POLICY TRANSFER AND SERVICE DELIVERY TRANSFORMATION IN DEVELOPING COUNTRIES: THE CASE OF MALAWI HEALTH SECTOR REFORMS

A thesis submitted to the University of Manchester for the Degree of Doctor of Philosophy (Public Policy and Management) in the Faculty of Humanities

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MANCHESTER BUSINESS SCHOOL
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<td>AAO</td>
<td>Aid Administration Office</td>
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<td>ACP countries</td>
<td>African, Caribbean and Pacific countries</td>
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<td>AfDB</td>
<td>African Development Bank</td>
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<td>ADC</td>
<td>Assistant District Commissioner</td>
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<td>CABS</td>
<td>Common Approach to Budget Support</td>
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<td>Commonwealth Educational Media Centre for Asia</td>
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<td>Civil Service Reform Action Plan</td>
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<td>Gross Domestic Product</td>
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<td>Gross National Income</td>
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<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit (German Society for Technical Cooperation)</td>
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<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
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¹ The Ministry of Health was previously known as Ministry of Health and Population
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<tr>
<th>Abbreviation</th>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNCDF</td>
<td>United Nations Capital Development Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>UTH</td>
<td>University Teaching Hospital</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WTO</td>
<td>World Trade Organisation</td>
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<td>ZCH:</td>
<td>Zomba Central Hospital</td>
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<td>ZO</td>
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ABSTRACT

The University of Manchester


Policy transfer defies the notion of national boundaries in policy making and development. With globalisation processes in the picture, purely state centric policy making models are not the only option. International and domestic policy entrepreneurs have been pivotal in transfer processes. For developing countries, international donor organisations have been instrumental through conditioning assistance to policy reform. Due to the prevailing hierarchical aid regimes, the assumption is that developing countries would implement these policies for the fear of losing the much-needed aid. However, this study argues that the actual implementation of reforms emanating from the global arena is not an automatic process even in the context of coercive transfers, as it is mediated by country specific contextual frameworks. Moreover, even if implemented, the extent to which the transfers attain the promised transformation ends depends on prevailing environmental factors, appropriateness of the reforms, and the implementers’ in-depth understanding of the reform instruments.

The analysis used the cases of hospital autonomy and district health management decentralisation reforms which are based on the new public management (NPM) paradigm to examine the mechanisms of policy transfer; factors constraining or facilitating the adoption and/or implementation of transferred policies; and the impacts of the policy programmes on service delivery transformation in Malawi. A multilevel framework was used to analyse the dynamics at international, national and application levels. It used a qualitative research strategy. Therefore, data was collected through in-depth interviews, focus group discussions, documents, and observations.

The study finds that due to Malawi’s heavy aid reliance, international donor organisations attempted to introduce the hospital autonomy and district health management decentralisation reforms on its policy agenda through aid conditioning mechanism which has coercive attributes. In the former, USAID as an international institutional entrepreneur was the driving force through its non-project assistance (NPA) aid regime while in the later case it was the European Commission within the institutional framework of the Lome IV Convention. A comparative analysis of the two reforms revealed that a combination of contextual issues of: mode of transfer, policy content and political-economic context, path dependence, parliament-cabinet configuration, bureaucratic politics, pressure from citizens, institutional compatibility and prerequisites, and social economic forces; determined their adoption and subsequent implementation. While hospital autonomy was rejected by cabinet, and not implemented, despite large amounts of donor resources invested in the transfer processes because of these contextual issues, decentralisation was implemented as the environment was favourable, although it met bureaucratic resistance. However, the study found that when implemented, decentralisation faced several contextual challenges including modest levels of application, reproductions, reversals, cultural factors, and unintended consequences so that it has not achieved the intended transformational results. To this end, the findings provide a better understanding of the dynamics of policy transfer in developing countries and work as a springboard for donor organisations to reorient their approach in aiding policy development in developing countries.
DECLARATION

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DEDICATION

For my dear late Mother Patricia, Dad Ignitious and Brother Martin and All - you are the inspiration of my struggle. May your souls rest in perfect peace!
ACKNOWLEDGEMENTS

First and foremost I thank my first supervisor, Dr. Richard Common for his unbeatable and profound advice, encouragement, inspiration, direction, constructive criticisms, insights and untiring support throughout the programme. Thanks should also go to my second supervisor Prof. Colin Talbot for the assistance rendered.

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Special thanks to all my study respondents, their assistants and anybody who offered me help in one way or another, during the study visits. Without their cooperation, assistance, and readiness in providing the needful information, this study would not have materialised.

Some sections of the thesis were presented at the Public Administration Committee (PAC) conference at Glamorgan University, Wales in September 2009; and International Research Society for Public Management (IRSPM) conference at the University of Berne, Switzerland in April 2010, where I received useful comments which also helped me shape the study. To this end, I thank participants at these conferences for the insightful comments.

Special thanks to my beloved wife Fainess, my boy Richard Jr. and girl Blessings, for their endurance when I was a part-time husband and dad, and encouragement that there is light at the end of the struggle. You are such a lovely family, you gave me the encouragement and support I needed and I couldn’t ask for more!! To my brothers: Felix, Luciano, Patrick, Robin, Chikumbutso and Emanuel; sisters: Blessings and Georgina; Uncle Eliot; all the Tambulasi’s, Lundu’s, Ngabus’, and Namaonas’ for their sacrifices, support and kindness.

To Andrew Chimena and wife Ellen, I salute you guys; you made life very easy for me and my family in Manchester. You were there for me whenever I needed help - words alone cannot express my gratitude. Thanks should also go to Mr Guta and family, Mr Vincent and Mrs Tamanda Chiwamba (you are indeed wonderful ‘Momba’ and ‘Mjombaless’), Mr Happy Kayuni (my fellow ‘barefoot soldier’) and family, the Kumpolota family, Matewere family, Gerald Tambula, Davemond Sawasawa, Fr Peter Kamtembe, Peter Nkwanda, Bosco Rusuwa, Simeon Makwinja, Hema Bhagavathi, Salome Ireri and all friends and relatives, too many to mention for all your support and encouragement. To Nixon Khembo (may his soul rest in peace), as promised, I will continue to keep the fire burning and turn the tables!

To God the Almighty for making me what I am!!!
ABOUT THE AUTHOR

The author lectures at the Department of Political and Administrative Studies of the University of Malawi. Richard possesses degrees of Master of Public Administration, Bachelor of Public Administration (Honours), both from the University of Stellenbosch in South Africa, and Bachelor of Arts (Public Administration) from the University of Malawi. As a researcher, Richard has published some articles as follows:

A. Parts of this thesis:
Parts of the thesis were presented at conferences, and have also been submitted for publication as follows

a. Journal Submissions
2. Policy Transfer and Bureaucratic Politics: Insights from Hospital Autonomy Reforms in Malawi, under review by Public Performance & Management Review

b. Refereed Book Chapter
1. ‘Why Can’t you Lead a Horse to the Water and Make it Drink?: Learning Oriented Transfer of Health Decentralisation Reforms and Bureaucratic Interests in Malawi’, in Carroll P. and Common R. (eds.), International Policy Learning and Transfer in Public Administration, Routledge: London (Forthcoming)

c. Conference Presentations
1. ‘Why Can’t you Lead a Horse to the Water and Make it Drink?: Learning Oriented Transfer of Health Decentralisation Reforms and Bureaucratic Interests in Malawi’, paper presented at the 14th International Research Society in Public Management Annual Conference, University of Berne, Switzerland, 6-9 April
2. Policy Transfer, Path Dependence and Veto Points: The Politics of Hospital Autonomy Reforms in Malawi, Paper presented at Public Administration Committee Conference, University of Glamorgan, United Kingdom, 7-9th September

B. Selected Articles in Refereed Journals


Tambulasi, R.I.C, 2010: Reforming the Malawian Public Sector: Retrospectives and Prospectives, Dakar: CODESRIA


CHAPTER ONE: INTRODUCTION

1.1. INTRODUCTION

Policy transfer studies have begun to take centre stage in public policy and management literature (see Dolowitz and Marsh, 1996, 1998, & 2000; Bennett, 1997; Rose, 1991 & 1993; Dolowitz, 2000a, 2000b, 2009a & 2009b; Common, 2001 & 2004a; Stone 2004, 2010; James and Lodge, 2003; Evans, 2004; Stone, 2004; Radaelli, 2000; Pemberton, 2009; Dwyer and Ellison, 2009; Pollitt, 2001). With globalisation and internationalisation processes brought into the equation, these studies have advanced that domestic policy making is no longer a monopoly of national governments as policy ideas are sourced from across space and time (Dolowitz, 2006; Dolowitz and Medearis, 2009; Lynn, 2001; Common, 2001; Stone, 1999). It would appear that while some countries may have adopted such globally formulated policies voluntarily, in aid dependent countries international donor organizations have been pivotal in transferring them (see Minogue, 2004; Bangura and Larbi, 2006; Common, 2001). Because of the prevailing aid dependency regimes, the general assumption is that such countries would implement these policies for the fear of losing the much-needed developmental aid that may come as a condition for implementation (see Hollinger and Knill, 2005). To this end, Dolowitz and Marsh (1996:356) observe that a “political leader in a Third World country has little alternative but to accept the policies imposed by the World Bank or the IMF given that the consequences of refusal are deepening debt and economic and, probably, political crisis”.

However, this study argues that the actual implementation of reforms emanating from the global arena is not an automatic process even in the context of hierarchical aid regimes. This is the case as country specific political, historical, institutional, cultural, bureaucratic and economic contexts matter for the implementation of reforms. The problem, however, is that the definite issues and processes involved in this regard are under-researched as most studies concentrate on voluntary types of transfer in developed countries (see Evans, 2004). It is in this respect that this study seeks to fill this lacuna by investigating the mechanisms of policy transfer and contextual factors that constrain or facilitate the transfer of public policies in Malawi which is a developing country. In addition, the policies transferred have been justified by ‘faith’ and not ‘works’ (Pollitt, 1995) as not many studies have examined their impacts on service delivery transformation especially in developing countries as a whole and
Africa in particular. This project therefore, seeks to bridge this research gap by examining the impacts of health sector reforms transfer on health service delivery transformation in Malawi. Thus with the aid of the cases of health sector reforms in Malawi, the study seeks to examine the full process of policy transfer by analysing policy transfer mechanisms, various factors that shape and determine the processes and the outcomes of such policies.

1.2. THE RATIONALE AND STATEMENT OF THE PROBLEM

Studies have noted that developing countries, particularly in Africa, have taken on board policy prescriptions formulated in developed countries with the insistence of international donor organisations and countries (see Barima and Farhad, 2010; Minogue, 2004; Polidano, 2001; McCourt, 2001; Batley, 2004; Common, 1998). Key to these policy transfers is the adoption of market-based policies in the delivery of public services commonly referred to as the New Public Management (NPM) (see McCourt, 2001; Batley and Larbi, 2004). NPM has gained massive publicity in the past two decades as one of the public policy prescriptions that is set to transform public service delivery (see Ferlie et. al, 1996; Osborne and Gaebler, 1992, Hood, 1991). To this extent, NPM-based policies have been implemented in many countries both at the “central and local levels of the public sector” (Siverbo, 2004) to the extent that they have been said to be “global” (Hughes, 1998), “inevitable” (Osborne and Gaebler, 1992), “public management for all seasons” (Hood, 1991) and a “new form of public management which would be globally applicable and permanent” (Talbot and Johnson, 2007:53).

The problem however, is that these NPM-based policies are transferred to developing countries wholesale without adequately examining if specific institutional, organisational, political, cultural and economic conditions for their effective implementation are available (see Therkildesen, 2001; Bangura and Larbi, 2006; Bale and Dale, 1998). It would seem that as a result, they have not led to meaningful intended transformations in the delivery of public services (Larbi, 2006). In some contexts, while countries have shown initial acceptance to adopt them for the fear of losing the much-needed developmental aid, they have been abandoned as soon as the counterpart funds have been received (White and Morrissey, 1997; Simwaza and Samaratunge, 2010). This seems to fulfil Polidano et al’s, (1998:285) prophesy that public sector reforms in “developing countries will resemble a landscape dotted with
ruined edifices and abandoned skeletal structures”. In addition, as McCourt (2003) observes, such failures have been blamed on the vague notion of lack of political commitment without specifically understanding its ‘antecedents’ (see also McCourt and Bebbington, 2007) and contextualising it into the institutional, political, bureaucratic and cultural frameworks within which reforms are made. These observations also point to Dolowitz and Marsh (2000) framework of ‘policy transfer failure’ characterised by ‘uninformed’, ‘incomplete’ and ‘inappropriate’ transfers. Therefore, while some efficiency gains are being claimed (see Hope, 2002) many commentators have warned of NPM’s inapplicability, inappropriateness and undesirable consequences in developing countries (see McCourt, 2002; Minogue et al, 1998; Schick, 1998; Bale and Dale, 1998; and McCourt and Minogue, 2001; Batley and Larbi, 2004).

Malawi is not an exception. The country adopted many NPM-based policies in the delivery of public services in various ministries and departments with the help of various international donor organisations. In particular, it appears that for the health sector, reform programs were adopted against the background of the World Bank’s (1993a:167) declaration that “countries that show a willingness to undertake reforms of the health system should be strong candidates for increased aid including donor financing of recurrent costs”. Some of the NPM policy prescriptions on the table include contracting out, cost recovery, corporatisation or commercialisation, public–private hospital partnerships, decentralisation, hospital autonomy, contract based performance management initiatives and patient charter (Ministry of Health, 1999a ; 1999b & 2004; Malawi Government, 2002). The aim of these is to transform the delivery of health services in order to attain optimum health service delivery outcomes.

However, a critical analysis of the NPM - based policies in Malawi’s health sector reveals that some policies were adopted in order to receive the much needed donor aid but have not yet been implemented. In this regard, despite policy endorsement by the Government, the intended transformations at service delivery level have not yet been actualised. In cases where these policies have been implemented they seem to have yielded undesirable impacts on public administration and service delivery. In some cases, there have been contextual challenges militating against the transferred policies which have even made their implementation problematic and at times impossible thereby failing to attain the intended

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2 See Chapter Three for a further discussion in relation to developing countries
health targets and outcomes. In particular, these policies have been seen to be constrained by bureaucratic, cultural, economic, institutional, organisational and political factors which have either affected their implementation or hindered the realisation of intended policy outcomes in terms of service delivery transformation.

However, the actual mechanisms that shape the policy transfer processes, the contextual factors constraining or facilitating policy transfer process, and the actual impacts and challenges these policy prescriptions have had in attaining health service delivery transformation in Malawi have not been measured. No study has been conducted to examine the mechanisms of policy transfer in this regard and establish the extent to which these policy prescriptions have transformed health service delivery. This study therefore, seeks to fill this particular empirical and theoretical space. The aim is to interrogate into and understand the dynamics that shape the mechanisms, processes and outcomes of policy transfer in Malawi’s health sector.

It is against this backdrop that the purpose of this study is three-fold. First is to undertake an in-depth analysis of the mechanisms of policy transfer in Malawi’s health sector. Second is to examine the extent to which the transfer and implementation of internationally championed policies are facilitated or constrained by the prevailing country specific contextual frameworks. The third objective is to analyse the role of policy transfer in health service delivery transformation in Malawi. In so doing, it is hoped that this study will provide a greater understanding into the mechanisms and effects of policy transfer which will benefit health service delivery in Malawi. To adequately obtain these aims, this study is guided by the following research questions:

- What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?
- What factors facilitated or constrained the implementation of health sector reforms in Malawi?
- To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?
- What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?
1.3. KEY CONCEPTS

The main concepts that shape this study are policy transfer, new public management, and service delivery transformation. This section discusses these concepts so as to provide the reader with an analytical understanding of the study’s key conceptual issues.

1.3.1. POLICY TRANSFER

The concept of policy transfer defies the notion of national boundaries in policy making and development as it involves the “application of knowledge of a set of policy instruments of one policy domain in another policy domain” (Lodge, 2003:161). Policy transfer can take place between states, within states, and across time. In addition, policy transfer can include the transfer of policies, institutions, programmes, ideologies or justifications, attitudes, ideas, negative lessons, administrative techniques, reform models and concepts (Dolowitz and Marsh, 1996; Goldfinch, 2006). It is in this regard that Evans and Davies (1999) categorised policy transfer as ‘soft’ and ‘hard’. Soft policy transfer includes the transfer of ideas, concepts and attitudes while hard policy transfer connotes the transfer of programmes and implementation.

1.3.1.1. POLICY TRANSFER CONTINUUM

Dolowitz and Marsh (2000) developed a continuum which represents various modes of policy transfer. At one extreme of the continuum is ‘purely voluntary transfer’ or ‘lesson drawing’ while at the other is ‘purely coercive transfer’ or ‘direct imposition’ (see also Dolowitz, 2000b:12) as shown in figure 1 below. As Dolowitz and Marsh (2000:15) observe, there are very few cases where transfer will embody these two extremes as “many instances of policy transfer will lie somewhere in the middle of the continuum” (see also Garrett, 2007:500). Below is a discussion of the various aspects of the continuum.
1.3.1.1.1. Voluntary Policy Transfer/Lesson Drawing

According to Dolowitz and Marsh (2000:14), voluntary policy transfer is based on the idea that “actors choose policy transfer as a rational response to perceived problems”. It is seen as a “rational, action oriented approach to deal with public policy problems” (Evans, 2006:481). Voluntary policy transfer works as an “aspiration to improve an existing situation – in the absence of internal/external pressure” (Dolowitz, 2009a:319). In this realm, it assumes that the state is an “autonomous actor” (Common, 2001:18) as government elites willingly draw lessons by making a comprehensive search and analysis of all the information about policy solutions from abroad to solve problems at home (Moseguer, 2005; Mossberger and Wolman, 2003).

1.3.1.1.2. Bounded Rationality

In their model, Dolowitz and Marsh (2000:14) argue that in most cases, purely voluntary policy transfer based on perfect rationality does not occur as most instances of policy transfer are guided by “bounded rationality”. Bounded rationality is based on the idea that policy makers are involved in “particular cognitive short cuts… [where] rather than scanning all information, governments look at relevant information…that is available or near to hand (in geographical, cultural, or historical terms) to the learner” (Moseguer, 2005:72) [emphasis
original]. This is because actors may not have enough and accurate information, they may be influenced by their perception of a situation rather than the ‘real’ situation itself, there may be time, resource, capacity and institutional limitations, and there may be a need to reduce the risk of adopting an innovation (Goldfinch, 2006; Dolowitz and Marsh, 2000; Moseguer 2005; Mossberger and Wolman, 2003). However, bounded rationality remains voluntary because just like purely voluntary policy transfer, it “entails a purposive search for information with which to resolve a problem” (Moseguer, 2005:73).

1.3.1.1.3. Voluntary but Driven by Perceived Necessity

Voluntary policy transfer that is driven by perceived necessity is presented by Dolowitz and Marsh (2000) as a middle ground between purely coercive and purely voluntary transfer. The necessity being referred to here can be the “desire for international acceptance” (p13) if the policy in question is adopted globally. In this case, the “emergence of an international consensus may also act as a push factor” (Dolowitz and Marsh, 1996: 349) as a country may “adopt a policy in order to avoid falling behind other nations which have already adopted the policy” (Newmark, 2002:156). Other reasons are to do with competitive pressures (Holzinger and Knill, 2005) where potential mobility of Transnational Corporations can force governments to adopt policies capable of attracting business (Dolowitz and Marsh, 1996: 348). The key aspect of this type of transfer is that national governments respond to external pressures without being “‘forced’ to do so” (Holzinger and Knill, 2005: 779).

1.3.1.1.4. Coercive Policy Transfer

Purely coercive policy transfer is ‘direct imposition’ where “one or more political systems or international organisations impose a policy, programme or institutional reform upon another political system” (Dolowitz, 2000b:12; see also Dolowitz and Marsh 2000). It occurs where a government or supranational institution “encourages or even forces a government to adopt a policy” (James and Lodge, 2003:182) “against its will and the will of its people” (Evans, 2006:481; see also Dolowitz and Marsh, 2000: 13). Holisingfer and Knill (2005) prefer to use the term “imposition” while Stone (1999) and Bennett (1999) call it “penetration” as it “entails a compulsion to conform and the use of power” (Stone, 2000:49). Tews (quoted in Holzinger and Knill, 2005:781) presents two characteristics of coercive transfer as follows:
The relations of the political units involved are characterized by structural asymmetry of power.

The new policy has been pushed through against the will of the legitimized politicians in the political unit forced to adopt the policy.

Evans (2004:11) highlights that occurrences of direct coercive transfer were common during the periods of formal imperialism. As Stone (1999:55) echoes, “the era of imperialism of last century resulted in significant coercive transfers of legal codes, parliamentary institutions, currencies and bureaucratic structures in the European colonies of Asia, Africa and Latin America”. Analyst have noted that in present times, instances of direct coercive policy transfer are rare (Newmark, 2002; Evans, 2004) as “many cases of transfer involve both voluntary and coercive elements” (Dolowitz and Marsh, 2000:14). These include instances of conditionality and obligated transfer as shown in figure 1 above and discussed below. However, as the general rule, the “closer to coercion transfer gets the less it is about learning than force and power” (Dolowitz, 2009a:320).

1.3.1.1.5. Conditionality policy transfer

Dolowitz and Marsh (2000) situate conditionality as a mode of transfer that is very close to pure coercion on the policy transfer continuum. In conditionality policy transfer governments are “compelled by influential donor countries, global financial institutions, supranational institutions, international organizations or transnational corporations to introduce policy change in order to secure grants, loans or other forms of inward investment” (Evans, 2006:481). Policy transfer through conditionality remains a coercive activity because “although an exchange process does occur… the recipient country is denied freedom of choice” (Evans, 2004:11) as the “resources are used as an incentive or penalty” (Holzinger and Knill, 2005:780). In this regard, the decisions to adopt the policy is not a product of autonomous choices by governments because the position adopted by international organisations in conditionality is that “no reform, no money” (Peters, 1997:72). Moreover, in some cases donors have also “controlled the agenda of negotiations” (Larmour, 2002:249) so that conditionality is “essentially coercive as countries adopt reforms at the lender’s insistence, that would not otherwise be undertaken” (Killick, quoted in Larmour, 2002: 251).
1.3.1.1.6. Obligated Policy Transfer

Obligated policy transfer refers to situations where “national governments can be forced to adopt programs and policies as part of their obligations as members of international regimes and structures” (Dolowitz and Marsh, 2000:15). Holzinger and Knill (2005:781) prefer to call it “international harmonisation” as it is a “specific outcome of international co-operation”. As can be seen on the Dolowitz and Marsh (2000) continuum in figure 1 above, obligated policy transfer has lesser degrees of coercion than conditionality policy transfer. This is the case as in obligated policy transfer, “member states voluntarily engage in international co-operation…and policies and programmes [come] as part of their obligations as members of international institutions” (Holzinger and Knill, 2005:781).

1.3.1.2. DEGREES OF POLICY TRANSFER

Policy transfer processes involve various degrees of policy adoption mechanisms by the transferee countries. In this regard, policy transfer is “not an all or nothing process” (Dolowitz and Marsh, 2000:13). These degrees of transfer include copying, emulation, synthesis, inspiration, and abortive outcomes (Rose, 1993; Dolowitz and Marsh, 2000; Bulmer and Padgett, 2005). Copying is the “strongest form of transfer” (Bulmer and Padgett, 2005:106) as it involves “direct and complete transfer” (Dolowitz and Marsh, 2000:13). It means borrowing a policy wholesale and enacting it as it is without modifications. Emulation entails the “transfer of the ideas behind the policy or program” (ibid). Synthesis involves either “combining elements of policy from two or more different jurisdictions” (Bulmer and Padgett, 2005:106) or “mixtures of several different policies” (Dolowitz and Marsh, 2000:13). Inspiration takes place where policy in another jurisdiction may inspire a policy change, but where the final outcome does not actually draw upon the original (ibid). Lastly, an ‘abortive’ outcome occurs where a “putative transfer is blocked by veto actors in the borrower jurisdiction” (Bulmer, Dolowitz, Humphreys and Pudgett, 2007:17; see also Bulmer and Pudgett, 2005).

The choice of these degrees of transfer is greatly shaped by the characteristics of the policy instruments, the nature of the problem at hand, past experiences of governments in dealing with the same or similar problems, the subjective preference of the decision makers and the
likely reaction to the choice by affected social groups (Howlett and Ramesh, 1993:13). In addition, a particular form of transfer adopted also depends on whether the transfer processes were initiated through coercive or voluntary means. Mostly, coercive transfer embodies copying and emulation while voluntary transfers are likely to take any of these forms. This is due to the freedom of choice embedded in voluntary policy learning (Evans, 2009), and the potential by the voluntary policy learner to carry out a critical analysis and understanding of the policy instrument and contexts both of which are absent in coercive transfers (see Dolowitz, 2009a; Dolowitz and Medearis, 2009).

1.3.2. THE NEW PUBLIC MANAGEMENT

The new public management (NPM) is one of the management models that has been transferred across the globe (see Common, 2004a & 1998; Stone, 2004; Turner, 2002) to the extent that it is highlighted as “one of the striking trends in public administration” (Hood, 1991:3). NPM is a very slippery and fluid concept to pin down because it has so many components which defy common agreement (see for example Hood, 1991; Osborne and Gaebler, 1992; Pollitt, 1995, Ferlie et al, 1996, McCourt, 2002). Moreover, the study of NPM has “gone off in many directions” (Barzelay, 2001:xii) as it is approached from different disciplinary grounds. At the basic level however, the thrust of NPM is the application of private sector based policies and organizational forms in public policy processes and administration. The argument is that the private sector runs effectively and efficiently due to market driven policies and management practices and therefore in order to make the public sector efficient, the same models for formulating policies and organizational arrangements have to be applied. The rationale is that by introducing these models public organisations will be “efficient, effective and provide value for money” (Turner and Hulme, 1997:106). In this regard, NPM-type policies point to deliberate interventions that ensure increased market orientation, competitive government, injecting competition into service delivery, management decentralisation, managerialism, enterprising government, earning rather than spending and leveraging change through the market (Lane, 1997:5, Christensen and Laegreid, 2002:1). Hood (1991) came up with seven ‘doctrinal components’ of NPM which Hope and Chikulo (2000:26-27) summarise in the following five elements:

- the adoption of private sector management practices in the public sector
- an emphasis on efficiency
• a movement away from input controls, rules, and procedures toward output measurement and performance targets
• a preference for private ownership, contestable provision, and contracting out of public services
• the devolution of management control with improved reporting and monitoring mechanisms

1.3.3. SERVICE DELIVERY TRANSFORMATION

Public sector transformations are generally regarded as fundamental changes in the delivery of public services with the aim of improving them (see Osborne and Brown, 2005). Specifically, transformation in the public sector means “metamorphosis or at least a movement away from the previous condition” (Child and Smith, 1987:577), denoting a process by which the “dominant organizational form in a field is replaced” (Kitchener, 1998:73). Particularly, the transformations have meant the abandonment of the traditional bureaucratic public administration and the adoption of new models of management (Hughes, 2003 & 1998). The reasoning is that these models would provide means for restructuring the public sector for effective and efficient results. In this regard, transformation has involved “sharp and simultaneous shifts in strategy and distribution of organisational power, structure and control mechanisms” (McNulty and Ferlie, 2004:1391). According to Ferlie et al (1996:94), transformation is characterised by the following indicators:
  • The extent of multiple, interrelated change across the system as a whole
  • The creation of new organisational forms at a sector level
  • The development of multi-layered changes which impact below the whole system at unit and individual level
  • The creation of changes in the services provided and the mode of delivery
  • Reconfiguration of power relations (especially the formation of new leadership groups)
  • The development of new culture, ideology, and organisational meaning
1.4. CHOICE OF EMPIRICAL CASE: THE MALAWI MINISTRY OF HEALTH

This study uses an empirical case of Malawi’s Ministry of Health (MOH) with the aim of unearthing in-depth “complex combinations of a variety of factors” (Campos and Esfahani cited in McCourt, 2003:1019) shaping policy transfer processes. The MOH is the largest provider of health services in Malawi accounting for 60% of the health services while the remainder is covered by missions and private sector providers. Appendix 2 shows organisational structure of the MOH. The health sector was chosen for this study because it is often used as a pilot sector for new donor funded reforms or the introduction of new development assistance approaches (Leiderer et. al, 2007) in developing countries. Moreover, as demonstrated in figure 2 below, the MOH in Malawi attracts the greatest number of international donor organisations presenting a potential for policy transfer.

Figure 2 Donor Allocations by Sector

Source: Ministry of Finance (2009:7)
1.5. SCOPE OF REFORMS UNDER STUDY

Dolowitz and Marsh (2000:12) illustrate the importance of having a clear understanding of “what is transferred” in policy transfer analyses. To this end, policies must be distinguished from programmes or reforms. While policies are broader expressions of intent in terms of what government seeks to do, programs are the activities themselves (ibid). Although some reference is made to policies, this study is about the actual programmes that are transferred which, as it will be seen, can be reflected in policy statements. Therefore, although the words ‘policy’ and ‘programmes/reforms’ will be used interchangeably as they are all embedded in the policy transfer framework, it will be visibly made clear what is specifically referred to.

Against this backdrop, to adequately operationalise the project to a manageable level, the study utilises central hospital autonomy and district health management decentralization reforms as units for either comparative or single case analyses. While central hospital autonomy reform seeks to grant managerial freedom to the four big hospitals in Malawi by transforming them into independent agencies, the district health management decentralization seeks to transfer managerial decision making to the district level under district health management teams. The hospital autonomy reform is modelled along the agency form advocated by the NPM paradigm within the decentralization framework. According to Talbot (2004:6) the agency model consists of three central elements which include:

- Structural disaggregation and/or the creation of task specific organizations
- Performance ‘contracting’—some form of performance target setting, monitoring and reporting
- Deregulation (or more properly reregulation) or controls over personnel, finance and other management matters

The model under study comprised of all these elements with one inclusion of cost sharing where users are to pay for services (Hanson et al, 2002). It must be noted that while this reform of creating “free standing health services” is modelled on the United Kingdom’s National Health Services (NHS) (McCourt, 2002:229), the payment component is not present in the NHS model. The user fees are an inclusion by the World Bank (see Batley and Larbi, 2004; World Bank 1993a) so as to ensure financial sustainability of big hospitals in developing countries (Hanson et al, 2002). On the other hand, district health management decentralisation reforms, also within the NPM realm, seek to transfer the management of
health service delivery to the district level. This involves devolving more managerial authority to district health management teams (Larbi, 1998). This differs from hospital autonomy as the district health offices (DHOs) are not autonomous but vertically linked to the MOH. In addition, unlike hospital autonomy, district hospitals are not subject to cost recovery.

The health care system in Malawi is based on referral principles organised in a three-tier institutional framework starting with health centres offering basic primary care, district hospitals offering general secondary care, and central hospitals providing tertiary specialist care. It was the central hospitals that would be made autonomous while the management of district health offices comprising health centres and district hospitals would be devolved to district health management teams headed by district health officers. Thus the MOH headquarters would cease to be a direct provider of services but rather responsible for overall policy making and standard setting functions.

These two reform measures have been chosen for this study because they draw their ideological framework from the NPM paradigm (see Batley and Larbi, 2004; Hope 2002, McCourt, 2002; Larbi, 1998). In addition, they have a transforming potential as they affect the whole system of service delivery (see Minogue, 2004; Ferlie et al, 1996). However, there are some non NPM-type reform components which characterise transformation of service delivery within the context of decentralisation reforms, for instance political decentralisation (see Polidano, 2001). These will only be analysed in the event that they characterise transformation of management practices in the new status quo. This is in cases where together they form a policy package that is intrinsically related in terms of transfer and implementation.

**1.6. OUTLINE OF CHAPTERS**

This study is organised into nine chapters. Chapter One introduces the study. It provides the background contextual issues for this study in terms of the rationale and problem statement, the study’s key concepts, choice of empirical case and scope of reforms. Chapter Two provides an analysis of policy transfer in a global context. It situates policy transfer within the processes of globalisation and reviews various theoretical perspectives of policy transfer. Based on these, the Chapter devises the multilevel policy transfer conceptual framework
which guides the study’s data collection methodologies, analysis and conclusion drawing. Chapter Three examines public policy transfer in developing countries in order to provide a theoretical contextual understanding of the case under study. Chapter Four provides methodology for the study. It highlights the study design, the data collection and analysis, methodological challenges, and ethical considerations. Chapter Five introduces the case of Malawi. It sketches the Malawian political, economic, institutional, historical, policy, cultural and reform contextual issues so as to provide a solid contextual understanding of the country under investigation. Chapter Six provides study findings on institutional and organisational mechanisms that shaped the transfer of health sector reforms in Malawi. This is done through a comparative analysis of hospital autonomy and district health management decentralisation reforms. Chapter Seven presents findings on factors constraining or facilitating the transfer of health sector reforms in Malawi. This is achieved by comparing the national contextual issues affecting the adoption processes of hospital autonomy and district health management decentralisation reforms. Chapter Eight presents research findings on the impacts of policy transfer in service delivery transformation. It does this by analysing the extent to which district health management decentralisation reforms have led to the envisaged transformations in health service delivery. Chapter Nine pulls all the findings together and draws conclusions and implications.

1.7. CONCLUSION

Studying and accounting for policy transfer dynamics present considerable challenges for researchers. This is because of the historical nature of the research, complexity and multidimensionality of the transfer mechanisms and influences of mitigating contextual factors involved. However, it is anticipated that by having understandable objectives and focusing on a clear set of reform prescriptions in a single country context, the multifaceted nature of the processes involved will be revealed.

The next Chapter presents an analysis of policy transfer in the global context. It situates the general occurrence of policy transfer within the globalisation movement, provides a theoretical nexus between policy transfer and policy making processes and reviews theoretical themes characterising studies of policy transfer. Based on these, the Chapter devises the study’s analytical framework that guides the entire study and upon which theoretical and empirical conclusions are drawn.
CHAPTER TWO: POLICY TRANSFER IN A GLOBAL CONTEXT

2.1. INTRODUCTION

Chapter One highlighted that this study has three main aims namely: to investigate into the mechanisms of policy transfer; to examine national contextual factors that facilitate or constrain policy transfer; and to analyse the role of policy transfer in the transformation of health service delivery in Malawi. To attain these objectives, this Chapter undertakes an in-depth review of literature pertinent to the issues under study to help build a theoretical framework for empirical investigation. Firstly, this chapter locates policy transfer within the wider discussion about the impacts and effects of globalisation processes. This is because policy transfer processes are generally linked to those of globalisation (see Dolowitz, 2006; Cerny and Evans, 2004; Stone, 1999; Common, 1998 & 2001). Secondly, through a comprehensive review of literature, this chapter draws up various themes that form theoretical perspectives of policy transfer. Thirdly, the Chapter draws the nexus between policy transfer and policy making processes. Fourthly, based on a critical analysis of perspectives of policy transfer and insights from the globalisation literature, this Chapter devises the ‘multilevel policy transfer analytical framework’ that is used as a theoretical tool for this study, guiding the empirical investigation and conclusion drawing.

2.2. GLOBALISATION

The concept of globalisation has been subjected to intense debates without reaching tangible agreements (see Held and McGrew, 2007; Rosamond, 2003). This is because the term is used in almost all academic disciplines making it “not a narrow phenomenon whose impact can be isolated in one sphere” (Bisley, 2007:18). However, what is generally agreed is that globalisation is happening and is “so entrenched [that] even its many critics have succumbed to the suggestion or claim that the process is inevitable and thus inescapable in its effect” (Veltmeyer, 2004:15). At the core of the globalisation debate is the increase in “worldwide networks of interdependence” (Nye, 2003:112). In this regard, globalisation entails the “widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life” (Held et al, 1999:2). Thus globalisation assumes a “borderless world” (Ohmae, 1993) where events taking place in one part of the world are quickly spread across the globe. The globalisation phenomenon is complex with various dimensions grouped according to the “types of flows and perceptual connections that occur in spatially extensive
networks” (Keohane and Nye, 2000:4). The dimensions range from political, economical, social, to ideational and “one could imagine other dimensions” (ibid: 5). For the purposes of this study, we examine economical, political, and ideational aspects.

The economic perspective is about the “development of an international capitalist trade and financial system” (Studlar, 2006:275; see also Kelly, 1999) that results in international economic integration. This entails the creation of a global capitalist system which Veltmeyer (2004:12) describes as a “new global world” characterised by the removal of national economic barriers, the international spread of trade, and the growing power of the transnational corporations and international financial institutions. It appears that this new economic ‘global world’ is sustained and regulated by specialised international organisations in the names of the World Trade Organisation (WTO), the International Monetary Fund (IMF) and the World Bank (WB). According to Boas and Vevatne (2004:98) the creation of the WTO is seen as a “conscious attempt to establish a strong global regulatory framework in support of increased trade liberalisation”. Likewise, the IMF is heralded as an “ultimate attempt to reconfigure territories in order to make them most attractive to international capital” (Taylor, 2004:124). Similarly, the World Bank is perceived as “directly seeking to influence the economic policy of its customers” (Nustad, 2004:13) and the whole world.

The political dimension of globalisation highlights a restructuring of power relations with the “emergence of new supranational centres of political authority so that citizens are now subject to multiple layers of political authority” (Skogstad, 2000:8). These include (but are not limited to), international organisations, international non-state actors, powerful country blocs and countries that influence nation-states. This has seen the limits of national politics and shifts in the state centred traditional orientations towards “global political economy, global commons, and the role of global institutions” (Kofman and Youngs, 1996:61). The crux in this new political form is the development of ‘multi-level governance’ characterised by “nested governments at several territorial tiers in which supranational, national, regional and local governments are enmeshed in territorial overarching policy networks” (Marks, 1993 cited in Stubbs, 2005:68). More specifically, the political role of the European Union has generally been seen as an example of this new political governance (see Bache and Flinders, 2004; Stubbs, 2005; Bernard, 2002). The ideational approach is more holistic as it looks at globalisation processes in terms of the spread of ideas (Meyer, 2002). As Bisley (2007:61) highlights, globalisation process is “making state boarders increasingly porous to ideas”. In
recent times, at the hub of these ideas has been the “displacement of embedded liberalism by market liberalism, deregulation and privatization” (Skogstad, 2000:8). The transfer of the NPM paradigm is situated in this context where globalisation processes are seen to have speeded up its spread (see Common, 1998 & 2001). This seems to have been facilitated by breakthroughs in information and communication technology processes that have brought time and distance together thereby working as a mechanism for increased spread of ideas. In this respect, while the “flow of ideas across borders and continents has been with us forever, the speed with which ideas can cover vast distances is perhaps the most distinctive aspect of contemporary globalisation” (Bisley, 2007:55).

2.3. GLOBALISATION AND THE STATE

It is argued that globalisation processes have reduced the state’s latitude of activities as a result of increased role of private economic actors (transnational corporations) and international organisations (Skogstad, 2000; Ohmae, 1993). This is because with globalisation, the state is no longer the sole authority in national governance but rather there are other players. Thus the state ceases to be the “Archimedean point upon which everything else turns...[but]...one actor amongst others” (Laïdi, 2002:394). Consequently, the state does not necessarily have to be the sole maker of public policy. In the era of multilevel governance, public policy is seen to emanate from any level whether local, national, international or transnational. This is thought to result into a “leakage of authority” (Jayasuriya, 2001:119) as states “appear increasingly constrained in their ability to make independent policy choices” (Bernstein and Cashore, 2000:67). To some scholars, this has signified the end of the state. For instance, Youngs (1996:115) regards globalisation as the “latest in a long line of assassins...[to cause the]...death of the state”. This is the case as national governments are relegated to being only “transmission belts” (Held, et al, 1999: 3) and “conduits for international bureaucracy” (Bisley, 2007:60) rather than being themselves on the driving seat in national governance.

However, although it is widely accepted that globalisation processes have reduced the scope of governments, the intensity of some of the functions of the state is seen to have been increased (see Cerny and Evans, 2004). The argument here is that globalisation does not weaken the capacity of the nation-state but strengthens it. According to Langhorne (2001:23-24), in the globalised world, the state “remains significant and is even enhanced in respect of
the policies it adopts which create encouragement for global companies to locate part of their operation within its territory”. In particular, globalisation challenges the state to be “competitive” (Cerny and Evans, 2004) an aspect which can increase its power and influence in consolidating its position in the global realm. This also indicates that the survival of globalisation relies on the competitiveness and willingness of the state to provide a conducive environment for the operation of international actors (see Dolowitz, 2006). Seen in this realm therefore, globalisation will “not make states disappear” (Laïdi, 2002:393) because “international governance rests on the ability of individual states to provide and guarantee stability” (Wolf, 2001:190).

2.4. GLOBALISATION AND POLICY TRANSFER

Policy transfer has been facilitated by globalization processes, and vice-versa (see Dolowitz, 2006). In fact some authors are very much overwhelmed by the impacts of globalization processes that they freely declare that “everything is caused by globalisation and at the same time everything is evidence of globalisation” (Ladi, 2005:2) since “all is being transformed by this pervasive force” (Bisley, 2007:9) because “we are more exposed” (Levi-Faur and Vigoda-Gadot, 2006:288). However, this view overstretches issues thereby losing the point of focus. Therefore, to ensure a more focused analysis, this study will be more specific by taking “globalisation to mean the universal application of public policy” (Common, 1998:440). It is generally agreed that the prevalence of policy transfer in the globalised world is facilitated by the presence of various globalisation triggers which include international organisations; information and communication technological advances; the role of epistemic communities, policy networks, policy transfer networks, and policy transfer as a rational choice as discussed below.

2.4.1. INTERNATIONAL ORGANISATIONS AS AGENTS OF TRANSFER PROCESS

International organisations have played a major role in policy transfer processes in the globalised world (see Stone 2000; Kaul, et al. 1999; Walt, et al, 2004). As Khor (2001:12) illustrates, international organisations have “become major makers of an increasingly wide range of policies that were traditionally under the jurisdiction of national governments”. This is because these international entities have a “global mandate and deliberately advertise international innovations worldwide” (Weyland, 2007:19). Thus the increasing number of international organizations has “served as a means of international policy
harmonisation...[since they are]...involved in policy coordination across the globe” (Newmark, 2002:164).

It has been noted that in some instances countries adopt these policies as championed by international organisations in order to “stay compliant with demands of international finance and trade agencies” (Studlar, 2006:275). The strategic aim is to remain competitive (Cerny and Evans, 2004) in the global world. As a result, governments and their policies are “no longer judged by their success or failure internally but by actors operating at the international level who are neither accountable nor loyal to individual states” (Dolowitz, 2006:263). In some cases, international organisations have made deliberate interventions to ensure the use of ‘best practices’ worldwide. For instance, Common (1998:442) observes that the Public Management Studies series which the OECD’s Public Management Committee produces, “clearly intends to facilitate policy learning between member countries”.

For developing countries, international organisations and other donor countries have put certain policies as condition for aid (Larmour, 2002; Killick, 2004) thereby aiding policy transfer (Dolowitz and Marsh, 2000). It is perceived that the aim is to make developing countries better manage their economies and political affairs so as to catch up in the global political economy which is currently characterised by a wide economic and political divide. In this realm, Schuyler (2004:99) observes that the IMF and the World Bank have “pushed many developing nations to replace their country-specific development strategies with a neoliberal formula” thereby demonstrating how “actors, institutions and economic forces that extend beyond state borders can influence domestic public policies and politics” (Bernstein and Cashore, 2000:67).

2.4.2. INFORMATION AND COMMUNICATION TECHNOLOGICAL ADVANCES

The occurrence of policy transfer in the global world is also facilitated by advances in information and communication technology processes (see Wolman and Page, 2002). In this realm, policy transfer is seen as a process “by which agents become aware of information relating to the policy domain of one political system and subsequently transfer this into another policy making system” (Dolowitz, 2009b:7). This information awareness is enhanced by the technological revolution which the world is currently experiencing, making it the specific global force that forges the global transfer of policies. Wolman and Page (2002) advance this stand in their formulation of the ‘information-theory approach’ to policy
transfer. They posit that policy transfer should be conceptualized as occurring through a communication and information framework. To this end, policy transfer is “shaped through processes of international communication” (Bennett, 1997:213) where the “faster communication of ideas leads to a faster rate of closing the knowledge gap” (Stiglitz, 2004:467).

2.4.3. EPISTEMIC COMMUNITIES, POLICY NETWORKS, AND POLICY TRANSFER NETWORKS

Epistemic communities, policy networks and policy transfer networks also play a role in policy transfer processes (see Stone, 2000; Evans and Davies, 1999; Ladi, 2004; Evans and McComb, 2004). An epistemic community is a “network of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy relevant knowledge within that domain or issue-area” (Haas, 1992:3). They are instrumental in giving policy advice as they are producers of policy knowledge which can be transferred. In contrast, policy networks are non-hierarchical and interdependent relationships that link a variety of policy stakeholders who exchange resources to pursue shared policy interests (Borzel, 1998:254). They are institutionalised contacts that exist at national and international levels. The international level policy networks can “clearly be one of the primary mechanisms for the spread of information amongst various actors on a global scale” (Dolowitz and Marsh, 1998:48). Moreover, owing to globalisation processes, the national level networks may also have international membership or affiliation thereby having a multiplier effect on policy transfer processes.

We should be aware that the transfer of policies through epistemic communities and policy networks is not an automatic process because these agents are not primarily created for policy transfer purposes. While policy networks primarily exist as instruments for interest mediation among various policy groups and stakeholders and as governance tools for “mobilising political resources in a situation where these resources are widely dispersed between public and private actors” (Borzel, 1998:255), epistemic communities are generators of knowledge which may or may not be transferred. At best epistemic communities “legitimise the actions of the international organisations” (Common, 2001:71) in transfer processes. However, policy transfer networks are primarily created for policy transfer purposes (see Evans and Davies, 2004) [emphasis mine]. They are “an ad hoc action oriented phenomenon set up with the specific intention of engineering policy change” (Evans and Davies, 1999:376) [emphasis
original]. As such, they “exist only for the time that a transfer is occurring...[and they]...matter because without them other policies might be adopted” (ibid). Unlike policy networks and epistemic communities, the role of policy transfer networks in effecting policy transfer is well established so that “no extensive process of bargaining or coalition building external to the transfer network is usually required” (ibid: 374).

2.4.4. POLICY TRANSFER AS RATIONAL CHOICE

The above discussion has centred on the role of globalization processes in aiding policy transfer occurrence. However, as Common (2001:25) highlights, the “transfer of public policy cannot be explained by globalization alone” (see also Dolowitz and Marsh, 2000). Rather, “assumption of rationality seems to be present in much of the debate on policy transfer” (Ram et al, 2007:782). In this respect, it is common for governments to import policies from other countries as a rational activity. It must be noted however that this approach does not dismiss the power of globalisation processes and transnational structures, but argues that states can at least choose from among multiple policies that are sustainable outcomes over time (Drezner, 2001). In this view policy makers are assumed to be “rational, calculating subjects” (Dolowitz and Marsh, 1996:355). To this end, policy transfer is regarded as a form of “rationalism or an expeditious way of preserving some semblance of the autonomy of the state” (Common, 2001:7).

2.5. THEORETICAL PERSPECTIVES OF POLICY TRANSFER

The major weakness of policy transfer literature has been that it does not possess a common unified theoretical and methodological ground from which further research questions can be drawn (Evans, 2004; Wolman and Page, 2002; Evans and Davies, 1999; Common, 1998). However, based on a thorough review of the available literature, this study identifies three main thematic theoretical leanings within the multidisciplinary fronts of the studies of policy transfer. These include political, policy learning, and new institutionalism. This study regards these theoretical leanings as informing perspectives on the study of policy transfer as discussed below.
2.5.1. THE POLITICAL PERSPECTIVE

The political perspective emphasises the primacy of politics in the policy transfer processes. It converges on the Dolowitz and Marsh (2000:5) definition which regards policy transfer as the “process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administration arrangements, institutions and ideas in another political system”. In so doing, it highlights the “function that policy transfer plays in the political process” (Mossberger and Wolman, 2003:429). In particular, this approach sees policy transfer as a discipline of politics (Dolowitz and Marsh, 1996; Jacobs and Barnett, 2002; Radaelli, 2000) or a “growing body of literature within political science” (Dolowitz and Marsh, 2000:5) whose emergence is to address the “absence of the politics of policy making and the internationalisation of policy processes” (Hulme, 2005:419). It is in this realm that Stone (2004:547) pinpoints that “policy transfer is directly concerned with the contested politics of who gets what policy”.

The emphasis is on political processes and imperatives that inform policy transfer. To this extent, the political perspective highlights the “crucial role of political structures” (Dolowitz and Marsh, 1996:356) in policy transfer. As a result, all actors involved in policy transfer are regarded as ‘political actors’. For example Radaelli (2000:38) regards policy transfer literature as “part of an explanation of political life based upon the role of political actors” [emphasis added]. For Dolowitz and Marsh (2000:10), the ‘political actors’ engaged in the policy transfer processes include elected officials, political parties, bureaucrats/civil servants, pressure groups, policy entrepreneurs and experts, transnational corporations, think tanks, supra-national governments, non governmental institutions and consultants [emphasis added]. However a closer look at this list reveals that not all actors mentioned can be categorised as ‘political’. Some actors for instance, transnational corporations, non governmental institutions and consultants may be transferring policies while indulging in purely commercial or social pursuits (see Stone, 2010). This is why Pantazis and Pemberton (2009:366) propose the use of the ‘political economy approach to policy transfer’ that highlights the “role played by political and economic elites and their interrelationships in the facilitation of policies being transferred”.

With this perspective politics direct policy transfer activities as the “definitions of policy problems are subjective and political” (Dolowitz and Marsh, 1996:347). For instance,
decision makers are seen to “import ideas as a quick fix to mollify political pressure or to respond to a [political] crisis” (Mossberger and Wolman, 2003:430). Elections are another political force for policy transfer (Dolowitz and Marsh, 1996). Here, Dolowitz and Marsh (1996) illustrate the central role of party competition in policy transfers for the development of social policies in Britain and Sweden. Other reasons are to do with the role of political ideological strategy (Hulme, 2005) and political legitimacy (Dolowitz and Marsh, 1996). For instance, in the case of privatisation countries that were committed to the neoliberal political ideology drew lessons from other countries that had already privatised to legitimize their decisions for privatisation (ibid). To this end, policy transfer is seen as a “political tool” (Stone, 2000:55) for political assertiveness.

Within the political perspective, the work of Evans and Davies (1999) presents an attempt to analyse how the complex operations of global, international, and transnational factors influence policy transfer at macro and inter-organisational levels. In so doing, they situate the impacts of international structure and agency, epistemic communities, domestic structure and agency, and policy transfer networks in policy transfer analysis. They use structuration as a core theory for their analysis. For them, the power of structuration theory is in allowing for the “generative and relational aspects of structuralism while simultaneously resisting the analytical separation of these generative structures from the practice of human agent” (p. 370). This is because the agent and structure are “co-determined” through the “duality of structure” (p. 371). However, the problem with the use of structuration theory is that it “poses tremendous explanatory challenges among which is the difficulty of identifying the causal (and thus sequential) relationships between preferences and rules (institutions)” (Jupille and Caporaso, 1999:433). In addition, the perspective of Evans and Davies overemphasised the role of policy transfer networks while ignoring other variables that may be central in analysing policy transfer processes, especially in developing countries. Although an important variable, policy transfer networks may not be applicable in most transfer cases particularly in the bulk of the developing world. This is not to undermine the importance of policy transfer networks, but rather they apply in specific policy and institutional environments. Moreover, the performance of policy transfer networks in transfer endeavours is to a greater extent mediated by country specific institutional frameworks which Evans and Davies only explain in passing.
This leads us to the other general shortfalls of the political perspective to policy transfer. Firstly, this orientation is narrow as it centres on political imperatives rather than encompassing broader issues that affect and determine the processes of policy transfer. In doing so, the political perspective “downplays the logic of appropriateness and puts emphasis on the logic of [political] choice” (Radaelli, 2000:39). This is not to downplay the importance of political structures but rather, in order to fully comprehend the impacts of political structures, they need to be understood within the broader institutional framework in which they affect policy transfer. Secondly, the political perspective is marked by the “absence of a discussion of the relationship between the processes and the outcomes of transfer” (Page 2000:9). In this regard, policy implementation and outcomes are taken for granted without regard to the impacts of a particular policy transfer mode and country-specific contextual variables.

2.5.2. POLICY LEARNING PERSPECTIVE

Apart from the political perspective, studies of policy transfer have taken a policy learning orientation. This perspective adopts organisational learning theoretical strands with insights from open systems, modern structural approaches (Senge, 1992; Nonaka, 1994) and rational cognitive assumptions about management and organizations (Blackler, 1993). Levitt and Marsh (1988) classify organisational learning into ‘learning from organisation’s direct experience’, and ‘learning from the experience of others’. The policy learning perspective is mostly informed by the latter. In this regard, policy transfer is viewed as a “form of policy learning that is done by governments” (Wolman and Page, 2002:478) so that “policy transfer is thus fundamentally about learning” (ibid:479). However, apart from the recent studies of Dolowitz (2009a) and Dolowitz and Medearis (2009) no one has really synthesised the literature. This section therefore works towards that direction.

Birkland (2004:344) looks at the literature of policy learning as “rich, complex, [but which] has yet to reach any consensus on the nature of learning”. This is manifested by different names that authors use when referring to policy learning. For instance, Sabatier and Jenkins (1993) call policy learning, ‘policy oriented learning’. They define policy oriented learning as “relatively enduring alterations of thought or behavioural intentions that results from experience and which are concerned with the attainment or revision of precepts of the belief system of individuals or of collectivities” (p.42). Rose prefers to use the term ‘lesson-
drawing’ where the emphasis is the examination of “whether a programme that is successful in one setting can be transferred to another” (1991:7). At the most basic level however, the learning approach emphases the “accumulation and application of knowledge to lead to better policies” (Birkland, 2004:345). In this manner, policy learning is viewed as a “purposive search for information with which to resolve a problem” (Moseguer, 2005:73). Therefore, for policy transfer purposes, a “solution is chosen on the basis of observed experience and a better understanding of which policies may lead to particular outcomes” (ibid).

The learning orientation does not regard policy change resulting from policy transfer to be automatic (Dolowitz, 2009a; Ross, 1991). Therefore, the claim that there should be “evidence of policy change, or at least movement in the direction of policy change to reflect...[that]...some sort of learning may have occurred” (Birkland, 2004:344), is misguided. Policy learning does not necessarily always mean policy change (Sabatier and Jenkins, 1993; Rose, 1991). This is because during the learning processes a “programme elsewhere may be evaluated negatively or the conclusion may be that there is no way in which it could be transferred” (Rose, 1991:7). However, this ‘evaluation’ is also not automatic as it depends on the form of learning adopted (see Dolowitz, 2009a). In ‘softer’ forms of learning there is little or no analysis and understanding of the policy instruments, the originating foreign systems and domestic conditions leading to outright mimicking and copying. In contrast, in ‘harder’ forms of learning policy makers analyse and gain an in-depth understanding of the policy, the foreign political system and domestic environment leading to the adaptation of the policy instruments to their own political systems [emphasis original]. It may also lead to non implementation if the analysis results are not positive.

The policy learning theoretical stand has some limitations. Firstly, it emphasises the voluntary nature of policy learning while overlooking coercive forms of policy transfer. This renders it inapplicable in most policy transfer analyses in developing countries where policy transfer has coercive attributes. Only one study includes the coercive form in the learning equation (see Dolowitz, 2009a) but even then, the learning is not instrumental because it is done during “post-transfer implementation and negotiation processes, and [is] motivated by policy makers’ desire to find ways to reduce the misfit between the existing system and that which is being imposed” (ibid:320). Secondly, the learning perspective highlights the role of rationality in policy transfer processes. Policy actors are viewed as rational actors who are continuously seeking for information necessary for policy development. However, it is “rare
those actors are perfectly rational [as] most act within limited information or within the confines of bounded rationality” (Dolowitz and Marsh, 2000:14). Moreover, in most cases actors are influenced by their perception of a decision making situation rather than the real situation (ibid). This is precipitated by the fact that policies are “attractive not necessarily for performance reasons but for their ideational content as policy instruments” (Lodge, 2003:161).

Lastly, because of the preoccupation with rationality, the learning perspective takes policy outcomes for granted. In this regard, there is a temptation not to link policy learning dynamics to policy outcomes and impacts. The assumption is that policy learning will lead to desirable policy outcomes because policy makers are assumed to act rationally. However, policy transfer through ‘rational learning’ may result in undesirable outcomes due to lack of comprehensive policy analysis and knowledge acquisition, and political, institutional and cultural imperatives that shape policy making processes (see Dolowitz, 2009a; Dolowitz and Medearis, 2009). In this regard, the learning perspective to policy transfer leaves out important contextual elements that are very pivotal in order to understand policy transfer processes.

2.5.3. THE NEW - INSTITUTIONALISM PERSPECTIVE

Policy transfer has also been studied through the lens of new - institutionalism (see Lodge 2003; Radaelli, 2000; Pedersen, 2006). The argument is that institutions matter in understanding policy transfer processes. This strand does not ignore political and organisational learning factors but highlights “organisational factors in political life” (March and Olsen, 1984). Here, institutions are referred to as the “rules of the game” or the “humanly devised constraints that shape human interaction” (North, 1990:3). The focal pillars are actors’ preferences and institutions. In this regard, institutions do not only shape actors’ strategies but their goals as well. By mediating their relations of cooperation and conflict, institutions structure political situations and leave their own imprint on political and policy transfer outcomes (Bulmer, 1994). As Jupille and Caporaso (1993:431) echo, institutions structure “incentives, instantiate norms, define roles, prescribe behaviour or procedurally channel politics so as to alter political outcomes relative to what would have occurred in the absence of (or under alternative) institutions”. The new institutionalism literature is divided into sociological, historical, empirical, rational choice and international (see Peters, 2005). Of
these, the sociological and historical versions have had major impacts on policy transfer studies as discussed below:

2.5.3.1. Sociological Institutionalism: Institutional Isomorphism and Institutional Entrepreneurship

Sociological institutionalism has been used to understand how policies transfer from one country to another (see for example Radaelli, 2000; Lodge, 2000 & 2002; Bennett et al, 2004). This is particularly because it focuses on “non-local environments, either organisational sectors or fields roughly coterminous with the boundaries of industries, professions, or national societies” (DiMaggio and Powell, 1991:13). This allows for an understanding of the impacts of international and transnational institutions on policy transfer processes. This literature draws from DiMaggio and Powell’s (1991) formulation of institutional isomorphism mechanisms as “triggers or sources” (Lodge, 2002:46) of policy transfer. Institutional isomorphism portends to “forces pressing communities towards accommodation with the outside world” (DiMaggio and Powell, 1991:66). It is in this regard that authors characterise “policy transfer as isomorphism” (Pedersen, 2006:987).

The institutional isomorphic mechanisms include “coercive”, “mimetic” and “normative” (DiMaggio and Powell, 1991:67). Coercive isomorphic pressures are caused by both “formal and informal pressures exerted on organizations by other organizations upon which they are dependent” (DiMaggio and Powell, 1991:67). In most instances, with coercive pressures policy transfer becomes a condition of “economic resources” (Radaelli, 2000:29) or “approval for lower level jurisdiction” (Roy and Seguin, 2000:452). Mimetic isomorphic processes result from imitation due to uncertainty (DiMaggio and Powell, 1991). Owing to uncertainty in the environment, countries tend to model policies on those countries that are seen to be more successful or legitimate in achieving policy objectives. Lastly, with normative isomorphic pressures policy transfer occurs due to an “increased consensus among an increasingly unified policy community on the appropriateness of particular ways of working” (Lodge, 2002:48). This emphasises the role of policy networks and epistemic communities that have policy knowledge which is in turn transferred.

It has been noted that the weakness of the institutional view is that it is static and has a structural orientation (Ingram and Clay 2000). However, this study like any transformation study is dynamic and as a result it has to be carried out within the structure and agent
framework within which policy transfer takes place (Evans and Davies, 1999). This anomaly can be corrected by introducing an agent in the policy transfer framework which is an institutional entrepreneur (Beckett, 1999; Koene, 2006; Maguire, 2004; Fligstein, 1997). The theory of institutional entrepreneurship “describe organized actors who leverage support and acceptance for new institutional arrangements to serve an interest they value highly” (Dorado, 2005:399, see also Kingdon, 1995). In this regard, institutional entrepreneurs possess resources that they use to lobby for policy change. They champion for policy models for which they invest their resources for implementation. It has been found that for policy transfer purposes, institutional entrepreneurs use their “causal powers, [going] beyond the existing routines to elaborate and diffuse new ones” (Leca and Neccache, 2006:633). They have been seen to “infuse beliefs, norms, and values into social structures” (Rao et al, 2000:240). Using Kingdon’s terminology, Stone (2000:51) propounds that institutional entrepreneurs do “not only open channels for...policy transfer...but seek to educate or socialise decision makers into new ideas and policy approaches that are developed in the ‘policy primeval soup’”.

It has been seen that institutional entrepreneurs as agents of policy transfer do not operate in a vacuum but seek to legitimatise their policy transfer activities through institutional isomorphic forces highlighted above (DiMaggio and Powell, 1991). However, it has been argued that the relationship between structure and agency in this regard is not based on Gidden’s duality of structuration which Evans and Davies (1999) advance but on critical realism perspective on dualism where “actors create and change institutions without disembedding from the social world” (Leca and Neccache, 2006:628). It appears that structuration is not preferred as it “poses tremendous explanatory challenges among which is the difficulty of identifying the causal (and thus sequential) relationships between preferences and rules (institutions)” (Jupille and Caporaso, 1999:433).

2.5.3.2 Historical Institutionalism

Along with sociological institutionalism, historical institutionalism is used to analyse policy transfer processes and outcomes (see Lodge 2003; Greener, 2002; James and Lodge, 2003). This perspective is historical because it recognises that policy “developments must be understood as a process that unfolds overtime” (Pierson, 1996:126). An important aspect of historical institutionalism is that it has a “particularly encompassing interpretation of the role of institutions” (Bulmer, 1998:370) in policy transfer processes. It contributes to the
understanding of why some transferred policies are adopted while others are rejected given the same institutional framework (for single case studies) or different/similar institutional settings for (comparative case studies). Moreover, institutional analysis “allows power relations within states and support or opposition for externally imposed policies to be examined” (James and Lodge, 2003:186). The argument is that to understand the outcomes of policy transfer processes “one must analyse the incentives, opportunities, and constraints that institutions provide to the current participants” (Immergut, 1992:85) because “policy making is mediated by institutions” (James and Lodge, 2003:185). For instance, in his comparative study of policy transfer of railway regulation policy in Britain and Germany, Lodge (2003:162) concluded that there are particular institutions that “structure relationships within the policy domain and between the policy domain and its policy environments and thereby facilitate and constrain the spread of particular templates”. To this end, what is central in this perspective is the understanding of the ‘logic of appropriateness’ that shapes individuals’ actions within institutions (Bulmer, 1998:375). The vitality of the logic of appropriateness in explaining policy transfer lies in the “selectivity of institutions in adopting particular policy options” (Lodge, 2003:161). The argument is that institutional imperatives embedded in the ‘logic of appropriateness’ “constrain(s) the limits of acceptable action of government” (Peters, 2005:75) as it gives way to “veto opportunities [which] allow political decisions to be overturned at different stages in the policy process” (Immergut, 1992:83).

Additionally, the notion of path dependence that forms an important core in the historical institutionalism literature plays a pivotal role in understanding policy transfer dynamics (see Greener, 2002; Dwyer and Ellison, 2009; Pantazis and Pamberton, 2009). Path dependence “means that history matters” (North, 1990:102). It means that policies are more “sensitive to historical legacies, cultural contexts, with the relations of power, with the ‘stickiness’ of institutions or their path dependent proclivity” (Leftwich, 2007:46). According to Peters (2005:20), “policies are path dependent and once launched on that path they will persist in that pattern until some significant force intervenes to divert them from the established direction”. To this end, policy transfer may fail because the status quo can become “so institutionalised and historically embedded that it becomes nearly impossible to break free from the established policy path” (Greener, 2002:164). This policy path can of course be changed but with much difficulty as it “requires a good deal of political pressure to produce that change” (Peters, 2005:71).
It can be argued that apart from the issue of agency rectified above, the shortfall of the new-institutionalism perspective is not in the theoretical formulations *per se* but the policy transfer studies using it. New institutionalism seems to provide a viable theoretical tool for understanding policy transfer processes. However, a survey of studies on policy transfer reveals that they seem not to fully exploit its potential to maximum limits. It is mostly used in a one-level fashion resulting in a ‘fragmented’ understanding of the role of institutions in policy transfer dynamics. In so doing, they fail to adequately establish “causal links between process dynamics and outcomes of policy transfer with further consideration to process beyond description” (Unalan, 2009:439). Therefore, the challenge for policy transfer studies is to utilise the new institutional variant in a “multi-level analysis” (see Evans, 2004). With globalisation processes brought in the equation of policy transfer, the ‘multilevel new institutional perspective’ is imperative.

2.6. LINKAGE BETWEEN POLICY MAKING AND TRANSFER PROCESSES

A survey of policy transfer literature reveals that there is little attempt to link the processes of policy transfer with those of policy making. In this regard, Common (2001:3) observes that “policy transfer is an increasingly integral part of the policy process, but it remains largely absent from standard accounts”. However, as Dolowitz (2000b:124) underscores, “policy transfer sheds light into the policy making process”. Moreover, since it is not explicitly linked to the policy making process, “policy transfer leaves questions unanswered about how decisions are made to accept or reject ideas from elsewhere” (Hill, 2009: 180) at various policy making levels. In addition, the absence in the literature of a linkage between policy transfer and policy making processes prevents an understanding of the complexity of policy transfer processes. This is especially the case where voluntary mechanisms are displayed at one policy making level while coercive ones are seen at another within the same policy issues (see Dolowitz and Marsh, 2000). Therefore, to understand the dynamics of policy transfer, there is a need to establish the nexus between transfer and policy making processes. In this regard, the use of the policy making model articulated by Hill (2009) can be instrumental in understanding this linkage. Hill’s (2009) model can be summarised as follows:

**Figure 3. Hill’s Model of Policy Making Process**

| Agenda Setting | Formulation | Implementation | Evaluation |

**Source:** based on Hill (2009:147-8).
Hill’s model is based on a cumulative account of the policy process being regarded as a set of steps or ‘stages’. According to Hill (2009:127), the first stage in the policy making process involves setting the agenda or “deciding where we want to go”. This is about articulating policy goals in view of the policy problems to be addressed. The formulation stage, on the other hand, is about designing tools deemed instrumental in obtaining policy objectives. As Hill accentuates, formulation is about “deciding how to get there” (p.148). The implementation stage, which Hill refers to as the “going” (p.148), is about the actual execution or operationalisation of the policy instrument. Lastly, the evaluation stage points to the feedback mechanism that examines the whole process of policy making. The aim here is to appraise “what we did and how we did it” (ibid) so as to identify shortfalls and strengths that may have led to the resultant policy failure or success.

It must be noted that these stages are not independent of one another as they provide feedback to each other (Hill, 2009:143; see also Kingdon, 1995). Moreover, actors involved may either be the same (Hill, 2009:143) or there could be “multiple actor situations more typical of the policy process” (Hill, 2009: 148; see also Kingdon, 1995). To this end, using the journey metaphor, Hill (2009:148) argues that the “conventional prescriptive position implies some sort of hierarchy and particularly a distinction between who decides where to go and who does the journey”. In traditional policy making models operationalised within the context of representative democracies, politicians are seen to make decisions, while senior civil servants are perceived to be pivotal in translating them into specific legislation and the implementation is regarded to be in the realm of junior civil servants (Hill, 2009). However, Hill is quick to add that “who does what should be regarded as an empirical question” (2009: 148) as policy making circumstances may not be always the same. To this end, in aid dependent country contexts, external networks, donor organisations and national actors are seen as playing a pivotal part in various stages of the policy process depending on the issue in question. For example in his study, Banik (2010:150) noted that in developing countries, “donors tend to lecture the government on various issues.... when designing and implementing development policy”. In addition, Carothers (1999:256) observes that policy making processes requiring aid is administered in the way that “people from the country providing aid dominate every step of the [policy making] process”. For Hill, (2009:149) the understanding is that in policy making instances involving international external actors “global politics increasingly determines...broad parameters but networks and local institutional arrangements need to be looked at to explain what happens at the ‘street level’”
(Hill, 2009:149). As is discussed in some detail in section 2.6.2 below, it is through these local actors at the implementation level that sovereignty may be exercised where attempts may be made to challenge or implement the externally backed policy. It is against this backdrop that it can be said that success at one stage of the process may not automatically translate to success in others as actor interests may be conflicting at various levels of the policy making processes (Hill, 2009). To this end, Kingdon (2006:3) gives an example that an “item can be prominent on the agenda ...without subsequent passage of legislation; passage does not necessarily guarantee implementation according to legislative intent”.

Moreover, it is important to highlight that illustrations of the policy model are perceived as heuristics and are therefore open to criticisms (see Hill, 2009; John 1998). However, as Hill (2009:7) argues, “there is a pragmatic case for the [policy making] model as it imposes some order on the research process and that such models are open to criticism”. To this end, policy scholars are warned against being uncritical disciples of ‘stages models’ but rather to use them as a framework for organising conceptual analysis of policy processes (see also John, 1998; Common, 2001; McCourt, forthcoming). Some of the criticisms raised are that policy making does not always follow the stages as the processes involved are complex and dynamic (Common, 2001; Dolowitz and Marsh, 2000; Goldfinch, 2006). To this end, the stages model has been attacked for misrepresenting the reality of the policy making process by emphasising rationality, being orderly, over simplifying the processes, and lacking a true depiction of policy making reality which is characterised by politics and chaos (McCourt, forthcoming; Kingdon, 1995; Hill, 2009; John, 1998). However, despite these criticisms, the stages model as articulated by Hill (2009) can be used as an illustrative device to understand the complexities of policy transfer at different stages of policy making processes (see Hulme, 2000, Dolowitz, 2000) as discussed below:

2.6.1. POLICY TRANSFER IN AGENDA SETTING

According to Hill (2009), the agenda setting stage is about shaping the direction of policy trajectory in view of the prevailing policy problems. It is a process of putting together a “list of subjects to which government officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time” (Kingdon, 2006:3). According to Kingdon (1995), the potential for issues to be on the agenda is at its greatest when problem, policy and political streams meet. This is the case as
this meeting provides a “policy window” (Kingdon, 1995) for a policy idea or issue to be placed on the policy agenda. It has also been stated that the creation of the “policy window” is precipitated by dramatic events which include (but not limited to) ‘democratisation’, ‘independence’ (McCourt, forthcoming), ‘problems pressure’, ‘generation of policy proposals’, ‘national mood’, ‘vagaries of public opinion’, ‘election results’, ‘changes of administration’ (Kingdon, 1995:17) or globalisation processes (see Cerny and Evans, 2004; Dolowitz, 2006; Common, 1998).

Hill (2009:151) asks “where do the issues or problems that get on the political agenda come from?” According to Kingdon (1995:7) policy issues or “ideas can come from anywhere” whether from within or outside the political system. If the origin of the idea is other political systems, then it can provide an opportunity structure for policy transfer (see Dolowitz and Marsh, 2000; Dolowitz, 2000b; Evans, 2004). As Hill (2009:180) accentuates, “policy transfer theory can be seen in terms of the general notion that new ideas and new discourses develop and are spread around the world”. To this, John (1998) adds that “what is being transferred is ideas….even though the transmission of policies is contingent, it is still the ideas themselves which are important” (p. 151). For example, internationally, the NPM paradigm is seen as an idea which is getting onto national policy agendas within the general framework of globalisation processes (see Hill, 2009; Pollitt, 2003; McCourt and Minogue, 2001; Common, 1998; Osborne and Gaebler, 1992).

It must be mentioned that an issue can land on policy agenda through coercive or voluntary mechanisms (see Dolowitz and Marsh, 2000). A voluntary process occurs if actors transferring the policy idea emerge from the political system in question and willingly relay the issue from other political systems to the country’s policy agenda. This assumes that actors involved “choose policy transfer as a rational response to perceived problems” (Dolowitz and Marsh, 2000:14) as set on the national policy agenda. As was highlighted in Chapter One, due to the complexities and limitations of pure lesson drawing, actors when transferring policies to national policy agendas voluntarily, generally engage on “bounded rationality” which involves ‘shortcuts’ where policy makers look at relevant policy ideas available in other political systems rather than scanning through all the information (Moseguer, 2005; Dolowitz, 2009a). Apart from voluntary mechanisms, a policy idea can be brought on to the national policy agenda through means that may have various degrees of coercion. This is generally the case when agents taking a leading role are influenced by
external factors or are themselves external policy entrepreneurs who impose the ideas on the policy agenda of the political system in question (see Dolowitz and Marsh, 2000 & 1996; Common, 2001; Evans, 2004). As has already been articulated in Chapter One, the transfer of policies to the national policy agenda through purely coercive mechanisms is rare (Dolowitz and Marsh, 2000; Stone, 1999). In most cases, it is the result of ‘conditionality’ where “resources are used as an incentive or penalty” (Holzinger and Knill, 2005:780) for the transfer of policies to the political system’s policy agenda and “obligated policy transfer” where member countries are involved in the transfer of policies to the national policy agenda as an obligation of their membership (ibid, Dolowitz and March, 2000).

2.6.2. POLICY TRANSFER IN POLICY FORMULATION

Dolowitz (2000b:123) tells us that “policy transfer studies give evidence of internationalisation of policy formulation”. This is the case as policy “formulation process involves the making of choices about ways to enact policy” (Hill, 2009:278) which can involve policy borrowing (see Dorey, 2005; Hulme, 2000). Authors have argued that the ability of a policy idea to land on the policy agenda does not guarantee its success of being made a policy (see Hill 2009; Kingdon, 1995; McCourt, forthcoming). This is the case as a policy idea has several alternatives (Kingdon, 1995), there exist vested interests and opposition (McCourt, forthcoming) and there are “threats to success” (Bebbington and McCourt, 2007). According to Hill (2009) the success of a policy idea is based on considerations about resource intensiveness, the extent to which precise target of policies is required, the level of political risk, and constraints on state activity. Similarly, Kingdon (1995:125) sees the judgement about “merits of a case as well as its political costs and benefits” to be key issues in this process. This is the case as the critical factor in the process is the “climate in government or receptivity to ideas of a given type” (Kingdon, 1995:72).

Similar mechanisms also seem to apply to a transferred policy idea as “policy transfer…involves formulation issues once a policy issue is on the agenda” (Hill, 2009:278). Moreover, as Hulme (2000:82) adds, “policy transfer plays an integral part in the politics of formulation”. In particular, even if voluntarily or coercively transmitted to the policy agenda as highlighted in section 6.2.1 above, there could be contextual forces that might constrain or facilitate the formulation of an idea into a policy at this level (see Street, 2004; Rose 1993). As Rose (1991:7) pinpoints, at the formulation stage a “programme elsewhere may be evaluated negatively or the conclusion may be that there is no way in which it could be
transferred”. In this regard, it would seem that a policy idea from other political systems may be passed on to the policy agenda whether through coercive or voluntary means but the strength of opposition to the new idea based on existing contextual factors may make its acceptability problematic (see Flynn, 2002; Hill, 2009). This typifies Bulmer, Dolowitz, Humphreys and Padgett’s (2007:17) notion of “abortive” policy transfer outcome “where putative transfer is blocked by veto actors in the borrower jurisdiction” at the formulation stage.

2.6.3. POLICY TRANSFER IN IMPLEMENTATION AND EVALUATION

Hill (2009:278) tells us that the “act of implementation presupposes a prior act, particularly the act of formulating what needs to be done”. In this regard, policy transfer theory can also aid our understanding of policy implementation and evaluation processes (see Hulme, 2000; Dolowitz 2000b). When a transferred policy successfully passes through the formulation stage, it is expected to be implemented whether through copying, emulation, synthesis or inspiration mechanisms as explained in Chapter One. However, the process is not always smooth as it is characterised by politics (Dorey, 2005; McCourt, forthcoming) and may lead to failure (see Dolowitz and Marsh 2000) which may best be indentified through evaluation. To this effect, Hill (2009:279) refers to evaluation as the “natural feedback cycle to subsequent policy improvement”. Dolowitz and Marsh’s (2000) formulation of ‘inappropriate’, ‘uninformed’ and ‘incomplete’ policy transfer is useful here in evaluating why some transferred policies fail to achieve their objects. Similarly, Ferlie et al’s (1996) analysis of the extent to which a policy achieves transformational goals can be employed. Dorey (2005:98) gives yardsticks for ensuring ‘perfect implementation’ which can also be useful in evaluating policy transfer outcomes as follows:

1. External agencies do not impose major constraints.
2. Dependency relationships are minimal.
3. Resources are adequate.
4. Policy is based on valid theory of cause and effect.
5. The objectives are clear, coherent and consistent.
6. The objectives are fully understood and/or accepted by ‘street level bureaucrats’.
7. That those to whom a policy is applied or targeted respond in the anticipated manner.

In terms of evaluating policy transfer outcomes, Dorey’s (2005) yardsticks stated above have implications on the success of the transferred policy based on the mechanisms through which
the policy in question was introduced on the national policy agenda. This is the case as, unlike in voluntary policy transfers, in transfers that have some degrees of coercion external agencies are seen to impose some constraints, dependency relationships seem to be higher (see Holzinger and Knill, 2005; Larmour, 2002; Peters, 1997), policy seems to be not based on valid theory of cause, and effect, and the objectives may not be fully understood or accepted (see Minogue, 2004; Dolowitz, 2009a; Evans, 2009). These issues seem to touch on the problem of erosion of sovereignty in policy decision making in view of conditionalities that characterise coercive policy transfer during the agenda setting stage. As Evans (2004:27) argues, “coercive forms of policy transfer demonstrate the incapacity of a state to maintain its national sovereignty over decision making”. However, it must be pointed out that aid dependent countries seem to regain this sovereignty during the implementation stage as domestic policy making processes take shape. In this regard, although the policies can be transferred through coercive means to a country’s policy agenda, the implementation is seen to be determined by domestic contextual forces and actors. To this end, attempts to regain sovereignty at the implementation stage in the context of coercive forces seem not to lead to ‘perfect implementation’ (see Dorey, 2005; Smith, 2003). It is in this respect that McCourt (2008:474) observed that it is the “enduring power of sovereign states within their own borders which explains the failure of the attempts to induce reform from outside, and which ultimately explains the return of divergence in public management”.

This section has provided some clarity to the nexus between policy transfer and policy making processes so as to better understand the mechanisms of policy transfer. It is within the backdrop of this understanding that the study provides the intricacies of policy transfer process within the ‘multilevel theoretical framework’ that guides this study as articulated in section 2.7 below:

2.7. THEORETICAL FRAMEWORK FOR THIS STUDY

To adequately operationalise this project, a ‘multilevel perspective’ is used. This framework draws from the strengths of the political and policy learning perspectives while taking institutionalism as its core. It also draws on Evans and Davies (1999) notion of ‘multilevel perspective’ of policy transfer. However, instead of using structuration theory as Evans and Davies (1999) did, this study uses new institutionalism theory as a core analytical element in
explaining policy transfer occurrence, processes, dynamics and outcomes. To this end, the study treats policy transfer both as a dependent and an independent variable. This is the case because “if one wishes to use policy transfer to explain policy outcomes, then one also needs to explain what causes transfer” (Dolowitz, 2000b:11). Institutions play a central role as they “have always been regarded as the basic building blocks of social and political life” (DiMaggio and Powell, 1991:3). Guided by the research questions and study’s objectives, the framework has three levels of analysis namely: international, national and application, as shown in the figure below.

**Figure 4. Multilevel Framework of Policy Transfer**

**Sources:** My own formulation with insights from DiMaggio &Powell (1991); Beckert, 1999 Pollitt and Bouckaert, (2004); Ferlie et al (1996), McCourt, (2003),
2.7.1. INTERNATIONAL LEVEL

This study locates policy transfer within the wider theorisation about the impacts of globalisation processes. This is the case as it is claimed that the “invasive character of globalisation has made the spatial or the territory a place where social interactions can be analysed” (Kuditshini, 2008:195). Here, international level structures and processes are regarded as those that “inform state-to-state relations” (Evans, 2009:255). Additionally, international level actors comprise (1) international organisations, (2) states, and (3) non state actors (Stone, 2004:545). The role of these actors in policy transfer is understood within the general framework of the “the globalisation of new public management” (see Common 1998).³

This study uses DiMaggio and Powell’s (1991) institutional isomorphism to analyse the necessary “triggers or sources” (Lodge, 2002:46) of policy transfer within the global context. This is the case as institutional isomorphism emphasises “how practices are diffused through organisational fields or across nations” (Hall and Taylor, 1996:947). As Lynn (2001:197) echoes, policy transfer may be a “resultant of socialised rather than rational choice within organizational fields of imitation, coercion, or ideology”. In this regard, the study analyses which institutional isomorphism pressures - “coercive”, “mimetic” or “normative” - are a critical force that informed the transfer of health sector reforms to Malawi’s policy agenda. This is the case so as to understand and examine particular institutional relationships in terms of mode of governance existing between Malawi and international donor organisations that account for specific institutional isomorphism pressures resulting in particular policy transfer outcomes. In this realm, international donor organisations are considered as institutional entrepreneurs in the policy transfer processes. This is because they influence “policies by bringing norms generated or promoted in the international sphere into the domestic political arena” (Bernstein and Cashore, 2000:71) thereby acting as “globalisers” or “players of globalisation” (Kuditshini, 2008:195).

³ Refer to the above discussion on globalisation and policy transfer. Like Common (1998), this study takes globalisation to “mean the universal application of public policy” as discussed above.
2.7.2. NATIONAL LEVEL

International level structures are constraints or opportunities but are not a determinant for the actions of state actors in policy transfer processes (Evans, 2004; Flynn, 2002). This is because national level factors play a critical role in facilitating or constraining the implementation of policies from the international arena. Particularly, the national level consists of ‘veto points’ which are arenas in the “policy process where the mobilisation of opposition can thwart policy innovation” (Steinmo et al, 1992:7) or borrowing. Veto points house ‘veto players’ who are “individuals or collective decision makers whose agreement is required for the change of the status quo” (Tsebelis, 2000:442). However, the decisions of veto players are shaped by deeply entrenched cultural, bureaucratic, organisational, economic, political, historical and institutional proclivity. This makes the potential for adopting transferred policies “basically dependent on the general contexts in which [political] systems are embedded” (Knill, 1999:113). There are many contextual factors affecting policy transfer in this regard but for feasibility purposes, the study examines the impacts of: mode of transfer, policy content and context, parliament-cabinet configurations, path dependency, citizen pressure, bureaucratic politics, and institutional compatibility and prerequisites as discussed below.

2.7.2.1. Modality of Transfer

Bennett and Howlett (1992) underscore the importance of ‘middlemen’ as catalyst agents in policy transfer. Quoting Heclo, they define ‘middlemen’ as experts at the “interfaces of various groups who have access to information, ideas and positions outside the normal run of organizational actors and have been able to package and promote policy innovations” (279). In practical policy transfer terms to developing countries, ‘middlemen’ are seen as technical assistants, consultants or advisors that are hired by international donor organisations to act as agents of policy transfer (see Tyson and McNeil, 2009). Middlemen can adopt various approaches in their attempts to transfer policies which play a role in determining the acceptability of such policies. While some agents have been seen to take a top down approach, working on their own without any or with very minimal local bureaucratic participation, others have adopted participatory learning approaches where government officers are actively involved in all processes (Godfrey et al. 2002). According to Godfrey et al, these various approaches have implications on the local ownership and commitment for
the implementation of the reform package. This study will therefore analyse the extent to which these modalities affected policy transfer outcomes in the Malawian health sector reforms context.

2.7.2.2. Policy Content and Political-Economic Context

McCourt and Bebbington (2007:10) advance that “there is a political economy of policy which shapes its content”. In this respect, although policy transfer may entail the transfer of managerial instruments, it is a political process which is mediated by economic imperatives (see Pantazis and Pemberton 2009). It is about how political decisions undertaken in policy transfer activities will affect economic choices in a country and vice-versa. To this end, decisions about implementation depend on “political feasibility” (McCourt and Bebbington 2007:9), and “political desirability” (Pollitt and Bouchaert, 2004:26), both of which go beyond technical optimality as they encompass country specific “economic, ergonomic, legal...political, and cultural” contextual considerations (ibid; see also Walt and Gilson, 1994). In this realm the content of the policy transfer package may be in itself a constraint in particular political-economic context. It is against this backdrop that the study therefore, will analyse contents of the health sector reform packages in Malawi and examine the extent to which their implementation is facilitated or militated by specific political feasibility and desirability contextual factors at the time of the transfer.

2.7.2.3. Parliament-Cabinet Configuration

McCourt (2008:473) observes that it is “national, not international politics which [is] decisive” in policy transfer processes. One of the key issues in national politics is the parliamentary and cabinet configurations (see Flynn 2002). The configurations form “working habits and conventions” (Pollitt and Bouckaert, 2004:46) that generate different sets of governing modes thereby determining the extent of policy continuity and change when pressures to implement externally originated policies arrive. Pollitt and Bouckaert provide the basic characteristics of legislative/cabinet configurations as follows:

- *Single-party or minimal winning or bare majority:* where one party holds more than 50 per cent of the seats in the legislature
- *Minimal winning coalitions:* where two or more parties hold more than 50 per cent of the legislative seats
- **Minority cabinets**: where the party or parties composing the executive holds less than 50 percent of the legislative seats; and
- **Oversized executives or grand coalitions**: where additional parties are included in the executive beyond the number required for a minimal-winning coalition.

Based on this categorisation, Pollitt and Bouckaert (2004) and Flynn (2002) propose that sweeping policy changes are likely to be possible with the single party majority as this ensures unanimity and not much ideological differences exist. However, as one moves further away from the single party majority, the proposed policy changes may not win the necessary support as it is harder to get the necessary consensus due to wide ideological difference and interests, and the zeal to perform as custodians of particular policy paths may be overwhelming. This argument is line with Tsebelis’s (2000: 464) proposition (that deal with public policy generally) that predicts policy stability when there are many veto players, big ideological differences exist among them and the requirement for a high qualified majority threshold in any collective veto players. Based on this understanding, the study will analyse the impacts of particular parliamentary-cabinet configurations prevailing in Malawi at a time the health sector reforms were transferred on their acceptability.

### 2.7.2.4. Path dependency Tendencies

Path dependence tendencies play a critical role in determining the enactment of policies sourced from elsewhere (Greener, 2002; Lodge 2003). As Yu (2008:192) advises, in studying reforms “it is important not to overlook the significance of their historical context”. This is because a “particular course of action once introduced may be virtually impossible to reverse” (Pierson, 2000:251) due to the existence of “causal processes that are highly sensitive to events that take place in the early stages of an overall historical sequence” (Mahoney, 2000:510). These ‘causal processes’ are “self-reinforcing”, “reactive” and have “deterministic properties” (ibid: 507) that “lock-in” (Wilsford, 1994:252) policies to particular path patterns as “increasing returns” (Pierson, 2000:251) persist. These ‘increasing returns’ are particularly important as they set in motion “positive feedback processes” that make “reversals of course [become] increasingly unattractive over time” (ibid: 259) so that the adoption of alternative policies becomes problematic. The implication of this is that seemingly efficient policies in operation in other countries may not be taken on board because of some historical intricacies which are currently providing ‘increasing returns’ but may not be compatible with the incoming policies.
Flynn (2002:75) pinpoints that path dependency “taken to extremes allows no options”. However, there is some room for the change of policy path that can enable policy transfer to result in policy change but this comes with much difficulty (Peters, 2005). This window of opportunity presents itself when there is an “interplay of structure with conjuncture” (Wilsford, 1994:251) resulting from a “number of diverse elements or events [that] come together across time, space, or both” (Greener, 2002:164). These elements or events include a “good deal of political pressure [or] some significant force” (Peters, 2005:71). However, in path dependence explanations “deviant outcomes or instances of exceptionalism” (Mahoney, 2000:508) are possible as ‘some forces’ that may be so powerful to likely alter policy path may not do so due to the “stickiness of institutions or their path dependent proclivity” (Leftwich, 2007: 46). It would appear that in such cases policy change may not be possible even in the context of combined push of ‘significant forces’ and coercive policy transfer. Against this backdrop, the study seeks to analyse the extent to which path dependency tendencies constrained or facilitated the transfer of health sector reforms in Malawi.

2.7.2.5. Pressure from Citizens

It is claimed that pressure from citizens can also be a determining factor for the implementation of policies. This pressure can take the form of individual citizenry acting on their own or as pressure groups and civil society organisations representing various interests (Flynn, 2002). Although in most cases it is not explicitly expressed in terms of active demands, it can “constitute background influence” (Pollitt and Bouckaert, 2004:31) when it implicitly provides feedback to the policy making machinery. Moreover, despite the assertion that the “public, unless sufficiently organised, remains a secondary actor behind top politicians and bureaucrats” (Common, 2004b:360), pressure from citizens would attract the attention of policy makers because failure to do so may lead to “legitimation problems for the government and/ or the ruling party or parties” (Flynn, 2002:67). Therefore, this study will examine the extent to which citizen pressure can be used as an explanatory variable for policy transfer processes of health sector reforms in Malawi.

2.7.2.6. Bureaucratic Politics

Another national level factor that the study investigates is the extent to which bureaucratic politics affects policy transfer processes. The role of bureaucratic politics in policy transfer
processes is under-established because bureaucratic interests are assumed to be aligned with
the efficiency gains advocated by the policy instrument (Street, 2004:121). Therefore, the
bureaucrats are assumed to “respond to external factors rather than just defend their bureaus’
interests” (John, 1998:45-6). However, bureaucrats are “not simply passive” but are
“proactive” (Pollitt and Bouckaert, 2004:193) since they “shape the outcome of policy
formulation and implementation in line with their interests” (Knill, 1999:115-116). This
implies that bureaucrats may have self interest that go beyond the policy transfer instrument
which may determine policy acceptability. Therefore, although bureaucratic influence is “not
autonomous”, it is “instrumental” (Knill and Lenschow, 2005) because it can impact on
policy goals and outcomes.

At the theoretical level, therefore, the bureau-shaping model (Dunleavy, 1991 & 1994) and
Niskanen’s budget maximization formulation can be useful in understanding bureaucratic
interests in policy transfer processes. In fact the bureau-shaping model has been used to
explain the motivations that sustain the NPM in the UK (James 2003, Dunleavy, 1991 &
1994), and it can also be used to highlight why bureaucrats may champion the transfer of
NPM models in other countries. This is because NPM “strategies are perfectly consistent with
bureau-reshaping and expanding senior managers’ utilities” (Dunleavy, 1994:51) where top
bureaucrats are assumed to prefer higher level policy related work rather than managerial
activities. In contrast, the budget maximisation formulation highlights that the motivation of
the bureaucrats to maximise budgets is achieved through empire building and expansion of
the bureaus (ibid). In this regard, top bureaucrats are seen to have preference for holding on
to managerial rather than policy power as it increases their overall budget maximising utility.

Also within the bureaucratic politics framework is the cross-cutting issue of the impacts of
bureaucratic culture. Bureaucratic culture encompasses historical institutional tradition, style
of governance (Christensen and Laegreid, 2006), general capacity for executive leadership,
the institutional entrenchment of administrative structures and procedures and the influence
of the bureaucracy on policy making (Knill, 1999). Bureaucratic culture however, exists
within the confines of national culture (Jabra and Dwivedi, 2005) as bureaucratic
preferences are not displayed in a vacuum but are “driven more by culture, rhetoric and
history, than science and technique” (Ellison, 2006:1276). In some cultures, bureaucratic
politics can be very pronounced and may involve highly unproductive tactics while in others
it is exercised as an underground and a very informal phenomenon. In this respect,
Hofstede’s (1980 & 2001) dimensions of national culture which include power distance, individualism versus collectivism, masculinity versus femininity and uncertainty avoidance are pivotal in understanding national cultural orientations that shape bureaucratic culture. This is the case as they form a “key starting point in any analysis of culture and its impacts” (Shanks et al, 2000:3) on public sector reforms (see Bouckaert, 2007). However, Hofstede’s work has suffered criticisms which must not be ignored. These include the use of surveys which are not well suited for a “value that is culturally sensitive and subjective” (Jones and Alony, 2007:413; also McSweeney, 2002), display of a limited understanding of the relationship between national wealth and culture (Javidan et al 2006), the assumption of permanency of cultural differences (Baskerville, 2003), Euro-centricity (Muller and Ziltener, 2004) and that the categories mask complexity of culture (Myers and Tan, 2002). However, despite these limitations, Hofstede’s study has “often been replicated and has influenced the literature” (Bouckaert, 2007:47) of public policy. Moreover, in replications “by and large...[it has been]...confirmed...[and]...no consistent pattern of non-confirmation could be established” (Søndergaard, 1994:452).

2.7.2.7. Institutional Compatibility and Prerequisites

Some analysts underestimate the importance of the fit between policy transfer instrument and the prevailing institutional framework within which it should be implemented, or its associated prerequisites in the absence of that match. For instance, Rose (1993:123) argues that “even though institutions are necessary, it does not follow that they are important...[as]...a new program can usually be administered in more than one way...one institution can be substituted for another”. However, Dolowitz and Marsh (1996:355) underscore that this view is “misguided” as the match between reform instrument and the institutional framework in which it is applied is one of the pivotal variables for effective transfer. Knill and Lenschow (1998:596) echo that “we expect effective implementation when...policy corresponds to national patterns and instinctive structure”. Therefore, the study will examine if the compatibility between the health sector reforms in question and the institutional framework within which they were to be implemented had any impact on their acceptability. Additionally, the impacts of absence or presence of institutional prerequisites of the reforms prior to policy adoption will also be analysed.

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4 See Chapter Five for a discussion of the actual dimensions and their application to Malawi
2.7.2.8. Social-Economic Forces

This study is carried out in an African developing country environment. As such, social-economic forces are regarded as a cross cutting issue in all the dimensions highlighted above. Issues emanating from this cross cutting theme include poverty, social economic policies, social demographic change, economic forces and cultural issues (Pollitt and Buckaert, 2004; Flynn, 2002).

2.7.3. APPLICATION LEVEL

The last level of analysis is the application level where programmes that are positively vetted at the national level are implemented. At this level, the study analyses the actual outcomes of transferred policies taking into account the existing local contextual frameworks. The aim is to examine the “extent to which policy transfer achieves the aims set by...[the actors]...when they engaged in transfer, or is perceived as a success by the key actors involved in the policy area” (Dolowitz and Marsh, 2000:17). This is studied within the administrative system that embodies the content of the reform package, implementation process and an analysis of the results achieved (see Pollitt and Bouckeart, 2004).

Evans (2009:247) highlights that one of the outputs of policy transfer processes is “the development of new institutions and delivery systems, and change to actual goals that guide policy”. This entails the transformation of service delivery systems through the change of the status quo. However, transformation is not an automatic process as its attainment is mediated by local level contextual factors (Osborne and Brown, 2005). In this respect, Hall and Taylor (1996: 941) reject the “traditional postulate that the same operative forces will generate the same results everywhere in favour of the view that the effect of such forces will be mediated by the contextual features of a given situation”. Therefore, the study will examine the extent to which the implemented health sector reform programmes have led to the desired service delivery transformation outcomes taking into consideration the contextual factors. Ferlie et al (1996) suggest indicators for measuring service delivery transformation as follows:

- The extent of multiple, interrelated change across the system as a whole
- The creation of new organisational forms at a sector level

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5 See Chapter Three for a discussion of policy transfer in developing countries
• The development of multi-layered changes which impact below the whole system at unit and individual level
• The creation of changes in the services provided and the mode of delivery
• Reconfiguration of power relations (especially the formation of new leadership groups)
• The development of new culture, ideology, and organisational meaning

Osborne and Brown (2005) however, observe that these yardsticks and hence total public service delivery transformation is difficult to achieve. This is due to the nature and complexity of public sector organisations and services. Therefore, the indicators will only provide insights to the study, although not followed to the book but contextualised to specific health sector reform issues under study and Malawian local setting.6 Thus the indicators will work as only a guide for specific Malawi case study analysis. Key aspects to be analysed will be multidimensional issues pointing into the extent to which the reform objectives have been achieved. Apart from intended results, unintended consequences will also be analysed. This is the case because it must not be taken for granted that policy transfer will yield the intended outcomes. However, “unintended consequences are likely and widespread” (Pierson, 1996:136) leading to “policy failure” (Dolowitz and Marsh 2000:6) because organisations are “recalcitrant and efforts to direct them yield unanticipated consequences beyond anyone’s control” (DiMaggio and Powell, 1991:14).

2.8. CONCLUSION

This Chapter has situated policy transfer within the global context. Drawing from the available literature on policy transfer, the Chapter has also drawn theoretical themes of policy transfer. These include the political, learning and institutional perspectives. It is based on these theoretical perspectives and insights from the general globalisation literature that the chapter drew the ‘multilevel analytical perspective of policy transfer’ that forms the theoretical framework for the thesis. This framework will guide the whole study and it will be the basis for methodology framing, empirical investigation, theoretical arguments and conclusion drawing. The Chapter also established the nexus between policy transfer and policy making processes. The next chapter presents an analysis of policy transfer in developing countries. This is done in order to contextualise the study as it is carried out in Malawi which is a developing country.

6 See Chapter Eight for a further discussion of this and rationale for contextualising
CHAPTER THREE: POLICY TRANSFER IN DEVELOPING COUNTRIES

3.1. INTRODUCTION

Chapter Two discussed policy transfer in a global context. This Chapter situates policy transfer in the developing countries’ specific environment within which the study is undertaken. Evans observes that policy transfer “analysts focus too much attention on policy transfer between developed countries and are largely ignorant of policy transfer activity in the developing world” (2004:25). As a result, we should be aware that the bulk of the developing countries most of which in Africa, remain understudied. Therefore, although this Chapter centres on developing countries in general, specific emphasis is placed on African countries. This is also because the study is conducted in Malawi which is in Africa. This Chapter begins by presenting the role of donor aid in policy transfer. This is followed by a section on coercive and negotiated variants of policy transfer in developing countries. Section three discusses voluntary processes while section four analyses some of the effects of coercive policy transfer. Finally, a conclusion is drawn.

3.2. DONOR AID AND POLICY TRANSFER

It has been observed that most developing countries cannot function without external aid due to extreme levels of poverty (Burnside and Dollar, 2000; Easterly, 2003). As a result, they depend on financial and technical resources from external donors, finance organisations and developed countries. Table 1 below shows the volume of aid to selected African countries. As can be seen from the table, the amount of aid to these countries has been increasing over the years. In addition, the table shows that without external assistance most countries cannot support their balance of payments. In particular, external aid has made much contribution to gross national income and gross capital formation.
Table 1: Volume of Aid in Selected African Countries, 1999 and 2004

<table>
<thead>
<tr>
<th>Country</th>
<th>Official Aid ($ millions)</th>
<th>Aid as a % of GNI</th>
<th>Aid as a % of GCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>211</td>
<td>378</td>
<td>8.9</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>398</td>
<td>610</td>
<td>14.2</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>643</td>
<td>1823</td>
<td>10.0</td>
</tr>
<tr>
<td>Ghana</td>
<td>609</td>
<td>1358</td>
<td>8.1</td>
</tr>
<tr>
<td>Madagascar</td>
<td>359</td>
<td>1236</td>
<td>9.8</td>
</tr>
<tr>
<td>Mauritius</td>
<td>219</td>
<td>180</td>
<td>20.1</td>
</tr>
<tr>
<td>Mozambique</td>
<td>805</td>
<td>1228</td>
<td>21.3</td>
</tr>
<tr>
<td>Niger</td>
<td>187</td>
<td>536</td>
<td>9.4</td>
</tr>
<tr>
<td>Rwanda</td>
<td>373</td>
<td>468</td>
<td>19.4</td>
</tr>
<tr>
<td>Senegal</td>
<td>535</td>
<td>1052</td>
<td>11.5</td>
</tr>
<tr>
<td>Tanzania</td>
<td>990</td>
<td>1746</td>
<td>11.6</td>
</tr>
<tr>
<td>Uganda</td>
<td>590</td>
<td>1159</td>
<td>9.9</td>
</tr>
<tr>
<td>Zambia</td>
<td>624</td>
<td>1081</td>
<td>21.0</td>
</tr>
<tr>
<td>Cameroon</td>
<td>435</td>
<td>762</td>
<td>5.0</td>
</tr>
<tr>
<td>DR Congo</td>
<td>132</td>
<td>1815</td>
<td>3.1</td>
</tr>
<tr>
<td>Guinea</td>
<td>238</td>
<td>279</td>
<td>7.0</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>52</td>
<td>96</td>
<td>24.9</td>
</tr>
<tr>
<td>Malawi</td>
<td>447</td>
<td>476</td>
<td>25.8</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>74</td>
<td>370</td>
<td>11.5</td>
</tr>
</tbody>
</table>

Source: Ilorah, 2008 (based on World Bank 2006:348-50)

However, it has been seen that in most instances external aid is not without conditions which present opportunities for policy transfer (Minogue, 2004; Lamour 2002; Killick, 2004). As Common (1998:61) illustrates, the impact of international organisations on policy transfer in the developing world is “unmistakable”. This is the case because some international donor organisations require specific policy interventions to be carried out as condition for aid and loans with the reasoning that “development assistance can contribute to poverty reduction in countries pursuing sound policies” (Easterly 2003:24). The rationale is that “to grow, developing countries need to get the policies right” (Grindle, 2000:206). For the health sector,

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7 Gross national income (GNI) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output, plus net receipt of primary income (compensation of employees and property income) from abroad.

8 Gross capital formation (GCF) consists of outlays (expenditures) on additions to fixed assets (land improvements; plant, machinery and equipment purchases; and the construction of roads, railways, schools, offices, hospitals, private residential dwellings, and commercial and industrial buildings) of the economy, net changes in the level of inventories (stocks of goods held by firms as precautionary measures), and net acquisitions of valuables.
the World Bank is of the view that “if developing country governments…embrace the key
health policy reforms,… improvements in human welfare in the coming years will be
everous” (1993a:171). Therefore, the World Bank even encourages other donor
organisations to support countries that adopt programmes through bilateral and multilateral
aid regimes. For instance, as early as 1979, the World Bank’s President Robert McNamara announced that

in order to benefit fully from an improved trade environment, the developing
countries will need to carry out structural adjustments...I would urge that the
international community to consider sympathetically the possibility of
additional assistance to developing countries that undertake the needed
structural adjustments...I am prepared to recommend to the Executive Directors
that the World Bank consider such request for assistance and that it make
available program lending in appropriate cases (quoted in Stein, 2004:15).

The World Bank renewed these calls by advising other donor agents and developing
countries themselves that “countries that show a willingness to...undertake reforms...should be strong candidates for aid” (World Bank, 1993a:167). Moreover, apart from making it a
ccondition, international organisations have aided policy transfer to developing countries by
actually funding the implementation of the World Bank/ IMF driven policies. For instance,
the United States Agency for International Development (USAID) announced that in the
“1999-2000 funding cycle it would support efforts aiding local government and support the
continued enhancement of decentralisation” (Kamarck, 2000:239) both of which were on the
Japan allocated 25% of its aid commitment to finance World Bank driven structural reforms.
Likewise, Fundanga and Mwaba (1997:8) pinpoint that the UNDP provided finances for the
privatisation, industrial reform, capital markets development and public sector reform
programs which were initiated by the World Bank. Moreover, international organisations also
provide technical assistance to policy receiving countries for effective implementation. For
example, Fundanga and Mwaba (1997) highlight that technical expertise to the Zambia
Privatisation Agency came through bilateral agencies such as USAID, GTZ, ODA, NORAD
and DANIDA.

McCourt (2008 & 2002) classifies reforms transferred to developing countries as ranging
from the Washington consensus model which characterised by structural adjustment regimes,
the NPM model, to poverty reduction programmes. However, he observes that “many of the
ships have had the NPM emblazoned on their funnels” (McCourt, 2001:115). More specifically, NPM has been identified as a “key component in World Bank praxis” (Harrison, 2005:245) because this is the “agenda that aid donors are intent on realising through both economic and political conditionalities attached to development assistance” (Minogue, 2004:173). Apart from NPM policy transfers, donor organisations have also been instrumental in transferring governance policy reforms (McCourt, 2008; Lamour 2005). The understanding is that good governance and NPM are “mutually supportive, with enhanced accountability and improved efficiency reinforcing each other” (Minogue 2004:172).

3.3. NEGOTIATED OR COERCIVE POLICY TRANSFER?

The nature of policy transfer facilitated by international donor organisations in the developing world has theoretically been described as either ‘negotiated’ (Evans, 2004) or ‘coercive’ (Dolowitz and Marsh, 1998). For Evans (2004:11), the magnitude of donor conditions for aid and other assistance is a “reflection of the pervasiveness of negotiated forms of policy transfer to developing countries”. He argues that direct coercive policy transfer was common during the time of formal imperialism but what is prevalent now is negotiated transfer (ibid). However, Dolowitz and Marsh (1998:42) highlight that, international organisations particularly lending agencies such as the International Monetary Fund (IMF) and the World Bank, “act as agents of coercive transfer by attaching certain conditions to loans”. Aid organisations are seen to have “pushed” (Schuyler, 2004:99) or “forced” (Dolowitz and Marsh, 1998:43) countries to adopt policies because those seeking to access loans were “required to accept conditionality” (Stein, 2004:22).

Literature analysis of the manner in which policies are transferred points to the prevalence of ‘coercive’ rather than ‘negotiated’ forms. As Chapman and Greenaway (2006:1061) suggest, donors “enforced policy transfer...[because it]...would not have occurred had the multilateral lending agencies...not imposed...[it]...as a condition of a given lending programme”. Moreover, in most cases developing countries do not have choices as the cost for refusing conditions is the much-needed developmental aid (Dolowitz and Marsh, 1996). As Batley (1999:762) attests, the “deepest reform proposals have occurred where there is the deepest economic crisis and multilateral lending agencies therefore have most influence”. The ‘negotiations’ also seem not to obtain because developing countries are in a “weak bargaining
positions” and do not have much input in the process (Grindle, 2000:193). In particular, institutional arrangements of international finance lending organisations deny developing countries adequate representation and participation at the discussion and ‘negotiation’ tables. As table 2 below demonstrates, developing countries have too few voting powers in IMF and World Bank making these organisations to influence the content and flow of policy conditionality. In this regard, the few voting shares mean that international institutions have “reduced the ability of individuals to participate in [policy] decisions affecting their daily lives” (Jones and Hardstaff, 2005:5).

Moreover, the powers of the United Nations in which the developing countries have a “more favourable position have been diminished whereas the mandate and powers of the institutions under the control of developed countries (the IMF, World Bank and WTO) have increased tremendously” (Khor, 2001:21). As a result, developed countries have leverage in the Bretton Woods institutions to “formulate policies which the developing countries have to take on” (ibid). Moreover, as the World Bank (2005:6) itself attests, “even when each country has equal representation in an international body such as the United Nations system or the World Trade Organization (WTO), powerful forces can chisel away at developing country interests (through separate bilateral agreements, for example)”.

**Table 2: IMF and World Bank Voting Shares**

<table>
<thead>
<tr>
<th>Region</th>
<th>IMF and IBRD voting share averaged (%)</th>
<th>World Population (%)</th>
<th>Voting Share to Population Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU States</td>
<td>29.9</td>
<td>7.1</td>
<td>+22.8</td>
</tr>
<tr>
<td>North America</td>
<td>19.7</td>
<td>5.2</td>
<td>+14.5</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>8.6</td>
<td>4.9</td>
<td>+3.7</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>7.7</td>
<td>8.5</td>
<td>-0.8</td>
</tr>
<tr>
<td>East Asia (excluding Japan)</td>
<td>7.1</td>
<td>30.9</td>
<td>-23.8</td>
</tr>
<tr>
<td>Japan</td>
<td>7.0</td>
<td>2.0</td>
<td>+5.0</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>6.5</td>
<td>6.7</td>
<td>-0.2</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>5.5</td>
<td>10.3</td>
<td>-4.8</td>
</tr>
<tr>
<td>South Asia</td>
<td>3.5</td>
<td>23.8</td>
<td>-20.3</td>
</tr>
<tr>
<td>Non-EU Western Europe</td>
<td>2.5</td>
<td>0.2</td>
<td>+2.3</td>
</tr>
<tr>
<td>Australasia</td>
<td>2.0</td>
<td>0.4</td>
<td>+1.6</td>
</tr>
<tr>
<td><strong>Developed Countries</strong></td>
<td><strong>61.2</strong></td>
<td><strong>20.7</strong></td>
<td><strong>+40.5</strong></td>
</tr>
<tr>
<td><strong>Developing and Transitional Countries</strong></td>
<td><strong>38.8</strong></td>
<td><strong>79.3</strong></td>
<td><strong>-40.5</strong></td>
</tr>
</tbody>
</table>

**Source:** Jones and Hardstaff (2005:33)
Negotiated policy transfer however, could be possible under the current assumed reorientation of donors from structural adjustment programs to poverty reduction reforms. Through this, the World Bank and IMF have begun to reconfigure their approach to conditionality (Bisley 2007) to make it more participative and country owned. This participation is achieved through the development of Poverty Reduction Strategy Papers (PRSPs) which stipulate ‘pro-poor’ policies as a requirement to benefit from debt relief and aid under the Heavily Indebted Poor Countries (HIPC) initiative. The development of the PRSPs is supposed to be country owned and participative involving all key stakeholders in the policy making process. However, analyst have noted that in reality it is “infinitely complex to translate into practice the intention of putting government and the people of developing countries in the driver’s seat” (McGee, 2002:103). Moreover, “being in the driver’s seat does not mean choosing the map or plotting the route” (Cammack P, 2004:198).

To this end, it is noted that policy transfers are more of a ‘coercive’ nature rather than ‘negotiated’ even under this arrangement. According to Jones and Hardstaff (2005:6), PRSPs have only presented a situation where “poor countries are now faced with an international financial landscape where loans, debt relief and aid are all subjected to meeting policy conditions”. This is because developing countries have had to undergo extensive macroeconomic, structural and administrative reform as conditions for debt relief. As Bello (2004:83) highlights,

beneath the thick rhetoric of poverty alleviation, the so-called consultative process reveals the same one-size-fits all policy matrix emphasizing rapid growth, the deregulation of monetary policy, the rearing down of the state sector in favour of private enterprise, deregulation, more liberal foreign investments laws, trade liberalisation, export-oriented growth and commercialisation of land and resource rights.

In this respect, donor organisations “continue to adhere to the same recipe, although the ‘cookbook’ has been changed and a few additional pages” (Stein, 2004:23) have been made. In particular, the Jubilee USA analysis highlighted that the PRSP programme was failing miserably because countries were forced to commit to unreasonable conditions and debt relief was tied to their living up to restructuring through IMF conditionality (Bello, 2004:81). Developing countries themselves regard PRSPs as “imported rather than home grown and are accepted under pressure as a means to obtain debt relief” (G 24 Group of Developing Countries Secretariat, quoted in Jones and Hardstaff, 2005:16). Therefore what donors are “failing to do is to give space to recipient governments to define their own priorities and set
down a framework” (Woods, 2005:4) making policy transfer to be ‘coercively’ oriented rather than ‘negotiated’.

3.4. VOLUNTARY POLICY TRANSFER

The foregoing discussion is not aimed at claiming that voluntary policy transfer in developing countries is absent. It has been seen that developing countries have engaged on policy transfer voluntarily “though it tends to be on a small scale” (Ivanova and Evans, 2004:97). Developing countries’ voluntary policy transfer demands “arise from the wider recognition that poor countries are held back in their development efforts by their failure to adopt and implement appropriate policies and to nourish the appropriate economic institutions” (Clague, 1997). As a result, developing countries have an “understandable desire to accelerate public sector reform by adopting the most advanced innovations devised by industrial countries” (Schick, 1998:123). This has made policy makers in developing countries to look “abroad for promising solutions to domestic problems” (Marmor et al, 2005:331) hence rational policy learning. For instance, Common (2004a) shows that the transfer of NPM reforms in Hong Kong, Singapore, and Malaysia was voluntary. In addition, Flores-Crespo (2004:134) demonstrates that the transfer of Technological University model to Mexico was a result of a “voluntary process of policy learning”.

Moreover, developing countries have many times voluntarily made requests for technical assistance from donor organisations and agencies to facilitate policy transfer (Ivanova and Evans, 2004). However, we should be aware that coercive elements can creep in if donors hijack the process and take their invitation into the policy space as a window of opportunity for advancing conditions. An example in this respect is the General Practice Funding policy transfer in the Kyrgyzstan Ministry of Health where to some extent the transfer was voluntary. However, there were “coercive elements to the development of policy because satisfactory progress on the reform proposals was a condition of subsequent WB and IMF loans” (Street, 2004:113).
3.5. EFFECTS OF COERCIVE POLICY TRANSFER

The current literature on policy transfer suffers from the lack of in-depth empirical analysis of policy transfer impacts and outcomes in developing countries. This is largely the case due to the “tendency to investigate ‘perfect fit’ and ‘completed’ processes of policy transfer” (Evans, 2004:41). This comes from the bias of investigating voluntary policy transfer processes among developed countries. However, there is need to study coercive policy transfer dynamics in developing countries as it is “potentially damaging” (Common, 2001:3). This is because coercive policy transfers lack a critical analysis and scrutiny by both the transferring and receiving agents (see Dolowitz, 2009a). As Minogue (2004:166) laments, it is “alarming to discover that influential donor policy initiatives often rest on ideas that are based on untested a priori assumptions, or strongly disputed by other practitioners”. This is the case as the underlying assumption with coercive policy transfer is that “policies that have been successful in one country will be successful in another” (Dolowitz and Marsh, 2000:17). Thus donors transferring policies to developing countries are faced with “a danger that it taken for granted that Western countries provide desirable exemplars” (Common, 2001:65).

However, the reality is that in most cases the transferred policies fail while in other instances they have negative impacts and consequences on service delivery. It is in this line that Murrell (1997:237) argues that a “model imported from the West is useful only to the extent that it provides a disciplining pedagogical device, not a magic key that will fit any door”. Dolowitz and Marsh (2000:17) draw three factors that play a significant role in policy transfer failure which are typical for developing countries as follows.

- **Uninformed Transfer**: the borrowing country may have insufficient information about the policy/institution and how it operates in the country from which it is transferred.

- **Incomplete Transfer**: although transfer has occurred, crucial elements of what made the policy or institutional structure a success in the originating country may not be transferred leading to failure.

- **Inappropriate Transfer**: insufficient attention is paid to the differences between the economic social, political and ideological context in the transferring and borrowing country.
Hulme (2005:423) underscore that the major problem with coercive policy transfer to developing countries is that there is no consideration of the “political, cultural, social and administrative specificity of the origins of policy ideas and instruments” and the context within which they are to operate. However, as Tews et al (2003:575) tell us, the “political, economic, societal and institutional capacities of any particular country influence the…feasibility” and applicability of the transferred policies. This is echoed by Schick (1998:124) who highlights that there are “important preconditions for successfully implementing the new public management approach and that these should not be ignored by countries striving to correct decades of mismanagement”. This line of thought has also been pursued by institutionalism and path dependence activists. Path dependence theory suggests that one would “never expect a program to transfer from one government to another without history, culture and institutions being taken into account” (Tews, et al, 2003:576). For example, it was in this tune that Common (2004a:152) was told by the Director of National Institute of Public Administration in Malaysia that “our political structure and history do not allow full implementation of these (NPM) ideas”.

Moreover, coercive policy transfer in developing countries has been seen to diminish the countries’ policy space. In this regard, “developing countries globally bemoan the fact that their policy space is increasingly eroded and constrained by multilateral trade agreements and loan conditionality” (Bugdahn, 2007:124). As Grindle (2000:195) observes, “national and international technocrats have filled places at the policy table formerly filled by line ministers, party leaders, and representatives of important interest groups”. The consequence of this has been policy-making paralysis as national policy making machinery has not been able to build the necessary capacity. In this manner, even the World Bank’s Gulhati (1988:14) noticed that in developing countries the “core economic agencies have not exhibited a capacity to undertake policy work; instead they have adopted the posture or reacting to policy proposals designed abroad”.

It has also been noted that coercively transferred policies have impacted negatively on service delivery. As Ilorah, (2008) observes, the “aid donors also use their economic power to influence the policies of recipient African governments in directions unfavourable for development”. Particularly, the policies have “usually generated a first impact of increased stress and poverty for those sections of the population that had had access to service and employment” (Batley, 2004:37). This is because some of these policies have meant reduced
access to services while in other sectors they have led to unemployment due to proposed redundancies thereby increasing vulnerability and raising equity questions (Kiggundu, 1998; McCourt, 1998). Similarly in his study, Evans (2004) observes that most policies transferred to Africa or Latin America did not bring sustained growth, and IMF policies deepened economic crisis in Thailand and Indonesia resulting in social and political chaos.

### 3.6. CONCLUSION

This Chapter discussed policy transfer in developing countries to provide a contextual background within which the study is undertaken. The Chapter highlighted that coercive policy transfers in developing countries are predominant due to overreliance on external aid. Donor organizations take this dependence as a window of opportunity to transfer policies through aid conditioning. Moreover, the nature of transfers reveals that they are more ‘coercive’ than ‘negotiated’. Although there are some learning instances present, in some cases donors hijack such activities with coercive mechanisms. As a result, most of the policy transfers have unintended outcomes and impacts on domestic policy making and service delivery. The next chapter provides the study’s methodological framework.
CHAPTER FOUR: STUDY METHODOLOGY

4.1. INTRODUCTION

Chapter Three analysed policy transfer in developing countries in order to provide a contextual background for the study. This Chapter discusses the methodology used to achieve the research’s objectives while being guided by the research questions and the ‘multilevel analytical framework’. To reiterate, the study’s objectives are to interrogate into the mechanisms of policy transfer, analyse factors mediating the policy transfer processes, and measure the impacts of such policies on service delivery transformation in Malawi’s health sector. To adequately operationalise the research objectives, this study focuses on addressing four research questions as re-articulated below:

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?

3. To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

4. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?

4.2. RESEARCH STRATEGY

This project is an empirical study based on qualitative research design. The justification for using the qualitative perspective is that qualitative research methodologies are data driven, flexible and they celebrate richness, depth, nuance, context, multidimensionality and complexity (Yin, 2009; Mason, 2002; Vandenabeele and Horton, 2008) all of which are fundamental for the generation of reliable and valid data for the analysis of policy transfer
processes. Moreover, qualitative research meaningfully operationalises research by unearthing various dynamics of the phenomenon under study and helps to build a narrative about policy transfer through an in-depth enquiry.

The research design is further operationalised through the Malawi case study of the Ministry of Health so as to measure the impacts and outcomes of policy transfer. The case study methodology is adopted because it is a “valid method for judging theoretical propositions on their merits” (Vandenabeele and Horton, 2008:5) and it provides a rare opportunity to carry out an in-depth and detailed examination on the phenomenon under study “within its real life context” (Yin, 2009:18). Moreover, case study methodology enjoys richness in capturing the required data in the case’s natural settings (ibid), it is “down to earth” (Stake, 2000:19) and has a “holistic focus, aiming to preserve and understand the wholeness and unity of the case” (Punch, 2005:144). It is in this regard that it is claimed that “truth, this method has been tried and found to be a direct and satisfying way of adding to experience and improving understanding” (Stake, 2000:24) [emphasis original]. While celebrating the richness of the case study methodology from which this study benefits, the researcher was also aware of its inherent limitations as articulated in the subsection that follows:

**4.2.1. INHERENT LIMITATIONS OF THE CASE STUDY METHODOLOGY**

It has been argued that the main limitation of case study methodology pertains to the extent to which results generated from the cases can be generalised to other populations (Yin, 2009; Stake, 1995). A classical understanding of generalisability is given by Kaplan who underscores that the “generalisations must be truly universal, unrestricted as to time and space. It must formulate what is always and everywhere the case, provided only that the appropriate conditions are satisfied” (quoted in Lincoln and Guba, 2000:27) [emphasis original]. To this end, it has been said that case study results may fail to account for causal linkages and outcomes in other cases beyond the present one (Gomm, Hammersley and Foster, 2000; Stake, 1995). Other authors go on to argue that case studies are not meant to generate wider generalisations but rather to be used for in-depth understanding of the uniqueness of the case in question (Silverman, 2002; Punch, 2005; Stake, 1995). The reasoning of these scholars has been that attempts to generalise from single case studies
would be problematic because generalisation to “cases not studied always entails some risk of mistaken inferences because they may differ from the case or cases studied in the values of potentially causal variables omitted from the theoretical framework” (George and Bennett, 2005:110).

However, despite these arguments, proponents of case study methodology have highlighted that there is some room for generalisations in case study designs (see Blaikie, 2000; Mjøset, 2006). As Winters and Mor (2009:1082) point out, “generalisation from case studies is possible” [emphasis original]. Flyvbjerg (2006:228) adds that “one can often generalize on the basis of a single case, and the case study may be central to scientific development via generalization” [emphasis original]. It is generally agreed however, that these generalisations are tentative (see Stake, 1978). As Kennedy (1979:664) argues, in case studies “an inference of generalisation is always tentative – that is data may offer confirming or disconfirming evidence but never conclusive”. In addition, Evers and Wu (2006:511) accentuate that “provisional generalisations from single cases” can be made when methodologically there is [emphasis added]:

- An exploration of the impressive amount of empirical knowledge that is contained within the theories that are used to make observations, to classify phenomena, and to understand and interpret cases.
- Recognition of the role of a pattern of inference known as abduction, or inference to the best explanation, in drawing conclusions from case studies.

It is against this background that the study will utilise the case study methodology to draw tentative generalisations in order to highlight the significance of the study to similarly placed country contexts. However, the generalisations made from cases are understood differently from the narrow ‘statistical generalisation’ appropriate to surveys (Blaikie, 2000; Yin, 1989; Stake, 1978). In this vein, the emphasis in case study generalisations is on ‘analytical generalisations’, where “previously developed theory is used as a template with which to compare the empirical results of a case study” (Yin, 1989:38; see also Johansson, 2003); ‘naturalistic generalization’, which is attained by recognizing the “similarities of objects and issues in and out of context and by sensing the natural co variations of happenings.. (with the aim of) being both intuitive and empirical” (Stake, 1978:6); ‘fittingness’, which refers to the degree of comparability of different contexts (Scapens, 2004:269); ‘relatability’, which
pertains to the extent to which the “details are sufficient and appropriate for other cases in a similar situation to relate their [sic] circumstances to that described in the case study” (Bassey, 1981:85); and ‘pragmatist strategy of generalization’ which is to “generalize without cutting off grounding in specified contexts because generalization is desired, but not at the cost of the grounding in specific contexts” (Mjøset, 2006: 759) [emphasis original]. To this end, as will be seen in Chapter Nine, the study’s provisional generalisations will not take the form of statistical generalisation because the project is based on qualitative design as discussed above. However, ‘naturalistic’ and ‘analytical’ generalisations will form the basis for drawing wider implication to other similarly placed country contexts.

4.3. STUDY POPULATION AND SAMPLE FRAME

It is generally accepted that in case study research, qualitative sampling involves “identifying the case(s) and setting the boundaries where we indicate the aspects to be studied and constructing a sampling frame, where we focus further selection” (Punch, 2005: 188; see also Silverman, 2002; Richie, Lewis and Elam, 2009). It is against this backdrop that the study’s population comprised of organisations and people with close proximity to policy making and implementation in Malawi. However, for practical reasons, only organisations that were involved in health sector reform programmes under study were purposively sampled. In addition, snowball sampling method was also employed because some respondents gave reference to other organisations and personnel that were equally significant but were not initially envisaged. Purposive sampling was particularly important to ensure that all the key constituencies of relevance to the study are considered and that within each of the key criteria, some diversity is included so that the impact of the characteristics concerned can be explored (see Richie, Lewis and Elam, 2009). Purposive and snowball sampling techniques have however, some inherent limitations which the researcher was aware of as discussed in a greater detail under section 4.4.1.2 below.

As illustrated in the ‘multilevel theoretical framework’ for the study in Chapter Two, this project was designed to be studied at three levels of analysis namely; international, national, and policy implementation levels. At the level of policy implementation seven hospitals were included in the sample. These are the four Central Hospitals in the country (Blantyre, Zomba,
Lilongwe, and Mzuzu) and three District Health Offices (Chikwawa, Salima, Mzimba) one from each administrative region to make the study representative of the Country. Also included in the sample at this level were the Local Government Assemblies and Non Governmental Organisations on health. At the national level the sampled organisations included the Ministry of Health headquarters, Ministry of Finance, Ministry of Local Government, the Office of President and Cabinet, Democratic Consolidation Programme, Non Governmental Organisations, and Donor Organisations (USAID, UNDP, DFID, WHO, EU, IRISH AID, GTZ) based in Malawi. Actors at the international level were found to be the same as those at the national level, as discussed above. The actual sampling techniques of participants and their limitations are provided in sections that follow.

4.4. DATA COLLECTION METHODS

As can be seen in figure 5 below, the study used various qualitative data collection tools so as to be robust in adequately gathering the necessary data for analysis. The use of a variety of data collection instruments was also particularly pivotal for triangulation purposes. Triangulation is important to ensure the validity, reliability and completeness of the information (CEMCA, 2002:44) due to the subjectivity and limitations that may be inherent in the use of one technique. In particular, the triangulation process is based on the understanding that any bias and limitations inherent in a particular data source or method would be neutralised when used in conjunction with other data sources and methods (Creswell, 1994, Yin, 2009). Therefore, the data collection methods used in this project included in-depth interviews, focus group discussions, observations, and documentary sources as discussed below. These research tools were systematically employed as shown in figure 5 below.

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9 Malawi has three Administrative Regions which are Southern, Central and Northern as discussed in Chapter Five
4.4.1. SEMI-STRUCTURED IN-DEPTH INTERVIEWS

In-depth interviews were employed to get information from key informants. Interviewing was seen as a key data collection method as it “provided information not recorded elsewhere, or not yet available (if ever) for public release” (Richards, 1996:200) but very central to the study. It was also used in order to get an in-depth understanding of the policy transfer issues.

Source: The Author
under study. In-depth interviews were done at all levels of analysis as shown in figure 5 above. Interviewees included officials from the Ministry of Health (both headquarters and hospitals), Ministry of Finance, Office of President and a Cabinet, Ministry of Local Government, donor organisations based in Malawi and their consultants, nongovernmental organisations in the area of health as discussed in section 4.3 above. Forty Six interviews were conducted in total. The people interviewed included those that are currently working in these organisations and those retired or relocated to other organisations but were central to the policy transfer processes under study.

The personal interviews were administered by the use of open ended semi-structured interview guides as shown in Appendix 6. Semi-structured questionnaires were used to give enough latitude and flexibility to the respondents of explaining the issues under study. The aim was “not to get simple yes and no answers but descriptions of an episode, a linkage, and explanation” (Stake, 1995:65). In addition, semi-structured questionnaires were employed as interview subjects “do not like being put in the straightjacket of closed ended questions [but] they prefer to articulate their views, explaining why they think what they think” (Aberbach and Rockman, 2002:674). This was followed by probes to bring out issues critical to the study. Through the use of semi structured questionnaires, some policy transfer issues that were initially overlooked by the researcher but were very important to the study were captured. For ethical reasons, all the interviewees were promised that their responses would be held in confidence and that the researcher would make no individually identifiable attributes. This encouraged the interviewees to give full information without the fear of some negative implications and consequences. Tape recorder was used to record the interviews and transcription begun within 48 hours so as to ensure timely familiarisation with the data.

4.4.1.1. Recruitment of Respondents for Semi-structured Interviews

The study wanted to investigate into the specific mechanisms, processes and outcomes of the transfer of hospital autonomy and decentralisation reforms in Malawi. As a result, the use of a random sampling technique would not work to select the required sample for in-depth interviews as it would include many that were not directly involved in the process and knowledgeable about the topic (see Silverman, 2002). As Schutt (2006:313) observes, “researchers should try to select interviewees who are knowledgeable about the subject of the interview, who are open to talking and who represent a range of perspectives”. It is in this regard that a non probability (purposive sampling) technique was used. By definition,
purposive sampling is a non-probability technique where sampling is done in a “deliberate way, with some purpose or focus in mind” (Punch, 2005:187). This is where the actual respondents were purposively selected on the basis of their positions and association with the policy programmes in question and hence their knowledge of the transfer dynamics. For the actual selection of the respondents in purposive sampling, the procedure is to “establish contact with a key person, or highly placed manager, [in order] to take his or her help in identifying the right persons” (Ghauri and Gronhaug, 2002:176; see also Hartley, 2006). To this end, since the researcher was an outsider to the reform processes and did not know the actual actors in programmes under study, the selection was done with the assistance of health planning officers from the MOH during the initial pre-study visit. The MOH officials assisted with the mapping out of stakeholder organisations and personnel that were key to the reforms in question from which research participants were recruited. This was critical in order to “maximise what we can learn” (Stake, 1995:4) as it enabled the selection of “information rich cases for in-depth analysis related to the central issues being studied” (CEMCA, 2002:47).

Apart from purposive sampling, snowball sampling technique was used in order to get key respondents who were not initially included in the sample-frame. This was important as snowball sampling provides an “efficient and economic way of finding cases that may otherwise be difficult or impossible to locate or contact” (Hendricks and Blanken, cited in Faugier and Sargeant, 1997:792).

4.4.1.2. Inherent Limitations of the Sampling Technique

The researcher was aware of the inherent limitations of the purposive and snowball sampling techniques that the study used. These include the following: firstly, there have been concerns that the purposive sample is not statistically representative which may affect the extent to which the findings can be generalised to other cases as already highlighted above. As Stake, (1995:4) underscores, participants selected through purposive sampling are “unlikely to be a strong representation of others”. However, Richie, Lewis and Elam (2009:78) elucidate that “the [purposive] sample is not intended to be statistically representative, the chances of selection for each element are unknown but, instead, the characteristics of the population are used as the basis of selection”. The other criticism against purposive selection is that it can be prone to “versions of selection bias that concern statistical researchers” (George and Bennett, 2005:22). This is the case as in purposive sampling ‘gate-keepers’ may direct the
researcher to certain interviewees while avoiding others knowingly or unknowingly (ibid: 21, Pole and Lampard, 2002). On the part of snowball sampling, the main concerns are two. Firstly, since new samples are generated through existing ones, it can limit the diversity of the study’s informants (Taylor and Bogdan, 1998; Richie, Lewis and Elam, 2009). Secondly, it can “lead to under-representation of those types of people who are not tied into the social network” (Pole and Lampard, 2002:36).

However, despite these limitations, the purposive and snowball sampling techniques have been seen to be central in qualitative research (Silverman, 2002). Moreover, “which methods and techniques are most suitable for which research depends on the research problem and its purpose” (Ghauri and Gronhaug, 2002:85, see also Yin 2009; George and Bennett, 2005).

4.4.2. FOCUS GROUP DISCUSSIONS

Focus group discussions were conducted at the policy implementation level of analysis with ‘street-level bureaucrats’ (Lipsky 1997:389). These are frontline officers that deliver health services at the hospital level who included nurses, clinicians, clerical and cleaning staff. They are at the hub of the policy implementation and are better placed to gauge the impacts and outcomes of policy transfer on organisational processes. Moreover, it has been noted that in many cases policy transfers are only a political rhetoric, “self-deception”, and “political hyperactivism” (Dunleavy et al, 2006:489) with no reflection on the ground. Therefore, focus group discussions at this level were key in generating information pertaining to the extent of the implementation and transformational impacts and outcomes of the health sector reform transfers.

In addition, focus group discussions were pivotal because they have a rare characteristic of allowing participants to “interact in a discussion on a particular topic, agree with other interviews in some respects and disagree in others and raise new issues and concerns” (Devine, 2002:199), an attribute which was instrumental in bringing out pertinent issues under study. Accordingly, people in managerial positions at hospital or district level were subjected to in-depth interviews rather than focus group discussions. This ensured free participation without fear. In total, seven focus groups were conducted each comprising of not more than eight people so as to give all participants equal chances to participate. Just like in the case of interviews, the data collected was treated with confidence making no
individually identifiable attributes for ethical purposes. The researcher tape recorded the discussions and transcription begun within 48 hours to ensure timely familiarisation with the data.

4.4.2.1. Recruitment of Respondents for Focus Group Discussions

The respondents for focus group discussions were recruited through the use of convenient non probability sampling technique (see Pole and Lampard, 2002; Ghauri and Gronhaug, 2000). In this regard, the focus group members consisted of those people that were available at the time the researcher visited the sites and were willing to be included in the sample. This was the case because focus group discussions were carried out in a hospital environment where most respondents were busy due to the nature of their work and it was difficult to make prearranged contacts. However, within this sample technique the researcher made deliberate attempts to have representation from various service deliverers for example, clinical staff, clerical staff, and nurses as has already been articulated above.

4.4.2.2. Inherent Limitations of the Focus Groups

The researcher was aware of the inherent limitations of the focus group technique. These pertain to problems associated with group culture and dynamics, and in achieving balance in group interaction (Punch, 2005:171). The concern here is how to deal with dominant individuals’ influence in focus group discussions. This is the case as while some participants may dominate the discussions, others may not give their views but passively follow the group trend (Ghauri and Gronhaug, 2002; Pole and Lampard, 2002). Moreover as Taylor and Bogdan (1998:114) highlight, “most people cannot be expected to say the same things in a group that they might say to an interviewer in private”.

4.4.3. FOLLOW UP TELEPHONE INTERVIEWS

There were some minor gaps identified through the data analysis process and these were followed up with telephone and Skype call interviews. This was mostly in cases where some key respondents were no longer working in Malawi at the time the researcher was there for research. In addition, when the study was being conducted the country had general elections which made some respondents not to be reached as they were busy with the electoral processes. The researcher therefore had to make follow up telephone calls in such cases.
4.4. 4. DOCUMENTARY SOURCES

Documentary analysis was conducted to bring out the prevailing contextual and practical policy issues under study. Documentary analysis was done in tandem with interviews since the researcher intended to “produce work with textural depth as well as empirical strength” (Lilleker, 2003:208). As can be seen from figure 5 above, the documents also worked to map up issues that were followed up or clarified by the interview process. In particular, documentary analysis was pertinent in pinning down the policy transfer processes which were not readily available from the interviews and focus group discussions. It is in this context that the documents provided the researcher with a “wealth of easily accessible and readily available research data” (Appleton and Cowley, 1997:1009) that was central in addressing research questions.

In this regard, the exercise involved the collection, review and analysis of pertinent literature of the issues under study. From the Malawi Government side, the researcher was interested in relevant publications, meeting minutes, policy documents, ministerial speeches, circulars, letters, memorandums, agreements, and operational guidelines. From the international donor organisations, of interest were publications, meeting minutes, communications, and loan agreement documents. Relevant literature from non-governmental organisations on health issues was also analysed. Also included were professional newsletters pointing to issues under investigation, and any other relevant literature providing insights into the policy transfer activities under study.

4.4. 4.1. Inherent Limitations of documentary sources

It must be known that just like the other methods of data collection stated above, documentary analysis has some inherent limitations which the researcher was aware of. Pershing (2002) lists these shortfalls as follows:

- Documents, in their creation may have been adjusted or selectively edited to make an organizational record look good and thus can be misleading.
- Employees may alter their work if they are aware that documents they produce are being analyzed.
- Documents may be inaccurate or out of date.
- Some documents may be difficult to access, if restricted to authorized staff or if recordkeeping procedures have changed over time.
• Documents are limited to a historical focus.

4.4.5. OBSERVATIONS

Apart from the formal data gathering processes outlined above, the study also relied on the researcher’s observations during the study. This was instrumental in getting “additional information about the topic being studied” (Yin, 2009:110) as it is about “collecting data in natural settings” (Pole and Lampard, 2002:71). This is the case as there were some issues that were not said by the respondents or recorded in secondary sources but could be observed by the researcher through the working habits of the organisations under study.

4.4.5.1. Inherent Limitations of Observations

The researcher was aware of the inherent limitations on observations as a data collection tool. Yin (2009:102) pinpoints these limitations as follows

• Observations are time consuming.
• There are problems of selectivity as broad coverage is difficult without a team of observers.
• There are challenges of reflexivity as event may proceed differently because it is being observed.

4.5. PILOTING OF RESEARCH INSTRUMENTS

To enhance the validity of the collected data, the semi-structured questionnaires for in-depth interviews and focus group discussions were first piloted before being administered to the research subjects. This piloting was done among fellow PhD students at the University of Manchester and academic members of staff from the University of Malawi working in the area of public policy and public administration. The piloting was pivotal in refining “data collection plans with respect to both the content of the data and procedures to be followed” (Yin, 2009:92). To this end, a number of issues came up during the piloting process which provided feedback to the research instruments for further improvement. These include the following:

The first issue was about language. It was noted that some public officials may not be conversant with the English language although English is the official language for Malawi. This mainly was in reference to focus group discussions administered to ‘street level
bureaucrats’ at the service delivery level. In this manner, the piloting process recommended that although English could be used as a primary language, the local language (*Chichewa*) could also be applied for further explanation and clarification of issues. In addition, it was also recommended that the respondents should be given room to express themselves in a language of their choice.

The second issue raised regarded the clarity of interview questions. It was felt that some interview questions were vague and had ‘technical’ language which could not be readily discernible by the respondents and therefore fail to adequately solicit the required responses. The said questions were therefore reconstructed to ensure clarity in articulating the issues under examination.

The last issue regarded the ordering of questions. It was felt that the interview questions were not properly ordered as some issues that were supposed to be asked first appeared at the end and vice versa. This was seen problematic as it facilitated the repetition of issues that had already been asked. The researcher revised the order of questions accordingly.

### 4.6. DATA ANALYSIS

The study used content analysis methodology to analyse data. This is because content analysis allows the researcher to “sift through large volumes of data with relative ease in a systematic fashion” (Stemler, 2001) and has “explicit procedure and quality control checks” (GAO, 1996:11). Content analysis has been defined as a “systematic and replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding” (Vehkapera, 2004:574). In this case, the analysis predominantly involved categorizing issues according to the recurrent themes emerging from the data collection exercise. In this regard, based on the data gathered, general thematic issues of the policy transfer mechanisms, processes and outcomes drawn were informed by systematic comparisons and aggregation of issues arising at each level of analysis. Special attention was paid to patterns, divergences, trends, theoretical constructs and themes evolving from the qualitative data collected. It is from these that general conclusions were formulated.
4.7. METHODOLOGICAL CHALLENGES

Below are the study’s methodological challenges and how the researcher tried to minimise their negative impacts:

First was the problem of recalling information. Some participants had difficulties in remembering the processes since this was a historical enquiry. The carrying out of multiple interviews and the use of documentary sources were seen as mechanisms to address this problem.

Secondly, some processes involved were regarded as ‘political’ and some participants were not comfortable to divulge all the information due to fear of sanctions. Again, the use of many interviews and documentary sources worked to mitigate the impacts of this problem. Particularly, focus group discussions with ‘street level bureaucrats’ worked to solve this problem as they are “often more critical of reforms than their bosses” (Pollitt, 2000:187). Moreover, all interviewees were assured of confidentiality and anonymity that enabled to reduce the fears.

The last challenge was about the timing of the data collection exercise because the country had presidential and parliamentary elections on 19th May 2009. Data collection for PhD students normally starts from the first six months of the second year. Since the researcher was a January PhD registrant and bound by scholarship timing, data collection had to take place from February 2009 to June 2009. The researcher feared that the electoral dynamics would disturb the research processes. In particular, on the opposition side there was the former president Dr Bakili Muluzi seeking to bounce back into power and on ruling side was the incumbent president Dr Bingu wa Mutharika who wanted another term of office. With this background, and in view of the general violence that characterise elections in Sub-Saharan African, the researcher feared that these would impact negatively on the research processes. Fortunately, although some participants were hard to get, the electoral process was peaceful and did not adversely affect the study. Moreover, those that could not be contacted during this time were followed up through telephone interviews as indicated above.
4.8. ETHICAL CONSIDERATIONS

The researcher adhered to ethical requirements for conducting research. The issues involved informed consent, confidentiality and time management. The researcher first obtained a letter of introduction from his employers the University of Malawi as required (see appendix 5). Additionally, the researcher obtained informed consent from all the participants by explaining the research project to them and asking them if they would agree to be interviewed. To observe confidentiality, all the interviewees were promised that their responses would be held privately and that the researcher would not refer to their names in the writing up process. The respondents were also assured that the results would be used for academic purposes only. Moreover, the researcher was time conscious so as not to unnecessarily inconvenience the respondents. Therefore, at the start of each session the participants were asked the time they could spare for the exercise which the researcher strictly adhered to. Lastly, ethical considerations did not only mean collecting and analysing data morally but also implied planning and framing research questions ethically (see Mason 2002).

4.9. CONCLUSION

This Chapter has presented the study’s methodology. It has highlighted that the methodology used was guided by the study’s objectives and the ‘multilevel analytical framework’ identified in Chapter Two. The study’s population and sample frame comprised of organisations at implementation, national and international levels. The study’s research strategy was qualitative. Four data collection tools were identified which include in-depth interviews, focus group discussions, observations, and documentary sources. The Chapter also pinpointed the data analysis method, methodological challenges and ethical considerations.

The next Chapter presents the case of Malawi so as to provide the country specific historical, institutional, economic, political and cultural contexts within which the study is conducted. This is important as we should be aware that policy transfer does not take place in a vacuum but in a country specific environment.
CHAPTER FIVE: POLITICAL, POLICY, ECONOMIC, CULTURAL AND REFORM CONTEXTS OF MALAWI

5.1. INTRODUCTION

Chapter Four presented the methodological framework for the study. This Chapter presents the case of Malawi. The aim is to provide the country specific contextual framework so as to adequately analyse the mechanisms, processes and outcomes of policy transfer in Malawi. This is because it has been observed that policy transfer does not take place in a vacuum but in a country specific environment (Taylor, 2002). This Chapter therefore provides the country specific physical, historical, institutional, socio-economic, political, policy and cultural milieus within which the study is conducted.

5.2. PHYSICAL AND INSTITUTIONAL CONTEXT

Malawi is a landlocked Sub-Saharan African country sharing boundaries with Mozambique to the South, Southwest and East; Zambia to the West and Northwest; and Tanzania to the North and Northeast. Administratively, the country is divided into three regions namely Southern Region, Central Region and Northern Region. The Regions are divided into districts which are headed by a District Commissioner. The Southern Region has thirteen districts, the Central Region nine, and the Northern Region six. These districts form autonomous local government authorities. Being a culturally traditional society, the districts are further subdivided into Traditional Authorities (TAs) which are headed by chiefs. Each Traditional Authority has villages which are managed by village headmen. Appendix 1 displays the Map of Malawi and its geographical location in the world. The institutional structures of government comprise of the traditional branches which are the executive, the legislature and the judiciary as shown in Appendix 2.

5.3. SOCIO-ECONOMIC CONTEXT

With a population of 13.1 million people, a series of World Bank and UNDP reports classify the country as one of the poorest in the World. The country’s Gross Domestic Product is US$ 3.5 billion and has Gross National Income (GNI) per capita of US$ 250 (World Bank, 2008). Poverty in the country is “widespread, deep and severe” (Malawi Government, 2002:5) with
52.4 percent of the population living below the poverty line (Malawi Government, 2006). This is an improvement from 65.3 percent in 1998 (Malawi Government 2002). However, the country’s economy has been growing averaging 8.3 percent with 6.7 percent in 2006, 8.6 percent in 2007, 9.7 percent in 2008 and 6.9 percent in 2009 (World Bank, 2009). To this end, the African Development Bank and OECD (2008a:401) comment that “despite remaining one of the poorest and least developed countries in Africa, Malawi is beginning to make real progress in terms of laying the foundations for faster economic growth and more effective poverty reduction”. Malawi’s social indicators are low with life expectancy at birth of 48 years which is lower than the Sub-Saharan average of 51 years and that of the low income countries of 57 years (World Bank, 2008). The Human Development Index for Malawi as of 2007 was at 0.493 ranking the country on position 160 out of 182 countries for which the index was calculated (UNDP, 2009).

5.4. POLITICAL AND POLICY CONTEXT

Malawi has been under three political regimes namely; colonial, one-party dictatorship and multiparty democracy. Below is a discussion of politics and policy making in these regimes.

5.4.1. POLITICS AND POLICY MAKING DURING THE COLONIAL RULE

Formerly called Nyasaland, the country was under British colonial rule from 1891 until independence on 6th July 1964. The government machinery owed its existence to the colonial masters as the land was previously organised along traditional institutions of tribal chiefdoms (Pike, 1968). The colonial administration was centralised with the Governor having absolute powers over the country. The Governor was “seconded from the colonial headquarters and acted as the chief representative and agent of the British Empire” (Kaunda, 1999:580). However, to articulate colonial policies to the natives, the use of indirect rule through traditional leaders was the administrative norm. Indirect rule was introduced in 1933 after prolonged resistance from traditional leaders who were constantly making greater claims to power and were justifying these claims on the basis that this power had existed before colonialism (Chanock, 1975). Therefore, the system of indirect rule worked as an instrument of “imperial social engineering to thwart class formation” (Power, 1992:317) and legitimize the colonial presence among the natives. Chiefly, traditional rulers functioned as assistants in the maintenance of law and order, the administration of justice, tax collection, and in other functions as directed by the colonial rulers (Kaunda, 1999).
It would seem that in policy making, the colonial regime advanced policies that benefitted the imperial rulers rather than uplifting the lives of the natives. The aim was to reinforce the “privileges and serve the wishes of the colonialist conquerors” (Kaunda, 1999:581). For example, a Colonial Chief Secretary attested that “our first and foremost care was to protect the interest of the British. [T]he natives...were to participate in all such advantages...as from time to time may be safely extended to them” (quoted in Williams, 1978:57). To attain this end, the key strategies were “domination”, “subjugation” (Mhone, 1992:3), and “control” (Foster, 2001:279). Generally, local policy realities were “not followed when they conflicted with European interests” (Foster, 2001:280) thereby relegating the natives to “vassals of the Colonial Office” (Ross, 2009:47). This was reinforced by a ‘repugnance’ clause, which outlawed certain traditional practices (Foster, 2001). However, despite the ‘repugnance clause’ the colonial policy machinery was not without some local resistance. This was mostly due to preference of traditional systems that were embedded into the society. For instance in 1938 a Colonial Agricultural Officer observed that,

the native is fairly tolerant of European methods but he still stands firm and adamant against attempts to change his normal time of planting cotton. He has so far resisted attempts to make him plant earlier and attempts to make him plant later (quoted in McCracken, 1982:101).

5.4.2. POLITICS AND POLICY MAKING IN THE ONE PARTY DICTATORSHIP

On sixth July 1964 Nyasaland became the independent state of Malawi through the Malawi Congress Party (MCP) under the leadership of Dr Hastings Kamuzu Banda. At independence, the country had “some of the paraphernalia of a parliamentary democracy” (Gulhati, 1989:30). However, just seven weeks after independence there were policy disagreements between Banda and his ministers leading to what is commonly called the ‘1964 Cabinet Crisis’ - expulsions and resignations of ministers (Ross, 2009). To avoid further resistance, Banda took a dictatorial style of leadership and made the MCP the only legally recognised party. The system allowed for elections to elect members of parliament but these were only a sham as the choice was between candidates from MCP, vetted and nominated by Dr Banda and were often returned unopposed because of a culture of coercion that prevented alternatives (Lwanda, 2004).
In 1971 Banda made himself Life President and had an absolute grip on the country. His regime was so autocratic that it was classified as the “most repressive, corrupt, predatory and violent political system in Africa” (Ihonvbere, 1997:225). It was characterised as a “thoughtless state of despotism” (Mapanje, 2002:184), “extreme authoritarianism” (Phiri and Ross 1998:10) and a reign of “death and darkness” (Englund, 2002a:12). According to Mhone (1992:1), the regime consisted of “mutually determining and reinforcing political apparatuses of authoritarianism, paternalism and repression, and economic relations of denomination and exploitation”.

For policy making, in principle, the Cabinet chaired by the President determined and formulated policies. However, in practice Banda monopolised the policy making process so that he alone became the source of policy (see Pryor, 1990; Short, 1974). He was the sole architect of policy “using the MCP as his instrument, parliament as the rubber stamp to provide legitimacy for his decisions and the ministers as virtually administrators of his policies” (Gulhati, 1989:30). As Banda himself admitted, “the Malawi style is that Kamuzu [Banda] says it’s just that, and then it’s finished. Whether anyone likes it or not, that is how it is going to be here. No nonsense, no nonsense. You can’t have everybody deciding what to do” (Banda quoted in Short, 1974:203). In this context, Banda “insisted upon lying down the overall framework and making the final decision, even on the most trivial matters and once made decisions cannot be altered except by Banda himself” (Thomas, 1975:31). Expert opinion and advice were only taken on board when they were in conformity with his thinking. Those that had different policy views were regarded as dissenters and were either dismissed or imprisoned (Short, 1974). As a result, civil servants “hesitated in conveying ‘bad news’ to the president thereby delaying policy responses to emerging problems” (Gulhati, 1989:33). As a former expatriate economic expert reveals, “under the idiosyncratic dictatorship of Dr Banda, it was at best useless and at worst dangerous to put forward any view that conflicted with his own preconceptions” (Giles, 1979:219). Banda himself did not hide this but he openly declared that

I am the boss here. Why beat about the bush? I am responsible for this country,...men and women, boys and girls. I am the boss...I am responsible. If anything goes wrong, it’s not my Permanent Secretary who is going to be blamed. Therefore, when the opinions of the officials on any subject conflict with my own opinions, my opinions should always prevail. Any official who does not like that can resign at any time. And that has been my policy all through. A leader...who depends on others, even his own officials or outside experts is a prisoner. And I never want to be a prisoner on any
subject, not one. I accept advice from my so called experts, so called advisors, so called specialists only when their advice agrees with my own ideas and not at any time (Banda quoted in Pryor, 1990:13)

It would seem this policy stance brought in some dividends because the country witnessed a remarkable economic growth over the years. Economically, the regime was doing well in comparison with other similarly placed African countries (Mhone, 1992). The country experienced positive balance of payments and rapid growth so that at one point it was characterized as a “star performer” (Chinsinga 2007:2). This economic performance in conjunction with the politics of the Cold War overshadowed the dictatorial nature of the regime to the outside world. In fact Banda was regarded as “one of the West’s favoured ‘strongmen’ in Africa” (Sahley et al, 2005:13).

However, the economic glory was short-lived as in the early 1980s the growth plummeted. This was because of the global recession which was triggered by deteriorating terms of trade, transportation bottlenecks, rising costs of fuel and adverse weather conditions (Harrigan, 2001; Mhone, 1992). The economic downturn in combination with the post Cold War politics acted as an entry point for the influence of the international donor organisations in policy making in Malawi and the rest of the developing world. In an attempt to ‘correct’ or ‘reverse’ these economic problems, the World Bank and the IMF would only provide financial assistance on condition that developing countries carry out prescribed economic policies in the name of Structural Adjustment Programmes (SAPs) (see Harrigan, 2001). Thus the economic bust of 1980 “drove Malawi into the ambit of the World Bank, and structure adjustment programs were adopted in the early 1980s” (Mhone, 1992:27). The realities of the economic crisis and the subsequent need to secure World Bank and IMF loans marked the end of the inward Banda centred policy making approach. The World Bank capitalised on Banda’s one man decision making style to convince him on the need to change policy orientation if the country was to move out of the recession. As the World Bank, noted “it is sufficient in Malawi if they [reforms] are pragmatic and are presented convincingly enough so as to appeal to and obtain the consent of the Life President” (quoted in Harrigan 2001:213).
5.4.3. POLITICS AND POLICY MAKING IN THE DEMOCRATIC ERA

The winds of democratisation blowing across the African region did not spare Malawi. Donors suspended aid in May 1992 so as to force the government to democratise. This was enhanced by internal pressure for the adoption of multiparty system. These pressures forced Banda to call for a referendum in 1993 where people overwhelmingly voted for multiparty democracy. The first multiparty elections were held in 1994 which saw the coming to power of Bakili Muluzi under the United Democratic Front (UDF) party. It would seem that because of old age and loss of support, Banda accepted defeat and went out of politics quietly. The next set of elections took place in 1999 where Bakili Muluzi was retained in office.

We should be aware that the adoption of the multiparty democracy has led to a great transformation of policy making process in Malawi. This is because, as expected in a democratic context, there are many actors and stakeholders in policy making processes. In general, there is a “complex of technical, stakeholder interests, and political forces driving policy-making in Malawi” (Sahley et al 2005:25). Since Malawi is heavily donor dependent, donor organisations are a key stakeholder. The country is so reliant on donors that without their support it can hardly operate. It is estimated that donors provide over 80 percent of Malawi’s development budget and some 50% of its annual recurrent costs (Chisinga, 2007:7). Claussen et al, (2006) estimate that the share of external resources of total state budget receipts fluctuates between 33% and 57%. As a percentage of nominal gross domestic product (GDP), development support increased from 16 percent in 2004/05 to 22 percent in 2006/07 (African Forum and Network on Debt and Development, 2007).

It appears that Malawians embraced multiparty politics with much enthusiasm and hoped that it would bring freedoms and meaningful economic development that were conspicuously absent during the one party regime. However, the case of Malawi exposes how “present multiparty politics has failed to erase past practices and institutions some of the latter promoting, some undermining popular participation” (Englund, 2002b:172). The legacies of the one party dictatorial regime are still haunting the democratic Malawi so that denials of rights and liberties have been “consolidated through the manipulation of state institutions of the public policy process and by tampering with the laws of the country” (Khembo, 2004a:18). In addition, a “culture of secrecy and silence are still present [and] an environment of open dialogue and free discussion has not fully set in” (Meinhardt and Patel, 2003:50).
The 1994 democratic reforms also ‘liberalised corruption’ (see Lwanda 2004; Anders, 2002) so that it has become systemic to the extent that a “culture of corruption is undeniably growing where the moral standards in public life have been lowered” (Khembo, 2004a:98). The third term and unlimited term discourses directed towards making Bakili Muluzi rule permanently despite the two consecutive term constitutional limit, only confirmed views that the country was slowly degenerating into a neo-liberal autocracy.

It seems that when the third term bid failed due to its unpopularity, Muluzi handpicked Bingu wa Mutharika - an outsider to the UDF - to be the party’s 2004 presidential candidate. However, soon after Mutharika won the election, he left the UDF the party that sponsored his election and formed his Democratic Progressive Party (DPP). Mutharika’s move did not please the UDF and they made several attempts to derail him. Owing to their large numbers in parliament, the UDF jeopardised government business so that it became extremely difficult for government bills, including the national budget to pass. The UDF dominated parliament even made attempts to declare all the seats of MPs that were sympathetic to Mutharika vacant under the Constitution’s Section 65 so as to enable them to impeach the President without resistance. These moves failed due to legal technicalities and public sympathy. In an attempt to consolidate his grip on power in this tumultuous political environment, Mutharika adopted a ‘tit-for-tat’ political leadership style which saw most of the UDF gurus either behind bars or before courts for corruption and fabricated treason charges. In addition, some constitutional provisions were not adhered to for the purpose of regime assertion. To this end, a human rights watchdog expressed that “President Mutharika has since taking office frequently and defiantly contravened constitutional provisions and flouted other regulations” (CHRR, 2007:11).

The May 2009 general elections saw the comeback of Bakili Muluzi to the electoral podium. The UDF presented Muluzi, a former president who had already served his constitutional two terms of office to provide a solid force to win the election. For Muluzi, removing Mutharika from power was an end in itself rather than a means to forge the country’s developmental

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10 Section 65 of the Constitution is against crossing the floor and provides that the “Speaker shall declare vacant the seat of any member of the National Assembly who was, at the time of his or her election, a member of one political party represented in the National Assembly, other than by that member alone but who has voluntarily ceased to be a member of that party and has joined another political party represented in the National Assembly”.

11 According to Section 83 of the Constitution, a President is allowed to serve for only a maximum of two consecutive terms of office
agenda. He did not hide his intentions but emphasised that “mine is a promise and a vow that I shall not let [President] Mutharika go scot-free for abusing my support and those of other UDF members by dumping the party that ushered him to power. I will not sit back and let his agenda of killing my party succeed” (quoted in Nation, 13/6/2008). However, the Electoral Commission disqualified his candidature only a few days before the elections basing on Section 83 of the Constitution which only provides for a consecutive two term limit. In a dramatic turn of events, Muluzi formed an electoral alliance with his bitter rival MCP leader John Tembo, urging all UDF members to vote for Tembo as president. The aim was to come up with a united force to unseat President Mutharika. However, this did not help as Mutharika won the election overwhelmingly with a massive 66 percent of the vote. It seems that Mutharika was re-elected mainly based on his sound economic policies, food security strategies and efforts to arrest corruption.

5.5. PUBLIC SECTOR REFORM CONTEXT

As already highlighted, the public sector in the colonial era consisted of structures that advanced imperial policies. It comprised of a hierarchical structure from the Governor through to various provincial and district commissioners. Positions were dominated by Europeans posted straight from the Colonial Office in London and the natives only occupied very junior posts. As Anders (2002:44) narrates, “characteristic of colonial service was strict division between European expatriate officers and Africans”. It was only in 1953 that the first Malawian was recruited in an administrative post as District Assistant after “an experimental period in which he had been gradually entrusted with a number of the routine duties which usually fall to an Assistant District Commissioner” (Baker, 1972:544). As appendix 4 shows, before independence in 1964 only a handful of Malawians made it to higher positions.

Moreover, the scope of activities the colonial public administration could do was very limited to those that enhanced colonial interests, leading to not having meaningful strides in development terms. According to Pryor (1990:30), the “story of Malawi’s underdevelopment is one of official neglect…the scope of colonial administration…[was] extremely limited”. Colby (1956:274) reports that “public utilities were not only entirely inadequate but in most cases almost completely non-existent”. Pike (1968:95) concurs that “all questions of education, health and agriculture were left to the missionaries and economic development
was left in the hands of few planters”. However, even the missionaries were overwhelmed due to the increasing demands. It was noted that “the education system is placing an intolerable burden on mission staff and funds...it is a burden which many would gladly transfer to the Government” (Baker, 1998:337).

It is against this backdrop that the history of public sector reforms in Malawi dates to the immediate post-independence days in 1964. The issues at stake were mainly two: first, was to ensure that the civil service is nationalised and be dominated by Africans. Second, was to reorient the public sector, making it viable for the attainment of local aspirations of higher socio-economic goals (Msosa, 1998). Therefore, a commission led by Thomas Skinner was engaged. The Skinner Commission concentrated on cutting cost, arguing that “it would no longer be appropriate and the country would not afford to continue with the generous standards” (Msosa, 1998:29) of the colonial regime. Recommendations included: pay reductions, introduction of fees for public services and appointment of natives to administrative posts whose remuneration would be based on local circumstances (Skinner Commission, 1963). However, the implementation of Skinner’s recommendations was intercepted by resistance from some cabinet ministers and the public as they perceived them as hardships for a population expecting a ‘better life’ after independence, leading to the ‘Cabinet Crisis’ (expulsions of three cabinet ministers and resignations of others in solidarity) (Ross, 2009; Baker, 2001).

Further efforts to reform were made in 1966 through the United Nations Economic Commission for Africa (ECA) that studied how the organisation and administration of the government could be revised to improve speed and quality (Malawi Government and UNDP, 2002). The ECA report recognised the need for effective leadership and institutional arrangements (Msosa, 1998). However, most of the recommendations were not implemented because of the politics of dictatorship. The next set of reform recommendations were through the 1985 Herbecq Review Commission. The recommendations included human resources and financial management for the improvement of the quality of the civil service while putting a cap on employment (Stambuli, 2002). Again, owing to Banda’s dictatorial politics, these were not implemented (Adamolekun et al, 1997; Durevall, 2001) and by 1987 the civil service had grown to 50,008 from 10,745 in 1964 (Msosa, 1998).
The early 1990s saw the commissioning of a number of World Bank studies leading to the development of reform frameworks. First was the 1991 study called the Public Sector Management Review (PSMR) which recommended for the restructuring of the public sector to make it more efficient and effective. This was because the civil service was weak due to poor definition of responsibilities, inadequate and poorly targeted training, failure to undertake programme evaluation and poor financial management (Ademolekun et al, 1997).

The 1994 study, called Civil Service Pay and Employment Study (PES) had the following recommendations: control of the wage bill, rationalisation of the pay structure and pay enhancement and the improvement of the quality and performance of the civil service (World Bank, 1994).

The two studies’ recommendations resulted into the formulation of the country’s first reform program called the Civil Service Reform Action Plan (CSAP) launched in 1996. While Durevall (2001:7) observes that the CSAP was “one of the most comprehensive reform plans ever attempted in Malawi”, Anders (2000:46) notes that it was “consistent with the focus of the World Bank and IMF on promoting good governance”. The CSAP was full of the NPM rhetoric. Its objective was to “improve the efficiency and effectiveness of the civil service, in terms of the quality of the services delivered to the public and the implementation of core government functions, and to ensure affordability and sustainability” (Malawi Government, 1996a:2). The goal was to “securing better value for money in the delivery of specified outputs” (ibid:4). The CSAP championed restructuring so that low priority management functions were abolished, decentralised, outsourced or privatised to ensure that “clear distinctions are drawn between policy making functions, appropriate to the centre of Government, and service delivery” (ibid:5). Moreover, the CSAP advanced for performance improvements through the implementation of management systems that would reduce overlaps and duplications. Finally, the CSAP also aimed at “giving line managers adequate authority in management” (ibid:9-10). This would require improved human resource and financial systems.

In 2002 the country adopted a World Bank driven Poverty Reduction Strategy Paper (PRSP) as a long term development strategy framework. The PRSP emphasised the need for reform with the rationale that modern managerial practices would be pivotal in developing an efficient and effective public sector oriented towards social economic development (Malawi Government 2002). The PRSP reform aspirations were operationalised in the UNDP
supported reform programme called the Public Sector Management Reform Program (PSMRP). Just like the CSAP, the PSMRP was full of NPM rhetoric advanced by the Osborne and Gaebler (1992) ‘reinventing government’ school. It aimed at developing a public sector which was “visionary and mission oriented and has the inherent ability to effectively deliver quality services” (Malawi Government and UNDP, 2002:9). The overall objective was “reshaping and revitalising the public service” (ibid:5) and “transforming” it to attain a “truly client orientation with continuous improvement of services” (ibid:9). The vision was to develop an “affordable, highly motivated, productive, professional and result oriented public service by the year 2010” (ibid:11). The key strategy was to “create an entrepreneurial public service” (ibid:9) that would conform to “public expectations for value, satisfaction and relevance” (ibid:5). The essence of such a public sector would be to:

- Empower citizens
- Focus not on inputs but outcomes
- Driven by mission and not rules and regulations
- Earn money and not simply spend it
- Prefer markets mechanism to bureaucratic mechanism
- Focus not simply on providing services but catalysing all sector
- Promote sustainable economic growth (ibid:9)

Based on the CSAP and PSMRP and other donor initiatives for specific sectors and departments, various reform activities have taken place. For the health sector which is the case under examination in this study, hospital autonomy and management decentralisation have been key reforms in an attempt to transform health service delivery.

5.6. NATIONAL CULTURAL CONTEXT

Culture is understood as the “collective programming of the mind that distinguishes the members of one group or category of people from another” (Hofstede, 2001:9). Understanding national culture is important to adequately analyse the transfer of public management models. This is because “culture and public management reforms are closely linked” (Bouckaert, 2007:29) since “cultural frames...establish approved means and define
desired outcomes” (DiMaggio and Powell, 1991:28). Hofstede (2001) highlights five main dimensions that reflect a country’s national culture which can be used to understand cultural configurations affecting reforms. These include large or small power distance, individualism and collectivism, masculinity and femininity, degree of uncertainty avoidance and time orientation. Malawi has cultural orientations which can be discussed along the first four of Hofstede’s dimensions as follows:

5.6.1. POWER DISTANCE: LARGE OR SMALL?

According to Hofstede (2001), the power distance dimension portends to a nation’s orientation towards authority. To this end, large power distance (LPD) cultures put strict observance on hierarchy and control where authority is unequally distributed in comparison to small power distance (SPD) cultures. LPD societies are very hierarchical and there is more centralisation of power while SPD societies are more equal and egalitarian (Bouckaert, 2007:47). There is emphasis on respect and fear for older people in LPD contexts while in SPD cultures order people are neither respected nor feared (Hofstede, 2001:98).

It has been observed that Malawi displays a high orientation towards the LPD variation. As Foster (2001:277) observes, the “traditional Malawian culture supported hierarchy” where those in authority display a remarkably powerful position. Indeed in Malawi “respect for elders, discipline and obligation are customary and important for social cohesion” (MLGRD, MGPDD, RNE, 2006:20). Cullen Young echoes that a ‘good village’ in Malawi is where “the headman and all the elders are respected by all...[and]...the young respect parents” (cited in Foster 1994:493). Malawi’s traditional culture is expressed and transferred from one generation to another through the use of proverbs. Proverbs for the display of the LPD culture include “Akulu akulu ndi mdambo mozimira moto” (elders are fountains of wisdom that solve all problems) and “mawu a akulu akoma akagonera” (elders’ words are always good advice).

Therefore, status, respect and privileges are normally accorded unequally between those with power and those without. In general, elders and those in leadership positions are treated with high respect and command tremendous powers over people and resources. The problem with this however, is that it breeds patron-client relationships where those in authority readily offer rewards and privileges to subjects in return for more respect and reverence. Dependency
based on lack of authority and power is also exploited by those that are higher up in the hierarchy.

5.6.2. INDIVIDUALISM OR COLLECTIVISM?

This dimension distinguishes societies that emphasise on individual freedom and those that regard an individual as attached to a collective community. In individualism cultures, ties between individuals are so loose that individuals are expected to be responsible for themselves and immediate family only while in collectivism societies people from “birth onwards are integrated into strong, cohesive in-groups which throughout people’s lifetime continue to protect them in exchange of unquestioning loyalty” (Hofstede, 2001:225). In collectivism cultures, individualism is “seen as alienating” (ibid: 209) as members have a collective claim towards each other.

Malawi, just like many African countries, appears to have a collective culture where an individual does not regard himself in isolation but as a member of a collective group. The philosophy employed is called umunthu (being a person), whose core principle is that a “person is a person through other persons” (Munyaka and Motlhabi, 2009:63). Examples of proverbs that portray this include: Ali awiri ndi anthu, kali kokha nkanyama (those that are more than one are people and he who is alone is an animal) and lende nkukankhana (one prospers with the help of others). Tensions between individualism and collectivism in Malawi are displayed by one of the prominent Malawians called Levi Mumba as follows:

the European came with his individualism and thrust it on the native...I hate individualism because it has suddenly torn the son from the father, or one man from another...so...that freedom and justice which was supposed would result from the disintegration of tribal communal life has not yet been achieved (quoted in Chanock, 1975).

Collectivism is also practiced at work place. Here, employees consider themselves as a cohesive collective in-group so that “tradition places social achievement above personal achievement” (Afro-Centric Alliance, 2001:61). While this is pivotal in generating increased conformity required to achieve organisational goals, there have been some undesirable consequences. For instance, there is a “social disapproval of an individual who places himself or herself above his or her fellow human beings, for example through self promotion in business or at work” (Bowa and MacLauchlan, 1994:10). As Booth et al (2006:ix) concur,
in Malawi, collectivism in the value system tends to generate conformism and tolerance of mediocrity. Individuals are expected to know their place, and if they ‘get ahead of themselves’, or stand out like ‘tall poppies’ in a cornfield, they are likely to be cut down by gossip, false accusations and other expressions of jealousy.

5.6.3. MASCULINITY OR FEMININITY?
Masculinity and femininity cultural dimensions attribute to the extent a society embraces particular gender roles. According to Hofstede (2001), a society with dominant masculine culture displays assertiveness (earnings, advancement), decisiveness, heroism, aggressiveness and that business is the survival of the fittest. On the other hand, feminine cultures have female nurturance (relation with manager and cooperation atmosphere) that deals with feelings, intuition, and consensus seeking rather than decisiveness.

Malawi, with the dominant collectivism culture highlighted above, is seen to tilt towards the feminine dimension. There is a general recognition of the need to care for others and seek consensus in decision-making. As Moto (1998:33) observes, in Malawi there is stress on “consultations and collective decision making”. A common proverb calling for nurturance is “mwana wa nzako ndi wako yemwe” (someone’s child is your child) and consensus decision making is highlighted by “mutu umodzi susenza denga” (to solve a problem one needs to get ideas from others).

5.6.4. UNCERTAINTY AVOIDANCE: HIGH OR LOW?
Uncertainty avoidance dimension is about the extent to which a society is comfortable in unstructured situations (Hofstede, 2001). Unstructured situations are those that are novel, unknown, surprising, and different from the usual. Highly uncertainty avoiding cultures are threatened by uncertainty and therefore tend to be conservative, avoid unstructured situations, and fear adopting the unknown. Cultures with a low degree of uncertainty avoidance are willing to handle unknown risks and are open to change and innovation.

It appears that Malawi is a high uncertainty avoiding society. In this respect, Booth et al, (2006) observes that the “traditional society has a high aversion to uncertainty...one of whose effects is a low tolerance for dissent”. The commonly proverb used is “khwangwala
"wamantha anafa ndi ukalamba" (literally meaning that the fearful raven died of old age - discouraging people from taking risks).

5.7. POLITICAL –BUREAUCRATIC CULTURAL CONTEXT

As highlighted above, to better understand the behaviours of national actors in the processes of policy transfer, an appreciation of the dynamics of national culture is imperative. Otherwise, “imported practices may fail or be ineffectively implemented if they are inconsistent with the core values of local settings” (Lachman et al, 1994:53). Particularly, there are observations that the effective implementation of NPM is culturally determined (see Bowornwathana, 2007; Koci, 2007; Schedler and Proeller, 2007; Hood, 1998). National culture, however, impacts on bureaucratic and political cultures. Unlike the national culture that pertains to societal mode of behaviour, political culture guides behaviours in the political realm while bureaucratic/administrative culture points towards the underlying behaviours of public servants. National culture together with administrative culture shapes the conduct of public management (see Peters, 2010). However, administrative culture is derived from politics and authority relationships so that “it is political culture that influences the administrative culture most because it brings its political values to modulate the behaviour of state employees” (Dwivedi, 2005:22).

In most African countries where there is a high interfusion between the political and bureaucratic realms, it is appropriate to analyse culture in the administrative realm in the context of ‘political-bureaucratic culture’ (Khembo, 2004b:279). As Batley and Larbi (2004:57) emphasise, “in Africa the bureaucratic arena is itself highly politicised and interconnected with societal interests; it’s where power, employment and patronage are concentrated”. Khembo (2004b:279) argues that “central to African debate about governance is generally a struggle for power...[where]...the state is still the source of that power, accumulation and wealth for those who wield control over it”. Unfortunately this creates an unhealthy breeding ground for corruption.

Malawi is not an exception. The administrative and political realms appear to be characterised by patron-client neo-patrimonial relationships where the state is seen as an avenue for the accumulation of resources to service such linkages (Anders, 2002; Khembo...
With the large power distance national culture put into the equation, Briscoe and Schuler (2004: 273) observed that in Malawi there is a “great importance on status differences. The relationship between managers and subordinates is viewed as authoritative: Workers give deference and expect managers to act paternally”. Malawi conforms to the classic definition and description of a neo-patrimonial state with ‘hybrid systems’ where modern bureaucracies coexist beside political authority that is based on the giving and granting of favours in an endless series of dyadic exchanges that go from the village level to the highest reaches of the central state (Cammack, 2004). In this respect, civil servants are “embedded in an intricate web of social relationships with various rights and obligations” (Anders, 2002:44).

Accordingly, Cammack and Kelsall (2010:35) observe that in Malawi “corruption remains ubiquitous within the public service”. The 2009 Transparency International Corruption Perception Index puts the country on position 89 out of the 180 countries surveyed. More specifically, the Anti-Corruption Bureau which is the country’s corruption watchdog, reported that in the month of January and February 2009, it conducted and concluded investigations in 70 cases. This is just a tip of the iceberg because with the very nature of corruption, many cases remain uncovered (see Rose-Ackerman, 1999). Corruption is rampant because “in Malawi private and public funds are co-mingled by those in power” (Commack, 2007:600). As Khembo (2004c:8) attests “some forms of corruption have almost become accepted as a normal way of life, corruption is difficult to identify and combat since some of its modes are not legally recognized”. In most cases, civil servants “follow the example of their political masters and see the state and their posts not as a means of helping the nation or its people, but as a resource for patronage and self-enrichment” (Booth et al, 2006:25). For instance, commentators have noted that government jobs are used as a “stepping-stone to business opportunities and consultancies” (Cammack and Kelsall, 2010:28) and “unauthorised use of government facilities...is considered by many civil servants to be an extra benefit of government employment” (Anders, 2002:46).

5.8. CONCLUSION

This Chapter presented the case of Malawi so as to provide the country specific context within which the study is conducted. The main conclusions for this chapter are that Malawi is
one of the poorest countries in the World with very huge inequalities. The Country has been under three political regimes namely; colonial, one party dictatorship and multiparty democracy. While the colonial rule was for the enhancement of British colonial interests, the one party rule was authoritarian with personalised policies geared towards sustaining the Banda regime. Although democratic dispensation brought hopes among the citizenry, this was short lived as the democratic elites displayed authoritarian tendencies which included corruption, constitutional manipulations, restrictions of human rights and the president’s attempts to seek for an unconstitutional third term of office. The country has undergone several reform initiatives in an attempt to improve service delivery. The national cultural context is characterised by large power distance, collectivism, strong uncertainty avoidance and feminine society. However, the political-bureaucratic culture is neo-patrimonial characterised by corruption, patronage links and power struggles.

The next chapter presents study findings on the study’s first research question which is: How were the health sector reforms transferred to Malawi’s policy agenda? This is done by using comparative cases of hospital autonomy and district health management decentralisation reforms.
6.1. INTRODUCTION

Chapter Five presented the contextual issues in terms of Malawi. The aim was to provide an understanding of the country specific environment within which the study is undertaken. This Chapter presents findings on the study’s first research question which is: What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda? It seeks to examine the mechanisms and dynamics of the transfer of health sector reforms to Malawi within the context of globalisation processes. The Chapter uses institutional isomorphism and institutional entrepreneurship theories to find out institutional forces and actors accounting for the transfer of the reforms. To this end, the Chapter undertakes a comparative analysis of the transfer of hospital autonomy and district health management decentralisation reforms. This is done so as to effectively gauge the impacts of specific institutional isomorphic frameworks within which various institutional entrepreneurs and players operated in effecting the transfers. The Chapter begins by examining the transfer of hospital autonomy reforms followed by an analysis of the transfer of district health management decentralisation reforms. Section Three discusses the changing nature of the relationship between the government of Malawi and donor organisations over the reform period. This is followed by a section on the comparative analysis of the two cases in order to draw conclusions. Lastly, a conclusion section is provided.

6.2. THE TRANSFER OF HOSPITAL AUTONOMY REFORMS

This section presents findings on the mechanisms of the transfer of hospital autonomy reforms to Malawi. It begins by presenting the concept of hospital autonomy and an analysis of hospital autonomy in a global context. This is followed by an examination of how hospital autonomy was introduced on Malawi’s policy agenda by unearthing the institutional isomorphic pressures and entrepreneurs involved.
6.2.1. THE CONCEPT

Hospital autonomy reforms owe their origin to Christopher Hood’s (1991) seven ‘doctrinal components’ of NPM which can simply be summarized as “disaggregation + competition + incentivisation” (Dunleavy and Margetts 2000:13). To this end, the core elements of hospital autonomy are “both decentralisation and a greater measure of exposure to market forces” (Hanson et al, 2002:73). It takes its building blocks from the agency model advocated within the NPM movement. Talbot (2004:6) highlights three main characteristic components of agencies as follows:

- Structural disaggregation and/or the creation of task specific organizations.
- Performance ‘contracting’ –some form of performance target setting, monitoring and reporting.
- Deregulation (or more properly reregulation) or controls over personnel, finance and other management matters.

An additional feature for the developing world is cost sharing measures where users pay for services (Hanson et al, 2002). The rationale is that most big government hospitals in developing countries are inefficient due to poor management practices and suboptimal structural and institutional arrangements so that the introduction of market mechanisms is pivotal in bringing the necessary efficiency. This is exacerbated by the fact that hospitals are becoming very costly to run and the only way for ensuring their sustenance was to expose them to market forces. Therefore, hospital autonomy reforms implied “providing for the introduction or increase of user charges, the incentive to pursue revenue generation and competition among public hospitals and with private ones” (ibid, 2002:76). This saw the provision of greater degree of autonomy to hospital managers to make them “free to manage” (Hood, 1991:4). The principle of purchaser-provider-split prevalent in the NPM (Silverbo, 2004; Ferlie et al, 1996) determines the configuration of relationships between the Ministry of Health and the autonomous hospitals.

For Malawi, the Draft National Policy on Hospital Autonomy defined an autonomous hospital as “a legal corporate entity under the direction and control of a hospital board, which is separate from the Ministry of Health but accountable to it, as well as accountable to the communities it serves” (Baekkey, 2004:1) The general strategy was to establish an “eyes on, hands off approach under which [the Ministry of Health] will end its direct involvement in the day-to-day running of hospitals” (JIP Sub-Committee on Hospital Autonomy, 2004)

The Draft Policy highlights the specific objectives of hospital autonomy as follows:

- Establishing a clear separation between the providers and the funders of hospital services so that hospital boards and managers (the providers) have maximum control over their finance, staff and other resources, but are held firmly and effectively accountable to MOH, communities and other funders for the services they provide.
- Improving the quality of care and strengthening the referral system.
- Introducing modern hospital management practices.
- Ensuring the financial viability of hospitals by increasing self-generated revenue – but guaranteeing equitable access to essential hospital care especially for the poor and vulnerable.

The goals of hospital autonomy were to improve efficiency, effectiveness, economy, quality and accountability of care. This was because “tertiary hospitals are hobbled by the lack of autonomy” (Malawi Government and World Bank, 2006:77). Additionally, the hospitals would raise income for their self-sustainability because in “recent years, the number and size of government hospitals have grown beyond what the government budget can support” (Picazo, 2002:45). In his address at a de-briefing meeting of hospital autonomy report by Partners for Health Reforms consultants in August 2000, the former Principal Secretary for Health Richard Pendame emphasised that

the issues of concern regarding hospital services especially the tertiary level were to do with the large financial investments which the government...was making,...yet there did not seem to be much positive impact on service delivery and outcomes. It became obvious that the tertiary hospitals were not delivering the specialist services they were meant to offer in an efficient manner.

Health care system in Malawi is based on referral principles organised in a three-tier manner starting with Health Centres offering basic primary care, District Hospitals offering general secondary care and Central Hospital providing tertiary specialist care. It was the Central Hospitals that would be made autonomous. Malawi has four Central Hospitals - Queen Elizabeth Central Hospital (QECH) in Blantyre, Kamuzu Central Hospital (KCH) in Lilongwe, Zomba Central Hospital (ZCH) in Zomba and Mzuzu Central Hospital (MCH) in Mzuzu. The proposal was to start with making QECH and KCH autonomous and then ZCH and MCH would follow later in the second phase.
6.2.2. HOSPITAL AUTONOMY REFORMS IN A GLOBAL CONTEXT

Debates about hospital autonomy reforms in Africa started in the early 1990s when the gospel about NPM begun to be preached worldwide. While developed countries undertook these reform elements voluntarily, developing countries were influenced by donor organisation as conditions for aid (see World Bank, 1993). This was possible since “aid is without doubt equivalent to a sizeable share of gross national income and domestic investment in many” (Ilorah, 2008:92) developing countries. Particularly, for the health sector, the World Bank in its 1993 World Development Report declared that “countries that are willing to undertake reform of the health system should be strong candidates for increased aid, including donor financing of recurrent costs” (World Bank, 1993a:167). This advice was both to developing countries if at all they were to access the much needed aid and also to other donor organisations to use conditionality as their modus operandi. In this perspective, the World Bank even reminded donors that they “have an important role in this regard especially when a significant proportion of investment is donor financed” (ibid).

The World Bank pioneered this process by advocating for the hospital autonomy reforms to developing countries. In its Population, Health and Nutrition Operational Review, the World Bank put hospital autonomy on its top priority list arguing that “increased financial and managerial autonomy for higher levels of health care…. should liberate public funds for basic services” (1993b:13). Against this backdrop, hospital autonomy “gathered significant international support” (McPake, 1996:156) so that among other donor organisations, the United States Agency for International Development (USAID) took a leading role in transferring it throughout Africa as a condition attached to its non-project assistance (NPA) aid regime (Foltz, 1994; McPake, 1996). NPA is characterised by policy “conditionality attached...to programmes...[to achieve]...two basic objectives: direct transfer of financial resources and policy reform” (Setzer and Lindner, 1994:5). Some of the countries where USAID transferred hospital autonomy reform through the NPA mechanism include (but not limited to) Kenya, Ghana, Uganda, Zambia, Zimbabwe, Nigeria, Niger, Togo, and Cameroon (Setzer and Lindner, 1994).
Maguire et al. (2004:657) illustrate that institutional entrepreneurship represents the “activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or to transform existing ones” (see also Kingdon 1995). It would appear that in international public management discourse, institutional entrepreneurs are political, bureaucratic, policy network or organisational actors either at the national or international levels that are interested in importing or transferring new organisational forms and reform templates (see Hill, 2009). These institutional entrepreneurs have “sufficient resources [and] see in them an opportunity to realize an interest that they value highly” (Dorado, 2005:399). To realise these ends, institutional entrepreneurs “stimulate policy transfer by catalyzing isomorphic processes” (Radaelli, 2000:25) either through coercive, mimetic or normative pressures (DiMaggio and Powell, 1991). For Malawi, the study found that the transfer of hospital autonomy reform was the intervention of USAID as an institutional entrepreneur. This was in line with the international trends discussed above and the World Health Organisation’s particular recommendation to the Malawi Government to introduce hospital autonomy that would provide institutional justification for the introduction of user fees in hospitals (WHO, 1993:28).

DiMaggio and Powell (1991:68) illustrate that coercive isomorphism involves “direct and explicit imposition of organisational models on dependent organisations” or countries as well as “more subtle and less explicit” pressures. Radaelli (2000) sees coercive isomorphism playing a role in policy transfer chiefly “via economic mechanisms”. The way USAID as an institutional entrepreneur transferred the hospital autonomy reforms to Malawi sparks concerns that it was oriented towards coercive isomorphic mechanisms. This is because the reforms were transferred through USAID’s non-project assistance (NPA) aid regime that emphasises on sector specific reforms as conditionality for the disbursement of counterpart funds. Hospital autonomy was the NPA conditionality under the “Strengthening Health Care Systems” program for increased budgetary support and health sector assistance. The characteristic feature about NPA programs is that they are “resource transfer programs driven by meeting conditions precedent linked to a policy reform agenda” (Setzer and Lindner, 1994:7). NPA is a “means of influencing national policy” (Moulton, 1997:1) involving
“specific conditions on programs...[and]...required policy or institutional reforms” (Donaldson, 1994). Inherent in NPA framework is the understanding that “accomplishment of conditioned reforms triggers the release of counterpart funds” (Foltz, 1994:371). It is justified on the basis of policy constraints and the need for policy reform and therefore, an important aspect of this type of program is conditionality (Setzer and Lindner, 1994).

Although the Government’s official version about the transfer was that “these reforms are happening in many countries and we copied from them. We saw other countries doing it so we followed suit through the help of the donor, USAID” (Interview with a former Secretary for Health Y), the actual situation was that this was an “instance where donors would say, ‘we will fund these reforms’ (referring to autonomy) but who decides that we need the reforms?” (interview with a Democracy Consolidation Programme official). The general consensus among the people interviewed was that hospital autonomy reform was “pushed by USAID” and “politicians did not quite understand what it entailed”. Hospital autonomy was presented as a “technical recommendation from USAID” who were “overzealous to get it done”. As a former member of the technical committee on autonomy highlighted

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\text{if it was Malawi government writing a proposal to USAID that we want this then they would not allow them to spend much money and say we do not want to do it. But because it came as a technical recommendation from USAID they were not committed. The donors made recommendations and put in the money but they were more overzealous to get it done. Due to this lack of political will it only shows that it wasn't theirs.}
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This was underscored by a former Secretary for Health X who articulated that

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\text{our system is generally founded by donors and this was part of trying to reform the health system. And if you look at health system reforms it was particularly USAID that was in the forefront trying to support health systems reforms. Within that process of reforming with technical and financial support one of the recommendations that came in as a way of making the Central Hospitals more efficient was to make them autonomous. So it was a technical support that came as a recommendation from USAID.}
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An interview with a former Director of one of the Central Hospitals revealed that “the whole thing had support of donors. It was the American Government through USAID that was supporting all this. All the donors supported this initiative but the main one was USAID”.

This was even corroborated by the donor officials interviewed. A former USAID consultant highlighted that “USAID brought in this”. The general consensus among the
donor officials was that their responsibility was to “influence policy changes for the betterment of Malawians”. Another official underscored this point by highlighting that “we push each other so that at the end of the day it is the people of Malawi that are to benefit”. The argument from a USAID official was that for hospital autonomy reforms and any reforms the principle is that “aid is normally directed to countries that are willing to take policy advice”. It was added that “although policies are not directly forced on the aid receiving countries, donors will be less inclined to continue supporting governments that do not take heed to policy advice”.

The Malawi Government was not without interests in this process as it needed to reform the central hospitals to make them efficient and there was also a need to secure the necessary donor money for the effective performance of the health system. To this end, a Health Planning Officer at the MOH articulated that

I know that the government of Malawi really needed to reform the health system. So they went to donors looking for money to reform the health system, but one of the recommendations that came from the donors was to make the hospitals autonomous.

However, it was revealed that these interests were only limited to the need for donor money and making the health sector efficient but not extended to the actual reform elements. Decisions about reform instruments were not in the ambit of governmental powers, but rather USAID. In this respect, when USAID was compared to other international donor organisations, a UNDP Technical Advisor in the Ministry of Finance underscored the point by illustrating that

there are the less flexible donors, the ones that are here on mandate from their national bodies and have their own agendas to advance. When it comes to fine-tuning their agendas with the government of Malawi’s agendas they find it very hard, and USAID is a very good example of this,...there is very little thing they can do to make things better.

It is against this background that the government gave an initial commitment to implement the hospital autonomy reforms. An interview with one of the former technical team members highlighted that on its part the Malawi government “initially gave them (USAID) a go ahead to come up with the policy and strategy in order to secure the aid money that was involved”. This initial commitment required the government to include hospital autonomy in its overall development planning strategy and health sector plans. Therefore, the Malawi Poverty Reduction Strategy Paper (MPRSP) which was the government’s overall development policy
document from 2002 to 2006 committed the government to “autonomise central hospitals within 3 years” (Malawi Government 2002:62). The Malawi Government could not miss out hospital autonomy in the MPRSP as the whole development of the MPRSP was driven and supervised by donors and in particular the World Bank which had also earlier on presented its interests in hospital autonomy reforms even before USAID started the project. As Braathen (2006:24) observes, “as with others PRSPs, the document [MPRSP] is heavily influenced by the guidelines and models available from the World Bank which create an expectation of what a PRP would look like”. In agreement, Sahley et al (2005:25) underscore that “while the stated intentions have been that Malawians should own the MPRSP...these are externally imposed conditions for substantial and desperately-needed financial support”. The World Bank itself agrees with these observations by attesting in its 2003 Malawi Health Support document that “the Bank has been a key driving force behind the MPRSP” (World Bank, 2003:2).

However, this initial commitment to adopt hospital autonomy program was not based on a clear understanding of the reform concerned but was motivated by the desire to secure the much needed aid that was conditioned in the USAID NPA regime. As DiMaggio and Powell (1991:74) underscore, with mechanisms that have a coercive isomorphic orientation a “position of dependence leads to isomorphic change”. Malawi is heavily donor dependent with an estimate of up to 80 percent of the country’s developmental budget and 50 percent of its recurrent expenditure provided by donors (Chinsinga, 2007). In this context, Hirschman (1993:126) observed that in Malawi the “culture of the civil service requires that nobody be seen as a person who is blocking aid” making local officials unable to “question seriously the continued flow of resources, opportunities and their accompanying evaluations and recommendations”. A Director of a key umbrella nongovernmental organisation in the health sector concurred that “many reforms that have happened are actually donor driven but this is no wonder as the government is desperate looking for money so they will always agree to everything”. In agreement, a Director from the government based Democracy Consolidation Programme which is heavily donor funded indicated that “not everybody feels comfortable to discuss problems with donors because they feel that they [the donors] will withdraw” the aid. As a result, the donors have capitalised on this aid dependency context by influencing policy development to the extent that they are “stepping into the government’s shoes substituting for it in the policy function” (Chinsinga, 2007:22).
6.3. THE TRANSFER OF DISTRICT HEALTH MANAGEMENT DECENTRALISATION REFORM

This section presents findings on the mechanisms of the transfer of district health management decentralisation reforms to Malawi. It begins by presenting the concept of decentralisation and its analysis in a global context. This is followed by an examination of how decentralisation was introduced on Malawi’s policy agenda by unearthing the institutional isomorphic pressures and entrepreneurs involved.

6.3.1. THE CONCEPT

Apart from hospital autonomy reforms analysed above, the Malawian health sector has also been exposed to district health management decentralisation reform. This has involved the devolution of managerial powers to district health offices for them to have a greater control and authority over service delivery. The rationale is based on the NPM philosophy of separating policy making from service delivery through purchaser-provider splits (Alford and Hughes, 2008; Kaul, 1997; Hood, 1991; Ferlie et al, 1996) in order to attain efficient and effective results. Unlike central hospital autonomy where big hospitals become autonomous under independent management boards, district health management decentralisation involves “vertical decentralisation to health management teams in the...districts” (Larbi, 1998:192; see also Hansan et al., 2002). In this regard, decentralised district health offices operate as cost centres making independent decisions while the central government maintains the general policy direction and coordination authority. It is claimed that the aim is to “lessen the dangers of centralised bureaucratic power and make governments more responsive to the citizens and customer demands” (Kennedy and Hays, 1998: 41). The World Bank (1993a:128) sees “decentralisation of planning and management of government health services [as a double edged] policy that can improve both efficiency and responsiveness to local needs”.

For Malawi, district health management decentralisation reform (thereafter decentralisation) meant the devolution of management functions from the MOH headquarters to the district level under district health management teams. The logic was to ensure that “health care moves...to flexible working arrangements” (Ministry of Health and Population, 1999a:18) where the MOH’s role was that of a “steward of the health sector rather than direct service
provider” (World Bank, 2004:9). Therefore, the process involved “decentralising the management of health facilities and health services to operational managers at district level” (Ministry of Health, 1999a:53). The principle is the adoption of policy making and service delivery functions split where the “MOH’s role will completely change from that of service delivery to a more normative and policy oriented role” (Ministry of Health, 1999b:12).

For the process of decentralisation to actualise, Regional Health Offices (RHO) which provided oversight, administrative and supervisory roles thereby acting as a link between the district health offices and the MOH headquarters were to be abolished. This was in line with NPM’s objective of “delayering” or “shortening what were previously long bureaucratic hierarchies” (Pollitt et al, 1998) in order to achieve efficiency. In addition, although not of much emphasis in this study, the processes also involved political decentralisation where the district health management team would be politically accountable to an elected District Assembly in line with the UNDP driven Local Government Act and National Decentralisation Policy both of which were approved in 1998. This was to ensure increased accountability, transparency and participation at the local level. As McCourt (2008) observes, reforms in the developing world are taking on board political and governance imperatives with the “renewed emphasis on the delivery of public services targeted at poor people”. In fact the National Decentralisation Policy and Local Government Act opened up a window of opportunity for various donor organisations that were standing in the wings waiting for these legal and policy instruments to be put in place so that they can embark on various decentralisation endeavours in various sectors including the Ministry of Health. As the UNDP itself attests, “given that the Decentralisation Policy and the Local Government Act were conditionality for several multilateral and donor agencies, the accomplishment [of UNDP in influencing their enactment] led to massive donor support” (MLGRD, UNCDF and UNDP, 2008:10).

6.3.2. DECENTRALISATION OF HEALTH SERVICES IN A GLOBAL CONTEXT

Decentralisation has been internationally championed within the context of the wider public management reforms. In this regard, decentralisation is advocated through the NPM slogan of “freeing managers to manage” (Pollitt et al, 1998:1). In the health sector, decentralisation to the district level has been among the most preferred reform trajectories over the years. As
Mills (1995:8) observes, a “number of structural changes have been proposed to improve efficiency, the most common being decentralisation of planning and management usually to the ‘district’ level”.

In this regard, the World Bank’s 1993 World Development Report did not only highlight the importance of health system decentralisation but also advised donor organisations to fund those countries that were willing to adopt it while warning all developing countries that they risked falling out of donor favour if they did not decentralise their health services to the district level management. The World Bank (1993a:168) advised that “donors can play an important role in these areas by supporting decentralization...reforms and by assisting the groups that formulate national health policies”. It would appear that in response, donor organisations worldwide brought decentralised health systems on their aid agenda and countries were eligible for aid if they showed commitment by at least including decentralisation in their health sector policy documents. In addition, international donor organisations responded to the World Bank’s call by sponsoring the production of decentralisation reform blue-prints that would be used in this regard. One of such was the WHO’s 1995 “Decentralisation and Health Systems Change: A Framework for Analysis” which was funded by international donor organisations that included DANIDA, NORAD, ODA (UK), SIDA and USAID. Paradoxically, these organisations were also actively involved in financing health sector decentralisation initiatives at the country level. To this extent, Bossert and Beauvais (2002:14) observe that decentralisation in the health sector is “reinforced by many donor supported projects”.

6.3.3. DISTRICT HEALTH MANAGEMENT DECENTRALISATION INTRODUCED ON MALAWI’S POLICY AGENDA: INSTITUTIONAL ISOMORPHIC PRESSURES AND INSTITUTIONAL ENTREPRENEURS

It has been observed that institutional entrepreneurs “go beyond the existing routines to elaborate and diffuse new ones” (Leca and Naccache, 2006:633). For health decentralisation reforms, several institutional entrepreneurs can be identified at different stages of the reform. These include the World Bank, GTZ, UNDP, DFID and the European Commission. However, the primary institutional entrepreneur in terms of the actual initiation and transfer of the health decentralisation reforms was the European Commission (EC). The EC made this intervention under the banner of Health Sector Reform and Decentralisation Project
An interview with one of the EC technical advisors on the project revealed that “the project was started by the EC but was managed by the British Council”. In this view, the British Council (2005:1) outlined that the “British Council managed this project to bring about reforms in health service management on behalf of the European Commission”. However, the British Council was only responsible for the management side of the project but in essence, the project was funded by the EC and operated on the EC ideologies, institutions and instruments so that ultimately the reform project was credited as an EC intervention rather than British Council’s (see Malawi Government and European Commission, 2002; Ministry of Health and Population, European Commission, and British Council, 1999).

DiMaggio and Powell (1991:67) tell us that coercive isomorphism occurs due to “formal and informal pressures exerted on organizations by other organizations upon which they are dependent”. As has already been discussed above, aid conditionality squarely fits in this category (see Dolowitz and Marsh, 2000). The study established that the health services management decentralisation reforms in Malawi were transferred within the mechanisms that tilt towards coercive institutional isomorphic pressures with aid conditionality as the prevailing governance regime. When asked about the origin of the programme, an EC Technical Advisor revealed that “it was not the case of conditionality from the European Commission. The only condition to get the money was to write an annual work plan which we did”. However, as DiMaggio and Powell (1991:67) pinpoint, “coercive pressures may be felt as force, as persuasion, or as invitation”. In this regard, a Health Planning Officer in the MOH argued that “these are reforms that were initiated in the MOH but with voice from the donor community because they are international reforms so obviously you see convergence between what donors will propose and what MOH will also request”. A former Principal Secretary for Health (Y) articulated the actual driving forces at work by expounding that

\[ \text{donors were drivers of the reform...you cannot remove the donors’ influence...Came the 1990s economists took over the aid agenda...[and]...it is when they were talking about structural adjustment programmes...And that is how decentralisation was becoming an issue. Decentralisation was a way of coping with the structural adjustment policies...[it]...was part of policy adjustment structures. Indeed there was donor ideological influence that was involved.} \]

A critical analysis of the project’s programme documents and EC’s aid institutions and instruments, which were the basis for the project, supports the view advanced by the former
Principals Secretary for Health (Y) above. The documentary analysis gave out insights that the decentralisation reform was introduced on Malawi’s policy agenda by EC through forces that point to Radaelli’s (2000:25) observation that “European institutions which have serious limitations in terms of legitimacy stimulate policy transfer by catalysing isomorphic processes”. Humphreys (2006:306) echoes that the “European Commission has...[been] a policy entrepreneur [instituting]...policy transfer, in various forms, both coercive and voluntary”. In particular, the support of the European Commission to the HSRD project in Malawi owed its basis from two of ECs funding instruments namely the 7th and 8th European Development Fund (EDF). EDF is EC aid financing institutional and regulative framework. It must be noted that the 7th EDF was sanctioned by the EC Lome IV Convention of 1989 which underwent minor revisions in 1996 forming the basis for the 8th EDF. The EC Conventions are aid modality agreements which are signed between the EC and African, Caribbean and Pacific (ACP) countries which the EC finances. Development aid disbursements in previous Conventions (before the Lome IV) were based on projects proposed by the ACP countries rather than EC conditionalities. In this regard, before the Lome IV Convention “funding disbursed by the European Development Fund (EDF) gained a reputation for its generous terms...[with]...relatively low conditionality, the EDF’s only stipulation being that it should be spent on EC goods and services” (Parfitt and Bullock, 1990:104).

However, the Lome IV Convention saw the inclusion of aid conditionality through Structural Adjustment Programs as a dominant aid disbursement mechanism to ACP countries. In this regard, the Lome IV aid regime was transformed into “more of a donor-driven mechanism of development assistance based on a growing number of political and economic conditionalities” (Arts and Byron, 1997:86). The EU justified the aid conditionality in Lome IV based on “being influenced by trends in political and economic thinking, the balance of power and the situation operating in the international scene” (The ACP-EU Courier No 155, 1996:1). The key trend in the ‘situation in the international scene’ was the adoption of conditionality by the World Bank and the IMF. As the EC explains, conditionality “as espoused by the Bretton Woods Institutions was also becoming the order of the day in economic management in many developing countries...[and]... was not surprisingly included in the Lome IV” (ibid:2). Central to these conditions are neo liberal policies and reforms in public management, economic and political governance (The ACP-EU Courier No 120, 1990:1). In particular, the EC set aside ECU 80 million “specifically reserved ... to enable the
Community to support institutional and administrative reform measures” (The ACP-EU Courier No 155, 1996:8). These reforms are based on the “modern consensus that genuine and sustainable development can only take place in a liberalised environment” (ibid:2).

Theoretically, the EC Conventions are supposed to be a forum where EC and ACP countries mutually agreed on the guiding principles of the aid regime. However, in practice for Lome IV, ACP countries were on the receiving end and were only required to accept the EC guiding principles and conditionalities if they were to receive aid (Wolf, 1997; Arts and Bryon, 1997). The ACP countries were expected to accept conditionalities as legitimised by the Lome IV since the European Commission “has changed... [and]... the ACP countries had matured sufficiently for them to accept this new situation in a resolute manner” (The ACP-EU Courier No 155, 1996:5). Moreover, the EC regarded the Convention as all encompassing for all ACP countries so that there would be no basis for them not to accept its provisions. As the EC highlighted, “the ACP state - whatever its economic and physical condition, whether it is least developed or landlocked or insular - has something special for it in the Convention” (ibid: 1). The hierarchical dominance of the EC in the arrangements must also be understood in the context that despite the signing of the Convention the “EC has often made adhoc policy changes” (Wolf, 1997:126).

Moreover, if an ACP country could not agree with the reforms and conditions attached and hence chose not to ratify the Convention, it would not be eligible for aid under the 7th and 8th EDFs. An example is Somalia which “had not been able to benefit from the 7th EDF since it has not ratified the Lome Convention” (The ACP-EU Courier No 155, 1996:6). However, most ACP countries could not afford to lose such aid as in most cases the EC was the largest donor. To this end, Bulmer and Padgett (2004) conclude that the “development aid under the Lome IV Convention [which] is conditional on the commitments of African, Caribbean and Pacific states” to adopt reforms, is an example of “coercive policy transfer” characterised by “financial conditionality” through “hierarchical governance” regime (see pp 115-116).

It is against this backdrop of EU aid institutional framework that the Malawi district health management decentralisation reforms were formulated. The decentralisation reforms were transferred under a conditionality arrangement within the structural adjustment facilities that the EC provided to Malawi within the 7th and 8th EDF framework. In particular, the EC has been providing conditioned structural adjustment support to Malawi since 1993 “with the overall objective of supporting the reform programmes but also of mitigating the impact of
the existing adjustment programmes’ fiscal austerity” (EC, 2001:17). In particular for the health decentralisation reforms, the Structural Adjustment Support Programme (SAF IV) emphasised “institutional reform measures in the health sector [as one of the] pre-conditions, accompanying measures and release conditionalities” (EC, 2003c:171) [emphasis added]. It must also be noted that the “structural adjustment counterpart funds (of the decentralisation project) were earmarked to a large extent for financing of budgetary non-salary expenditure for district health services” (EC, 2003b:20) [emphasis added]. This confirms the observations of one of the respondents in the study who in referring to health sector decentralisation reforms expounding that “the theoretical part of it is that government develops policies and propose them to donors to fund but the practice is still that there are certain conditionalities. ‘You do not get this money unless you do this’...so it’s always there. We still have these funny conditions” (Interview with Democratic Consolidation Programme official). Even the donor organisations agreed to this end. As one of the donor officials articulated, in the health sector decentralisation reform just like “in most cases it is usually donors that come to government with projects and programs rather than the government requesting from donors”.

A point requiring emphasis moreover, is the fact that health management decentralisation reforms were already on the World Bank’s conditionality agenda to Malawi. In particular, one of the main conditionalities highlighted in the World Bank’s 1991 “Population, Health and Nutrition Sector Credit” to the Malawi Government was to “implement the decentralization of health service...[where]...the Borrower [Government of Malawi] has transferred responsibility for the management and administration of all MOH [facilities]...to district management teams under district health officers” (World Bank 1991:6). The fact that the EC took it up in terms of the actual transfer despite it being already highlighted by the World Bank is not a misnomer. The Lome IV Convention sanctioned the EC to fund conditionality activities championed by the World Bank and IMF. In this particular one, the Lome IV Convention particularly articulated that “ACP states undertaking reform programme that are acknowledged and supported at least by the principal multilateral donors or that are agreed with such donors but not necessarily financially supported by them shall be treated as having automatically satisfied the requirements for adjustment assistance” (ACP-EC, 1989, article 246 [2]). These ‘principal multilateral donors’ are the World Bank and IMF (ACP-EU 1989; ACP-EU Courier No 155, 1996). The basis for this strong collaboration with the World Bank is that “there would be little point in one donor suggesting changes to...policy only to be contradicted by another donor” (ACP-EU Courier No 155,1996:24).
To this end, the EC has been criticised for “uncritically accepting [World] Bank conditionality as the basis for its own programme...without actually knowing what form that conditionality would finally take” (Parfitt and Bullock, 1990:112). However, in the case of the decentralisation reforms to Malawi, the synergies between the World Bank and the EC were easily established as decentralisation reforms were already one of the desired EC reforms championed within good governance related conditionalities of EC’s decentralised cooperation strategies. The reasoning for the EC was that “decentralisation has quickly become a new development mantra” (EC, 2008:x). The EC justified the health decentralisation reform transfer to Malawi on the basis that “health service has moved beyond experiments with decentralisation; this reform is now an accomplished fact” (Ministry of Health, European Commission and British Council, 1999:5).

6.4. THE CHANGING NATURE OF RELATIONSHIP BETWEEN MALAWI GOVERNMENT AND DONOR AGENCIES OVER THE REFORM PERIOD

This study neither intends to portray donor organisations in Malawi as a monolithic block nor does it want to depict their relationship with the Malawi Government as static. There are many donor organisations in the country which, as the figure below shows, employ different aid mechanisms that shape their relationship with the government. In particular there have been changes in the relations between donors with the government over the reform period and the differences within donors have even been more noticeable in view of the 2005 Paris Declaration on Aid Effectiveness where donor countries, agencies and recipient countries agreed to certain general principles of aid administration. They include the following:

- **Ownership by Countries**: Partner countries exercise effective leadership over development policies, and strategies and coordinate development actions.
- **Alignment with countries’ strategies, systems and procedures**: donors base their overall support on partner countries’ national development strategies, institutions and procedures.
- **Harmonisation**: Donor actions are more harmonised, transparent and collectively effective.
- **Managing for results**: managing and implementing aid in a way that focuses on the desired result and uses information to improve decision making.
- **Mutual accountability**: donors and partners are accountable for development results.
These principles were reinforced by the 2008 Accra Agenda for Action where donors and recipient countries endorsed to “accelerate and deepen the implementation of the Paris Declaration on Aid Effectiveness” (Accra Agenda for Action, 2008:1). In order to operationalise the Paris Declaration, the Malawi Government developed the Development Assistance Strategy 2006-2011 that guides donors in channelling their aid towards meeting the country’s development programmes as stated in the Malawi Growth and Development Strategy (MGDS). As has already been stated, the MGDS is Malawi’s overall development policy. There are three main aid instruments that donors adopt which include General Budget Support (GBS), Direct Project Support (DPS) and Sector Budget Support (SBS). It must be noted that for Malawi the “GBS and DPS are the preferred modalities of aid delivery by the Government” as they work to enhance the realisation of the Paris Declaration (Malawi Government, 2009c:8). However, as can be seen in the figure below, it would appear that donors have preferred to use Direct Project Support. It seems this is the case since it gives them more latitude to influence policy and institutional reform (USAID, 2007& 2004; Save the Children, 2009) as discussed below.

Figure 6. Aid Modality by Method of Delivery

Source: Save the Children (2009)

6.4.1. GENERAL BUDGET SUPPORT

Aid modality through Direct Budget Support (DBS) is “financial assistance that a donor provides directly to the Government budget to meet its financial gap” (Malawi Government 2009:8). Funds are transferred to the general budget without being earmarked for pre-
identified expenses and support the overall strategy of the recipient countries (UNDP, 2005: 3). For Malawi, donors that use GBS operate within a group called Common Approach to Budget Support (CABS). Although the aim of GBS is to realise the Paris Declaration principles by enhancing country ownership, alignment and harmonisation as “agendas and priorities are no longer dictated from outside” (European Commission, 2008:13), it appears that the instrument is not without conditions which gives some room for donor organisations to influence policy transfer. As the UNDP (2005: 3) highlights, GBS has “provided donors with increased access to and involvement in setting the policy agenda in countries”. Specifically, the Head of DFID in Malawi Gwen Hines who is the chairperson for CABS hinted that “there are usually certain needs that have to be met by government before budget aid is disbursed” (quoted in Daily Times, 18 October 2010). Moreover the CABS group itself “has clearly become the privileged forum for policy discussion with the Government of Malawi” (European Union, 2008: 5). In general, the CABS group “consider the Government’s commitments to peace and to promoting free, credible and democratic political processes, independence of the judiciary, rule of law, human rights and good governance, including the fight against corruption to be underlying principles of governance for the provision of budget support” (CABS and Malawi Government, 2005:2).

Moreover, individual donor agencies operating within the CABS have also their specific requirements to be met by government before they release the funds. To this end, Barnett et al (2006:35) were concerned that “in practice, the CABS group is more an umbrella than a real concerted effort. Each donor has its own separate budget support programme with its own separate conditionality, calendar and implementation modalities”. For instance eligibility for the European Union to funding under GBS depends on the fulfilment of the following three “mandatory conditions”:

- A national development strategy targeting growth and improvement in general living conditions.
- A stability-oriented macroeconomic policy seeking, for example, improvements in indicators such as inflation, debt and the exchange rate. Reviews by the International Monetary Fund (IMF) play a key role in assessing whether countries fulfil this condition, even if the existence of an IMF financing programme is not a necessary prerequisite for receiving budget support from the Commission.
• An assessment of the public finance management system, and a credible and relevant programme of reform and improvement. Needless to say, as with all forms of aid, respect for human rights, good governance and the capacity to fight corruption also enter into the equation (Malawi-EU, 2008: 14; European Commission, 2008:9).

For the DFID, the overall policy is not to use conditions as its instrument for aid. The general principle is that

we will not make our aid conditional on specific policy decisions by partner governments, or attempt to impose policy choices on them (including in sensitive economic areas such as privatisation or trade liberalisation). Instead we will agree with partners on the purpose for which aid is being given, and will agree benchmarks to assess progress. We will draw these from countries’ own plans, where available, and these benchmarks will relate to the impact and outcome of countries’ overall programmes in reducing poverty, rather than to specific policies (DFID, 2005:2).

However, Barnett et al (2006:26) note that the understanding for DFID aid modality in Malawi is that “although there is no conditionality, the (implicit) rationale still is that an influence is expected” through

• a disciplining effect of donor scrutiny of Public Financial Management policy,
• the dialogue on policy needs, possibly in combination with Technical Cooperation (TC) projects (Barnett et al, 2006:26).

With the African Development Bank (AfDB), the insistence is on the country’s adherence to macro-economic policy. For instance, it was only in May 2010 that the AfDB “finally released its 2009/2010 budgetary support to Malawi worth K2.7 billion after holding it for close to 11 months following concerns over Malawi macro-economic policy slippages in the earlier months of the financial year” (Daily Times, 10 May 2010).

It appears that the donors involved in the CABS group also wait for indications on Malawi’s performance in achieving IMF economic programmes before they release their aid (World Bank, 2006; USAID, 2004; Malawi-EU, 2008; European Commission, 2008). In some cases it has been seen that failure to attain IMF programme targets has lead donors in the CABS group to withhold their funds for budget support. It is in this regard that the IMF programmes were described by Reserve Bank of Malawi Governor Perks Ligoya, as a “do-or-die situation” (quoted in Malawi News 17 January 2010) because “without an IMF programme nobody wants to give you their money” (Minister of Finance Ken Kandodo quoted in Daily
Times 28th October 2010). In his 2010/11 budget speech in Parliament, the Minister of Finance underlined that from 2009 to 2010 the CABS donor groups had withheld their budgetary support as the IMF had not yet endorsed a new economic programme for Malawi (Kandodo, 2010:15). This has been supported by the Acting Head of Delegation for the European Union in Malawi Horst Pilger who hinted that “Malawi is now close to an agreement with the IMF which should enable us to resume disbursement [of GBS funds]” (quoted in Daily Times, 16 December 2009).

6.4.2. SECTOR BUDGET SUPPORT

The relationship between donors and government is also reinforced through Sector Budget Support (SBS) where just like the GBS, donors allocate funding without pre-identified expenses “however, it is designed to support policy implementation in specific sectors [so that] dialogue, conditions and targeted results are related to the sector concerned” (European Commission, 2008:5). In this regard, unlike GBS where donors support the general balance of payment, SBS targets a particular sector. The aim is to attain the Paris Declaration principles by enhancing sector programme ownership, alignment and harmonisation. In the Malawi health sector, the donors use what is called Sector Wide Approach (SWAP) where they pool finances together for the health sector with a common framework for planning, budgeting and performance monitoring. The aim of the health SWAP has been to replace a system which “involved the ‘Balkanisation’ of the health sector by donors which led to ‘islands of excellence’ operating within an ever-weakening public health structure” (DFID, 2010:20). From the experience of the health SWAP, the African Development Bank (2008:9) has noted that although harmonization appears to reduce transaction costs, “effective implementation requires that government provides strong leadership to better manage the scaled-up operation and coordinate the many development partners involved”.

The education and agriculture sector donors have also started to operate under SWAPs. The Agriculture SWAP is organised by the Donor Committee on Agriculture and Food Security. However, although agriculture SWAP was set to achieve the Paris Declaration ideals, it has been seen that “lack of a consistent commitment to agreed policies makes donor coordination mechanisms difficult to sustain [the]... challenge is accentuated by the very complex array of donor and Government initiatives” (International Fund for Agriculture Development, 2009:7). Moreover, although the Government prefers pooled funding in the Agriculture
SWAP, “none of the donors so far has committed to the pooled funding modality [as] there is recognition that pooled funding is not a realistic prospect at this stage as Government systems are not adequately resourced” (ibid, 2009: 6).

For the education SWAP, there appears to be little progress as the agreed conditions and targets are not being met. It is in this regard that in November 2010 the donors threatened to cut or withhold their funding to the SWAP initiative in the Ministry of Education if progress continues to deteriorate on set indicators (see The Nation, 10 November 2010). The German Ambassador to Malawi Rainer Muller in his capacity as chairperson of the Development Partners Group in the Education Sector highlighted that “our concern is that we are four months into the financial year and 10 months from the signing of the JFA [Joint Financial Agreement] but there are very few results to show for the acclaimed SWAP. I have to stress [that] if there is no progress as shown by the indicators, considerable amounts of development partners’ funds will not be released” (quoted in The Nation, 10 November, 2010).

6.4.3. DIRECT PROJECT SUPPORT

The final aid modality is Direct Project Support (DPS). This is where donor funding targets their own specific activities and programmes at times even without reference to the country’s priorities and preferences (Malawi Government, 2009c). It has been noted that this is a particular area where donor funding targets policy based conditionality to promote institutional reform (USAID, 2004:1). To this extent, project support provides an avenue for “hard policy transfer” (Evans and Davies, 1999) as donors determine the choice of the programmes and implementation (Save the Children, 2009; Ntonya and Chizimbi, 2006; USAID, 2007). Although this is the least preferred modality by the Malawi Government as it does not promote the 2005 Paris Declaration Principles (Malawi Government, 2009c; International Fund for Agriculture Development, 2009), it would appear that most donors prefer this method as can be seen in the figure above. Save the Children (2009) estimate that in 2006/07, 67 percent of foreign aid to Malawi was provided as project support. The percentage for 2008/2009 was 54.4 (Malawi Government, 2009c).

Although most donors have some percentage of their funding in project support, USAID exclusively operates under the project support system as can be seen in the figure above. This trend is unlikely to change as USAID has expressed that it “will continue to provide aid in
Malawi through specific programs defined in the Mission’s operational program” (USAID, 2007:37). However, the problem with this method is that it does not promote alignment, harmonisation and ownership as highlighted in the Paris Declaration since programmes are not based on the Government’s priorities but externally initiated. As Save the Children (2009:5ff) observed in the case of USAID “initiatives and priorities determined outside of Malawi challenge the ability of USAID to promote a coherent response to Malawi’s unique needs…with the budget effectively decided by Washington, USAID has very limited ability to align its programs with those of the national development strategy or other donors”.

6.5. PUTTING IT ALL TOGETHER: TRANSFER OF HOSPITAL AUTONOMY AND DECENTRALISATION REFORMS COMPARED AND DISCUSSED

This chapter has answered the study’s first research question namely: What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda? This section summarises these findings through a comparative discussion of the two reform instruments under study with the aim of drawing conclusions.

It has been observed that “globalization…[has]…imposed NPM-style reforms as preconditions for economic development” (Samaratunge et al, 2008:102). The case of Malawi’s health sector reforms confirms this view. Through the use of the Malawi’s MOH reforms, this study has found that policy transfer took place within the realm of the global spread of managerial ideas. In particular for the health sector, hospital autonomy and district health management decentralisation which are informed by the NPM model were seen to be the most dominant reforms.

It has been found that specific isomorphic pressures were responsible for the transfer of these reforms to Malawi’s policy agenda. Due to Malawi’s heavy aid dependence, mechanisms that tilted towards coercive isomorphic pressures comprised the institutional framework for the transfer of hospital autonomy and decentralisation to Malawi’s policy agenda. This is in line with observations that coercive pressures are “somewhat stronger for those…that are conventionally considered to be failing, that are relatively weak and undervalued” (Carolan, 2008:446). Thus international institutional entrepreneurs, who in this case are international donor organisations, seem to have capitalised on the hierarchical international aid regimes to transfer health sector reforms. According to DiMaggio and Powell (1991:74) “coercive
pressures are built into exchange relationships”. In this realm, conditionality in the form of aid in exchange of adopting particular reforms has been the mechanisms through which these policies were introduced to Malawi’s policy agenda. The World Bank’s *World Development Report* of 1993 is seen as a reference point in this regard. It vehemently called upon all developing countries to adopt health sector reforms, key of which were hospital autonomy and decentralisation if they were to be candidates for aid. In the same way, international aid organisations were advised to only assist those countries that were ready to adopt the reforms.

As Bruton et al (2004:415) propound, “coercive isomorphism occurs when institutional fields contain environmental agents powerful enough to impose practices on organizations” or countries. In the case of hospital autonomy reforms, USAID through its non-project assistance (NPA) aid institutional framework coercively transferred the reform to Malawi. The NPA aid regime requires that a recipient country adopts reforms as a condition for the receipt of aid. It was on this institutional isomorphic basis that USAID began initiating the transfer of hospital autonomy reforms to Malawi within the ‘Strengthening Health Care Systems’ project. As a poor country which could not afford to lose the much needed aid, the Malawi Government initially showed commitment to the same in order to receive the conditioned aid. The institutional mechanisms applied in the hospital autonomy reforms were similar to those used in the district health management decentralisation reform. In this particular one, the EC provided decentralisation as a condition to Malawi for accessing structural adjustment funds under the 7th and 8th EDFs which were sanctioned by the Lome IV Convention aid regime. The Lome IV institutional framework emphasised reform measures as a condition for receiving aid or loans within the structural adjustment framework. Again, because of the aid involved and earlier push from the World Bank to implement decentralisation in the health sector, the government of Malawi adopted the reform. All these findings support Dolowitz and Marsh (2000:16) contention that “when aid agencies are making loans it is likely to lead to coercive policy transfer”.

The difference between USAID’s NPA and EC’s Lome IV institutional frameworks is that the Lome IV Convention was legitimised by the ratification of all the ACP countries that receive assistance from the EC thereby legitimising the coercive pressures involved. Although the negotiations and discussion were based on preconceived EC decisions and the ACP countries did not have much input, their ratification legitimised the aid regime. In this context, the adoption of decentralisation championed by EC through aid conditionality means
that it was regarded as legitimate by the Malawi government since the country was a signatory to the Lome IV Convention. This is in line with DiMaggio and Powell (1991:66) postulation that coercive isomorphic pressures can be deployed for institutional legitimacy reasons. On the other hand, the USAID’s NPA aid regime is a once off donor organisation and aid recipient country bilateral arrangement where the “accomplishment of conditioned reforms triggers the release of counterpart funds” (Foltz, 1994:371). In this regard, the aid recipient country does not go through the process of prior ratification and legitimisation as was in the Lome IV but it is based on the specific program at hand. However, despite these differences, the two reform transfers are of a ‘coercive’ nature since without the isomorphic forces at work, the government could have either adopted alternative policies or maintain the status quo. In this regard, although ratification informed the EC decentralisation transfer, it “remains a coercive activity because the recipient country [was] denied freedom of choice” (Evans, 2009:245).

6.5. CONCLUSION

This Chapter was set to answer the study’s first research question which is: What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda? Using the cases of the transfers of hospital autonomy and health management decentralisation reforms to Malawi, the study has found that international institutional entrepreneurs in the name of donor organisations used coercive isomorphic oriented mechanisms in placing these reforms on Malawi’s policy agenda. In this regard, donor organisations took advantage of hierarchical aid regimes to transfer international public administration models to Malawi’s’ health sector. In addition, the Chapter found that donor organisations in Malawi are not a monotonous group and the nature of their relationship with the government of Malawi has changed over the reform period in view of the 2005 Paris Declaration on Aid Effectiveness. The next Chapter presents findings on the contextual factors that facilitated or constrained the implementation of health sector reforms in Malawi. The aim is to find out if the decision to implement policies generated from the international realm is automatic in the context of coercive pressures discussed in this Chapter.
7.1. INTRODUCTION

Chapter Six presented findings on the study’s first research question which is: What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda? With the aid of hospital autonomy and decentralisation reforms as case studies, the Chapter illustrated that international institutional entrepreneurs took advantage of hierarchical aid regimes to transfer the policies using coercive isomorphic oriented means. This Chapter presents findings on the study’s second research question which is: What factors facilitated or constrained the implementation of health sector reforms in Malawi? This question follows the hypothesis that the decision to implement internationally sourced policies is not an automatic one even within the context of coercive isomorphic pressures as veto players are constrained by contextual factors which work as “filters” (Dolowitz and Medearis, 2009) mediating policy development processes.

Through the use of hospital autonomy and decentralisation reforms, the study analyses the impacts of the following national level factors: mode of transfer, policy content and political-economic context, parliament-cabinet configuration, path dependency tendencies, pressure from citizens, institutional compatibility, and bureaucratic politics. The Chapter begins by examining hospital autonomy reforms followed by an analysis of district health management decentralisation reforms. Section Three maps the policy transfer dynamics of hospital autonomy and decentralisation on Dolowitz and Marsh policy transfer continuum. This is followed by a comparative analysis of the two cases to draw conclusions. Last section concludes the Chapter.

7.2. HOSPITAL AUTONOMY REFORMS

This section presents factors that constrained or facilitated the transfer of hospital autonomy reforms in Malawi. The contextual dimensions of measurement used include mode of
transfer, parliament-cabinet configuration, path dependency tendencies, reform content and political-economic context, pressure from citizens, institutional compatibility and bureaucratic politics as discussed below.

7.2.3. MODALITY OF TRANSFER

According to Bulmer and Padgett (2005:109) coercive mechanisms of policy transfer are “variants of hierarchical governance...designed to ensure a top-down process of emulation”. An analysis of the modality in which hospital autonomy reform was introduced to Malawi demonstrates a top-down process. Specifically, to ensure that hospital autonomy program is fully implemented, USAID did not work with the Government in formulating and implementing the reform concept but contracted international consultant organizations that were also implementing the same policies elsewhere. It was learnt that USAID has a policy of not working with government ministries but rather consultants to make sure that its projects are effectively implemented. As one respondent highlighted, “USAID can’t do things through government we need to do it through NGOs and that is part of the rules...There are things like headquarters having some rules that you can’t break”. This was confirmed by a former Principal Secretary for Health (Y) adding that “donors have different policies. There were other donors like USAID, who want their own people to come in”.

In the initial years USAID contracted an American organisation called Partners for Health Reform (PHR) to come up with the reform programme. PHR did all the background work to prepare the MOH for the hospital autonomy reforms. As one respondent indicated, PHR “wrote everything and we started doing what they had said in terms of hospital autonomy”. However, after two years PHR was replaced by Management Sciences for Health (MSH), also an American organisation. The reason for this change was explained by a former Principal Secretary for Health (Y) that “unfortunately, this is a problem when you depend too much on donor resources. The modality of USAID is that an organisation would win the tender to initiate the process of hospital autonomy and after two years, they tender again. So they tendered and another group came”. This created some problems as the two organisations had different styles of working which confused the MOH officials. The view of PHR was to introduce hospital autonomy policy first and the improvement of the health system would follow while MSH was of the idea of improving the health systems first before making the hospitals autonomous. As the former Principal Secretary (Y) indicated MSH had to “rework the documents on a much longer scale, which meant that the timetable was
extended because their view was we had to improve everything before the autonomy started”. The result of this was that “we carried out some of the things MSH said, but they extended the whole process and it was too complex for us to implement”.

The study revealed that MSH did everything that was required for the hospital autonomy to be implemented without technical input from the MOH. It was mentioned that MSH “championed” and “spearheaded the whole process of hospital autonomy because of their experience elsewhere in other countries”. To this end, a former MSH employee highlighted that “MSH did everything, from drafting the hospital autonomy policy, bill, and we developed all the systems, strategies and structures in all areas of management required for hospital autonomy”. This was corroborated by another MSH technical member who indicated that “USAID brought MSH...to come up with the policy and strategy”. It was articulated that when we started working at MSH, we first started doing two jobs at once. The first job...was documenting system in terms of how they were working. And on the other side we were working on the legislation. We developed the hospital autonomy bill and hospital autonomy policy. We started with the policy.

Officials from the MOH confirmed this end. As a Director attested, “they were the ones who drafted the policy and they were the ones who came up with the strategies so they were like providing technical support in terms of what type of systems to implement”.

The study learnt that these structures and institutions MSH was setting up were based on models they were also implementing in other countries. One respondent in this regard highlighted that MSH had expertise on “how a modern hospital is supposed to function so they were borrowing some aspects they were using somewhere. We had to buy human resources system that is used in South Africa for example”. Particularly, it was noted that MSH had “90 percent of their members from outside Malawi”. In addition, apart from the organisation itself, the majority of the personnel were also “doing the same work in other African countries so they were more of learning from there”. For example, there was a hospital systems specialist who was once director of the University Teaching Hospital (UTH) in Zambia and was actively involved in making the UTH autonomous. In fact one respondent estimated that almost 99 percent of the structures developed were borrowed from other countries highlighting that this was a new thing in Malawi, so I would say almost 99% of the structure... was based on something that was done in other countries. This
was the first time in Malawi we were more of a socialist country where almost everything was free so bringing in an element of pay we never had that experience that’s why USAID had to bring these people to come in with the experts from outside. So 99% of what we were doing was from outside and the whole work was based on experience from outside.

These observations were underscored by another former MSH employee who indicated that

the reforms were championed by MSH, which is an international organisation, basically American and it has worked in other countries before coming to Malawi. For example Zambia and Kenya which have now functioning autonomous hospitals based on the same principles that we want to implement here. MSH was instrumental in bringing reforms to these countries. So it had quite a lot of experience from these countries which could be transferred to Malawi. So whatever we were doing in Malawi we had reference to Kenyatta Hospital in Kenya, Zambia, Cambodia and other countries where MSH worked.

The interface between MSH and the Ministry of Health (MOH) was not strong enough to allow the MOH to own the reform program and build their capacity in policy formulation. In the first place, the project was under MSH which is an international non-governmental organisation and they were the ones who were housing this project as consultants rather than the MOH. It was further noted that even the head of the program was sitting in MSH rather than the MOH. In this regard, MSH was doing the work independent of MOH technical input and would only report its progress during some arranged meetings. As the former Principal Secretary of Health (Y) emphasised, the “problem was that the donors were paying the consultants directly and then the consultants would do the work and report to the Ministry”. However, it was revealed that such reporting meetings were initiated and organised by MSH rather than MOH.

The study unearthed that MOH officials were only engaged in international study tours for them to appreciate the success of hospital autonomy at the international level, rather than letting them have hands on experience in the policy and systems formulation stages. In this regard, these study tours were mostly aimed at buying their support rather than building their capacity. Some of the countries the MOH officials visited include Lusaka University Teaching Hospital in Zambia, Jomo Kenyatta Hospital in Kenya, Muhimbiri in Tanzania, Ghana, Johannesburg and Blufontein Hospitals in South Africa where hospital autonomy was fully operational. As a former Director in the MOH hinted, with the study tours “we had quite a lot of evidence that this has worked elsewhere”. These tours were financed by USAID and
they were arranged by MSH rather than the MOH. As one MSH former employee accentuated,

*the big issue is that USAID brought in money depending on how you were making your budgets. The budgets were wide enough to allow studying, bring in an international expert, you would involve USAID to bring in technical assistants, they had no problem they would scout for you and bring them in. There was no problem if you factored in that you want cars, you would get them so it was flexible and everything depended on the programme itself.*

As has been highlighted above, USAID paid this money to MSH rather than MOH and therefore this appending was based on MSH’s budget items rather than MOH’s. Moreover, USAID was also organising international workshops for all countries carrying out these reforms in order to buy the support of government officials who were hesitant about the reform. In these workshops, international experts and thinks-tanks were invited as resource persons. This was in keeping with the World Bank’s (1993a:165) advice that “senior officials of ministry of health can be strongly influenced by the prevailing views of international health community...by participation in international seminars on health policy and management”.

By 2004 MSH had come up with the whole hospital autonomy structures and institutions complete with relevant policies and a bill and presented them to the MOH. The MOH was then supposed to submit the policy proposal on hospital autonomy to Cabinet for approval after which the Cabinet would present the bill to parliament for the actual realisation of hospital autonomy in Malawi.

7.2.4. VETO POINTS FOR THE HOSPITAL AUTONOMY POLICY TRANSFER

The Cabinet and Parliament were important veto points whose support was required for the complete transfer of hospital autonomy reforms to Malawi. This is the case as these are at “arenas of institutional vulnerability” (Steinmo et al, 1992:7) and their “agreement [is] required for the change of the status quo” (Tsebelis, 2000:442). An interview with a Director in the Government’s Rationalisation and Reform Unit revealed four factors that were critical for the likelihood of a reform to successfully pass through these veto points as follows:

- The degree of its responsiveness to the agenda of government - nothing is going to pass if it will compromise government goals.
Nothing is going to pass that would compromise the long term microeconomic growth of the country.

No reform will pass if does not gather enough political consensus - this depends on the extent to which consultations have been made with politicians.

No reform will pass if it has any serious political implications- especially for donor driven reforms.

The policy proposal to implement hospital autonomy reforms in Malawi was submitted to Cabinet in 2004 by the Minister of Health for them to approve. However, the Cabinet rejected it. In the words of various respondents, the proposal was “rejected immediately there and then”, there was “an outright no”, as it was “a pure rejection”. To this extent, this was the case of a failed or “abortive” transfer outcome because it was “blocked by veto actors” (Bulmer, Dolowitz, Humphreys and Pudgett, 2007). This was a surprise to donor organisations as they thought that based on Government’s initial commitment (as discussed in Chapter Six above) and the enormity of the resources spent, the Cabinet approval would be automatic. As one respondent pinpointed, the donors were “overzealous to get it done”. The donors thought they had done all the technical work required for the reform transfer and time was ripe for the government to implement it. Specifically, the World Bank noted that “no technical constraints have been identified in the analysis preventing the granting of autonomy to hospitals” (Malawi Government and the World Bank, 2006:91). However, as Pollitt and Bouckaert (2004:26) emphasise, the “perceptions of what is desirable are not merely identifications of what is technically optimal. There are very much cultural, as well as technical, as equally are perceptions of what is feasible”. In the case of Malawi, there were critical contextual variables that were so entrenched in Malawian health policy realm that favoured the sustenance of the status quo despite the efficiency, effectiveness and performance promises of the proposed hospital autonomy reform. As one respondent articulated, “the President Dr Bingu wa Mutharika being an economist himself he understood it and he was for it. But looking at the political complications he went along with the Cabinet that refused the proposal”.12 This was echoed by another interviewee who argued that

That's the other thing most of these policies are donor driven. Government is very tricky they would rather discuss and get these policies from donors. But when it comes to implementation those policies fail. That is why these things get stuck at cabinet level. Because when it reaches at cabinet level a politician

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12 President Bingu wa Mutharika holds a PhD in Development Economics, MA in Economics and a BA in Commerce
knows whether this thing can work and that's why it will just stall there [at cabinet].

Below is a discussion of contextual variables that constrained the cabinet from approving the policy and passing the bill over to parliament for enactment. These include policy content and political-economic context, parliament-cabinet configuration, path dependency tendencies, pressure from citizen, institutional compatibility and bureaucratic politics.

7.2.4.1. Policy Content and Political-Economic Context

The dominant factor that accounted for the rejection of hospital autonomy policy was the introduction of user fees that formed an important core of the hospital autonomy concept. Hospital autonomy reforms are about strengthening hospital management to ensure efficiency. Within that framework, management would be empowered to independently mobilise and utilise financial resources to attain efficiency and effective results. The dominant revenue mobilisation avenue is user fees. In fact the “introduction of fees at central hospitals is an essential requirement for functional autonomy” (Cripps et al, 1998:12). As the World Bank lamented the “stalled fee reforms have been due to the little substantive action in the granting of autonomy to central hospitals so that they can set their own fees” (Malawi Government and World Bank, 2006:86). Interviews corroborated this view as one respondent hinted that “of course the hospitals would be generating funds through user fees”. In fact the whole concept of hospital autonomy was motivated by the desire to generate revenue through user fees. The two former Principal Secretaries for Health interviewed confirmed this end. In this respect, former Principal Secretary (Y) argued that

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\text{this hospital could be an income generating institution for the state, so that the state could reduce its own input into the hospital as they would be making money. If the services are jacked up, the market is there...Otherwise we are stuck in the inefficient structure.}
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The response from another former Principal Secretary (X) was more illuminating as he even highlighted the politics of the introduction of user fees behind the whole rhetoric of efficiency and effectiveness and nomenclature of hospital autonomy by articulating that

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hospital autonomy was coming in to say that can’t these central hospitals that are consuming a lot of tax payers money actually manage themselves and they can find a way of mobilising resources from the people that are seeking the services. It was much of cost recovery that they stand on their own; they manage their own and can even put charges on the services. However, people knew about the sensitivity of talking about paying. So if
you read most of the documents they will not tell you about making them to be financially independent because of the political sensitivity of the nature of reform, people were talking of making them to be more efficient. As you are bringing in these reforms you have to consider the political connotations, implications, administrative and social implications. And people were quite careful on how to word the hospital autonomy.

It was found that in the context of Malawi where people have traditionally not been paying at public hospitals, such a proposal to introduce user fees was politically damaging. With high poverty levels prevailing in the country the hospital autonomy policy was deemed to be unpopular as it would have serious socio-political implications. As has been illustrated in Chapter Five, poverty in Malawi is “widespread, deep and severe” (Malawi Government, 2002) with 52.4 percent of the population living below the poverty line in 2004 and 65.3 percent in 1998 (Malawi Government 2006 & 2002). Based on this high poverty level, hospital autonomy was seen to be socially, economically and politically not viable. Respondents were of the view that with the prevailing rates of poverty, many people would not afford hospital services even if the user fees are set at much subsidised rates. As a former Director of a health based umbrella nongovernmental organisations explained the “concerns were that most people in Malawi are too poor. Even if you talk of K50, people were too poor to pay and particularly when one is ill there are a lot of costs due to increasing necessities”.

Another official from a health sector civil society group added that

who does not know that we are very poor? If you go to the villages you see very poor people and how they survive only God knows. It’s very difficult for them. Now we can’t even talk about hospital autonomy. The issue is that these are policies that are being driven by donors.

It was also learnt that the government’s overarching developmental policy strategy was poverty reduction where pro-poor policies were encouraged. It was based on this strategy for instance, that school fees at the primary school level were removed. Therefore, introducing user fees in central hospitals would be tantamount to development strategy reversal and contradiction. As a MOH Director highlighted in his memo of 22 July 2003 to the Senior Technical Adviser, “Government... has made a policy decision that...services will be free of charge at the point of delivery at all state owned health facilities. This policy decision is in line with the overall government policy on poverty reduction as outlined in the Poverty Reduction Strategy Paper”. Moreover, the user fees would not only contradict the country’s

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13 K (Kwacha) Kwacha is Malawi’s currency as of 15 September 2010, 1 US$ = K 149.15
overarching policy but also internationally championed policies that call for universal access to health service within the framework of achieving the Millennium Development Goals. As a Director of one of the Central Hospitals indicated,

this issue is a very tricky one. Firstly you have an overall government policy of poverty reduction and then you are looking at improving efficiency of institutions and quality of services offered. At the same time there is...also globally about universal access to health so you have these other pushes and at the same time you have to improve the quality of services. And then as a country we have the desire to improve our health indicators, you have the Millennium Developments Goals, so it’s tricky. Unless the overall government policy of poverty alleviation changes, I do not see the government changing its policy of offering free services.

The dominance of user fees in the hospital autonomy reform concept also brought conceptual understanding problems as many equated it with privatisation. It was learnt that even at Cabinet level, because of advancing user fees, hospital autonomy reforms were equated to the privatisation program that was also taking place in the country. In this regard, a former Director in the MOH indicated that “there was misconception of the issue. People thought that this was privatisation and hospitals would be given to the private sector, and people will be paying much”. A former MSH official clarified that

people were equating hospital autonomy with privatisation. Hospital autonomy has gradations that can range from full autonomy to semi-autonomous. What was proposed in the Malawian context was semi-autonomy and not complete autonomy which entails privatisation. Of course the hospitals would be generating funds through...user fees.

Interestingly, this conceptual misunderstanding also applied to some key MOH staff in the Planning Department who were supposed to be well conversant with the reform concept. To this end, a Planning Officer at the MOH underlined that “many of us had reservations about the hospital autonomy reforms. It is just the same as privatising the hospitals”. This lack of understanding from personnel that were supposed to be well knowledgeable about the conceptual grounding of the reform only reflects the problems in the modality of transfer highlighted above. It hinges on their lack of hands on involvement in the reform formulation processes. No wonder, there was misunderstanding at Cabinet level. Of course the documentary analysis for this study revealed that the objectives stated in the Privatisation Act enacted in 1996 and the proposed policy objectives for hospital autonomy were very similar. Obviously the only notable difference in objectives was that hospital autonomy was narrower in scope being health sector specific and involved the public realm while privatisation
programmes were wide encompassing and involved the economy in broad terms. Ultimately, this conceptual confusion of autonomy with privatisation contributed to the Cabinet’s rejection of the reform. To this end, a former Director in the MOH postulated that “but with the use of autonomy which is equated to privatisation, then it was a no at Cabinet level”.

7.2.4.2. The Parliament-Cabinet Configuration

Flynn (2002:63) accentuates that “organisation of power relationships through political institutions...has an important impact on decisions and actions about the public sector”. Central to this ‘organisation of power relationships’ is the parliament-cabinet configuration. The parliament-cabinet configuration prevailing at the time the hospital autonomy proposal was presented to cabinet can also highlight why the policy was rejected. Pollitt and Bouckaert (2004:46) tell us that the parliament-cabinet configuration generates different sets of governing modes which “shape the boundaries of what is politically feasible”. Taking this perspective therefore, policy outcomes will “vary depending on who controls political power as well as where the status quo is” (Tsebelis, 2002:17). In this regard, the study found that the Cabinet rejected the proposal and did not pass over to the parliament to enact the bill because they knew that the parliament would not enact it, a situation which could threaten government’s popularity in the context of the proposed user fees. This is because at this time the government operated within the institutional environment of Pollitt and Bouckaerts’ (2004:46) “minority cabinet” where “anxiety-provoking tug-of-war fuelled by actors’ struggles to make sense of underlying tensions” (Luscher, et al, 2006:491) prevented the enactment of any government legislation including the passing of the National Budget.

This must be understood in context. President Bingu wa Mutharika came to power through the 2004 election under the United Democratic Front (UDF) ticket. He was handpicked by the former president, Bakili Muluzi following his unsuccessful attempt to fight at a third term of office. Soon after his election, Mutharika left the UDF - the party that sponsored his election - and formed his Democratic Progressive Party (DPP). This move had massive implications on the relationship between the legislature and executive which affected all government business. Although some members of parliament also defected from the UDF and joined the President’s DPP, the new party and consequently the executive had a minority membership in parliament. In fact the ‘true’ DPP members of parliament were only six (out of the total number of 193) that were elected through bye-elections.
This scenario resulted in the DPP having difficulties in enacting its policies and programs. In fact almost everything that the government sent to parliament was rejected to deliberately frustrate the government side in retaliation to the President’s leave of the UDF. The former president Bakili Muluzi incited the MPs against Mutharika and he was often quoted in the local media saying, “chubu chopopa ndekha sicingandivute kuphwetsa” (literally meaning, I cannot fail to deflate a tube that I inflated, referring to his handpicking and support of the president in 2004). Muluzi emphasised that “mine is a promise and a vow that I shall not let (President) Mutharika go scot-free for abusing my support and of other UDF members by dumping the party that ushered him to power” (Muluzi, quoted in Nation, 13/6/2008).

Therefore, the relationship between the executive and the legislature was “characterised by near anarchy” (Shugart, 2006:355) and was paralysing all government business including the national budget. In most cases the President relied on populist strategies to push the parliament to pass the budget. One of such appeals is the following National Address by President Mutharika of 20th July 2006 where he stressed that

I am very sad to address you this evening because the Opposition in Parliament are refusing to pass the national Budget...The Opposition Parties have united and mobilised their people to reject the Budget, simply to frustrate my Government...Their hidden motive is to turn around and tell the people that my Government has failed...But what you should know is that by rejecting the Budget,...[they]...are in fact denying you, the people of Malawi, the chance to prosper...They are denying you the human rights guaranteed under the Constitution...And these are the people you elected to represent your interests in Parliament... our country is facing a serious economic crisis because the Opposition MPs whom you have elected are not serving you but serving their own interests...I leave all to you to decide what to do about them.

It is therefore against this background that the President could not request the parliament to enact the hospital autonomy bill as it was clear that just like any other bill they would reject it. This is based on the “predominant belief that a minority government corresponds to some kind of divided government...and that legislation requires the agreement of both government and parliament to be enacted” (Tsebelis, 1999:594). The consensus among the interview respondents was that the “timing was not politically right” (former MSH official) as it was “not a stable government” (former Secretary for Health Y) and it would be “political suicide to do that [to introduce the bill]” (a former Director in the MOH) due to the “impasse in parliament” (a Planning Officer in the MOH) as it was “100 percent likely that it would be
rejected” (a health based civil society organisation director) and the “outcome may be politically disastrous” (a former hospital administrator).

Moreover, apart from the high possibilities of rejecting it, the Cabinet was also afraid that the opposition parties would capitalise on the issue of user fees in order to make the government unpopular. In this case, by introducing the bill the government would be “shooting itself on the foot” (a former health based civil society organisation director). The former Secretary for Health (Y) articulated that

> the parliament was full of political opportunists who just wanted to put off the government. And this would be difficult for the minority government as it was by then for it to pass in parliament. The opposition would just say that they are privatising the hospitals and that would put the government off. That is another risk that was there that people would misinterpret what we were trying to do for something else which is not for political reasons.

The actual issues at play were highlighted by a former MSH official who indicated that

> if it had gone to parliament it would be rejected. Much as the Cabinet was to approve it, it was supposed to go to parliament to be enacted into law. So it would have been thrown out. This was when we had the Bingu/Muluzi saga so it would have been thrown out. It was at a wrong time.

In conformity to this observation a former employee of a health based umbrella non-governmental organisation hinted that

> government had to weigh it from the political point of view and technical point of view and said, ‘much as it will improve the health system, but it will kill us on the political side so what do we go for?’; these are politicians and had to go for political reasons...The political situation was very tense at the time and so it was very difficult for the government to proceed because its popularity would have gone down...Much as the policy perspective was ok, the political side wasn’t right [emphasis added].

7.2.4.3. Path Dependency Tendencies: From the ‘ Tickey’ to Hospital Autonomy

Path dependence theory can also enrich our understanding of the cabinet’s decision to reject hospital autonomy reform because it contains “insights into the mechanisms that sustain particular patterns of politics” (Thelen, 1999:385). Particularly, path dependence tendencies may affect the decisions of veto players and conversely, decisions of veto players may inform on policy trajectory. Therefore, Cabinet’s rejection of the hospital autonomy reform based on the dominance of user fees must be understood within the institutional historical context of health sector policy development in Malawi. This is because free hospital services in the
country have historical roots that have been embedded in the cultural and institutional sinews so that attempts to break that path have historically resulted in serious political consequences. In this regard, the hospital autonomy model has faced “institutionally embedded policy preferences against which the model is evaluated” (Padgett, 2001:1) and hence its rejection.

As explained in Chapter Five, Malawi attained self governance in 1963 and independence in 1964 under the leadership of Dr Hastings Banda after being a British colony for a long time. During the colonial rule, there was universal free health care as an attempt to introduce modern medicine to the natives and because of the prevailing low incomes (WHO, 1993). However, after receiving self governance it was observed that it would be very difficult to continue with the colonial policies since most of them were too expensive for the brand new government to afford. As a result, a reform commission was set (called the Skinner Commission) to make recommendations in this regard. One of the recommendations that affected the free hospital policy was that “some services which are provided free or at less than cost, should attract economic charges and other services should be made available to the public against payment” (Skinner Commission, 1963:109).

It was against this background that Banda who was then Prime Minister proposed to introduce user fees for health services. In this respect he “imposed a nominal charge of three pence (locally known as tickey) per person at government hospitals which hitherto had come under the…(Colonial) government and had provided free medical attention to all Africans” (Pike, 1968:166). However, a few weeks of its introduction, this fee was resented by many because free hospital services had been institutionally embedded into the society so that they could not understand why Banda wanted them to be paying. Moreover, the country had just gained self governance from colonial rule and the people, including some Ministers, expected a better life than the “politically dangerous hardship caused by the Skinner report and the hospital charges” (Baker, 2001:132). The Minister of Finance at that time John Tembo explained that “the people felt that there was no sign of the improvements which they had expected to see once independence had been achieved” (Tembo, quoted in Baker, 2001:116).

In addition, the then Minister of Local Government Henry Chipembere observed that “the people had throughout the colonial era never been made to pay for government health services….and the three-Malawi-penny fee was a heavy burden which prevented many people from taking their fever-stricken children to a dispensary” (Chipembere quoted in
Baker, 2001:133). Therefore, the ministers demanded Dr Banda to drop the *tickey* in a set of dramatic events that led to the dismissal of three ministers and a parliamentary secretary, and the resignation of three other ministers in solidarity, which is popularly referred to as the 1964 *Cabinet Crisis*. In his 8th September 1964 Parliamentary address, Banda highlighted the tensions that this policy caused and the resultant cabinet crisis as follows:

> My Ministers begun to attack me. They all attacked me. I was shocked. I was shocked Mr Speaker Sir, because there I was, the Prime Minister, isolated, deserted by every one of my Ministers...they attacked me on charges in the hospital. They told me that there was unrest in the country, resentment and bitterness among the people all over the country from Karonga to Port Herald, from Nkhotakota to Mchinji because they said I was charging *tickies* when people go to the hospital...They told me that there was trouble everywhere; and if this trouble was to be avoided...I had to drop the *tickey* charges immediately...[they said]...people do not want the *tickey*. You are unpopular, the government is unpopular. If the Government is to regain the confidence of the people you must drop the *tickey* now.

It appears that the people were in support of the ex-ministers because the “*tickey* charge did cause hardship” (McMaster, 1974:61) and “was also causing concern” (Baker, 2001:116). Ross (2009:221) reports that the “ex-ministers were cheered to the echo while Dr Banda, for the first time ever, was booed and jeered at by a Malawian crowd” in the main cities of Zomba and Blantyre. It was in this regard that shortly Dr Banda dropped the hospital charges and hospital services have remained free.

A critical analysis of this fee policy (*tickey* payment) reveals that it is not much of the affordability problem that attracted resistance but the historical institutional set up of colonialism *vis a vis* independence within which it was introduced. This was the case because during this time the people were paying for traditional medicine willingly. To this extent, Banda demonstrated in his 9th September 1964 parliamentary address that

> Oh *tickey* charges to the people, these shouldn’t be difficult to explain, this is easy, even under ordinary African system or *Sing’anga* (traditional healer), you do not go to the African *Sing’anga* with empty hands, you take something, it may be a chicken or *mbuzi* (goat).

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14 What was particularly intriguing was that people used the old anti-colonial chants against Dr Banda. During the battle against colonialism the people were shouting *Welensky-zi, Welensky-zi* (literally meaning Welensky out-we don't want Welensky, referring to Roy Welensky , the Colonial Governor), and now they shouted *Banda-zi, Banda-zi* (literally meaning Banda out-we don't want Banda referring to the Prime Minister Dr Hastings Banda).
It is therefore against this historical institutional background of the 1964 cabinet crisis, that politicians have been reluctant to introduce hospital reforms whose core is user fees. Multiparty democracy that Malawi had in 1994 which facilitated the proliferation of liberalisation reforms would be seen to present Wilsford’s (1994) “conjuncture” that would break the free health service policy path and therefore work as a springboard for the introduction of hospital autonomy. However, its force was not strong enough just as the 1964 independence could not break the free health service policy path that was introduced during colonialism. In fact the 1964 independence and 1994 democracy presented “lock in” (Wilsford, 1994) effects due to people’s expectation for a better life as an outcome of these political reforms of which hospital fees were the opposite. Particularly, liberalisation reforms introduced after the 1994 democratic dispensation heightened the opposition against user fees as most people equated hospital autonomy with privatisation which had many social costs and hence had a ‘lock in’ effect and formed a basis for rejection as already highlighted above. Therefore, the current policy of free health services is a product of colonial institutional legacy which has been so “self-reinforcing” (Mahoney, 2000:507) and deeply embedded into the social fabric that it is difficult to change and as a result making hospital autonomy reforms virtually impossible. As a former Principal Secretary for Health (X) who witnessed the cabinet crisis illuminated:

the issue of paying for health services has always been an issue in Malawi and as you recall that was what caused problems and caused the 1964 cabinet crisis. One of the major issues was the tickey issue and believe you me the tickey issue is still with us in Malawi and even when we were talking about hospital autonomy...The moment you mention anything to do with collecting funds and trying to get other sources of revenue apart from the exchequer’s budget that is looked at suspiciously by the politicians and the general public.

A Director in the MOH corroborated this view by underscoring that:

the other part which may be the biggest part of it is based on history. The 1964 Cabinet Crisis based on the reform suggestions that people should be paying a tickey charge at the hospital. That element you know politicians would capitalise on things of that kind. The President said there was this cabinet crisis based on this tickey, what’s more with autonomy which is not only payment but also privatisation- which could lead to a greater crisis. So

\[15\] After the Cabinet Crisis in 1964 Banda declared Malawi a one party state with Malawi Congress Party as the only legally accepted party. Banda became a dictator and suppressed all opposition with brutal killing and arrests without trial. Due to internal and external pressures Malawi had its first multiparty election in 1994 where Bakili Muluzi was elected President under the United Democratic Front (UDF).
it was like no, Malawi is not ready for this kind of reform as it would lead to a crisis.

7.2.4.4. Pressure from Citizens

Citizens were an important stakeholder to the hospital autonomy reforms since it would affect their access. As Pollitt and Bouchaert (2004:31) expound, “although lay citizens are unlikely to be brimming with concrete proposals for better management, they can and, on occasion, do exert pressure for change”. Because of the historic nature of this study, it was not possible to get the actual public views from the citizens themselves. This is heightened by the fact that hospital autonomy reform was more of top-down from donors and there was no meaningful input from the general citizenry as highlighted above. However, it was possible to get the enormity and feel of the citizens’ pressure as it fed in various policy making processes and mechanisms.

The study learnt that the citizens’ views about the reform and hence the demand were divided. On one side were the relatively rich who had the ability to pay and on the other the poor who could not afford. The well-off were in support of the reform as it would improve quality. However, since Malawi has a very high economic inequality, these were only a few elite group and the minority of the society. The majority who are the poor were not in favour of the reform as it would adversely affect their access to health services. It was revealed that these people have no choice and do not care much about quality as what matters to them is access. As the former Principal Secretary for Health (X) elucidated

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\text{the beneficiaries were of two types, there were those that liked the idea in terms of hospital autonomy and these were those that had ability to pay...[they]...would say ‘we should be paying for these services to make them efficient’. But there was a group of the poor of the poorest that did not like the hospital autonomy because they were afraid that if you start paying it means that the chance that they have to get services would not be there.}\n\]
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\text{For these, the issue of quality is not very important. Quality is not a big issue, the issue is whether they have received the service or not.}\n\]

A Director of one of the Central Hospitals concurred that

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\text{a certain group of the society is looking for paying services because they are looking for quality services and then there is this other group of the society who earn very little, those ones would want to continue with the free services because that’s the only place they can get a better service.}\n\]
Moreover, the reform was seen to favour the rich while alienating the poor. It appears that the reform was aimed at targeting the elite for the promised efficient and quality services rather than the whole populace. This suspicion was confirmed by an MSH official who indicated that “we know that there are certain members of the public who are affluent, they would want quality services and these central hospitals would provide these at a cost”. Therefore, civil society organisations in the spirit of acting for the poor pressurised the government not to implement the reform. To this end, a Director of a health sector civil society organisation indicated that

*I am grateful for the role of the civil society because some of these policies would be implemented long time ago if it was not for the civil society. The civil society has been making noise saying that this cannot work, putting pressure on government as well as donors.*

The pressure from the civil society was too large that in a divide and rule fashion, MSH recruited personnel from one of the key civil society organisations in the advocacy area. This was to act as a buffer zone against the prevailing pressures. To this extent, an interview with the co-opted official revealed that “news started going out and the civil society started talking about it. And I was engaged to diffuse the civil society. That was my job to help them understand how efficient this would be”. However, things got out of hand when the media joined the bandwagon and as a former MSH official put it, “there was bad publicity”. A former Principal Secretary for Health (X) concurred that an “article appeared in the Weekend Nation (one of the main newspapers) which destroyed everything as their view was that this was something that was not popular, that the opposition was against it, civil society was against it because their view was that it was privatisation of the central hospitals”. Since health issues in Malawi are highly politicised and issues pertaining to the poor are a political capital, the cabinet had to succumb to the pressures. As a Health Planner at the MOH indicated “you can burn your figures with politicians on this one. Unless you have a politician who does not care about a second term of office otherwise if you want a re-election that is not an area you would want to touch”.

7.2.4.5. Institutional Compatibility and Prerequisites

It has been noted that institutional compatibility is an important element in predicting the transferability of policies (Godard, 2001). As Schleyer (2008:9) observes, the effectiveness of “new policies depend on the compatibility between the characteristics of their institutional
design and the institutional arrangements already in place”. The study revealed that the hospital autonomy reform had lower degree of compatibility with the prevailing institutional framework of health care in Malawi which also explains its failure. The Malawi health care is based on a three-tier referral institutional framework comprising of health centres providing primary care, district hospitals providing secondary care, and central hospitals providing tertiary specialised care. The principles of referral institutional framework require that these facilities must be complementary.

However, hospital autonomy means that one does not necessarily have to go through this referral system to access services at the central hospitals as the determining factor for access is ability to pay. For those that cannot pay, it means they will end up at secondary level regardless of the severity of their ailments unless the government bails them out. Of course a Director in the MOH hinted that within this referral system, it means that the government will pay for those that are referred to the central hospitals but cannot afford. However, based on the current government financial outflows to the health sector of per capita expenditure on health being only US$5 (Mkandawire and Nguluwe, 2008), it is very unlikely that the government can sponsor these poor patients for tertiary care and the sustainability of such an arrangement is very much questioned. As a result, unless district hospitals are strengthened, they would be much overloaded. In this realm, a former civil society organisation official indicated that

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\text{the problem was that if you put a cost how much small it is,... it will suffocate the district hospitals because those patients that do not have money to access or be referred to central hospitals would rather stay at district hospitals so they will suffocate that system.}
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This was corroborated by a MOH Zone Supervisor who underscored that

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\text{the problem is that if you talk of autonomy there is the issue of cost...But if you look at our referral systems who is going to bear those costs because districts have to refer to central hospitals due to capacity and expertise they have and in the spirit of the referral system. We have this referral system which does not favour hospital autonomy.}
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It has been argued that institutional incompatibility is not “entirely a hindrance for reform but can act as a necessary though, not sufficient, condition for the change of existing institutional framework” (Borzel and Risse, 2002:60). However, for this change to materialise, it requires the existence of organisational and institutional prerequisites to support the incoming institutions. As Coyne (2005:327) observes, prerequisites serve as the “outer limits of
reconstructed orders...[because]...without them to serve as a foundation, reconstructed orders will fail to be self-sustaining over time”. This study found that the absence of prerequisites meant that change of the existing referral institutional framework in the context of incompatibility with hospital autonomy reforms was problematic.

It was learnt that the first prerequisite was to construct district hospitals in the districts where the central hospitals are. In the districts where the four central hospitals are situated there are no district hospitals to offer secondary care which leaves the central hospitals to be the only place for such services. Therefore, if such hospitals become autonomous, even secondary care will not be accessed by the majority of Malawians residing in districts where these central hospitals are allocated. The construction of district hospitals was therefore, a prerequisite for the operation of autonomous hospitals in the context of a country where poverty levels are high. In this respect, a former Principal Secretary for health (Y) underscored that “the cabinet observed that there was need to build district hospitals first in places where these hospitals would gain autonomy”. Moreover, a Director of an umbrella civil society organisation on health issues quizzed this researcher that “Lilongwe, Blantyre, Zomba and Mzuzu [districts where central hospitals are] do not have district hospitals, so how do you make these institutions autonomous when these other structures are not available?”. The actual issues necessitating the need to construct district hospitals were articulated by a MOH Health Planning Officer who underscored that

*the central hospitals although they are tertiary institutions, 80% of what they provide is primary health care. What that means is we have no alternative for 80% accessing the primary care at these facilities. Now you can’t give central hospitals independence and you have no equivalent secondary level facility because central hospital facilities are working more as district hospitals in the districts they are in as well as referral for the other hospitals,...so there are prerequisites...until we construct district hospitals in Lilongwe, Blantyre, Zomba, Mzuzu, we cannot talk of hospital autonomy.*

Even street-level bureaucrats at the point of service delivery corroborated this view. A focus group discussion participant at one of the central hospitals indicated that

*all the districts where there is a central hospital do not have district hospitals where the poor can primarily go and would only be referred to central hospitals. The whole district comes here for treatment but this was supposed to offer tertiary services as such minor issues were to be handed by the district hospitals. So autonomy would present challenges.*
The second prerequisite was the strengthening of the existing district hospitals. It was learnt that the existing district hospitals do not have enough technical and resource capacity even to handle cases in their realm. As a result, they refer to central hospitals cases which according to the referral principles, were supposed to be theirs. Consequently, people bypass the referral system and go straight to central hospitals since these are perceived to be the only places where services are available. Therefore, strengthening of district hospitals so that they can handle certain specialised care became a prerequisite for central hospital autonomy. As a former Principal Secretary (Y) outlined, the “cabinet observed that most patients bypass the referral system because they perceive that it is the central hospitals that have better medication. So the cabinet thought of strengthening health centres first and then autonomy would follow”. The actual institutional challenges in the advent of hospital autonomy and hence the necessity for this prerequisite was highlighted by a Director of a civil society organisation who emphasised that

we need first to strengthen health centres and district hospitals so that they can even handle some cases so that cases referred to central hospitals should be major cases. But how can you make an institution like Queen Elizabeth Central Hospital autonomous as this is the only institution that has life saving machines in the whole country? So if you make it autonomous you are making it favour the rich because the poor will not access. Maybe these are some of the things we have learnt from other countries but looking at the challenges we have I think we are very far from implementing these policies.

7.2.4.6. Bureaucratic Politics: Political-Bureaucratic Culture

The study found that political ministers and senior bureaucrats also played a pivotal role in determining the acceptability of the hospital autonomy reform. As Pollitt and Bouckaert (2004:50) observe, “major public management reforms usually involve both executive politicians and senior public servants [and] together they usually constitute the main part of the elite which makes the crucial decisions about reform”. To this end, the study observed that resistance emanating from the ministers that have served the MOH over the years and senior executives at the MOH contributed to the failure of the hospital autonomy reforms. This is because hospital autonomy reforms would delink the central hospitals from the direct MOH ministerial and bureaucratic control and thus losing the powers and control they previously used to have. Below is a detailed examination of this finding highlighting the influences at the ministerial, bureaucratic and central hospital levels.
At the ministerial level, power and control over public resources are highly cherished and jealously safeguarded. In particular, there is a general belief in the Malawi’s political value system that government’s legitimacy, control and power are measured by the number of institutions it directly controls. Accordingly, a minister is perceived as powerful if he or she has many departments and structures that are directly under his or her control. The understanding is that the bigger the Ministry, the better the perceived ministerial power and control. Moreover, as Rakner et al (2004) point out, in Malawi the “most politically powerful [ministry] gets the largest proportion of the budget”. It was in this respect that a DFID official observed that hospital autonomy reforms are “something that is affected by the political power games”.

Additionally, it was found that government institutions like central hospitals also work as resources for increased patronage based on clientelist politics. As highlighted in Chapter Five, in Malawi the “distribution of the spoils of office takes precedence over the formal functions of the state, severely limiting the ability of public officials to make policies in the general interest” (Booth et al, 2006:vii). Therefore, giving central hospitals autonomy would be tantamount to losing such ministerial power and control and it would also lead to the “potential loss of patronage resources (in the form of public sector employment and rents)” (Robinson, 2007:523). As a MOH Health Planning Officer hinted, hospital autonomy reforms “meant to bring efficiency but at the same time divorcing the politicians from direct influence, so basically they can’t be favoured by politicians”. The extent of the ministerial clout on central hospitals which the MOH was not prepared to shed off can be seen in the speech made by the former Minister of Health Aleke Banda when he was opening a conference on health sector decentralisation reforms where he told delegates that

we have three Central Hospitals which report to the MOH...These are national institutions. As such they will continue to report to this Ministry. They will remain our infrastructure. This is the extent to which decentralisation will rob us of our massive infrastructure (Banda, 2000) [emphasis added].

The actual issues were stated by a former Secretary for Health (Y) who highlighted that

in fact one or two ministers raised this issue, because there is this perception that is very strong that if you are a minister then you have all these institutions. These are symbols of ministerial power. Last but one minister felt the same and did not want to hear anything about hospital autonomy for that reason. But this is a selfish myopic view...You do not lose
power and actually you become more influential because you give out the guidelines and milestones against which each hospital should be performing.

However, he was very quick to put the record straight that “yes in a way you lose something but in the final analysis it is for the good of the country”. A Central Hospital Director concurred that

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\text{to de-link these institutions from being government wholesale, they did not know what was going to happen. You see they always want these institutions to be wholly government so that they can have that control. I think the way government was going to control these institutions was not clear and how independently they were going to operate apart from the fact that the systems will be improved and the hospitals were going to be more efficient- that they knew, but how that was going to impact on everybody [ministers] they had unknown fears.}
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It was further learnt that it is against this backdrop that the Minister of Health at the time of presenting the hospital autonomy proposal to Cabinet for approval did not adequately prepare and lobby his fellow cabinet ministers so as to increase the acceptability chances. According to a Director in the Malawi Government’s Rationalisation and Reform Unit, one of the reasons a reform would attract disapproval at cabinet level is “if it does not gather enough political consensus”. The hospital autonomy reform proposal did not have such political consensus as the Minister of Health himself was not committed to it and hence did not lobby other cabinet ministers to obtain the required political consensus. In this respect, key informants at the MOH had the view that if the minister had lobbied his colleagues, it would increase the chances of its acceptability. However, he did not because of the fear to lose the direct power and control over the central hospitals. Here a former Director in the MOH underscored that, the Minister of Health

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\text{normally, politically, he was supposed to lobby fellow cabinet ministers but he did not. We the Ministry of Health officials could not start lobbying the cabinet, it was difficult...we were banking on him (Minister of Health ) to sensitise his cabinet colleagues well before so that they could understand the small things highlighted in the concept paper and other necessary documents...But the minister did not do this...so that contributed to the rejection...being politics you know what it means.}
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This was emphasised by a Central Hospital Director who highlighted that

\[
\text{whatever initiatives you introduce in government...which also need at some point the blessing of cabinet if you don’t do a lot of advocacy at cabinet level that thing will not be approved because they need to put the final stamp. But there was not any at the cabinet and with all these unknown}
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fears they had so it was a pure rejection. It was rejected immediately there and then.

7.2.4.6.2. Senior Bureaucrats at Ministry of Health Headquarters

Just as at the ministerial level, the study also observed resistance towards the reform among senior bureaucrats at the MOH. The same issue of fear for the loss of administrative control and power was attributed as a cause for this resistance. Senior bureaucrats at the MOH have the authority to oversee and control all MOH facilities including central hospitals. Central hospitals report to them thereby making important administrative decisions for them even at times on routine issues. In the context of Hofstede’s large power distance culture, this brings respect for the MOH officials. As Briscoe and Schuler (2004:273) demonstrate, in Malawi the “relationship between managers and subordinates is viewed as authoritative: workers give deference and expect managers to act paternally”. Moreover, “civil servants in Malawi regard the state primarily as a resource for patronage and self enrichment” (Anders, 2002:48). In this regard, granting central hospitals autonomy would be tantamount to closing avenues for increased patronage, respect and power. As a former civil society organisation official highlighted, “when the policy was presented [by MSH to the MOH] it was difficult to move ahead because the issue was not getting support”. This was echoed by a former MSH official who observed that “in the Ministry (of health), for them hospital autonomy is a misconception and it was very difficult to get the support”. A MOH Planning Officer concurred that for hospital autonomy “many of us…had reservations about the reforms”. These reservations were articulated by a former Principal Secretary for Health (X) when he highlighted that the resistance

was [about] fear of losing control, fear of losing power, fear of losing resources. This resistance was both whether it was hospital autonomy or decentralisation. Still in both contexts, they had something to lose and nothing moved fast.

It was revealed that most senior managers including the Principal Secretary for Health at the time were not for the reform and they could not offer the required support. As an MSH official recalled,

when we were working on hospital autonomy Dr Sangala was the PS (Principal Secretary for Health). He had the same problem…he did not provide the adequate support. It was only towards the end that he was very supportive when he stopped working as PS.
Against the backdrop of these fears, combined with the fact that the MOH officials were not technically involved in the policy and systems formation processes (highlighted in section on mode of transfer above), they were not committed towards the actualisation of the reform. There was a conspicuous lack of ownership and commitment in the reform process. As one MSH official lamented,

*instead of the Ministry demanding and calling us (MSH) to go and give a report on the progress, it was MSH who was forcing the Ministry to come and hear progress. The program was asking the Ministry to give it feedback and it was not the thing that was demanded by the ministry... and if they had something else to do they were giving excuses all over [emphasis added].*

However, there were some senior managers that were sympathetic to the reform and provided some support. As a former MSH official demonstrated, *“every now and then when MSH would have a meeting with MOH officials...you would find one or two people confused and converted”*. However, the strength of the resistance meant that those MOH officials who were seen as reformists and sympathetic to the reforms were removed from the Ministry. This involved some members of the Planning Department that were contact points between the MOH and MSH and were sympathetic to the reforms. These were seen to be providing the necessary interface and support to the MSH for the actualisation of the reforms and hence they were replaced by managers that had reservations of the whole reform process. To this end, a former MSH official emphasized that at a time

*there was a person from the Ministry. But he was moved. And this was why the problems started. He was driving it very hard but when things were getting hot that we now need to implement it, this guy was moved out. But the new guy that came in had a lot of reservations. So when the old guy was moved out it was difficult to continue with the process.*

The impact of the removal of reformists on the reform process was substantiated by another former official who argued that

*there is a problem. The relationship between Ministry and MSH was highly dependent on individuals. So the question is can we substitute him for the ministry. At what point does it became a Ministry’s thing. When he left there was no sustainability. So it was like it was not the Ministry but him as an individual who was pushing it...so when he left it died there.*
An official from DFID corroborated these observations by underlining that

you will be surprised to learn that there were a number of reformist in the Ministry who were removed from the Ministry by the Minister of Health Marjorie Ngaunje because of her own reasons. Perhaps she wanted to establish a power base where she couldn’t be challenged. To some extent that is also looked at as something that has contributed to some of the failures because we had change agents in the Ministry who were removed due to political power games.

However, despite this visibly lack of interest from MOH officials, MSH continued to develop the program and made them push it to the cabinet level. This collaborates Hirschman’s (1993:126) observation that in Malawi, “donors are mostly set on continuing with their programmes whether or not the Malawians show evidence of, or even concern for maintaining them”.

**7.2.4.6.3. Central Hospital Level: The Incentive Problem**

The role of incentives in health sector reforms at the level of implementation has been acknowledged (Diamond and Kaul, 2009). As Gauri (2001) elucidates, reforms in the health care systems should focus on “getting the incentives right” for the implementers. Hospital autonomy reforms were aimed at making central hospitals efficient and effective by increasing the autonomy of managers. In general, personnel at central hospitals supported the reform because of the necessary managerial independence required for their work. One Director at a central hospital indicated that “*the concept was good it would benefit central hospitals and all of us in improving quality of services we offer*”. However, there were no enough incentives for them to advocate and push for it in light of MOH headquarters bureaucratic resistance outlined above. Most of them were very suspicious of the project. With the issue of cost recovery, they perceived the project as a ploy to use them as income generating entities for the government.

This was against the backdrop of the prevailing regulations that any finances that hospitals collect in one way or another (for example, medical examination for private company employees) are not supposed to be used by the hospitals that generate it but deposited at government’s account number one which is hosted in the Treasury Department of the Ministry of Finance. The Treasury then makes this money available to general government activities and not ploughing it back to the specific hospital that generated it. As money is not
ploughed back to the hospitals, personnel at central hospitals informally refer to this account as a “bottomless account”. With this understanding, although the hospital autonomy draft bill and policy provided for cost recovery, they did not clearly put in place mechanisms for the hospitals to use the money they will be generating for efficient service delivery. As a Director at one of the central hospitals commented, “we send our revenue straight to Government account number one at Treasury. But we are told that with time may be the government may start thinking of allowing us to use that money. But that is just hearsay it’s not on paper”.

The resentment of this arrangement and the resultant lack of incentives it generated were highlighted by medical personnel who added that all revenue collected goes to government account number one and does not stay at the hospital or even ministry of health in general but goes to government. So you tend to say, ‘why should we trouble ourselves with hard labour when we do not see the money?’ The money is just general government revenue and goes to government account and does not come back.

This was also exacerbated by feelings among administrative staff at the central hospital level that they would lose their jobs. This was because the autonomous hospitals would require professional personnel with higher skills and qualification so as to be competitive. Therefore, many of the existing administrative staff at central hospitals would be under-qualified and hence making them redundant. To this end, a former Principal Secretary (Y) underscored that, administrators at central hospitals feared that they might lose their jobs. Of course not everyone would lose their jobs but we were looking for people with high level skills to run the hospitals for example people with good business administration, human resources, purchasing skills so that they operate business-like.

### 7.2.5 HOSPITAL AUTONOMY REFORM EXITS MALAWI’S POLICY AGENDA

With the cabinet’s rejection and a combination of contextual issues articulated above, it would appear that the hospital autonomy reform project is exiting the Malawi’s policy agenda. The signals of that exit were noticed at donor, political, MOH, and central hospitals levels as follows: At donor level, when the policy proposal was rejected by cabinet, USAID stopped funding the program and that signified the end as USAID was the only source of financing. As a former Principal Secretary for Health (X) recalled, “so everything stopped and USAID was no longer interested and the program died”. An MSH official concurred that “the donor, USAID, said ‘we do not see any commitment from government’. So USAID pulled
out”. This was not strange since as per the rules of the NPA regime, funding is stopped if the conditionality is not met (see Fotz, 1994; Setzer and Lindner, 1994; Moulton, 1997; Donaldson, 1994).

Secondly, at the political level, the study observed the Government changed its overarching development policy framework so that the Poverty Reduction Strategy Paper (PRSP) which committed the Government to implement the hospital autonomy was replaced by the Malawi Growth and Development Strategy (MGDS) in 2006. It is interesting to note that the MGDS does not commit the Government to undertake the reform as the PRSP did. In fact the MGDS does not even mention anything about hospital autonomy. In short, hospital autonomy reforms do not appear in the MGDS signalling its exit from the Malawi’s policy agenda. Additionally, at ministerial level, the Minister who had presented the policy to cabinet and his principal secretary were moved out of the MOH and “a new minister had come. For the new minister and principal secretary to understand the whole process, it was very difficult” (interview with former MSH official).

Moreover, at the MOH organisational level, hospital autonomy “documents we had submitted went missing in the ministry” (Interview with former MSH official). This, combined with the removal of the reformists from the MOH, as already highlighted above, signalled the end of hospital autonomy program. It was noted that although the recommendation from cabinet was to institute a committee that would rework the proposal, the chairman of the said committee reported that the committee has never met since it was formed five years ago as “there is no motivation”. Lastly, it was observed that at the central hospitals level “all the people that were trained were moved out of the central hospitals” (ibid) and all the systems that were established have since stopped working. The former Principal Secretary for Health (Y) stated that at the central hospitals, “all the financial people left, human resources and technical staff left. And the computers and other equipment that were provided by the donors, as soon as the donors left, they could not be maintained and everything collapsed”. Thus hospital autonomy exited Malawi’s policy agenda symbolising a case of failed policy transfer or what Bulmer, Dolowitz, Humphreys and Padgett (2007:17) call an ‘abortive’ outcome as the “putative transfer” was “blocked by veto players”.
7.3. DISTRICT HEALTH MANAGEMENT DECENTRALISATION REFORM

This section presents factors that constrain and/or facilitate policy transfer in the context of health decentralisation reforms. This is done so as to compare with the case of hospital autonomy highlighted above. The same dimensions of measurement which include mode of transfer, policy content and political-economic context, parliament-cabinet configuration, path dependency, pressure from citizens, institutional compatibility and bureaucratic politics are used.

7.3.3. MODE OF TRANSFER

According to Bennett and Howlett (1992) ‘middlemen’ in policy transfer are “transmission belts by which changes in the socioeconomic environment are transmitted to governments”. For donor driven policy transfer to developing countries, these are technical assistants that are hired by donor organisations to act as agents of policy transfer. In this vein, technical assistance is defined as the “transfer, adaptation, mobilisation and utilization of services, skills, knowledge and technology...[which]...includes...personnel from both national and foreign sources, plus training, support equipment, consultancies, study visits, seminars and various forms of linkage” (Tyson and McNeil, 2009:93). A UNDP technical assistant in the Ministry of Finance put the role of a technical assistant in being a ‘middleman’ in its right perspective by emphasising that “UNDP supports a number of activities...you should think of me more as a tool to deliver these activities as opposed to a UNDP official”.

Therefore, to make sure that the decentralisation reforms were actually transferred and internalised by the MOH, the EC engaged international technical experts that were gurus in the area of decentralisation and had experience in implementing such reforms elsewhere. For instance, one of the former EC experts on the project highlighted that “we run the programme based on our own international experience”. Referring to his colleague as “a big lady in decentralisation”, he recalled how he was also previously involved in similar reform assignments in other countries, one of which was Cambodia. Their role was clear. A former EC technical advisor on the project illustrated that “basically when you are a technical assistant...I would not say that you do not drive anything you are an input and that is what is expected from you”. In this respect, the technical advisors were very instrumental in building the systems, institutions and capacities required for implementing the necessary reform tools.
According to Sabatier (1993:19) policy learning entails “a relatively enduring alteration of thought or behavioural intentions that are concerned with the attainment (or revision) of the precepts of a policy belief system”. The way the EC transferred the health sector management decentralisation reform package to the MOH exemplifies a policy learning approach. Although the international governance institutional framework within which decentralisation reforms were implemented concerned coercive institutional pressures as discussed in Chapter Six above, it was found the actual mode of transfer was based on learning approaches. However, it must be emphasised that this learning mechanism was not “instrumental” (Sabatier and Jenkins, 1993; Howlett and Ramesh, 1993) because the MOH did not actively undertake a “purposive search for information with which to resolve a problem” (Moseguer, 2005:73) so that a “solution is chosen on the basis of observed experience and a better understanding of which policies may lead to particular outcomes” (Moseguer, 2005:73; see also Dolowitz, 2009a) owing to the coercive institutional pressures legitimising it. Rather, the learning mechanisms adopted can be equated to Bennett and Howlett’s (1992) notion of “Government learning” where bureaucrats acquire ‘process related’ knowledge that results in ‘organisational change’ with the help of the technical advisors as ‘middlemen’. In this respect, the project document highlighted that the reform programme was “underpinned with a learning approach to planning and management” (Ministry of Health, EC and British Council, 1999:4). Particularly, it was “considered essential to the project outcome that the process approach is adopted mirroring in the project the participative learning approach” (ibid:6).

The reasoning was that if the “project is to produce sustainable results...changes must be done so as to be based on an integrated development of structures, systems and people” (ibid). In addition, it was disclosed that the learning approach was particularly useful due to the acute lack of the necessary bureaucratic and institutional capacities critical for the reform. The study unveiled that the mode of bureaucratic learning in this regard was three-fold, namely: learning by doing, formal academic training and capacity building at the district level. There was also an aspect of systems building within the ministry that would ensure reform sustainability.

7.3.3.1. Participatory Learning

The study revealed that the dominant learning approach adopted by the decentralisation reform ‘middlemen’ to ensure the sustainability of the program was participatory. As one of
the former EC Technical advisors underscored the “core philosophy behind all this was working together with government colleagues... We were not only providing technical advice but also being hands on and doing the work with them”. As the reform was being transferred within the context of very limited capacities on the part of the MOH, participatory learning approach was regarded as an effective means for institutional change and development necessary for implementation of reforms. This was on-the-job learning method involving a ‘learning-by-doing’ approach where the MOH officials were actively involved in the reform process. As a former EC technical advisor highlighted, the approach was about “working with them on daily basis and getting them involved in drafting technical documents, technical guidance, and concept notes and so on and so forth”.

In this respect, one of MOH Directors underscored that it was important that the EC technical advisors work with them because

> when you have technical assistants who are working all by themselves it becomes difficult to transfer the expected capacities to the locals. So it really depends whether the technical support from the donors gets transferred to the locals so that we can stand on our own and address the issues as expected.

The underlying principle was the active integration of the EC technical advisors with the MOH bureaucratic officials working with them in building systems and processes. In this regard, the Technical Advisors were part of the MOH machinery, working with the necessary key personnel in decentralisation reform institutional building. As an EC technical advisor testified, “we were part of the family spending all that time and based in the ministry, working in close contact with them”. In addition, to ensure that the actual institutional development and capacity building is attained, the participatory learning process was implemented at the pace of the MOH officials. This was done taking into consideration the “absorptive capacity at both central MOH and districts” (Ministry of Health, EC and British Council 1999:4). The rationale was that since the critical capacities for the reform were missing, it would be pivotal if the processes were internalised at all levels within the MOH learning potential. The importance of this was underscored by an EC technical advisor who emphasised that

> what is very important is that we were working at their pace. You know when you launch new reforms like that you find that there are not a lot of people in a particular ministry that are going to be conversant. So we were
Moreover, the EC technical advisors adopted a holistic approach to the learning process. In this regard, they were not only involved in issues related to decentralisation reforms but also assisted in other activities in which they had expertise. As one of the EC advisors recalled, “we were taking part in a lot of tasks at the Ministry. We did so many things that I do not remember all the details”. In the same regard, they also participated in MOH meetings even those that did not directly fall under their mandate. As one EC advisor estimated, “we were invited to over two thirds of all the meetings in the ministry”. The holistic approach adopted ensured that they were fully integrated into the MOH and they were seen as part of the Ministry as a whole.

7.3.3.2. Formal Academic Training

Apart from the on-the-job participatory learning approach highlighted above, the programme also involved formal academic training. The acute lack of the required capacities necessitated that a critical mass of the bureaucrats equipped with theoretical and ideological grounding about the reform programme be developed. This was pivotal for sustaining the program and also institutional development of the MOH as a whole. The bulk of these trainings involved sending MOH officials involved in planning and policy to the United Kingdom to do Masters degrees. These degrees were in the fields of health policy, economics and management which are closely related to the decentralisation idea. Seven people were sent for the masters programmes to the Universities of Leeds, York and Keele as they were seen to be strong in these key subject areas at the time.

7.3.3.3. Capacity Building at District Level

Decentralisation reforms also necessitated the strengthening of district health offices so that they are able to effectively carry out the decentralised managerial tasks. In this respect, the EC technical advisors carried out capacity building exercises at the district level as well. These sessions involved the development of planning and management systems, and training workshops on several issues including planning, costing, budgeting and human resources management. They also involved dissemination of manuals on decentralisation produced within the project framework and inter-district visits to make them ready for decentralisation. It also included equipment support and rehabilitation works.
7.3.3.4. Building Systems within the Ministry

For the institutionalisation and consolidation of the programme within the Ministry, the EC technical advisors established systems within the MOH. The structures were working as coordination mechanisms for the project. Additionally, the structures were seen to be central for the sustainability of the reforms as they acted as both decentralisation reform initiation structures and were also planned to act as a launch pads for future reforms and MOH institutional development. These structures included the Aid Administration Office (AAO) and the Health Sector Reform Unit (HSRU) based at the MOH headquarters, and Health Sector Reform Office (HSRO) in Blantyre district which is a commercial centre of Malawias shown in the figure below.

Situated in the MOH Planning Department, the HSRU was envisaged as a technical arm which was to be pivotal in the development of health sector reform strategies including strategies to improve management of donor funded support. The aim was to create a Unit which could foster debate on reform ideas with relevant parties and in so doing act as a reform catalyst. Therefore, the HSRU was to act as permanent secretariat for all future reform initiatives. The EC advisors were primarily based here. The Blantyre Health Sector Reform Office (HSRO) was set up as a temporal structure to perform administrative and accounting functions in a government capacity during the transition to decentralised management. The role of the HRSO was therefore to coordinate the introduction of reforms in the Southern Region districts whilst supporting project activities. The long term plan for the HRSO was that it would evolve to an institutionalised model of inter-district co-ordination to respond to selected decentralisation requirements.

Based in the Department of Finance and Administration, the AAO was to provide administrative support to all EC projects and project staff in the health sector. The aim was to optimise aid management and develop new competences within the ministry (e.g. tendering, contracting, contract follow-up and evaluation). This was because “EC interventions are varied and complex and mechanisms through which they are funded require multiple administrative and managerial competencies and capacities that are not readily available at the MOH” (Ministry of Health, European Commission, British Council, 1999:9). The long term plan was to evolve it into administrative machinery for the facilitation of Sector Wide Approaches (SWAPs) that call for the pooling together of donor resources. In order to
develop capacity on a sustainable basis, all these three were to be integrated Government structures staffed by Government officials and supported by technical expertise as can be seen in the figure below.

Figure 7. New Structures to Support Decentralisation Reform Execution

Source: Ministry of Health, European Union and British Council (1999: 22)

**KEY**

|......| New structure |
|AAO  | Aid Administration Office |
|HSRU | Health Sector Reform Unit |
|HSRO | Health Sector Reform Office |
|EC   | European Commission |
|TA   | Technical Assistance |
7.3.4. VETO POINTS FOR THE DECENTRALISATION REFORMS POLICY TRANSFER

The EC technical advisors worked with the MOH officials from 1999 to 2001 in initiating the decentralisation reform. It was expected that at the end or during the intervention the MOH would actually implement it. However, despite the EC adopting a learning oriented intervention, the actual implementation was not an automatic process as it was determined by the prevailing political, cultural, historical, institutional and administrative factors. In particular, the study uncovered that the political elites were in support of the reform while the bureaucrats were not. Thus despite the learning interventions in the MOH, the ultimate move to decentralise health services has been a political one with a push from donors while the MOH’s bureaucrats have resisted. This section presents an analysis of how policy content and political context, parliament-cabinet configuration, path dependency tendencies, pressure from citizens, institutional compatibility, and bureaucratic interests, either facilitated or constrained the implementation of the reform.

7.3.4.1. Policy Content and Political-Economic Context

Batley and Larbi (2004:88) observe that “health sector decentralisation is a common theme in health within the broader context of political devolution”. Although the EC intervention hinged on management decentralisation of health services to the districts level, the political imperatives it was associated with facilitated the transfer process. In this respect, the EC decentralisation reform transfer was easily institutionalised within the Malawian health system because it was championed within the wider democratisation reform context. The general understanding was that the political devolution that was necessitated by the democratic transition in 1994 made the management decentralisation to the district level imperative. In this regard management decentralisation was readily accepted as it was regarded as an instrument of democratic consolidation within the wider political decentralisation reform framework. In this respect, an interview with a member of one of the civil society organisations underscored that “democratisation winds brought in the need for decentralisation. After the approval of Local Government Act in 1998, the ministry of health had to decentralise”. This was echoed by the former Principal Secretary for Health (X) who indicated that “local government decentralisation reinforced our ideas about health sector
decentralisation”. A Director of Finance at one of the district assemblies highlighted the actual forces at work

> the change from one party to democracy necessitates decentralisation to come in. With multiparty dispensation, the donors said we want power to the people as soon as possible. That change of system...also meant that we had to change some things; they were automatically coming...the approach of doing things had to change.

Viewed within this democratisation environment, the political acceptance of health sector management decentralisation reforms therefore, should be understood within the context of historical political institutionalism of the one party state highlighted in Chapter Five. The suffering that the nation had undergone at the hands of the one party dictatorship entailed that any mechanisms that were seen in the light of democratic consolidation were readily acceptable. It was in this regard that the EC took advantage of this window of opportunity to advocate for the health management decentralisation reforms within the Lome IV’s institutional framework of conditionalities that were seen to enhance democratic consolidation through good governance.

Moreover, unlike the hospitals autonomy reform, management decentralisation did not have cost recovery as its hub but strengthening health services at the district level that would benefit the poor. As the country was implementing poverty reduction strategies at the time, any attempts that were deemed to be in line with this drive were acceptable. This was against the backdrop that the Banda’s dictatorial regime did not seriously put in place poverty reduction interventions. Indeed as Chinsinga (2002:27) highlights, in the one party regime it was “virtually a taboo to consider poverty as public problem requiring urgent policy interventions”. In this respect, inasmuch as management decentralisation was regarded as a way of enhancing health service delivery at the district level and complement to measures to reduce poverty, it was readily acceptable.

### 7.3.4.2. The Parliamentary-Cabinet Configuration

Flynn (2002:64) propounds that managerial changes are easier to implement where such changes do not require legal or constitutional change. Unlike the hospital autonomy reforms highlighted above, the health sector management decentralisation reforms did not require new legislative provisions. The National Decentralisation Policy that was passed in 1998 and the Local Government Act enacted by parliament in the same year sanctioned management
decentralisation and other devolution endeavours in all sectors including health. As the EC propounds, “as an immediate result of Act 42 [Local Government Act], decentralisation is no longer a perspective but a reality [and therefore], the MOH face the need to implement decentralisation” (Ministry of Health, European Commission, and British Council, 1999:10).

In this regard, although the balance of power in parliament was not favourable and the opposition parties were geared towards rejecting any bill proposed by the government side as highlighted above, this had no effect for the decentralisation reforms since their enabling legislations were already in place. It must be mentioned that when the national decentralisation enabling Act (Local Government Act) was enacted by Parliament in 1998, the government side was a majority so that government bills could easily be passed. Within the context of UNDP donor push as highlighted above, it was not surprising that parliament passed the Local Government Act just a few months after the cabinet approved the National Decentralisation Policy.

In addition, the study found that members of parliament and politicians generally, have been in support of the health sector decentralisation reforms. Within the context of neo-patrimonial political culture highlighted in Chapter Five, the parliamentarians have regarded the decentralised health facilities as their instruments for increased influence and control. This is the case as management decentralisation would bring the hospital management closer to their constituencies where they can easily influence service delivery. With political decentralisation brought into the equation, the influence of the members of parliament in health service delivery issues within the managerially decentralised context is increased. This is against the backdrop that within political decentralisation members of parliament are also non-voting members of District Assemblies. To this end, a civil society organisation director indicated that “there is commitment in view of emphasis on decentralisation...politicians are committed to ensuring that decentralisation is implemented”. The actual issues at play were articulated by the former Principal Secretary for Health (X) who emphasised that

politicians liked decentralisation because they were looking at strengthening facilities that are close to them (MPs). And that is what politicians would always push for. If you go to parliament, they will always ask for a health centre in their constituency, nurses in their constituency. And when they were told that the aim of decentralisation is to make sure that services are closer to them, they were supportive. They were really supportive. The only part that the politicians were not taking in is the issue of hospital autonomy. That one they did not like it because of the pay.
7.3.4.3. Path Dependency Tendencies and “Critical Junctures”

Path dependency can also aid our understanding of why health sector decentralisation reforms were politically acceptable. Wilsford (1994) highlights that with the “path-dependent model, actors are hemmed in by existing institutions and structures that channel them along established policy paths”. Following this framework, ‘path dependent’ forces of health policy along the centralised management model would propel the political elites not to adopt health decentralisation reforms. This is especially because of “fixed costs, resource dependent constituencies and established standard operating procedures” (James and Lodge, 2003:188) that have been enjoyed within the centralised health service framework. Therefore, decentralisation reforms being path breaking would be very difficult and even impossible to be adopted.

However, the theory of path dependence does not mean that policy change is entirely impossible as the presence of ‘critical junctures’ along the policy path can change the policy trajectory (Howlett and Rayner, 2006; Wilsford, 1994, Greener 2002). In the context of the health sector decentralisation reforms in Malawi, the democratic reforms adopted in 1994 can be regarded as the ‘critical juncture’ leading to a trajectory change. Thus democratisation was a “strong conjunctural force” (Bevan and Robinson, 2005:54) required to move from the status quo based on centralised service delivery to a new trajectory of decentralised health management. The power of democratic reforms as a ‘critical juncture’ lies in the understanding that the end of the dictatorial one party era meant that certain modes of service delivery which were associated with it (centralised service delivery for example) were no longer relevant. This is in line with Palier’s (2005:135) observation that “path-shifting reforms...have been conceived with negative reference to the past’. To this end, Langer et al (2000) observe that in new democracies health sector decentralisation reforms are “part of a democratic process that is redefining the role of government and the public sector”. In this respect, the adoption of democratisation in Malawi required the use of service delivery mechanisms that would be compatible with it, thus working as a ‘critical juncture’ necessary for the adoption of decentralised management in health service delivery. As a former minister of health Aleke Banda emphasised,

the change [democracy] that was ushered in by the UDF Government is unprecedented, because it is a complete turnaround of most of the systems, which were operating in the previous Government. Following the adoption of the new [democratic] constitution, the UDF Government also took
important initiatives to ensure that the local government system was compatible with the provisions of the new constitution.

7.3.4.4. Pressure from Citizens

Just as in the hospital autonomy reforms highlighted above, it was difficult to gauge the impacts of public pressure on health service decentralisation reforms. This was because this was a historical event which could not validly be measured through public opinion. As explained above, this was exacerbated by fact that management decentralisation reform was top-down transfer from donors and there was no meaningful input from the general citizenry. However, it must be mentioned that at the onset of decentralisation reforms in 1999, people were generally dissatisfied with government performance in health service delivery at the district level. In an Afrobarometer survey carried out in 1999, the majority of the Malawians expressed that they were not satisfied with government performance in health service delivery as compared to other countries in Africa as depicted in the figure below.

![Figure 8. How Well Would You Say Government is Improving Health Services](source)

**Source:** Afrobarometer, 1999 data, graph is the Author’s formulation

As can be seen in the figure above, the 1999 public opinion survey showed that the majority of Malawians were not satisfied with health service delivery in comparison with other African countries. It must be noted that the majority of these services are provided at the district level as it caters for over 80% of all MOH services (Malawi Health Equity Network, 2007). Indeed the Ministry of Health (1999b:91) attests that the “bulk of health provision is the responsibility of district health care delivery system”.

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In this regard, although this public dissatisfaction did not translate into tangible citizen pressure to push for better service delivery, it opened up a policy window of opportunity for the political acceptance of reforms that would strengthen service delivery. Interviews with district health officers supported this view. They articulated that in 1998/99 district hospitals systems were collapsing as they were poorly managed from the MOH headquarters. For instance, it was a common sight for hospitals to run out of drugs and with very acute understaffing problems. It is therefore in this context that decentralisation reforms were seen as a feasible mechanism to improve the effectiveness of health service delivery at the district level. As one District Health Officer articulated “I think decentralisation started when everything was collapsing and donors said, ‘but we can help’”.

**7.3.4.5. Institutional Compatibility**

It has been argued that for public sector reforms to be politically acceptable, “appropriate changes in the role of the public sector require compatible institutional structure” (Silverman (1992:3). One of the reasons that the health decentralisation reforms received political support was that it was compatible with the existing institutional health service delivery framework of a referral system. The study revealed that in fact health sector management decentralisation reforms would work to strengthen the referral institution rather than undermine it. This is because management decentralization was aimed at strengthening the district level service delivery which would go a long way in effectively making the referral institutional framework operational. As already highlighted, people by-pass the referral institution and go straight to tertiary hospitals because the district hospitals do not provide services at the optimum capacity due to the MOH’s centralised management control. In this regard, district management decentralisation was aimed at strengthening their service delivery capacity so that they can effectively manage all cases that were to be handled within their realm. In fact the weakness of district hospitals due to centralised control was seen to jeopardise the operationalisation of the referral institutional framework. To this end, the former Principal Secretary for Health (Y) propounded that

> *the issue that was coming up was that we had much reliance on central hospitals because the district health office is weak. It [district] can’t plan, it can’t monitor and everything was planned by MOH Headquarters. So it was one way of making sure that district hospitals had the capacity to plan, monitor and implement their activities.*
A former Minister of Health articulated institutional compatibility issues at play by emphasising that

the secondary level health service providers function mainly as backup to the primary level providers by providing surgical backup services, mostly for obstetric emergencies, and general medical and paediatric in-patient care for common acute conditions. It is therefore important that all these be managed at district level to create maximum complementarity (Banda, 2008:8).

7.3.4.6. Bureaucratic Politics: Political-Bureaucratic Culture

Although health sector decentralisation reform received political support, the MOH bureaucrats showed resistance to the reform. In the summative words of the former Principal Secretary for Health (Y), “politicians were supportive, the administrators were not supportive”. Another former Principal Secretary for health (X) corroborated this view by highlighting that “there was some resistance in some quarters mostly administrative staff were not very keen”. In this regard, although the EC technical advisors administered learning approaches highlighted above, the MOH was reluctant to implement the reform. This resistance was so strong that there had to be donor coercive pressures from the World Bank and DFID with full conditionalities to push the MOH to actually implement it. Below is a discussion of the extent of this bureaucratic resistance and donor forces at work.

Christopher Hood (2002:309) highlights that “who is to control whom and how is always the central issue in the bureaucratic politics of public sector reform”. This study confirms this observation. The key element that made the MOH bureaucrats resistant to the reform was their perceived loss of power, influence and control in the decentralised system. As the former Principal Secretary for Health (Y) articulated, decentralisation has been “slow because people in positions always looked at decentralisation as loss of influence, loss of power, loss of resources and they did not like it. And they were making as much efforts as possible to frustrate it”. An interview with MOH Health Planning Officers corroborated this view. One of them expounded that “incentives are quiet clear as policy makers we want more control over the system, so you see that all policies that give control to a policy maker where the policy maker seems to have more power over them, they will easily get implemented”. Decentralisation reform was not an example of such policies. In particular, decentralisation meant the transfer of managerial control of the health service delivery system.
to the district level. This entailed that the MOH headquarters would only be responsible for policy issues while service delivery would be in the realm of the district health management teams. In addition, decentralisation would also see increased powers of the Ministry of Local Government and Rural Development (MLGRD) since district health officers would have to be politically accountable to elected District Assemblies which are under the MLGRD. For the MOH, this effectively meant passing on some powers and control to the MLGRD. In this regard a former Minister of Health told MOH officials that “decentralisation will rob us of our massive infrastructure” (Banda, 2000:12). In the same vein, the World Bank, Ministry of Finance and Ministry of Economic Planning and Development officials pleaded with MOH bureaucrats at a meeting that, “decentralisation did not have to be looked at more as the handover of the management of sectoral funds to the Assemblies but rather, the implementation of activities and the delivery of satisfactory services to the local clients” (Ministry of Health, 2004b:3).

This perceived loss of control should also be seen in the context of hierarchical large power distance culture that exists in Malawi which does not match decentralised management. In this particular one, Briscoe and Schuler (2004:273) observed that “Malawian managers rarely delegate authority because the culture believes that delegation strips managers of their authority and this lowers their status in the eyes of subordinates”. Decentralised management entails passing on power to lower levels of service delivery and this would entail loss of influence and control and was seen as striping of their powers. In this respect, an official from Irish Aid highlighted that “in terms of funding if the money should go straight to districts it means that the PS (Principal Secretary) will not have some power somehow to control the resources”. This is particularly because in most cases such central authority and power comes with monetary privileges to the office holder. Central to these privileges are allowances which programme directors get when they go to supervise district health offices. It was learnt during the interviews that because of the control and powers that senior managers have, most would take advantage of this system and make allowance claims even if they did not go for such supervisory visits. In other instances, they would inflate their claims to cover more days than they actually spent. Decentralisation reforms would mean that the MOH would assume new roles that would see them having these procedural supervisory trips reduced. In addition, since money for the districts would go straight to districts and be controlled by the districts themselves, this would entail the MOH having reduced or no
access and control to district money thereby reducing their base for resource misuse. In this regard, the former Principal Secretary for Health (X) articulated that

_of course, in any reform you get people that are not interested because they are benefiting somehow. There is always a little pilferage that takes place [at the MOH]. Once you start closing the gaps in financial systems people do not like it. People like loose systems where they can manoeuvre around, so they were not keen._

The role of neo-patrimonial bureaucratic culture that exists in Malawi also underscores the perceived loss of power and control in the context of decentralisation. District health facilities are seen as resources available for servicing patrimonial linkages by MOH officials. These include MOH influence on resource distribution, education, employment, workshop attendance (which attracts financial allowances) and other tangible and intangible benefits which are allocated based on neo-patrimonial networks. In this regard therefore, the more the facilities that the MOH centrally manages and controls, the greater the patronage power. Decentralising the management of these facilities to district managers therefore effectively removes their influence and works to destabilise such neo-patrimonial linkages. Realising the impact of this, a former Minister of Health told senior health managers that “the district infrastructure was...managed by the MOH. This has to change in the devolved system. Surely you can count this as a loss. I would however urge you to calculate it as a gain as well” (Banda, 2000:9).

The study also found that bureaucratic resistance arose because decentralisation would mean the loss of jobs or job reallocation for some officers at the MOH headquarters. Foreseeing this, the former Minister of Health Aleke Banda (2000:5), told senior MOH officials that “emotions will come to play because there will be both gains and losses in the process, there will be casualties as well”. This is because with decentralisation the MOH would assume new functions, necessitating organisational restructuring. In so doing, some of the officials whose managerial tasks would be transferred to the district level would be reallocated. These allocations would unfortunately mean losing power, control, monetary and intangible benefits that they were previously obtaining as articulated above. As the one of the EC technical advisors observed

_these things are political and you can’t avoid people. When decentralisation arises there are people at the central level who are going to lose their power. Obviously when these reforms are undertaken there are vested personal interests. They are there and we have to live with them and there was some kind of reluctance in some instances._
To this extent, the resultant uncertainty and fear of the unknown led to reluctance in implementation. This is exacerbated by the high uncertainty avoidance cultural environment within which the decentralisation reforms were implemented. For many MOH officials, decentralisation was a journey into the unknown as some of the critical issues of the new status quo had not yet been made clear. A former Minister of Health admitted these fears by articulating that decentralisation is “a journey whose destination is not very well known as a result, we do not even know how long it will take to complete the journey” (Banda, 2000: 8).

In addition, the study unveiled that the way the reform was introduced alienated people in departments that were not very key for the initiation processes but would be pivotal in the implementation processes as these would need to relinquish their managerial functions to the district level. As has been highlighted above, the EC technical advisors created initiation systems in the MOH namely, Health Sector Reform Unit and Aid Administration Office. These were housed in the Departments of Planning and Finance and Administration respectively. It was learnt that these units enjoyed privileges that were not available to other personnel in the MOH. For instance, government employees working in these were paid salary supplements and allowances over and above their monthly entitlements. The reasoning was that work on the reforms was so demanding that it included doing some tasks that were in addition to their daily formal undertakings. In this regard, the other personnel that were not in these units could not give much in terms of their support as there were no direct monetary benefits accruing to them. Therefore, although the units were central in institutionalising the reforms, they only provided incentives to those that were directly involved to the reform formulation but not to the MOH staff as a whole, resulting in alienation. Even a former EC technical advisor highlighted the disadvantages the structures brought by illustrating that

_ donators sometimes are pushing towards that type of distinct implementing structure on the ground that rewards and pays people in it better and so on. But in that regard they are weakening the ministry...because reform relies on all the capacities of the ministry and all the technical expertise. The director of nursing is for that matter as important as the director of finance and all the others. Separate implementation units are certainly a push from donators and people in the Ministry especially the brightest of them because they know they stand a chance of being recruited and have a better salary._

Not only did these new structures bring resistance from other departmental heads, but they also created frustrations resulting in the resignations of some key reform personnel from
these other departments. Those that saw that there was nothing for them in the decentralised framework voted with their feet. As a former EC technical advisor recalled

when you create these parallel implementation units and you take the best of the best to man these units, what are the others becoming? They get frustrated and leave the place. You need to take even the weakest of them provided they develop their capacity to create an internal motivation.

7.3.4.6.1. Resistance Tactics

The study findings reveal that the resistance was portrayed in three main ways. First was to reallocate those that were involved in the decentralisation initiation process. In this case, the people that were trained by the EC technical advisors and hence seen as potential champions for reform were reallocated to other ministries. This was done in order to sabotage the whole process. In this regard, a DFID official lamented that the

Ministry provided counterparts to the TAs and they were able to be trained. Just after they had completed their training the government posted them to other Ministries...at the moment we are facing problems in terms of getting the things in time...because those that had been trained to do the work are not there.

The other tactic was non-implementation of the stated activities within the scheduled time. The EC technical advisors were in the MOH from 1999 to 2001. Implementation was to start during or soon after this time but it had not. As it will be highlighted below, it had to take donor interventions to push the MOH to start the actual implementation after several years. In this context, the EC noted that many “areas of work...have been slow to take off...this has been due to the fact that the MOH did not wish to rush into work on devolution” (Malawi Government and European Commission, 2002:39). Although the EC technical advisors worked at the pace of the MOH officials due to capacity problems as already articulated above, they became worried of the continued implementation delays due to lack of bureaucratic commitment. This was aggravated by the fact that the project had a limited three-year life time. In this regard, one of the EC technical advisors expressed that the

Main challenge is that donors and projects are very impatient and want to go fast and I was not exempt from them. There are a lot of things I would like to have done much faster.... [but they] took too long because of little internal politics with some people trying to undermine the entire thing.

Moreover, the study also noted that the MOH gave a lot of excuses to justify their delay in implementation. However, much as some of these excuses may be valid, it was learnt that
their championing were just a cover up so as to delay the process. In this context, they gave excuses of low capacity and lack of accountability at the district level as part of the reasons for the delay. For example one EC technical advisor observed that the MOH was trying to “dilly dally...and was dragging its feet because they were saying if we decentralise everything at once it is going to be a disaster”. Paradoxically, the MOH headquarters itself had carried out the initial activities at the headquarters level with EC technical advisors when they did not have meaningful capacities as highlighted above. In addition, it was now the MOH’s responsibility to pass on the capacities they had acquired through the reform exercise to the district level for the effective implementation. Moreover, the capacity gap from MOH officials to train district officers was a deliberated creation due to the fact that most people that the EC technical advisors had trained were reallocated, as pinpointed above. This led one EC technical advisor to conclude that “at the end of the day we had the impression that the government was not eager to fully decentralise and they were using technical arguments like a pretext or an excuse as they did not want to decentralise”. It is also interesting to note that some of the arguments that the MOH put forward against the implementation of the programme were against the central doctrine of decentralisation itself. In this realm, minutes of the meeting that the Ministry of Health had with the Ministry of Finance, Ministry of Economic Planning and Development and World Bank officials revealed that MOH staff were adamant that

on the matter of decentralizing Health Centres, it was made clear that the Ministry was rather uncomfortable...[because]...Health services delivery works only as a system as opposed to disaggregated entities under different authorities trying to coordinate. As a result, no programs or activities would be isolated and then decentralised (Ministry of Health 2004b:2).

This was a surprise and indeed a key NPM contradiction as the EC learning oriented interventions were aimed at imparting such decentralisation ideological issues to the MOH bureaucrats. This indicates that the learning approaches seem not to have achieved their desirable end.

The other tactic to display resistance was that the MOH sought for political intervention to enable them not to decentralise soon. This was in a form of a Presidential appeal so that the President should let them remain a centralised sector by the time all the functions were supposed to be decentralised. Since the decentralised sectors would be politically accountable to an elected Assembly under the MLGRD, all problems and requests about
decentralisation process were to be lodged through the MLGRD’s Decentralisation Secretariat. However, the MOH chose to appeal to the President so as to get political sympathy for them not to decentralise. The MOH indicated that they went straight to the State President rather than through the Decentralisation Secretariat because the “Decentralisation Secretariat was pushy, using threats and not ready for discussion and compromising...arguing that devolving at the rate the Secretariat was envisaging would disrupt the effective provision of health services” (Inter Ministerial Committee on Decentralisation, 2002:2). However, as already explained above, these were just excuses for them not to implement decentralisation program as no tangible moves were seen in terms of the MOH going the decentralisation way. Obviously the President could not back them up because of the political support that the management decentralisation movement had at the time. In particular, a former Minister of Health told senior MOH managers that “I would like to emphasise that from the perspective of the Government, there is no looking back at all” (Banda, 2000:5).

It would be expected that there would be demand from the district health officials for the reform since it would effectively mean transferring powers to them. However, much as the district officials were ready to work within the decentralised framework, they did not do much to demand for it due to the asymmetry of information. As one of the tactics for delaying decentralisation, the MOH officials did not pass on the required information to district health offices. This made the district officials unaware of certain decentralisation issues requiring their attention. Although the districts underwent training sessions through EC technical advisors, these were not enough to effectively make them demand for decentralised powers. There was supposed to be active transfer of information on modalities of operation in the proposed status quo from the MOH headquarters which did not take place. As a result, there has not been ownership of decentralisation process at the district level that would necessitate them to demand its implementation. As an official from a German donor organisation GTZ observed, the “trickling of information from the centre to the responsible management has not been there, the orientation has not been as thorough as we would expect so that they take decentralisation as their own against which their performance could be evaluated”.
7.3.5. DISTRICT HEALTH MANAGEMENT DECENTRALISATION REFORMS IMPLEMENTED

Knill and Lenschow (2005:588) observe that “bureaucratic self-interest in ensuring institutional persistence can be overturned by political and societal mobilization”. In this regard, despite the bureaucratic resistance highlighted above, the political imperatives were so strong that the reform was finally implemented. Apart from the contextual factors highlighted above, these imperative involved pressures from donors, and ‘hide and seek’ tactics from the Ministry of Finance as highlighted below.

7.3.5.1. Role of Donors

As there was resistance from the MOH, donor organisations put pressure on the MOH to start implementing the reform. The reasoning was that the EC technical advisors had effectively carried out their tasks and there were no technical reasons for the delayed implementation. This was also heightened by the general political support of the system. The first pressure was from DFID as they were carrying out some activities at the district level whose implementation relied on the effectiveness of the decentralisation process. The centrality of the decentralisation programme in DFID projects was so strong that it was even feared that “there is some duplication between the HSRD project and other reform initiatives financed by DFID but these have been manageable in the climate of partner coordination” (European Commission, 2003b:20). Therefore, when there was lack of MOH bureaucratic commitment to decentralise after the EC intervention, DFID had to intervene. The intervention of DFID was its commissioning of about 18 to 25 international experts to study the whole process and provide advice on how the MOH should proceed with the decentralisation process, complete with timelines and log-frames. However, this mission did not succeed as the report only complicated the issues on the ground as they made recommendations that could not be readily absorbed by MOH. The report was too big and technical so that the MOH only swept it under the carpet. To this extent a former EC technical advisor bemoaned that

there was a major push from a big donor DFID which convened this gigantic unfamiliar power steering mission...of about 18-25 international experts...at the end of the mission we had this huge report of 250 pages and a log frame of 40 pages on how the government should proceed and it was very ridiculous because it was so obvious that it contained most of the information that would not be absorbed by government. These are the things for you to understand what may happen in a country when the push from donors becomes too big, it can go wrong quite quickly.
Secondly, a number of donor organisations have been pressing the MOH to show commitment to implement decentralisation through their influence in policy development. When the MOH was formulating its policy framework for 2004-2010, a number of comments from donor organisations were to the effect that the MOH must clearly show its commitment to decentralisation in this policy document. For instance one of the joint comments from NORAD and SIDA (2004:1) was that “MOH position/commitment to the ongoing process of decentralisation needs to be specified” in the policy document. In the same manner, DFID’s (2004:1) comments on decentralisation read “decentralisation: It would be helpful for MOH to include a clear statement on the current status, its intention with regard to devolution of its sub-sectors/functions and a schedule for implementation”. Apart from these comments, donor organisations in the health sector sent delegations to the MOH to discuss on the inclusion of its decentralisation plan in the policy document. The MOH responded positively to these requests and comments on the account of the tactical and diplomatic manner they were put across. For example the Principal Secretary for Health responded to one of the joint delegations of NORAD and DFID that “first let me thank NORAD and DFID for the manner and the spirit in which the issues were presented and discussed. I particularly appreciate that these were presented not as conditionalities of support but rather as matters which need to be addressed in their own right...MOH agrees to include its plan for [decentralisation]” (Pendame, 2004:1). However, commitment to include plans for decentralisation in the policy document was one thing and the actual implementation was another matter.

It was against this backcloth that it had to take tangible pressures from the World Bank that the MOH actually begun implementing the decentralisation process, albeit reluctantly. The World Bank gave the Malawi Government a tied credit of U$$ 50 million under the Financial Management, Transparency, and Accountability Project (FIMTAP) whose main objective was to facilitate reforms in the ministries of Finance, Education, Agriculture and Health. For this project, “release of funds is contingent upon...completing a specified set of key activities/conditionalities which for the Ministry of Health is the devolution” (Ministry of Health 2004b:1). It was observed that for the MOH, decentralization was in fact “one of the key conditionalities to access the second tranche of the Bank’s structural adjustment credit (SAC) which is due to commence this year, 2005 [but]...it was felt by some quarters that the Ministry [of Health] has not gone the distance” (Inter Ministerial Committee on Decentralisation, 2005:2).
Since the government could not afford to lose such a credit, it pressurised the MOH to implement the reforms. In this regard, at a joint World Bank, Ministry of Finance, and Ministry of Economic Planning and Development meeting, the MOH was ordered to draw a timetable for the implementation of outstanding activities on decentralisation “as well as resolve the constraining factors holding the Ministry back” (Ministry of Health 2004b:3) from implementation. A MOH official who attended this meeting recalled that decentralisation had to finally take root because of pressure from the World Bank in the form of the conditionality on the credit. He highlighted that

> I remember...the World Bank, in order to release some money, decentralisation was one of the reforms as a condition...It was a condition that some millions of dollars were not going to be released until decentralisation took place...because the MOH was jittery about decentralisation...because of the management arrangement but now because it was like a condition, people had to think about how to do that.

7.3.5.2. Hide and Seek Tendencies

With the World Bank credit conditionality on the table, the government was under pressure to ensure that the MOH starts implementing decentralisation. In an attempt to give an indication to the MOH that Government was serious about the decentralisation move, the Ministry of Finance started implementing the fiscal aspect of decentralisation without the blessing of the MOH. In this regard, the government started unilaterally channelling money meant for health in the major districts of Blantyre, Lilongwe, Zomba and Mzuzu directly rather than through the MOH headquarters. As an official from the MOH recalled, “it was quite rapid, you would see that all of a sudden all moneys cease to be held by the MOH at the centre and they will be going straight to the Districts without prior management approval” from the MOH. To cover themselves up, the Ministry of Finance only informed the MOH about this when they had a joint meeting with the World Bank officials. Although the MOH “took issue with this and wondered on what grounds the transaction in question was made and how the funds would be accounted for” (Ministry of Health, 2004b:3), this worked as an indication to the MOH that the decentralization movement was a reality and it was time they started making meaningful attempts to implement it.
7.4. MAPPING THE HOSPITAL AUTONOMY AND DECENTRALISATION REFORMS ON DOLOWITZ AND MARSH POLICY TRANSFER CONTINUUM

As highlighted in Chapter One, cases of direct coercive policy transfer or pure lesson drawing are rare (see Dolowitz and Marsh, 2000; Evans, 2004; Newmark, 2002). To this end, it is imperative to pin down the extent of coercion or learning in policy transfer instances under study. It is in this regard that this section seeks to map the policy transfer dynamics as discussed in Chapter Six and this Chapter on Dolowitz and Marsh (2000) policy transfer continuum shown in the figure below. The aim is to provide a nuanced understanding of the mechanisms of coercive pressures involved and the outcomes that ensued. The discussion starts by highlighting issues pertaining to hospitals autonomy followed by decentralisation.

**Figure 9. Policy Transfer Continuum**

Obligated Transfer (transfer as a result of treaty obligations etc)

Lesson-Drawing (perfect rationality)

Lesson-Drawing (bounded rationality) Voluntarily but driven by perceived necessity (such as the desire for international acceptance) Conditionality

Coercive Transfer (Direct imposition)

**Source:** Dolowitz and Marsh (2000:13)

7.4.1. HOSPITAL AUTONOMY: THE CASE OF ‘CONDITIONALITY’ POLICY TRANSFER WITH ‘ABORTIVE’ OUTCOMES

In Chapter Six the study found that hospital autonomy was introduced on Malawian policy agenda through mechanisms of a coercive nature. Linking to coercive pressures identified in Dolowitz and Marsh (2000) policy transfer continuum shown in the figure above, it can be said that the forces that made the hospital autonomy reform to be found in the Malawi’s ‘policy stream’ fall within the ‘conditionality’ variant rather than the extreme end which is
pure coercion or ‘direct imposition’. As has been explained in Chapter One, policy transfer through conditionality refers to the situation where policy makers are “compelled by influential donor countries, global financial institutions, supranational institutions, international organizations or transnational corporations to introduce policy change in order to secure grants, loans or other forms of inward investment” (Evans, 2006:481). In the case of hospital autonomy reform, the NPA institutional framework within which USAID brought the reform on Malawi’s policy agenda was based on conditionality. According to the principles of NPA, a country receives aid if in principle it agrees to implement a policy reform and in this case, the reform in question was hospital autonomy. As Setzer and Lindner (1994:5) highlight, NPA is characterised by policy “conditionality attached...to programmes...[to achieve]... policy reform”. Moreover, aid is stopped if the country is not seen to be putting in place structures that point towards the implementation of the reform or if the reform processes is aborted (see Moulton, 1997; Fotz, 1994). To this end, the NPA aid institutional framework within which hospital autonomy was introduced, operated on “no reform, no money” (Peters, 1997:72) basis. It is on account of this conditionality that the country showed initial commitment by including hospital autonomy on its policy agenda as operationalised in its Poverty Reduction Strategy Paper (MPRSP) which was the country’s overall development policy document from 2002 to 2006 so as to secure the funding. In this respect, the MPRSP committed the government to “autonomise central hospitals within 3 years” (Malawi Government 2002:62). In addition, the government allowed donor consultants engaged by USAID to develop the reform structures and institutions.

However, as this Chapter shows, these pressures and initial commitments were limited to the agenda setting stage. At the level of policy formulation where decisions about the actual hospital autonomy reform were to be made so that it is “institutionalised into the formal structure” (see Bebbington and McCourt, 2007), the cabinet rejected the policy. This was due to the prevailing contextual institutional, political, organisational and bureaucratic frameworks that could not accommodate the reform instrument. In this regard, the policy transfer had ‘abortive’ outcomes defined as a case where “putative transfer is blocked by veto actors in the borrowing country” (Bulmer, Dolowitz, Humphreys and Padgett, 2007:17). Thus although the transfer processes that made the policy to be brought on Malawi’s policy agenda were based on conditionality which has coercive aspects, the actual decision by the cabinet as veto players about policy implementation was based on contextual variables rather than external pressure. To this end, these findings attest to McCourt’s (2008:474) observation that
“it is the enduring power of sovereign states within their own borders which explains the failure of the attempts to induce reform from outside, and which ultimately explains the return of divergence in public management”.

7.4.2. DECENTRALISATION: THE ‘TRICKY’ CASE OF ‘OBLIGATION’ AND ‘CONDITIONALITY’ TRANSFER

Dolowitz and Marsh (2000:14) outline that policy transfer continuum can assist in “capturing the subtleties involved in the transfer process, such as if the transfer remained voluntary or transformed into a more coercive process over time”. To this end, by using Dolowitz and Marsh’s (2000) continuum of policy transfer as shown in the figure above, it can be seen that the transfer of health sector decentralisation reforms to Malawi moved from being ‘obligatory’ to ‘conditionality’. Dolowitz and Marsh (2000:15) highlight that obligatory transfer takes place where “national governments can be forced to adopt programs and policies as part of their obligations as members of international regimes and structures”. As has been seen in Chapter Six, Malawi is a member of an international grouping of countries that receive aid and assistance from the European Commission known as African, Caribbean and Pacific Countries (ACP Countries). As a requirement for membership, all ACP countries are required to accede to the ACP-EU guiding principles and institutional frameworks. It has been discussed in Chapter Six that the Lome IV Convention was the operating institution and aid infrastructure which all ACP member countries had to ratify if they were to enjoy the benefits of their membership in terms of loans and aid under the European Development Fund (EDF). As was seen in the case of Somalia in Chapter Six, countries that do not ratify are prevented from enjoying the benefits of membership.

The critical aspect of the Lome IV Convention was the acceptance for a country to allow the European Commission to use reform conditionalities as an instrument for disbursement of loans and aid. In this regard, by willingly ratifying the Lome IV Convention for continued membership and hence by implication legitimising the accompanying reforms, it can be said that at this level the transfer was of an ‘obligatory’ one. However, the ‘obligatory’ nature of the transfer turned into ‘conditionality’ as ‘conditionality’ was the actual instrument used for the actual transfer of decentralisation reforms to Malawi’s policy agenda. In this respect, since the implementation of decentralisation was requirement for loan disbursement under a
structural adjustment programme facility, the actual transfer was a case of ‘conditionality’. This is because it is an example of an instance where the country was “compelled by influential... international organization [EC] ...to introduce policy change in order to secure grants, loans or other forms of inward investment” (Evans, 2006:481), hence ‘conditionality’ transfer.

As this Chapter has shown, unlike in the case of hospital autonomy, the decentralisation transfer resulted in implementation. As has been articulated above, due to favourable political, institutional, and organisation contextual factors the reform was implemented although there was bureaucratic resistance.

7.5. PUTTING IT ALL TOGETHER: HOSPITAL AUTONOMY AND DECENTRALISATION REFORMS COMPARED AND DISCUSSED

This Chapter aimed at answering the study’s second research question which is; What factors facilitated or constrained the implementation of health sector reforms in Malawi? This section discusses the Chapter findings through a comparative analysis of the two reform instruments understudy so as to draw conclusions.

Through the cases of hospital autonomy and decentralisation reforms in Malawi the study has found out that a combination of political, cultural, economic, mode of policy transfer, administrative and historical institutional variables determined the implementation of reforms. This Chapter has demonstrated that although the reforms were initiated using mechanism of a coercive nature and were initially adopted so as to secure the much needed developmental aid, the actual implementation of the reforms was not an automatic process. This is because both veto players and implementing administrators were constrained by the deeply entrenched political, economic, administrative, cultural and historical institutional proclivity that led either to ‘abortive’ transfer outcomes as in the case of hospital autonomy or sustained resistance as was in the case of decentralisation reforms. These were measured through the following seven dimensions: mode of transfer, policy content and context, parliament-cabinet configuration, path dependency tendencies, pressure from citizens, institutional compatibility, and bureaucratic interests.
Firstly, for the two case studies, the mode of transfer was found to be a necessary though not a sufficient condition in ensuring reform implementation and the general institutional and capacity development of the MOH. It is claimed that an “important condition for policy transfer and implementation is that all relevant actors are included in the process” (Street, 2004:120). In the case of USAID’s hospital autonomy transfer the reform instruments were devised by external international consultants working outside the institutional realm of the Ministry of Health (MOH) and the MOH was just given the final reform product to pass on to the relevant veto players and implement. The problem with this mode of transfer was that it presented lack of ownership among the MOH officials due to lack of involvement and little or no interface between the MOH officials and USAID consultants. In addition, there was no institutional and capacity development for sustainability of the same since MOH officials were not involved in the reform and policy formulation processes.

On the other hand, the EC technical advisors adopted a learning approach where they actively involved MOH officials in the reform process. There was capacity and institutional building in the forms of learning by doing, formal academic scholarship at the masters degree level for the key MOH personnel, and capacity building on management issues in the districts. However, although these approaches worked to build capacities, the creation of reform implementation structures and systems that highly rewarded those that were directly involved in the reform (from the Planning Department) alienated other departments that were key to the implementation process, but not in the initiation stages. As a result, these either sabotaged the implementation process or left the ministry due to frustrations thereby seriously jeopardising the actual implementation process. Since reforms were aimed at transforming the health service delivery mechanism as a whole, it was important to carry this out in a holistic fashion since the whole MOH was pivotal for the success of its implementation.

Secondly, the study found that the reform content and political-economic context played a pivotal role in determining the political acceptability of the reforms under study. As it has been noted, an “administrative reform is essentially a political process” (Common, 2004b:348). The hallmark of hospital autonomy reforms was the implementation of user fees in central hospitals to improve quality. Although this was technically sound, it did not attract political attention because of the context within which it was applied. Malawi is a very poor country and the introduction of such fees would mean that many people would not afford. The problem with the fees is also that it would mean policy contradiction as the
government’s overall policy framework was about poverty reduction and increased access to health services. This context combined with the conceptual confusion of hospital autonomy with the privatisation reforms meant that the reform was unacceptable.

In comparison, the district health management decentralisation reform laid emphasis on the strengthening of district health infrastructure through the transfer of managerial powers to the district level. This was championed within the context of democratisation reforms that Malawi had just embraced. In this regard, although health sector decentralisation entailed the transfer of managerial power to districts, the political ends of consolidating democracy were seen to be imperative and hence attracted political support. With the historical context of suffering under the one party dictatorship, any reforms that were seen in the context of democratic consolidation were acceptable. In this particular one, there was a match between the reform content and the context within which it was applied. Moreover, unlike in hospital autonomy, decentralisation reform did not entail user fees.

Bulmer et al (2007:27) articulate that policy transfer can be affected by “an inability to secure a parliamentary majority”. Therefore, the study investigated the extent to which political power games affected the acceptability of the policies under study by examining the impact of the parliamentary-cabinet configuration. It was found that during the time when hospital autonomy bill was due to be sent to parliament for them to enact it into law, the opposition parties were a majority. In addition, the government side could not form a coalition to pass bills because the president formed government after leaving the party that sponsored his election. This brought anger among the now opposition side and in an attempt to frustrate the president, no bills including the national budget were successful. In this case, the president was aware that the hospital autonomy bill would, just like the others, not pass. And in particular for the hospital autonomy bill, the opposition would also capitalise on the introduction of user fees to gain political mileage. As a result the cabinet did not only disapprove it but also did not pass it on to parliament.

For health management decentralisation reforms the case was different as it did not need to go to parliament at the time of its implementation. This is because a national decentralisation bill was already passed in 1998. This meant that even when at the time of implementation in the health sector the balance of power in parliament did not favour the government, it did not affect the reform process. In addition, the national wide decentralisation legislation did not
find hurdles to be passed through parliament because the government dominated the parliament at that time. This is also strengthened by the fact that health decentralisation attracted political support regardless of political divides because it meant transferring managerial power to the district where their constituencies are based and hence increasing their political influence on the health system.

It has been observed that “accounts of transfer that are not integrated with those of path dependency do not offer fully developed discussions of policy development” (Pemberton, 2009:316). Therefore, this study set out to find if policy transfer of the two health sector reforms was constrained or facilitated by path dependence tendencies. Key here was the analysis of the impacts of historical institutional issues in terms of the impacts of “existing state capacities and policy legacies on subsequent policy choices” (Hall and Taylor, 1996:938). The study found that historical institutions mattered in policy transfer processes. In particular for hospital autonomy reforms, it was found that the historical colonial institutional framework within which the health policy of free services was based was embedded within the society so that attempts to change the trajectory have not only resulted in political problems but have also proved impossible. When the country got independence in 1964 attempts were made to introduce the nominal hospital three pence fee in the name of the tickey. However, these were resented by the public and politicians leading to a cabinet crisis where the prime minister fired three ministers, a parliamentary secretary, and three other cabinet ministers resigned in solidarity. In an attempt to close up further policy resistance, the prime minister took a dictatorial leadership style. However, the tickey was dropped. The 1964 independence and the 1994 democracy the country adopted could work as “conjunctures” and “critical junctures” to facilitate policy change. However, due to the embeddedness of the free health policy into the sinews of the social milieu, the 1964 cabinet crisis experience and the 1994 privatisation ushered in by liberalisation reforms in the context of democracy, only worked as ‘lock in’ mechanisms.

On the other hand, health management decentralisation reforms were possible since they were generally regarded as a democratic requirement. In this case democratic reforms implemented in 1994 were a ‘critical juncture’ necessitating the change of policy path characterised by centralisation which was seen as an instrument of dictatorial rule. In the historical context of the previous dictatorial centralised rule, the adoption of decentralisation
was seen as pivotal in terminating the legacy of dictatorship and attaining democratic consolidation and hence acceptable.

Pressure from the citizens was also examined to analyse if it had any facilitating or constraining impacts on the adoption of the reform instruments. Batley (2004:35) underlines that because reform is “led by external agencies (donors) rather than government, public reaction is likely to have little capacity to influence the course of reform”. However, the study found that although there was no active citizen pressure for the reforms, their perceptions and feedback they gave to the policy making machinery created a policy window to either adopt or reject the reforms. In the case of hospital autonomy reforms, the citizens gave a divided feedback to the policy making system. There was a group of the rich who because of their ability to pay wanted high quality and efficient services and hence were for the reforms, and there were the poor who did not care much about quality but access to health services. The poor could not pay and feared that user fees would limit their access to health services. Since the poor were the majority and hence a political capital, they got the political support.

In the case of management decentralisation, since it did not involve ability to pay but strengthening health services, the citizens presented a unified feedback to the policy making machinery. This was in the context of perception of lack of meaningful government efforts to improve health service delivery. In this case, although the dissatisfaction did not ultimately translate into active demands, it provided a window for government to adopt reforms that were seen to strengthen health service delivery.

Clemens and Cook (1999:459) underscore that the “essence of institutional entrepreneurship is to align skilfully an organizational form and the specific institution it embodies with the master rules of society”. In this regard, the study also analysed the impacts of compatibility between the reform instruments under study and institutional framework within which they were to be implemented. This was done to investigate if reforms and institution fit and prerequisites could be seen as factors constraining or facilitating the implementation of the reforms under investigation. In the case of hospital autonomy reform, making hospitals autonomous and the resultant cost recovery mechanisms were seen not to be compatible with the referral institutional framework upon which health service delivery in Malawi is based. This was exacerbated by the fact that the required prerequisites for the alteration of this
institutional framework which were the need to construct district hospitals in the districts where the central hospitals are and strengthening the existing district hospitals were absent. Districts where there are central hospitals do not have district hospitals and the rest of the district hospitals do not have the capacity even to carry out activities under their mandates thereby making hospital autonomy problematic. On the other hand, management decentralisation was aimed at strengthening health service delivery at both the district level and primary level. In this case, it was seen to be both compatible with and strengthening the existing referral institutional framework and hence politically acceptable.

Lastly, the study was interested in investigating the impacts of bureaucratic politics on the implementation of the reforms. The study found that bureaucratic interests determined the pace at which the reforms were implemented. However, where these interests aligned with political interests they did not only determine the pace but also the ultimate implementation. In this case although the bureaucratic influence was “not autonomous”, it was “instrumental” (Knill and Lenschow, 2005). In both hospital autonomy and district health management decentralisation, the study found that there was bureaucratic resistance to the reforms. This resistance was based on the perceived loss of power, influence, control and resources when the reforms actually take place. This was heightened by the existing high power distance cultural environment in Malawi that socially rewards authority and power. In addition, neo-patrimonial relationships that emanate from such authority and power dependencies meant that hospital autonomy and management decentralisation inasmuch as they were perceived to entail loss of power, authority, influence and resources were not bureaucratically acceptable.

In the case of hospital autonomy, this was in the realm of both the ministerial and senior bureaucratic levels and was enhanced by the general political resistance to the reform. As a result it finally saw its exit from the policy agenda. On the part of management decentralisation reforms, although bureaucrats tried to resist the implementation through delays, reallocation of reformists, presenting technical excuses and appealing for presidential intervention, they finally had to give in. This was due to donor pressure through credit conditioning on the implementation of the reform and the Ministry of Finance’s hide and seek tactics where they begun the fiscal decentralisation phase by transferring money straight to some districts without the blessing of the MOH. Clearly, it can be seen that the reasons for bureaucratic resistance were ‘budget maximising’ rather than ‘bureau-shaping’ ones (Dunleavy (1994). Through the lens of the bureau-shaping model one would expect such
NPM models to be adopted as they would facilitate the passing on of managerial activities to lower levels to enable top managers to concentrate on policy work - the work the model assumes them to prefer. However, cases studied display the opposite thereby concurring with Dunleavy (1994:51) that “budget-maximizing models in public choice...lead us to expect minimal change in response to the contemporary NPM challenge because of bureaucratic resistance especially by senior officials”.

7.5. CONCLUSION

This Chapter has answered the study’s second research question which is: what factors facilitated or constrained implementation of health sector reforms in Malawi? Using the case of the transfers of hospital autonomy and management decentralisation in Malawi, the study has found that national contextual factors determined the implementation of internationally generated public management reform models. It was revealed that where reforms were not seen to be favourable within this context, the resultant political and bureaucratic resistance forced the reform to exit the Malawi’s policy agenda even when the reforms were transferred through coercive economic conditionality means by international donor organisations. However, the study found that where political feasibility was secured within this institutional context, chances of reform implementation increased as donor influence only enhanced political pressure to implement the reforms. By mapping the policy transfer dynamics under study on Dolowitz and Marsh (2000) policy transfer continuum, the Chapter found that hospital autonomy was a case of ‘conditionality’ with ‘abortive’ outcomes while decentralisation was a ‘tricky’ instance of ‘obligatory’ turning into ‘conditionality’ transfer.

The next Chapter presents findings on the impacts of policy transfer on service delivery transformation in Malawi. The aim is to examine the extent to which health sector decentralisation has transformed the delivery of health services as per the reform transfer objectives.
8.1. INTRODUCTION

Chapter Seven presented and discussed research findings in relation to the study’s second research question which is: what factors facilitated or constrained the implementation of health sector reforms in Malawi? The Chapter found that although coercive pressures were applied, the actual implementation of these policies was not an automatic process as it was mediated by various national level contextual factors which constrained the actions of veto players.

Evans and Davies (1999:379) articulate that “the study of policy transfer is incomplete without an implementation perspective”. It is therefore pertinent for this study to analyse the outcomes of the reforms that have passed through the national level. To this end, this Chapter uses the case of district health management decentralisation to analyse the extent to which the transfer has led to the transformation of health service delivery mechanisms and locates the policy outcomes and impacts of the same in the MOH. In doing so, the Chapter aims to answer the study’s third research question that is: to what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi? The Chapter starts by presenting the transformational nature of the decentralisation reforms. It is from this that four main aspects of the reform transfer are examined so as to analyse the degree to which the envisaged transformations have been attained. This is followed by a discussion of the linkages between health sector reforms transfer processes and domestic policy making processes. After this the Chapter presents a discussion and summary section. The last section is conclusion.

8.2. DISTRICT HEALTH MANAGEMENT DECENTRALISATION AS A TRANSFORMATION CHANGE

McNulty and Ferlie (2004) characterise transformation change as involving “sharp and simultaneous shifts in strategy, distribution of organisational power, structure and control mechanisms”. It has been observed that decentralisation to empower district level health
managers entails a transformational change in the delivery of services (Shaw, 1999). For Malawi, decentralisation was regarded as a “process of fundamental and radical change...which needs to be reflected in the organisational arrangements for health care delivery and followed through in implementation” (MOH, EC and British Council, 1999). The aim was to change health service delivery mechanisms from the centralised, rigid and hierarchical mode to flexible decentralised structures that would offer services that are in line with local needs. To this extent, the MOH would be playing a policy and coordination role rather than the actual management. The transformational impacts of the decentralisation programme were articulated by a former Minister of Health who hinted that the reform was a total transformation of the system...The change that we will experience...is unprecedented in the delivery of health services in this country. The change will mark a major shift in the paradigms for delivering health services. It will affect me as your Minister, it will affect the Ministry Headquarters, the district health delivery system and every other aspect of the health delivery systems (Banda, 2000:8).

8.3. INDICATORS OF TRANSFORMATION USED

This chapter is an evaluation of whether the decentralisation reform transfer has achieved the intended service delivery transformation. However, as Boyne et al (2003:14) observe, evaluation research is “bedevilled by a lack of agreed criteria for judging policy consequences”. The only readily accessible indicators of transformation of the health sector emanating from public sector reforms are those by Ferlie et al (1996) which comprise of six components namely:

- The extent of multiple, interrelated change across the system as a whole.
- The creation of new organisational forms at a sector level.
- The development of multi-layered changes which impact below the whole system at unit and individual level.
- The creation of changes in the services provided and the mode of delivery.
- Reconfiguration of power relations.
- The development of new culture, ideology, and organisational meaning.

According to this formulation, organisational transformation is said to occur only after all the six criteria are fulfilled (McNulty and Ferlie, 2004). Although, these indicators have the potential in measuring transformational issues under study, they have a few shortfalls. Firstly,
they were developed for measuring NPM reform in its totality within the four models characterised as “efficiency drive”, “downsizing and decentralisation”, “in search of excellence”, and “public service orientation” (see Ferlie et al, 1996). Although reference is made to other aspects of NPM, the major model under examination in this chapter is ‘decentralisation’. In this regard, taking all of Ferlie et al’s indicators in their totality would be problematic. Secondly, Ferlie et al’s indicators lay emphasis on system-wide changes while this analysis is mainly at service delivery level as such issues pertaining to higher levels have already been discussed in Chapter Seven. Third, is the issue of context as the Ferlie et al’s indicators were primarily developed for measuring system wide transformation in a developed country context (UK National Health Service). This study therefore adapts them to the Malawian context while avoiding duplications that may ensue if applied wholesale. It is against this background therefore, that rather than going through the individual indicators, the study contextualises them in the main components of the decentralisation reform initiative. The aim is to find out whether what was transferred as a reform is in line with what is actually in action or practice. This is because the “extent of change in policy in action is the most meaningful answer to the question whether a public management reform has occurred” (Boyne et al, 2003:30). Therefore, while being guided by Ferlie et al’s indicators, the assessment will comprise of four main components of the reform as stated in the government’s policy documents namely;

- Abolition of regional health offices
- Managerial responsibilities decentralised to district health management teams.
- Devolving accountability oversight to elected local government assemblies.
- Development of a new culture, ideology and organisational meaning (Ministry of Health, 1999a; 1999b & 2004; 2007; Malawi Government, 2001)

8.3.1. ABOLITION OF REGIONAL HEALTH OFFICES

The first aspect of the decentralisation reform was the abolition of Regional Health Offices. To this extent the Ministry of Health (1999b:93) highlights that “Regional Health Offices will be phased out in favour of decentralising operations to districts”. As articulated in Chapter Five, Malawi is administratively divided into three Regions namely, Northern, Central and Southern. Regions are divided into districts. In terms of health services management organisational setup, in each district there is a District Health Office headed by a District
Health Officer (DHO) responsible for service delivery at the district level. Representing the MOH headquarters in the three Regions were Regional Health Offices (RHO) responsible for District Health Offices existing in the Region. The DHOs were reporting to RHOs for all administrative and technical issues. In this respect, the RHOs operated as managerial, administrative and technical hubs for the DHOs within the spirit of centralised service delivery. In effect, the RHOs were an extension of the MOH Headquarters directly managing and administering the DHOs. The kind of powers the RHOs had were elucidated by a MOH official who hinted that “Regions had all the powers in issues to do with discipline, finance, transfers, and everything was controlled by the Region”.

Pollitt et al (1998:1) argue that decentralisation enables “organisations to shed (‘let go of’) unnecessary middle managers”. The aim is in “cutting out hierarchy” (Common et al, 1992:52). Likewise, the decentralisation thrust in the MOH necessitated the abolition of the RHOs. The study noted that the abolition of RHOs was seen as a key element for the realisation of decentralisation reforms as it would necessitate the required transfer of administrative and managerial powers to the DHOs. In this regard, the dissolution of RHOs would allow the DHOs to assume the ‘hands on management’ of the delivery of health services required in a decentralisation setting. In fact one of the study’s respondents highlighted that

\begin{quote}
with decentralisation, to maintain such offices (RHOs) would be conflict of interest and hence they were abolished. The reasoning was that if sectors are to be decentralised why maintain Regional Offices because all powers were controlled through the Region and finances were going through the Regions.
\end{quote}

It must be highlighted that although the MOH officials resisted the whole decentralisation movement (as discussed in Chapter Seven), the abolition of RHOs was not a difficult task for them. RHOs were abolished as soon as it was recommended. Apart from the fact that the dissolution of RHOs would be necessary to give passage for the effective implementation of decentralisation reform, the speed at which they were abolished was facilitated by organisational power politics within the MOH. It was revealed that the quick abolition of RHOs was facilitated not by the need to decentralise but the struggle to control donor financial resources by the MOH, most of which was expended at the RHO level. The study unearthed that some donor organisations when they wanted to make interventions at the district level used to go directly to RHOs and not through MOH headquarters as RHOs were
direct managers and overseers of DHOs. Donor organisations regarded this bypass as an
effective and efficient way for interventions in an otherwise highly bureaucratic organisation.
However, this arrangement did not go well with the bureaucrats at the MOH headquarters
because it reduced their control over such resources. In this respect, recommendations by the
decentralisation movement for the abolition of RHOs were considered as a way of getting rid
of an otherwise already unwanted layer of management by the MOH bureaucrats. As a
former Regional Health Officer attested,

*let me give you the reason why the RHOs were killed*...We became very
important in the system but we ended up being hated by headquarters
because we were seen as being more important than them. It came even a
time that we had more resources at the region office than the head office.
We could ask anything from the donors in terms of vehicles or computers
and the donors used to say the headquarters is more of administration than
operational. That way people hated RHOs. No meeting would take place at
headquarters with the donors without representation of RHOs,...as donors
would say that there is no representation from the ground. Then we started
getting powerful. Now the headquarters started to say that ‘I think we do
not need the RHOs. It’s just a postmaster; we should just have
headquarters and the districts [Emphasis added].

It was also learnt that this was exacerbated by the fact that just like the MOH headquarters,
DHOs did not like RHOs. DHOs considered RHOs as a hindrance for their direct access to
MOH head office. As a former Regional Health Officer illustrated, “some of the districts
also felt that RHO is a sieve as they could not go directly to headquarters [without passing
through the RHO]. So they wanted to have direct access to headquarters”. This was
particularly because the RHOs were characterised by delays and inefficiencies. The RHOs
were so inefficient that in most cases the DHOs regarded them as unnecessary managerial
barrier. The extent of such inefficiencies can be seen from the remarks of various
interviewees as follows:

A former administrator at a DHO highlighted that

*I operated in a system when we had Regions. Cheques for DHOs were
prepared at RHOs. I tasted how bad it was. I could move from Mchinji
District to follow a cheque at RHO, for 2 or 3 days just to get a cheque and
I was in the forefront to say that the RHOs should be abolished.*

In agreement, A District Health Officer at one district added that

*for example if a certain NGO wants to fund a hospital, that money was not
received directly, it could get stuck at the Regional Office and by the time it
reaches you it would take too long and you would miss it at times.*
In the same manner, a focus group discussion participant hinted that

when we had regions, one major problem was delay. Things that needed the
attention of Headquarters were delayed at Regional Health Office. That is
why they abolished Regional Offices so that each health institution should
report directly to the Ministry of Health headquarters.

Thus the abolition of RHOs presented a transformational change in the MOH organisational setup in the context of decentralisation reforms. The RHOs were abolished in 2000 and all the powers and functions that used to be within their realm were concentrated at the MOH headquarters awaiting the full decentralisation process. For the first time the DHOs were reporting directly to the MOH headquarters as the decentralisation process was underway. However, as has already been highlighted in Chapter Seven, the MOH headquarters held on to these powers for too long because the actual granting of managerial power and control to DHOs was being resisted by the MOH headquarters bureaucrats.

8.3.1.1. Creation of Zone Offices: Institutional Reproduction and Contradiction?

According to the planned decentralisation programme, the abolition of the RHOs meant that there would be no intermediate offices between the DHOs and MOH headquarters. This is because DHOs would be managerially autonomous in service delivery and the MOH headquarters would be responsible for policy issues. The idea was to attain increased efficiency and effectiveness by “debureaucrat(ising) the public service and delayer(ing) hierarchies within them” (Larbi, 1999:17). However, the transformation symbolised by the abolition of RHOs was only short-lived. When the MOH begun implementing the actual decentralisation reforms after a push from the donors as was discussed in Chapter Seven, Zone Offices (ZO) which were to work as intermediate offices between the MOH headquarters and DHOs were created. In total, five ZOs were put in place namely; Northern Zone, Central East Zone, Central West, Southern East Zone, and Southern West Zone to oversee DHOs existing in them.

The Zones were justified as a means to “provide technical support to district institutions” (Ministry of Health, 2004:28). However, the study found that the formation of the ZOs was just an institutional reproduction of the old RHOs. Although the ZOs did not take all the
functions of the RHOs as some were to be passed to the DHOs (as will be noted below), the recreation of intermediate offices was regarded as institutional reproduction. In this particular one, the language of reproduction is preferred to that of stability or inertia as the organisational arrangements are not the same as they used to be prior to the reform programme (McNulty and Ferlie, 2002) although they occupy the lacuna left by the abolished organisational setup. Firstly, while the regions were three, the ZOs are five. The paradox of this increase is that it highlights the importance of intermediate organisational setup that was abolished as a decentralisation reform transfer requirement. Moreover, ZOs are handling lesser issues than those previously handled by RHOs. The RHOs were responsible for administrative, supervisor and technical issues. However, the ZOs are responsible for supervisory and technical issues while administrative issues are to be decentralised to the DHOs. As a former Regional Health Officer articulated,

> at the region office we were so powerful. We were commanding the budgets, we were commanding the expenditure. The Zones are not commanding any expenditure or authority over the districts...Their role is on technical side and what they have put there are technical people that would support managers to ensure that things are going on ok and if there are issues for headquarters they can relate to headquarters and see how they can support the districts. They have not just taken roles of previous regional head offices as it were.

This was echoed by a Zone Supervisor who added that

> when we compare Regions and Zones, you see that Regions had all the powers on issues to do with discipline, finance, transfers, everything was controlled by the Region while this time finances go straight to the districts. DHOs are supposed to manage those finances and use them without interference. The only thing the Zone can do is just to supervise and advise DHOs. Or in issues to do with disciplining members of staff the DHOs are supposed to handle that and they just have to report to us and we carry it forward to the ministry. So all powers are with the districts.

However, despite these differences, the general consensus during the interviews was that the institution of ZOs is a reproduction of the RHOs. The transfer of decentralisation reforms entailed the abolition of RHOs to enable DHOs to carry out independent decisions that would be pivotal in enhancing efficiency and effectiveness. However, ZOs reproduce the organisational setup that the decentralisation reforms were meant to abolish. In a discussion that centred on whether ZOs are now taking over the place of RHOs a focus group discussion (FGD) participant highlighted that “somehow, yes”. At another site, a FGD participant expounded that “exactly only that they have just now increased the numbers because we had
3 Regional Offices and now we have 5 Zone Offices, but it is almost the same”. A District Health Officer at one site put this in its right perspective by highlighting that

yes it is like we are going back to the Regional Offices. Soon after the dissolution of regional offices, they saw that supervision of the districts from the central level was a problem. So at the Zonal level, most of their work is supervision. Though now they will have experts like TB officer, but they will not work as the Regions were.

The study also noted that the creation of Zone Offices was apart from being a reproduction of the former RHOs, a contradiction of the decentralisation reform transfer. In this realm, institutional contradiction refers to “various ruptures and inconsistencies both among and within the established social arrangements” (Seo and Creed, 2002:225). As one Zone Officer illustrated “people were looking at it as a threat and an objection to decentralisation”. As already highlighted, decentralisation was aimed at minimising centralised control and cutting out administrative hierarchy. As Lam (1996:31) propounds decentralisation within the NPM framework encompasses a “reduction of bureaucratic hierarchies and rules” and in so doing it is “completely contradicting to the traditional bureaucratic practices based on hierarchical commands and orders” (ibid:41). To this extent, the decentralisation reform transfer envisaged to “provide unique opportunity for the centre to adopt a truly strategic and leadership role within the whole health system” (MOH, EC and British Council 1999:12). Organisationally, this means a reduction of the presence of the MOH headquarters at the service delivery level. However, the study discovered that the creation of ZOs offices was meant to enhance the presence of the MOH central office at the service delivery level, a thing which was contrary to the spirit of the decentralisation reform transfer. All the people interviewed were of the view that ZOs are the MOH headquarters at the local level. For instance, a Zone Supervisor alluded to the fact that “we are taking the Zones as part of the central ministry, an outpost of central ministry” while a District Health Officer echoed that “we take the Zone office as part of the Central level, an arm of the ministry central office”. Similar sentiments were expressed by a director of a non-governmental organisation on health equity issues who articulated that “with the Zones we are creating another level of centralisation. While we are decentralising on one hand we are centralising on the other”. Critical issues were articulated by a Planning Officer at the MOH headquarters who hinted that

the Zones, unlike the Regional Offices which were administrational offices, are just an extension of headquarters because headquarters retains the role of policy so, basically, the Zones are meant to be as an extension of
headquarters. The Zones are not just headquarters, but headquarters brought down close to the people- headquarters decentralised. There is a problem because when we were creating the Zones we said ‘these are not Regional Offices, they are extension of headquarters but then in practice what they are doing is kind of like old Regional Offices, now with less power.

Moreover, the creation of ZOs only increased the bureaucratic reporting chain that the abolition of RHOs was meant to avoid. For the service deliverers on the ground, the replacement of the RHOs with ZOs has not meant any transformation of service delivery organisational framework. For them, the creation of ZOs is just the maintenance of the old hierarchical system with bureaucratic structure. It was in this respect for instance that a participant at one of the FGDs indicated “I think it’s just a chain of command. Because the head office commands the Zone Office and the Zones command the DHOs. So it is just the reporting system that has changed”. One District Health Officer referred to the Zone office as a “bridge that boarders the MOH and DHO”. This line of thought was well articulated by a member of a District Health Management Team who emphasised that “instead of things going directly to MOH, Zone office acts like a bridge. Things coming from here will go to the Zone Office and from there they will go to the MOH, even the MOH when they want to come here they go through the Zone Office”. This was exactly what was happening when RHOs were in place.

The problem with this ‘re-bureaucratisation’ is that it reproduces the same inefficiencies and delays which the transfer of the decentralisation reform was designed to address by abolishing the RHOs. As has been emphasised above, the abolition of the RHOs to pave way for decentralised management was aimed at enhancing efficiency and effectiveness. In this regard, the reproduction of RHOs through the establishment of ZOs does not help in terms of addressing these issues. As FGD participant at one sites observed, “Zone Offices are good for small things that can be solved straight away. But for those that need the attention of headquarters they are delayed as they have to go through the Zone”.

8.3.1.2 Support and Legitimacy Crisis of Zone Offices

The study found that although the ZOs had support from the donor organisations and MOH Headquarters, it suffered a legitimacy crisis among the DHOs and the Malawi Central
Government as a whole. This section highlights the extent of support and legitimacy crisis experienced in this regard.

8.3.1.2.1 Donor Organisations

According to Mahoney and Thelen (2010:5), “actors carry their existing scripts forward when building new institutions even when doing so is not ‘efficient’”. The findings support this view as the ZOs despite being reproduction of old structures and a contradiction to the decentralisation reform transfer, had the support of donors. The study noted that the ZOs were set up with the recommendations from the donor organisations. In this regard, one of the Zone Officers highlighted that “initially the Zone offices were done by donors and up to now they are still being supported by donors because it was with the influence of donors that Zones were created”. In the same way, a Principal Human Resources Management Officer at the MOH indicated that “the creation of Zones was an initiative of the donors”. This donor support was beyond initiation of the Zones but even creating them. As will be mentioned below, the study found that the Central Government through the Office of President and Cabinet’s Department of Human Resources and Development did not support the establishment of the Zones and therefore could not approve its staffing and financial allocations. Therefore, Zone Offices operated with the funding from donor organisations. As the Principal Human Resources Officer at the MOH illustrated, “all their salaries and whatever they do [at the Zone] is supported with donor money”.

It must be emphasised that this was a contradiction from donor organisations as they initially recommended the abolition of an intermediary organisation -the RHOs- within the spirit of the decentralisation transfer. In fact a fully fledged study funded by DFID and conducted by the Liverpool Associate in Tropical Health which provided some inputs for the EU decentralisation reform programme had the abolition of RHOs to pave way for decentralisation as its main recommendation. However, as has been highlighted above donor organisations preferred dealing with RHOs rather than MOH as these were seen to be directly in contact with the DHOs. Therefore, even the recommendation to dismiss the RHOs within the decentralisation reform transfer did not come without some reservations from donor organisations. Although donors justified the institution of ZOs based on capacity problems at the district level, this shows that the policy transfer did not receive a unified direction and support among the donor organisations. The study established that this is the problem of
policy transfer emanating from overreliance of donor aid. As the Director of Debt and Aid in the Ministry of Finance indicated,

> donors are having to push to make sure that particular ways of doing things are maintained...there was too much of ‘cut here, cut there, get rid of this and that’ and now these donors are coming back to say ‘we need more of those’ [structures we said you should cut] so there are some inconsistencies in what donors will tell you about how to reform the public service.

8.3.1.2.2. The Ministry of Health Headquarters

Just like the donor organisations, the MOH headquarters was in support of the establishment of the Zone Office although it was counter to the decentralisation reform. The first reason for their support of ZOs was functional. As has been highlighted above, the decentralisation reform transfer meant that the RHOs be abolished to allow autonomous decision making by DHOs. The result of this was that DHOs would be making independent decisions and reporting directly to the MOH. In the same manner, the MOH headquarters would be required to directly supervise DHOs to ensure adherence to policy standards. This was important as districts though independently managed were to deliver services within the same policy framework so as to raise national health standards. However, this task proved to be too heavy for the MOH. The time that the RHOs were abolished, the supervisory role proved to be too demanding for the MOH to the extent that most districts remained unvisited. As one Zone Officer articulated, “what was happening was the Director of Clinical Services sitting at the MOH headquarters had to supervise all the districts and that was very difficult for him and by the end of the year he could only travel to 3 or 4 districts”. The same sentiments were raised by one of the focus group participants indicating that the “MOH had problems in overseeing the whole nation from Capitol Hill (head office) so what the ministry came to think is that it’s better to come closer to the people so that is why we have these Zones”. A former Principal Secretary of Health (Y) illustrated the actual issues at work by underscoring that

> it was found that you hardly found time to supervise and it became clear in the reviews that you cannot just decentralise without having mechanism to ensure that you are doing facilitative supervision to guide the people in the districts. That is why the Zones were now created so that they can supervise regularly. So the Zone is part of decentralisation because it is known that you cannot just decentralise without supervision. You have to supervise to make sure that people are supported and guided.
Powell (1991:191) outlines that “practices and structures often endure through the active efforts of those who benefit from them”. In this regard, the second and perhaps more important reason for the MOH’s support of the ZOs had informal institutions and bureaucratic politics underpinnings. These related to the MOH’s earlier resistance to embrace the decentralisation reforms as articulated in Chapter Seven. The study established that although the MOH head office did not want the RHOs as highlighted above, they supported the creation of ZOs as they were seen as a way of extending their control on DHOs in the realm of the decentralised governance. Since the MOH was resistant to decentralisation, Zones as much as they were seen as an extension of the headquarters to the service delivery level were preferred as a means of gaining back the lost power, resources and influence (as analysed in Chapter Seven). It is in this regard therefore that a Planning Officer at the MOH headquarters justified ZOs as making it “clear that even within this decentralized environment there is a role for headquarters”.

Related to the above, some people at the MOH headquarters championed for the creation of the Zones as they thought that they would personally benefit from their establishment. They thought that Zones would bring with them superior positions and promotions which would otherwise not obtain. As the former Principal Secretary for Heath (Y) articulated, “what was happening was rationalising but at the same time people were saying I’m I losing something or gaining out of this change”. With the large power distance cultural orientation that Malawi has, the assumption was that the positions at ZOs would be more superior to those of DHOs and this would provide a status avenue for most people at the MOH headquarters. Again viewed in the context of neo-patrimonial bureaucratic orientation in Malawi, the assumed superior positions at ZOs would provide resources for MOH managers at the head office for servicing patronage linkages that would be created with the DHOs. With the background that the MOH headquarters was generally resistant to the decentralisation movement as illustrated in Chapter Seven, this was aimed at paralysing the managerial autonomy of the district health managers as only those that would dance to the tune of the MOH headquarters patrimonial masters would be promoted to superior positions at the ZOs. It is in this regard that when most people at the higher positions at the Zone Office were not recognised by the Government-wide Department of Human Resources and Development (as will be discussed below), they backtracked. It was also for the same reason that the ZOs have faced a lot of staff turnovers. An interview with one Director hinted that
they did that with the view of influence that change should come their way and that officers in the Zones should be senior officers. This development did not take place. Zone Officers are still at P5 and you find that most of the Zone supervisors have actually backtracked. There is only one Zone Officer who is still active...but in all the other Zones there is nobody. People have actually had to ask to go elsewhere; they are developing a case to say ‘can you find us something better, can you consider raising this office’. I think there are still squabbles. It is a cloudy development.

However, it was observed that not all the managers at the MOH are in support of the ZOs. This is especially true for those that either do not envisage any patronage benefits through the system or are highly committed to the original unobstructed decentralisation reform transfer. These do not appreciate the role of the ZOs in health service delivery within the decentralisation framework. For these officers, the Zone Office is an unnecessary technical management layer and a hindrance to the efficient and effective service delivery. In their supervisor endeavours, these managers prefer to engage straight with the DHOs thus bypassing the ZOs.

8.3.1.2.3. Department of Human Resources and Development at Office of President and Cabinet

The government-wide Department of Human Resources and Development (DHRD) which is an arm of the Office of President and Cabinet (OPC) responsible for overall public service management was also a key stakeholder to the decentralisation process whose role in the Zone Office structure cannot be ignored. The DHRD accepted the original transferred structure which recommended for the removal of RHOs. Owing to the contradictions and reproduction highlighted above, the DHRD has been at pains to accept the institution of the ZOs within the decentralisation framework. The reasoning has been that the ZOs are against the spirit of decentralisation reform. As one Zone Officer illustrated, “from the government side this was a new structure and the concept of the Zone was not accepted by the Department of Human Resources and Development (DHRD) at the OPC”.

However, with pressure from donor organisations and MOH headquarters, the DHRD reluctantly accepted the establishment of ZOs. Nevertheless, this study established that to demonstrate that they did not see any room for ZOs in the decentralised framework, the DHRD recommended that the ZOs should have only one person - called Zone Supervisor. This person could be responsible for supervising all the DHOs in the Zone. In addition, the DHRD recommended that the Zone Supervisor should be at grade P5 which is lower to that
of the DHOs he or she is supposed to supervise which is at P4. As highlighted above, in the context of a large power distance society where seniority commands obedience, by putting the Zone Supervisor at a lower grade than the DHOs that they are to supervise, the DHRD demonstrated that they did not see the importance of the ZOs later alone support their establishment. It was in this respect the a Planning Officer at the MOH commented that,

\[\text{worse still, up to now Zones do not have an establishment, as the DHRD has not yet approved the revised one. Actually, the approved establishment is even more of a problem than the solution because the positions have been degraded. Somebody who should supervise you must be senior but you find the District Health Officer is more senior because DHOs would be at P4 and the Zone Supervisor; the senior guy is at P5, so eventually the Zones are inferior to districts in many aspects.}\]

The study also found that apart from the staff establishment issue, the DHRD paralysed the resource envelope of ZOs by not making them a cost centre. Since the ZOs were presented as part of the MOH headquarters, the DHRD did not see the need of establishing them as a cost centre. Moreover, the dilemma was that making them a cost centre would also mean openly reverting to the RHO framework which is contrary to the decentralisation reform. This means that the ZOs do not have a separate budget but operate within the framework of MOH with donor resources as outlined above. In this regard, the Zones are taken as part of the MOH rather than independent technical advisors of the DHOs. While this means that the MOH increased access to ‘their’ resources allocated by donor organisations as opposed to a situation when RHOs were in place, the study established that this presents a challenge as it increases inefficiencies because financial management issues have to take place at MOH headquarters. This means for example that cheques are to be raised from the MOH central office and this takes too long. As a Zone Official added, “it takes two to three weeks when we have no resources and we fail to operate. It is sometimes tough as we reach a point when we do not have resources, fail to move to districts and do our work”.

\[\text{8.3.1.2.4. District Health Officers}\]

The study found that for many DHOs, the ZOs are an unnecessary hindrance to their direct access to the MOH headquarters. Most of the DHOs do not appreciate the ZO’s role and at best, they are seen as an unnecessary layer of technical experts. This result is not surprising because as has been discussed above, the DHOs were in the first place against the RHOs. In this regard, the reproduction of the RHOs in the name of ZOs was not a welcome idea. It is for this reason that most DHOs do not recognise the presence of ZOs and many a time they
are bypassed. Issues requiring the attention of the MOH are sent straight to the MOH headquarters without going through the ZOs as was supposed to be the procedure. All the DHOs interviewed highlighted that on most occasions they bypass the ZOs. In their verbatim, the DHOs had this to say “functionally that is what happens. I forget that there is the Zone Office” (DHO at site A). “In practice, issues go straight to MOH. it is not necessarily that we report to Zone” (DHO at site B). “Sometimes we report through them [ZO] but most of the times we report directly to MOH” (DHO at site D). “You find that technically people report straight to the MOH bypassing the Zone, there is that grey area” (Principal Administrator at site E). Zone Supervisors also concurred with this observation. The general consensus was that the DHOs were finding it hard to recognise the Zone structure. As a Zone Supervisor illustrated “old habits are difficult to die out. We still have some who report directly to the Ministry bypassing the Zone but in most cases the matter is referred back to the Zones”.

Scott (1991:169) advances that legitimating concerns the “problem of...justifying the social order in such a way as to make institutional arrangements subjectively plausible”. In this regard, the study unearthed that apart from bypassing them, the DHOs have also questioned the legitimacy of the ZOs to present technical recommendation to them. Specifically, the Zones’ supervisory recommendations and action points are not taken into account by the DHOs. This mostly arises from the fact that the Zone Supervisor is at a lower grade than the DHO as already discussed above. As expected in a very large power distance society, their superiority in terms of ranking has made the DHOs to look down upon the Zone Supervisors and not adhere to their recommendations. For instance, one of the Health Planning Officers at the MOH hinted that “DHOs have actually defied the Zones telling them that ‘we can’t listen to you...You can’t tell us what to do...We don’t recognize you’. To this end, the Ministry of Health (2009a:19) even noted that only 15% of recommendations and action points from the Zone Offices have been acted on by the DHOs. The impacts of this were outlined by another Planning Officer at the MOH who added that

*technically, it means the role of the Zones is redundant, they can just go to DHOs as visitors or tourists. Of course, they can recommend but they cannot do anything beyond recommendation, they cannot enforce. So just recommendation without enforcing is not a motion in this game of money and power.*
8.3.2. MANAGERIAL RESPONSIBILITIES DECENTRALISED TO DISTRICT HEALTH MANAGEMENT TEAMS (DHMTs)

The Ministry of Health (1999b:53) articulates that the ministry will “decentralise the management of health facilities and health services at district level”. To this extent, apart from the structural and organisational issues highlighted above, another aspect of decentralisation reform transfer was to grant autonomy to District Health Management Teams (DHMTs) to carry out a wide range of managerial activities at the district level. The team comprises of all heads of departments at the district health office headed by the DHO. In fact the abolition of RHOs was to pave way for the decentralisation of managerial responsibilities to DHMTs. This is in line with Kernaghan’s (1994:629) observation that in management decentralisation the central issue is that “empowered public servants commonly working in teams in de-layered organizations and committed to continuous improvement, seek to provide high quality service to their clients and to the general public”. In essence, according to the EC decentralisation project concept document, the reform transfer placed emphasis on the “centrality of the district health system from both the organisational and decentralisation points of view” (Ministry of Health, EC, and British Council, 1999:6). The reasoning was that “decentralisation allows districts to develop locally appropriate health systems and to maximise involvement of local actors” (ibid). Therefore the reform was geared towards “resulting in districts having to take new responsibilities” (ibid). These ‘responsibilities’ included the “management of health facilities and health services by operational managers at district and facility levels” (Ministry of Health, 1999a:53). This is in line with the NPM doctrine of ensuring “hands on professional management” where managers are “free to manage” (Hood, 1991:5). For the decentralisation reform the hub was therefore, to “review job descriptions of the district health management team so as to give them responsibility to manage, plan and monitor the resources” (Interview with Former Principal Secretary for Health Y). This would mean a major transformation of the health service delivery as for the first time the DHMTs were to be given the responsibility to manage.

However, an analysis of the latitude of the managerial responsibilities enjoyed by the DHMTs in the decentralisation set up indicates that not much has been decentralised. Most activities are still centrally managed by the MOH central office and those that have been decentralised meet a lot of challenges and at times produce unintended consequences. This section examines these dynamics with the aid of core management functions in areas of human resources, finance, drug budget, contracting-out of non-core services and planning.
8.3.2.1. Human Resources Management Function

The first management function to be transferred to DHMTs is that of hiring and firing of medical, professional and ancillary health staff members. The aim was to give districts “greater responsibility for managing their human resources over and above the recruitment, disciplining and promotion” (Ministry of Health, 1999a:56). This would enable the district to make independent human resources decisions that are pivotal in recruiting and maintaining high quality staff members necessary for obtaining efficient and effective service delivery. However, the study found that this function is not fully decentralised. Apart from support staff (e.g. security, messengers and cleaners), the core medical and clinical personnel are still centrally recruited, promoted and disciplined at the MOH headquarters. The districts have not yet been given powers to carry out the necessary hiring, promotion and firing decisions of medical and professional staff. In fact there is a centrally controlled Health Service Commission (HSC) housed in the MOH headquarters that recruits health workers nationwide. In this regard, the first step to granting staffing autonomy to districts would be either to dissolve the HSC or reform it. However, these policy options are not even on the table of the MOH agenda thereby bringing in uncertainty on the commitment and willingness of the MOH to decentralise recruitment functions to DHMTs. The consequences of this were well articulated by one DHO who attested that

we are not fully decentralised...Things are still centralised...People are recruited at central level and just distributed to district hospitals and we just receive them. You may discuss as a disciplinary committee to make a decision but what you do is to make recommendation to the headquarters and decisions will come from there.

Another DHO concurred by adding that

health has not yet decentralised, as everything is still central. There is staff establishment, which you cannot fill; there are vacancies, which you cannot fill. We should be able to hire and fire, and we are forced to work with those that cannot work and keeping around with the deadwood floating along in the system.

In addition, the study found that even for the support staff, their recruitment and disciplining at the district level is not an automatic local autonomous managerial process. This is because the DHMT requires seeking authority from the MOH headquarters. However, in most cases such authority is not given. This only demonstrates that the MOH headquarters is not willing to pass on the managerial power and control to the districts.
Apart from the human resources management function, the decentralisation programme had also the fiscal aspect. The idea was that the “management of financial resources should be passed to the districts” (Ministry of Health, 1999a:53). In this regard, instead of financial resources being controlled by the MOH headquarters, the proposal was to let the districts manage them in line with local priorities. In this realm, finances would be sent to DHMTs through Districts Assemblies. The DHMTs would then manage and spend the money based on the local needs.

Batley and Larbi (2004:102) highlight that “managers should not only have the freedom to manage but also be allowed to manage”. However, the study found that instead of sending the financial resources to the DHMTs wholesale, the MOH headquarters ‘ring fenced’ them. In this regard, the MOH began sending the money with prepared instructions on how to use it thereby not ‘allowing them to manage’. By so doing, the MOH headquarters maintains to be the ultimate decision making machinery of financial resources which should have been decentralised. This hints on the resistance of the MOH to increase the scope of decision making at the district level in tandem with the decentralisation requirements. As the former Principal Secretary for Health (Y) hinted, this “resistance to decentralise went on for the Ministry and the only thing that we did in health and we fought for is that even though the money for health is going to districts it must be ring fenced”. It was revealed that the reasoning for this was to make sure that when the money goes to the district level, it was used for the right purpose. However, although this could be reasonable on the part of the MOH, it was against the spirit of decentralisation. To this end, the MOH was advised that it “would have gone further than having each DHO as a cost centre. It was pointed out that ring-fencing is not consistent with the concept of [decentralisation]” (Inter Ministerial Committee on Decentralisation, 2005:2). Decentralisation champions the use of money based on the priorities on the ground which implementing managers would identify with the citizens. However by ring-fencing the money the MOH effectively limited the decision making and managerial space that was supposed to be enjoyed by the district officials. In effect, therefore, this meant that the MOH was still seeking to cling to powers rather than fully transferring them to the lower levels.

16 Detailed discussion of this particular one is in section 8.3.3 below
The study particularly noted that even within the framework of ring-fencing, the distribution of resources has not been in favour of districts to which managerial responsibilities were decentralised. It was noted that from the time decentralisation was implemented in 2004/5, resources to the districts have been extremely reduced in favour of the MOH headquarters and the four central hospitals compared to the country’s 28 district hospitals. In fact the country’s districts have had their share of the health budget significantly cut from close to 60% in 2004/5 to less than 15% in the 2007/8 budget whereas the MOH headquarters allocation has dramatically increased from 20% to close to 60% and central hospitals from 20% to close to 30%. These trends are shown in the figure below.

**Figure 10. Trends in Recurrent Health Expenditure Allocations by Levels**

![Graph showing trends in recurrent health expenditure allocations by levels.](image)

**Source:** Malawi Health Equity Network (2007)

In this realm, a respondent added that “you find that more resources are given to the central government than the lower level”. Of particular mention as is seen in the figure above is that the allocations to districts begun to be reduced in 2004/5 when decentralisation begun to be implemented. This hinges on the resistance of the MOH headquarters to grant managerial autonomy as already highlighted. It is not surprising therefore, that shortage of adequate financing was repeatedly mentioned as a hindrance to effective management decentralisation during the interviews because most planned activities at the district level could not be achieved. One official particularly highlighted that

*powers and responsibilities that are decentralised are not matched with the resources provided. So there is a discrepancy. There are enormous responsibilities matched with very few resources.*
8.3.2.3. Decentralisation of drug budget Management

Another aspect of financial decentralisation is the decentralisation of the drug budget. To this end, the Ministry of Health (1999a:53) articulates that the “presently centralised drug...budget will ...be passed to the districts”. In this realm, the “DHOs will hold budgets for the purchase of drugs” (Ministry of Health, 1999a:53). This aspect requires a special analysis because it has other components of NPM in the name of internal market testing that needs further examination. Internal market testing is a way of bringing competition in the public sector through the “deployment of markets for the delivery of public services use” (Pollitt, 2003:28). The aim is to create rivalry which is “the key to lower costs and better standards” (Hood, 1991:5). Before the decentralisation reform initiative medical supplies were centrally purchased and distributed to DHOs by the MOH headquarters through its body called Central Medical Stores (CMS). However, this proved to present massive efficiency and effectiveness bottlenecks as it was not possible to satisfy all the medical requirements of the DHOs from the centre. In most cases, the CMS could not effectively obtain its mandate as it used to run out of the required supplies. In particular, due to its centralised control, there was “no systematic way of measuring demand [as] CMS simply ordered drugs based on previous consumption levels [leading] to procurement of drugs and equipment that are not needed while urgently required medicines are often not sourced” (Lawson et al 2008:12).

In this regard, the study unearthed that the decentralisation reform transfer also meant the drug budget to be decentralised so that the DHOs can purchase the medical supplies they require (see Ministry of Health, 1999a). As one Zone Officer emphasised, the “drug budget is with the districts and not at central ministry, that money is sent to the DHOs and when they order drugs to central medical stores they are supposed to pay”. In this respect, the DHOs were granted ‘freedom’ to choose whether to purchase medical equipment and supplies from CMS or private suppliers. They have also the autonomy to determine the required quantities. One DHO explained the processes at work by illustrating that “there is certain allocation of money that is for drugs and when that money comes...We have control on what drugs we have to buy and we can choose which ones are to be bought”. It was assumed that this would create the necessary competition for quality and efficiency results.

However, it was learnt through the interviews that this has not created real competition. This is because in the context of the MOH headquarters still hanging to powers and authority, the
DHOs were required to regard the CMS as their first priority for the procurement of medical supplies. In this regard, the DHOs are required to purchase from private pharmacies only if the CMS does not have such supplies. In addition, it was learnt that even in that context, the DHOs are supposed to first seek authority from CMS whenever they want to procure from private pharmacies who would in turn specify quantities that can be purchased. A Zone Officer highlighted this requirement when he argued that “when the order is not available at central medical stores, they [DHOs] were supposed to request for authority from CMS to buy from somewhere [private pharmacies] and the CMS would indicate the quantity to be bought from these private pharmacies”. This effectively hampered the necessary competition and DHO managerial autonomy that was envisaged by decentralisation transfer.

The MOH justified this as a means to protect the system from abuse by the DHOs. However, the study found that despite this ‘control’ the system is in fact being abused by DHOs so that it has only increased avenues for corruption at the local level. In particular, despite the requirement to seek permission from the CMS, the DHOs prefer to purchase from private pharmacies rather than CMS anyway. This is because the private pharmacies offer ‘commissions’ in form of kickbacks to attract DHOs to buy from them. In this regard, although the medical supplies from private pharmacies relatively cost higher, the personal ‘incentive’ that they give to DHOs makes them favourable market places. To this end, a Health Planning Officer at the MOH Headquarters hinted that

*the trouble is that this system can easily lead to corrupt practices. Because if you are the purchaser at the district level you would create deliberate situations for ensuring that you are given the weaver to buy from private guys. With CMS, prices are regulated but with private guys you can buy at any price and you can negotiate to have your commissions.*

As a Director of an NGO dealing with health equity issues concurred,

*DHOs prefer to buy from private pharmacies and not CMS even when that drug is available at CMS just because they were getting commissions from private pharmacies. The private pharmacies are very expensive but they give commissions which attract DHOs.*

It was further highlighted that the system has even created ‘incentives’ for DHOs to ‘own’ pharmacies so that they can easily indulge in the corrupt activities within and have increased benefits. The following illustration from a Health Planning Officer articulates the issues at play.
There is a lot of collusion that is happening because if I’m a DHO and I have the liberty to buy from private sector why can’t I own one private pharmacy and be a drug distributor and negotiate internally. You see, these things have happened and we are not just speculating.

However, the problem with this is that even if private pharmacies have no drugs but the CMS has, some DHOs would prefer to wait for the private pharmacies to have the stock. The Ministry of Health (2009a:11) even acknowledges that “some health facilities experience stock outs of drugs which are available at CMS”. Table 3 below is an example of district health offices with a number of days that run out of essential drugs which were however, available at the CMS.

Table 3: Essential Drug Stock in Selected Districts

<table>
<thead>
<tr>
<th>Drug supply and Medical Supplies</th>
<th>District Health Offices and stock out days</th>
<th>Chikwawa</th>
<th>Phalombe</th>
<th>Dedza</th>
<th>Nkhotakota</th>
<th>Kasungu</th>
<th>Mzimba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzyl penicillin</td>
<td></td>
<td>96</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Paracetamol tablets</td>
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<td>76</td>
<td>0</td>
<td>22</td>
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<td>0</td>
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<td>38</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>0</td>
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</tr>
<tr>
<td>Penicillin Tablets</td>
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<td>75</td>
<td>37</td>
<td>123</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
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<td>11</td>
<td>21</td>
<td>0</td>
<td>29</td>
<td>89</td>
</tr>
<tr>
<td>Depo provera</td>
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<td>0</td>
<td>0</td>
<td>28</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Diazepam injectable</td>
<td></td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Magnesium sulphate</td>
<td></td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>Ferrous sulphate</td>
<td></td>
<td>32</td>
<td>132</td>
<td>0</td>
<td>0</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Gentamycin injectable</td>
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<td>72</td>
<td>45</td>
<td>42</td>
<td>8</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Metronidazole tablets</td>
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<td>77</td>
<td>0</td>
<td>33</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Norplant</td>
<td></td>
<td>41</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>153</td>
<td>180</td>
</tr>
<tr>
<td>Surgical gloves 7.5</td>
<td></td>
<td>56</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: Ministry of Health (2008:20)

It was learnt that in most cases only when the DHOs did not have the money on hand it was when they could go to CMS. This is because it is possible to get medicines from the CMS on credit which most of times is never paid back. The problem is that this has only created huge unpaid bills making the CMS fail to effectively operate as required. On this account, a Zone Officer lamented that the “system was being abused so that we have huge bills that the districts have not yet paid to the CMS. I think the bill is at K1.8 billion per year for the whole country and some hospitals have as big as K70 million”. The ministry of health records put the current cumulative unpaid bills at K1.7 billion (Ministry of Health, 2009b).
It is on the account of these abuses and loopholes for corruption that the MOH has recently thought of recentralising the drug budget. Now DHOs no longer have the autonomy to make decisions about the purchase of medical supplies but rather the decisions are centrally made as it was in the pre-decentralisation period. As a DHO emphasised, “they [MOH] have taken back the power and authority for us to buy medicines”. A focus group discussion participant expressed that the government “reversed the decision that DHOs should buy from private because there was too much stealing”. However, as it was revealed, this was “against decentralisation…but it’s a way of controlling it [corruption]” (Interview with Director of a Health Based Civil Society Organisation). In essence, it means “you are decentralising programmes and at the same time centralising those that were already decentralised” (Interview with a District Health Officer). The MOH defended this reversal of managerial autonomy to districts in terms of the drug budget by outlining that “the fear is that there is corruption and chaos so meanwhile we keep on controlling” (Interview with MOH Principal Human Resources Management Officer). This result demonstrates the failure of internal market testing in the country environment where corruption is high. As has been examined in Chapter Five above, corruption in Malawi is prevalent and such reform transfers only opened flood gates for increased corruption rather than the promised competition which is key for efficiency and effectiveness.

8.3.2.4. Contracting out of non-core services Management

Contracting out of various functions at the district health office was one of the issues that the decentralisation programme was supposed to achieve (Malawi Government, 2001; Ministry of Health, 1999b). In particular, contracting out of non-core health services is viewed as an “inherent part of the overall decentralisation programme” (Picazo, 2002:52). The principle here is that some of the services and functions that were traditionally carried out in-house by district health facilities were to be contracted-out to external suppliers to enhance efficiency and effectiveness (see Flynn 2007; Stewart, 1993; Walsh 1995). These services include non-core hospital functions like cleaning, transport, building and ground maintenance, laundry, security, catering and mortuary (Picazo 2002). In this respect, outsourcing was seen as a way of transforming health service delivery in the context of decentralised management so that the DHOs should only be concerned with core functions to achieve higher levels of efficiency and effectiveness. However, the study found that only a few districts were contracting out their non-core services in the decentralised setting. In most cases, services that were to be contracted out were still delivered in-house while in other instances it was only a selected
few functions that are outsourced thereby not attaining the required transformations. For instance, at one district health office a member of the DHMT highlighted that “this is not happening here but we just hear that it is happening in other hospitals. So here, we operate as it was before”. At another, a focus group discussion participant illustrated that “we have started with cleaning, security and grounds but on a pilot basis and it is upon the success of these that this will be extended to other areas like kitchen and laundry”. The study unearthed various issues that underpinned non or partial implementation, most of which demonstrate the importance of contextual factors as discussed below.

8.3.2.4.1. Capacity of contractors

The first reason was to do with lack of a viable and vibrant private sector that should effectively carry out the outsourced functions at the district level. In was noted that in most cases, especially in rural districts the private sector was either unavailable or not adequately capacitated to do the job to the preferred quality. As a DHO lamented, “the challenge is that people that apply present very good paper work and when evaluating contracts you base yourself on the papers they present. You take them through all the processes...and cannot deliver”. This is because the private sector in Malawi like in most of the developing world is not well developed as they lack the necessary resources and capacities to run their facilities. Moreover, the majority of contractors are not professional enough to undertake the proposed service delivery projects to the desired standards and specifications. As Chinsinga and Dzimadzi (2001:86) also observed, “most of them are just interested in payments not necessarily in carrying out the work”. Moreover, in other instances only one supplier was available thereby making the required principle of competitive bidding unattainable. In such cases, contracting out was just as a matter of principle rather than attaining the expected quality and efficiency that is claimed to arise from competition.

8.3.2.4.2. Nature of functions

In addition, the study observed that, in areas where there was partial implementation, the nature of services constrained full contracting out. These were mainly in the areas of ambulance and mortuary services. In this regard, it was noted that despite being highly recommended for outsourcing, none of the decentralised health facilities are doing it. The respondents highlighted that by their nature, these services require direct provision for effective implementation due to their complexity arising from multidimensional issues of logistics, professionalism and equity. As one MOH Director emphasised, “there are certain
areas where it is difficult to contract out...mortuary services for example, as it can be complicated”. In agreement, a Health Planning Officer at the MOH indicated that the future of contracting out such services is very uncertain even if they were to remain centralised arguing that

\[\text{those are things that even those who were crafting them [the EC] cannot do, these things even in advanced countries, they can go to some limits. You can never advertise ambulance services even in the UK, NHS holds ambulances.}\]

8.3.2.4.3. Financing problems

Contracting out also depends on the availability of adequate public finance to purchase the services required at a most competitive bid (Flynn, 2007). However, the other contextual issue observed in this study was about problems of viable financing mechanisms to effectively administer the contractual agreements. As already highlighted above, the decentralised health facilities depend on financing from the central government treasury which has both been dwindling over the years and is mostly ring-fenced by the MOH in terms of decisions they can make and the resultant services they can purchase. However, within this ring-fencing there is no particular allocation for the contracting out function as this is assumed to be financed under the general ORT (other recurrent transactions). This is funding for all other activities that is not even enough considering the many demands available. This presents limitation on outsourcing activities as in most cases health facilities do not have enough resources with which to outsource. A DHO highlighted the issues here by articulating that

\[\text{the problem is also where to get the funds for this [contracting out]. This is because the government does not give us money for this activity...If anything you will be doing it from ORT. But the challenge with ORT is that the requested figure is slashed.}\]

This is exacerbated by the perception that contracting out is a very expensive undertaking which most DHOs cannot adequately undertake. While acknowledging the quality, efficiency and effectiveness promises that contracting out brings, respondents were of the view that it cannot adequately obtain in the context of the Malawian poor economy. It is in this respect that some DHOs did not see this option to be viable and continue with direct provision. Sentiments from a DHO were that

\[\text{it takes time for one to do the contracted work and in the long run, it becomes expensive because you are not buying direct and you have}\]
competition procedures that require some money and the whole process becomes expensive.

A Principal Hospital Administrator at one district put this in context by interrogating that

what is the objective of contracting out? One of the elements is quality and this means that the hospital will be required to pay more to the contractors. And the question is, is our economy ready? When you look at contracting out ambulance services, with what will we pay that contractor? The idea is ok, but will the economy sustain it? With the economy that we have you see that some of these things are just academic but not a reality.

The other problem was the difficulty and unreliability of financial flows. It was noted that despite not having enough finances as indicated above, the flow at which the money is disbursed to the districts is unpredictable making contractual agreements difficult to honour. This also makes would be private contractors unwilling to bid for contracts as there are uncertainties about payment times. As one director of an NGO on health issues pinpointed, “many people that supply...substances to the government face these challenges as there are irregular cash flows and so it means every supplier must really have a very strong financial base”. However, this ‘very strong financial base’ is most of the times unobtainable because as Durevall (2001:7) observes, banks in Malawi are hesitant to finance firms even after being awarded contracts by government due to delayed payments.

8.3.2.4.4. The old and new mix

For most of the services that were contracted out, the study found that this was done not as a means to attain the desired competition as set in the transfer instrument but as a way to increase staffing levels. In such cases contracted out staff have been working side by side with government permanent employees. The idea about contracting out is to rationalise health services at the district level so that management concentrates on core services rather than directly employing noncore officers in order to improve efficiency and effectiveness. This would mean retrenching the government staff that were doing these jobs and replace them with contracted staff managed by a private company. However, what is seen on the ground is that the two systems operate together. In this regard, where contracting out has been done the old government officers are still working side by side with the contracted workers. As a DHO commented, “in general where contracting out is done, they are not doing it 100% because the employees from government to do that particular work are also in the system”. Another respondent added that “the challenge is that you still have people on the payroll who are supposed to do that work”. In this realm, the study found that contracting
out was only done to beef up on the numbers of non-core staff members as the health facilities are restricted in their recruitment functions. A DHO made it clear that “the main reason why institutions do that contracting-out is because of the problem of shortage of staff”.

It must be noted that even in the context of beefing up on members of staff, retrenchments can still be possible as the additional required labour would be taken care by the contractor. However, it appears that there is a general propensity not to lay-off employees even if it means enhancing efficiency. Several contextual factors explain this. The first is to do with cultural orientation. As has been highlighted in Chapter Five above, Malawi like most African countries embraces a collective culture based of the ubuntu (being a person) African philosophy of belongingness. This permeates in organisations where employees are regarded as collective family members. There is much cohesion so that taking out a ‘family member’ in the form of redundancy arising due to contracting out becomes a very difficult decision. In addition, there is also an existence of Hofstede’s feminine culture where there is high concern and care for others with guiding proverbs like mwana wa nzako ndi wako yemwe (someone’s child is your child). In this regard, apart from the prospects of ‘loosing’ a colleague, management also considers the future welfare of the retrenched workers. In most cases, the non-core staff members, most of whom are unskilled (e.g. guards, cleaners) find it hard to get the next job in the country where, like in most developing countries, unemployment is very high. The reaction from a Zone Supervisor brought this issue to light as he articulated that

for me it is a good idea but the question would be about what to do with the government people that were previously doing the job. Are we going to lay them off? Or will they be assisting these people [contractors], if they will assist these people [contractors] why are we contracting out? If these people will be given some other job to do then I would support that so that we can concentrate on core services.

A Hospital Administrator concurred that

we have partly contracted security service to guard houses for senior staff. We have not done contracting at offices because we have Government security guards and contracting out will mean firing them. Moreover, for the employee, the future is uncertain when you fire them, so firing them may indicate that you are not being humane.

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17 see discussion on human resources decentralisation section 8.3.2.1. above
The second problem hinges on financial implications in terms of payments of terminal benefits to retrenched staff. Laid-off non-core employees that give way for the establishment of outsourcing regimes, require severance payments. However, the study noted that lack of funds to compensate retrenched staff pose a challenge. This is in the context of persistent financial problems that DHOs face as has already been highlighted above. The complexities in this respect were highlighted by a Hospital Administrator who indicated that

\[\text{this is a tough decision as we do not have money to give them as benefits when we fire them. This is a problem because we are even failing to pay our direct employees in time because we do not have a very good revenue base...We can do away with them but there are implications.}\]

8.3.2.4.5. Managerial capacity

Contracting out requires the presence of certain skills such as negotiation, accounting, information systems and monitoring without direct supervision (Flynn, 2007). Malawi has capacity problems at the district level in this regard. Although the EC decentralisation project advisors carried out capacity building activities at the district level in some of these aspects as highlighted in Chapter Seven above, it was not enough to effectively institutionalise these critical management processes. This is also affected by managerial turnover and lack of the required personnel to do the job. For instance, the MOH has only 50% of its administrative vacancies filled and has only 11% of planning staff most whom are stationed at the headquarters and not districts (Ministry of Health, 2008). However, it is the district administrators and planning officers that are supposed to make managerial decisions about contracting out at district level in liaison with DHOs. Their absence therefore raises concerns on district’s ability to effectively fulfil this function. The following concerns from a DHO illustrate these issues.

\[\text{the first challenge is on continuous monitoring, as there is need for continuous monitoring of the contractors. You also need to set out criteria [performance benchmarks] that have to be met every month if you have to pay them. The administration has very few people on the ground so it is a challenge to make sure that the set areas; the checklist has been completed to mandate payment.}\]

It must be emphasised that the issue of capacity at the local level is not only in the areas of contracting out but cuts across all managerial and technical arenas. As Larbi (1998) observes, adequate technical, policy, planning, professional and managerial capacities must exist at both headquarters and devolved units in order for them to carry out tasks effectively.
However, the MOH as a whole and the district health offices to which power is decentralised have an acute unavailability of the requisite human resources to carry out the decentralised responsibilities effectively thereby adversely affecting the transformation process. This problem is so much that at one site it was observed that “certain programmes are not fully implemented because they have no specific programme managers or else someone is heading two programmes hence finding problems in coordinating the programmes” (Mzimba DHO, 2008). Figure below shows the extent of the vacancy rate of key health personnel in the MOH. As has already been highlighted, most of the available managerial and administrative staff shown in the figure are based at the MOH headquarters rather than the districts. Because it is a cross cutting problem, capacity challenge pose a threat to the whole decentralisation project.

Figure 11. Vacancy Rate in the Ministry of Health

![Vacancy Rate in the Ministry of Health](image)

Source: Ministry of Health (2008)

In addition, the study found that, the capacity problem is not only in terms of quantity but also quality. Some of the few available personnel do not possess the required skills to adequately carry out the decentralised management functions they are supposed to. An interview with a former MOH administrator brought out the managerial skill challenges at the local level as follows.
The districts have not achieved the intended objectives because of management problems. You have the DHO and doctors that have no experience in managing public health systems. You have administrators - that group is so terrible - most of them have not been trained but they are given the whole purse of health. Now their priorities are something else. The accountants are the same. They are seconded to the ministry, they go to the districts, they are from the accountant general, and their priorities are something else. Now when they come into contact with administrators who do not know what is supposed to be done and with DHOs who do not have experience, then they run a very difficult dance... These are real things that are happening.

Unfortunately, instead of beefing up this lack of capacity for effective delivery at the district level, the MOH headquarters celebrates on this as a justification for their persistence in holding on to authority which was supposed to be decentralised. In the context of the general resistance by the MOH to decentralise managerial authority to districts, their lack of capacity in these key managerial aspects is regarded as an apparent way to justify the resistance. A Central Hospital Director was of the view that the “MOH central level is failing to relinquish some of the responsibilities because...they do not see capacity in the decentralised system therefore they hold on”. In agreement, a Principal Human Resources Management Officer at the MOH outlined that the “fear is that there will be chaos due to lack of capacity, so we still control”. However, in the context that human resources function is not fully decentralised as articulated above, the qualitative and quantitative lack of the required personnel at the district level should be blamed on MOH as it is the recruiting authority through the HSC. In this regard, it can be argued that, bearing in mind the resistance to the decentralisation project, lack of capacity at the district level is a deliberate attempt by the MOH to stifle the decentralisation movement. In fact an administrator at a DHO alluded to this issue by pointing out that

*the problem is that of capacity building. Since we are just developing the system...we are still facing some challenges...It seems that our top management at the headquarters are not for this, to give us this opportunity and support us.*

### 8.3.2.4.6. Governance challenges

Apart from the issue of management capacity challenges or because of it, contracting out has presented governance challenges at the district level. In this regard, unintended consequences of corruption and mismanagement in contract and procurement processes at the district level have been prevalent. Instead of working as a mechanism of instituting competitive tendering
that would be used to achieve quality and efficiency, contracting out has only created a window for increased corruption activities. In particular, it was found that lack of following proper procurement procedures, bribery, and collusion are common in contracting out processes. Some of the specific cases in this regard are provided in table 4 below.

Table 4: Cases of Mis-procurement / Corruption

<table>
<thead>
<tr>
<th>Procuring Entity</th>
<th>Malpractice reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kasungu DHO</td>
<td>Supply of cement awarded to Shaikh Enterprise. Indications that procurement was done without following procedure. Paper work done after goods were procured</td>
</tr>
<tr>
<td>Ntchisi DHO</td>
<td>Quotation for the contract awarded to Modern Driving School (K502,500) does not tally with payment made (K516,000)</td>
</tr>
<tr>
<td>Rumphi DHO</td>
<td>Procurement committee minutes in respect to the procurement of 1 Toshiba laptop awarded to Computer Connections dated one day after LPO suggesting decision to procure was made outside the committee meeting</td>
</tr>
<tr>
<td>Mangochi DHO</td>
<td>Contract awarded to A&amp;B General Dealers for cleaning materials. 1. Amount approved by IPC different from LPO 2. Names of companies who provided quotations different from what is on file</td>
</tr>
<tr>
<td>All DHOs</td>
<td>Collusion</td>
</tr>
<tr>
<td>All DHOs</td>
<td>Record keeping, filling and missing documents</td>
</tr>
<tr>
<td>All DHOs</td>
<td>Advance payment to suppliers</td>
</tr>
<tr>
<td>All DHOs</td>
<td>Contract slicing</td>
</tr>
<tr>
<td>All DHOs</td>
<td>Wrong use of procurement method, non issuance of acceptance reports, poor contact administration and failure to obtain approvals</td>
</tr>
</tbody>
</table>

Source: Adapted from Ministry of Health (2009a)

In some cases, the problems of governance have been so huge that management has decided to stop contracting out all together to avoid institutionalising such practices. In these cases, collusion and bribery have permeated the contracting out decision-making machinery to the extent that administrators have been supplying the goods and services rather than the private entities. In these instances, the bidding process is just a formalisation endeavour to award themselves to contracts. An interview with a DHO at one site alluded to the fact that contracting out is not done here. At one time, we tried to contract out in terms of the grounds work and cleaning. But we had many problems and our experience is that this has caused problems and we are better off with our permanent staff.

Although the DHO was not ready to pinpoint the ‘many problems’, two of the focus group discussion participants at the same location outlined them. Participant A indicated that
it happened here; some people were working on the grounds and cleaning. Someone was given a contract. The problem is that people are crafty, they can create a company. For example, the one who won the contract is Mrs X, Human Resources Management Officer’s wife. The Human Resources Management Officer manoeuvred and gave the contract to his wife. But it did not last long.

Participant B hinted that “sometimes what happens is that managers would have contracts in the name of their relatives that are their own”.

It must be highlighted that contracting out as a manifestation of local managerial autonomy, is not the cause of corruption per se, but rather it opens up an avenue for increased corruption. As has already been articulated above, corruption in Malawi is high and the health sector is not spared. In this regard, the problem of governance is not only in contracting out endeavours but also permeates the whole decentralised health system so that managerial freedoms at the local level, like contracting out, only create more opportunities for increased corruption. To this end, an interview with one official highlighted that

although we have no proof, corruption is very high. For example you hear that there are plans to build a health centre...you find that as soon as the building finishes the DHO is also finishing building his house or buying a house. Although there is no evidence and you do not catch him, it speaks volumes that, ‘why did he not build all this time’. Kickbacks are high where some people falsify documents, delivery notes so that they can have some of the resources. Drug pilferage is also high. You will find that in government hospitals there are no drugs but government labelled drugs are found in private hospitals. So issues of corruption are high.

In fact the former Principal Secretary for Health (X) attested this by highlighting that “there is always a little pilferage that takes place [at the MOH]”.

Focus group discussions also corroborated this as one participant underscored that “theft of drugs is very high. Yes we steal drugs because we are not paid highly. We must be honest. You cannot let your children suffer or die, or sleep without food”.

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18 All, government drugs, where possible, are labelled MG (for Malawi Government)
8.3.2.4. The Planning Function

The final measure of managerial autonomy is the extent to which the DHMTs carry out the planning function. To this end, the decentralisation reform requires districts to “identify their own needs and develop five year plans” (Ministry of Health, 1999b:53; see also Ministry of Health, 2007). The rationale is that “district planning functions will give districts...a tool to identify their needs and design a responsible programme of work addressing their specific needs” (Ministry of Health, 1999b:91). This is a key function in the context of ‘letting managers manage’ as the planning function feeds to all the managerial activities discussed above. It lays the foundation for the whole management function. In fact the general justification for the decentralisation reform transfer was to enable management to plan its activities so that they can effectively and efficiently be implemented. As a former Principal Secretary for Health (Y) articulated, before decentralisation it was seen that the district health office “can’t plan, it can’t monitor and everything was planned by MOH Headquarters. So decentralisation was one way of making sure that districts had the capacity to plan, monitor and implement their activities”. The reasoning is that the DHMTs since they are on the ground will make plans that reflect local needs thereby attaining effective results.

However, the findings of this study were that this managerial function is not effectively carried out because of a number of contextual reasons most of which point to the issues highlighted above. In the first place, planning at the local level is adversely affected as managers have no or little power on most of the issues they plan for. This is because of the limitations on managerial autonomy on a number of activities as already articulated above. With the ‘ring fencing’ of financial resources, the only money they can plan on is that under other recurrent transactions (ORT) which is very meagre. Moreover, although they had the autonomy to decide on what drugs to buy, planning in-terms of budgeting and allocation was centrally done by the MOH based on past utilisation rates and population levels. In addition, in terms of Human Resources (as highlighted above) district level managers have not yet been given the authority to recruit and as a result this makes the planning function in this regard to be reduced to a centrally managed payroll activity.

Moreover, even within this limited planning environment, the study found that lack of adequate finances means that effective planning is unattainable. The DHMTs may make plans to carry out activities accordingly but they are very much limited due to financial constraints. In this respect, a DHO hinted that
it becomes difficult when money is small. You know there are so many programs but you cannot run. It is good that we can plan, but then the resources are not enough so that we can do what we may want to in a given situation.

In the same regard, views from a focus group participant at one site were that “unfortunately it is not always that the plan document is followed because you may find that you can plan for 10 activities and if you implement 2 of them you are lucky”.

Apart from financial constraints, there is the problem of skilled personnel as has already been outlined above. As figure 11 above highlights, the MOH has only 11 percent of its planning positions filled most of whom are based at the central office. In fact in all the district health offices visited, there were no skilled planning officers available. Because of this, the strategic importance of the planning function at the district level is not appreciated so that the plans are more of routine instruments for getting money rather than a tool for exercising the other managerial functions. In this respect, a former MOH administrator observed that “currently planning has just become a routine factor of getting money”.

8.3.3. DEVOLVING POLITICAL ACCOUNTABILITY OVERSIGHT TO THE LOCAL GOVERNMENT ASSEMBLIES

The last aspect of the decentralisation reform transfer was devolving the political oversight of the district health system to an elected local government. To this end, the DHMTs were to be “accountable directly to the District Assemblies for decisions on financial management, planning and expenditures” (Ministry of Health 2004:18; see also Ministry of Health 1999a & 1999b). The concept was that while having some internal managerial autonomy as highlighted above, DHOs should be politically accountable to an elected district assembly. This was to ensure that managers truly make decisions that represent the local needs. This particular aspect connotes political decentralisation (McCourt, 2008; Pollitt et al, 1998). Although some authors argue that political decentralisation is a “key element of NPM-type reforms” because it enhances popular participation required for accountable and legitimate governance (Hope, 2002; Hope and Chikulo, 2000), the consensus is that it is not an element of NPM (Levy 2002; Scott, 1996; Polidano 2001; Larbi and Batley 2004; Pollitt 2005 and McCourt, 2008). This is due to its emphasis on political rather than managerial imperatives.
Since this study is mainly about NPM type policy transfer, this aspect would not qualify as a subject of analysis. However, it is discussed here as the case of Malawi demonstrates the discrepancy that may exist between the intentions or contents of the reform transfer and what is actually implemented on the ground thereby highlighting the importance of context. Moreover, as Elcock and Minogue (2001) propound, “NPM reforms must always be evaluated within...the political context of their operation”. Additionally, as Pollitt (2000:194) tells us, “systems improvements...are not to be judged on the basis of the success or failure of a single project, programme or policy but rather in a more holistic way”.

In this respect, the study found that the other intention of the decentralisation reform programme was that the DHOs despite being managerially free as analysed above, should be accountable to an elected district assembly. This was in line with the ongoing UNDP pushed political decentralisation programme as discussed in Chapter Seven above. The aim was to ensure increased accountability and participation so that within their freedom to manage, managers should make decisions that truly reflect the needs of the local people. However, when the implementation of the EU health decentralisation reform intervention begun in early 2005, the term of office of local political leaders (councillors), to whom the DHOs would be accountable had just expired (in March 2005). The councillors have not been elected up to now (December 2010), a situation which has disabled the realisation of the political accountability aspect of the health decentralisation transfer. Although the apparent explanations for this are economical, the real ones are political. The economical excuses do not hold because donors have many a time expressed interest in funding the elections should the government come up with an electoral calendar which it has not been committed to. In fact with pressure from donors, the government allocated money for local elections in the 2007 budget only to be diverted to alternative uses in the mid-year budget review (Chingsinga 2008). Against this background, the actual reasons for this non commitment to having viable local government in place are mostly owing to the backdrop of the problems President Mutharika’s minority government was having as highlighted above. Since the DPP was as a result of President Mutharika’s ditching of the UDF, the party that sponsored his election, it did not have grassroots structures. The UDF was very powerful and it had its grip and sympathy among the local populace. Therefore, Mutharika was afraid that the DPP would not

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19 The first set of councillors was elected in 2000 and their term of office ended in March 2005. There was supposed to be an election at this time to replace them. However, this has not been done up to now. The health sector decentralisation programme has therefore been in place in the absence of the political leaders.
gain a sizeable number of local seats, a situation that would undermine his legitimacy. Moreover, the UDF winning the local elections would undermine Mutharika’s regime as it would create an alternative centre of power at the local level that would work to advance its ends. Obviously, the UDF would use its local level grip as buffer-zone for the next general elections which the DPP was not prepared to lose. It is along this line of thought that Cammack et al (2007:8) observe that “logic behind centralising...political power was strong, as was the fear of creating alternative seats of power for opposition politicians to exploit”.

Moreover, the politics of the minority government in parliament did not create a conducive environment for holding the local elections generally. As already stated, the minority government has been having difficulties in conducting business in parliament including on programs central for the effective operation of local governance system. For instance, there was a prolonged battle over the election of electoral commissioners between the parliament and the executive which derailed plans for local elections. Here Mutharika unilaterally appointed electoral commissioners who were disapproved by the opposition parties. The opposition defended their action by arguing that the President appointed the electoral commissioners without consulting them (Nation on Sunday 25 March, 2007). In addition, the other issue was the failure to pass the amendment bill that would give new dates for holding local election. Because of the souring relationship between the executive and parliament, the bill could not be passed thereby effectively barring the holding of elections. To this end, the Electoral Commission Chairperson Justice Anastasia Msosa announced that local elections will only be held “if the piece of legislation will be in place” (quoted in Nation on Sunday 25 March, 2007). However, as it was a minority government, the bill could not be discussed. Moreover, parliament had in many a time been disrupted because the opposition members sought for the invocation of Section 65 of the constitution for the MPs that defected to the government side to lose their seats. Since the government could not afford to lose these MPs, the President protected them by proroguing parliament which affected the discussion of the amendment bill and the national budget which could finance the elections.

It must also be noted that on their part, members of parliament including those from the opposition parties did not want the councillors to be in place. Therefore, even within this political quagmire on the part of the government, there have not been tangible demands from the opposition party MPs for the local elections. This is the case as when the councillors...
were in place, their relationship with the MPs was conflictual (Chinsinga, 2008; Chiweza, 2007). The MPs regarded councillors as a threat to their position since they were the ones in contact with the local population. Most MPs dwell in towns and are not in touch with the masses and therefore they “perceived councillors as a threat to their candidacy in the subsequent general elections” (Chinsinga, 2008:88). Moreover, the councillors even regarded their position as a stepping-stone to being an MP as becoming a Member of Parliament is regarded as more prestigious and rewarding than being a councillor. Thus personal political calculations and interests on the part of MPs have made them not to be a cooperating party in the quest for the revival of local governance in the country.

8.3.3.1. Implications of the Failure Of Political Decentralisation on The Health Sector Management Decentralisation Policy Transfer

McCourt and Gulrajani (2010:85) elucidate that “management [interventions] must embrace politics...especially in order to understand how propitious conditions for effective administration can be created in situations where they are currently absent”. To this end, the failure of political decentralisation has had implications on the health sector management decentralisation reforms. This is the case as within the timeframe under investigation, the appointed managers and administrators at the local assemblies have continued to manage without the councillors who are pivotal for the attainment of the political ends. In this realm, the absence of councillors has removed the ‘politicalness’ of the district assemblies as it has strengthened the managerial aspects. This means that the political functions that the district assemblies were supposed to provide to DHOs within the context of the policy transfer, have been disabled. By default therefore, the absence of councillors makes the whole District Assembly an administrative structure rather than the envisaged political instrument for accountability in service delivery. Interviews with various managers at different District Assemblies demonstrate the extent to which assemblies have been robbed of their political clout which the health decentralisation program was to capitalise on. The views were that,

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20 Constitutionally, local governments (District Assemblies) are composed of the political wing comprising elected councillors, and management wing consisting of administrative personnel (Secretariat). The Secretariat is subordinate to councillors to execute and administer the lawful resolutions and policies of those councillors. The management wing is headed by a district commissioner in the case of district and municipal assemblies, and a chief executive in the cases of city and town assemblies.
since the owners of the assembly are councillors, their absence means that we are operating illegally and all these are illegal arrangements (Interview a Director of Administration).

because we do not have councillors, everything that is taking place is illegal. Legally according to the Local Government Act, councillors are the Assembly and without them, we cannot operate (Interview with a District Commissioner).

we are really handicapped in the political arm, and the assembly lacks checks and balances in the absence of councillors (Interview with a Human Resources Officer).

the absence of local politicians (councillors) is affecting the processes. Councillors have an impact in terms of monitoring, transparency and accountability ...to rightly deliver the services” (Interview with a Director of Finance at a District Assembly).

The study found that against this backdrop, the original reform intentions of making the DHOs accountable to the elected local government have not been attained thereby strengthening the managerial aspect of the reform at the level of district health office. At best, the District Assembly only acts as a channel for finances to the DHOs. However, this remains an administrative arrangement for fulfilling legal requirements only as highlighted in the Local Government Act rather than a means to attain the required political accountability. Moreover, the managers at the District Assembly do not administratively hold the DHOs accountable for the financial resources but only act as channels for the same. As a participant at one of the focus group discussions outlined, “on the money part, the District Commissioners’ office is just a new path through which this money now is going but it has no real powers in terms of control”

This is exacerbated by the fact that the DHOs do not regard the District Assembly as a critical institution for discharging their duties as compared to the MOH headquarters. The DHO has a line ministry which is the MOH and respect is paid more to the MOH than the District Commissioner (DC) as far as reporting on various activities is concerned. In addition, programs have coordinators, programme managers, or directors at the MOH headquarters. Coordinators and programme officers at district level (DHO) have to follow that line of reporting. The DC therefore is not considered as an important figure to report to unless a deliberate emphasis is made. This makes the DC lose grip of what is happening. Moreover, the study noted that in most cases the DHO is more senior in terms of grade (scale) than the
DC. In fact the DC was said to be “way behind both in terms of remuneration and even grade or ranking in government, he is not even responsible for DHOs discipline or promotion” (Interview with GTZ Official). In a culture that is highly hierarchical fused with neopatrimonial politics where centres of power and control are seen as points for disbursement of organisational rewards and punishment, the DC is in most cases left out of the equation of health service delivery. In this regard, the DHOs report to MOH headquarters on all matters including those that should have gone to the District Assembly for accountability purposes. A DHO for example attested that “in most times we concentrate on the line ministry (MOH) because they push you and you know if you do not report something is not going to happen. So much concentration is on MOH and then the Zone”.

A GTZ Officer had this to say “you find that what is given precedence is what comes from one’s boss as this will affect their job – that is what is given priority as compared to decentralisation lines per se”.

In a memo, the Chief Executive Officer of Zomba Assembly (2009:2) complained that “each sector tends to cling to its own resources and the Chief Executive of the assembly has no say”.

Minutes of a meeting from another Assembly read,

there are many Health Surveillance Assistants (HSAs) at the Mzuzu Health Centre supposed to be doing Environmental Health work in the City of Mzuzu. The Mzuzu City Assembly does not receive any reports of work from these HSAs and yet it has a fully fledged Environmental Health Department that could provide technical supervision of these HSAs but lacks mandate as the DHO simply posts them to Mzuzu Health Centre without communicating with Mzuzu City Assembly (Mzuzu City Assembly and Mzimba DHO, 2008).

In conclusion, although not an aspect of NPM, the study could not afford to give a blind eye to the political aspect of the management decentralisation programme because of the contextual issues that potentially increased the managerial realm. In this regard, although the management decentralisation design was to make DHOs to be politically accountable to an elected District Assembly, the absence of the political leaders meant that the whole arrangement is administrative rather than political. In fact the absence of councillors potentially increases DHOs managerial autonomy championed by the management
decentralisation without any political accountability and control. This is akin to Ferguson’s (1990:21) “anti-politics machine” where, as has been seen in this study,

outcomes that at first appear as mere side effects of an unsuccessful attempt to engineer [political] transformation become legible in other perspectives as unintended yet instrumental elements in a resultant constellation that has the effect of expanding the exercise of a particular sort of state power while simultaneously exerting a powerful depoliticizing effect.

In this regard, the failure of political decentralisation insulates the health management decentralisation reform from becoming an apparatus for increased political accountability in service delivery as per the aims of the transfer, but makes it a “machine for reinforcing and expanding the exercise of bureaucratic state power” (ibid:255) which incidentally takes political aims as its entry point.

8.3.4. DEVELOPMENT OF NEW CULTURE, IDEOLOGY AND ORGANISATIONAL MEANING

In analysing public management reforms, organisational culture is regarded as “both an external phenomenon that is not susceptible to management-induced change and as an internal variable that managers can manage and therefore change” (Hookana, 2008:310; see also Flynn 2002). The later formulation means that public sector reform institutionalisation should be reflected in the change of organisational culture. In this way, Ferlie et al (1996) postulate change in organisational culture to align with that characterised by the proposed reform as one of the indicators of the reform in successfully transforming the public sector. In the context of NPM, increased managerial discretion that ushers in business-oriented culture is expected to replace hierarchical and centralised cultures that characterised the traditional public administration era (Ferlie et al, 1996; Van Der Wal et al, 2008; Kernaghan, 1994; Lonti, 2005). It was for this reason that the study analysed the extent to which the management decentralisation reforms have led to the development of a new culture that is akin to such reforms. Here the study adopts Ferlie et al’s (1996) broader formulation of organisational culture that considers patterns of meaning and the cognitive frameworks in use, mindsets and values of organisational members because effective transformation can only be characterised by the change of these cognitive elements.
The study found that the decentralisation reform transfer has not led to the desired change in people’s mindset for them to adhere to the new way of working. Most managers at the local level saw no change in the underlying belief system. The feeling was that although decentralised management was in operation, managers at both the local and central government levels did not change their orientation to adhere to the new way of operating. For example, a former MOH official underscored that “we have not reached a point where we are dictated by the real needs of the public in terms of what health interventions should we do. So you find the same old pattern of service delivery”.

A Principal Administrator at a DHO echoed that “we have inefficiencies where some people have the hangovers of the past...So it is a confused thing. It’s not because of the system but the mentality of the people we are still having the past mentality”.

There are several reasons that account for this. Firstly, as has been seen above, the rate of application has been modest, with reversals, reproductions, high levels of resistance, unintended consequences, and challenges. These have made it difficult for the institutionalisation of the decentralisation reforms within MOH thereby failing to bring the desired changes to the organisational culture. This is in line with Kernaghan’s (1994:629) observation that “features of the emerging public service culture will depend heavily on the extent to which this new model, with its new values, is implemented in public organisations”.

There was a general feeling that the reform had not been adequately implemented and as a result, it would be expecting too much to have a change in organisational culture in that regard. The following responses were frequently coming out from the participants at all levels demonstrating the extent to which management decentralisation has been applied.

-Decentralisation is there but not implemented, it’s just on paper (FGD participant at site X).

-No. For me it’s the same. Things have not changed with decentralisation. It is only the fiscal part where money comes though the DC but everything is the same. The process is as it was (FGD participant at site Q).

-I think we are not fully decentralised...things are still centralised (Interview with a DHO).

-You find the central level failing to relinquish some of the responsibilities (Interview with a MOH Director).
On paper, you find that it is stated that things are to be done in particular way but in reality some areas are operating the way they were (Interview with GTZ [donor organisation] Official).

Decentralisation is on paper but in practice their hands are tied (Interview with an NGO official).

The study also observed that the other problem is that the lower level staff (‘street level bureaucrats’) who are at the centre stage of service delivery were not involved in most of the decentralisation reform initiatives. Most of them do not have any knowledge about the reforms being implemented. It was learnt that at the district level, the reform initiatives only concentrated on the District Health Officer and his or her DHMT and not the service deliverer who are central if organisational culture is to align with the dictates of the decentralisation reforms. These were left out of the picture and as a result, the institutionalisation of the reforms ethos into the organisational infrastructure at the lower level has been problematic. It is because of this non involvement that staff members at this level therefore do not have a “shared sense of corporate culture, leadership, purpose, and direction of the public service” (Lonti, 2005:125) which is required for the necessary organisational cultural change in the context of the NPM reforms. Focus group discussions with street level bureaucrats revealed this. One participant indicated that

at our level, we are not very conversant about decentralisation...To say that we know about decentralisation we will be lying to you. For us junior staff, we are not told anything...we just see things taking place but we are not involved...We just hear that there is decentralisation but we do not know what it is all about. These policies are only concerned with top management and it ends there, we are not benefiting.

Another FGD participant observed that

we just work with the patients. But it’s the District Health Management Team (DHMT) that knows what is happening. Unless you are a coordinator of a programme, you could know because your money may delay because it has to go through the DCs office and that is how you could learn about decentralisation.

Yet another FGD participant illustrated that

we implement things through decentralisation but because of people not telling us what is happening, we are not aware of it. But we are working through the decentralised system. We are implementing things within the decentralised system but we do not know that it is decentralisation.
This is exacerbated by the fact that the DHOs themselves are not willing to pass on authority to lower levels of management. The existence of the past centralised mentality is even seen among the DHOs who would be unwilling themselves to allow officers in Health Centres that are under them to exercise some degree of discretion in decision-making. The DHOs are themselves not flexible and have a bureaucratic culture that is not in line with the flexible service delivery mechanism that was supposed to ensue in a decentralised environment. An out-standing example is the case of a DHO who would want to make all the decisions about donations to be received by Health Centres that are under him despite the acute need that exists in such facilities and bureaucratic bottlenecks that may put away potential donors. Although procedurally he is supposed to be informed about such donations, the DHO prefers a bureaucratic approach in handling such issues that is not in line with the spirit of decentralisation where emphasis is put on a “shift from extensive regulation and compliance management to increased discretion and initiative for operating managers in achieving targets” (Lonti, 2005:122). In his memo to all managers of Health Centres under his jurisdiction, the DHO emphasised that

it has been observed that Officer in Charge in some of the Health Centres receives donations without seeking authority from the DHO. Now let me emphasise that no one should receive donations without prior authority from the DHO (Mzimba DHO, 2009:1).

In a letter directly addressed to the manager concerned, the DHO expressed that

it is learnt that you received some donations without seeking authority from the DHO...You are immediately requested to return all the items delivered at the Health Centre, and request the donor to formally contact the District Health Office first in writing (Mzimba DHO, 2009:1).

Third, is the strength of the prevailing national cultural background within which the management decentralisation reform was implemented. As Flynn (2002:71) observes, if “management changes go against the flow of...[cultural] characteristics they are less likely to be successful than if they go with the cultural flow”. Even countrywide, it seems that people’s mindset is still geared towards centralised arrangements. The study found that Malawians’ cognitive frame about public organisations has been characterised by the centralised mode of service delivery. Within the largely collectivism and large power distance cultural background that exists, the central government has carried a ‘fatherly
figure’ and has been seen as a focal point of service delivery. As a result, even within the realm of decentralisation reforms, citizens have preference of centrally controlled management of service delivery rather than decentralised ones. An Afro Barometer study conducted in 2008 randomly selected citizens were asked who they thought had primary responsibility for managing health clinics among central government, local government, traditional leaders or members of the community. As can be seen in the figure 12 below, the results were overwhelmingly in favour of central government management. It is interesting to note that this trend cuts across urban/ rural and gender divides and was not only limited to health clinics but also schools as it illustrated in figure 13 below.

**Figure 12. Who Do You Think Actually has Primary Responsibility for Managing Health Clinics**

![Bar chart showing the preference for primary responsibility for managing health clinics among central government, local government, traditional leaders or members of the community. The results were overwhelmingly in favour of central government management.](image)

**Source:** Figure is the Author’s formulation using Afro barometer survey 2008 data
Figure 13. Who Do you think Actually Has Primary Responsibility for Managing Schools

Source: Figure is the Author’s formulation using Afro barometer survey 2008 data

8.4. DECENTRALISATION AND HOSPITAL AUTONOMY POLICY TRANSFER AND POLICY MAKING PROCESS LINKAGES

The study findings reveal that the policy transfer case studies under investigation are complex so that at one level there are coercive elements where external donor agents introduced the reforms to Malawi’s policy agenda through conditionality as discussed in Chapter Six while at another there were voluntary attributes in terms of the decisions for the actual acceptance of reforms for implementation as depicted in Chapter Seven. Therefore, to adequately understand the dynamics at play and to provide the necessary link with implementation feedback issues outlined in this Chapter, there is need to provide a linkage between the policy process stages and policy transfer processes. As has been already highlighted in Chapter Two above, the understanding of the nexus between policy transfer processes and policy making stages is critical in unveiling the nature of policy transfer changes at different stages of policy making processes (see Dolowitz and Marsh, 2000). The table below provides the linkage through the use of policy processes accounts outlined by Hill (2009) and Bebbington and McCourt’s (2007) political model of policy making.
Table 5. Policy Making and Transfer Processes Linkages

<table>
<thead>
<tr>
<th>POLICY PROCESS STAGES</th>
<th>POLICY TRANSFER PROCESSES OF MALAWI HEALTH SECTOR REFORMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Autonomy</td>
<td>Globalisation of NPM, Democratisation in Malawi</td>
</tr>
<tr>
<td>Decentralisation</td>
<td>Globalisation of NPM, Democratisation in Malawi</td>
</tr>
<tr>
<td>Agenda setting</td>
<td>Social Energy</td>
</tr>
<tr>
<td>Policy Idea</td>
<td>Hospital autonomy</td>
</tr>
<tr>
<td></td>
<td>Decentralisation</td>
</tr>
<tr>
<td>Coalition</td>
<td>World Bank (1993) and International agreement of hospital autonomy (NPM)</td>
</tr>
<tr>
<td></td>
<td>World Bank (1993) and International agreement of decentralisation (NPM)</td>
</tr>
<tr>
<td>Leader</td>
<td>USAID brought it to the policy agenda through aid conditionalities (more coercive means)</td>
</tr>
<tr>
<td></td>
<td>EU brought it to the policy agenda through aid conditionalities (more coercive means)</td>
</tr>
<tr>
<td>Policy formulation</td>
<td>Institutionalisation</td>
</tr>
<tr>
<td></td>
<td>Voluntarily rejected by cabinet, not implemented and institutionalisation failed (due to opposition arising from unfavourable contextual factors)</td>
</tr>
<tr>
<td></td>
<td>Voluntarily accepted and implemented (due ability to align with contextual factors that and overcame bureaucratic opposition)</td>
</tr>
<tr>
<td>Implementation and evaluation</td>
<td>Feedback</td>
</tr>
<tr>
<td></td>
<td>‘abortive’ transfer outcome</td>
</tr>
<tr>
<td></td>
<td>Intended transformational goals not achieved due to reversals, reproductions, unintended consequences and implementation challenges.</td>
</tr>
</tbody>
</table>

**Source:** The Author with aid of Hill (2009), and Bebbington and McCourt (2007)

Dolowitz and Marsh (2000) tell us that policy transfer can take place at any stage in the policy transfer process. However, Smith (2004:80) observes that “policy transfer ends at some point and domestic policy processes take over”. More specifically, Stone (1999:56) asks “at what point does policy transfer end in practice?”. The findings of this study reveal that for the two reforms under investigation, policy transfer was concentrated at policy initiation and agenda setting stages after which the domestic processes took over. As can be seen in the table above, at the initiation stage hospital autonomy and decentralisation reforms made it to the ‘policy stream’ through the help of international donor organisations. The existence of ‘social energy’ in the form of the ‘globalisation of NPM’ on the basis of which these reforms are spread worldwide and the democratisation processes taking place in Malawi which ended the reign on Hastings Banda’s inward policy orientation opened up a ‘window of opportunity’ for the transfer of these reforms. The World Bank (1993) report that highlighted that countries would be eligible for aid if they implemented the reforms and
imploring donor organisations to assist countries that are eager to implement these reforms is seen as a way of building a ‘coalition’ for the reforms. It is through this that in the case of hospital autonomy USAID came up as a ‘leader’ or ‘policy entrepreneur’ to facilitate the introduction of the reform on Malawi’s policy agenda through NPA aid conditionalities. For the decentralisation reform, the ‘coalition’ threw up the European Commission that was instrumental in introducing the reform to Malawi’s policy agenda through aid conditionalities as espoused by the Lome IV Convention institutional framework.

Once USAID and EC transferred these reforms to the country’s policy agenda, domestic policy making process took over. Although the reforms were brought to the policy agenda through conditionality means, the Malawian political elites had to decide which reforms were acceptable at the policy formulation stage. The case of hospital autonomy reform was an instance of failed transfer because it was not ‘institutionalised’ for the necessary implementation as the Cabinet rejected it due to the prevailing contextual environment articulated in Chapter Seven above, which acted as “threat to success” (Bebbington and McCourt, 2007). The outcome here is what Bulmer, Dolowitz, Humphreys and Padgett (2007:17) refer to as ‘abortive’ because the “putative transfer” of hospital autonomy reforms was “blocked by veto players” in Malawi at the policy decision stage. Thus although the policy was introduced on the policy agenda through conditionality thereby tilting towards the coercive variant of policy transfer, the Cabinet exercised autonomy at the policy formulation stage in rejecting it. The same mechanisms applied to the decentralisation reform. However, due to favourable political and institutional contextual factors and the success that the donors leading the decentralisation reform had in overcoming bureaucratic opposition, it successfully passed through the decision stage and was institutionalised into the “formal structure” (see McCourt forthcoming).

According to Dolowitz and Marsh (2000:17) implementation and evaluation in policy transfer concerns analysing the “extent to which policy transfer achieves the aims set by a government when they engaged in transfer, or is perceived as a success by the key actors involved in the policy area”. These are the issues that this Chapter has discussed as regards to decentralisation reform. Since the hospital autonomy policy was rejected and not implemented, there was no allowance for the feedback process to ensue. For the decentralisation reforms, this Chapter has analysed the ‘feedback’ process as per the extent to which the reforms were able to attain the envisaged transformational goals (Ferlie et al,
The findings have been that the intended transformational objectives have not been adequately achieved due to bureaucratic interests resulting in reversals and reproductions, and unfavourable local contextual factors resulting into unintended consequences and challenges, thereby characterising Dolowitz and Marsh’s (2000) “inappropriate transfer”.

8.5. DISCUSSION AND SUMMARY

The aim of this Chapter was to find out whether management decentralization has led to the transformation of health service delivery mechanisms and locate the policy outcomes, impacts and consequences of the same in the Ministry of Health. The objective was to answer the study’s third research question that is: to what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

The Chapter has shown that decentralisation reforms have not adequately transformed the service delivery mechanisms in the MOH. The rate of application has been very modest, with reversals, reproductions, unintended consequences and massive challenges. These have made it difficult for the institutionalisation of the decentralisation reforms within the MOH thereby making the planned transformations unattainable. The key theme has been that these problems have ensued because of the high resistance of the MOH headquarters to carry out the decentralisation programme because of vested interests, and various contextual factors that have militated against the reform thereby exemplifying Dolowitz and Marsh’s (2000) “inappropriate transfer”. Four main reform components formed key areas of investigation and they included the abolition of regional health offices, managerial responsibilities decentralised to DHMTs, devolving political oversight to the local government assemblies and development of a new culture, ideology and organisational meaning as discussed below.

According to Streeck and Thelen (2005:19) institutions are the “object of ongoing skirmishing as actor try to achieve advantage by interpreting or redirecting institutions in pursuit of their goals or by subverting or circumventing rules that clash with their interests”. The case study confirmed this view as the abolition of regional health offices which was favoured to pave way for the decentralisation programme was only implemented as it satisfied the implied needs of the MOH headquarters to effectively regain their power, resources and influence which were seen to be eroded by the increased importance of the
RHOs in dealing with donor organisations. This was worsened by the RHOs inefficiencies as perceived by the DHOs. However, much as the abolition of RHOs was praised as a step forward in attaining the required transformations, this was short-lived as the RHOs were reproduced through the formation of Zone Offices. Although, Zone Offices carried out lesser activities than RHOs, their creation reproduced the intermediate layer of management which decentralisation was supposed to abolish. In this regard, Zone Offices are seen as a contradiction to decentralisation as they are designed to be an outpost of the MOH headquarters. It is in the context of these contradictions that the legitimacy of Zones is being questioned. This is seen in the government-wide Department of Human Resources and Development’s reluctance to authorise its establishment and the DHOs’ frequent bypassing and non-recognition of the Zone structure.

Secondly, the granting of managerial autonomy to DHOs that was to symbolise the intended transformation was only modest and met a lot of contextual challenges. In particular, the human resource management function is still centralised as the management of core medical personnel is still within the control of the MOH. For the support staff, the DHOs cannot make a decision without seeking authority from the MOH thereby limiting their latitude of control. In terms of the financial management, despite the need for financial decisions to be made at the district level as decentralisation demands, these resources are ‘ring-fenced’ where decisions on the mode of expenditures are already done by MOH headquarters thereby limiting the decision space for DHOs. It was also noted that from 2004/5 when decentralisation started to be implemented, resources to the districts have significantly been reduced in favour of the MOH headquarters and central hospitals despite the high demand at the district level. This further demonstrates the resistance to decentralise. In addition, the decentralisation of drug budget which took the form of internal market testing met a lot of challenges and led to unintended consequences. The process did not lead to real competition as DHOs were required to give priority to the MOH based Central Medical Stores. In addition, purchases to private suppliers would only be done with the authority from CMS and mostly when CMS did not possess the required supplies. Moreover, within the general context of corruption in the country, the system was grossly abused as it created an avenue for corruption because in most cases the DHOs preferred purchasing from private pharmacies where they received kickbacks in form of ‘commissions’. The wrong incentives created meant that even when private pharmacies had no suppliers the DHOs would wait for them despite the availability of such supplies at the CMS thereby causing unnecessary stock-outs.
of essential drugs, a situation that forced the MOH to recentralise the drug budget. For the function of contracting out of non-core services, the study found that it was only a few districts that were doing it due to several contextual factors. Firstly, this was because the country does not have a robust private sector base that could be engaged in this regard, especially for rural districts that unfortunately are the majority. Secondly, by their nature, some services for example mortuary and ambulance were regarded as not appropriate candidates. Third was the issue of financial incapacity to finance the contracts. For the services that were contracted, the study observed that they were not fully outsourced as government employees worked side by side with those from the contractors. Mostly, this was seen as a mechanism of beefing up personnel shortages rather than attaining efficiency. The cultural background of collectivism also prevented many a manager from retrenching employees as they were emotionally attached to them and worried about their future welfare. Financial implications of such retrenchments were also a bother as DHOs did not have the required resources to make severance payments. In addition, there was the issue of managerial capacity as it was seen that most local level managers do not have the requisite skills required for outsourcing functions. This presented governance challenges so that unintended consequences of corruption and mismanagement in contract and procurement processes have been prevalent. The last function was that of planning. The study found that limitation on the latitude of authority in human resources and finances constrained the planning function at the local level. This is compounded by lack of adequate planning skills at the local level.

Third is the devolution of political oversight to the elected local government assemblies for political accountability purposes. The study found that although this was more political than managerial and hence not directly falling under NPM, it was imperative to analyse because of the contextual issues in Malawi that made this to increase managerial autonomy rather than the intended political accountability. In particular, the local councillors that were supposed to present the political clout for this to obtain, have been absent since March 2005 thereby failing to attain the political ends. As a result, appointed managers at the district assembly have been operating without the political wing making the whole arrangement an administrative rather than a political instrument. In this regard, the district assemblies have only been used as a channel for financial disbursements to DHOs to satisfy legal mandates rather than as a mechanism for political accountability. Because of this, the managers at the district assembly do not hold the DHOs accountable. This is compounded by the fact the
DHOs do not regard the DCs as critical in discharging their duties as they are directly accountable to programme managers at the MOH headquarters through the Zone Officers. In addition, the DHOs are in most cases more senior as compared to DCs thereby presenting command problems in the context of Malawi’s highly hierarchical society.

Lastly, the Chapter was set to examine if management decentralisation has led to any desired organisational cultural changes so as to align with the reform dictates thereby signalling transformation. Streeck and Thelen (2005:18) point that “fundamental change...ensues when a multitude of actors switch from one logic of action to another”. However, the study found that the mindset of people had not changed in the context of decentralisation. Several reasons accounted for this. Firstly, the low rate of implementation combined with reproductions, reversals, high levels of resistance, unintended consequences and challenges made the institutionalisation of the decentralisation reform to facilitate the desired cultural change difficult. Secondly, lower level employees who form the hub of service delivery were not involved in the reform initiative thereby making the institutionalisation of the reform ethos into the organisational sinews difficult. Thirdly, it was found that the DHOs themselves are not willing to pass on some authority to lower level staff thereby making their organisations too bureaucratic to adapt to the changing environment. Lastly, it was seen that nationally, the cultural flow regards the central government as the manager and provider of service, making the socialisation process of the envisaged transformations problematic.

8.6. CONCLUSION

The aim of this Chapter was to answer the study’s third research question which is, to what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi? This was done using the case study of district health management decentralisation reforms that were transferred through the EC intervention. The study found that decentralisation has not led to meaningful transformation in the delivery of health services. The reform has been characterised by a very modest application, with reversals, reproductions, unintended consequences and massive challenges. These problems have ensued because of the high resistance of the MOH headquarters to carry out the decentralisation programme due to vested interests, and contextual factors that have militated against the reform. Ultimately these have made it difficult for the institutionalisation of the
decentralisation reforms within the MOH thereby making the planned transformations unattainable. The Chapter also provided the link between policy transfer and policy making processes. It was seen that the transfer was concentrated at the policy initiation and agenda setting stages while domestic policy making processes took over from the policy formulation stage to implementation.

The next Chapter concludes the study. It pulls all the study findings together to come up with key summary of findings, implications and contributions. Lastly a chapter conclusion is drawn.
CHAPTER NINE: CONCLUSIONS AND IMPLICATIONS

9.1. INTRODUCTION

Chapter Eight analysed the role of policy transfer in health service delivery transformation in Malawi. Through the case of district health management decentralisation reform transfer, the Chapter found that the reform did not lead to meaningful transformational ends. This was because of the high resistance of MOH bureaucrats and non favourable contextual factors at the implementation level.

In addition to reviewing the major findings of the thesis, this chapter draws implications and tentative generalisations for developing countries on the dynamics of the transfer of hospital autonomy and decentralisation reforms in Malawi. The Chapter begins by presenting a summary of key findings. It is from these findings that implications of the study are drawn. Through these implications the Chapter answers the study’s final research question which is: what lessons can be drawn from a greater understanding of the causes and effects of the health sector reforms in Malawi? This question is mainly a concluding one and it seeks to draw lessons and some generalisations from the case studies analysed. The Chapter then presents theoretical and empirical/practical contributions of the study. This is followed by a section on areas for future study. Lastly, concluding remarks are made.

9.2. SUMMARY OF KEY FINDINGS

The main aims of this study were three-fold. The first intention was to undertake an in-depth analysis of the mechanisms and the nature of the transfer of health sector reforms to Malawi within the context of globalisation processes. Second was to examine the extent to which the implementation of health sector reforms was facilitated or constrained by the prevailing country specific frameworks. The third objective was to analyze the extent to which the health sector reforms have led to health service delivery transformation in Malawi. Through this examination, the study sought to provide a greater understanding into the mechanisms, processes, and effects of health sector reforms transfer which would benefit health service delivery in Malawi and similarly placed aid dependent countries. For these aims to obtain, the study came up with four research questions three of which have been answered by the
study. The fourth one is about implications drawn from the finding and it is answered in this Chapter. Below is a summary presentation of answers to these four questions.

9.2.1. What Were the Mechanisms for the Transfer of Health Sector Reforms to Malawi’s Policy Agenda?

The study found that hospital autonomy and decentralisation reforms in Malawi’s health sector were designed along the NPM paradigm whose worldwide spread has been facilitated by globalisation processes. The study also identified specific international institutional entrepreneurs that were instrumental in transferring the health sector reforms to Malawi’s policy agenda. In particular, international donor organisations were pivotal in the transfer process at the agenda setting stage through the use of aid conditionalities. In this regard, coercive isomorphic pressures were the institutional infrastructure within the highly hierarchical international aid regimes for transferring these reforms. At this stage, Malawi was only at the receiving end since the country could not afford to lose the much needed aid and loans under condition.

In the case of hospital autonomy reform transfer, USAID was the institutional entrepreneur that introduced it to Malawi’s policy agenda. Through its NPA aid regime USAID required the Malawi government to introduce the reform as condition for aid within the ‘Strengthening Health Care Systems’ project. For the district health management decentralisation reforms, the European Commission was the institutional entrepreneur through a conditional loan agreement under the 7th and 8th EDF institutions that were within the Lome IV Convention aid regime. The Lome IV aid institution emphasizes reform as a condition for aid by the recipient countries within the structural adjustment framework. Despite the similarities between USAID’s NPA and EC’s Lome IV Convention in aid conditioning, Lome IV was ratified by the loan/aid receiving African, Caribbean and Pacific (ACP) member countries thereby legitimising the issuance of coercive mechanisms that form the loan/aid regimes. Although the EC was the architect of the conditions, ratification by the ACP countries legitimised them. However, the transfer remained coercive because the recipient country was denied freedom of choice.
On the other hand, USAID’s NPA aid infrastructure was a once off arrangement based on a specific programme where the achievement of certain arranged reform milestones invited the release of counterpart funds. In this respect, there was no prior country ratification as in the case of Lome IV but it was based on the specific reform programme at hand. Therefore, the aid recipient country was not party to the origination of the aid institutional framework as was the case with EC. Clearly this was coercive policy transfer through conditionality as failure to implement the stated reforms meant the stoppage of aid.

9.2.2. What Factors Facilitated or Constrained the Implementation of the Health Sector Reforms in Malawi?

The study also carried out a comparative examination of the actual transfer processes of hospital autonomy and management decentralisation reforms with the aim of finding out and analysing contextual factors that facilitated or constrained the implementation of the reforms at the national level. The findings were that combined forces of political, cultural, economic, mode of transfer, administrative, historical and institutional variables were pivotal for the actual implementation of the reforms. In this regard, despite the coercive mechanisms that international institutional entrepreneurs applied in the transfer of these reforms to the country’s policy agenda, the actual implementation depended on national level contextual variables.

In the first place, the mode of transfer was seen as a necessary although not sufficient variable in securing institutional and capacity development for the health sector reforms implementation. USAID engaged independent external consultants who developed the reform programme, policies and institutions outside the MOH bureaucratic structure. The MOH officials were not involved in the process but were required to pass on the final reform tools to relevant veto actors for implementation. This brought lack of ownership and commitment and did not facilitate the necessary capacity building in the MOH. As a result, the reform was not supported by the MOH bureaucrats. On the other hand, EC engaged technical advisors who worked with the MOH officials in the development of the programme through learning interventions. These took the forms of learning by doing, formal academic scholarships and capacity building in the districts. Although this was pivotal in building the necessary capacities and institutionalising the reform, the creation of special project
implementation units that rewarded those key to initial stages of the reform made other organisational members feel alienated and they either sabotaged the implementation process or left the ministry due to frustrations.

Second, the study found that the actual reform content and political-economic context of application determined political acceptability of the health sector reforms. Mismatch between content and context resulted in a higher likelihood of non implementation. Hospital autonomy was based on cost recovery through user fees. This was seen to be not politically acceptable in Malawi where poverty levels are very high. Due to the fact that the Government’s overarching strategy was that of pro-poor policies, this was also regarded as policy contradiction and hence unacceptable. On the other hand, management decentralisation was for strengthening district health infrastructure through the transfer of managerial powers to districts. This was championed in the context of low performance of these facilities and democratic reforms that Malawi had just implemented. Therefore, despite the managerial objectives to be attained, the perceived political ends of democratic consolidation attracted political support.

Third, the study found that political power games resulting from the configuration of the parliament and the cabinet determined the political acceptability of the health sector reforms. In particular, where the opposition parties dominated the legislature, the executive was less inclined to present health reform proposals that were potentially discrediting. It was found that when hospital autonomy reform proposal was due to be presented to parliament for it to pass into law, the opposition members of parliament were in majority. In addition, the executive was very weak in parliament because the President left the party that sponsored his election to form his own. As a result, the opposition parties deliberately turned down all bills presented including the national budget for the sake of frustrating the President. In this case, the President did not pass the hospital autonomy proposal to parliament because he knew it would automatically be rejected. In addition, the opposition would capitalise on it to gain political mileage due to the social economic implications of cost recovery. On the other hand, the management decentralisation reforms did not need to go to parliament as a UNDP-pushed national decentralisation act that authorised all sectors to engage in decentralisation activities was already enacted in 1998. Therefore, even if the balance of power in parliament was not in favour of the executive, this reform was not affected. Moreover, during the time the national-wide decentralisation bill was presented in parliament, the government side was a majority
and hence it was overwhelmingly accepted. To this end, it can be said that parliament and cabinet configuration determined the actions of veto players for the transfer of health sector reforms in Malawi.

Fourthly, the study was set to find out if path dependency tendencies can explain the acceptability of the health sector reforms in Malawi. The study found that history mattered in policy adoption processes. For hospital autonomy reforms, the historic colonial institutional infrastructure within which health sector policy of free services was created made it difficult to change the policy. When the country attained independence in 1964 the first President tried to introduce user fees but this was opposed by ministers and the public. This resulted in the dismissal and resignation of several ministers while the President, in an attempt to prevent further policy resistance, took a more dictatorial leadership style. In 1994 when the country became a multiparty democracy, a general privatisation drive was embarked on which resulted in retrenchments and closing down of public facilities. This had consequences that affected the poor and hospital autonomy was perceived by many as privatisation. In addition, democratisation was presented as a start of pro-poor government policies because the dictatorial regime did not effectively reduce poverty. Therefore, although the 1964 independence and 1994 democratic reform represented a potential ‘conjuncture’ that could favour the introduction of the hospital autonomy reforms, they had a ‘lock in’ effect that made change difficult. On the other hand, the health management decentralisation reforms were implemented in the context of the general local government decentralisation reforms that were generally regarded as a democratic requirement. They were considered as a key element for the consolidation of democracy as they were seen as a tool of replacing the centralised service delivery that characterised the one party dictatorial state. Therefore, democratic political reforms that Malawi embraced in 1994 were seen as a ‘critical juncture’ requiring change of any policies that were regarded as instruments of the centralised dictatorial regime.

Fifth, pressure from the citizens was also examined to analyse if it had any facilitating or constraining impacts on the adoption of the reform instruments. The study found that although there was no active citizen pressure for the reforms, their perceptions and the feedback they gave to the policy making machinery created a policy window to either adopt or reject the reforms. In the case of hospital autonomy reforms, the citizens gave a divided feedback to the policy making system. There was a group of the rich who, because of their
ability to pay, wanted quality and efficient services and hence were for the reforms and there were the poor who did not care much about quality but access to health services. The poor could not pay and feared that user fees would limit their access to health services. Since the poor were the majority and hence a political capital, they got the political support. For management decentralisation, since it did not involve ability to pay but strengthening health services, the citizens presented a unified feedback to the policy making machinery. There was perception of lack of meaningful government efforts to strengthen health service delivery which provided a window for the government to adopt reforms that were seen to strengthen health service delivery.

Sixthly, the study analysed the impacts of the compatibility between the health sector reform instruments and institutional framework within which they were applied and the need for prerequisites for effective implementation. It was found that health care delivery in Malawi is based on the referral institutional framework. In this regard, hospital autonomy and the embedded cost recovery mechanisms were seen not to be in line with this institutional framework. Moreover, prerequisites in the context of such misfit which included constructing hospitals in district where central hospitals operated and strengthening of the existing district hospitals were absent. For management decentralisation, it was seen that this was not only compatible with but also strengthened the existing referral institutional framework. This is the case as it aimed at strengthening district and primary level health service delivery.

Lastly, the study found that bureaucratic interests determined the ultimate pace at which the health sector reforms were implemented. The study demonstrated that although donor organisations took a leading role in transferring health sector reforms to Malawi, the speed at which they were implemented depended on the general bureaucratic interest, institutional capacities and the general cultural environment within which such reforms were implemented. It was also found that where these interests aligned to political interests, they determined not only the pace but also the actual implementation. Case studies under examination revealed that MOH bureaucrats resisted both the hospital autonomy and management decentralisation reforms because they implied loss of resources, power, influence and control which are highly valued in Malawi as it is a highly hierarchical power distance cultural environment. For hospital autonomy, the impacts of this permeated through the ministerial and senior bureaucrat level and were fuelled by the general political resistance, resulting into the failure of the transfer. For the decentralisation reform, although bureaucrats
attempted to resist the implementation through delays, reallocating reform champions, presenting technical excuses and appealing for presidential intervention, they had to succumb to political and donor pressures.

9.2.3. To what Extent has the Transfer of Health Sector Reforms led to the to the Transformation of Health Service Delivery Mechanisms in Malawi

The study has found that the transfer of decentralisation reforms has not adequately achieved the intended health service delivery transformation in Malawi. At best, the decentralisation reforms have been characterised by reproductions and reversals, and the rate of application has been very modest with unintended consequences, and massive challenges. This was attributed to top-level bureaucratic resistance against the implementation the reforms and that the contextual prerequisites of capacity, financial adequacy, accountability, transparency, a robust private sector and a conducive culture have been absent. Moreover, the political bedrock at the local level has not been available thereby preventing the realisation of the transfer’s political accountability goals. These have been exacerbated by contextual problems of corruption and neo-patrimonial orientations.

In particular, the transformation emanating from the abolition of Regional Health Offices to de-bureaucratise and pave way for managerial autonomy at the DHO level was short-lived. They were reproduced through the creation of Zone Offices which were the extension of the headquarters as soon as the decentralisation reform begun to be implemented. ZOs have been regarded as reproductions of RHOs and unnecessary layer of management that is contradictory to the decentralisation movement. It is in this context that they have suffered a legitimacy crisis through lack of recognition by Central Government’s Department of Human Resources and Development and bypass by the DHOs.

Secondly, the decentralisation of management has not led to increased latitude of discretion and responsibility by the DHOs. Most activities are still managed at the MOH headquarters. Firstly, for the human resources management function, the study found that the core medical and clinical personnel are still managed at the central level in terms of recruitment, disciplining and rewards. Moreover, although DHOs were given responsibility for recruiting and disciplining support staff, they only make recommendations but need to seek authority
from MOH headquarters on any decision they make. Secondly, in terms of the financial management function, the study found that the MOH headquarters ‘ring-fences’ the resources so that decisions about their expenditure are already made at the central level thereby constricting local level managerial decision making. In addition, it was found that from the time decentralisation begun to be implemented, the allocations to districts have drastically been decreasing while those of the MOH headquarters have been increasing despite the acute need at the district level in view of the increased responsibilities. This further demonstrates the reluctance of the MOH to decentralise. Thirdly, the decentralisation of the drug budget through internal market testing was short-lived as it did not create real competition and was rocked with corruption. The DHOs were supposed to give preference to the MOH’s Central Medical Stores which was also the ultimate authority for DHOs seeking to purchase from private pharmacies. However, it was found that the DHOs abused the system and they increasingly purchased from the private sector as they offered kickbacks through ‘commissions’. The wrong incentives created led to a situation where most DHOs could only buy drugs from CMS on credit when they had no finances, leading to huge unpaid bills. On the other hand, when the finances were available, DHOs preferred to purchase from private pharmacies even in cases where those pharmacies did not have the drugs in stock but CMS had thereby leading to unnecessary stock outs of essential drugs. Fourthly, the contracting out of non-core services to let DHOs concentrate on the management of core functions for improved efficiency and effectiveness has not led to the intended transformational outcomes. The implementation has been modest due to lack of a viable private sector especially in rural districts which are the majority, the nature of some services in the context of high poverty levels has made direct provision the most feasible means of delivery, and there have been lack of resources to finance the contract arrangements. For those that were contracting-out, it was seen that they did not out-source wholesale, but did it as a means of getting additional staff who worked side by side with the government employees. This was because of fear of laying-off employees due to emotional attachments based on collectivism cultural background and shortage of finances to make severance payments. In addition, there were management capacity problems where skills on the ground did not match those required by the contract processes. Moreover, it was found that outsourcing met governance challenges where corruption and mismanagement were rampant. Lastly, it was found that the planning function was adversely limited by the reduced managerial discretion latitude in finance and human resource management as already stated. In addition, the lack of the required planning skills also adversely affected this function.
Thirdly, despite being more political than managerial and therefore not falling within the NPM framework, the study also examined the impacts of making the DHOs politically accountable to an elected district assembly as espoused by the decentralisation reform transfer. This was especially the case because Malawi is unique since the elected councillors that were supposed to make it a system for political accountability have been absent from the time the health sector management decentralisation was implemented. This means that it was the appointed district assembly officials that made decisions rather than the elected councillors making the whole system an administrative rather than a political arrangement. Moreover, the DHOs did not mostly regard managers at the district assembly as important in decision making as they reported to programme managers at the MOH headquarters and the Zone Offices. In addition, the DHOs were more senior than District Commissioners thereby resulting in authority crisis in a culturally highly hierarchical society. As a result, the District Assembly was in most cases out of the picture in terms of health service delivery and hence failed to discharge the envisaged accountability role. In this regard, the management decentralisation transfer only presented a potential for strengthening district health management teams without any political clout for accountability purposes.

Fourthly, the study found that there has not been any change to the Ministry of Health organisational culture to align with the cultural orientations of the decentralisation reforms so as to symbolise transformation. The management decentralisation reforms have not resulted into the desired change in the mindset and ethos of personnel. This was because of high levels of resistance at the MOH level that led to modest levels of application, reproductions and reversals compounded by unintended consequences and contextual challenges. In addition, the lower level employees at the DHO level were not involved in the reform process thereby preventing the necessary institutionalisation of reform into the organisational infrastructure. Moreover, the DHOs themselves have not passed on the responsibilities to lower level managerial staff under them thereby making the districts too rigid and bureaucratic to adequately assume the new culture. Lastly, it was seen that nationally the cultural flow has been in support of centralisation rather than decentralisation. The majority regard the Central Government as the manager and provider of services and there has not been the required socialisation processes for the decentralised management to result in meaningful cultural transformation.
9.3. IMPLICATIONS: WHAT LESSONS CAN BE DRAWN FROM A GREATER UNDERSTANDING OF THE CAUSES AND EFFECTS OF THE TRANSFER OF HEALTH SECTOR REFORMS IN MALAWI?

As articulated in Chapter Four, although most authors have argued that case study methodology suffers from the limitations of generalisations (Yin, 2009), it is still possible to draw “tentative” or “provisional” generalisations although they are not conclusive (see Evers and Wu, 2006; Kennedy, 1979; Flyvbjerg 2006; Mjøset, 2006). Moreover, since this study used various data collecting methods, it provides a unique instance of, where appropriate, providing some generalisations accordingly (see Blaikie, 2000). The generalisations generated from this study are based on Stake’s (1978) concept of ‘naturalistic generalisations’ where the emphasis is on generalising to similar or comparable contexts (which in this case are other aid dependent developing countries) and ‘analytical generalisation’ where theoretical constructs are used to compare the empirical results of the case study (see Yin, 1989:38).

To this end, it can be said that the study findings have significant implications for policy making and development in Malawi and, to similar developing country settings. These implications are mainly drawn from the findings, as has been demonstrated by the study, that the actual implementation of the health sector reforms was mediated by variables that were beyond the technical scope of policy entrepreneurs whose ignorance led to non-implementation or undesirable consequences on health service delivery mechanisms despite the enormity of financial resources spent in the transfer processes. The cases show that although the reforms were coercively transferred to the country’s policy agenda through hierarchical aid mechanisms, not all were implemented. This is because there were national specific “filters” (Dolowitz and Medearis, 2009) that determined which policies were acceptable at the decision making stage. In this regard, the application of foreign health reforms depended more on the underlying “political feasibility” and its “antecedents” (McCourt and Bebbington, 2008) that were beyond the technical satisfaction, efficiency and effectiveness gains promised by the policy instruments. Moreover, local level context at the point of implementation did matter in the application of the transferred health reforms. In the case of decentralisation, there was the absence of local prerequisites which affected implementation. Therefore, a tentative generalisation to be drawn from these findings is that policy transfer of a coercive nature to aid dependent countries is likely to fail. This is due to
the link with aid conditionality that ignores country specific contexts which are necessary for implementation.

As the reforms under study were modelled along the NPM paradigm, these findings further imply that the theoretical portrayal of NPM as an internationally applicable reform does not hold in this and similar developing country scenarios. This is the case as has been demonstrated by the study, these reforms were not easily transferable to the Malawian health sector. Donor organisations as bearers of the NPM gospel have preached it as an automatic model that can rectify all public sector problems regardless of country specific conditions. In this realm, NPM is regarded as “public management for all seasons” (Hood 1991) and as an “example of globalization at work” (United Nations 2001). However, as this study has shown, NPM is “not a panacea for all the problems in the public sector” (Larbi 2006:47). For many developing countries, such as Malawi, NPM instruments are simply not appropriate because of the prevailing contextual environments. It is in this vein that Minogue (2002:134) alludes to the “difficulty of making such policy transfers across different political and bureaucratic cultures”. This is because, as has been found in this study, the “conditions on which new management practices are premised may not be present” (Bangura and Larbi 2006:11) in many aid dependent developing country contexts resulting in numerous suitability and sustainability hiccups. For instance Bale and Dale (1998:116) attribute the overwhelming acceptability and success of the NPM reforms in New Zealand to “a tradition of a politically neutral, relatively competent civil service, little concern about corruption or nepotism, a consistent and well-enforced legal code including contract law, a well-functioning political market and a competent but suppressed private sector”. As has been shown by the study, a combination of these factors are absent in most developing country scenarios leading to policy acceptability and implementation problems and a failure in attaining the promised transformational goals.

Lessons drawn from this case study call for the change in the orientation of donor organisations in influencing policy making and development in developing countries. Of course, as we have discussed in Chapters Three and Five, Malawi and many aid dependent countries cannot do without donor funds in policy development because as an official at the Ministry of Finance’s Debt and Aid Department argued, “a policy which is not funded is not a policy. The implied activities have to be funded then it’s a real policy”, but coercive policy transfer orientations need to be avoided. As discussed in Chapter Six, the 2005 Paris
Declaration on Aid Effectiveness which formed the basis for Sector Wide Approach (SWAP) where donor organizations made commitments to increased ownership, alignment, harmonization, management for results and mutual accountability are a positive stride in this regard. However, it has been observed that in most developing country cases, these commitments have been more of rhetoric than reality (OECD, 2008). In this regard, as it emerged from the interviews, the “Paris principles are very good principles but they have not been complied with. The challenge is that the developing countries are pushing but the developed countries are not for this because it takes away the liberty from them to dictate on certain issues and put a sticker on the project they have funded”. More succinctly, the Paris declaration objectives have been seen to be “off-track and will be difficult to achieve” (OECD, 2008:25) as they are “too prescriptive on developing countries, not binding enough on Development Partners and...are donor driven” (Wood et al, 2009: 29).

Therefore, donor organisations need to move away from this rhetoric and instead of transferring policies wholesale through aid conditionalities, there is need to build meaningful capacities of policy makers in developing countries for increased voluntary policy learning. In this regard, policy makers in these countries would choose “policy transfer as a rational response to perceived problems” (Dolowitz and Marsh, 2000:14) leading to policy ownership and commitment. They will indulge on hard forms of learning (Dolowitz, 2009a) where they will critically analyse and understand the international policy instruments in question, both the originating and domestic political systems and environments, and conditions that can effectively make it fit their existing circumstances. During this exercise, policies that are likely to face institutional, economic, cultural, bureaucratic, and political huddles would either naturally be dropped or mitigation mechanisms (which include utilising policy transfer for policy inspiration) would effectively be construed. To this end, policy makers in developing countries would adaptation transferred policies to their specific contextual circumstances as is the practice in other settings.

9.4. CONTRIBUTIONS TO FIELD OF STUDY

This study has made tremendous theoretical and empirical contributions to the study of public policy and management in general and the policy transfer subfield in particular as highlighted below.
9.4.1. THEORETICAL CONTRIBUTIONS

This research project is conceptually located in the relatively new but growing field of policy transfer analysis. However, the current policy transfer literature is biased towards developed countries. As Evans laments, policy transfer “analysts focus too much attention on policy transfer between developed countries and largely ignorant of policy transfer activity in the developing world” (2004:25). Therefore by investigating the phenomenon of policy transfer in the field of public administration in a developing country context (in this case, Malawi’s health sector), the project has added to a literature that overlooks policy transfer activity in developing countries in general, and Africa in particular.

Moreover, studies on policy transfer mostly concentrate on voluntary policy transfer while ignoring coercive variants which are common in most aid dependent countries. This means that a majority of issues in regard to policy transfer of a coercive nature are just assumed rather than based on empirical enquiry. For instance, there is a theoretically taken for granted stance that coercive transfers will lead to policy implementation by developing countries for the fear of losing developmental aid (see Dolowitz and Marsh, 1996). However as this study has shown, policy implementation by these countries may not be automatic even in the context of transfers of a coercive nature. Therefore, this study makes a big theoretical contribution to the study of policy transfer.

In this respect, through the use of the cases of Malawi health care reforms, this study has massively contributed to the theoretical understanding of the mechanisms, processes, dynamics and outcomes of coercive variants of policy transfer within the general framework of globalisation processes and has mapped out factors that may facilitate or hinder the same. In particular, through the use of multilevel theoretical framework, the study has made a unique theoretical contribution to the study of policy transfer by highlighting international, national and implementation contexts of policy transfer in developing countries contexts. In this respect, this study therefore, has filled an important theoretical gap of policy transfer dynamics in an area which is heavily understudied.
9.4.2. EMPIRICAL/PRACTICAL CONTRIBUTIONS

Apart from the theoretical significance, the study has also made empirical contributions to the knowledge vacuum of the mechanisms, impacts and applicability of the NPM-based policy transfers in developing countries. In this regard, empirically, the study provides information and insights for policy makers and international institutional entrepreneurs in developing countries to consider the institutional, historical, organizational, bureaucratic, political, economical and cultural environments so as to prevent counter-productive consequences that may present massive negative implications on public policy outcomes.

9.5. AREAS FOR FUTURE RESEARCH

The study proposes the following areas for further examination of policy transfer dynamics. Firstly, as a way of strengthening the tentative generalisations drawn by this study, future research can apply the contextual variables identified in this study in other country contexts and sectors so as to bringing out some more contextual issues that have not been unearthed by this study. The second issue requiring further study is about the nature of policy transfer under study here. This study has dwelt on coercive forms of policy transfer. However, as has been noted in Chapter Three, this does not mean that voluntary policy transfer does not take place in aid dependent developing countries. It would therefore, be interesting to come up with a study that examines voluntary policy transfer in such countries. This would also go further in highlighting the extent to which these countries can reclaim their policy space in view of the increasing aid dependence and coercive policy transfers.

Thirdly, this study has concentrated on the role of ‘Western’ international donor organisations in policy transfer. In this regard, an area that also remains understudied is the role of African regional blocks for example, African Union (AU), Southern African Development Community (SADC), Economic Community of West African States (ECOWAS); development banks (for example African Development Bank) and other organisations in Africa. In addition, the increasing role of China in Africa’s development cannot be ignored. Therefore, there is need to research on the extent to which China’s engagement in Africa has led to policy transfers and, if any, the nature and dynamics of such transfers.
9.6. CONCLUDING REMARKS

Clearly, the concept of policy transfer defies the notion of national boundaries in so far as policy making is concerned. Moreover, globalisation processes have brought in a situation where purely state centric policy making models are no longer attainable as policies are sourced across space and time. International policy entrepreneurs have been pivotal in facilitating the policy transfer processes in this regard. For the transfer of health sector reforms to Malawi, donor organisations took centre stage through coercive means by conditioning aid and loans to policy reform implementation. The problem however, was that donors transferred the reforms wholesale in a one-size-fits-all fashion without considering the specific social, bureaucratic, cultural, political, economic and institutional environments within which the reforms were to be implemented. As a result, the reforms have either encountered political constraints that have prevented their implementation (as the case of hospital autonomy) or met bureaucratic resistance that have made their implementation problematic (as in management decentralisation). In addition, when implemented, the reforms have met several contextual challenges so that they have not achieved the transformational results but have led to unintended consequences (as in management decentralisation).

Since the findings have implications for other aid dependent developing countries, this study therefore calls on donor organisation to change their orientation in dealing with policy makers in these countries. Instead of coercive policy transfers, donor organisations need to develop their capacities in policy making and development so that they should be able to carry out policy transfer as a rational voluntary learning activity. In this regard, the policy makers would be able to adopt policies that are in line with the prevailing contextual conditions and if they are not, such policies would be used for inspirational purposes rather than wholesale application. To this extent, this study makes a great contribution to the study of policy transfer in an area which is greatly understudied.
REFERENCES


Accra Agenda for Action, 2008, Accra Agenda for Action, Accra

ACP-EU, 1989: Fourth Lome Convention, Signed at Lome, Brussels: European Commission


Baekey, C. 2004: Draft Malawi Hospital Autonomy Bill, Kloof, South Africa, unpublished draft


Banda, A, 2000: Speech by Minister of Health Aleke Banda made at a National Workshop on Decentralisation of Health Services at Malawi Institute of Management, Lilongwe, 24-25 August, unpublished


Bowa, M. and MacLachlan, M. 1994: No Congratulations in Chichewa: Deterring Achievement Motivation in Malawi, Zomba: Department of Psychology, University of Malawi
British Council, 2005: Health Reform and Decentralisation, Malawi, Manchester: British Council


Carnegie Endowment for International Peace

CEMCA (Commonwealth Educational Media Centre for Asia), 2002: *Manual for educational media researchers: know your audience*. New Delhi: Commonwealth Educational Media Centre for Asia


CHRR (Centre for Human Rights and Rehabilitation), 2007: *Whither Malawi?: a Broad Appraisal of Three Years of the Mutharika’s Administration*, Lilongwe: Centre for Human Rights and Rehabilitation

Common, R. 2001: Public Management and Policy Transfer in Southeast Asia, Ashgate: Aldershot
DFID, 2004: Comments on Programme of Work, unpublished


Donaldson, D. 1994: Health Sector Reforms in Africa: Lessons Learned, Boston: Harvard School of Public Health


Dunleavy, P. 1994: ‘The Globalisation of Public Service Production: Can Governments Be The Best In the World?’, Public Policy and Administration, 9 (2): 36-64


Dwyer, P. and Ellison, N. 2009: ‘We Nicked Stuff From All Over the Place’: Policy Transfer or Muddling Through?, Policy & Politics, 37(3):389-407


Englund, H. 2002a: A Democracy of Chameleons: Politics and Culture in the New Malawi, Blantyre: Christian Literature Association in Malawi
Eurodad (European Network on Debt and Development), 2006: World Bank and IMF Conditionality: A Development Justice, Brussels: Eurodad
European Commission (EC), 2008: Supporting Decentralisation and Local Governance in Third Countries, EC: Brussels
European Commission 2008b Commission Approves € 90 Million Budget Support Programme for Malawi, Brussels: European Aid
European Commission, 2008: 10th EDF for the period 2008 – 2013, EC
Evans, M. 2004: Policy Transfer in a Global Perspective. Ashgate: Aldershot


Foster, P. 2001: Law and Society Under a Democratic Dictatorship: Dr Banda and Malawi, 34(3):275-293


GAO (United States General Accounting Office), 1996: *Content Analysis Methodology for Structuring and Analysis Written Material*, GOA: Washington


Hofstede, G. 1980: Culture's consequences: International differences in work-related values, Beverly Hills: Sage


Inter ministerial Committee on Decentralisation, 2002: *Minutes of the Inter Ministerial Committee on Decentralisation Meeting Held at Mkopola Lodge in Mangochi*, 20-21 July, unpublished

Inter ministerial Committee on Decentralisation, 2005: *Minutes of the Inter Ministerial Committee on Decentralisation Meeting Held at Sun and Sand, Mangochi* 15-16 January, unpublished


Jabbar, J. and Dwivedi O. *Administrative Culture in a Global Context*, Whitby: de Sitter Publications


Kandodo, 2010: 2010/11 Budget Statements Delivered in the National Assembly Of the Republic of Malawi by the Minister of Finance Honourable Ken Kandodo MP at the New Parliament Building in Lilongwe on 28th May 2010


Ladi, S. 2004: ‘Environmental Policy Transfer in Germany and Greece’, in Evans M (Ed) *Policy Transfer in Global Perspective*, Aldershot: Ashgate
Lawson, M., Mazenger, S., Nkhoma-Mbawa, F. And Noel, T 2008: *Malawi Essential Health Service Campaign*, London: Oxfam International
Leiderer, S., Hodick, B., Kabey, E., Roll, M., Schnitzer, S, and Ziegenbein, J. 2007: *Public financial management for PRSP implementation in Malawi: formal and informal PFM institutions in a decentralising system*, Bonn : Deutsches Institut für Entwicklungspolitiik gGmbH
Levy R, 2002: Modernisation, Decentralisation and Governance: A Public Management Perspective, *Political Sciences Association Annual Conference, University of Aberdeen, 4-6 April*

271


Malawi-EU, 2008: *Joint Annual Report*, Lilongwe: EU


Marks, G. and Hooghe, L. 2004: ‘Contrasting Visions of Multi-level Governance.’ In Bache, I. Flinders, M. (Eds.), *Multi-level Governance*, New York, Oxford University Press,


Ministry of Health, 1999b: *To the Year 2020: A vision for the Health Sector in Malawi*, Lilongwe: Ministry of Health


MLGRD (Ministry of Local Government and Rural Development), MGPDD (Malawi German Programme for Democracy and Decentralisation), RNE (Royal Norwegian Embassy), 2006: *A Strategy for Capacity Development for Decentralisation in Malawi*, Lilongwe: GTZ


Mutharika B, 2006: Address to the Nation By His Excellency Dr. Bingu Wa Mutharika President Of The Republic Of Malawi, 20th July, unpublished


Mzimba DHO, 2008: Minutes of Core Management Meeting Held on 24th October Ref No MZ.H/1/3/2,

Mzimba DHO, 2009a: Donations, Memo of Mzimba, DHO Ref No MZH/H/1/4/18(7), 9th March 2009

Mzimba DHO, 2009b, Donations, Memo of Mzimba, DHO Ref No MZH/H/6/1(12), 9TH March 2009).

Mzuzu City Assembly and Mzimba DHO, 2008: Minute DHS/05/08 of Minutes of Health Services Meeting between the DHO Mzimba and Mzuzu City Assembly, Ref No MZH/H/8/2, 18 September


NORAD and SIDA, 2004: Comments on Draft Health Swap MOU, unpublished


OECD, 2003: Harmonising Donor Practice for Effective Aid Delivery, Paris:OECD

OECD, 2004: Lessons Learned on Donor Support to Decentralisation and Local Governance, OECD: Paris

OECD, 2007: Survey on Monitoring the Paris Declaration, Malawi, Paris:OECD


OECD, 2008: African Economic Outlook, Paris: OECD:


Paris Declaration, 2008: *Paris Declaration on Aid Effectiveness*, Paris: OECD


Pendame, R. 2000: Background-Hospital Autonomy, address by Secretary for Health at a de-briefing meeting of a report by Partners for Health Reforms consultants, August unpublished


Ross, A. 2009: *Colonialism to Cabinet Crisis: A political History of Malawi*, Zomba: Kachere Series
Save the Children, 2009: *Modernising Foreign Assistance Insights from the Field: Malawi*, London: Save the Children


Street, A. 2004: ‘Policy Transfer in Kyrgyzstan: The Case of General Practice Funding’, in Evans, M. Policy Transfer in Global Perspective, Ashgate: Aldershot, pp 113-127
Tavakoli, H. and Hedger, E. 2010: Aid Effectiveness in Malawi: Options, Appraisals and Budget Support, London: Oversees Development Institute
The ACP-EU Courier 1990: Lome IV, No 120, March –April, Brussels: European Commission
The ACP-EU Courier, 1996: Special Issue On the Revised Lome Convention, No 155, January –February, Brussels: European Commission
The Nation, 2010: Donor threaten on education aid, 12 November
UNDP, 2005: Role of UNDP in a Changing Aid Environment; Direct Budget Support, SWAPs, Basket Funds, New York: USAID
Veltmeyer, H. 2004: Globalisation and Ant globalisation: Dynamics of Change in the New World Order, Ashgate: Aldershot


Yin, R., 1989: *Case Study Research: Design and Method*, Newbury Park: Sage


Zomba City Assembly, 2009: *Memo by Zomba City Assembly Chief Executive Officer*, 24 February, unpublished.

APPENDICES

Appendix 1: Map of Malawi
Appendix 2 Ministry of Health Organisational Structure

CHAM Secretariat
Professional Regulatory Councils
NGOs and Donor Agencies
Department of Local Government
National AIDS Commission

Central Medical Stores
College of Medicine
College of Health Sciences
College of Nursing
Other health training institutions
4 Central Hospital
28 District Health Management Teams

Minister of Health
Deputy Minister of Health
Principal Secretary for Health
Chief Technical Adviser
Senior Technical Adviser

Director Finance & Administration
Director of Planning
Director of Technical Support Services
TB Program Manager
Director of Nursing Services
Director of Preventive Health Services
Director of Clinical and Population Services

Source: Conticini, 2004
Appendix 3: Institutional Structure of the Malawi Government

SPEAKER OF PARLIAMENT
(Head of the Legislature elected by fellow members of parliament)

MEMBERS OF PARLIAMENT
(Directly elected in elections)

PRESIDENT
(Head of the Executive directly elected in elections)

VICE PRESIDENT
(Elected together with the President)

SECOND VICE PRESIDENT
(Appointed by president)

CABINET
(Political heads of ministries-ministers)
(Appointed by president)

CHIEF JUSTICE
(Head of the Judiciary appointed by the President)

- Supreme court of appeal
- High court
- Magistrate courts
- Industrial Relations Courts
- Traditional courts

MINISTRIES AND GOVERNMENT DEPARTMENTS
- Principal Secretaries (PSs) – overall controlling officers for ministries and government departments
- Heads of Departments
- Public servants

Source: The author
### Appendix 4: Administrative Service, 1960-1962

<table>
<thead>
<tr>
<th>Year</th>
<th>Administrative Officer</th>
<th>Senior Admin. Officer</th>
<th>Principal Admin. Officer</th>
<th>Under Secretary</th>
<th>Deputy Under Secretary</th>
<th>Permanent Secretary</th>
<th>All Officers in percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>E</td>
<td>A</td>
<td>M</td>
<td>E</td>
<td>A</td>
<td>M</td>
</tr>
<tr>
<td>1960</td>
<td>4</td>
<td>88</td>
<td>92</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>1962</td>
<td>5</td>
<td>83</td>
<td>88</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: **M** = Malawian Officers, **E** = Expatriate Officers, **A** = All Officers

**Source:** adapted from Baker (1972:547)
Appendix 5: Letter of Introduction

UNIVERSITY OF MALAWI

PRINCIPAL
Emmanuel Patirano, BSc, MSc., Ph.D.

CHANCELLOR COLLEGE
P. O. Box 280, Zomba,
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Department of Political and Administrative Studies

18th March, 2009

TO WHOM IT MAY CONCERN

Dear Sir/Madam

LETTER OF INTRODUCTION: MR RICHARD TAMBULASI

The bearer of this letter is Mr Richard Tambulasi. He is a lecturer at Chancellor College in the Department of Political and Administrative Studies. Mr Tambulasi is currently pursuing PhD studies in Public policy at the University of Manchester in the United Kingdom.

As part of his studies, he is supposed to do research and he has sampled your organisation as key to his study. Therefore, Mr Tambulasi intends to carry out a data gathering exercise for this purpose.

Any assistance rendered to him in the course of this exercise will be highly appreciated. Let me also point out that the information gathered will be treated as confidential and purely for academic purposes.

Yours faithfully

Mr H. Kayuni
DEPUTY HEAD OF DEPARTMENT

17 MAR 2009
ADMINISTRATIVE STUDIES
DEPARTMENT
P.O. BOX 380, ZOBA
Appendix 6: Semi-structured Interview Guides

A. INTERVIEW WITH DONOR ORGANISATIONS

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?
   - What is your understanding of globalization in relation to the role of your organisation? How do you position your organisation in the globalisation process?
   - What is the operational relationship between your organisation and the government?
   - How do you interact with the government on policy matters
   - Why are reforms in the MOH important for Malawi?
   - What has been your role in the reform process in the health sector
   - What reforms have you proposed to the Malawi government in terms of health service delivery (probe: decentralisation, hospital autonomy etc)
   - Why have you proposed these reforms
   - Were these reforms influenced by another model in other countries? if yes from which one and why
   - Among the donors, bureaucrats and politicians, which one is the most influential in these reforms? Explain
   - To what extent are the local views/needs reflected in the reform proposals (PROBE: Has there been involvement of the general public in these reforms? Has the general public fully accepted these reforms? Is there a mechanism to get the views of the general public?)

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?
   - Out of these what reforms have been adopted? Why (probe what factors have facilitated the adoption: political, economic, institutional, cultural, organisational)
➢ Out of these what reforms have not been adopted? Why not (probe what factors have constrained the adoption: political, economic, institutional, cultural, organisational )
➢ Out of the adopted reforms, which ones have been implemented? Why (probe what factors have facilitated the implementation: political, economic, institutional, cultural, organisational )
➢ Out of the adopted policies which ones not been implemented? Why not? (probe what factors have constrained the implementation: political, economic, institutional, cultural, organisational )
➢ Do you think that there are any prerequisite that the country needed to have for the implementation of these reforms (probe: How prepared is Malawi for these reforms taking into consideration the political, social and economic factors?)
➢ To what extent has the relationship (or mode of operation) between your organization and the government facilitated or constrained the adoption and implementation these reforms

3. To what extent has policy transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

To what extent have the reforms led to the transformation of service delivery?
(Probe using indicators of Ferlie et al.)

- Has there been numerous related changes across the health sector?
- Has there been evidence of new organisational forms created in the health sector due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent has reforms made some offices more or less powerful?
- Have people in the organisation embraced new organisational practices, ideas and understanding?

4. What are the impacts of the transferred health sector reforms on service delivery?
➢ Have the reforms worked or been implemented as expected?
  - What are the noted impacts?
5. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?

➢ What lessons can be drawn about process of implementing these reforms?
➢ Do you think that countries that implement the same reform programs should be similar or can be different?

6. Any other comments on the reforms in the health sector?

B. INTERVIEW GUIDE MINISTRY OF HEALTH HEAD QUARTERS: (Principal Secretary, Directors and Administrators)

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?

➢ What is the operational relationship between the Ministry of Health (MOH) and donor organisations (Probe: which ones)
➢ What reforms have been implemented in the MOH? (probe: decentralization and hospital autonomy)
➢ What has been the role of the following actors in policy making and reforms in the health sector
  . Donors (probe: beyond funding programs)?
  . Politicians?
  . Bureaucrats in the MOH?
➢ Among the donors, bureaucrats and politicians, which one is the most influential in these reforms? Explain
➢ Why are reforms in the MOH important for Malawi?
➢ Were these reforms influenced by another model in other countries? if yes from which one and why
➢ Which sector is responsible for reform policy guidance in the MOH?
➢ Which mechanism is put in place to ensure that policy reforms are disseminated to all sectors?
➢ To what extent are the local views/needs reflected in the reform proposals (PROBE: Has there been involvement of the general public in these reforms? Has the general
public fully accepted these reforms? Is there a mechanism to get the views of the general public?)

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?

➢ Out of these, which reforms have been adopted? Why (probe what factors have facilitated the adoption: political, economic, institutional, cultural, organisational)

➢ Out of these, what reforms have not been adopted? Why not (probe what factors have constrained the adoption: political, economic, institutional, cultural, organisational)

➢ Out of the adopted reforms, which ones have been implemented? Why (probe what factors have facilitated the implementation: political, economic, institutional, cultural, organisational)

➢ Out of the adopted reforms, which ones have not been implemented? Why not? (probe what factors have constrained the implementation: political, economic, institutional, cultural, organisational)

➢ Do you think that there are any prerequisite that the country needed to have for the implementation of these reforms? (probe: How prepared is Malawi for these reforms taking into consideration the political, social and economic factors?)

➢ To what extent has the relationship (or mode of operation) between your organization and the donors facilitated or constrained the adoption and implementation these reforms?

3. To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

To what extent have the reforms led to the transformation of service delivery?

(Probe using indicators of Ferlie et al.)

- Has there been numerous related changes across the health sector?
- Has there been evidence of new organisational forms created in the health sector due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent has reforms made some offices more or less powerful?
• Have people in the organisation embraced new organisational practices, ideas and understanding?

4. What are the impacts of the transferred health sector reforms on service delivery?
   ➢ Have the reforms worked or been implemented as expected?
     • What are the noted impacts?
     • What are some of the noted challenges?

5. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?
   ➢ What lessons can be drawn about process of implementing these reforms
   ➢ Do you think that countries that implement the same reform programs should be similar or can be different

6. Any other comments on the reforms in the health sector?

C. INTERVIEW GUIDE TO HOSPITAL DIRECTORS AND ADMINISTRATORS

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?
   ➢ What reforms have been adopted by the ministry of health? Why (probe: hospital autonomy, decentralisation, contracting out, user fees, public private partnerships)
   ➢ Do you know how decisions about these reforms are made? (Probe: Role of donors, politicians, bureaucrats)
   ➢ Out of the adopted reforms, which ones have been implemented at your hospital? Why? if not, Why not? (Probe what factors have constrained the implementation i.e. social, economic, political, organisational, institutional and cultural)
   ➢ Do you think that there are any prerequisite that the country and your hospital needs to have for the effective implementation of these reforms?
   ➢ To what extent has the relationship (or mode of operation) between the MOH and donors facilitated or constrained the adoption and implementation these reforms?
2. To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

To what extent have the reforms led to the transformation of service delivery?

(Probe using indicators of Ferlie et al.)

- Has there been numerous related changes in your organisation as a result of these reforms?
- Has there been evidence of new organisational forms created due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent have reforms made some offices more or less powerful?
- Have people in the organisation embraced new organisational practices, ideas and understanding?

3. What are the impacts of the transferred health sector reforms on service delivery?

- Have the reforms worked or been implemented as expected?
  - What are the noted positive impacts?
  - What are some of the noted challenges?

4. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?

- What lessons can be drawn about process of implementing these reforms
- Do you think that countries that implement the same reform programmes should be similar or can be different?

5. Any other comments on the reforms in the health sector or policy transfer
D. FOCUS GROUP DISCUSSION GUIDE TO HOSPITAL OFFICIALS

1. What factors facilitated or constrained the implementation of health sector reforms in Malawi?

- What reforms have been adopted by the ministry of health? Why (probe: hospital autonomy, decentralisation, contracting out, user fees, public private partnerships and SWAPs)
- Do you know how decisions about these reforms are made? (Probe: Role of donors, politicians, bureaucrats)
- Out of the adopted reforms, which ones have been implemented at your hospital? Why? if not, Why not? (probe what factors have constrained the implementation i.e. social, economic, political, organisational, institutional and cultural)
- Do you think that there are any prerequisite that the country and your hospital needs to have for the effective implementation of these reforms?
- To what extent has the relationship (or mode of operation) between the MOH and donors facilitated or constrained the adoption and implementation these reforms?

2. To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

To what extent have the reforms led to the transformation of service delivery? (Probe using indicators of Ferlie et al.)

- Has there been numerous related changes in your organisation as a result of these reforms?
- Has there been evidence of new organisational forms created due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent have reforms made some offices more or less powerful?
• Have people in the organisation embraced new organisational practices, ideas and understanding?

3. What are the impacts of the transferred health sector reforms on service delivery?

➢ Have the reforms worked or been implemented as expected?
  • What are the noted impacts?
  • What are some of the noted challenges?

4. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?

• What lessons can be drawn about process of implementing these reforms?
• Do you think that countries that implement the same reform programmes should be similar or can be different?

5. Any other comments on the reforms in the health sector?

E. INTERVIEW GUIDE TO MINISTRY OF FINANCE, MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?

➢ What is the operational relationship between your Ministry and the MOH?
➢ What reforms have been implemented by the MOH? (probe: hospital autonomy and decentralisation)
➢ What is the role of your ministry in the health sector reform program?
➢ Which agents played a significant role in the introduction of these reforms? (your ministry, donors, MOH, politicians) [Probe: How were decisions about these reforms made i.e. roles of your Ministry, donors, politicians, MOH]
➢ Among the donors, MOH, politicians, and your institution, which one is the most influential in these reforms? Explain
Were these reforms influenced by another model in other countries? if yes from which one and why?

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?

- What factors have facilitated the adoption of these reforms
- What factors have affected the adoption of these reforms
- What factors have facilitated the implementation of these reforms
- What factors have affected the implementation of these reforms
- Do you think there are any prerequisites that the country needed to have for the effective implementation of these reforms? (Probe: How prepared is Malawi for these reforms taking into consideration the political, social and economic factors).
- To what extent has the relationship between donor organisations and the government facilitated or constrained the implementation of reforms?

3. To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?

To what extent have the reforms led to the transformation of service delivery?
(Probe using indicators of Ferlie et al.)

- Has there been numerous related changes across the health sector?
- Has there been evidence of new organisational forms created in the health sector due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent has reforms made some offices more or less powerful?
- Have people in the organisation embraced new organisational practices, ideas and understanding?

4. What are the impacts of the transferred health sector reforms on service delivery?

- Have the reforms worked or been implemented as expected?
  - What are the noted positive impacts?
What are some of the noted challenges?

5. What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?
   - What lessons can be drawn about process of implementing these reforms
   - Do you think that countries that implement the same reform programmes should be similar or can be different?

6. Any other comments on the reforms in the health sector?

F. INTERVIEW GUIDE TO DISTRICT ASSEMBLIES

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?
   - What is the operational relationship between your assembly and the MOH?
   - What reforms have been implemented by the hospital in your area?
   - What is the role of your assembly in the health sector reform program?
   - Which agents played a significant role in the introduction of these reforms? (your ministry, donors, MOH, politicians) [Probe: How were decisions about these reforms made i.e. roles of your Ministry, donors, politicians, MOH]
   - Among the donors, MOH, politicians, and your institution, which one is the most influential in these reforms? Explain
   - Were these reforms influenced by another model in other countries? if yes from which one and why?

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?
   - What factors have facilitated the adoption of these reforms
   - What factors have affected the adoption of these reforms
   - What factors have facilitated the implementation of these reforms
   - What factors have affected the implementation of these reforms
3. **To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?**

To what extent have the reforms led to the transformation of service delivery? (Probe using indicators of Ferlie et al.)

- Has there been numerous related changes across the health sector?
- Has there been evidence of new organisational forms created in the health sector due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent has reforms made some offices more or less powerful?
- Have people in the organisation embraced new organisational practices, ideas and understanding?

4. **What are the impacts of the transferred health sector reforms on service delivery?**

- Have the reforms worked or been implemented as expected?
  - What are the noted positive impacts?
  - What are some of the noted challenges?

5. **What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?**

What lessons can be drawn about process of implementing these reforms

- Do you think that countries that implement the same reform programmes should be similar or can be different?

6. **Any other comments on the reforms in the health sector?**
G. INTERVIEW GUIDE TO NON GOVERNMENTAL ORGANIZATIONS IN THE HEALTH SECTOR

1. What were the mechanisms for the transfer of health sector reforms to Malawi’s policy agenda?

- What is the operational relationship between your NGO and the MOH?
- What reforms have been implemented by the MOH? (probe: Autonomy and decentralisation)
- Why were the reforms introduced at this time?
- What is the role of your NGO in the health sector reform program?
- Which agents played a significant role in the introduction of these reforms? (your ministry, donors, MOH, politicians)  
  [Probe: How were decisions about these reforms made i.e. roles of your Ministry, donors, politicians, MOH]
- Among the donors, MOH, politicians, and your institution, which one is the most influential in these reforms? Explain
- Were these reforms influenced by another model in other countries? If yes from which one and why?

2. What factors facilitated or constrained the implementation of health sector reforms in Malawi?

- What factors have facilitated the adoption of these reforms
- What factors have affected the adoption of these reforms
- What factors have facilitated the implementation of these reforms
- What factors have affected the implementation of these reforms
- Do you think there are any prerequisites that the country needed to have for the effective implementation of these reforms? (Probe: How prepared is Malawi for these reforms taking into consideration the political, social and economic factors).
- To what extent has the relationship between donor organisations and the government facilitated or constrained the implementation of reforms?
3. **To what extent has the transfer of health sector reforms led to the transformation of health service delivery mechanisms in Malawi?**

To what extent have the reforms led to the transformation of service delivery?  
*Probing using indicators of Ferlie et al.*

- Has there been numerous related changes across the health sector?
- Has there been evidence of new organisational forms created in the health sector due to these reforms?
- Do you think that the reforms have had an impact on how individual employees work and even departments or units?
- Has there been any changes in the nature of services provided and mode of delivery?
- To what extent has reforms made some offices more or less powerful?
- Have people in the organisation embraced new organisational practices, ideas and understanding?

4. **What are the impacts of the transferred health sector reforms on service delivery?**

- Have the reforms worked or been implemented as expected?
  - What are the noted positive impacts?
  - What are some of the noted challenges?

5. **What lessons can be drawn from a greater understanding of the causes and effects of the transfer of health sector reforms in Malawi?**

- What lessons can be drawn about process of implementing these reforms
- Do you think that countries that implement the same reform programmes should be similar or can be different?

6. Any other comments on the reforms in the health sector?