBCs and suggests the need for plugging the existing information gaps.

Lastly, all the CHBC groups interviewed indicated they were successful in meeting their group aspirations as indicated by the ‘successfully achieving goals’ (SAG) indicator (see Table 5.9 in Section 5.2.4. This is one factor that motivates them. On the other hand, it is interesting to note in the same table that the achievements are realized at the expense of the welfare of their households. About 58% of the groups reported that their own households suffer due to CHBC work. Households find the trade-offs between allocating time and other resources to CHBC as opposed to their own household demands more taxing. However, the tradeoff becomes negligible when allocations are made to other activities associated with benefits such as participating in other community based organizations’ (CBO) activities. For example, a contrary indication is observed when members were asked whether being members of other groupings (NPM) such as farmers’ clubs had any negative effects on their households. Table 5.9 clearly shows that parallel membership did not have negative effects on the households. This suggests that the tendency to make decisions based on utility maximization still underline the interactive nature of individuals on CHBCs; in line with the suggestion made in the earlier discussion that an individual is first and foremost a member of the household before considering membership on any grouping, such as committing to the normative standards and aspirations of the CHBC. This is what the rational choice theorists refer to as the ‘logic of consequentiality’ as opposed to the normative approach of institutionalism which emphasizes the role of the group interests in the ‘logic of appropriateness.’

### **7.7.1 Perceptions of the Impact of External Conditions on CHBCs**

An understanding of the impact of exogenous factors such as rules, constitutional laws and the role of the resources brought in by external partners is important for an institutional analysis of this nature. One way to understand the impacts of such factors is to study how the actors themselves perceive their external partners and what they bring into the response matrix. Their perceptions are deemed to have an impact on how the actors fashion their own routines in the course of service delivery.

Firstly, the findings presented in Section 6.5.1.4 suggest that support from external agents in the form of funding and medical supplies does not meet the expectations of the recipient communities. The perception is that funding is inadequate compared to the community care giving demands. The agents have also been giving out a standardized medical kit over the years while the burden of the HIV/AIDS pandemic has clearly been on the rise. The inadequacy of support is compounded by the sporadic nature with which it reaches the communities. This perception is explained by the observation that the external agents have focused on horizontal expansion in order to reach out to more communities. In so doing they have not been able to adjust to the changing needs of the groups they have already been in contact with. It is logical for the agents such as the NAC to expand in that manner because wider geographical coverage is one of their indicators of success. It is not only a more important indicator from a political perspective, but one that is also easier to quantify.

In reality the situation is a reflection of the numerous organizational arrangement problems prevalent in the rural development sector. The organizational arrangements are dogged by incomplete structures such as the SWAP. Transitional policy such as the decentralization processes and implementation frameworks such as the establishment of the coordination units in the districts go a long way to holding up progress in the communities. This gives a broader picture of the severe malaise in coordination of what is an ever growing matrix of partners in the health sector. These are the major bottlenecks

stifling the flow of resources to the communities, thus compromising the performance of the CHBCs significantly by keeping transactions costs high.

Section 6.4.1 in Chapter Six clearly shows that public policy is undergoing a massive change towards decentralization and devolution of functions to lower levels. The process is far from complete and at the same time the policy framework is still being formulated to ensure that it accommodates partners with varying interests. The structures at district level are yet to be clarified in terms of how the coordination roles must be accomplished. Effectively the system is transposing the facilitation roles in the form of incoherent approaches, insufficient and varied degrees of reinforcements, onto the CHBCs who are at the bottom end of the hierarchy.

Fixing the district organizational arrangements to the level of SWAP will take a long time, but once it is done more donor aid could easily be committed and channeled to the communities. The transaction costs of coordinating the resource flows and implementation will decline and obviously the performance of the grassroots agents will improve alongside their perception of the entire matrix. Meanwhile the situation is leaving the actors feeling vulnerable. Realizing this, the actors are putting priority on capital augmenting efforts so that they can generate their own resources to feed into the CHBC work as well as in addressing other background states of deprivation discussed above.

The need to streamline the coordination and implementation arrangements will also address the misunderstandings such as that the CHBCs are working for the NGOs. The system will then put all partners in their rightful positions for the operational roles they must contribute towards. Thus, government, civil society organizations and donor organizations will be seen to be equal partners. Alongside this is the need for the political structures and traditional leadership to show a stronger commitment in encouraging the CHBCs than is the case hitherto.



## 7.8 Summary and Conclusions

This chapter sought to analyze and interpret the findings in Chapters Five and Six in line with the theoretical insights from the New Institutional Economics (NIE) in an application of the IAD Framework. The discussion centered on how the various CHBC operations are arranged and how these translate into transaction costs economising habits.

Transaction arrangements are negatively influenced by the communities' economic vulnerability which arises from the community background conditions and a lack of resources. This has impacted on the actors' own perception of who they are and what they expect from the response matrix. Consequently this has resulted in community members exhibiting the tendency to exercise self-interestedness. The study also concluded that there is a strong resource dependency syndrome developing among the groups due to the highlighted background conditions. Rational choice theories reveal that opportunism has negative effects on conduct towards achieving group goals. In light of this it can be concluded that opportunism is a strong factor raising transaction costs against the achievement of the CHBC goals.

Training and Skills are the most important formal incentives that are created within the framework of the CHBC service delivery. Agents on higher levels have monetary and other benefits attached to their positions. This explains the need for monetary rewards expressed by the CHBC actors who view themselves as bridging the gaps that should otherwise be covered by the upper levels of the national response. On the other hand, *self-esteem* is the most predominant informal incentive operating to enhance the performance of the actors.

Transaction costs are increased by the incoherence between the informal modes of operation that have to mix with the formal standards set by the higher level organizations such as the regulations for accessing and accounting for funds drawn from the donors. By nature the CHBC work is a low specificity activity while the formal standards of the organizations are high specificity. Application of the latter in a low specificity situation

results in economic inefficiencies. The transition in the policy arena towards decentralization and cascading the SWAP to lower levels is also affecting the transactions costs by creating uncertainty and weak coordination across the agents.

Furthermore, CHBCs have devised working methods that aim to create stability. They have put in place unwritten codes that guide operations and they have sought ways to augment their resource bases. They follow strategic guidelines that harmonize their objectives with those of their supporting partners. Along with the connection to the partners, the study also concludes that CHBCs arrangements are exhibiting elements of path dependency which suggests that historical contingencies about the origins of each group have a bearing on how subsequent developments unfold.

It has also been established that there are falling numbers of individuals working on CHBCs with time and that this has two implications on the performance of the CHBCs. The first is that the smaller numbers have made the groups more effective and secondly, that human resources are being overstretched by the growing numbers of both patients and the partner organizations coming to interact with CHBCs.

## Chapter Eight

### **Summary, Conclusions and Policy Propositions**

#### **8.1 Introduction**

This study set out to evaluate the activities of local communities and, in particular, stakeholders' participation with regard to Community and Home Based Care and Support for HIV/AIDS sufferers. The broad aim was to apply an institutionalist approach to contingencies of information, resources, technologies and the background environment of these communities in Malawi, drawing on specific research within the communities of Thyolo and Ntcheu. The reason for applying the New Institutional Economics (NIE) was to exploit the advantages it offers by enabling the researcher to examine the operational methods of the institutions without having to embrace the inputs and outputs as per standard economic models. The NIE approach focuses on unveiling the empirical reality by capturing the normative, cognitive and institutional patterns that anchor the actors' decision-making, which is decision making within the CHBC organizations. The study thus adopted the Institutional and Development Framework (IAD) to examine how rules of the game, incentive systems, knowledge and information contingencies, traditionally occurring routines and available resources, influence what the actors do in the national response to the HIV/AIDS pandemic, in particular within the community and home based care dimension.

Since understanding processes which constitute the operational nuances of community and home based care and support of the communities are central to this study, qualitative research techniques were predominantly applied in studying meanings to symbolic processes, strategic working arrangements and other internal as well as external factors that reinforce the actors' behaviour. Tolbert and Zucker (1994:27) point out the usefulness of applying the New Institutional Theory to analyses where the material benefits associated with a given structure are not readily calculable. Therefore in an attempt to assess how social institutions, such as CHBC, work towards their goals, the NIE provides a more appropriate framework than that of efficiency oriented approaches.

The findings as regards the main factors influencing how the CHBC actors operate and the relevant policy insights are summarized below.

## **8.2 Issues from Policy Structures and Implementation Arrangements**

In responding to the HIV/AIDS crisis the government of Malawi drafted a ‘National HIV/AIDS Policy’ to guide their partners in the response. First, the policy seeks to prevent the further spread of HIV infections and secondly, to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation. Malawi is faced with a lot of socio-economic and fiscal challenges. In particular, there are glaring shortages in resources to fight the HIV/AIDS pandemic despite International donor institutions, national governments, international and national NGOs, churches, and some private foundations being engaged as partners in the process of resource mobilization.

### *New Social Networks and Capacities created*

Consequent to the changing international and national terrain for responding to health care needs, the health sector has had to be reorganized. Firstly, the sector has been streamlined in a Sector-wide Approach (SWAP) arrangement which is a coordination structure. Implementation and funding efforts into the Malawi Health Sector are now channeled through the SWAP. This is augmented by Government Budgetary Support (GBS). The GBS is support allocated within government budget so that it can reach government institutions involved in the fight against HIV/AIDS.

Secondly, the National AIDS Commission (NAC) has emerged as a new coordinating body for HIV/AIDS efforts at the national level. The NAC works closely with international NGOs who are in direct contact with the communities on issues of implementation. This is a transitory arrangement pending government’s efforts to address the absence of well resourced and coordinated government departments at district level. In particular the international NGOs, normally referred to as Umbrella Organizations, are

used as conduits for funding the community level organizations such as FBOs and CBOs. The picture is complemented by roles of various NGOs, FBOs and CBOs working at the community level.

In the light of multiple players coming together, the study observes that there are new dimensions of social capital emerging within the community strategically placed to fight against the HIV/AIDS pandemic. Mainly, the birthing of the CHBC groups, the enrollment and participation of volunteers at the community level, is seen to be a breakthrough in organizing the response at grassroots. The volunteers make sacrificial contributions of their own resources to complement inputs from other partners in delivering the care and support services for the sufferers. It has been observed that community members are under resourced but efforts to deal with the crisis are such that external resources only come to complement them.

Similarly, the social networks created allow for pooling of funding from the multiple organizations and governments that are channeled into the health care delivery programmes. Coordination challenges have been observed particularly in the funding mechanisms of the lower level organizations. Nevertheless, commendable progress has been made by the partnerships in delivering care and support to those in need. An example is the efforts for counseling and voluntary testing being driven at the community level before individuals can be put on free ARVs available at formal health facilities. It can be concluded that new capacities have been created in the communities. New capacities from networking have positive effects of reducing transaction costs of delivering the care and support to AIDS sufferers.

#### *Coordination and funding challenges observed*

The emerging policy and implementation frameworks have generated a series of notable concerns, especially with regard to the flow of aid resources to the targeted populations at community level. It is in light of the efforts to address the HIV/AIDS pandemic and the

effectiveness of the CHBCs in particular that aid transmission concerns and policy suggestions are highlighted in the following sections.

### **8.2.1 Concerns emerging from AID Transmission**

According to the OECD, the Paris Declaration of 2005 provides the background to the need for a concerted effort for enhancing the effectiveness of delivering aid. This proposes that funding efforts from donors ought to be linked to development strategies of the aid recipient country or organization within a single framework of conditions and/or a manageable set of indicators that seeks to achieve lasting results (OECD, 2005:1). In Malawi specifically, there have been notable shifts in roles from central government to semi-autonomous public sector agents such as the National AIDS Commission (NAC), and an increasing involvement of non-governmental organizations within the health development agenda.

In the first place, literature suggests that the appropriateness of the institutions adopted to fight the scourge should be examined against the capital augmenting effects on the efforts of the individuals within the economies concerned (Duncan, 2002:3). According to Aligica (2005:161) the understanding of intended and unintended consequences of policy arrangements paves the way for its success. In this regard, observing the outcomes of the SWAP arrangements which are the organizing structures for the health policy and implementation, in particular the role of the Umbrella NGOs and the NAC in delivering funding to the communities, must give a reflection of the success of goal attainment in health and HIV/AIDS treatment delivery in Malawi.

- i) With regard to the SWAP, it has been noted in the discussion in Chapter Three that the funding situation has been improving over the years. The emergence of the Global Fund to provide ARVs through government facilities has also made significant contributions to the flow of funding in the sector. However, the situation regarding funding at community level remains poor. While part of the blame could be

apportioned to coordination capacities at the national level and the limitations on the amounts of funds donors are able to mobilize, on a more technical level the reservations held in respect of community capacities by donors and government is responsible for this situation. This is observed through the limited funding of the SWAP by the donors and the limits on the sizes of the NAC grants offered to communities, apart from other procedural limitations communities face. Given that there is evidence that a lot of uncoordinated interventions outside the SWAP continue to take place in the communities (GOM, 2005:3), it is concluded that community capacities are not the limiting factor to aid absorption. Therefore, their role in the national response to HIV/AIDS can be enhanced by further efforts to improve funding and coordination. It is thus concluded that holding back on improving coordination structures and limiting the amount of funding are factors mitigating against the reduction of transaction costs faced by those delivering care at community level, in other words transaction costs are being raised to higher levels they need not to be and in so doing the productivity of those economic agents is compromised.

ii) As part of the wider government effort to decentralize services and functions to district levels, the positions of District AIDS Coordinator (DAC) have been envisaged at district level but there has been no movement to put these in place. This process has stalled since around 2000 and is another source of raised transaction costs for delivering home based care. The delays in this process mean holding back the district level inclusion of HIV/AIDS activities, in particular treatment, care and support, in the planning process. This situation is responsible for the only anecdotal success of the CHBCs who must rely on being reached by NGOs in the interim who are themselves not evenly spread in these communities. A rapid process of decentralization and completion of the SWAP at district level should clearly increase the AID-benefit incidence.

iii) The creation and coming together of a variety of organizations, pooling of resources to deal with the pandemic and rolling out of the ARVs have created significant outcomes such as new capacities at community level leading to significant

returns for the entire economy. The numbers of people enrolling for ARVs is on the rise. CHBC kits are distributed in the communities who have received training to handle voluntary counseling and testing aspects as well as referring patients to hospitals when there is need. These aspects are performance enhancing to those delivering service through CHBC. However, the introduction of the ART has contributed to further strains on the already existing shortage of human resources by diverting clinicians from other facets of the health care delivery system in Malawi. So in this case the transaction costs being raised are at the health facility level, however, they are felt at community level because communities are the ultimate beneficiaries of health care.

iv) The coordination processes are making resources available for implementing HIV/AIDS programmes in the communities, such as the NAC grants. The competitive nature of these grants for CHBC makes them generally inaccessible to the rural poor. The methods of obtaining these grants are too formal and stringent on the rural communities who have been punished on numerous occasions for non adherence of the NAC standards. Punishment comes in two ways. First the production of a poor proposal results in complete non-approval for funding or delays as long as a year to get feedback and rework it.

Secondly, communities suffer sanctions from funding agents if specific reporting requirements of previously obtained funding have not been properly followed. The NAC procedures appear to be one way of indirectly limiting the scramble for the limited resources available. The current approach is clearly promoting asymmetries in the communities' access to funds by instituting such formal proposal requirements among the uneducated and under-resourced masses. Sections that are capable of facing up to the challenge of drawing proposals will continue absorbing funds leaving those who cannot even hire agents to write proposals to continue being marginalized. This is another clear case of high transaction costs that the structures of the national response to HIV/AIDS, in particular the CHBCs, should be seeking to reduce.



### **8.3 Structures and Processes at Community level**

At community level harmonization structures include the CHBC groups. These groups have been formed with efforts from a wide range of partners in the HIV/AIDS sector. The religious bodies, NGOs and government agents and the community members have all been involved. CHBC processes have generally sidelined traditional leaders and political leaders at the community level. This has resulted in limiting capacities for local initiatives such as mobilization of resources and enforcement of credible commitment on the part of volunteers. Traditional leaders and politicians have influence on villagers so they should play a more integral role in shaping the behaviour of the volunteers.

#### *The Role of Community Conditions*

Owing to limitations in cognitive capacities, which results mostly from a lack of education and the already emphasized information gaps, rural communities have developed particular perceptions that are shaping their behaviour. For example, communities perceive that there are large sums of money coming from donors meant for them and on account of this they have made themselves largely dependent upon these external resources while losing focus on their own initiative.

This perception has been exacerbated by the conduct of some of the NGOs who have a tendency of giving handouts for any little interaction they have with community members. This has been criticized for deepening the spirit of dependence. NGOs have also been criticized for not being developmental because the handouts are not designed as developmental tools. Rather they are designed to have short term impacts by luring the participants to engage with these intervening organizations. Developmental tools must have reinforcement aspects built into them. But these tendencies raise the transaction costs by promoting opportunism. The spirit of self interest raises transaction costs for other development initiatives which do not offer such handouts to the volunteers. This can be classified as a system taking advantage of the inadequacies of the communities to

reach the benefactors' goals. These are destructive signals that aid partners must try to iron out of the system if theirs is to be a facilitative role.

Along the same lines cognitive capacities of the actors have played a role in misrepresenting what is called their own 'job interpretation'. The perception that the communities are working for the partner organizations does not serve to promote the partnership qualities and characteristics envisaged of the HIV/AIDS response network. This arises for reasons such as the sense of inadequacy of the communities who see themselves to be in a weaker position as compared to the organizations they work with. It also arises as an indirect expression of the self interestedness towards benefiting from the potential incentives, such as financial rewards. Such motives are a function of the real and at times only perceived inadequacies amongst the actors.

Further to that, the interpretation of the formal working principles prescribed by external organizations and with which local people must comply are often too stringent and not in harmony with the low specificity nature of the CHBCs service delivery. In light of being trained to work in this new mode, CHBC members are bound to interpret their position as formal employment and compare themselves to their supervisors.

#### *Role of formal incentives*

Institutional economic theory recognizes the importance of responding to incentives as a driving force for performance. In CHBCs, responding to incentives takes many forms. Some of the notable examples at the initial formation of the groups as a response to incentives existing in the framework are the training and skills acquired from CHBC structures, and community recognition of the roles played, among others. In analyzing incentives and motivational aspects, and the perceptions that influence the choice of working arrangements put in place in order to attain group goals, the study concluded that 'Training and Skills' acquired are the most important formal incentives driving the CHBC service delivery.

The significant number of members exercising of the ‘exit’ option, however, suggests that there is need for financial incentives. The CHBC actors note that they do not get remunerated for doing the work of bridging the gaps between hospitals and communities, which would otherwise be done by the higher level agents in the partnerships. They also note that personnel from partner organizations benefit from inducements of monetary rewards attached to their positions. This appears to be an incoherent approach which demotivates the actors who are faced with enormous costs of delivering health care. The national response matrix needs to consider adopting a policy which would occasionally offer a token remuneration to keep the actors motivated. This does not have to cover all their operational costs; rather it should target to induce the right mix of perceptions which will in turn spur the members’ efforts. A similar principle is already applied to the traditional leaders who get some token payment for carrying out their social responsibilities. It will also help to level the playing field among all partners.

In support of better incentives discussed above there is a perception that the workers’ efforts are not adequately appreciated. Their image in the communities can be improved. For example, providing uniforms which will serve to identify them as community health service workers would make them more recognizable and accepted by the communities. Furthermore, the actors feel this would motivate them as it would make them feel closer to their professional counterparts in the care and support continuum. After all, they are doing the work that would have otherwise been undertaken by community nurses and health surveillance assistants under normal circumstances, but in the face of HIV/AIDS circumstances are not normal. In this situation, the CHBC workers would also be liberated from the stigma of being HIV positive to being appreciated as community health personnel.

#### *Informal incentives*

‘Self-esteem’ was found to be the most important informal incentive spurring the performance of the CHBC actors. Self esteem reflects the pride associated with success in saving lives of the HIV/AIDS sufferers as well as counseling of the communities towards

prevention of further infections. The actors, however, recognize the low specificity nature of their activities. That is to say the consequences of the activities cannot only be associated with CHBCs; rather various activities contribute to the performance. For example, if a patient dies you cannot place the blame on the CHBCs but if the patient recovers there is an apportionment of the success. Secondly, whereas self-esteem is largely felt in the short term, often the resultant tangible success at the developmental level is mostly experienced in the medium to long term when the recovered or saved patients are able to engage in economic activity again.

### *Considerations for facilitating Community service delivery*

Facilitation plays a role of shaping the agenda of responding to HIV/AIDS demands and must focus on motivating groups to continue participating by not only removing obstacles they face, but also promoting working techniques they are familiar with. With regard to the community's activities in CHBC the idea should be one of promoting social capital, adaptability and flexibility of working principles within the cultural perspectives manifested by the actors. To conduct effective facilitation, the partner organizations need to understand the obstacles existing in the communities, how these are perceived by the local people as well as the informal techniques and styles of working around them. Facilitation, a transaction cost reducing process, must try to build these organizations into responsive and adaptable entities that will be meaningful in the long term.

From the research findings it is clear that background characteristics suggest that communities are severely constrained by undertaking the CHBC work. Their constraints are manifest in the form of limited sources of incomes, lack of real employment opportunities and over dependence on crop production in which they also have very limited capacities. Communities suffer from considerable shortage of land and successful production requires use of fertilizer which is hardly affordable for the majority. In attempting to facilitate the livelihoods and associated social interactions that these communities engage in, the partner organizations need to recognize these fundamental

factors affecting the everyday lives of the villagers. The CHBC service delivery is closely connected to these factors in many ways.

Care givers have to invest their time and other resources to the demands they face within their own households first before getting engaged at a wider community level. Decisions pertaining to time and human resources mainly focus on the factors enumerated above because those are at the center of household survival. There is ample evidence of the constraints imposed in the falling numbers of participants involved in CHBC work. The dominance of women while men pursue household survival responsibilities is also a clear indication of the effects that background factors have to play in this case. In this regard it becomes obvious that interventions in CHBC must focus on developing the community systems that operate from the household level. Situations at household level manifest themselves at the CHBC grouping in many ways; in particular constraints at that level are mirrored by decisions for health care at the group level. Investing for long term impact at the household must, therefore, go along way to sorting out CHBC shortfalls.

Secondly, and connected to the foregoing argument, is that besides allocation of time, human and other resources towards production for the household, there are issues around the methods that people use to achieve their targets. This also provides the interventionist organizations with an opportunity to facilitate the roles of the households. By making the processes easier, time and human resources become more efficient and less is expended on production. Therefore, time is freed towards the social exchanges such as the CHBCs.

It is clear that all economic and social engagements in the rural areas are heavily dependent on application of labour resources and there is also a clear indication of resource and path dependence exhibited by these economic agents. In this regard it makes sense to suggest that capital and labour augmenting interventions are critical for the sustenance of the households as well as the pursuit of the home based care and support for HIV/AIDS. On account of the bigger picture emerging from this study, it makes more sense to have more fundamental interventions undertaken within the backyard of each household than at the CHBC grouping level. Although emphasizing facilitation of CHBC

group projects appears to assist the group to cope with the demands of CHBC service delivery, it leaves the background factors affecting each participant in their own households unaddressed. The latter have greater effects on the participants' aspirations and capacities. To this effect this study suggests that the HIV/AIDS response needs to strongly consider examining the existing and the lack of community level response assets. In particular the aid going to the communities must be tied to initiatives that seek to building these response assets for long term impacts.

Lastly, the CHBC actors are currently kept busy with their focus of emphasizing the importance of observing the standards and formal techniques of their higher level partners, for example, the Umbrella Organizations. In the event that all the partners have created ample capacities for households to be self sustaining then CHBCs would be run purely on the traditional methods of interaction and exchange. This suggests that the capacity of CHBCs to operate effectively is further influenced by geographic and climatic conditions. It is these methods that ensure that communities remain well knit together, operate in harmony and stability. This would not only help to get rid of the misperceptions CHBC members have about the partner organizations, it would also relieve the huge pressure of attending to standards the actors are not accustomed to as these raise the transaction costs for their operations.

This also brings up the importance of the contingences of information gaps in the rural areas. Information flow is very important for CHBCs and other social movements involving external agents. The conditions in the rural areas in Malawi do not permit a smooth flow of information because of a lack of infrastructure as well as the effects of poverty whereby the modern forms of communication such as radios, television and the internet are almost non-existent. These obviously work against the villagers with regard to effective participation due to information delays or it being completely unavailable. This also provides a clear cut opportunity where development intervention can have an impact on the performance of the actors not only in the CHBC groups but throughout entire communities.

### *Placing focus where it belongs*

Transaction costs are increased by the incoherence between the informal modes of operation of CHBCs that have to interact with the formal standards set at a higher level, such as the regulations for accessing and accounting for funds drawn from the donors. By nature CHBC work is a low specificity activity while the formal standards of the organizations are high specificity. Application of the latter in a low specificity situation results in economic inefficiencies. They also want to apply what in mainstream economics is termed 'competitive pressure' to spur improved performance from other economic agents within the market structures. For instance, application of sanctions, such as suspending funding implemented in case of non-compliance, is equivalent to invoking the 'exit' option in competition modes of economic operation.

An absence of coordination between the informal methods and formal techniques in decision making are an obvious source of conflicts and tension. The pursuit of freedom and independence over decisions pertaining to resource allocations have contributed to the existing enthusiasm for group resource generating projects. Leibenstein's work, cited in Israel (1987:97), on competition surrogates shows that competitive inducement has its own setbacks. It reduces the areas of discretionary behaviour of the actors within a given set-up. One consequence of this is that it leads to the development of a tendency to avoid the tightening effects of competition (entropy).

Similarly, if we apply the assumption by Simon (1955:99) that human behaviour conforms more to the notion of the 'administrative man' than to the notion of 'economic man', members of organizations make decisions affecting themselves and the organization on the basis of incomplete information. They do not attempt to find an optimal solution in the economic sense but one that is acceptable in the light of their own aspirations and the known possibilities. In this case they are understood to try to make their environment more controllable and predictable. While higher level and more formal organizations thrive on strong managerial signals, such as tighter controls to perform, to

the lower and more informal agents these standards can only compromise their performance.

From this discussion the policy options that are likely to succeed are those whose core content for the implementation strategies is built on the communities' own informal methods of conducting business. The framework should promote the traditional methods that are undergirded by cultural principles and offer more flexible and adaptable tactics that are not readily available in the formal constructs followed by organizations such as the NAC. Otherwise in the current form the formal principles are almost replacing or uprooting the traditional methods and thus increasing the transaction costs they seek to work against.

#### **8.4 Policy Propositions**

In order to improve the situation of poor funding at the grassroots level noted above, the first step needs to involve addressing the structural obstacles that are responsible for this. One major obstacle noted in the discussion is the lack of structures that are responsible for administrative and technical capacities at district level to coordinate community activities. In doing this government and the development partners have to rationalize the inter-relationships and responsibilities for all actors. With specific reference to health and HIV/AIDS a district level SWAP arrangement needs to be mooted to guide resource allocations, coordination and implementation roles. These are currently missing. The district level arrangement offers several potential transaction costs saving advantages of which the following are a few.

i) Arrangements at this level have the potential to simplify further the grant application procedures and delays in receiving feedback from the central Financial Management Agency office at the NAC. More importantly rationalizing the system at this level will serve to clarify capacity issues specific to each district so that no blanket decisions across all districts regarding capacities will be taken. In light of this opportunities for funding community activities will expand. It will then create room to



focus on implementation rather than the long and winding funding processes. Besides, this approach will reduce the current discrimination of funded community organizations. At this level it is much easier to conduct a pre-granting capacity audit. This will clarify what role each entity will be able to play and they will be entrusted with such roles. This will also serve to have diversity in the funding mechanisms based on different groups with varying capacities and roles. The funded organization will have a better chance to engage in *ex-ante* contract negotiations if they become part of the district level planning process which will lower sticking points in the care activities.

ii) The role of traditional leaders and politicians need to be elevated. Traditional and political leaders have an enormous potential in organizing efforts leading to resource mobilization at the local level by applying the rules and norms they are already stewarding. At the moment the leaderships are only involved as periphery figures. In this manner CHBC becomes an integral part of the entire community's agenda.

iii) The authorities in the partnership matrix need to consider deliberate targeting of funding to communities based on poverty and a set of social network indicators. For example limitations of factor endowments in Thyolo coupled with the absence of effective social networks beyond family settings calls for deliberate targeting that is not required in Ntcheu district. At the moment all groups compete for the same financial grants regardless of the above factors. The suggested way forward is likely to have more equitable outcomes than the current attempts which have looked at geographical coverage of institutions.

iv) The efficacy of investments must be found in specific circumstances. Hitherto, grants are given in small varying amounts on account of two major concerns. The limited size of the cake to be shared around or capacity concerns such as accountability. The implication is that the grants only have very short term impacts on the recipients. A follow-up consequence of that is the development of a culture of aid dependency. Indeed by design HIV/AIDS funding continues to be disbursed in such way. This perpetuates the inadequacies of capacity within the communities as well as those of the funding agents.

To get around these problems, it is proposed that flexibility of funding investments based on circumstances and conditions be adopted. This will involve determining what kind of funding goes to which organization based on conditions and capacities instead of the uniform granting methods which create asymmetries due to competition for funds. The funding should seek to build on the existing systems of those organizations to make them more independent and sustainable.

v) The significance of the formal and informal incentives in the framework should not be underestimated. The response to these is reflected in the variations in voluntary membership signals of the incoherence between the lowest tier of the AIDS response matrix and the upper tiers. All the tiers have positions that attract remuneration except the lowest level, and the actors are aware of this. A token rewarding of service delivery must be considered particularly as the gaps being covered are those created by the overwhelming effects of HIV/AIDS leading to the abandonment of reliance on the formal community health staff. Investing in systems that allow for *ex-post* contract negotiations must also be in a position to help get around this problem. If there is room for renegotiating contracts, utilization of the exit option will be minimal in the CHBC structures. This should also be supported by the role of pre-contract negotiations which will clarify expectations before activities begin.

vi) It has been observed that the presence of NGOs has helped to reduce voluntarism amongst the community workers. This is supported by the observed need for monetary rewards, regular formal training which is associated with per diems or allowances. These are sought together with the informal incentives such as self esteem. What is clear is that the national response needs to infuse incentives in the working methods. The incentives must be designed to enforce the informal community mechanisms within the growth oriented strategies mentioned above. These will help curb the element of self interest which clearly has roots in the actors' own inadequacies. Furthermore, adopting a growth oriented route will bring the issue of aid effectiveness to the front. What is invested will clearly be additional to what the actors already do, and will be evident in the long term projects which will have an identifiable impact on the HIV/AIDS situation.

## **8.5 Study Limitations and Areas for further Research**

The scope of this study was limited to investigating factors behind the operational methods that the actors of CHBCs choose to use. This was done within the context of the academic requirements of evaluation research. The research and discussion was thus limited to two districts where populations were sampled. Thyolo is a typical poor district in the southern region of Malawi. Ntcheu, however, is not the poorest of the central region. It was chosen for budgetary and logistical purposes as well as the low levels of NGO activities implied in the NAC partners' data base. This suggests that there are poorer districts such as Ntchisi and Dowa in the central region that could provide more comparative cases for the impact of poverty on CHBC work. From this perspective it would be a good idea to extend the study to those districts and other parts of the northern region of Malawi because the three regions are known to have distinct socio-economic patterns that make studying CHBCs in this manner worth while.

A further interesting question arising from this research is, 'what is the ideal number of participants in a single CHBC group'? Widely varied numbers of participants normally join a group and they tend to drop out with time on account of the limited incentives the structures offer or some background limitations faced by these actors in their households. While dropping out appears to be a bad signal and exerts pressure on the remaining members, it has been observed that fewer members become more effective as a cohesive team. But what would be the ideal balance? To what extent do the reduced numbers of actors compromise contributions to the care and support services?

Finally, the national HIV/AIDS response has attracted the involvement of numerous organizations and institutions to share responsibilities in the belief that with more hands you are bound to complete the work quicker and more efficiently. This approach has created a lot of new organizations as well. The sizes and focus of the different organizations vary widely. However, they all have one thing in common, that is the 'community'.

Considering that there are lots of organizations, especially NGOs infiltrating the communities without a deliberate formula for geographical coverage, the matrix is creating a situation whereby some areas already have many external organizations whereas others are hardly reached. The unevenness of interventions has obvious implications on the development process, and particularly the response to HIV/AIDS. This raises the question of how much intervention is necessary in a particular community and what can be done to affect a balance of external assistance without having to overwhelm some and deprive others?

This is a pertinent policy question especially as the coordination roles and aid transmission mechanisms are still being worked out. Research is the best way forward to determine the effective complementarities in terms of such factors as the numbers and types of organizations that would be performance enhancing and the ideal number of participants on each CHBC group.

## **8.6 Conclusions and Recommendations**

This chapter sought to summarize the main points arising from the analysis of the study findings and to draw key policy propositions from the resulting implementation bottlenecks in order to pave the way for improved CHBC operations. The following are the major conclusions and policy recommendations.

- i) There have been significant shifts in the roles from central government to semi-autonomous public sector agents such as the National AIDS Commission (NAC), and autonomous non-governmental organizations in the health development agenda. As a result of these changes, the flow of funding in the system has improved drastically but funding at community level remains poor because of incomplete coordination structures which are more focused and much clearer at higher levels than at the district and community levels.

- ii) Coordination capacities at national level and limited funding for health arrangements such as the SWAP have significantly curtailed the performance of the community agents. To this end, the capacity constraints currently envisaged at the community level are rather exaggerated. The study has concluded that significant performance enhancing capacities are still potentially available for exploitation at the community level. It is recommended that the Malawi Government should seek to develop and complete the district level structures of SWAP and decentralization. These will harmonize the planning, funding, and coordination processes and ensure that district specific development packages are applied.
  
- iii) An application of some standardized formal methods governing processes such as the HIV/AIDS funding support for community activities of CHBCs do conflict with the informal standards of the communities. These methods have been responsible for the sporadic nature of the absorption of resources due to an inability to meet the requirements for drawing and accounting for the funding, resulting in the stop-start nature of funding at grassroots levels. Discretionary behaviour of the actors within the CHBC set-up is reduced. In order to eliminate the asymmetries in the absorption capacities of the communities it is recommended that a deliberate targeting policy be adopted. This will entail specialized packages that are based on the background conditions and the needs of each society. It should also focus on motivating them by promoting traditional methods that each community already uses.
  
- iv) The study also concluded that training and skills that are offered through the CHBC structures are the most valuable formal incentives. This is not to suggest that the CHBC groups would not respond to a financial incentive. Rather that these trainings should be used more strategically in order to motivate the actors while also trying to close the evident information gaps in the communities. In this regard it is recommended that all CHBC groups should be given training and refresher courses from time to time. Similarly,

traditional and political leaders should be considered for relevant training that will help them to close the information gaps that create and sustain stigma as well as divisions in the communities. This is to underscore the need for incentives in the HIV/AIDS response in the communities.

- v) There is a gap in terms of the monetary inducements attached to roles undertaken in service delivery. Individuals working for higher level organizations involved in supervising community organizations have monetary rewards attached to their positions, such as salaries and traveling allowances, which the CHBC groups do not get. This demotivates them when they are being visited. Considering that the communities contend that they are doing work of bridging the gaps that should be done by the higher organizations, they are in a position where they would accept a token remuneration from time to time. To achieve the importance the CHBC deserves, it is recommended that they should be considered for a reasonable occasional symbolic remuneration such as has been the case with the traditional leaders for playing their roles in the communities. In the long term this can be bypassed by eliminating their dependence on external organizations by allowing them to work independently on their own projects.
- vi) Self esteem is the most important informal motivational factor among the community members working on CHBCs. Self esteem reflects the pride associated with success and recognition for saving or prolonging the lives of HIV/AIDS sufferers and the prevention of new infections. In this regard it is recommended that recognition and the image of members be at the center of the policy targeting the improvement of their performance. For example, supplying them with the uniforms which will serve to identify them as community health service workers should be considered as an incentive.
- vii) Finally the study has concluded that interventions are likely to be more effective if they are located within the backyard of each household rather than

at the CHBC group level. Conditions and decisions within an individual's household have greater effects on the participants' aspirations and capacities for performing CHBC service. In this regard the study recommends that interventions for CHBC must closely prioritize the integration with initiatives that seek to develop the households' capacities such as poverty reduction and economic growth. While small grants appear to be very manageable, in the long term it creates a dependency which raises the transaction costs of operating at the CHBC. A well calculated package embedded with long term sustainability will help to overcome the short term effects of the assistance and the dependency syndrome. These must be tied to the everyday life of a member of a household.

## 9.0 Notes

- 1 The Highly Indebted Poor Countries (HIPC) Initiative is an approach applied by multilateral funding institutions to reduce the debt burden for heavily indebted poor countries by addressing their socio-economic problems through IMF and the World Bank support. Eligibility for debt-service relief is largely tied to poverty reduction strategies, pursuit of the Millennium Development Goals among other socially oriented reforms.
- 2 The Alma Ata 1979 Declaration was a statement which reaffirmed that access to basic health services was a fundamental human right. Health refers to a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.
- 3 The Essential Health Package is a comprehensive framework, adopted by the Ministry of Health and the funding institutions, focusing delivery on the key health problems in Malawi. Targets included strengthening delivery of health services closest to the communities, strengthening of the Medical Stores, improving the quality of services and support for health facilities such as transportation and making access to health as equitable as possible.
- 4 The Global Fund was created to finance an aggressive combat on the three major diseases, namely AIDS, tuberculosis and malaria, responsible for the highest number of deaths annually. Funding is sourced from various donors and is disbursed in the form of grants to requesting countries. Disbursement of grants is done on a performance-based criterion.
- 5 The Harare Declaration of the Commonwealth Heads of States in 1991 sought to harness sound and sustainable development for the betterment of commonwealth countries. Adhering to the commonwealth principles the heads of states committed to facilitate development by tackling a range of problems such as environmental degradation and the problems of communicable diseases among many other socioeconomic ills.
- 6 The Millennium Development Goals (MDGs) are goals assented to by all countries together with development institutions under the leadership of the United Nations to try to drastically reduce extreme poverty, reverse the spread of HIV/AIDS and provide universal primary education, among others, by year 2015. There are eight such goals.
- 7 The Paris Declaration was endorsed on 2 March 2005, as an international agreement among one hundred Ministers, Heads of Agencies and other Senior Officials committing their countries and organizations to increase efforts in harmonizing, aligning and managing aid for result centered actions and indicators.
- 8 The Poverty Reduction Strategy Paper is a blue print of a consultative process involving a cross section of stakeholders in Malawi, such as government, donors and civil society organizations seeking to reduce the burden of poverty on the general population.



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## **11.0 Annexure One**

### **11.1 Community and Home Based Care Discussion Guides**

#### **A. Exploring Group formation and dynamics**

1. Identify group and its members (group name, size, members' names, age and sex, when formed, why etc)
2. Classify by profession, qualifications or other prominent roles played in society, Origins or basis of group formation
3. Length of service on the CHBC group by each member
4. How do you keep track of membership or attendance? Specific roles played on this CHBC service delivery by each member (committee members or otherwise) How are roles between men and women decided?
5. Mandates of the group (Policy or constitutional based)
6. What were the reasons for composing the group this way? Were there other ways of doing it?
7. Reasons/incentives for joining the membership (individual or group incentives). What are the important issues one would have to consider strongly at the time of composing a CHBC group?
8. What are the main rules you follow in this group?
9. Who is responsible for enforcing them? If broken?
10. Stability of the CHBC group over time? (Size & composition of sex and age)?
11. Any observed changes in strength of the group (weaker or stronger) why?

#### **B. Exploring Institutional dynamics and service delivery**

12. Ownership of assets by the group? What assets do the members have in their personal capacities? (Specify type and values if possible)
13. Do you use any of your assets used for the CHBC work?
14. Which assets are put at the disposal of the health care delivery service?
15. In what order are assets considered for use in community support?
16. What services do you deliver?
17. What are the main challenges to discharging the CHBC service? Rank order
18. What are the key CHBC service delivery requirements in this locality?
19. How are the requirements for service delivery sourced? (Within/externally etc)
20. How has the support from within (from outside) been changing since you started?
21. How do the resources contributed by members compare with those externally sourced?
22. Who makes decisions about when and where to get resources, and how do you arrive at what should be expended?
23. Have there been any changes in the operational methods of service delivery since you started your group? What changes? What necessitated these changes? How about methods of acquiring resources?
24. Who prepares your work plans/programme and reports?
25. How frequently do you have to do this?
26. What would you say highlights of your CHBC service delivery?
27. Are there any preferred ways of doing things that you would like to recommend?

#### **C. Exploring External influence**

28. What organizations do you work with? What does each org do? What do you for the org mentioned?
29. Which organisations do you consider critical for support? (Locally, externally, other) What support do you get? (type and size) How frequently?
30. What are the requirements/conditions for you to get support from various organizations?
31. Do you succeed in getting all the support you need from them? If no, what are the obstacles?
32. What is the role of the external organisations in your day-to-day service delivery? Do they help with decisions, distribution etc? Specify
33. What would you consider as the main strength of your interaction with outside organizations? And weaknesses?
34. Would you run CHBC without external assistance?
35. What do you do when resources are in short supply? Who takes the initiative to redress the situation? How often?
36. Who is main user of the information in your programmes and reports?

**D. Exploring Social/kin-networks and multiple membership**

37. Are there any other similar groups doing the same work in the neighborhood? How many? What are the similarities or differences with your own activities?
38. Do you interact with them? In what way?
39. Explore Parallel membership on other groupings (committees, clubs etc)
40. How does your involvement in the CHBC work affect your household? Do you get any assistance for CHBC from family members (achibale)? Specify
41. Does Parallel membership influence your participation on CHBC
42. Any benefits or losses associated with this work to your family? Specify.
43. What would happen if you were not a member of the CHBC group?
44. How do you decide who gets involved in the CHBC work from your own household?
45. Do the political groups play a role in the CHBC work? Specify
46. What role do faith based orgs and the traditional leadership play in your service delivery?

## **11.2 Traditional and Political Leaders Discussion Guide**

1. Identity of the Respondent and Location (Traditional or Political)
2. Identify the organizations and classify into political or traditional
3. Their major objectives and motives/incentives in the society
4. What role do the political and /or traditional organizations play in contributing to the CHBC and health delivery continuum
5. Explain what you know about CHBC
6. Do you get involved in the issues of CHBC? Explain.
7. How do you interact with the day-to-day running of the CHBC groups?
8. Are you satisfied with the current CHBC arrangement? Why?
9. What are the major challenges to health care delivery and support in this area?
10. What external support do CHBCs in this area get? Specify type and sources.
11. What is your opinion of the capacities of the CHBC membership in dealing with the day-to-day activities?
12. Do they have the requisite skills and knowledge to make decisions and act? Specify
13. Do the CHBCs turn to you for any critical decisions in the running or coordination of CHBC's activities at any time? Elaborate
14. How important is your role as a political/traditional leader in the continuity of the CHBC in this area?
15. How is your organization/office used by other organizations in passing information and other supplies for CHBCs? State the frequency.
16. Are you satisfied with the procedures?
17. How is information about CHBC communicated?
18. Do you get any form of feedback pertaining to CHBC operations? How and in what form?
19. What kind of contributions from the beneficiary community can you enumerate? Monetary or otherwise
20. Compared to support from other organizations, how do you rate contributions from members?
21. What things would you like to see changed in the current set up of the CHBC? Who do you think has the responsibility to change such things?
22. What have you done to change anything that might not be working well in the CHBC? How should CHBC be shaped for the future?

**Thank you for sparing your time to respond to my questions.**

### 11.3 NGO and Local Assembly Organizations Discussion Guide

#### **A. Exploring Organization and Group dynamics**

1. Identity of the organization, name of the respondent and position
2. Its major objectives and incentives in the CHBC realm
3. Identify the major role they play in the programme activities (coordination/financing or actual grass roots activities etc)
4. How their roles are done? How do these roles identify with your organizational structure? And professional capacities?
5. What kind of partnerships do you work with? (Identify and specify the links)
6. What guides your involvement? (Policy/constitution etc.)
7. How does the organizational guide help you to fit in with other players in the bigger picture?
8. Do the communities have the capacity to spend and account for all resources obtained? What are the major incentives to participation?
9. Are there any concerns about the level of participation at the community level? How do you ensure that there is sufficient participation at grass roots level in the programmes you support?
10. What are the key obstacles to participation at community level? Solutions for the future?
11. Are there any future opportunities you can see arising in the system and must be taken advantage of to improve the operations of the CHBC in your area?
12. Has there been a change to the number of partners you work with in the last one-year (exit/entry)? Give the numbers and explain.
13. Do your partners perceive and appreciate benefits of the CHBC work? Specify

#### **B. Exploring service delivery**

14. How do you communicate with your partner organizations?
15. What formal and informal rules do you follow in respect of CHBC
16. How are the rules coordinated amongst the partners?
17. How do the formal rules of organizations get harmonized with the informal rules of the community workers?
18. Do you have to conform to standards of other organizations that you work with? Specify. What are the merits and demerits of these standards?
19. How do you manage to keep the standards? Are there any sanctions associated with them?
20. What standards of your own do other partners have to follow? Specify who and how they are expected to follow.
21. Do they meet the requirements? Explain.
22. What specific measures do you take to ensure your partners conform?
23. Overall what is your perception of the effectiveness of the current CHBC?
24. What are the important challenges?
25. How are these challenges dealt with?
26. What are the major strengths of the arrangement?
27. What would you consider as the main contributions made by the CHBC groups themselves?
28. Do the CHBC groups have the requisite capacities to deal with the managerial coordination and financing demands of CHBC?
29. Are there any concerns about the flow of finances from sources to the end point where they must be used? (Timeliness/procedures etc)
30. Are there any conflicts that work to the detriment of the CHBC service? Specify
31. How do such issues impact on programme planning and implementation by the communities?
32. How does this impact on your goals?
33. What is the size of the CHBC budget line in relation to the rest of the budget?
34. How do you get involved in acquisition of supplies for CHBC for your partners? Explain

#### **C. Exploring External influence**

35. Classify the types of contributions you make to CHBC (financial, medicinal, human resources etc and values if possible)
36. How does your contribution compare with the group members own contribution?
37. What do the groups contribute?
38. How do these contributions compare with outside sourcing of help?
39. Enumerate the organizations that contribute to CHBC in your area and what they give

40. Who makes decisions about contributions/sourcing of supplies for CHBC activities at the community level?
41. Do they have capacity to source help from outside?
42. Are there any potential resources that these people are unable to tap? If yes, why?

**D. Exploring Social/kin-networks and multiple membership**

43. From your knowledge how much do members of CHBC groups depend on grants/gifts from other family relations?
44. How does the assistance from organizations compare with the informally sourced gifts/grants in the day-to-day service of CHBC?
45. What are the other aspects associated with Kinship would you consider important in CHBC and HIV/AIDS in general? (Positive and negative aspects)

**Thank you for sparing your time to respond to my questions.**

## 12 Annexure Two

### 12.1 List of Key Informants

	<u>Name</u>	<u>Position</u>	<u>Place</u>
1.	F. Mamela	Village Head	Matchuana
2.	D. Kavalo	District AIDS Coordinator	Local Assembly
3.	J. Masamba	Political Leader	Lupiya
4.	J. Molosoni	Political Leader	Nchilamwera
5.	P. Kenede	Traditional Leader	Chimaliro
6.	L. Steven	CHBC Coordinator	MSF
7.	Tsikulamowa	Village Head	Manjawira
8.	O. Zuze	Supervisor	NAPHAM
9.	C. Banda	Community Nursing Officer	MOH
10.	M. Mankhwala	District AIDS Coordinator	Ntcheu Hospital
11.	D. Kalomba	M & E	NAC
12.	P. Revill	Planner	MOH
13.	None	UNAIDS	(Interview Declined)

## 13 Annexure Three

### 13.1 Categorical Summaries

#### 13.1.1 Subjects' Perspectives

##### NACHIPERE

###### *Perspectives held by subjects*

- Galvanized by love and unity
- No need for constitution or policy
- Reward in heaven
- Pride in saving lives
- Serves to associate with others
- Development of the villages
- Growing stronger with dedicated members only
- Lacking in basic requirements for service delivery
- Support on the decline
- Been successful
- Still need capital as an operating base
- Can deliver without external assistance

##### 2 MIKOMBE

###### *Perspectives held by subjects*

- Many were dying and needed support
- Every member keeps vigil of the others
- No constitution
- Everyone is responsible
- Relieved from purchasing drugs by supplies from MSF
- Believe MSF staff visit because of huge money allowances
- Volunteers get nothing
- Use own money in some cases to support patients
- Would still run CHBC without external bodies
- CHBC does not negatively affect their households
- Households help and benefit from CHBC e.g. medicine, training
- Work closely with church but not traditional leaders

##### 3 KWAKWANJANA

###### *Perspectives held by subjects*

- Aim to develop the village
- Many patients and orphans needed care
- Custodians of knowledge and expertise for other villagers
- No policy or constitution
- Unwritten rules are used
- Every member has responsibility to reinforce rules
- Non-monetary rewards demotivating members
- Have more patient workload due to dropouts
- Perceived to be in gainful work by others
- Overlooked in the FFW due to CHBC work
- Member contributions sporadic due to hunger and poverty
- External support also dwindling
- Business investment e.g. maize mill can help cope with demands
- All members besides the executive committee need training
- MSF makes regular supplies is the most critical for them
- Would prefer getting some monthly grants

- However, they do understand it as charity work
- Household work does get disrupted by CHBC emergencies
- Saving many lives by sending them for VCT
- No traditional or political leaders get involved but FBOs do

#### 4 GOLIATI

##### *Perspectives held by subjects*

- Wanted to help caring and supporting
- Well placed to spread the message of HIV/AIDS
- Care for orphans is reciprocal
- Not for profit
- Entails hard work, love and kindness
- Confidentiality is critical for the service
- Increasingly dominated by women
- Getting stronger
- Discriminated against in the Food for Work activities
- Sometimes ridiculed by other villagers
- Own contributions have been inconsistent
- External support falling
- Number of patients increasing
- Absence of monetary incentives is a weakness
- CHBC would survive without external support
- No conflict from parallel memberships, follow different schedule
- Double standards as counselors get some kind of pay
- Have saved many lives
- No traditional or political leadership help
- Religious bodies assist with care and support of patients

#### 5 SENZANI

##### *Perspectives held by subjects*

- No constitution
- Mandates assigned by voting executive
- Wanted to fulfill a good Samaritan biblical role
- Had been promised training by WVI
- CHBC would work better with IGA, e.g. maize mill
- Confidentiality a necessary attribute
- Always on call for emergencies
- Have enforceable rules to be adhered
- Membership falling due to non-monetary benefits
- Smaller numbers are more effective
- Weak support from traditional leaders
- Inadequately equipped
- No training yet but they need it
- Internal donations inconsistent
- External support irregular
- Work undertaken on ad-hoc basis without planning
- WVI trashed and never used their reports
- Now they report to DAC monthly
- Mind sets have changed due to CHBC
- VCT clinics are frequented now
- NGOs should help with finances
- Parallel memberships have complimentary roles
- Transfer of ideas or use of assets, e.g. bicycle fro CBO



- Many lives have been saved due to CHBC
- No role played by political and traditional leaders
- Churches disseminate information

## 6 MANJAWIRA

### *Perspectives held by subjects*

- Hospital very far so CHBC was meant to bridge the gap
- Group has no constitution and meet sporadically
- HAS undertook preliminary initiatives to galvanize the group
- Members join coz they want to be trained
- Also want to help patients
- Emphasize exercise of confidentiality
- Adherence to group rules also important
- Many left the group due to other commitments
- The group is stronger now
- Major activities are awaiting installation of maize mill
- Preparing to keep cattle and chicken
- Inadequately resourced so far
- Villagers do not have much confidence in group
- NAC has stopped support while MASAF comes in
- External support better than internal
- MASAF support is critical coz it will last
- Clear reporting is critical for getting support
- NAC has too many orgs to support
- If trained would run CHBC without external support
- Parallel membership not a problem
- CHBC doesn't affect households
- Households benefit from the CHBC foods and medicines
- Many people would have died without us
- Don't work with politicians deliberately to avoid confusions
- Traditional leaders help with messages
- FBOs help with prayers for patients

## 7 MATCHUANA

### *Perspectives held by subjects*

- It was catholic fathers idea, villagers agreed with them
- Many members dropped out due to voluntary nature
- More men have dropped out to look for gainful jobs
- MSF assumed control of the group later
- VH also helps with the charity work in the village
- Remaining men do not participate much
- Do not have constitution
- Have rules and sanctions
- Lamented men's position of pursuit of paid work
- Group activities similar to what we do at church, visit sick
- Not proper to expect payment at CHBC
- Remaining members are growing stronger in service
- Household chores suffer
- They must be given permission to call for ambulance
- Have inadequate training
- Hunger has increased the drop out rate
- Number of patients growing
- Need more assistance such as food and materials
- MSF main source of supplies
- MSF support has fallen over the years

- Requests given to MSF do not bring our outlined needs
- Community nurses no longer visit to encourage us and patients
- Villagers gossip & call us names (a edzi awo)
- Resorted to visiting individually than in groups as before
- Many who had VCT and ARVs are now working normally
- Would prefer to work in uniforms and be identifiable
- Cant run CHBC without external support coz of poverty
- Parallel membership has no effect as work on different days
- Household work suffers
- Traditional leaders praises CHBC good work in the village
- Many would have died
- No FBO involved in their work now
- Political leaders do take part

## 8 LUPIYA

### *Perspectives held by subjects*

- Catholic church initiative
- Due to increased numbers of patients
- Only keep track of committed volunteer members
- No policy or constitution
- Volunteers cant discriminate amongst people
- Should not depend too much on external support
- Should not join to earn money
- Have sanctions for enforcement of rules
- Size has still dropped due non-payment of members
- The fewer remaining are stronger and hard working
- Internal contributions inadequate for service
- Lack of training to produce funding proposals
- Need small businesses for CHBC
- Need training and exchange visits among CHBCs
- MSF donations have dropped
- Number of patients has increased
- FBO assistance withdrawn as well
- MSF critical for CHBC
- MSF does not realize that number of patients is up now
- Can still survive on contributions
- Still feel they belong to RC Church
- Parallel membership has no effect
- Households are reported negatively affected
- Households Benefit from free medicines
- More people could have died
- Community is knowledgeable now
- Politicians don't have a role
- Church contributed but stopped
- Traditional leaders misunderstand us to be gaining money

## 9 NANSATO

### *Perspectives held by subjects*

- Splinter of CCAP church charity work
- Caters across different churches
- No constitution but guided by discussions
- Growing numbers of the affected in community
- Knowledge of volunteerism is important
- Have sanctions for rules

- Mostly men have dropped out due to non-payment
- The smaller group is more committed
- Are challenged by inadequate resources for service
- Increased number of patients
- External resources do match the increased numbers
- Own contributions very limited
- External dependency has still been on the ascendancy lately
- More people have come forward for VCT
- Have good methods of working resources permitting
- Assisted by MSF, OXFAM and Social Welfare
- All above are critical
- Can still cope without external support
- Parallel memberships have no effect
- Household work not affected
- We also get free medicines for family members
- No role for politicians and traditional leaders
- Church donates and visits patients too
- Chief diverted money meant for CHBC to other things

## 10 MPANDO

### *Perspectives held by subjects*

- Started due lessons from another group
- Number of patients and orphans also contributed
- Meetings decide the agenda from time to time
- No constitution or policy
- To extend a helping hand based on religious beliefs
- Demands hard work knowing there is no pay
- Rules must be adhered to or sanctions apply
- Numbers dropped from 30 to 15
- Non payment is the major reason
- Too few men left
- Only those left got training
- Are more effective now
- Lots of challenges met
- Inadequate medicines and materials, gossip against group
- Limited Own contributions complimented by MSF
- Hunger has affected internal contributions badly
- Have saved many lives since 1996
- Loans for IGAs would really help CHBC
- Source help from MSF, Soc. Welfare and Thyolo hospital
- MSF most crucial for CHBC for medicine and likuni phala
- Reports are the key condition to get the support
- MSF have too many communities to attend to
- They cant give adequate support to all their groups
- MSF nurses occasionally get down and help with some decisions
- Group would weaken without MSF support
- Would survive coz MSF found the group in existence
- Not affected by membership on other groupings
- Households not affected as work is well organized
- Knowledge from training is most valuable thing to them
- Donations are a constraint on their families
- Politicians help with campaign messages
- Churches disseminate information during service
- Traditional leaders also speak about HIV/AIDS

## 11 NJOLOMOLE

*Perspectives held by subjects*

- Members dropped from 55 to 30
- Initiative of the Save the Children fund
- The hospital is far and CHBC was to bridge the gap
- Monthly meeting determine the agenda
- No constitution
- Were told in advance there were no monetary benefits
- Have specific rules followed by members
- More men left than women they are more after finances
- Are faced with inadequate medicines and other inputs
- There internal contributions
- They are however inconsistent due to hunger crisis
- Support obtained through development of proposals to NAC
- NGOs have also helped
- They are poor so cant contribute much so depend on external
- Training changed some of their working methods
- They are able to give medicines to patients now
- There is more donor help after training in sourcing help
- Community recognize the group and more VCT attended
- NAC is critical for support
- NGOs only get involved occasionally in patients decisions
- Reporting is crucial for support
- They are running a piggery project
- Can cope without external support
- Own contributions needed when other resources run out
- Group not affected by multiple memberships on groupings
- Households do suffer from time splitting
- Other family members not involved as are not trained
- Don't see any major benefits except for helping out
- Community has benefited a lot from CHBC
- Politicians and chiefs do help
- FBOs have their own groups to work with

12 NCHIRAMWERA

*Perspectives held by subjects*

- Initiated by one RC Priest
- MSF asked them to formalize the group
- Were promised continued support for activities
- Organized into executive and disciplinary committees
- Women participate more regularly and do more of the work
- No constitution
- Have rules of their own
- Motivated by the need to help sufferers
- One must understand volunteerism
- Do have and implement sanctions
- Confidentiality a must
- Number grew with coming of MSF
- Group is stronger now
- Most assets came from MSF
- Own assets are also used by individuals
- Major CHBC challenge is availability of food
- More orgs are coming to help
- MSF make decisions how and when to get resources
- Operating methods have been changing with time
- Do depend on plans and programs made by MSF

- Own plans do complement MSF ones
- Many saved and are on ARVs now due to CHBC
- Should be given more medicine to distribute
- Need a room allocated for counseling at hospital
- HIV/ADS patients should be given preferential treatment
- Consider themselves almost working for the organizations
- MSF most critical for their work
- Reporting is critical for the support to come
- Support not always adequate
- Have control over day to day decisions
- Cannot run without external support
- Parallel memberships don't affect them
- Households are affected by CHBC work
- Benefit from medicines themselves and families
- Use of programmes assets like bicycles also benefits them
- FBOs play a role
- Politicians don't
- Traditional leaders help and witness CHBC activities

### 13 CHIMALIRO

#### *Perspectives held by subjects*

- Formed by RC priest
- Strengthened by MSF later on
- Motivated by idea of saving people
- In line with what was going in church groups
- Have rules
- Emphasize confidentiality
- Numbers have increased
- Heavily dominated by women
- MSF changing methods not favorable to them
- Referring patients to hospital instead of home treatment
- Have some IGA activities to support CHBC
- External support has been on the decline
- Many people are on ARVs and are working well
- Need a place for their meetings, VCT n sharing experiences etc.
- Need a business loan for profits to drive CHBC
- Have MSF, MASAF, NAC Soc. Welfare on their side
- MSF critical
- Reports in exchange are critical
- Support inadequate as orgs say they have no money
- In absence of reports support drops or is stopped
- Group would sustain CHBC in absence of external support
- Parallel membership has no effect
- Other groups don't meet that often
- Households get affected as they leave to attend emergencies
- Have benefited knowledge from trainings
- Have saved many lives
- Their time is lost and families suffer the consequences
- Politicians have no role
- FBOs do
- Traditional leaders do

14 LIZULU

*Perspectives held by subjects*

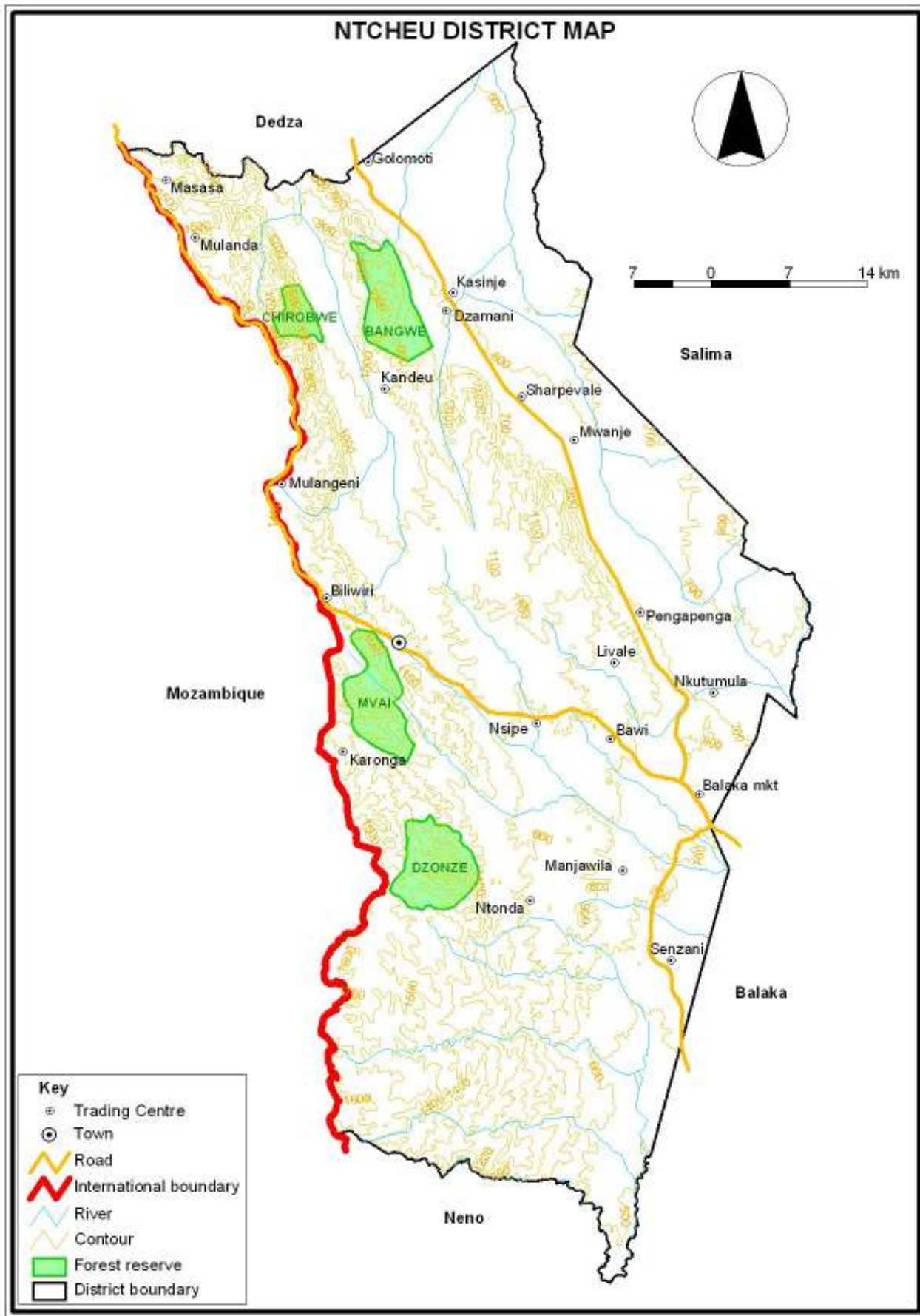
- Formed by individuals who assisted one very sick man
- Aimed to extend help to others in similar situation
- No constitution
- Have formal rules
- Motivated by church convictions and self fulfillment
- Group has been unstable and numbers falling
- Members expected remuneration
- Females dominate membership
- A numbers of organizations have come with help
- Own contributions also help
- Patients appreciate food not mere cheer-up visits
- Members ridiculed by the society for non-paying work
- Various members still in need of training
- Training has improved their work significantly
- Bicycle ambulance has also come handy
- Are working on IGA initiatives
- NAC,PSI,AFRICARE,SANASO,UNICEF,MANASO,MASAF WVI and USAID as well as MOH have helped
- Soc welfare and hospital not mentioned above but interact with
- Notably these don't contribute material resources
- MASAF and NAC critical
- Lack human resources to draw up proposals for funding
- Would still run without external help
- They are the only health related group in the area
- They are not members on other groupings
- Want to focus on CHBC
- Don't really see negative effects on households, only occasionally
- Training and knowledge obtained has saved many lives in community
- Counseling has ended with lots going for VCT
- MP helped with transportation for constructing maize mill
- Chiefs help with information dissemination
- FBOs also help including financial contribution

15 SHARPE VALLEY

*Perspectives held by subjects*

- With 75 members, including board members and executives
- Initiated due to increasing number of patients in the area
- Hospital administrators came up with the idea
- To reduce workload at hospital
- No constitution
- Group deliberates on how to work from time to time
- Roles often divided on gender lines
- Have sanctions and rules
- Group reported to have been increasing over time
- More women getting to join and work
- Workload has consequently reduced
- Group has no assets of its own
- Members make contributions
- Challenged by lack of training, transport and supplies
- No external support so far
- Been struck by a hunger crisis
- Have to fund raise for CHBC e.g. working on people's farms

- They still provide reports to hospital on what they do
- Training would make a difference
- There are other groups that get external support in the area
- They interact and get ideas from them
- Not affected by membership on other groupings
- Household work affected by CHBC commitments
- Giving counsel has proved to be beneficial in the area
- Politicians not involved with the group
- FBOs offer spiritual motivation to patients
- Traditional leaders also offer counsel





# THYOLO DISTRICT MAP



**Key**

- ⊙ Trading Centre
- ⊙ Town
- Main road
- Secondary road
- Tertiary road
- River
- International boundary
- Contour
- Forest reserve
- District boundary



Annexure 4:

4.1 Map of Malawi showing NTCHEU and Thyolo Districts

