NORAD **Report 3/2004**

discussion

SWAps and Civil Society

The role of Civil Society organisations in Malawi's Health Sector Programme

Malawi

January 2002

NORAD
DIREKTORATET FOR UTVIKLINGSSAMARBEID
NORWEGIAN AGENCY FOR DEVELOPMENT COOPERATION

CSOs and SWAps in Malawi

The Role of Civil Society Organisations in Malawi's Health Sector Programme

A Report to
Norwegian Agency for Development Cooperation
(NORAD)

January 2002

By
Stein-Erik Kruse
Centre for Health and
Social Development (HeSo)
Oslo

Table of Content

Acronyms

ARV – Anti Retroviral Drug
BLM – Banja La Mtsogolo
CHAM – Christian Health Association of Malawi
CMS – Central Medical Store
CONGOMA – Centre for Non Governmental Organisations in Malawi
CSO – Civil Society Organisation
DFID – UK Department for International Development
DHMT – District Health Management Team
EHP - Essential Health Package
GFATM - Global Fund Against AIDS, Tuberculosis and Malaria
HIPC - Highly Indebted Poor Countries
MASAF – Malawi Social Action Fund
MDHS – Malawi Demographic and Health Survey
MOHP – Ministry of Health and Population
NAC – National AIDS Council
NCA – Norwegian Church AIDS
NGO – Non Governmental Organisation
NHP – National Health Policy
PRSP - Poverty Reduction Strategy Paper
SWAp - Sector Wide Approach

1. INTRODUCTION

1.1. Background and Objectives

This report about the health sector and civil society in Malawi is part of a broader study "SWAps and Civil Society" initiated by NORAD in Oslo. This study seeks to explore the roles of civil society organisations (CSOs) in sector wide approaches (SWAps) - with a focus on health and education programmes supported by NORAD. The background, purpose and design of the overall study are presented in the report "SWAps and CSOs. The Role of Civil Society in Sector Wide Approaches" (2002).

This study brings together and illustrates several important issues and new trends in Norwegian development cooperation. NORAD's strategy for poverty reduction advocates new forms of cooperation – sector and budget support. NORAD has also developed new guidelines for funding civil society organisations – both Norwegian based CSOs and local CSOs.

The first generation SWAps focused almost exclusively on improving the effectiveness of Governments and public sectors while the involvement of CSOs was given little attention, both by the countries themselves and the development partners. Lately, there has been more involvement of civil society – not least as a parallel trend to the involvement of civil society in PRSP processes at country level.

But there has been – both in Norway and internationally limited knowledge about what roles CSOs have played in sector programmes, their level of involvement and what the results are. Not only is there a need to understand better the features of current involvement, but also potentials for what roles and how CSOs can be involved in the future. Not least because international development cooperation policy has moved towards more partnerships among governments, donors, private sector and civil society in achieving sustainable development.

To begin the study, it was therefore necessary to explore the field - collect available information, define some key concepts and identify and formulate relevant questions. We are now in the second phase with analysis and testing of questions and hypotheses from the desk study in five countries: the health sectors in Malawi, Mozambique and Uganda and the education sector in Zambia and Nepal. This is the report of the first case study from Malawi. A synthesis report for all the case studies will also be prepared at the end.

The entry point for the study is civil society organisations in NORAD partner countries and their interactions with national SWAps - and not the roles of Norwegian CSOs as such. On the other hand, we are interested in the contributions and perspectives of Norwegian organisations, so they are also involved.

The objectives of the country studies are[1]:

(a) To review the roles of civil society organisations in selected sector programmes – in particular in relation to roles played by CSOs, analysis of opportunities and constraints and results achieved.

(b) Provide advise and recommendations to NORAD, Embassies and Norwegian NGO on how to improve the interaction between social sector SWAps and civil society.

Next chapter (Chapter 2) presents the Malawian context - the socio-economic situation and particular the health challenges and the subsequent health policy response. The characteristics of CSOs in the country are also presented and analysed. The justification for this chapter is to explain the background and needs for a SWAp design process. Chapter 3 portrays the new architecture of development assistance to the Malawian health sector - PRSP and HIPC, the health SWAp and the HIV/AIDS Global Health Fund proposal and the linkages between these initiatives. Chapter 4 builds on the description and analysis in the previous chapters and seeks to respond and discuss in summary form the questions and hypotheses in the mandate.

We are using most of the time the broad term "civil society organisation" (CSO) in this report, which in Malawi includes NGOs, faith community organisations, labour organisations and traditional formal and informal organisations (PRSP p. 23). NGO is used when that group of CSO organisations is referred to.

1.2. Methods of Work

The study approach and methods are presented and discussed in the background document. A number of roles CSOs could play in SWAps are first presented: as contributors to policy discussion and formulation, advocates and lobbyists, service deliverers (operators), monitors (watchdogs) of people's rights and particular interests, innovators introducing new concepts and initiatives and finally as financiers.

Based on a review of literature and interviews of key informants in NORAD and among Norwegian NGOs key questions were formulated and for each question assumptions or hypotheses were proposed. The assumptions were intended to represent "common wisdom" about CSOs and SWAps - what was taken for granted and thought to be true. All questions and hypotheses are presented in Annex 1.

The case studies serve as the empirical testing ground for the assumptions. The individual country programmes should help us to find out to what extent the assumptions could be confirmed, partly confirmed or had to be rejected. Following such an approach we would be in a better position to describe and explain the roles CSOs actually play in SWAps.

In Malawi key documents relating to the health sector programme and the PRSP were reviewed. Since the HIV/AIDS proposal to the Global Health Fund had recently been accepted for funding, it was also decided to look at the linkages between this proposal and the health sector programme and the issue of CSO involvement.

[1] See Mandate Annex 1.

We met with key representatives from Government (Ministry of Health and Population and the National AIDS Council), multi- and bilateral donors to the health sector and national and international CSOs. At the end of the visit findings were discussed with key informants and later presented in a draft report, which was circulated to NORAD and stakeholders in Malawi.

The use of assumptions or testing of hypotheses through case studies were found useful and relevant, but as no guarantee for "objectivity". The process of verification was open for subjective interpretation, but in most cases clear patterns or trends emerged after several interviews. In some cases representatives from Government and organisations presented opposing views and we have tried to reflect both in the report.

The work in Malawi was supported by Salephera Consulting.

2. COUNTRY CONTEXT

2.1. Widespread, Deep and Severe Poverty

The recent Malawi Poverty Reduction Strategy Paper (MPRSP, April, 2002) states that poverty in Malawi is widespread, deep and severe. According to the1998 Integrated Household Survey, 65% of the population are poor, or roughly 6.3 Million people. Within this figure, about 29% of the population are living in extreme poverty. Generally, poverty is worse in the rural areas.

Literacy rates have remained almost static for several years, with particularly low rates for women. Female- headed households also tend to be generally poor as compared to their male-headed counterparts. Women have lower education, limited access to productive resources, a narrower range of formal sector labour market opportunities than men and lower wage rates.

Sectoral analyses of poverty show that social, human capital and income indicators are very poor. Moreover, socio-economic trends for Malawi remain unfavourable when compared to other countries within the region. According to the Human Development Report 2000, the country was ranked 161 out of 174 countries reviewed, and only reached nine places higher using GDP per capita.

The Current 'Hunger' Situation

On 27 February 2002, the Government of Malawi declared a State of Disaster indicating that *"Malawi is facing a catastrophic situation with up to 78% of farm families (2.2 million people) being without food"*. Poor harvests in 2001, low maize stocks, rapidly increasing food prices, late rains and devastating floods in several districts have contributed to this food crisis. The worst affected areas are in the Central and Southern regions.

World Food Programme now estimates that 3.2 million people in Malawi are currently seriously affected by the food crisis. There are also early indications that next year's harvest is also under threat from an El Nino effect. Some experts anticipate that this emergency in Malawi may last for two years.

2.2. Health Challenges

Poor Health Indicators

On health matters, the 2000 Malawi Demographic and Health Survey (MDHS) indicate that there has only been a modest decline in fertility over the previous ten years (from 6.7 to 6.3). Thus, fertility rates remain high, especially in rural areas, and are closely related to the socio-economic status of women.

The 2000 MDHS data indicate that mortality of children under the age of 5 has declined since the early 1990s (though more recent data that fully reflect the HIV/AIDS epidemic might suggest otherwise). Nonetheless, the rate of the downward trend reported is only modest, and childhood mortality remains at a very high level. Vaccination coverage rates show rates of decline (from 82 to 70% in the last decade) with suggested rises in reported morbidity and declines in the use of

health facilities for treatment. No appreciable change is recorded in the nutritional status of children since 1992; still nearly half of the children under 5 are chronically malnourished or stunted in their growth. Of continuing concern, is the estimated rise in maternal mortality from 620 to 1,120 per 100,000 live births between the 1992 and 2000 MDHS reported results.

In short: Malawi has a number of poor health indicators. Life expectancy at birth is now estimated to have fallen to 39 years. 23% of children are reported to die before they reach the age of 5 years. The maternal mortality rate has almost doubled in the past decade.

HIV/AIDS

In addition, Malawi has one of the highest HIV/AIDS prevalence rates in the world, with 15 percent of those aged 15-49 infected, while the national prevalence is estimated at 8.4 percent. By 2000, life expectancy declined to 39 years from a projected 54 years without the HIV/AIDS epidemic. The epidemic has taken a great toll on the young and middle-aged population, thereby undermining the country's ability to reduce poverty. The very high rates of HIV prevalence in women of reproductive age, together with high fertility rates, imply high rates of Mother to Child Transmission (PMTCT) of HIV.

The National AIDS Commission estimated that in 2001 there were about 1,000,000 adults and children with HIV in Malawi. HIV/AIDS is now the leading cause of death in the most productive age group (20-49 years), resulting in an estimated 50,000 to 70,000 adult and child deaths annually. The cumulative number of orphans, directly related to the AIDS epidemic, is approximately 400,000, and more than 60,000 will be added each year. AIDS is, therefore, undermining development gains and acts as a major barrier to economic growth. HIV/AIDS-related conditions currently account for over 40 percent of all inpatient admissions and these are likely to increase, thereby overwhelming health services.

Fragmented Health Support

Donor assistance to the health sector is very fragmented, particularly when looked at geographically, with substantial "balkanisation" of the country. Currently, external assistance comes largely in the form of projects or commodity support. Malawi suffers also from an unequal geographic distribution of such funds, with many individual donors or agencies targeting their support to particular districts. Examples include the USAID CHAPS districts, UNICEF impact areas, the DFID Safe Motherhood project in the Southern Region, Netherlands support to Lilongwe District Health Office, GTZ in Machinga District, 8 WHO focus districts, and the part of the EC-funded Health Sector Reform and Decentralisation Project which is earmarked for its four focus districts.

Some partners (particularly NORAD, SIDA and DFID) are willing to consider direct (budget) support to districts in order to assist in EHP delivery. A proposal to NORAD from the Health Planning Department suggests that such funds should be channelled using an agreed formula to Development Budget accounts at district level – a sort of "mini-SWAp" at district level.

Other donors (particularly JICA, USAID, and most of the multilateral agencies), are unable to channel their funding in such a way at present, and alternative mechanisms are proposed to ensure that all such external funding is captured in the overall Programme of Work for the sector.

A Plurality of Health Service Providers

In Malawi, the health sector is characterised by a plurality of health service providers. MOHP accounts for 40% of the total number of health facilities, followed by Christian Health Association of Malawi (CHAM) with 20%. Other formal health service providers include Local Government (3.6%), companies/firms (17.3%), and private-for-profit (13.7%). The scale of the traditional health sector (traditional healers and traditional birth attendants (TBAs) is unknown. A TBA attends approximately 25% of deliveries and it is thought that most communities have a traditional healer.

Other sources of care include grocery stores and pharmacies, and to a lesser extent Community-Based Distribution Agent (CBDA) for family planning commodities, Drug Revolving Fund (DRF) provided by community volunteers, home based care volunteers and faith healing groups.

The health sector in Malawi also includes some health services provided by the private sector, including industry and tea estates: these services include 109 clinics and 8 private hospitals. There are also many practitioners in traditional medicine. A whole-sector health policy should therefore include a strategy for the private sector.

In a survey of health care seeking amongst 1264 households in Malawi, the most widely used health care provider was the drug vendor or grocery shop (68%), followed by the health centre or clinic (57%), CHAM facility (28%), traditional healer (23%) and private clinic (20%). Several studies highlight the importance of the local grocery shop or drug vendor as the first source of health care for poor people. Government health facilities are also an important initial source of care. In a study of user perceptions of health services, many rural respondents reported paying for private medical treatment because the government (free) service was too far away. Reasons for visiting private providers are related to distance and also to the quality of the service (quick treatment, availability of drugs, and friendly service).

Weak Institutional Capacity

The MOHP has limited capacity to lead and manage the sector and utilise external resources efficiently and effectively. High vacancy rates across most departments are reported with consequences for their operations. There is a resulting heavy reliance on donor-funded technical advisors across core functions of the Ministry. The lack of a MOHP Action Plan and the modest absorption capacity of the MOHP with regard to donor funding allocations (MOHP absorbed just 47% of donor health allocations available to it in the period 1994 to 1999), all serve to highlight current institutional limitations in MOHP capacity.

Hence, external donors have often bypassed Government systems, established parallel structures, selected their own districts and areas of intervention, and tried to create "islands of success" in these areas. NGOs and other donors have also contributed to

the weakening of the public sector by attracting the best-qualified personnel with higher salaries.

An overview of the health sector shows also that the health system has been centralised with a lot of centrally designed and vertically managed projects, resulting in substantial duplication of efforts, poor coordination and high administration costs. The central ministry is not only facing challenges in its central coordinating and district support functions. The Local Government Act transfers all managerial authority over health service delivery at district level from MOHP to local assemblies.

The role of the MOHP is thus changing: from one focused on coordination of service delivery, to a more normative and policy-oriented role. Core functions will be in such areas as policy formulation and enforcement, standards formulation, regulation and international representation. Such changes will require institutionalisation of new ways of working and strengthening of the analytic capacity of the MOHP personnel to support service providers at district level.

The challenges faced by the central MOHP are of key relevance for this study of CSOs and SWAps, given the widely accepted importance of strong central ministry leadership in enabling SWAps.

The challenges explain also the background for introducing a SWAp in the health sector. The intention of a SWAp is to break the vicious circle of fragmentation by introducing an overall national health plan with selected priorities in terms of on what, where and how much resources should be used.

2.3. Malawi's Health Policy Response

National Health Policy
The document "To the Year 2020: A Vision for the Health Sector in Malawi" (May, 1999) portrays the MOHP vision for a reform of the Malawian health sector over the next twenty years. Its companion document, the "Malawi National Health Plan: 1999 – 2004", provides an overview of health services and health-related policies, objectives, targets, strategies and activities. It highlights human resource and human facilities' needs and projections and a financial framework within which to consider the programmes' resource implications.

Within the NHP: 1999-2004 eight medium-term objectives were developed to support the translation of health policy into implementation. Accordingly, a number of important initiatives have since been taken, including: the movement to greater measures of autonomy for large institutions (e.g. Central Hospitals; CMS); capacity building at the district level; rehabilitation, upgrading and new construction of physical facilities and physical asset management, the development of a Health Management Information System; the production of a Malawi-specific Essential Health Package in 2001, with a costing of the package.

All of the above efforts can be said to be highly relevant to the design of a SWAp: either, as perceived pre-requisites to the introduction of such a framework; or as necessary conditions for the disbursement and accountability modalities. EHP is

already seen as a suitable basis for a joint programme of work between development partners and the MOHP and with other key stakeholders (e.g. CHAM). The main components of the EHP capture those health services that address the major causes of deaths and diseases in Malawi, together with the supporting structures and systems to enable delivery. The cost of implementing the package has been estimated at just under US$ 17.53 per capita. This figure is comparatively low and may be increased due to additional costs of. anti-retroviral treatment for AIDS, support and supervisory services.

Health Expenditure

The Government of Malawi has increased annual expenditure on health from an average of 6-9% in the 1990s to 12-15% in 2001 in line with commitments made in Abuja, 2001. With a population of 10 million (1998), the per capita expenditure on health (all sources) was about US$12.4, of which government accounted for about one quarter of the sector's health finances, though more than one third of its provision of health care.

The Role of External Donors in Health

Of total health expenditure Government accounted for only 25%, and donors for around 30% (MOHP, 2001). A breakdown is given in the table below.

Financing sources, FY 1998/99

Source	US $ m	%
Ministry of Finance	28.4	23
Ministry of Local Govt	3.9	3
Donors	35.9	29
Employers	23.5	19
Households	32.2	26
Total	***123.9***	***100***

Source: MOHP, 2001

Taking Malawi Government and donor sources together, public funds accounted for 55% of health expenditure in FY 1998/99. Private sources accounted for the remaining 45%, of which more than half came from out-of-pocket expenditures by households.

Government funding for the health sector comes primarily through budgetary allocations from MOFEP to the MOHP, to districts and hospitals and through a subvention to CHAM.

A large number of donors, both bilateral and multilateral, currently support the health sector through a variety of modalities. Obtaining up-to-date information on the nature and level of their support is a problem, and much is not captured through the official development budget. Among the largest contributors are the DFID, NORAD including SIDA, USAID, the Netherlands Government, and the European Community. As seen in the table above external assistance contributed about 29% of total health spending in 1998/99.

The SWAp design process and its outcomes are presented in the next chapter.

The Local Government Act and Decentralisation

The political landscape in Malawi changed with the passing of the Local Government Act (1998). This Act devolves administrative and political authority to the district level, through the creation of District Assemblies. At the present time, there is in every district a District Health Management Team (DHMT) that is responsible for clinical and nursing services, environmental services, and all management, for the district hospital and all other health facilities in the district. The full decentralisation of health services is not yet completed

It is intended in the Local Government Act that district structures will constitute a means of delivery of goods and services, and also provide the democratic structures for poor people to participate in their own development. The channel for people's participation should be through the Village Development Committee and sub committees and community-based organisations, through the Area Development Committees to the District Development Committee, which reports to the District Assembly.

Early analysis of these community-based structures suggests that for them to function as an effective channel for people's participation, much more work is required. For example, in some areas the Village Development Committees may have been formed without the knowledge of the community. A recent study, which examined the potential benefits of decentralisation in enhancing the livelihoods of the rural poor, concluded that effective representation and accountability may not be achieved without a parallel process of community-based activities (led by NGOs) and institutional reform.

At district and national levels there are limited, but interesting examples of participation of civil society in the health sector. Some expanded District Health Management teams include representation from NGOs (CHAM and others) that provide health services within the district. Recently, the Malawi Health Equity Network, conducted an assessment of the Priority Poverty Expenditure in the health sector outlined in the PRSP. This assessment was presented to the Budget and Finance Committee of the National Assembly and represented civil society monitoring and reporting to the Parliamentary Committee. This initiative provides a mechanism to support Parliamentary oversight of the executive arm of Government and its' sector ministries.

So far districts lack the capacity to effectively plan, implement and evaluate services on a sector-wide basis. There has been significant development of the institutional capacity of DHMTs over the last three years, but there is a need to address the continued enhancement of such capacity, particularly in the context of political devolution to District Assemblies.

2.4. Characteristics of Civil Society

Civil society – A Recent Phenomenon
Malawi is a young democracy – so is civil society. Malawi became an independent Republic in 1966, but Dr. Banda transformed it quickly into a one party state and ruled the country for 30 years with an iron fist clamping down on any opposition. A few CSOs were allowed to function – mainly Church organisations, but opposition was effectively stopped. One example is the Christian Services Committee (CSC) that was started in the late 1960s and was the largest and best organised of the religious welfare organisations.

Once the authoritarian rule of the late Dr. H. Banda was democratically destroyed in 1993/94, CSO activities became visible and started mushrooming. There is currently no updated NGO Directory with an overview of number and types of NGOs[2].

Several factors led to the growth of this young sector. Relief NGOs came in to assist the Malawi government with programmes aimed at supporting Mozambican refugees from mid 1980s. These emergency NGOs started transforming into development organisations in response to the widespread drought of 1992/93. With the advent of democracy, several new Malawian NGOs started to address issues of human rights and good governance. In the early 90s, some human rights organisations were established (e.g. CILIC, PAC). The implementation of the structural adjustment programmes motivated also the formation of more CSOs aimed at addressing issues of poverty and marginalisation of rural people in Malawi.

The socio-political, economic, technological and the development challenges facing Malawi in the 1990s meant also that there was more need for CSOs and more donors willing to finance CSO activities. Increasingly, the CSOs were seen as having an important role to play in the development through their contacts with grassroots communities; their potential and experience in delivering essential services, such as health and education and in assisting in the process of democratisation and good governance.

Two Categories of Organisations
There are two important categories of NGOs. International NGOs, those registered outside Malawi and with an operation in the country and local NGOs, those that originate and are registered in the country. Usually, the INGOs are stronger, have more resources and experience. On the other hand, the Malawian local NGOs are weak, resource poor and inexperienced. Issue number three of CABUNGO News (January 2000) summarises NGO categories well: *"NGOs existing in Malawi belong to various categories such as local or international; established or emerging or CBOs; human rights or environmental or developmental etc. Despite the variation, power issues seem to be cross cutting in various NGOs"*.

[2] There is surprising little information and analysis of civil society in Malawi – at both national and district level. No overview exists of the "third sector" in Malawi – meaning a document presenting key organisations according to appropriate categories and analysing their strengths and weaknesses.

CSO Features
Many CSOs are built around personalities with no clear delegation of powers in the organisation. CSOs are also limited by the fact that most of them are in urban areas and more in the South than the North. Urban organisations try to reach rural areas, but lack often the funds, have limited outreach and weak technical and managerial capacities.

It is also echoed that many CSOs are in competition and suspicious of each other. The competition is most often for funding and NGOs are not easy to coordinate because of the desire to dominate in their own area and fear of loosing independence. They most often collaborate before and during elections when donor funds are abundantly available for civic education.

Many CSOs are organised in thematic networks, like the Coalition for Quality Basic Education, the Health Equity Network, Malawi Economic Justice Network and Land Reform Task Force (James 2001). The history of NGO involvement in for instance gender dates back to the early 90s. In 1996, NGOs decided to come up with a Gender Task Force. The NGO Gender Network was established in 1999. Those networks have played important roles, but vary in coverage and quality. The networks have not received any support from CONGOMA.

New groups have also emerged in the NGO sector. Malawian Human Rights groups have sprung up to maintain a watch on the progress of the new democracy and the HIV/AIDS pandemic has drawn the attention of another group of local NGOs.

Increased Tensions Government – Civil Society
The Government passed last year an NGO Law, which CSOs fear will allow the Government to punish or disband those found too critical of Government policies and practices. The Churches and other CSOs have increasingly criticized the Government for its totalitarian and oppressive attitudes and behaviour. Instead of having a dialogue with the organisations, the Government has attacked religious leaders and critical voices in particular from human rights organisations.

It is said that the situation in Malawi points towards a deeper distrust, cynicism and acrimonious feeling between civil society and the state Government. The World Bank and other donors want the participation of civil society in political processes and programmes, but there is reluctance in the Government to follow such a course – at least with the more vocal and critical organisations. Mainly service delivery organisations are accepted and supported.

There are a number of human rights organisations with an understanding of international human rights standards and being relatively effective, but a majority is small and weak - and completely dependent on external funding. There is also declining funds available from donors to CSOs – partly because of the cut in Danish aid.

Donor Dependency
The CSO sector in Malawi depends almost completely on international donor agencies. This is a condition that is taken for granted and is of such dominance that it is barely discussed. It is difficult to identify any completely autonomous Malawian

organisations. In many cases the presence of international donor money either through religious connections or foreign governments has influenced the creation of NGOs in Malawi.

Donors indicate that the Government has a limited absorptive capacity and that there are substantial amounts of unspent funds at the end of each year. Donors therefore need NGOs as conduits of aid. Some of the donors supporting NGOs include DFID, EU, USAID, OXFAM, Danish Church Aid, DANIDA, CIDA and CORDAID. The World Bank has an NGO desk officer and there is an increasing tendency to collaborate with NGOs and financially support their work in Malawi.

Whilst NGOs in Malawi have significant potential to promote material and social development, *"many are fragile, lacking vision, capacity and credibility"* (OXFAM 1996:24) and USAID state that "*unless we invest in the capacity-building of NGOs we are not going to have any or any strong NGOs in Malawi"* (James and Ndalama 1996).

Capacity Building Needs
As a relatively recent phenomenon, CSOs in Malawi show the full spectrum of capacity building needs. The 1995 SHARED Project consultancy report into NGO Training Needs identified no less than 39 areas of need such as strengthening leadership, strategy, values, staffing and internal management systems. This has led many donors to prioritise capacity-building programmes for their partners.

New Developments
Major bilateral donors such as DfID, EU, DANIDA, CIDA, GTZ, NORAD and others are investing large amounts of financial resources for development with the strong involvement of civil society organisations. DfID alone has quadrupled its aid to Malawi over the last three years and is currently opening two new funding windows for NGOs and civil society groups as outlined in its three-year country assistance plan 2003-2005.

There is also a conducive environment created by the Malawi government for the proliferation of service delivery oriented NGOs and CBOs. NGOs are recognised by the Malawi government as partners in development. Since 1993, the government has increasingly been collaborating with NGOs particularly in the implementation of the Malawi Government's poverty alleviation policies and programmes.

Status of CONGOMA
CONGOMA is an umbrella organisation for NGOs in Malawi with more than 200 members comprising both indigenous and international NGOs. NGOs in Malawi are not a homogenous group with similar interests or needs. There are large NGOs and small NGOs, strong and weak, general and sector specific, religious and secular organisations - all being members of CONGOMA.

The organisation was originally a parastatal working with emergency assistance during the drought in the early 90s. Later, it was agreed that CONGOMA should become an umbrella membership organisation with a different purpose.

A consultative appraisal carried out in 2001 found that:

- NGOs perceive CONGOMA as an umbrella organisation with weak collaborative linkages with its members, struggling in its service delivery and one that requires considerable strengthening. There is a lack of ownership among the members and a weak perception that CONGOMA is their organisation.
- The NGOs are unsatisfied with the performance of CONGOMA, but see the need for such an organisation and a large majority is willing to offer their support if CONGOMA is revitalised and able to re-establish itself as a credible umbrella organisation.
- NGOs expect CONGOMA to provide leadership and to be effective as a coordinating, collaborating, networking, facilitating and information-sharing agency for all members.
- They expect CONGOMA to play a leading role in advocacy by standing firmly for the interests of its members and the civil society as a whole.
- CONGOMA is perceived by several NGOs to be too close to the Government – not standing up and protecting the interests of civil society. There is also a fear that this trend will be strengthened with the new NGO Law in which it is stated that all NGOs should register with CONGOMA.
- The appraisal revealed also adverse relations within the NGO sector and between NGOs and CONGOMA. There is growing mistrust at different levels between the NGOs, NGOs and CONGOMA, international and indigenous NGOs and NGOs and Government. These problems seem to be a manifestation of inherent misunderstandings and insufficient consultations between the various stakeholders.

The Role of NGO Health Service Providers

A significant proportion of the health services in Malawi are delivered by NGOs. In terms of curative facilities, CHAM units provide 37% of all Malawi health services (CHAM Annual Report, 2000). Primary care and preventive service providers include not only a wide range of organisations who receive external support, such as Banja La Mtsogolo, Africare, Action Aid, Save the Children Fund, Medicine Sans Frontiere and World Vision, but also and increasingly, locally-established NGOs such as networks of support organisations for people living with HIV/ AIDs. They collaborate to differing degrees with national policies and Government district services.

NGO providers are currently not fully integrated in health sector planning and service delivery, and their relationships with Government are not well formulated or formalised.

Involvement at National Level

Many of the NGOs working in the health sector deliver services across multiple districts. Some NGOs participate in MOHP planning committees, especially at a technical level: Banja La Mtsogolo has a seat on the Reproductive Health Co-ordinating Committee and CHAM is represented on several of the sub-committees. But, there is at present no mechanism for the involvement of health NGOs in national-level discussion of health *policy* development, even when they will be immediately involved. There is no co-ordinating mechanism specifically for health-related NGOs and no sense of a coherent voluntary sector.

Involvement in Districts

In a number of districts, NGOs have become increasingly involved in the development by the DHMT of the District Implementation Plan. Evidence of collaboration in service delivery, or resource sharing between MOHP and NGO partners, is less widespread. In some instances, the DHMT has virtually no information about the activities of some NGOs although they make demands on health staff such as health surveillance assistants.

3.0. A NEW ARCHITECTURE OF DEVELOPMENT ASSISTANCE?

We refer to three initiatives which will have a significant impact on the future architecture of development assistance in the health sector: PRSP and HIPC, the SWAp design process and the Global Health Fund.

3.1. Poverty Reduction Strategy Paper (PRSP)

Like other countries in the region, Malawi has recently gone through the process of developing a Poverty Reduction Strategy Paper, which was finalised and officially launched by President Muluzi in April 2002. Although the country had a Poverty Alleviation Program since 1994, this programme did not adopt a holistic approach to poverty reduction, but instead a number of discrete projects such as the Malawi Social Action Fund (MASAF) and the Bakili Muluzi Health Initiative. In addition, it lacked a well-articulated action plan.

The MPRSP was developed through a broad consultative process involving 21 Thematic Working Groups comprising members from Government, Parliament, academia, employers associations, non-governmental organisations, faith-based organisations and donors. Civil society networks such as the Malawi Economic Justice Network provided inputs and response to various drafts. Continued involvement is envisaged, although apparently to date only one seat has been allocated to civil society on the national steering committee on MPRSP monitoring and evaluation.

After the consultations a drafting team was formed, drawing members from the Technical Committee, civil society and private sector and the resulting draft was discussed at a series of stakeholder's workshops.

The primary health strategy of the PRSP is the implementation of an Essential Health Package (EHP). The EHP explicitly rations resources in order to prioritise cost-effective interventions to reduce poverty. It addresses the major causes of morbidity and mortality among the general population and focuses particularly on medical conditions and service gaps that disproportionately affect the rural poor.

HIPC Initiative

An opportunity for upward adjustment of public expenditure allocations to health care has also arisen out of the HIPC (Highly Indebted Poor Countries) initiative. In writing off a large proportion of Malawi's debt, the HIPC initiative offers great scope for Malawi to divert expenditures from debt service to social sector expenditure. The criteria that Malawi has to meet to trigger full debt relief under the HIPC initiative from 2002/3, are to display progress towards reduction of the human resource, drugs and medical equipment constraints. Potentially, it will represent a considerable absolute increase in resources.

3.2. The Health SWAp Design Process

In 1999, as a means to improve the overall management of the health sector, MOHP decided to move away from a project and capital development planning approach to health development towards a Sector-Wide Approach (SWAp). This move was not unique to Malawi or to the health sector. Other countries within Africa were active in the same direction and other sectors in Malawi (e.g. education, agriculture) were and are also developing plans for SWAps, a process coordinated by the Ministry of Finance and Economic Planning (MOFEP), and the National Economic Council (NEC), but the health SWAp was the first.

In 2001, a WHO-supported consultancy took place with the twin objectives of raising awareness among health sector partners on issues involved in SWAp and based on both an assessment of the Malawian context in respect of SWAp and international experience, sought to achieve consensus on the current situation and to determine options for further development of a Malawian SWAp. The subsequent report (the 'Tinorgah' Report) discussed the general definitions and principles of a SWAp, drew some operational implications for the Malawian health sector and offered a set of actions and decisions deemed necessary to start the implementation of a SWAp.

In October, 2001, the MOHP and its development partners issued the Terms of Reference for another consultancy with the overall purpose: *"to recommend to MOHP partners how they could move forward to provide whole sector support, within realistic institutional and financial frameworks"*.

TOR was supplied via a competitive tendering process, the contract being awarded to the Liverpool Associates in Tropical Health. In total, some twenty five resource persons were engaged in the production of the report and all development partners currently based in Malawi supported the work. MOHP counterparts should work with the international consultants, but the collaboration was limited due to the absence of MOHP counterparts. The report recommends an Implementation Plan of three years (2003/6), with an Inception Plan period of six months (Jan-June 2003).

Recognising the Plurality of the Health Sector

The SWAp report recognises the plurality of the health sector in Malawi by promoting effective partnerships with CHAM, NGO and private providers, who can more easily provide essential health services to remote or hard-to-reach populations.

It is stated clearly that civil society organisations have a role to play in promoting accountability and responsiveness of the health sector. CSOs are seen to encompass NGO health providers, health-focussed community-based organisations, patient organisations and wider rights-based organisations and networks, such as women's organisations. CSOs are seen to provide a complementary mechanism by having user views represented in planning and monitoring of health services, and in making links to Parliament.

Involvement of Civil Society in SWAp Design

During the August 2002 mission it was recommended to MOHP and its' partners that a meeting be organised in September to allow for a wider consultation between the SWAp design team and representatives of civil society.

During the September design phase, social development resource persons were part of the design team. These resource persons led the consultations between representatives of the sub-teams and representatives of civil society (CSOs, political and traditional leaders, representing local, district and national levels). The aim of the meeting was to provide an initial forum for civil society to engage with and contribute to the design of the Sector Wide Approach for the health sector.

Further to the formal civil society consultation workshop, the views of health service users and non-users were sought during field visits to Dowa, Mzimba and Mwanza Districts. Focus group discussions, one-to-one meetings and inter-active sessions were held with CSOs and service users at sub-district level.

During 23rd-24th October 2002, a stakeholder workshop was held to present and discuss the draft report of the SWAp design team. Representatives of civil society, including CSOs and political and traditional leaders, attended this workshop. The meeting provided an opportunity for group work discussion and feedback on the draft document.

SWAp Recommendations
The SWAp Report presents several recommendations for more effective Government/CSO partnerships at district and national levels. None of these are yet implemented.

(a) The establishment of an NGO Planning, Support and Liaison office within the MOHP Planning Department. The tasks of this office would include publishing a quarterly bulletin on current health policy issues of concern and interest to health NGOs. The office would act as point of first contact with MOHP for NGOs (including CHAM) on policy and planning issues. It should also foster the involvement of NGOs that work in areas that contribute to the health sector, but which are not considered specifically health-sector NGOs, e.g. NGOs working in citizen rights, governance issues.

(b) The establishment of a health coordinating resource centre, including a library within CONGOMA. To encourage NGOs to participate in planning and policy development and to promote the emergence of a coherent NGO "voice", it is proposed that a health NGO coordinating office should be established under CONGOMA of which all NGOs are, by law, members already. The role of the office would be to provide information and support services to NGOs and to enable meetings for networking, information exchange and development of common policies and plans, especially in relation to planning consultations with MOHP. The office would also house a Resource Centre.

(c) Efforts to increase the financial management capacity of CHAM and other NGO providers. The most significant NGO provider by far is CHAM, through its network of mission hospitals and units managed by a multiplicity of church organisations. The membership fees in 2000 contributed only 37% of the Secretariat's costs, with the remaining 63% being found by external donors (CHAM Annual Report, 2000). The new requirements for reporting under the MOU, the need for support to units in making local agreements with decentralised

Districts will all make substantial further technical and workload demands, which the Secretariat at present would struggle to meet.

It is proposed as part of the SWAp to strengthen the Secretariat by providing funding for four additional technical posts at CHAM Secretariat in information technology and systems development, clinical supervision, cost accounting and planning. Funding for non-staff costs, principally for software development and logistic support will also be required.

(d) A Health Management Information System standardised across all health facilities (including CHAM and other NGO providers).

(e) NGO providers should be encouraged to address some of the gender inequities in current health service provision through targeted services (such as BLM).

(f) Formal signed agreements between an NGO provider and a DHMT, either for service provision or supervision is suggested. Such agreements support and reinforce collaborative relationships, ensure systematic participation of partners in all stages of the planning and management of services. An unresolved issue is how funds should be channeled to NGO providers in the future, such as CHAM, Banja la Mtsogolo (a family planning service provider), MACRO (who provide voluntary counseling and testing) or other such organisations. One view is that the recurrent grant should continue to be channeled through the national secretariats, e.g. through the CHAM Secretariat for distribution to units, even after devolution, since many of the district units do not have the capacity to handle the funds.

(g) The SWAp Plan suggests a system for registration and regulation of NGOs and CSOs at district level – not to replace national systems for regulation, but to complement and strengthen these. The reasons are that Assemblies should be able to question activities of the NGOs and feel enabled to raise questions and discuss such issues as the relationship between their work and the NHP. The District Health Office should be fully informed about the work of NGOs in the district and also able to integrate their contribution with all others.

(h) The SWAp Plan suggests establishing a quarterly meeting as a health policy forum where current MOHP plans and draft policies, health, social and economic trends and NGOs' current concerns are explored. This should enable NGOs to participate in policy development, as well as in more technical service planning where they will be included in the relevant committees/task forces.

(i) The proposed Inception Phase activity (January-June 2003) is to institute annual fora with civil society organisation, health service users and lower-level health committee representation, Group Village Development/Health Committees (GVD/HC) and Health Centre Advisory Committees (HCAC).

(j) An annual national forum of civil society stakeholders will review health service provision to evaluate how much it is responsive to users' needs and how it seeks to reduce the number of non-users. The forum will additionally debate health development issues, where district-level civil society organisations, health service user and provider representatives, the MOHP, parliamentarians and development

partners come together to consider how to maximise civil society involvement in national provision of health service delivery.

(k) A support fund for civil society organisations is proposed to support activities and District-level projects addressing specific issues of improving health equity and access.

(l) Civil Society should be involved in monitoring and evaluating health service delivery. The participatory development of M&E systems, with appropriate analysis of data and feedback/dissemination procedures is suggested to be completed by mid-2004.

(m) It is assumed that external donors – governed by the MOU of the proposed SWAp - will not use Malawi-based NGOs as an alternative channel of influence or funding to avoid engaging with the District authorities, but will both expect and enable the NGOs to collaborate fully with Government and to disclose relevant financial and other information when requested.

3.3. The Global Health Fund

The President launched the National Strategic Framework for HIV/AIDS Prevention and Care in October 1999 and has championed the fight against HIV/AIDS. A National AIDS Commission (NAC) as a multi-sectoral board and Secretariat is established to facilitate coordination of the national response to the fight against the epidemic.

The Global Fund to combat HIV/AIDS (with further additional funds sought for malaria) is estimated to be worth US$19 million in the financial year 2002/2003 alone and potentially considerably more over 5 years (total US$ 196 million).

The Government of Malawi will contribute US$14.5 million over the 5-year implementation period of the Strategic Framework for HIV/AIDS. HIV/AIDS will also benefit directly from HIPC Funds as outlined in the Poverty Reduction Strategy Paper (PRSP). Government funding of the Ministry of Health and the Christian Health Association of Malawi will also contribute towards HIV/AIDS care. The prospects for funding over the next five years is:

- Global Fund 196 mill
- Donors Strategic Framework 77.2 Mill
- Malawi Government NACP 14.8 Mill

The proposal provides an overall plan highlighting the need for involving civil society. The plan does not consist of specific projects – in the sense that NGOs have submitted applications, which are approved and included in the plan. The application presented a frame and NAC starts now the process of inviting CSOs to apply for support for specific projects. It is not yet worked out clear guidelines for how CSOs can get access funds from NAC.

The first application to the Global Health Fund was prepared with a short deadline and was also rejected by the Fund with questions relating to the size of the budget and

in-country absorptive capacity. A relatively small technical team developed the proposal after consultations with a selection of CSOs (for membership see box next page).

The funds will impact significantly on the financial landscape of the health sector in Malawi, but it is too early to assess how and how much. Most of the funding can be said to lie within the definition of the Essential Health Package (EHP), but it will imply a widening of the "package" in light of the addition of ARVs to the WHO Essential Drugs List. It will also raise important matters about disbursement mechanisms, financial monitoring, synergy between the initiatives, as well as matters of absorptive capacity, capacity building and long term sustainability both within the public sector and among the non-governmental organizations.

Number and composition of members of MGFCC:

Public Sector members	
Academic/Educational Sector	3
Government Sector	5
Sub-total	8
Private Sector	
Industry	1
Subtotal	1
Civil Society	
People living with HIV/TB	1
NGOs	1
Community Based Organisations	1
Religious/Faith Groups	1
CHAM	1
Traditional Leadership	1
Sub-total	6
International Organisations	
Bilateral agencies	1
Multilateral agencies	1
UNAIDS	1
Sub-total	3
TOTAL	**18**

The proposal addresses HIV/AIDS prevention, care and support through six components:

- Voluntary Counselling and Testing 11.6 Mill
- Prevention of Mother to Child Transmission 4.3 Mill
- Community Based Home Based Care and Treatment 21.4 Mill
- Management of Opportunistic Infections and Anti Retroviral Drugs 124.6 Mill
- Systems Strengthening and Cross Cutting Issues 22.4
- Management and Institutional Support 11.8 Mill

There is a concern among CSOs that almost half of the resources from the Global Fund will be used for ARVs – and not prevention, and that few resources will eventually be made available for CSOs because of unclear funding mechanisms and no earmarking of funds for CSOs. If the Global Fund follows its strict principles of results-based disbursement, there is also a risk that disbursements will be delayed or stopped before all funds are disbursed.

The SWAp report raises a number of questions regarding the GFATM funding relating to the linkage or lack of linkage between the SWAp and HIV/AIDS:

- How such funds, if and when received, will be channelled to the sector?
- Whether they will be additional to existing flows (as required by GFATM)?
- The extent to which they will support EHP services and systems development?

- How they can/will be incorporated into budgets and financial management systems?

In addition, a malaria proposal is about to be finalised, also for submission to GFATM. The requested funding of US$40m over five years would represent a substantial addition to the sectoral resource envelope, largely for activities within the EHP. Again, similar questions arise regarding the channelling of funding.

From the side of the National AIDS Commission there are so far no formal impediment to include the approved funding from the GFATM within the joint Programme of Work; but, whether or not the funds of the GFATM will be channelled like other external contributions is still to be decided upon.

The catastrophic HIV/AIDS problem asks for an effective immediate solution. HIV/AIDS programme staff use often this argument for creating more efficient parallel structures than the Government's. There is, however, a genuine concern that not including the GFATM into a SWAp would undermine the SWAp development process.

4. ASSESSMENT OF CSO ROLES

This chapter seeks to answer more directly and in summary form the questions posed by the study through a discussion of the suggested hypotheses from the Inception Report. The chapter does not stand-alone and builds on the presentation and analysis in the previous two chapters about the country context and the various new programmes and initiatives in the health sector.

4.1. Level of Involvement

What is the level of involvement of CSOs in the formulation and implementation of the sector programme for health in Malawi?

- *There has been an increasing involvement of CSOs in SWAps, but originally the involvement was marginal and CSOs contributions were not recognised as important.*

CSOs are given a prominent place in the new health SWAp in Malawi. This is the first sector programme in the country, so there is no other sector or programmes to compare with in order to assess an increase in involvement. CSOs and in particular the churches have played and play an important role in provision of health services in rural areas. The current health plan can therefore not be implemented without the involvement of CSOs. This is also recognised and expressed in the SWAp report. The Malawi Health Sector Network of NGOs is also seen as an avenue for inputs into policy, advocacy and health sector programme issues.

The SWAp joint review process highlighted and took as a point of departure the plurality of health sector partners in Malawi and encouraged the strengthening of collaboration between the Government, private sector and civil society. The design team was also asked to approach CSOs as both health service providers and as monitors of implementation and results. In brief, the policy intentions of involving CSOs in the formulation, implementation and monitoring of the health SWAp were unambiguous and strong.

Several of the donors encouraged the involvement and participation of CSO in the SWAp process. They are also providing institutional support to CSOs including those in the Malawi Health Sector Network.

What was then the level of involvement of CSOs during the design process? As explained previously, donors promoted and encouraged consultants to involve CSOs in the planning process. MOHP was not opposed to CSO involvement, but not entirely supportive either - explained partly by the lack of experience dealing with NGOs and organisations in the civil society. Ministry representatives were of the opinion that participation of CSOs during preparations and formulations had been low and insignificant.

Various stakeholders point out that limited and discontinued high level CSO representation at SWAp meetings became a major concern and challenged CSO participation and contribution to the design process. There was a lack of commitment from CSOs to the process, uncertainty about what CSOs could gain from participation. The complexity of the issues was also a constraining factor coupled

with limited capacities and capabilities of NGOs for advocacy and policy influence at the high strategic levels.

- *The new generation SWAps have moved towards a redefinition of the state – providing a framework for enabling interventions by a variety of actors.*

Confirmed. The Government's regulatory and enabling functions are emphasised in the plan – including the need for a plurality of participants from private sectors and civil society for the implementation of the SWAp. On the other hand, the MOHP has problems moving out of its paradigm of control to a paradigm of partnership, directing and regulating service provision rather than providing services.

The new "architecture of development assistance" in Malawi provides budget support for PRSP implementation, sector support to health and increased funding to HIV/AIDS from the Global Health Fund and World Bank (MAP). Substantial increase in funding is envisaged, funding largely through Government budget, but also through a broad range of public-private partnerships.

- *Interactions between Government and CSOs is still limited and strained by mutual scepticism and reluctance.*

Mostly confirmed. Despite clear policy statements on CSO involvement in the programme design, collaboration and involvement during the design process was limited and focused around certain consultative events. The relationships between the public sector and civil society is still characterised by "mutual wariness". There is considerable cynicism among CSOs about government practices and in Government about CSOs legitimacy. The organisations fear loosing their autonomy and the Government its authority.

It is important to make a differentiation between CSOs. The cooperation and communication between the Government and the group of larger health service NGOs (e.g. CHAM, MACRO, BLM) are generally good while MOHD have much less contact and cooperation with the group of smaller NGOs and is sceptical about the vocal advocacy organisations. The implementation of the NGO bill is beginning to cause concern since demands for re-registration with the NGO Board are being made. Recently in a New Article the Board Chairperson warned NGOs that if they have not yet registered they would risk losing their NGO status. The government has also removed certain tax benefits from NGOs for goods and services. These are trends causing more strained relations between NGOs and government in Malawi.

- *Policies of stronger public/private partnerships are still more aspirational than providing clear and realistic guidelines.*

Partly confirmed. Intentions in the SWAp are serious and recommendations far reaching, but still aspirational. There are several ideas and proposals in the report, which have not been discussed in MOHP and with the CSOs. They may not be translated into realities. MOHP representatives were for instance not aware of the proposed NGO desk to be established in the Ministry, nor was CONGOMA of their role as a resource centre for NGOs in health.

A simple problem is that few people have read the SWAp report. It is a long document (250 pages) and has not been widely circulated. None of the organisations we met with had read the entire report. Some had seen the shorter version. The SWAp report is an interesting analytical document providing a broad overview of the health sector, but it is not an operational plan with clear guidelines for improved public/private partnerships. The operational plan is supposed to be worked out over the next six months.

The absence of deliberate efforts to engage in a dialogue between NGOs and government makes it difficult for partnerships or collaborative efforts to go beyond aspirations.

4.2. What CSOs were Involved?

What CSOs were asked to take part in the design process and why?

- *Participation is first and foremost based on invitation from Government.*

Confirmed. The Government invited a range of health service NGOs to the CSO consultative workshop. CONGOMA as the NGO umbrella in Malawi was not invited. CHAM tried an initiative and offered counterparts to the international consultants, but they were not used. As a matter of fact, the counterpart system did not function well and the international consultants worked to a large extent on their own.

- *Controversial advocacy organisations tend not to be invited by the Government to discuss SWAps.*

Mostly confirmed. Rights-based advocacy organisations were not invited to discussions and consultative meetings also because they were not considered as relevant for the discussion of a health SWAp. The Health Equity Network was, however, invited because of the members medical knowledge and proven achievements – an example where advocacy combined with professional knowledge and experience – supports the legitimacy and impact of such a group.

CHAM (or rather Bishops in the churches) and other health service NGOs do at times speak out on certain issues (mostly operational) and are listened to because of their position in the health sector and the specificity of their comments while purely advocacy organisations are perceived as "shouting from the sideline".

- *The basis on which involvement from CSOs take place is unclear.*

Not confirmed. It was clear what CSOs the Government wanted to invite for discussions – the major health NGOs. Whether this was sufficient and the right choice is another question.

- *Mostly national CSOs are involved in SWAps.*

Not confirmed. National as well as international CSOs have been involved and the international NGOs are significantly stronger than national organisations.

4.3. Roles CSOs Played

What roles have CSOs played and how have they played those roles?

(a) As contributors to policy discussion and formulation:

- *The involvement of CSOs as contributors to policy discussion is on the increase, especially at national level.*

Confirmed. It is clear that CSOs and more CSOs contribute to policy discussions today than only a few years ago even if numbers are missing to prove the trend. There is a favourable climate for involving CSOs, but not all of them. The larger health service organisations are preferred. The scope of involvement and the quality of contribution from CSOs have on the other hand been quite limited. The involvement is also skewed towards larger national CSOs while smaller organisations – particularly from the north of the country are left out. Donor interests usually determine the level and extent to which NGOs get involved. For example, DFID recently conducted nation-wide consultations with CSO on its Country Assistance Plan for the next three years. It is difficult to know if these consultations will include the implementation and monitoring phases of the DFID programmes.

- *Sectoral policy documents make limited reference to the involvement of civil society.*

Not confirmed. The SWAp document makes many and extensive references to CSO involvement and the same is true for the proposal to the Global Health Fund on HIV/AIDS and the PRSP document. Other examples of NGO involvement in policy documents are the Vision 2020, the Land Reform Policy, National HIV/AIDS strategy and the Forestry Policy.

- *Policy formulation is still extremely centralised.*

Mostly confirmed. The SWAp design process was heavily dominated and driven by a group of external consultants (and donors) in collaboration with a relatively weak MOHP. Consultations took place at all levels – also at the district level, but the process was centralised as most policy processes are. The criticism is that the SWAp process is donor driven and has limited Malawian ownership.

- *Consultations have tended to be strongest at the development stage of a SWAp and fade away once the programme gets underway.*

This is too early to assess since implementation has not yet started. It is said to be true for PRSP and the same development is expected to be found for the SWAp. CSOs were actually more involved in the formulation and discussion of the PRSP for Malawi than the health SWAp, but their involvement is said to have gradually faded out when discussions and preparations were finished.

- *CSOs lack the capacity and skill to take part in policy discussions.*

Partly confirmed, but there are large differences between the organisations. The large and well resources international NGOs have staff with relevant expertise. Few of the

local CSOs have personnel to take fully part in a complex SWAp design process. They lack sufficient experience and competence in addressing broad strategic sectoral issues and there is also a lack of clarity about how to engage with the Government. There is an opportunity to develop collective capacity of CSOs in Malawi on issues and processes of advocacy and policy influence and this is a potential area for future investment.

The organisations were also often not represented by senior management - which was indicative of their ambivalence towards the process. CHAM's and others capacity are in general limited even if they have practical experience and technical knowledge relevant for the substance of SWAp and the discussion of HIV/AIDS. CHAM is supposed to be strengthened as part of the SWAp. Norwegian Church Aid with support from the Norwegian Embassy is also working with CHAM to strengthen its capacity.

- *There is limited capacity in Governments to interface with CSOs and the private sector.*

Confirmed. There is limited knowledge in the MOHP about the range of organisations in civil society – except for the larger health NGOs and a lack of recognition of CSO/private sector contribution to for instance sexual and reproductive health. There are also few forums and mechanisms for systematic collaboration and consultations between CSOs and the Ministry. It has for instance taken a long time to prepare a MoU between MOHP and CHAM. Such a document has only recently been signed (December 2002) after 3 years even if Government funding of CHAM health staff has been in place for several years. A similar MoU is planned between BLM and MOHP. It is also suggested in the SWAp report to establish a NGO liaison office in the Ministry.

(b) As advocates and lobbyists:

- *Governments are uncomfortable with CSOs in their roles as advocates and watchdogs and reluctant to accept the legitimacy of an oppositional "voice".*

Mostly confirmed. As most public institutions, MOHP are uncomfortable with vocal advocacy organisations. On the other hand, there are examples where NGOs have served as watchdogs and pointed to weaknesses in the Government health delivery systems without being punished (e.g. the Health Equity Network documented the lack of drugs in health centres and hospitals in the country). The acceptability of an external "voice" is often a question about how the advocacy work is being done and what issues are addressed.

CSOs addressing technical and operational issues in a diplomatic way experience few problems, while CSOs expressing clear opinions about sensitive political issues come in another category. The current political climate is not conducive for political opposition. Several CSOs find the Government increasingly repressive. The presidential third term bill may increase the level of tensions between government and CSOs and this will potentially affect how CSOs relate with government.

- *Civil society is fragmented with competing networks and umbrella organisations.*

Mostly confirmed. Civil society in Malawi is young, weak and fragmented. There are some coordinating structures in place. CONGOMA is a national umbrella organisation for all NGOs (all organisations have to register according to the NGO Act), but it is weak and does not function as intended. There are some promising examples of CSO networks – coalitions of CSOs organising themselves around a specific issue (agriculture, health, education, etc.), but they are dependent on a few individuals and so far extremely vulnerable.

It is interesting that selected CSOs were prepared for and involved in the PRSP process, but neither CONGOMA nor any of the networks were actively involved in the formulation of the SWAp or the HIV/AIDS proposal to the Global Health Fund even if individual CSOs were involved to a varying extent. CONGOMA is not widely accepted as an overall umbrella organisation and other coordinating bodies have conflicting mandates to that of CONGOMA making it difficult for NGOs to speak with one voice. In the new NGO Law all NGOs must register with CONGOMA and NGOs will do this by legal mandate and not desire or choice. This makes a strong case for support to strengthen CONGOMA to be an effective organisation capable of building and supporting a strong and vibrant NGO sector in Malawi.

- *There is a weak articulation of cross cutting issues like HIV/AIDS in the SWAp.*

Not confirmed. HIV/AIDS as a crosscutting issue is addressed in the SWAp, but on the other hand the concept of SWAp is weakly articulated in the HIV/AIDS proposal to the Global Health Fund. The two processes of SWAp and HIV/AIDS (Global Health Fund) have run in parallel even if they are closely interlinked. The implications are so far unclear, but the substantial additional funds to HIV/AIDS (from the Global Health Fund, World Bank/MAP and bilateral donors) may distort agreed national priorities in the SWAp (the cost of and composition of the Essential Health Package). On the other hand the external resources may end up filling significant gaps in the funding of the current SWAp. Evidence also indicates that substantial increase in funding followed by high expectations about rapid results will lead to reinforcement of vertical programming.

- *The gender perspective is weakly articulated.*

Partly confirmed. The gender perspective is reflected in the documents as a cross cutting issue while the processes as such have been male dominated (consultants, attendance in meetings, etc.). The whole area of "rights-based programming" is new in Malawi. Mainstreaming of cross cutting issues is a challenge in CSOs in Malawi as most of them tend to be sector or issue specific with weak programmatic linkages to others.

(c) As service deliverers (operators):

- *CSOs are mainly being invited and involved in SWAps as service providers – sub contracted by national or district authorities.*

Mostly confirmed. A key word in the SWAp plan is service agreements – meaning that CSOs will be sub contracted to implement selected activities. On the other hand, monitoring of implementation by CSOs is also mentioned explicitly in the plan, but the service delivery role is expected to be much more prominent than the watchdog function.

Private sector organisations are heavily involved in for instance social marketing of condoms, in treating the majority of STIs and play an emerging significance in the provision of ARVs.

There was limited discussion among CSOs about the implications of sub contracting for their identity and independence. Large international NGOs (e.g. PSI) were prepared and eager to channel as much resources as possible from donors and Government, while smaller CSOs with an advocacy mandate expressed some concern about being coopted and silenced by and through large service contracts.

- *Service delivery and rights based CSOs are perceived as antipodes while the relationships between service delivery and rights based programming remain unclear and underdefined.*

Partly confirmed. The Government makes a clear distinction between service oriented NGOs and advocacy organisations while several of the organisations seek to maintain a balance between the two. UNICEF and several of the larger CSOs have adopted the principles of rights-based programming, but the concept appeared unclear in CSOs we met (except CARER addressing HIV/AIDS as a rights issue). It seems that organisations supporting a rights based framework still continue with service delivery functions. The needs- and rights based approaches are not perceived as alternatives, but complementary with the argument that poor people need both the legal rights and the services. In an emergency situation a strict separation will often be of only academic interest.

- *CSOs are seen to have comparative advantages in providing services to marginalised and hard to reach groups in ways Government cannot.*

Confirmed. CSOs important roles in particular in rural and marginal areas are clearly recognised and their active participation is seen as a condition for delivering an Essential Health Package at a national scale. Collectively, NGOs in Malawi contribute substantially to the overall investment into rural development programmes. Their community mobilisation service delivery is widely acknowledged by both government and donors.

- *CSOs involved in service delivery have often higher legitimacy as lobbyists and impact on policy processes than CSOs only doing advocacy.*

Confirmed. This is true for organisations like CHAM, BML, CARE and ActionAid. There are examples where CHAM has advocated for changes – often when the interests of their own health institutions are threatened – and they have been listened too. On the other hand, the advocacy potential of national CSO service providers are unsystematic and under utilised. There are also examples where technical competence can substitute for service delivery experience (Health Equity Network).

(d) As monitors (watchdog) of rights and for particular interests:

- *The Government is not willing to open up for systematic review and impact analysis of SWAps from field based CSOs.*

Too early to discuss. There are examples where CSO monitoring has taken place in the health sector and it is also mentioned in the SWAp report, but it is uncertain to what extent it will happen during implementation. There are examples where CSOs have influenced access to health services, provided advocacy for consumers to access pharmaceuticals, etc.

(e) As innovators introducing new concepts and initiatives:

- *There is little evidence that CSOs contribute to SWAps as innovators – introducing innovative concepts and initiatives.*

We do not have sufficient information to draw any conclusion. CSOs have been at the forefront in the response to HIV/AIDS by supporting communities through awareness raising, targeting vulnerable groups, providing VCT, care and support, etc. and those strengths are emphasised in the SWAp plan and the HIV/AIDS proposal to the Global Fund. On the other hand, we could not find examples where CSOs actively introduced innovative concepts and initiatives in the preparatory processes. They were more reactive than proactive.

(f) As financiers:

- *CSOs play a marginal role as financiers of SWAps.*

Confirmed. CSOs do not fund the SWAp, but they participate in funding the Essential Health Package, which indirectly supports the SWAp.

- *CSOs are part of national sector policy, but funds do not flow through the Government budget.*

Yes and no. CSOs are not an integrated part of national sector policy and funds are not reflected in Government budgets and flow through the Government system. On the other hand, most CSOs seek to complement Government services through their own structures. The Government's funding of CHAM (salaries) is exceptional. Most CSOs do not believe that the Government will fund their activities in the future, that it

will be extremely difficult to access any funds and that funding in any case will be limited – in particular at district level.

Decentralised funding of CSOs with national structures through District Assemblies will create tremendous capacity problems for those organisations (e.g. CHAM). A two-model approach might represent a pragmatic solution – funding national NGOs directly and district-based organisations through the Assemblies while both should be reflected in the district health plans. This issue is not yet resolved.

- *CSOs are increasingly funded directly by the government through contractual arrangements.*

Not confirmed. The CHAM arrangement is not new and unique for CHAM. It is more common that the Government expects to receive funds from CSOs and in particular international organisations. Sub contracting may be increased as part of SWAp or as a result of the rapid increase in funding from the Global Health Fund to HIV/AIDS. The practical modalities of sub contracting are not yet worked out (for the Health Fund and HIV/AIDS) and CSOs have not properly discussed the implications of more funding. However, the National AIDS Commission is already supporting NGOs by giving them grants and support services. This is likely to continue and the size of grants will potentially increase with more funds being available as CSOs increase their capacity to effectively deliver programmes.

4.4. What are the Effects of SWAps

(a) To what extent and how are CSOs funded as part of the SWAp?

- *The funding of CSOs through SWAps is limited.*

This is too early to assess. Significant funding is expected to be channeled through the SWAp and also NAC for HIV/AIDS programmes, but it so far unknown how much and what the opportunities and constraints will be. Local CSOs are worried about the hurdles of accessing funds directly from the Government at both national and district level.

Among CSOs cash strapped districts are expected to be reluctant in releasing funds for their activities. It is not yet clear to what extent funds will be channeled to District Assemblies through the new decentralised system or directly to national CSOs.

- *International CSOs and bilateral donors remain the donors of national CSOs.*

Confirmed. The common pattern of Northern NGOs (e.g. OXFAM, CONCERN, CARE, etc.) funding local partners seems to persist. There is little awareness of what SWAp could mean for the future funding of international NGOs and partners. BLM has for instance been asked to use the Central Medical Stores for procurement as a result of the SWAp process, but BLM has no positive experience so far from this arrangement. It seems that bilateral donors (e.g. DFID, NORAD) will continue to fund international NGOs directly - in particular organisations from their own countries.

- *The Government wants to maintain control and dominate CSOs.*

Mostly confirmed. Governments often want to control and MOHP has not yet gained strength in strategic sectoral leadership.

(b) Have SWAps supported or delayed ongoing decentralisation efforts in the country?

- *Decentralisation have challenged the monopoly of a top-down Ministry approach and opened up for stronger CSO involvement.*

Partly confirmed, but implications of decentralised funding of CSOs are not yet clear and we do not have sufficient information for answering the question. According to the decentralised vision the district and the district health plan are the points of departures, but districts are not yet fully prepared for such a system. It seems that national CSOs would not benefit from a decentralised funding system.

There is growing evidence that despite the devolution of funds to the District Health Offices, relatively little is subsequently channelled to lower levels of the health system. Civil society monitoring processes have for instance identified critical shortages of drugs at health centre level.

- *If district- and community based CSOs are involved in SWAps, it is the role as service providers.*

Too early to discuss, but most likely true. There exists a poor orientation of health workers to increased civil society participation in DHMTs. CSOs in the health field are not systematically identified and the collaboration with NGOs in the context of district health priorities and community participation in the planning and monitoring of health services, is not systematic.

(c) Have Norwegian/international organisations been involved and how are they affected?

- *Few Norwegian CSOs are involved in SWAps.*

Confirmed for Malawi with Norwegian Church Aid as an exception. NCA's role is interesting as a supporter of CHAM and churches in the area of HIV/AIDS. The programme objectives for the CHAM project are: (a) financing of CHAM's core budget, (b) improving capacity at six training schools, (c) strengthening structures for supervision and referral, (d) development and funding of PHC activities, (e) advocacy, and (f) facilitating international networking. The HIV/AIDS project aims at developing common approaches to prevention, care and support through a church consultation, improve and increase the scope of the churches IEC activities, strengthened clinic based services and capacity building among church partners.

- *International NGOs are still the dominant technical and financial supporters of national CSOs.*

Confirmed. It seems that the major bilateral donors (e.g. USAID, DFID, GTZ) will continue to fund international and national CSOs on a bilateral basis.

- *There is no forum and few mechanism through which Norwegian CSOs can take part in SWAps.*

Confirmed. There is no formal and institutionalized mechanism for discussing their involvement in SWAp, but several informal opportunities and discussions take place.

- *There has been a tendency in NORAD to view Norwegian NGOs mainly as service providers in relation to SWAps.*

Not confirmed for Malawi and NCA. NORAD and the Norwegian Embassy are sub-contracting NCA (funded as part of the country frame), but NCA is supposed to play different roles – more relating to capacity building and facilitation and the organisation should not be operational.

4.5. Potential for Stronger CSO Involvement in SWAp

The study assessed also the "potential, promising and realistic approaches for the strengthening of participation of civil society at local and national levels in sector programmes" - including an identification of preconditions for stronger involvement.

We will discuss this set of issues at various levels: the political level with reference to preconditions and then the institutional and programmatic levels.

The SWAp recognises the plurality of the health sector in Malawi and promotes effective partnerships between public and private providers – both for- and not for profit providers. Such partnerships, however, require a certain level of trust and communication between all the partners involved. Confrontation and conflicts do not promote foster partnership.

The report presents a complex picture of the relationships between civil society and Government in Malawi. On the one hand, there is a thriving civil society with active and strong support from Government and donors. On the other, there are increased tensions between civil society and Government – not with the service oriented NGOs, but with those organisations criticising the Government for its totalitarian and oppressive attitudes and behaviour.

A stronger participation of CSOs in sector programmes does not require a harmonious relationship between Government and civil society, but mutual recognition and a minimum level of trust are necessary – in other words an acceptance of each other's legitimate roles in society. The difficult question is to what extent the situation in Malawi will move towards a deeper distrust and conflict between civil society and Government or towards more open and positive working relationships.

We are not in a position to forecast the short- and long-term political developments impacting on Government - civil society relationships. Perceptions and opinions are also mixed and conflicting among donors, CSOs and in the Government itself. If the conflict-scenario surface we may observe a widening gap between a few large national and international NGOs delivering effective health services as part of contractual arrangements with the Governments on the one hand and advocacy organisations funded by international donors on the other. If the CSO-Government climate becomes conducive, substantial resources will most likely be available for local organisations. The critical question then is to what extent the organisations have the capacity to utilise such opportunities and how increased public funding will affect the profile and performance of the organisations – in other words whether they will be able to maintain their NGO identity and play a role watchdog vis-á-vis the Government.

At this stage there is a need for CSOs to discuss to what extent they should seek as much involvement as possible in the implementation of the health programme – or in other words get access to as much resources as possible from the Government funded health SWAp, the Global Fund, etc. or if they should rather focus their resources and attention on small targeted interventions with innovative features and take a more active role in monitoring and evaluating the implementation and effects of programmes.

It seems clear that most CSOs currently do not have the capacity to manage large amounts of funds and will not function well as sub-contractors for the Government. In the long run, extensive sub-contracting may also distort their character as independent CSOs. One solution is to make a differentiation between CSOs where only some of them become involved in implementation of a Government funded health programme. Both the health SWAp and the Global Health Fund seem over ambitious on behalf of civil society – too much is expected from too few and too weak organisations, which may in the long run represent a disfavour to civil society. If the CSOs are not able to deliver – meet all the expectations and fill gaps in Government systems, the opportunities for stronger CSO involvement will eventually weaken and not strengthen civil society.

At the institutional and programmatic levels there are several ideas and suggestions in the SWAp design report and from CSOs themselves, which could help bridge the gap between CSOs and Government and provide the basis for a stronger involvement of CSOs in the health SWAp.

Some of the most effective strategies for building trust and collaboration are to create more opportunities for CSO and Government representatives to meet and work together around common concerns and initiatives – not so much in workshops and seminars, but around specific issues and needs which require a solution. We will in particular mention the following:

(a) The establishment of an NGO Planning, Support and Liaison Office in MOHP. Such an office will create more capacity in the Ministry to collaborate with the organisations (a quarterly bulletin, regular meetings, common initiatives, etc.). The position as NGO liaison officer needs to be filled by a

person with relevant experience, but equally important – with trust and support from CSOs.

(b) CSOs should be represented in the relevant national committees and fora.

(c) CONGOMA should be strengthened as a coordinating organisation for CSOs in Malawi – playing roles in capacity building, being a resource centre, supporting thematic networks, etc. In brief, CONGOMA should become what it was meant to be. Most CSOs in Malawi are small and weak and need to work together – in particular when it comes to involvement in sector programmes. CSOs need a platform or basis for coordination and collaboration with SWAps, which could and should be provided by CONGOMA.

(d) CONGOMA should try to build stronger links with existing thematic networks, e.g. the Health Equity Network. Those networks have the technical knowledge, which CSOs need in order to become a real partner in planning, implementation and monitoring of SWAps. If the current plans to strengthen CONGOMA does not succeed, the thematic networks could take on more of the formal coordination and collaboration between CSOs and the health SWAp.

(e) The thematic networks are well placed and have also the technical knowledge to play an active role in monitoring the implementation of SWAps – in our case the health programme.

(f) There is a need to strengthen the technical and administrative capacity of CSOs – and develop new strategies for such capacity building. Most CSOs in Malawi are as mentioned young and weak and need to be strengthened in most areas – and considerable efforts and resources have recently been invested in capacity development by international donors and NGOs – with less knowledge about results and what approaches have been effective. The role of Norwegian Church Aid with supports from NORAD – and in particular its active collaboration with CHAM and local churches are interesting and promising and the experience and lessons learned should be closely monitored and documented.

(g) There is an urgent need to establish clear and transparent guidelines and systems for budgeting CSO involvement and procedures for application in Government programmes. A major concern among CSOs in Malawi is the Government's unwillingness to budget for and actually release funds to organisations at local and national levels. The Government may not object as long as CSOs are funded by international partners, but would be reluctant to release Government funds to CSOs as long as Government services are weak and under funded. CSOs are concerned that they are mostly rhetorically involved in SWAps as a result of pressure from donors – and demand clear and transparent budgeting and procedures for applying for funds in the future.

(h) A support fund for civil society organisations should be established at district level addressing issues of health equity and access. We do not have sufficient

knowledge about the dynamics at district level, but are not convinced that all funding to CSOs at district level should be channelled through district assemblies. It might be much more cost effective to fund large CSOs operating in several districts (e.g. CHAM) through national secretariats.

(i) The health SWAp report assumes that external donors in the future will not support Malawi based NGOs directly or through NGOs in their own country. In order to reduce the fragmentation of health sector support and increase transparency of funds channelled through CSOs – more CSO funding could go through designated "CSO windows" in sector programmes, but national CSOs need also opportunities to operate independently from Government and maintain their international partner networks. We do not envisage that CSOs should be funded in the future only through sector programmes.

Annex 1: Mandate

Objectives
The objectives of the country studies are:

(a) To review the roles of civil society organisations in selected sector programmes – in particular in relation to roles played by CSO, analysis of opportunities and constraints, and results achieved.
(b) Provide advise and recommendations to NORAD, Embassies and Norwegian NGO on how to improve the interaction between social sector SWAps and civil society.

The country studies will be used to discuss the relevance and validity of the issues and questions developed in Chapter 4 in this report. The entry point is the interface between national CSOs and sector programmes. Within this context we will also review the roles played and contributions made by Norwegian NGOs.

In countries where NORAD has undertaken a study on Norwegian support to Civil Society, the insights from these studies should be linked to the studies proposed here.

Questions for the Case Studies

1. What are the characteristics of CSOs in the social sector in the respective countries and who are the key players?
2. Who are funding CSOs and what is the role of Norwegian organisations?
3. What are Government policies and practices vis-à-vis civil society?
4. What is the background for and scope of SWAps in the country?

Assessment of CSO Roles
1. What is the level of involvement of CSOs in the formulation and implementation of SWAps in the country?
    - There has been an increasing involvement of CSOs in SWAps, but originally the involvement was marginal and CSOs contributions were not recognised as important.
    - The new generation SWAps have moved towards a redefinition of the state – providing a framework for enabling interventions by a variety of actors.
    - Interactions between Government and CSOs is still limited and strained by mutual scepticism and reluctance.
    - Policies of stronger public/private partnerships are still more aspirational than providing clear and realistic guidelines.

2. What CSOs were asked to take part and why?
    - Participation is first and foremost based on invitation from Government.
    - Controversial advocacy organisations tend not to be invited by the Government to discuss SWAps.
    - The basis on which involvement from CSOs take place is unclear.

3. What roles have CSOs played and how have they played those roles?

(a) As contributors to policy discussion and formulation:
- The involvement of CSOs as contributors to policy discussion is on the increase, especially at national level.
- Sectoral policy documents make limited reference to the involvement of civil society.
- Policy formulation is still extremely centralised.
- Consultations have tended to be strongest at the development stage of a SWAp and fade away once the programme gets underway.
- CSOs lack the capacity and skill to take part in policy discussions.
- There is limited capacity in Governments to interface with the private sector.

(b) As advocates and lobbyists:
- Governments are uncomfortable with CSOs in their roles as advocates and watchdogs and reluctant to accept the legitimacy of an oppositional "voice".
- Civil society is fragmented with competing networks and umbrella organisations.
- There is no common CSO voice and national networks are weak or absent.

(c) As service deliverers (operators):
- CSOs are mainly being invited and involved in SWAps as service providers – sub contracted by national or district authorities.
- Service delivery and rights based CSOs are perceived as antipodes while the relationships between service delivery and rights based programming remain unclear and underdefined.
- CSOs are seen to have comparative advantages in providing services to marginalised and hard to reach groups in ways Government cannot.
- CSOs involved in service delivery have often higher legitimacy as lobbyists and impact on policy processes than CSOs only doing advocacy.

(d) As monitors (watchdog) of rights and for particular interests:
- The Government is not willing to open up for systematic review and impact analysis of SWAps from field based CSOs.
- The Government is not willing to invite to discussions or fund their own critics.

(e) As innovators introducing new concepts and initiatives:
- There is little evidence that CSOs contribute to SWAps as innovators – introducing innovative concepts and initiatives.

(f) As financiers:
- CSOs play a marginal role as financiers of SWAps.
- CSOs are part of national sector policy, but funds do not flow through the Government budget.

- CSOs are increasingly funded directly by the government through contractual arrangements.

Effects of the SWAps

1. To what extent and how are CSOs funded as part of the SWAp?

   - The funding of CSOs through SWAps is limited.
   - International CSOs and bilateral donors remain the donors of national CSOs.
   - Local CSOs meet several barriers in accessing funds from the Government.
   - The Government wants to maintain control and dominate CSOs.
   - Cash strapped districts are reluctant to release funds for CSO activities.

2. Have SWAps supported or delayed ongoing decentralisation efforts in the country?

   - Decentralisation have challenged the monopoly of a top-down Ministry approach and opened up for stronger CSO involvement.
   - CSO involvement has provided support for a multi-sectoral response.
   - Mostly national CSOs are involved in SWAps.
   - If district- and community based CSOs are involved in SWAps, it is the role as service providers.

3. Have Norwegian/international organisations been involved and how are they affected?

- Few Norwegian CSOs are involved in SWAps.
- International NGOs are still the dominant technical and financial supporters of national CSOs.
- There is no forum and few mechanism through which Norwegian CSOs can take part in SWAps.
- There has been a tendency in NORAD to view Norwegian NGOs mainly as service providers in relation to SWAps.

4. What are potential, promising and realistic approaches to strengthening the participation of civil society at local and national level in sector programmes?

- What are the potential roles of formal and informal groups?
- Which groups/organisations have capacity and skills to a more active involvement?
- What are the most relevant area of involvement?

Annex 2: People Met

NAME/S	TITLE OR POSITION	ORGANISATION
Dr Michael O'Carroll	Technical Advisor	MOH
Dr W.O.O. Sangala	Chief Technical Advisor	"
Ted Nandolo	Director	CONGOMA
Sister Nympha Que	Pharmaceutical Supplies Officer	CHAM
Monica Djupvik	Programme Officer	UNAIDS
Joachim Neunfinger	Country Director	GTZ
Dr Juan J.Ortiziruri	Head of Health Section	UNICEF
		CARE
Elise Jansen	HIV/AIDS Team Leader	USAID
William Aldis	WHO Representative	WHO
Robert White	Advocacy coordinator	OXFAM
	Deputy Director	CARER
C. Connor		CARER
Timothy Malaidza	Administrator	Torch Trust for the blind
Janet Stafford	Overseer	
Dr. Adamson Muula	Coordinator	Health Equity Network
Dr Desmond Chavasse		PSI
Katawa Msowoya	Centre Manager	MACRO
Gavelet Mzembe	Senior Counselor	
Samson Hailu	Director	CONCERN
		UNIVERSAL
Gavelet Mzembe		BLM
Linely Vinyo		BLM
Clement w. Mauje		BLM

Annex 3: References

Arild Jacopsen (2001), Report on Mission to Malawi for Norwegian Church Aid".
Bodil Maal et.al. (2001), "Appraisal of Project Proposal on an Integrated Gender and Development Project".
CHAM Annual Report (2000).
DFID (2002), "Malawi. Country Assistance Plan. Abridged Edition."
Gil Enterprise (2001), CONGOMA Consultative Appraisal.
Gilbert Mkamango (2000), Strengthening Malawi's Umbrella Organisation. Funded by World Learning, USAID/SHARED Project.
Government of Malawi
Government of Malawi (1996). "Programme Plan of Operation for Health".
Government of Malawi (2001), "Malawi Poverty Reduction Strategy Paper", Third Draft.
Government of Malawi/UNICEF (1999), "Health Sectoral Review".
GTZ (2002), "Malawi-German Cooperation. Health."
Lornts Finanger et.al. (2001), "Appraisal of Democracy Consolidation Programme, Malawi".
Ministry of Health and Population (2002), "SWAp Design Mission, Final Report (Volume one: Main Report), SWAps: Today, Tomorrow, Together".
Oxfam (2000), "Strategic Change Programme for Malawi 2001-2004".
Rebublic of Malawi, Democracy Consolidation Programme-Phase 2. Focus on Good Governance.
Republic of Malawi (2001), "Malawi Poverty Reduction Strategy Paper".
Republic of Malawi (2001), "NGO Law, Act No. 3 of 2001".
Republic of Malawi, "Decentralisation Process in Malawi. A Technical Cooperation Programme 2001-2004".
Republic of Malawi, "Guidelines for Sector Devolution Plans".
Republic of Malawi, "Review of the Decentralisation Process in Malawi".
Republic of Malawi (1998), "Local Government Act.
Republic of Malawi (2001), "Malawi Intergovernmental Fiscal Transfers Study".
Rich James (2001), "Breaking New Ground, Learning from Experiences of CSO Coalitions in Malawi", INTRAC.
Sammy Modiba (2002), The Socio-Economic and Political State in Malawi, OSISA.
Stein-Erik Kruse (2001), "CONGOMA, The Road Ahead", A Report to CONGOMA and the Norwegian Embassy.
Stein-Erik Kruse (2002), "CSOs and SWAps. The Role of Civil Society Organisations in Sector Wide Approaches", NORAD.
Wiseman Chirwa et.al. (1998), "Civil Society Empowerment for Poverty Reduction in Sub-Saharan Africa", A CODESRIA/UNDP Programme.

NORADs rapportserie

Year	Nr	Title	Type
00	1	NORAD's Good Governance and Anti-Corruption Action Plan 2000-2001	Position
01	1	Coordination of Budget support programmes	Discussion
01	2	Poverty Reduction Strategy Processes in Partner Countries	Position
01	3	Aids handlingsplan	Standpunkt
01	4	Aids Action Plan	Position
02	1	Study on Private sector Development: Summaries	Discussion
02	2	Study on Private sector in Bangladesh	Discussion
02	3	Study on Private sector in Malawi	Discussion
02	4	Study on Private sector in Mosambique	Discussion
02	5	Study on Private sector in Sri Lanka	Discussion
02	6	Study on Private sector in Tanzania	Discussion
02	7	Study on Private sector in Uganda	Discussion
02	8	Study on Private sector in Zambia	Discussion
02	9	Ownership and partnership: Does the new rhetoric solve the incentive problems in aid?	Discussion
02	10	Study of Future Norwegian Support to Civil Society in Mozambique	Discussion
02	11	Report of a study on the civil society in Uganda	Discussion
02	12	Private Sector Development in Albania	Discussion
02	13	Private Sector Development in Bosnia and Herzegovina	Discussion
02	14	Review of Christian Relief Network in development co-operation.	Discussion
02	15	Budsjettstøtte	Standpunkt
02	16	Direct budget support/	Position
02	17	Fattigdom og urbanisering	Standpunkt
02	18	Urbanisation	Position
02	19	Information and Communication Technology (ICT)	Position
03	1	Helse i utviklingssamarbeidet	Standpunkt
03	2	Principles for Delegated Co-operation in NORAD	Position
03	3	Building demand-led and pro-poor financial systems	Position
03	4	Study on Private sector Development in Nicaragua	Discussion
03	5	Study on Private sector Development and Prospects for Norwegian trade and investment interests in Nepal	Discussion
03	6	Study on Private sector Development and Prospects for Norwegian trade and investment interests in Vietnam	Discussion
03	7	Study on Norwegian Support to Civil Society in Uganda	Discussion
03	8	Tanzania: New aid modalities and donor harmonisation	Discussion
04	1	SWAps and Civil Society – The roles of Civil Society Organisations in Sector Programmes – Synthesis Report	Discussion
04	2	SWAps and Civil Society – The roles of Civil Society Organisastions in Sector Programmes – Desk Study	Discussion
04	3	SWAps and Civil Society – The roles of Civil Society Organisastions in Malawi's Health Sector Programme	Discussion
04	4	SWAps and Civil Society – The roles of Civil Society Organisastions in Zambia's Basic Education Sub-Sector Investment Programme (BESSIP)	Discussion
04	5	SWAps and Civil Society – The roles of Civil Society Organisastions in Uganda's Health Sector Programme	Discussion
04	6	SWAps and Civil Society – The roles of Civil Society Organisastions in the Health Sector in Mozambique	Discussion

NORADs rapportserie består av to typer rapporter: *Standpunkt* uttrykker NORADs syn på et tema, mens *Diskusjon* er et faglig innspill, som ikke nødvendigvis uttrykker etatens vedtatte policy.
NORAD's list of publications comprises two categories: *Position* is NORAD's official opinion, while *Discussion* is a forum for debate that not necessarily reflects NORAD's policy.

NORAD
DIREKTORATET FOR UTVIKLINGSSAMARBEID
NORWEGIAN AGENCY FOR DEVELOPMENT COOPERATION

This report can be obtained free of charge on NORAD's website:
www.norad.no

Or by contacting:
NORAD's Information Centre
P.B. 8034 Dep.
N-0030 Oslo
Norway

Tel: +47 22 24 20 60
Fax: +47 22 24 20 66
informasjonssenteret@norad.no

ISBN: 82-7548-193-7
ISSN: 1502-2528