

Bielefeld University
School of Public Health

GOVERNING
HUMAN RESOURCES FOR HEALTH
IN A GLOBAL CONTEXT –
THE CASE OF
THE REPUBLIC OF MALAWI

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Foreword

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Abstract

Background: At the beginning of the new millennium, Malawi receives international attention for its Human Resources for Health (HRH) crisis, together with 57 other developing countries identified in the World Health Report 2006. Poverty-related diseases including HIV/AIDS have added to the workload and perpetuated attrition from the Malawian health workforce. After president H.K. Banda's 30 years of autocratic rule ended in 1994, the health labour market has also become increasingly international. Opportunities have opened up to find work and better payment either abroad or with private and non-governmental organisations. By 2009, a large-scale intervention of international donors is underway to re-strengthen HRH as a basis for delivering an essential health package to the Malawian population and reducing poverty.

Starting from the idea of sustainable development that has evolved since the Rio Declaration 1994, the underlying assumption of this study is that qualified health work can be seen as a common-pool resource system. Commons theory suggests that self-organization and rule-setting by relevant actors could help to balance the appropriation and (re)production of a resource in a circumscribed system. This study investigates how the cooperation of Malawian and international employers can be regulated to achieve a well-performing and sustainable health workforce.

Methodology: Malawi has been selected as the research site for a country case study based on qualitative and quantitative, primary and secondary data. A field research phase of six months in 2009 has been used for collecting text documents and statistics, and for conducting 25 expert interviews. Secondary data has been analysed to reconstruct the historically grown structures and conditions of HRH and international cooperation. Interview data has first been subjected to thematic analysis, with themes deducted from the UNDP capacity development framework. Relevant findings feed into an institutional analysis (Oakerson 2003; Ostrom 2005), looking at strategies, norms and rules applied to HRH in Malawi. The focus is on the district health system as an action arena, but other linked arenas are also considered.

Results: The HRH system in Malawi shows warning signs of depletion, as reproduction through training cannot meet the domestic demand and compensate for attrition. Expectations to revert this trend are focused on the government and the Christian Health Association of Malawi (CHAM) as those who have historically been in charge of securing the availability of different cadres of health workers. At the same time, the appropriators of HRH (organisations acting as employers or contractors) have multiplied and diversified. This group is characterized by striking asymmetries

regarding their dependence on HRH, their financial and technological endowments and their autonomy in decision making. International actors' entry to and exit from the system is weakly regulated.

As for the level of the health district, three basic strategies of international aid agencies emerge: (1) direct implementation of health-related activities, (2) implementation through the District Health Office as a governmental structure, (3) implementation through other Malawian organisations or consultants. Although HRH is a cross-cutting issue in health service provision, the interview statements hardly convey explicit rules concerning the inter-organisational cooperation on HRH appropriation and/or reproduction. Concepts of staff supervision and professional development continue to be geared towards control and hierarchy. Even when it comes to the zonal or national level, the special features of HRH - such as individual decision-making and mobility of health workers, their socio-cultural embeddedness and their capacity to organize – only begin to be addressed.

Discussion: Human resources largely meet the economic attributes of a common-pool resource, namely subtractability, indivisibility and limited excludability. As such, it appears promising to apply governance concepts to HRH which have originally been devised for sustaining natural resources. However, compared against the sustainability criteria named in commons theory, the findings for Malawi (together with the political developments since 2009) do not give rise to optimism. New forms of governance in this field are likely to be inhibited by the degree of deterioration of the HRH system and the existing incentive structures, the difficulties of monitoring, a lack of trust and reciprocity among the different actors and low levels of autonomy from external forces.

At the same time, the study has revealed some potential points of intervention if collective rule setting at the level of the health district is to be enabled, involving local and global, governmental and non-governmental actors. Political decentralisation appears to have reached a new phase in Malawi, with the local elections finally conducted in 2014. The district assemblies and the Zonal Health Support Offices may take responsibilities with regard to monitoring and conflict resolution in the HRH system. The increasing frequency of strikes among health workers also underlines the need for clearer regulative frameworks at the constitutional level in Malawi, providing for new actor constellations and a new understanding of HRH.

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Acronyms

ACB	Anti-Corruption Bureau
AEHO	Assistant Environmental Health Officer
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
BBC	British Broadcasting Service
CABS	Common Approach to Budget Support
CBO	Community-based Organisation
CHAM	Christian Health Association of Malawi
CIM	Centre for International Migration
COM	College of Medicine
COMREC	College of Medicin Research and Ethics Committee
CONGOMA	Council for Non-Governmental Organisations in Malawi
CSO	Civil Society Organisation
DAC	Development Action Committee (OECD)
DED	Deutscher Entwicklungsdienst
DEHO	District Environmental Health Officer
DFID	Department for International Development (UK)
DHA	District Health Administrator
DHO	District Health Officer
DNO	District Nursing Officer
EH	Environmental Health
EHO	Environmental Health Officer
EHP	Essential Health Package
EHRP	Emergency Human Resource Programme
EU	European Union
GDC	German Development Cooperation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHWA	Global Health Workforce Alliance
GIZ	Gesellschaft für Internationale Zusammenarbeit
GTZ	Gesellschaft für Technische Zusammenarbeit
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health-Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HSC	Health Service Comission
HSS	Health Systems Strengthening
IAD	Institutional Analysis and Development
ICESCR	International Covenant on Economic, Social and Cultural Rights
IGO	International Governmental Organisation
ILO	International Labor Organization
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
IRIN	Integrated Humanitarian Information Network

JLI	Joint Learning Initiative
KCN	Kamuzu College of Nursing
MASAF	Malawi Social Action Fund
MD	Medical Doctor
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
MPH	Master of Public Health
MS	Microsoft
MSH	Management Sciences for Health
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Cooperation
OECD	Organization for Economic Cooperation and Development
OPC	Office of the President and Cabinet
PAP	Poverty Alleviation Programme
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PH	Public Health
PHC	Primary Health Care
PoW	Programme of Work
SADC	Southern African Development Community
SAP	Structural Adjustment Programme
SoSc	Social Scientist
SWAp	Sector-Wide Approach
SWEF	System-Wide Effects of the Fund
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
Unicef	United Nations Children's Fund
US	United States of America
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WHR	World Health Report

1 INTRODUCTION: MALAWIAN HEALTH SYSTEM IN CRISIS

Human Resources for Health (HRH) are considered a key factor in health systems today. At the same time, the worldwide shortage of health workers has turned out to be a major bottleneck to the achievement of the Millennium Development Goals (MDG), which will be evaluated in 2015 (Dussault and Dubois 2003; Kabene et al. 2006)

Health care reforms are usually oriented at the criteria of efficiency, equity and quality of services provided. In a labour-intensive service sector such as health care, all these aspects are immediately connected to adequate qualification and motivation of staff (Rigoli & Dussault 2003). However, in the planning process of reforms, HRH are still not considered in their full complexity. Short-term thinking and reactivity are particularly prevalent in international development aid, which is characterised by short project and programme cycles. Questions of staffing in the public sector of recipient countries are often delicate and the responsibilities are unclear. Moreover, important dimensions of work, especially immaterial factors of motivation or professional ethics, are often pushed to the background by financial arguments (Segall 2000, Dussault & Dubois 2003).

Over the recent decade, HRH have moved high on the global political agenda, not least due to the activities evolving around the World Health Report 2006, titled “working together for health” (Joint Learning Initiative 2004; Chen et al. 2004; WHO 2006b). The 10-year plan of action laid out here is based on the principles of *country leadership* and *global solidarity*. It has spawned a number of alliances as well as the development of regional and national strategic plans. The WHO Headquarter is now hosting the Global Health Workforce Alliance (GHWA), which is bringing together national governments, donors, international agencies, professional bodies, academia and civil society.

The Republic of Malawi is chosen for a case study on HRH because it is one of 57 countries named in WHR 2006 which are facing a combined HIV and HRH crisis (McCoy et al. 2008). The country has also lent itself to field research as the German Development Co-operation was already engaged in the field of HRH and participated in the health Sector-Wide Approach (SWAp) in Malawi from 2004 to 2010 (Windisch et al. 2009). While employment as well as pre-service training for health workers in Malawi

continue to take place largely in the governmental sector, there is growing NGO and private sector involvement, and the labour market is becoming increasingly international (Gama and McPake 2009; Barber and Bowie 2008).

The thesis is taking an institutionalist approach developed in political sciences, to explore possibilities of regulating the interaction of Malawian and international organisations which act as employers of HRH. The question is how respective cooperation and joint rule-making can contribute to the sustainable functioning of the Malawian HRH system.

This introductory chapter outlines the political situation and the state of HRH research in Malawi in the early 2000s. Further developments from 2010 onwards can be found in Annex 7.2. The background chapter is then taking a more theoretical perspective, looking for models and frameworks that might be transferred to international aid in the field of HRH.

1.1 HEALTH AND SOCIAL POLICY IN MALAWI, 1994-2009

Hastings Kamuzu Banda, the first and self-declared 'Life President' of Malawi, was in office from 1964 until 1994, when non-violent resistance led to the first multi-party elections. Banda's foreign policy course had been the alignment with the Apartheid regime in South Africa. He had also provided Western governments with a base in the region to observe communist activities in neighbouring countries. Domestic politics evolved around the idea of integrated rural development (including health), which was supported by international donors. This neo-patrimonial governance model continued to be influential after 1994. This is also known as the 'big man syndrome' prevalent in many African countries after independence. Bakili Muluzi (president 1994-2004) is seen as having fostered patronage and corruption throughout the Malawian society. His successor Bingu wa Mutharika is perceived as at least subordinating the patronage principle to an overall political vision (Booth et al. 2006).

The Muluzi government introduced the Malawi Social Action Fund (MASAF), to ensure community participation and direct disbursement to communities for public works projects. Social Action Funds are a prominent tool of the World Bank to support decentralisation processes and participatory structures in recipient countries; the first round of World Bank funding for MASAF was issued in 1995. The administration of MASAF funds was to be integrated with the existing district administration structures, as part of the decentralisation process formally initiated by the Local Government Act of 1998. However, as van Donge (2004) highlights, the authoritative political culture in Malawi prevented the reversal of a 'top-down' management approach into sustained community participation in MASAF. Disappointed by the lack of support on behalf of district administration staff (now renamed district assemblies), MASAF established its own parallel structures at district level. This again led to tensions with the pre-existing departments in the districts, where MASAF was perceived as drawing on their over-stretched budgets. Van Donge (2004) concludes that the chances of MASAF may also have been missed due to the political ideal of decentralisation pursued in Malawi. Instead of going ahead and gaining first experiences with pre-designed intervention modules for communities, it was insisted that the capacity of district administrations

and communities first needed to be built before meaningful decentralisation could take place.

However, the World Bank appears to have adopted its approach accordingly, as the ongoing MASAF round 3 (2003-2015) operates with five pre-determined service packages (Kalanda et al. 2008). These include health, education, water & sanitation, transportation & communication and household food security. MASAF is to be seen as an instrument deployed within larger policy frameworks of poverty alleviation. The end of MASAF round 3 is synchronised with the evaluation date of the Millennium Development Goals (MDG). Respective indicators have been established, to be compiled at the district level (Kalanda 2007; Kalanda et al. 2008).

The new political freedom and economic deterioration in Malawi also led to a massive 'brain drain' of doctors and nurses from public services. According to article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), countries have an obligation to ensure that their citizens can enjoy their 'right to health' (Physicians for Human Rights 2004). Having ratified the covenant in 1993, Malawi is therefore required to equip health workers and their workplaces sufficiently, so that this right can be fulfilled. At the same, other articles of the ICESCR stipulate the right to safe working conditions, to education and to an adequate standard of living, which of course also applies to health workers. They are principally free to change their employer and work in the private sector (or to leave their country, as stated in the International Covenant on Civil and Political Rights), if they decide to seek better conditions elsewhere. The rights of the population and the rights of health workers can thus be in conflict with each other.

The post-Banda era has thus brought significant changes in health and social policy. This was also due to the growing HIV/AIDS problem, which was now brought to the fore by donors, international foundations and non-governmental organisations (NGOs). The number and presence of these 'new players' in Malawi increased rapidly, which was also furthered by the food crisis in 2002/2003. The president declared the state of emergency and invited international NGOs to assist. HIV/AIDS also started to take its toll on the civil service including the health workforce. The National Health

Plans of 1994 and 1999 in large parts dealt with increasing the stock of health personnel (Physicians for Human Rights 2004; Muula and Maseko 2005).

Malawi has been a beneficiary of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) from its very beginning in 2002. The first disbursements targeted to HIV/AIDS were released to the country in 2003, followed by malaria funds in 2006. The establishment of GFATM was accompanied by the concern that already weak health systems might be further fragmented through largely vertical, disease-specific programmes. The Systemwide Effects of the Fund (SWEF) Research Network was therefore launched to assess the interactions of the Fund with recipient health systems, in terms of policy environment, human resources, public-private mix, and pharmaceuticals and commodities. The SWEF case study for Malawi found both positive and negative effects (USAID and Abt Associates 2006).

In any case, the growing global sensitivity for such interactions caused the WHO to launch a Health Systems Strengthening (HSS) framework (WHO 2007b), while GFATM opened up for generic HSS proposals in its Round 5 to meet the prerequisites for successful programme implementation targeting the three diseases. Malawi successfully applied, using dramatic wording to describe the status of the health workforce in the country (Dräger et al. 2006). At the same time, national and international forces were joined in Malawi to set up a six-year Emergency Human Resources Plan (EHRP) for the health sector (Task Force for Scaling Up Education for Health Workers 2008). The funds disbursed by GFATM in Round 5 were integrated in the EHRP in 2004, serving mainly for the training of community-based Health Surveillance Assistants (HSA).

During the phase of its fourth National Health Plan (1999-2004), Malawi had also prepared for a donor harmonisation and pooled funding arrangement known as Sector-Wide Approach (SWAp). SWAps are another instrument of the World Bank developed during the 1990s, as a reaction to fragmented, donor-driven project-type aid. The overall goal of the Malawian health SWAp is the delivery of an Essential Health Package (EHP) to the population. The SWAp Programme of Work (POW) and related expenditure plans eventually covered the period of 2004 to 2010. The EHRP as well as the disease-specific funds of GFATM were again integrated into the SWAp,

programmatically as well as financially (USAID and Abt Associates 2006). Such integration has been promoted by donors to other African countries as well (Brugha 2005).

In Malawi, the health SWAp was adopted by a group of donors despite reservations regarding the weak planning and administrative capacities of the national government, which had already surfaced e.g. in the context of support to the Malawian Poverty Reduction Strategy Paper (Krakowski 2004; Vaillancourt 2009). The German Development Cooperation (GDC), which is a partner in the Malawi Health SWAp Donor Group, had gained previous experiences with SWAPs in other countries. With regard to their impact on HRH in particular, the expectations were moderate, considering the cultural embeddedness of HRH and the structural entanglements with the broader civil service (Schmidt-Ehry and Lauckner 2001; Schwefel et al. 2007). The engagement of the GDC in the area of human resources and capacity development within this donor group has been all the greater. A needs assessment study for this area was commissioned by the GDC, with particular regard to anchor points of technical assistance (Ministry of Health et al. 2007). The study report has been a valuable resource at the outset of my own field research in 2009, as it provided detailed and up-to-date information on HRH.

1.2 RESEARCH ON HUMAN RESOURCES FOR HEALTH IN MALAWI

Exact figures on the status on the Malawian health workforce are difficult to come by, and statistics are often limited to the medical and nursing professions. The studies and reports cited in the following show striking variations in the total numbers of different categories of health workers. This demonstrates that quantitative approaches and projections of HRH in Malawi are generally hampered by unreliable and incompatible data sources.

In preparation of the World Health Report 2006, the WHO conducted a survey in the country in 2004, which numbered physicians at 266 and nurses at 7,264. In relation to a total population estimated at 12.68 million in 2004, this gives a density of 0.02 physicians and 0.59 nurses per 1,000 population (WHO 2006b). No timelines are available, and it is highlighted in the report that the survey method may diverge from national data collection mechanisms. In order to calculate the number of health workers required to meet the needs of the Malawian population for highly active antiretroviral therapy, Muula et al. (2007) compared these figures with data from national professional registries and with internal staffing figures of the Ministry of Health and the Christian Health Association of Malawi (CHAM), as the predominant providers of health services. The staff available for patient care in those health facilities was calculated to be 194 physicians and 4,714 nurses in 2005, while the number of physicians registered at the medical council was 214 and the number of nurses registered at the Nurses and Midwives Council of Malawi was 4,211 at the end of 2006. Due to the discrepancies of data in the nursing field, the authors decide to treat the figures from the nurses' register as an underestimate and consider the WHO figure to be more likely. However, assuming that the figure remained stable between 2004 and 2006, this would mean that more than 2,500 nurses in Malawi were either working in non-clinical fields, were employed by private or non-governmental health care providers or were not participating in the health workforce at all.

According to the more recent Human Resources for Health Country Profile for Malawi (Africa Health Workforce Observatory 2009), which is based on the Malawian Health Worker Census of 2008, generalist and specialist medical practitioners add up to 257,

while nursing professionals (including midwives) and associate nursing professionals add up to 3,900. This is in relation to a general population estimated at 13.18 million in 2008.

Attempts to estimate migration flows of health workers also rely on professional registries as the predominant data source. Dovlo (2007) describes the limitations of this approach, as annual re-registration is not always mandatory, and the numbers of those professionals seeking verification of their qualification only reflects their intention to migrate. On the other hand, when relying on the registration data in destination countries, those immigrants who find work outside their profession are missed out. The World Health Report relies on data from seven OECD destination countries, to arrive at the number of 453 Malawian nurses and midwives working abroad (WHO 2006b). In the same table, the various data sources of which remain unclear, it is stated that nurses and midwives working in Malawi amount to 11,022. Furthermore, referring to a study by USAID in 2004, the report stipulates that the largest cause of attrition from the Malawian health workforce is death – in most cases due to HIV/AIDS (WHO 2006b).

Based on domestic verification data, Record and Mohiddin (2006) indicate possible net gains from remittances of Malawian health professionals working abroad. They assume that about 103 nurses left the country in 2002 and 108 left in 2003, mostly to the UK. They compare the official salaries paid by the Malawian Ministry of Health to those in the UK. In addition they quote a 2005 survey among African nurses working in London. 60% of those nurses regularly sent money back home, amounting to more than a quarter of their earnings in 20% of the cases. However, the authors abstain from estimating overall achievable remittances due to the weakness of available data.

Equity in health service provision has been investigated by Zere et al. (2007). They find that the 'inverse care law' applies to Malawi, meaning that the quality of health care worsens the greater the need for it. Having analysed data from Demographic and Health Surveys in 1994, 2000 and 2004, they state that the provision of basic health services is not only favouring the rich, but that the gap between the rich and the poor is even widening. Such equity issues are supposed to be addressed by offering a free Essential Health Package to the population within the scope of the SWAp.

Much of the Malawian research on HRH in the early 2000s focuses on the working environment and perceptions of the health workers on the ground, notably in governmental health facilities. In an interview and focus group study, Muula and Maseko (2005; 2006) find numerous challenges as perceived by these professionals: Salaries are inequitable and even discriminatory, responsibilities are overwhelming and HIV is having its toll. Interaction at the workplace and supervision are considered demotivating or inadequate, while prospects of career progression and further training are deteriorating. The authors also present various 'survival strategies' of health workers, in terms of increasing income or reducing expenditure. Additional income can be achieved legally through overtime arrangements, private practice, time-limited consultancy contracts and other economic activities, as long as they are carried out during off-duty periods. However, illegal and corrupt practices are also common, which includes stealing drugs or providing material supplies to their workplace. Some respondents are apologetic, stating that the health system was responsible for creating such an environment, and that health workers do not have many other opportunities to secure their livelihood. Muula and Maseko (2005) conclude by a comprehensive list of policy recommendations concerning material and non-material incentives for health workers.

Mangham and Hanson (2008) present a study on employment preferences. They have conducted a discrete choice experiment asking Malawian nurses to trade-off between six monetary and non-monetary job attributes. They find that all attributes have significant influence on employment preferences, but opportunities for further qualification, housing schemes and higher net payment prove most influential. Incentive structures and respective initiatives of various organisations and at different levels of the health sector are also described in another EQUINET-report, which is bundling information from 16 countries in South and East Africa (Dambisya 2007).

In the attempt to find suitable retention strategies, studies also often focus on job satisfaction of Malawian health workers. In this regard, HRH management structures and skills are beginning to receive attention. McAuliffe et al. (2009b) have conducted a questionnaire survey among mid-level health workers who were given greater work responsibilities within the scope of task-shifting between health cadres. They find that

perceived organisational justice (i.e. procedures, fair treatment and managers' communication) correlates with high job satisfaction in this group. This indicates that besides payment, 'softer' management factors also play an important role to enhance the performance of health workers. These findings have been further explored in focus group discussions and interviews (Manafa et al. 2009). While health workers deplore the insufficiency of supervision and feedback on performance, members of District Health Management Teams and HRH Managers in the Ministry of Health do not consider these relevant to health workers' motivation.

The economic and social rights of health workers (including labour rights and the right to strike) receive little attention in the Malawian HRH discourse. A major strike at Malawi's biggest hospital in 2001 (Muula and Phiri 2003) triggered a debate among health workers about whether it is ethical to go on strike. However, the government managed to sit out the action, ignore the demands and fine some prominent individuals. The authors of the article draw the conclusion that industrial relations in the health sector urgently need to catch up with the democratisation process.

Considering the health-related research on Malawi over the last 10 to 15 years, a research gap regarding the political-economic side of HRH can be seen. Fritzen (2007) outlines different dimensions of health workforce research, which also cater for the influences of the broader policy environment as well as external forces. In developing countries, civil service policies and administrative arrangements are likely to be shaped by the strategies of international donors and lenders. Within the present research, the focus will therefore be on the dimension of workforce-related interactions between the public and the private sector in the area of health services. The research question is outlined in the chapter below.

1.3 RESEARCH QUESTION AND ASSUMPTIONS

Health systems are meant to contribute to the goal of improved population health in an effective and efficient manner. At the same time, they should provide for equitable access to health care and for the quality and responsiveness of the services (Joint Learning Initiative 2004). The performance of HRH is understood as comprising availability, competence, responsiveness and productivity (WHO 2006b).

The principles and mechanisms based on which international aid is delivered in the health sector are assumed to have consequences for the job profiles and employment arrangements of health professionals. Such effects might either result from policies and interventions directly targeting national HRH development, e.g. increasing the national training capacity to raise the number of new graduates. Or they may be an indirect consequence of the arrangements of cooperation, e.g. topping up the salaries of public sector staff or hiring local experts on a consultancy contract. Hence, the service providing organisations (composite actors) as intermediaries between foreign development assistance and the health professionals deserve special attention. They are recipients of assistance - possibly even direct contractors - and the actual employers of the professionals. The following research question will thus be pursued in this thesis:

How can the cooperation between Malawian and international actors be regulated with regard to HRH appropriation and production, aiming at a well-performing and sustainable health workforce?

The notion of sustainable development underlying the research question is based on a comprehensive human needs concept as proposed by Littig and Grießler (2005). This requires that health work and the related institutional arrangements meet the principles of social justice, human dignity and participation. However, the focus of this study is on qualified health work as provided within the scope of health occupations or professions, rather than on voluntary or unpaid work. Health work is conceived as an 'access good' to population health, carrying the features of a common-pool resource rather than those of a private good. As such, the resource system is prone to social

dilemmas such as over-exploitation, and neither 'market-only' nor 'state-only' approaches offer an ideal solution (Ostrom 2005).

The Institutional Analysis and Development (IAD) framework elaborated by Ostrom (2005) is applied to work out the institutional statements (i.e. shared strategies, norms, rules) that are structuring the system of HRH in Malawi. As an approach to empirical case studies, Oakerson (1992) suggests to look for underlying reasons and generative mechanisms of observable phenomena. The results chapters of this thesis will therefore answer to the following sub-questions:

How are the patterns of interaction of resource appropriators and the outcomes of their interaction influenced by

- *the physical and social attributes of HRH and related technologies?*
- *the decision-making arrangements in the Malawian health sector and the larger polity?*

The wording of the research questions is grounded in political-economic, social and institutionalist theories concerning Human Resources for Health (HRH). These will be outlined in the following background chapter.

2 BACKGROUND: HEALTH WORK AND HUMAN DEVELOPMENT

Investigating the role of Human Resources for Health in sustainable human development requires considering a variety of theoretical approaches. The term 'resources' points to economic theory, which will be looked into first (chapter 2.1.) However, the research question focuses on the possibilities of regulation, which suggests an institutionalist methodology. Respective theoretical building blocks refer to the health professions on the one hand, and organisations as employers on the other hand (chapter 2.2).

Some historical background information is also required when dealing with a health system in a so called 'developing country' like Malawi. Chapter 2.3 thus outlines some central health-specific lines of development, from the post-colonial era until today. In chapter 2.4, some more general concepts of contemporary international development policy are introduced. These include the concepts of global governance, capacity development and sustainability. They have to be viewed against the disputed terminology of development per se, and the inherent political ideology. A brief introduction to this discourse will be provided in the following.

Decolonisation in the 20th century led to the rise of development cooperation. Based on the work of Talcot Parsons in the 1950s and the historical observation of the industrialisation process within western societies, modernisation theory was established and applied to the 'third world countries'. Development cooperation followed the idea that societies have to move through several universal stages in a linear way, to evolve from traditional to modern societies. The implicit belief was that development was to be achieved by taking over western values and institutions (Mols et al. 2006). The newly independent former colonies generally adopted a state-driven development approach, often taking over the highly centralised features of colonial health administration and disease control programmes.

The breakdown of socialism in Eastern and Central European countries induced a revision of development strategies in the 1990s. Instead of the uni-dimensional belief in economic progress a more differentiated understanding of development was promoted, and a stronger emphasis was put on democratisation and institutions of

governance. In addition, globalisation requires new governance mechanisms to solve global problems. However, the assumptions of linear development in which unindustrialised countries are meant to 'catch up' with modern societies remain essentially the same. Major features of modern societies are capitalist markets, democratic participation, juridification of relationships and conflicts, secularisation, decline of family and friendship relations and a bureaucracy that is oriented at rational criteria (Nuscheler 2006).

Today most western societies are even considered to have passed into a stage of late modernity or post-modernity, marked by deindustrialisation and growing importance of the service sector. It remains essentially unanswered whether a 'catch up' development of other societies should still take the route of industrialisation, or whether they could take a 'short cut'. In addition, modernisation may not be equated with progress in a sense of 'social improvement': a number of recent social phenomena in developing countries, which have emerged under the conditions of modernisation, in fact appear as a regression in human development (Oswald 2007).

The challenge for development policy and practice is to provide normative orientations without aiming at a new macro-theory of development, and to deal with multiple antagonistic tendencies of integration, inclusion and entanglement on the one hand, and differentiation, marginalisation and fragmentation on the other hand (Mols et al. 2006, p.367). With work and knowledge being at the heart of the development process, such challenges are also concerning the field of HRH.

2.1 HUMAN RESOURCES IN NATIONAL ECONOMICS

In classical economics, including physiocratic and utilitarianist schools of thought, labour predominantly occurs as a production factor. Land and natural resources, capital and investment goods, and labour are known as the three major production factors. In the days of the industrial revolution, labour was mainly unqualified and thus easily replaceable - still its availability is principally limited. Within this economic thinking of utility, labour is also frequently seen as a 'resource'. Resources are usually consumed or transferred in the production process and are therefore at risk of depletion, depending on whether they are renewable and at what pace.

Labour is subject to markets, where in the classical sense supply and demand meet in an equilibrium point. These so called 'marginal benefit curves' are based on the principle of methodological individualism, meaning that they represent the aggregate of individual decisions to buy or sell a good at a certain price (Wonnacott and Wonnacott 1990; Krugman and Wells 2013). The underlying assumption is therefore that individual workers, as suppliers of qualified labour, are rational-egoist actors. This idea is reflected in contemporary Human Capital theory, which will be outlined in chapter 2.1.1. This mainstream theory classifies labour as a private good. However, considering the economic features of the human resource, other classifications are also conceivable, while still referring to cost-benefit-comparison as an underlying utilitarian principle. Chapter 2.2.1 introduces common-pool resources as one of four basic types of goods in classical economic theory. The idea of treating Human Resources for Health (HRH) as a commons, which requires regulatory provisions against overuse, will be further pursued in this thesis.

2.1.1 LABOUR MARKETS AND HUMAN CAPITAL

Human Capital theory is concerned with the knowledge, skills and competencies which are embedded in human beings (Becker 2009). The term 'competences' goes beyond formal qualifications; it refers to the general and special ability to solve a task. Part of the definition of human capital is that these qualifications and competencies are applied in economic activities and contribute to an increase in productivity. From a macro-economic perspective, Human Capital refers to the qualitative component of

workforce capacity, e.g. viewed as a stock of qualifications available. For example, Theodore Schultz (winner of the Nobel Prize in economics in 1963, 1972, 1981), focused on national stocks of health workers. He argued for state investment in the education and qualification of its people, and for respective programmes in developing countries. In micro-economic approaches, the term 'Human Capital' describes the possibility to convert personal qualifications and competencies into income. Gary Becker (Nobel price in 1964 and 1976) emphasized individual rational decision-making in this sense. He highlighted that investments - in terms of time and money- in one's own education are usually returned at a later point in time, at a certain discount rate.

The labour market is rarely characterised by a free play of supply and demand, however, but skewed or limited by numerous policies and state interventions (Becker 2009). These include mechanisms of collective bargaining or the fact that the risk of realising individual investments in qualification is often being taken over by the state, e.g. by protecting diplomas. Proponents of a 'free market of skills' call for abolishing state interventions in the workforce, and for strengthening individual responsibility in terms of acquiring necessary skills and realising these investments. The idea of rational egoist actors also implies 'free-rider behavior': If an organisation offers training opportunities to its members (or a national government offers training to its citizens), it risks that some individuals will not return this investment by providing their qualified labour for a certain period of time. Human resource development programmes are thus at risk of overuse (Becker 2009).

Rather than relying on market dynamics on a national economic scale, governments traditionally refer to national workforce planning in order to meet the needs of the population for health services. Certain ratios of health professionals to persons served are usually set as a target; policies to increase or decrease the output of training institutions are then deployed to influence this figure. As Vujcic and Zurn (2006) point out, this common approach often fails to bring substantial improvements to the population, for two basic reasons:

The first challenge lies in adequately determining health care needs and in the fact that these do not directly translate into a demand for health care (i.e. the government's or individuals' willingness to pay). The set of health services to be

provided is thus fixed on a more or less deliberate basis (e.g. targets of the health-related Millennium Development Goals), ideally oriented at demographic as well as epidemiological data. In a second step, the number of health professionals to produce this set is derived, based on estimates of their productivity. With a fixed wage level, however, the number of persons actually working in the health sector would either be limited by the supply side (in case of low wages) or by the demand side (in case of high wages). Even in the case that the aggregate demand and supply curve meet at the given wage level (market equilibrium), the corresponding level of employment is not to be equated with what is required to meet the needs of the population. Vujicic and Zurn (2006) argue that it is essential to know whether this employment level is above or below the needs-based level and to estimate the size of the gap. Following the market logic, the wage level would have to be adjusted to reach the needs-based employment level. This could be backed up by other policies increasing or decreasing demand or supply respectively.

The second challenge to national workforce planning described by Vujicic and Zurn (2006) is that a number of external social, economic and political factors influence the actual health labour market. For example, government health spending would be weighed against spending in other sectors, which again influences the staff budget of public sector employers. Wages for health workers are usually tied to other public sector pay scales and are often the outcome of collective bargaining. Employers' resulting willingness to hire will lead to a demand-based staffing level that is separated from the needs-based level. As for the supply of labour, the authors highlight that this is not to be equated with the number of persons qualified in health care, but with the share of qualified persons who are willing to work in the health sector. A rational decision to participate in the health labour market depends on the wage level in comparison to the cost of living and to income opportunities for the same individual in other economic sectors – or even in another country.

A more sophisticated model for national human resource management in the health sector was aimed at in preparation of the World Health Report 2006 (WHO 2006c; Joint Learning Initiative 2004). The report highlights that such management systems cannot exist in isolation, but they are entangled with the domains of politics, finance,

education, partnerships and leadership. All these need to be considered in the planning cycles for HRH, together with other internal and external factors which influence the performance of a health system. The mere number of domains and factors indicates the vulnerability - and maybe the pretension - of national planning in this field. The question arises whether a third approach to HRH besides the market and the state is conceivable.

2.1.2 PUBLIC GOODS AND COMMON-POOL RESOURCES

While the Human Capital approach largely treats qualified labour as a private good, other perspectives are also possible. Economic theory describes purely private goods and purely public goods as two ends of a spectrum, with a number of hybrids in between. 'Goods' in the economic sense are defined as "anything that produces a benefit, be it a physical commodity or a service" (Woodward and Smith 2003, p.4). The classification of goods is mainly based on the economic criteria 'subtractability' and 'excludability' (see figure 1). Commons, or common-pool resources, as well as club goods, or toll goods, share some features of public and private goods. They are therefore sometimes called impure public goods.

		Subtractability of use	
		<i>Low</i>	<i>High</i>
Difficulty of excluding potential beneficiaries	<i>Low</i>	Toll goods	Private goods
	<i>High</i>	Public goods	Common-pool resources

Figure 1: Four basic types of goods

Source: Ostrom 2005, p.24

Commons are also defined as “a natural resource (or durable facility of human design and construction) that is shared by a community of producers or consumers” (Oakerson 1992, p. 41). Such shared resources can be fixed or fugitive, renewable or not, and more or less indivisible. Similarly to this definition, Ostrom (2005) emphasizes the aspect of communitarian use and also maintenance of the resource. Therefore, the social and cultural attributes of the community also form an important part in analyzing the commons. The major physical and technical attributes and the related economic concepts of commons are further described by Oakerson (1992):

- **Subtractability (degrees of jointness):** refers to the immediate non-availability to others of the resource share which is taken by one user. Different modes of usage of the same resource may be more or less subtractable. A second feature applicable to the commons is the reduced capacity of the resource over time to generate benefits. Commons are partially subtractable; their use becomes subtractible if a certain threshold is passed.
- **Excludability:** Originally refers to the ability of sellers to exclude potential buyers unless they pay a certain price. Applied to the commons, the interest lies in whether excludability exists on an individual user basis, or whether it is only applicable collectively to outsiders of the community. In the former case an increase in demand might stem from a rising number of users, in the latter the reason would be higher utilization levels within a closed user group.
- **Indivisibility:** Although physical boundaries of the resource are not always obvious, their identification is necessary at least for analytical purposes. This allows for investigating boundary conditions and determining the appropriate scale and measures for regulation. Divisibility determines whether a privatization of the resource is possible at all.

With commons, suboptimal aggregate use will lead to the depletion of the resource system. The economist Garret Hardin maintained that this ‘tragedy of the commons’ is unavoidable due to the incentive structures inherent in such a resource, which induce ‘free-rider’ behavior in independent gain-maximising actors (Hardin 1968). Fidler (2007) is applying the term ‘tragedy of the commons’ to the policy space of global health: “Political incentives, epidemiological evidence, technological advances,

globalization and funding have significantly lowered barriers to entry into global health activities, creating activities for more government actors and others to plan and implement projects” (p.244). Over-exploitation as the generally proclaimed core feature of this tragedy can be found in the “local and national capacities for public health and health care” (p.244), particularly in developing countries. This points to human resource capacities in a qualitative and quantitative sense. At the same time, Fidler states that fragmentation and lack of coordination in public health and health care systems lead to insufficient resource utilization for critical health issues. “Technological fixes are not available for these challenges, as they are fundamentally political and governance problems” (Fidler 2007, p.244).

Health is often regarded as a public good, as individuals cannot be generally excluded from enjoying good health, and the health of one person does not subtract from the health of another. By contrast, Smith et al. (2003) state that individuals are the primary beneficiaries of their health and thus health is principally a private good, albeit with positive externalities to other persons. Eventually they prefer to simply view health as the ultimate goal of activities in the health sector and related fields, and instead focus on the goods that are necessary to reach that goal. These are called ‘access goods’, and they might be public or private in nature. Nevertheless, the authors argue that goods with considerable externalities in this context should be treated ‘as if’ they were public goods, meaning that they require collective action to ensure reciprocity, communication and enforcement mechanisms among actors. Private goods with positive externalities would otherwise be undersupplied, as private consumers and suppliers do not take these externalities into account (Smith et al. 2003).

Health is – among other social and economic determinants – maintained or re-established through health care systems. These fall into several sub-systems or building blocks, as outlined in the WHO framework for health systems strengthening (WHO 2007b):

1. Service delivery: packages; delivery models; infrastructure; management; safety & quality; demand for care
2. Health workforce: national workforce policies and investment plans; advocacy; norms, standards and data

3. Information: facility and population based information & surveillance systems; global standards, tools
4. Medical products, vaccines & technologies: norms, standards, policies; reliable procurement; equitable access; quality
5. Financing: national health financing policies; tools and data on health expenditures; costing
6. Leadership and governance: health sector policies; harmonization and alignment; oversight and regulation.

It is clear from this WHO framework that human resources are nowadays considered to be a main field of action within health systems strengthening. Furthermore, they are neatly interwoven with the other health system components, as those all require specific skills and competences. HRH can therefore be considered an impure public good or access good, the sufficient provision of which requires collective action. While clinical and nursing services delivered on a personal basis are definitely dominating the global discourse on HRH, from a Public Health perspective it is also of interest how non-personal health services contribute to better population health. Powles and Comim (2003) introduce the concept of 'Public Health infrastructures', falling into three components:

- Institutional capacities (legal and regulatory framework, capacity to monitor and respond to changes)
- Staff education and training, and wider knowledge (vocational and research training, capacity to absorb latest Public Health knowledge)
- Physical infrastructures (concerning water and sanitation, food hygiene, housing, road safety, product safety, pollution control etc.)

Although Powles and Comim (2003) see some analytical benefits in viewing Public Health infrastructures from the perspective of 'access goods', they warn that such economic concepts may suggest that shortfalls could be solved if only the monetary investment was sufficient. Rather, the components named above are linked to a range of social institutions, which must be considered in devising coordination and transmission mechanisms for the provision of Public Health infrastructures.

Moreover, it should be noted that health care is not only provided as a formal professional service, but also includes informal measures at group level and self-care. Those build on similar resources such as labour, knowledge and information, physical and monetary assets. Stubbs (2004) argues that individuals and families have always played a large role in producing welfare – which includes health –, and that this fact should be more acknowledged also in research and policy making. Social institutions of the larger Malawian society will therefore also play a role in the present study.

2.2 INSTITUTIONALIST VIEWS OF HUMAN RESOURCES

Public goods for health, as they have been outlined in the previous section, do not only comprise health systems per se, but may also consist in knowledge, policy and regulatory regimes (Woodward and Smith 2003). In the political sciences tradition, regulatory regimes – ‘the rules of the game’ – are usually referred to as institutions. Influences from political economy as well as from sociological organisational theory have led to a New Institutionalism in political sciences, which has moved from historical description to systematic empirical research. Within this framework, institutions can be considered as dependent or as independent variables (Mols et al. 2006). While the New Institutional Economics emphasise the potential of institutions to reduce transaction costs, i.e. their instrumental value to reach organisational goals, New Institutionalism in organisational sociology is more concerned with the normative, cultural and cognitive nature of institutions, i.e. their explanatory value in organisational behaviour (Powell and DiMaggio 1991).

Mayntz and Scharpf justify the integration of rational choice views or game theory on the one hand, and institutionalist or structuralist views on the other hand: “What is gained by this fusion of paradigms is a better ‘goodness of fit’ between theoretical perspectives and the observed reality of political interaction that is driven by the interactive strategies of purposive actors operating within institutional settings that, at the same time, enable and constrain these strategies” (Scharpf 1997, p.36). Such a fusion is undertaken in their own approach known as Actor-Centered Institutionalism, but also in the Institutional Analysis and Development framework proposed by Ostrom and colleagues (Ostrom 2005). They understand institutions as rules and norms which affect the costs and benefits that an actor draws from a specific action. This is not only meant in a formalised, legal sense but also in terms of social norms which may be sanctioned by loss of reputation or withdrawal of cooperation (Scharpf 1997).

Organisational theory is generally dealing with circumscribed organisations and their goals, characterised by the interdependent actions of members and their internal division of work. Externally, organisations are also ‘players in the game’ of larger societal systems (or within markets, from the perspective of business administration).

Scharpf (1997) defines them as “social entities that are capable of purposive action” (p.38). In the context of the research presented here, the term ‘organisation’ includes public administrative bodies, private firms and non-governmental organisations. It may also describe a profession in the sense of an association of professionals purposefully interacting with each other. However, professions are better understood as institutions which fulfil particular functions within a society.

Furthermore, professionals constitute a special category within the larger entity of experts. Uncovering expert knowledge may be the aim of interviewing people in exposed positions, possibly decision makers. This methodological approach is pursued for data collection in this study. Both the profession and the organisational affiliation are used as sampling criteria and for structuring the findings of the research. Chapters 2.2.1 and 2.2.2 outline some theoretical correlates of these ‘two sides’ of the experts interviewed.

2.2.1 HEALTH OCCUPATIONS AND PROFESSIONALISM

Dussault & Dubois state that all health policies should comprise explicit HRH policies, because human resources play such a crucial role in this labour intensive sector and failure of policies often stems from their neglect. Difficult modifications in the organisation of work and the opposition of professions regarding their changing roles are rather qualitative factors in this regard, which should not be overlooked besides questions of staff availability and affordability. It is therefore essential that HRH policies be explicit about their underlying values and coherent with service objectives and health objectives, to make them legitimate and socially acceptable (Dussault and Dubois 2003).

Professions in the classical sense are marked by the pursuit of their own collective interests and autonomous quality control, e.g. through training standards and codes of practice. Freidson (2001) works out the logic of professionalism as a third way besides the logic of the free market and the logic of rational-legal bureaucracy. The latter can be found in large firms as well as governmental organisations. His ideal-typical professionalism refers to “institutional circumstances in which members of occupations rather than consumers or managers control work” (Freidson 2001, p. 12).

The commitment to a high quality of work and to an equitable coverage of persons in need of their services is seen as the core of professional ethics. This refers to public goods as ultimate goals of practice and rejects profit maximisation as a legitimate goal for professionals. Freidson (2001) emphasises that the professional logic is not to be equated with state provision, but that the state needs to be regarded as a separate entity from the professions. Ideal-typical professionalism questions both the competency of the state and the consumer to make decisions on the grounds of best available knowledge in a specialist field.

The notion of professionalism is strong in the health sector, with medicine being one of the 'status professions' originating in medieval university education. Many other health-related occupations have orientated themselves at this model in their strife for professionalisation. Evetts (2006) assumes that they usually envisage the traditional notion but may be confronted instead with what she calls 'organisational professionalism'. This recent discourse is emerging in the context of work organisations, especially in health and education. According to Evetts, it is being deployed by managers to control the performance of sub-ordinates (see also Leicht et al. 2009).

Empirically and historically, totalitarian regimes have referred to establishing state agencies as professional bodies and selecting politically suitable schools of thought to establish them as the professional mainstream. According to Freidson (2001) this will have a toll on the outcomes of professional practice, but it does not destroy the core institutions of professions that serve to generate and contain specialist technical knowledge. At the same time, this demonstrates that the state is a contingency for professionalism, providing it with instrumentalities to organise and exercise power.

Unionism on the other hand appears rather weak in the health sector, which may also be a consequence of strong professionalism. Muula and Phiri (2003) state that health workers around the world are facing qualms and also legal restrictions when it comes to going on strike. Public Services International (an umbrella organisation of unions) states that out-migration of health workers can be seen as a symptomatic reaction to unbearable working conditions in the absence of other options (Gencianos 2008).

2.2.2 ORGANISATIONS AS COMPOSITE ACTORS

Besides their profession, health workers may also be characterised by their organisational affiliation and the function that they fulfil within this organisation. Health workers in leading positions will normally be charged with decisions regarding human resource management and development.

The description, explanation and configuration of decisions made by individuals within a group/organisation, or by the group/organisation as a composite actor is a subject of business administration theory. Becker (2007) states that the focus here is on the appraisal of alternatives, with regard to their effectiveness, costs and intended or unintended consequences. Decisions are driven by the desire to reach a certain goal. Thus in business studies, decision-making theory combines a normative and a descriptive tradition: the goal is set on a normative basis, while the means to reach a goal may be optimised on the basis of empirical findings. According to Becker, applications of decision-making theory can be divided into analytical methods (e.g. utility analysis, marginal analysis), which aim to identify optimal solutions under set conditions, and heuristic methods (e.g. structuring complex matters, focusing), which aim at finding satisfactory solutions for singular problems. However, rational decision-making is said to be unavoidably limited (bounded rationality), which means that decisions are always made under more or less uncertain conditions and thus are likely to remain suboptimal. This is not just a matter of cost for gathering the necessary information, but there is always uncertainty regarding the perception of the situation and the prognosis of consequences. Furthermore, only a limited selection of alternative options can be considered.

In a modern understanding of qualified labour or human resources, the importance of knowledge, abilities and skills are emphasised. Likewise, the talent and motivation incorporated in human beings, who render these assets into the production process or into service delivery, is to be recognised. As for the organisational context, Becker (2007) distinguishes three elements of 'competence for action', namely ability, willingness and authorisation. In this model, training and qualification only constitutes the foundation on which actual performance of a worker can evolve. By contrast,

earlier models of production-oriented business administration emphasised the value-generating character of labour, with the division of labour increasing collective efficiency. In Erich Gutenberg's model dating from the 1950s, knowledge does not fall in the 'labour' category, but in same category as physical and technical assets. Furthermore, leadership functions are separated and labelled as a 'derivative factor' external to the actual productive functions.

According to Brose (2000), the way how service providing organisations relate and react to their external environment is reflected in the deployment and remuneration of their staff, i.e. in the way they deal with human labour as a resource. Organisations thus have to consider internal and external requirements and dynamics in their human-resource-related decisions (Becker 2007): Individual staff members need to be stimulated and retained by customised recruitment, appraisal and coaching. Measures of continued professional education need to suit demand and situational requirements. Initial training has to be renewed in terms of putting greater emphasis on methodological and social competences as compared to technical skills. In addition it should be better connected to continued professional development. Last but not least, Becker stipulates that Human resource development and organisational development need to be integrated in order to cope with change.

The health sector is disposing of a broad range of organisational types who are considered composite actors in the scope of this study. Not-for-profit organisations (also called third sector organisations) make up a considerable share among the employers. Moreover, it is a sector that is proximal to the state, and modes of health care financing have a strong influence on the organisational environment. Thus when it comes to policy-making regarding HRH and to governance of the HRH system, institutionalist frameworks in the political science tradition are applicable (Mayntz and Scharpf 1995). The following chapter 2.3 will therefore take a political science perspective, looking at common models of health systems development which have also shaped the HRH system in Malawi.

2.3 POST-COLONIAL HEALTH SYSTEMS DEVELOPMENT

Health care delivery to the population displays a number of imbalances and inequalities which are linked to the field of Human Resources for Health (HRH) in multiple ways. While this accounts for any existing health system to a greater or lesser extent, it is particularly true for many countries in Africa that are facing an HRH crisis. For many decades the World Health Organization (WHO) has appealed for a partnership of member states to achieve a more equitable provision of health services and availability of health workers worldwide.

Imbalances in the health workforce can refer to the economic perspective, meaning that the quantity of a given skill supplied by the health workforce and the quantity demanded by employers diverge at existing market conditions. It may also have a qualitative component in terms of the 'skill mix' within a team of health workers, and its appropriateness to fulfil a joint goal. Hence, imbalances can also be asserted on normative grounds and value judgements of appropriateness (Zurn et al. 2004).

Chapter 2.3.1 is meant to be a critical appraisal of Human Resources for Health (HRH) policies in international development cooperation, taking a historical perspective. With regard to policy making, the demand 'Health For All by 2000' marked a new era in the health sector, with its requirement of strategic and comprehensive planning for Primary Health care (PHC). It will be demonstrated how a global policy like the Alma Ata declaration of 1978 has influenced national policies concerning health personnel. The promotion of leadership on the one hand, and of community health workers as a key staff category on the other hand, illustrate the spectrum of HRH policies. Chapter 2.3.2 then looks into the influences of globalisation and global health initiatives on HRH in more recent years.

2.3.1 PRIMARY HEALTH CARE AND DISTRICT HEALTH SYSTEMS

The Primary Health Care concept can be regarded as a normative approach to health care provision, which has a number of implications for HRH. The manpower requirements to reach 'Health for All by 2000' were taken up by the WHO Manpower Development Programme, outlining objectives in terms of quantity, quality, equality,

coverage, efficiency, planning, relevance and integration. This included community-oriented learning and respective teacher training, as well as management of health personnel and coordination through teams (Fülöp and Roemer 1982). A WHO expert committee established in 1983 was concerned with planning, producing and managing manpower. It had to establish necessary inputs in terms of funding, monitoring and research, but also deal with essential interactions of health workers, and with their attitudes and values (WHO 1985).

The Alma Ata Declaration highlights the responsibility of governments for their people's health, but it does not explicitly call for 'leadership development'. However, the issue was soon brought up by Flahault & Roemer (1986), who assumed that the shortfalls of the suggested team approach to PHC, including the integration of community health workers, might be due to a widespread "managerial defect". This defect was seen in the "deficiency in leadership provided for primary health care workers from higher levels" (Flahault and Roemer 1986, p.1). They consider the functions of leadership in PHC to be closely corresponding to 'effective management'. This comprised the vertical integration within the health system, the promotion of community involvement and of intersectorial cooperation.

Besides the technical implications of PHC (such as the management of funds, facilities, drugs or health data), the social aspects require special attention. As medical education is essentially centred on the individual patient rather than on the community, Flahault and Roemer (1986) also recommend that leaders, at least those situated at the national or provincial level, should be trained in Schools of Public Health. Regardless of these insights, in many countries a medical degree remains the major prerequisite for attaining higher posts in ministries of health. As Lawn et al. in their policy review on the occasion of the 30th anniversary of the Alma Ata Declaration conclude, community participation and intersectoral collaboration have remained the weakest strands of PHC in practice (Lawn et al. 2008).

Görge et al. (2004) describe how the idea of an integrated District Health System - as a means to implement the PHC concept - was devised by WHO in 1983, in its district health policy. The prefix 'integrated' refers to the fact that a wide range of preventive and curative health services are meant to be provided, rather than singular disease-

specific programs. Also non-governmental and private providers of health-related services are supposed to be integrated. Being part of the national health system, the district health system does not only cover the primary level (communities and health centres), but also the referral level (district hospitals). The ideally sized health district is said to cover a population of 200,000 to 300,000. The authors state that the importance of the district as a core piece of health system development increases in importance with recent decentralisation policies in many developing countries. However, in some instances they consider the regional health offices to be in a better position for effective and efficient management, and to be especially well suited to provide support, supervision and coordination to the district (Görge et al. 2004).

The Primary Health Care concept has faced many political and economic as well as epidemiological and demographic challenges, and it has undergone respective modifications over the years in different settings. Segall (2003) emphasises that the governmental services should remain the lead provider at district level, who may contract non-governmental organisations if necessary. He strongly rejects calls for privatisation, marketization and provider competition. Furthermore, he pleads for careful involvement of international aid organisations supporting communicable disease control, and for a phased model of decentralisation, so that the district health system will not be overwhelmed with new tasks.

In the World Health Report 2008, which carries the title “Primary Health Care – Now more than ever”, the WHO puts forward four sets of PHC reforms to respond to such challenges (WHO 2008). They are also referring to rising expectations of populations towards the health system. One of these reform sets is again concerning leadership, with the aim of making health authorities more reliable. Leadership here does not mean the management of service provision any more, but calls for government officials to become 'brokers' for PHC in a policy dialogue that involves multiple stakeholders. This is based on the assumption that in modern societies the idea of participation has changed. The population is conceived as expecting transparency and fair political procedures rather than being directly involved in the technicalities of priority setting.

Nevertheless, the World Health Report 2008 stipulates three major drivers of reform to be mobilised, namely the production of knowledge, the commitment of the workforce and the participation of people. The latter is essentially a plea for building alliances between the diverse agents of civil society from the trans-national to the local level. At the same time, the report acknowledges that the 'premium' in all four areas of PHC reform is to be placed on health workers - last but not least because their resistance would thwart any significant reform. It calls for an 'empowerment of health staff' of all cadres, by providing them with opportunities to "learn, adapt, be team players, and to combine biomedical and social perspectives, equity sensitivity and patient centredness" (WHO 2008, p.110).

2.3.2 GLOBALISATION AND HEALTH WORKER MOBILITY

Globalisation is considered to be a consequence of modernity - a process which was induced mainly by an increase in international trade relations, but has now captured many other areas, such as politics, environment, communication, jurisdiction and culture. Nevertheless, research and politics are still dominated by economic approaches (Kreckel 2008).

With regard to globalisation, Giddens (1990) criticises that social research tends to be orientated at the immanent developments of a bounded society or nation state, thereby neglecting the international context of social structures and processes. In his view, society and human beings cannot be analysed without reference to historical time and spatial location (situatedness of modern institutions in time and space). Time and space are providing the basis for social order, being an external condition and inherent component of interaction at the same time. Modern societies systematically appropriate and make use of their past to build their future. Interaction is not dependent on synchronous physical presence of persons in the same place, but may also occur over large distances. Social systems in globalisation are characterized by an expanded capability to span time and space (Giddens 1990).

With social activity thus being disconnected from physical presence, it rather depends upon coordination within time and space. Modern organisations are said to connect the global with the local (Giddens 1990). How this may be achieved is also reflected in

Urry's 'mobilities paradigm': On the one hand, transport technologies have increased mobility, helping to physically overcome distances in short time. On the other hand, communication technology brings people together on a virtual basis. He introduces the term 'co-presence', which describes not the mere physical presence of other human beings, but closeness and familiarity (Urry 2007, 1991).

Globalisation also marks an increased intensity of worldwide social relations. Giddens sees three sources of dynamism of modernity, the first of which has been described above as separation of time and space. Second, systems such as technical expertise or the money economy contribute to disembedding human action from its immediate context. A third source is the systematic production and reflexive appropriation of knowledge. Giddens rejects the idea that some industrialised societies have moved into a stage of post-modernity. He maintains that most ways of life and forms of social organisation are still nurtured by modern institutions, although they may develop at a larger pace (Giddens 1990).

The worldwide increase of migration can therefore be considered a major feature of modernity and globalisation, which of course includes the mobility of health professionals. The orientation at the British educational system in many former British colonies facilitates labour migration, as the recognition of degrees abroad is easier. This has already been observed by Mejjia in 1978, who highlighted certain forms of undesirable migration from the perspective of the newly independent countries. Sub-Saharan Africa nowadays is particularly affected by excessive migration for political and economic reasons (WHO 2006b). The excessive loss of capacity is described with the term 'brain drain', usually referring to international or rural-urban migration of qualified health personnel. The two phenomena also appear to be connected with each other, in the sense of a 'global conveyor belt' of health professionals for the benefit of rich countries (Schrecker and Labonte 2004).

The observed problem of migration has also been the trigger for action at the WHO level. A resolution of the World Health Assembly in 2004, carrying the title 'WHA57.19: International migration of health personnel: a challenge for health systems in developing countries' has been a first milestone in this process. It levelled the ground for the preparation of 'Working together for Health' (the World Health Report 2006),

and for the installation of the Global Health Workforce Initiative (GHWA) under the umbrella of the WHO in the same year. The World Health Report set up a 10-year action plan based on the two principles of national leadership (regarding workforce management, education and planning) and global solidarity (including knowledge exchange, supportive policies as well as technical and financial assistance). As far as migration is concerned, strategies are distinguished by falling under the responsibility of source countries (e.g. adapting training schemes to demand for health workers) or destination countries (e.g. fair treatment of immigrants), or require international/multilateral instruments (e.g. ethical recruitment policies, trade agreements) (WHO 2006b; Dovlo 2007). Such 'managed migration' is proposed to mitigate the negative effects of a globalised labour market in health. In order to monitor the mobility of health workers and the status of national health workforces, WHO has furthermore established a Global Atlas of the Health Workforce as a searchable data base (<http://www.who.int/globalatlas/default.asp>). The database is rooted in a variety of data sources, ranging from censuses, labour force/household surveys or specific WHO surveys, to administrative sources or other established health data bases.

The links between changes in the labour market, training and international migration have remained underexplored so far, as Bach (2003) asserts. He adds that "policy in this sector needs to recognise the need of health professionals to gain skills and career enhancement through short-term mobility" (p.4). A frequently mentioned aim of managed migration is to ensure that health workers return to their country of origin after a period of training and gaining work experience abroad. However, some authors also state that the focus should shift to how expatriate professionals can serve their country from abroad, e.g. through IT connectivity, online lectures or the targeted investment of remittances (Dodani and LaPorte 2005). While remittances may be a considerable source of income on a national economy scale, the payments of individual health workers usually serve to support families at home and do not necessarily benefit the health sector of the country of origin (Stilwell et al. 2004). From the perspectives of 'pay-offs' at the country level, the payment of compensations by countries which receive qualified migrants is another policy option. Such compensations could then be used for investments in education and training in the

source country, for example. There are few signs that this approach is being further advanced, hence cost calculation models and respective evidence are scarce (Buchan and Sochalski 2004; Stilwell et al. 2003). This model is less restrictive for the individual, but unpopular among recipient countries (Eastwood et al. 2005). Instead, recipient countries highlight their engagement as donors and providers of technical assistance in the source countries. Such voluntary commitment is also underlying the 'Global Code of Practice on the International Recruitment of Health Personnel', for which an extensive global consultation process started in 2008. The code was eventually passed as in May 2010 by the World Health Assembly (WHO 2010).

Besides international migration, some authors also point to the loss that occurs when health workers take up jobs outside the health sector (Diallo 2004). An even less straightforward form of 'brain drain' may be captured by what Van Lerberghe et al. (2002) call 'individual coping strategies of underpaid health personnel'. This is referring to working time that is not dedicated to their core functions in the public health service, but diverted to more lucrative or otherwise attractive activities. Prominent examples are the participation in workshops and trainings to gather per diems, moonlighting for private practice, or consultancy work for aid agencies. In order to break the silence and overcome the blaming of individual health workers, an international conference in Lisbon was initiated in 1998. Aid agencies were also invited here to reflect on their practices of 'income topping-up' for local personnel. Up to this point, the side-effects and the sustainability of staffing policies in health-related development aid had rarely been considered in a systematic way (Ferrinho and Van Lerberghe 2000).

2.4 SHIFTS IN INTERNATIONAL DEVELOPMENT CO-OPERATION

International development policy in the health sector reflects the shifts that can be observed in development aid in general. Human resource development has always played a more or less overt role in it. Kuehl (2009) describes how the focus moved from vertical programmes and institution building in the 1950s, to general education and health measures in the 1970s. The latter were aimed at a broad human resource base of competent citizens, in an attempt to support more endogenous development. Within a decade, however, this concept was again superseded by a New Institutionalism, which included ‘good governance’ as a conditionality for development aid. While the self-regulation of markets was increasingly doubted in this context, the importance of institutions for development is emphasised (Post-Washington Consensus in 1999, see Mols et al. 2006, p.366). The term ‘governance’ is related to a stronger involvement of the non-governmental and private sector, including public-private partnerships. These ideas are also reflected in the policies of major donors to Malawi, and they have informed the official decentralisation policy in the country. They will therefore be further described in chapter 2.4.1.

The concept of Capacity Building / Capacity Development, which emerged in the 1990s, is now meant to combine approaches aimed at the individual with approaches targeting institutions at the organisational and systemic level (Kuehl 2009). Capacity development in the Malawian health sector is also a major objective of the Sector-wide Approach, which has dominated HRH policy at the time of the field research. Chapter 2.4.2 describes sustainability and capacity development as two predominant concepts in the contemporary international development discourse.

2.4.1 NEW GOVERNANCE CONCEPTS

There is a call for new regulatory mechanisms on a global or supra-national level, which are also known as ‘global governance’ or ‘global public policy’ (Reinicke and Witte 1999). This concept is based on the belief that globalisation evokes phenomena which fall out of reach of a state’s regulatory power or of conventional ‘inter-national’ arrangements. The principles of global governance are voluntary involvement of state and non-state actors and cooperative decision making in a decentralised manner. As

for the health sector, global governance arrangements have clearly emerged within the scope of fighting HIV/AIDS, where broad alliances of actors from various sectors and countries, from the global to the local level, have been built to prevent the disease or enable medical treatment. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) stands for global governance in this field like no other global alliance (Hein et al. 2007). The containment of major communicable diseases such as HIV/AIDS and Malaria is only one out of three specifically health care-related Millennium Development Goals. However, the aims of reducing childhood mortality and maternal mortality have not managed to mobilise similar support.

At the same time, there has been increasing awareness of a lack of coordination and effectiveness of international aid provision to reach the MDGs. The High Level Forum in Paris 2005 was aimed at finding solutions to this problem. It was attended by a range of national governments, bilateral and multilateral agencies and other agencies. These also included the GFATM and the Gates Foundation, representing a recently emerging type of financially strong agents in the global aid arena. The resulting 'Paris Declaration on Aid Effectiveness' is a commitment to the following principles (High Level Forum 2005):

- **OWNERSHIP:** Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions
- **ALIGNMENT:** Donors base their overall support on partner countries' national development strategies, institutions and procedures
- **HARMONISATION:** Donors' actions are more harmonised, transparent and collectively effective
- **MANAGING FOR RESULTS:** Managing resources and improving decision-making for results

Since the Paris Declaration is not health-sector specific, the OECD Development Co-operation Directorate has taken over the monitoring of the process. However, with WHO usually being a key partner in Global Health Initiatives or Partnerships such as GFATM, the WHO Health and Development Policy unit is looking at this issue in the context of the complex inter-linkages of global poverty reduction and health. One

example is the institutionalisation of health systems strengthening – in response to vertical, disease-specific programmes – by setting up a respective WHO department. Another one is the launch of International Health Partnerships by the WHO in 2007, which gathers governmental and non-governmental agencies under the aid effectiveness agenda (WHO 2007a). In fact, various approaches to donor harmonisation, ownership and alignment have been tried out in the health sector even before the Paris Declaration. Most developing countries nowadays have some form of aid coordination mechanism with regard to health, in which the WHO is indirectly involved (WHO 2006a).

These initiatives indicate that there may be a number of side effects of Global Health Governance on health systems and on HRH in particular. Although the Paris Declaration aims at a stronger involvement ('ownership') of the receiving country's government in regulation and resource management, civil society strengthening is a major goal pursued. Nation states and their governments might therefore be weakened in the traditional role by global governance mechanisms. Stubbs (2003) points to the fact that the emerging global development aid regime of "co-ordinated poverty reduction" (p.335) has largely incorporated the logic of 'New Public Management'. This concept was mainly promoted by Anglo-Saxon authors starting from the 1980s. Besides the development of professional managerial roles, it also implies a shift from 'management by hierarchy' to 'management by contracts' (Segall 2000). The practice of contracting is meanwhile widespread in international aid. Competition has been enforced by the practice of major donors to link grants and credits with technical assistance, and to make sub-contracts on the basis of competitive tendering. According to Stubbs (2003), this has led to rising number of internationally operating consultancy agencies, non-governmental organisations (NGOs) and other non-state actors, mostly in the North but increasingly in southern countries.

Also the international research network 'System-wide Effects of the Fund' (SWEF) has observed a fast growth of the NGO sector in many African countries receiving GFATM support. They partly attribute this to opportunities for partnerships and public/private arrangements offered by large funding agencies (USAID and Abt Associates 2005). The

implications for the job market in the health sector of developing countries may be substantial: Such organisation can often afford to pay much higher wages than local employers, including the ministry of health. At the same time, as NGO activities are usually externally funded, they follow short project cycles. The results-orientated terms of reference and short-term contracts are generally at the expense of sustainability and do not allow local communities much leeway to decide about the aims and modes of intervention (Pfeiffer 2003).

New types of actors in welfare are therefore emerging between the traditional state actors (governments, bilateral and multilateral agencies) and the purely private level, which is the household. The public-private dichotomy in social service provision appears to be dissolving. Stubbs (2003) explains that these new non-state actors can be civil society organisations, philanthropic foundations, consultancy agencies or private business. With mutual learning and knowledge exchange being an explicit aim of global governance structures in social development, individual experts may also play an important role as knowledge brokers. The boost of international consultancy and overseas operation of such non-state actors has also been made possible by the information technology revolution. Stubbs (2003) describes a “detraditionalization” of labour and a “new non-permanent Western professional labour force” offering “intellectual services in real and virtual space” (p.326). He raises the question whether and how this phenomenon is now expanding to the workforce in developing and transitional countries. Similarly, he argues for more research on the role of subcontracting within the aid and development sector: “subcontracting regimes need to be judged from a position that, rather than focusing on cost-effectiveness, focuses on ways in which to guarantee the incorporation of lessons learning and the preservation of institutional memories”(p.340). In other words, one major criterion is the ability of aid processes to really build local capacity.

Apart from facing the side effects of the global aid regime in the health sector, global governance mechanisms have also been actively embarked upon to improve the situation of the health workforce worldwide. As stipulated in the World Health Report 2006, nation states are still considered to be in the best position to develop effective strategies to meet the human resource crisis in the health sector. This is due to its

linkages with other areas of state responsibility, such as educational or economic policy (WHO 2006b). At the same time, the health sector in developing countries has traditionally been characterised by the large-scale involvement of public, faith-based, non-governmental and also private actors from abroad. The 'Global Health Workforce Alliance' (GHWA), simultaneously established in 2006, aims at bringing together the technical knowledge and political influence of this range of actors on a global scale, under the umbrella of the WHO. It has established various internet-based working groups and activities, and it regularly conducts international meetings. The first 'Global Forum on Human Resources for Health' was held in Kampala in 2008 and set up an agenda for global action (Global Health Workforce Alliance 2008).

2.4.2 SUSTAINABILITY AND CAPACITY DEVELOPMENT

Trying to define 'development' in an ahistorical and universal way is a vain endeavour, as Mols et al. (2006) point out. Yet some kind of definition is necessary to describe positive as well as negative developments. Respective concepts and indicators have been suggested and further advanced at the level of the United Nations and the OECD since the 1970s. They include economic growth, employment, equity and justice, participation, and independence or autonomy as five core aspects, which may either function as a means or a goal of development. To date a relatively broad consensus has been reached how human development could be comparatively observed and measured, resulting in the Human Development Index (HDI). During the 1980s, ecological aspects started to be integrated in the development discourse (Mols et al. 2006), leading to the Rio Declaration on Environment and Development in 1994.

The concept of sustainable development thus stems from the environmentalist movement, but has increasingly come to include social aspects. Since traditionally there have been disputes and trade-offs between environmental and social improvements, Omann and Spangenberg (2002) argue that development criteria should give equal weight to both sides. Other concepts are more anthropocentric, asking how to govern and maintain the resource systems of the world for the long-term benefit of humanity. Focusing on the interplay between economic well-being and environmental assets, Heal (1998) states that the underlying principle of sustainability

is 'discounted utilitarianism', meaning that values which lie in the future have to be considered in present decisions. McMichael et al. (2003) put forward the following definition: "For human populations, sustainability means transforming our ways of living to maximize the chances that environmental and social conditions will indefinitely support human security, well-being and health" (p.1919). Against this background, the authors argue that the disciplines of demography, economics, ecology and epidemiology should be central to our understanding of sustainability, and that other disciplines need to be involved, such as the social and natural sciences, engineering and the humanities.

A prominent German contribution to the sustainability discourse has been made by the 'Work & Environment Interdisciplinary Project' (Hans Böckler Foundation 2001). The role of work in sustainable development has been central in this project. In their attempt to connect the discourse with social theory, Littig and Grießler (2005) stipulate that work constitutes the "foremost organisational principle of society" (p.71), as the exchange between society and nature for the satisfaction of human needs generally involves some sort of work. This includes care work, paid and unpaid labour. Social sustainability by their definition (p.72) refers to a quality of societies, namely their relationship with nature and the relationships within the society:

"Social sustainability is given, if work within a society and the related institutional arrangements

- satisfy an extended set of human needs
- are shaped in a way that nature and its reproductive capabilities are preserved over a long period of time and the normative claims of social justice, human dignity and participation are fulfilled." (Littig and Grießler 2005)

The concept is not only analytical, but also normative. It is focusing on socio-ecological transformation rather than preservation, recognizing that the social organization principles of (Post-)Fordist working society and the consumption patterns going along with it are not sustainable. It is going beyond a basic needs definition which includes food and clean water, housing, freedom from bodily harm and illness, sexuality etc. Littig and Griesler (2005) argue that for enabling human beings to take responsibility

for shaping their own lives, the definition of needs has to comprise issues such as education, leisure, social relationships and self-fulfillment. This concept exemplifies that although modernisation as the capitalist 'way to development' has remained unrivalled in world politics after the end of the Cold War, the 'aim of development' is increasingly questioned. A possibility to dissolve the resulting theoretical perplexity might lie in integrating the 'way' and the 'aim' of development, as Mols et al. (2006) indicate. They relate this to the idea of integrating transitive and intransitive concepts of development. The former refers to 'development of an object' by external development assistance, while the latter refers to development of a society 'from within'.

The UNDP capacity development framework is aimed at such an integration of concepts. Capacity is defined as "the ability of individuals, institutions, and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner" (UNDP 2010). The framework is essentially about how to enable a society to develop towards the aim of an increased well-being of people. Moreover, it is taking a distinctly institutionalist approach, asking how institutions can be improved to foster and deliver human development. A policy review of 2007 required the United Nations Development Group to also look into how the sustainability of their own assistance programs to member states could be assessed. The measurement concept put forward is meant to capture changes in institutional performance (effectiveness and efficiency), institutional stability (institutionalisation and risk mitigation) and institutional adaptability (investment for innovation and continuous improvement). It has to be noted, however, that the term 'institution' blurs with the term 'organisation' in this framework; it does not focus solely on the norms and rules of human interaction.

This also becomes clear in the 'input-output-outcome-impact' model underlying the UNDP responses (UNDP 2010). The availability of resources, including human resources, is conceived as an input to institutions. Human beings - as actors and bearers of competencies - are thus not at the centre of the model, but they are found at the input and at the impact level. Nevertheless, the four core issues of capacity development cater for the aspects of competencies (ability, willingness and authorisation, see Becker 2009, p.10) from an institutionalist perspective. These core

issues, also called 'levers of change', are supposed to drive the UNDP programmatic responses (UNDP 2010):

1. Institutional arrangements (e.g. streamlined processes, definitions of roles and responsibilities, appraisal mechanisms, coordination mechanisms)
2. Leadership (e.g. clear visions, communication standards, management tools, outreach mechanism)
3. Knowledge (e.g. research supply and demand linkage, brain gain and retention strategies, knowledge sharing tools and mechanisms)
4. Accountability (e.g. audit systems, practice standards, participatory planning mechanism, stakeholder feedback mechanisms)

As for the labour-intensive health care sector, it appears that capacity building/capacity development is still largely equated with training, i.e. interventions at the individual rather than the organisational or systemic level. The 'input-output-outcome-impact' model also supports the usual preference of international development assistance to take over investment costs (e.g. training) rather than recurrent costs (e.g. salaries), to stay in line with the policies of the International Monetary Fund. However, especially workshop-based, technical training receives most criticism here for being disintegrated with needs-oriented service provision, and a transfer into national curricula often does not take place (Chen et al. 2004; USAID 2003). Another means of aid delivery closely connected to human resource development is technical assistance. The idea is to have technical experts working together with local counterparts for a set period, in order to transfer knowledge and skills and enable local personnel to take over the task. Investments in this case do not only include the remuneration of the technical expert, who is usually an expatriate, but also salary top-ups for their counterparts. The accompanying risks of disintegration and widening disparities among health workers have been highlighted (Chen et al. 2004; Ferrinho and Van Lerberghe 2000). Capacity development may thus also serve as a source of legitimation for the plethora of organisations engaged in development aid, regardless of whether they intervene at individual, organisational and systemic level. Kuehl (2009) points out that it provides criteria for the tendering processes in which these organisations or individual experts usually compete for funding. These global markets appear to be

dominated by western players, but they are likely to have an impact on labour markets in developing countries, e.g. in terms of contracting practices (Stubbs 2003).

A somewhat different institutionalist approach to sustainability can be found in commons theory, which has evolved around the issue of cooperation to achieve sustainable use of natural resources, such as fisheries, forests or ground water. Schlager (2004) lists ten variables which have empirically shown to be relevant in ensuring adequate levels of usage in common-pool resource systems, as they support the emergence of cooperation among resource appropriators. They fall into the categories of 'attributes of the resource' and 'attributes of the appropriators'. The former includes that the resource is neither too deteriorated nor too underutilised, that valid and low-cost indicators of the resource status are available, that the flow of resource units is predictable, and that transportation and communication technologies are appropriate to the spatial extent of the resource system. The latter category includes that resource appropriators are dependent on the resource, that they share a common understanding of the system and their own impact upon it, and that their discount rate is low in relation to future benefits to be achieved from the resource. Furthermore, the community of resource appropriators should maintain trust and reciprocity, be rather autonomous from external authorities countermanding their decisions, and dispose of prior organisational experience and local leadership (Schlager 2004). She highlights that commons theory is *configural*, meaning that the value of one variable depends on other variables, and also *contingent*, meaning that the relevance of the individual variable depends on the specific context. Therefore, although the number of variables considered is not large, the theory can become rather complex.

According to commons theory, collective action and rule-setting is required to ensure the sustainability of the resource. Based on empirical findings, eight sustainability criteria - or principles for robust governance of environmental resources - have been put forward by Elinor Ostrom and collaborators (Ostrom 2005; Schlager 2004; Dietz et al. 2003). The formulations, which differ slightly in the three relevant sources, have been merged in the following list:

1. Clearly defined boundaries: Legitimate appropriators and boundaries of the resource are clear.
2. Proportional equivalence between benefits and costs: Rules are congruent with ecological conditions, and they link the restriction of appropriation with the provision of input.
3. Collective-choice arrangements: Individuals affected by the rules are involved in analytic deliberation and can participate in modifying them.
4. Monitoring: Monitors are accountable to the appropriators.
5. Graduated sanctions: Depending on seriousness and context, offenders face graduated sanctions.
6. Conflict resolution mechanisms: Rapid access to low cost conflict resolution is provided.
7. Minimal recognition of rights to organise: External governmental authorities do neither challenge the institutions nor their variety.
8. Nested enterprises: Authority is allocated at multiple levels from local to global, to allow for adaptive governance.

Although commons theory originates from the study of natural resources, its application is basically aimed at collective action problems and adequate governance arrangements. Such problems do not only occur in the environmental field, but are characteristic to all pure or impure public goods (Smith et al. 2003). Considering the health needs of mankind and the respective interactions with the natural environment, the health workforce has a central role to play in sustainable development. For the purpose of this study, qualified health work shall therefore be conceived as an 'access good' to human welfare.

The findings will be related to the sustainability criteria for common pool resources (Ostrom 2005). In the sense of policy advice, the discussion chapter then looks into how institutional statements could be used to improve the governance of the HRH system in Malawi and achieve sustainability.

3 METHODOLOGY: RESEARCH STRATEGY AND ANALYSIS

Considering the complexity and interdisciplinary nature of the HRH field, the task of identifying an analytical framework is not straightforward. The contributions and approaches of various disciplines may lead to a research design that is more adequate to the complexity of the phenomenon under study. At the same time, they imply different theories and methodologies that need to be integrated (Oswald 2007).

On top of that, studying a social field in a foreign country has to allow for flexibility in research design and for an evolving focus of the research. This claim is often made for field research approaches in the social sciences (Layder 1993). Hence, a 'single case' study design was chosen to investigate the resource system HRH in Malawi in 2009, combining different data sources. During the analysis, the focus was then put at international aid at the level of the health districts.

The present case study is taking an institutionalist approach used in political sciences, which is informed by both economic and sociological theory. These two theoretical domains are often seen as opposing. Powell and DiMaggio (1991) highlight that economics are based on the assumption of rational choice and intentional human action. This has been criticised in the wake of the cognitive turn in psychology and sociology. In contemporary sociology, institutions are more commonly seen as a result of human action, but not as being purposefully designed (see also Giddens 1984).

However, as Scharpf (1997, p. 36) has pointed out, policy is intentional action by definition. Therefore, both elements of rational-choice as well as action theory are needed in empirical policy research. The health sector is considered a sector which is proximate to the state and populated by strong composite actors. The Institutional Analysis and Development (IAD) framework suggested by Ostrom 2005 appears as a suitable framework to pursue a research question which evolves around the regulation of a resource system, aimed at improved performance and sustainability. The framework is complemented by two distinct analytical methods required for the structural data and the interview data. The different methodological building blocks will be outlined in the present chapter.

3.1 LITERATURE SEARCH AND SELECTION OF THE RESEARCH SITE

The work on the doctoral thesis was started in October 2007 within the scope of the Doctor of Public Health programme at Bielefeld University. The initial literature research concerned empirical, theoretical and methodological publications relevant to Human Resources for Health in general. International Organisations such as the World Health Organization (WHO), the International Labour Organization (ILO) or the Organisation for Economic Cooperation and Development (OECD) have increased their efforts during recent years to improve the statistical monitoring of health personnel, national labour markets and international work migration. There is a growing body of country-specific reports, project or programme data and grey literature on health systems, which can be accessed via the websites of such organisations. At a later stage, the capacity development approach promoted by UNDP, the sustainability discourse in international development policy and literature on expert knowledge and professionalism were looked into, in search of analytical tools for this study. Apart from the websites and cross-referencing, relevant literature has been identified through the library catalogue of Bielefeld University and the Bielefeld Academic Search Engine (BASE), which provides grey literature from databases around the world.

The Republic of Malawi was eventually chosen as a research site for this study, as it had for some years been in the focus of international efforts concerning the human resource crisis in the health sector. The Sector-wide Approach (SWAp) running from 2004 to 2010 has formally included the human resource crisis by featuring a 6-year Human Resources Emergency Plan. The German Development Cooperation (GDC) has been involved in these activities and thus offered good opportunities for field access. Further literature research was thus focused on the Republic of Malawi in particular, including scientific databases from a range of disciplines. While health-specific databases such as Medline and CINAHL were searched for a combination of “Malawi” and “Human resources for health / health workforce”, the broader social and political sciences databases (Social Sciences Citation Index, JADE and EconLit) were screened by combining the key word “Malawi” with “health”, “work”, “human resources”, “industrial/labour relations”, or respective synonyms. At the point of writing up the thesis, the country-specific literature search was renewed to also cover the period of

2010 to 2015. This also included a search of the Nexis Lexis database and selected online news providers, for an update on general political developments in Malawi.

3.1.1 FIELD ACCESS

The preliminary findings of the literature search were used to refine the research proposal and to establish contact with the GDC in Malawi. On this basis I have planned the field research phase with a duration of six months, starting from February 2009. Travel and living costs were funded by the Hans Böckler Foundation, within the scope of a scholarship. An outline of the field research can be found in Annex 7.3.

At the point of field research, the GDC in Malawi comprised four specialised bilateral agencies, namely the German Technical Cooperation (GTZ), the German Development Service (DED), the Centre for International Migration (CIM) and Inwent as a provider of strategic human resource development. They were supporting the Malawian health sector at different levels, i.e. the Ministry of Health, tertiary health facilities, the five Zonal Health Support Offices (ZHSO), the district level and the individual level. Forms of support included the recruitment and deployment of international experts, technical assistance and collaboration with academic institutions (e.g. local consultancies). Furthermore, GDC provided assistance to the Christian Health Association of Malawi (CHAM) in the area of nurse training and technical maintenance.

Within this scope, the GDC has also commissioned different studies and assessments dealing with the size and profiles of the health workforce in Malawi, as well as the practice of technical assistance in the health sector. In preparation of the SWAP mid-term review, GTZ has conducted a study in 2007 titled 'Human Resources / Capacity Development within the Health Sector' (Ministry of Health et al. 2007). The document is at the one hand dealing with the size and profiles of the whole spectrum of health workers in Malawi, also considering the implications for education and training. On the other hand, it examines the practice of technical assistance in the health sector and provides recommendations to foster national capacity in this area. This highlights that the question of capacity development, as a core issue in aid provision, is neatly interwoven with the subject of HRH. The document has provided valuable starting points for the field research.

Against this background, the GDC in Malawi showed an interest in my proposed study and offered practical help in terms of initial orientation, providing an office workplace and finding an accommodation for the first weeks. In addition, German development workers have offered me private accommodation and indicated interview partners to me during my stays in the different regions of Malawi. On the one hand, this 'German' field access is a potential source of bias. On the other hand, it would have been very difficult to gather sufficient data as an individual foreign researcher within the restricted period of 6 months. Besides a well-established health-related German network, there were of course other practical aspects in favour of Malawi as a research site. The country is comparatively small and well accessible; District Health Offices can usually be reached by public transport. Moreover, English is widely used as administrative language, and health workers are trained in English at all academic training institutions. This made it possible to conduct interviews with the target group without having to involve a translator.

3.1.2 ETHICAL APPROVAL

Health research receives increasing international attention in Malawi. Studies and assessments are often carried out in the context of development programmes in the health sector - in this case they are often contracted out to consultants. Moreover, since the College of Medicine was established in 1991, it has been successful in acquiring international collaborations in clinical research. The establishment of the National Health Research Council, including the requirement of ethical approval for research projects, came along with these developments. Besides the control of potentially maleficent effects of research, the procedure also serves the purpose of assuring that the Malawian academic and health system benefits from research being carried out in the country. This requirement also concerns thesis projects of foreign students, even if it is social science-oriented health research that does not involve contacts with patients or users of the health system. In 1996, the COM installed its own Research and Ethics Committee (COMREC) for projects carried out within its academic scope.

Hence I sought ethical approval through the COMREC. After one resubmission with methodological amendments concerning the sampling, the approval was granted on 06/05/2009 (Reference number: P 03/09/470), under the provisional title 'International Aid in the Health Sector: Human Resource Development or Contribution to Brain Drain'.

One prerequisite in this procedure was to formally link up with an academic institution in Malawi. My resulting linkage with the Division of Community Health at the College of Medicine (COM) proved useful to establish contacts with persons, institutes and organisations situated in the field of public health and capacity development in Malawi. It also facilitated access to certain research documentation and allowed for first-hand observation in the institutional context international collaboration in health research.

3.2 DATA COLLECTION

The field research approach pursued in this study included the collection of primary and secondary data, which was quantitative as well as qualitative in nature. Primary data comprised

- expert interviews with Malawian health professionals in leading positions
- field notes incl. accounts of observations and exchange with key informants.

Secondary data was gathered on the country's health sector and on major development organisations working within it. This included

- published research, grey literature and statistics on Malawi
- newspaper advertisements
- data bases relevant to HRH.

The present section of the thesis provides further details on the approaches to data collection (including sampling), the topics and time periods covered, and the amounts of data collected.

3.2.1 DOCUMENTS AND SECONDARY DATA

The documents were meant to provide the larger (historical) context for the interviews and also served for working out a first draft of the interview guideline. Documents were collected by searching the internet and the library catalogues accessible through Bielefeld University, but also during and partly after the field research.

Some documents and statistics issued by the various Malawi-based organisations involved were only accessible upon personal contact on the ground. These included serials such as the Malawi Medical Journal or Moyo, the newsletter of the Ministry of Health. For me to gain access to archives and libraries, the proof of affiliation with the COM was requested in several instances. Relevant articles and documents were photocopied or photographed with a digital camera.

Due to time constraints, the initial collection of this secondary material during field research only followed loose criteria, namely that they dealt with issues of HRH in Malawi from the colonial period until today. Documents were only considered if they

- make explicit statements about Malawi
- are written by Malawians and/or published in Malawi
- were issued before 2010.

In total, I collected 47 articles, 17 policy documents and laws, 23 reports, books or academic theses (in parts), and 17 other documents such as information material.

In order to gain an insight in the job market, I screened the three major national newspapers for job advertisements related to Public Health. These newspapers comprised the Daily Times (including Sunday Times), Malawi News and The Nation, (including Weekend Nation). For this purpose, I requested access to the archive of the Daily Times in Blantyre and manually searched the archived papers. The kinds of position covered (a) employment in a managerial/supervisory position, (b) consultancy/ technical assistance, (c) academic research and teaching, (d) scholarship / fellowship. Advertisements were included - regardless of the advertising organisation's background - if the tasks fell into one of the following categories:

- Health services management/programme management (NOT: purely clinical or accounting)
- HIV/AIDS
- Family Planning
- Water & Sanitation
- Pharmaceuticals
- Health communication
- Nutrition (NOT: purely agriculture)
- Disaster management (NOT: purely community development)
- or were published by an employer whose core business lies in the health or HIV/AIDS sector.

I developed an MS Access database and entered the information for the month of June 2008 as a pilot. After excluding duplicates that were published in several newspapers, a total of n=53 advertisements could be identified for that month. The subsequent 8 months I commissioned to two Bachelor students of Environmental Health at the Polytechnique. They identified a total of n=56 advertisements for this period, i.e. 7 advertisements per month on average. Since it appears very likely that the inclusion criteria was applied differently for this period, further analysis was restricted to the month of June 2008.

As for secondary quantitative data, I also acquired statistics about graduates from Public Health-related training schemes upon personal visit at the training institutions. The same accounts for the registry of non-governmental organisations, which was only purchasable in print at the CONGOMA office.

Furthermore, I gained official permission from the MoH (Department of Human resources for Health) to use an anonymised copy of the database containing information from the HRH Census for secondary analysis. The census was carried out in 2007 throughout Malawi by the MoH and the Centre for Social Research at the University of Malawi, gathering data by questionnaire from 33,470 members of all professional groups in the health sector.

The different data sources were used for reconstructing the conditions at the point of the field research, when also the interviews were conducted. Chapter 3.3.2 outlines the further analytical measures.

3.2.2 OBSERVATIONS AND KEY INFORMANTS

The pursuit of qualitative social research can be generally viewed as a continuous communication process between the researcher and the field of study. Observations and interactions need to be systematically written down as field notes and be reflected by the researcher in order to refine hypotheses and questions towards the field (Przyborski and Wohlrab-Sahr 2008). This also informed the sampling process to conduct the expert interviews. In this sense, participant observation in the actual

working context of Malawian public health professionals constitutes the backbone of this study.

During the field research phase I had the opportunity to participate in a range of meetings and events concerning the subject of HRH and development assistance in Malawi. All of these meetings involved Malawian as well as international participants, which allowed me to make observations on the immediate interactions between those parties and on the roles that individual participants fulfilled. In these settings I was usually introduced - or I introduced myself - as a German PhD-student working on HRH and hosted by the GDC. Moreover, I had individual appointments or informal conversations with key informants working in this field. Due to the above mentioned network, many of those informants were deployed as technical assistants and were either German or of European or US-American origin. Some of the authors who conducted studies commissioned by the GDC also agreed to give me an interview, and I had the opportunity to participate in a 'peer review' meeting on these studies. Furthermore, I talked to some Malawian authors of articles on HRH which have been published in international journals. There were also a number of informal contacts with Malawian health professionals and students, for example as I was staying in a nursing school dormitory during my time in Zomba. These meetings and encounters I have noted down and reflected in my field notes. For an outline of the field research, see Annex 7.3.

The study in its present form, including the six months' field research phase in Malawi, was only possible through the financial support of Hans-Böckler-Foundation, flexible work arrangements of the researcher, and the specific institutional background and linkages at Bielefeld University. Along with these enabling resources, however, come certain constraints such as being a singular researcher in an unfamiliar geographical and cultural setting, having a time-limited field access, and communicating and analysing data in a foreign language. I have aimed to reflect the effects of both the opportunities and constraints on the scope and depth of the research, and to integrate this into the analysis.

3.2.3 EXPERT INTERVIEWS

The method of open, theory-generating expert interviews (Meuser and Nagel 2005) was applied to capture the special role of health professionals who are holding a leading position within their organisation. The interviews were aimed at finding out about the transnational contacts and collaborations and the mobility of these professionals. Furthermore, their idea of Public Health and their personal involvement with human resource management, capacity development and policy making were of interest.

The group of Public Health practitioners has received little attention in the international research on Human Resources for Health (HRH) so far, the focus usually being put on medical doctors and nurses. The assessment of the Public Health workforce is often hampered by problems of definition. Beaglehole and Dal Poz (2003) highlight that even the term 'Public Health' is used with a variety of meanings, e.g. referring to a condition, a discipline, an infrastructure or a philosophy. They refer to Public Health professionals in a very broad manner as those who are mainly carrying out non-personal health services, irrespective of their organisational base. The AfriHealth project differentiates between field level Public Health staff (e.g. laboratory personnel and staff offering immunisation and screening services) and Public Health professionals. The latter are defined as "those responsible for providing leadership and expert knowledge to health systems at district, provincial, national and international level to manage the health of the public" (Ijsselmuiden et al. 2007, p.914). Such professionals are not only working in the governmental service, but international aid agencies and non-governmental or private actors involved in the health sector of developing countries require similarly qualified staff for planning, implementing and evaluating projects and programmes.

Health workers might be primarily qualified for personal health service provision, but can be deployed to carry out non-personal health services. Similarly, they may have qualified in neighbouring disciplines, but specialise in health-specific activities and even acquire a Master of Public Health (MPH). For the purpose of this study, particularly the sampling, the term health workers is therefore used in the larger

sense. It includes qualified clinical, nursing and environmental health personnel as well as social scientists, managers and administrators working in the health field.

Sampling

Due to my limited period of stay in Malawi, it was not possible to synchronise the collection of primary data with the unfolding analysis. Instead, my approach was to develop a sampling matrix and determine the requirements for study participants 'ex ante'. This is aimed at covering the major dimensions supposedly shaping the field of study. At the same time, it is giving leeway to enlarge the sample if new theoretical aspects occur during the data collection phase (Merkens 2005; Przyborski and Wohlrab-Sahr 2008).

The following general inclusion criteria were used to define local professional experts in the health sector:

- Malawian origin
- academic qualification in health and/or related sciences (public health, medicine, nursing, management/economics)
- currently holding a leading position in the health sector or a consultancy contract, working at least at district level or comparable position
- working in a development aid context (contractual relations or collaboration, remuneration (co-)financed by international development aid)

For reasons of anonymity, the composition of the sample can only be presented at an aggregate level in the form of cross-tabulations, see tables 1 and 2.

qualification/employer	MoH	NGO/CHAM	University	self-employed	Total
Medical doctor	4	1		1	6
Clinical Officer	1				1
Nurse	1	3			4
Env. Health Officer	3		1		4
Administrator	3			1	4
Social Scientist	1	2	2	1	6
total	13	6	3	3	25

Table 1: Distribution of initial qualification and current employer among the interview partners (n=25)

In total, 25 expert interviews were carried out. Interview partners were identified through staff of the GDC or the COM, through the NGO register and through snowball sampling. For the research not to interfere or to be confused with evaluation and supervision activities, I preferably contacted potential participants personally or by phone call, rather than being introduced by third parties. Having acquired ethical approval by COMREC, I could approach participants working in the public sector directly. As the sample of interview partners consisted of health personnel in leading positions, it was not necessary to approach superior levels of management as a first step to gain approval.

Age group / sex	male	female	total
≤34 years	4	7	11
35-49 years	6	2	8
≥50 years	5	1	6
total	15	10	25

Table 2: Distribution of age and sex among the interview partners (n=25)

I aimed at including participants working in various geographic regions of Malawi and at different hierarchical levels within their respective organisation, at reaching a relatively even distribution of age groups and sexes, and at covering the spectrum of relevant professions as differentially as possible.

Developing the interview guideline

As leaders and decision makers, Public Health professionals would be in a position to influence the political process by their professional engagement and interpretative authority. Regarding the field of HRH, they have a potential double function as policy makers (or policy translators at least) and policy targets. They often have considerable experience as interviewees and informants in the context of health sector development. Due to this specific position of the interview partners within the research field and in relation to the researcher (having the same professional background), I decided to change the method from biographic to expert interviews upon my arrival in Malawi. The theory-generating expert interview, based on Meuser and Nagel (2005) and further differentiated by Bogner and Menz (2005), proved to be

a more suitable approach to data collection. According to these authors, expert interviews mainly fulfil the purpose of reconstructing expert knowledge in the sense of operational knowledge about their specific field of action. Operational knowledge can be distinguished into exclusive technical or institutional know-how on the one hand, and into interpretations or appraisals of circumstances and situations on the other hand. The latter is of relevance precisely because the experts are attributed or take over a prominent role in a field of action, which comes along with interpretative authority and often with the authority to make decisions. Both forms of knowledge can be covered within the same interview, but require different interview strategies (Przyborski and Wohlrab-Sahr 2008).

Usually a semi-structured interview guideline is applied to focus the expert interview to the area of interest. This also gives credit to the often limited amount of time that experts can make available, and to the status constellation of interviewer and interviewee in the interview situation. Przyborski & Wohlrab-Sahr (2008) highlight that, as any guideline interview, expert interviews should only be considered a qualitative method if the interview partner is given sufficient leeway to explicate and amplify those aspects that he or she considers relevant. The interview guideline should therefore stimulate narrations and detailed descriptions and be handled in a very flexible way, in order to not force the accounts of the interview partner into a direction preconceived by the researcher. Interview material produced in this way can then be submitted to interpretative and reconstructive analysis.

The interview guideline was slightly amended throughout the 6 months of field research, especially to include some more questions on the issue of personal leadership experience. Annex 7.5 shows the last version of the guideline. The interviews were started with an initial stimulus for the participants to tell about their own career and professional development – a tribute to the originally pursued biographic approach. Probing questions were inserted particularly on episodes that involved international contacts and exchange. The interview guideline then included questions about future career aspirations, leadership and human resource management, personal understanding of public health, involvement in policy making and consultancy activities. Interfaces with international agencies or partners were

covered, as well as their view of the Malawian health system and its human resource problems. The order of the questions was adapted to the individual course of the interview and the topics that the interview partners raised.

Conducting the interviews

The interviews were mostly carried out at the interviewees' workplace; two interviews took place at the GDC office and five were conducted in restaurants. The duration of the interviews ranged from 40 minutes to 3 hours, with the majority taking approximately 1 hour. Upon first contact, I informed the potential study participants about my research intent. I then asked them whether they would be willing to give an open interview and whether they would accept me visiting their workplace. The consent form included a short description of the research project and issues of data handling (see Annex 7.4).

I considered the consent form mainly as a commitment on behalf of the researcher, which is why I handed it over to the participant to read and to remain with him or her. Consent was generally asked verbally, before the start of the interview. In 23 out of 25 cases the interview partner accepted the use of a digital recorder, while the other two were documented in writing after the interview. I generally wrote down field notes on the interview situation and other observations on the same day of the interviews.

3.3 DATA PREPARATION AND ANALYSIS

The Institutional Analysis and Development (IAD) framework is applied for the analysis as well as the synthesis of the different types of data gathered on HRH in Malawi. The framework is rooted in games theory on the one hand, and large numbers of case studies of resource systems on the other hand. It therefore provides for the conduct of rational-choice oriented games in the lab as well as for empirical field research. Ostrom (2005) explains that using the framework in field research means to make summaries of legal, written or oral statements which are or relevance to the action arena under study: “the researcher’s task is to discover the linguistic statements that form the institutional basis for shared expectations and potentially for the observed regularity in behaviour” (p. 171).

Within the overall IAD framework, two practical analytical methods are pursued, namely structural data analysis according to Lueger (2010) for documents and secondary statistics, and thematic analysis according to Froschauer and Lueger (2003) for the interview data. These will be outlined in the following (chapter 3.3.1 and 3.3.2). Some relevant components from the IAD framework and their application to the subject of this study are then described in the final part (chapter 3.3.3).

3.3.1 STRUCTURAL DATA ANALYSIS

The analysis of historical and contemporary documents within the scope of this study aims at reconstructing the internal and external conditions under which HRH as a social system has been evolving in Malawi. As a first step of data preparation, published documents and grey literature were archived in a literature database using the software Citavi. This is concerning print documents as well as those which were only available in PDF format or as digital photographs. In structural data analysis (Lueger 2010), documents are examined for information about time, actor constellations, contents of activities and localities. These may be found in the contents of texts or statistics, but also in their formal characteristics (e.g. authors, date and place of publication, media). The Citavi database for the structural data was kept separate from the general literature cited in the thesis, and the citations of sources

within the results chapter are formatted as footnotes. This allows the reader to directly refer to the formal characteristics of a source.

By means of the structural data analysis, the health district as an action arena is demarcated and distinguished from its external context. This allows for a look into the internal conditions, figurations and processes of the action arena, to then relate them to the external conditions. The borderline between the inner and the outer context of the phenomenon under study is not to be seen as an absolute line, but as a means of sensitisation and an analytical tool (Lueger 2010). The definition requires a specification of which persons and which activities are part of the inner figuration, and how the phenomenon is demarcated in time and space. The different health occupations and health-related tasks represented in a Malawian District Health Office shall serve as a definition. In terms of space, activities taking place at higher administrative levels (e.g. MoH headquarters) or even outside Malawi are treated as external conditions. A time-related demarcation line can be drawn around 2003, when international NGOs were invited to assist Malawi during a hunger crisis, and preparations for the EHRP and the SWAp were taken up within the MoH. Both are considered to mark a change in the conditions of district-based health work. The inner context of the health district is assumed to be reflected in certain structural data, meaning mutual dependencies of actors, linkages between different processes, or triggers of change. The external context comprises the material/biophysical conditions of the resource system and attributes of larger the community, i.e. Malawian society and the health system.

External factors are considered if they either have a direct link with internal structural data, or they constitute a rough conditional frame for internal developments (Lueger 2010). The aim of the analysis is to identify peculiarities from general lines of development (i.e. 'normal', expectable processes under the given conditions), to gain a more in-depth understanding of the social field. Structural data analysis is deliberately speculative; the findings are contrasted but not harmonised with the empirical findings from primary data sources (Lueger 2010).

Where documents lend themselves to quantitative analysis, this is used to establish 'average' cases and to compare cases among each other (descriptive statistics). For this

purpose, information from several data sources has been transferred into an electronic database or spreadsheet format:

a) **HRH census 2008:** Although I had obtained a data set from the MoH which was supposed to contain the HRH census data, inconsistencies were discovered between the set and the data presented in the draft report (Ministry of Health 2008). Furthermore, occupational groups had been aggregated in the data set and certain variable definitions were missing, so that the options for further analysis within the scope of this study were limited. Hence, I decided to only refer to the publicly available version of the census data. Relevant tables from the PDF version of the draft report were transferred into MS Excel, control sums were calculated and percentages were added. Four tables from the HRH census are eventually presented in Annex 7.7. Information from these tables is referred to throughout chapter 4 where suitable.

b) **CONGOMA 2008 NGO registry:** The statistical analysis of the data provided in this registry is focused on three work fields for NGOs: (1) health, (2) HIV/AIDS and (3) water& sanitation. The latter two fields were included because they coincide with the responsibilities of the District Health Office. An overlap with explicitly health-related activities (and employment opportunities for health professionals) could be expected. The inclusion of these fields thus provided opportunities of comparison to explicit health NGOs.

Data on organisations was extracted from the print directory, with each organisation constituting a case. A total of n=234 organisations, which were self-reportedly engaging in at least one of the three fields, was identified from the 'index by sectors'. The variables included: location of headquarters and districts of operation, work fields, selected activities, modes of implementation, sources of funding and number of employees. The data was gathered and analysed using the open source statistics software PSP. As detailed information was missing for 7 organisations, the eventual sample comprised of n=227 NGOs. The findings are presented in chapter 4.3.3 under 'Contemporary structural data on NGOs'.

- c) Job advertisements in June 2008:** vacancies announced over the period of 30 days in five national newspapers (print copies) were screened in the archive of the “Daily Times” in Blantyre. Relevant information on health-related vacancies was entered into MS Access, with each advertisement constituting a case (n=53). This did not include positions that required nursing, medicine or biomedical qualifications only. The variables were: date of publication, number of posts, name of employer, location of post, mode of employment, duration, level and type of qualification required. Further analysis was carried out in MS Excel. The resulting table can be found in chapter 4.3.4 under ‘Contemporary data on research and consultancies’.
- d) Database for Technical Assistance for the National HIV/AIDS response in Malawi, 2007:** This electronic database issued by the National AIDS Commission Malawi was acquired as a CD-ROM. The profiles of n=107 individual consultants are accessible through a fixed user surface. 29 of these individual profiles are attached to profiles of consultancy firms. The electronic format did not lend itself to a transfer into MS Excel or another database. Moreover, the information contained in the individual profiles was very heterogeneous. Quantitative analysis was therefore restricted to establishing rough categories and making simple frequency counts. The findings are included in chapter 4.3.4 under ‘Contemporary data on research and consultancies’.

Hence, chapter 4 of this study presents the results of the structural data analysis. The focus is on professions or occupations in the first part, while the second part characterises organisations operating in the Malawian health sector and their relationship among each other.

3.3.2 THEMATIC ANALYSIS

The thematic analysis of the interview data in this study is used to extract institutional statements (strategies, norms and rules), which are largely shared by at least a sub-group of interviewees. The field notes supplement the interview data in this respect;

they are not analysed as a distinct corpus of data. Most of the text material gathered and produced within the scope of this research, as far as it could be converted into Rich Text Format, was analysed using the software MAXQDA 2010. This predominantly applies to the transcripts of the interviews and the field notes. MAXQDA has been designed for qualitative data analysis and mixed-methods-approaches (quantitative and qualitative). It is offering the possibility to link different elements of data with each other through coding and writing memos, and to apply filter variables for text retrieval.

Expert interviews are not aimed at individual case reconstruction but allow to generate theory about the experts' larger field of action and its social organisation. Due to the interview guideline, the interview data constituted the most homogeneous section within the corpus of data for this study, which facilitates comparisons between different expert accounts (Meuser and Nagel 2005). The approach, which was taken up by Bogner et al. (2005), is located in the discipline of knowledge sociology, however. The related constructivist schools of thought and the abstraction process suggested by these authors for the data analysis proved difficult to apply to a case study conducted in a foreign country. Therefore the thematic analysis proposed by Froschauer and Lueger (2003) was chosen as an alternative method.

Thematic analysis is aimed at text reduction and at working out 'who is saying what in which context' (Froschauer and Lueger 2003). Considering the different occupations and employers that are investigated in this study, this method allows to work out similarities and differences between certain interviewees and between certain narrative contexts. The term 'narrative context' in this case refers to the course of the interview; it is asked in which immediate context within his or her narration the interviewee made a statement. Four different contexts are considered for the purpose of this study, namely whether the interviewee is talking about:

- professions / occupations
- organisations (employers) or contractual work arrangements
- activities and interactions of organisations to provide health services
- opportunities of policy development and international cooperation.

Thematic analysis does not require literal transcription. Therefore only the first 6 interviews were literally transcribed, but the recorded material was revisited to write an extensive chronological protocol for each interview. Information was anonymised through masking names and places. MAXQDA allows for the protocols to include hyperlinks to the respective passage in the audio file of the interview. This way, the most relevant sections of the interviews could be easily retrieved later and be transcribed in detail where necessary. Furthermore, relevant variables concerning the circumstances of the interview or attributes of the interviewees can be attached to the files. This feature provides the basis of sorting, filtering and descriptive statistics within MAXQDA. Related field notes and observation protocols can complement the interview data, which is possible through memos that link up different files.

The themes in this study have been deduced from the UNDP literature on capacity development. The UNDP framework provides the four 'levers of change', i.e. knowledge, leadership, accountability and institutional arrangements (UNDP 2010). As special attention was supposed to be given to international mobility and the interaction between Malawian and international actors, I added the themes availability and ownership (UNDP 2003). The interviewees' statements were collated with these thematic codes, which comprised 21 sub-codes (see Annex 7.6). The UNDP framework is taking an institutionalist approach to capacity development (UNDP 2010), however, it does not provide analytical tools or a research methodology. Therefore, to actually extract relevant findings from the interview data, a combination with the IAD framework was necessary, particularly with the 'grammar of institutions' (Ostrom 2005).

Double coding of the interview protocols (thematic codes X narrative contexts) and the use of filter variables (occupation and employer of each interviewee) provided the basis for the identification of relevant interview statements. The results are thus not presented 'theme by theme'. Rather, the most important themes or statements are presented under the headings referring to occupations, employers or other narrative contexts. Findings from the thematic analysis are presented both in chapter 4 and 5, each referring to different contexts in which statements were made.

3.3.3 INSTITUTIONAL ANALYSIS AND DEVELOPMENT FRAMEWORK

The application of the IAD framework in an empirical case study is principally an analysis and synthesis of written or spoken text. Two central elements of the IAD framework appear particularly relevant for the study of HRH in a country like Malawi and shall therefore be introduced here. First, in order to analyse and develop institutional statements, Ostrom (2005) presents a so called ‘grammar of institutions’ to be applied at the linguistic level. The second element is the concept of action arenas (or action situations) as ‘nested holons’. This concept can be used to narrow the focus on the interactions of a particular set of players, while at the same time systematically considering external influences. The integration of different methods and data sources (thematic and structural data analysis) under the IAD framework will subsequently be described in the summary (chapter 3.4).

Grammar of institutions: Ostrom (2005) distinguishes three grades of institutional statements by their binding force, namely shared strategies, norms and rules. A rule is the most obliging institutional statement by this definition, as it contains all five syntax components of the ‘grammar of institutions’. These components are:

- [ATTRIBUTE], identifying the attributes of the actors which are concerned by the statement (e.g. age, citizenship or qualification)
- [DEONTIC], prescribing the mode of action within the scope of the physically possible (i.e. that the actor may, must or must not do something)
- [AIM], indicating at what action or outcome the institutional statement is directed (e.g. setting up a roster, or a certain percentage of skilled birth attendance)
- [CONDITIONS], specifying the circumstances under which the statement applies (e.g. during outreach activities in remote communities, at the quarterly meeting of the management board)
- [OR ELSE], stipulating a sanction which will apply in case of default (e.g. withdrawal of a license, budget cutbacks)

A norm by this definition includes all syntax elements except for the [OR ELSE], meaning that it still has a prescriptive or moral character. Even if the adherence to the

norm is monitored, this is not backed-up by prescribed sanctions. Finally, a shared strategy only comprises [ATTRIBUTE], [AIM] and [CONDITIONS]. It is therefore a non-prescriptive statement taking the form of an advice. Shared strategies rely on prudence and on the expectations that the actors have about each other's future behaviour.

The present study aims at uncovering strategies, norms and rules from the data, as far as these statements are concerning HRH management and development in conjunction with international aid. Notably, the emphasis in Ostrom's work lies on 'rules-in-use' rather than 'rules-in-form' (e.g. laws and written policies), since the actors might not be aware of the latter in their day-to-day decision making. Therefore the institutional statements in this study are largely derived from interview data. This is supplemented by the field notes on the researcher's interactions with the interviewees and with various other actors involved in international collaborations.

Nested holons: The set of institutional statements concerning HRH in Malawi is principally infinite, since the wider social context also needs to be taken into account. The field is characterised by a multitude of different kinds of actors operating at the international, national, district and community level, but also transcending these levels. The IAD framework aims at capturing this complexity by focusing on action arenas or action situations. For example, organisations can on the one hand be considered as participants in an action arena interacting with other participants (e.g. the Ministry of Health interacting with CHAM). On the other hand, they may also host several action arenas within themselves (e.g. the District Health Offices, or CHAM technical colleges). This concept is called 'nested holons', with the outcomes of one action arena influencing the other arenas either in a hierarchical or a sequential manner (Ostrom 2005, pp. 11-13). For an empirical case study, it is indispensable to concentrate on circumscribed settings or situations for which the rules and patterns of interaction are to be analysed. While Ostrom (2005) does not provide a clear discriminatory definition, I apply the term 'action arena' to the general setting of interaction, and the term 'action situation' to a specific constellation of actors within this arena.

The focus of this study is on an action arena at the operational level, namely the health district with its planning and coordination activities for the provision of health care. Particular attention will be paid to the norms, strategies and rules that govern staff deployment and development in this arena. Within one health district, there may be a range of action situations with different actors in specific constellations, who are making operational choices of relevance to health workforce performance. The centre piece of an action situation is its link between actions and outcomes, which can again be captured and refined by institutional statements. The statements can refer to different components of the action situation. On the 'action side', they may specify positions, as well as the participants and actions assigned to the positions. On the 'outcome side', they may define the envisaged state of the world and the net costs and benefits (pay-offs) assigned to it. Thirdly, institutional statements may relate to the information about and the control over the action-outcome link as such. The components and related types of rules are displayed in figure 2.

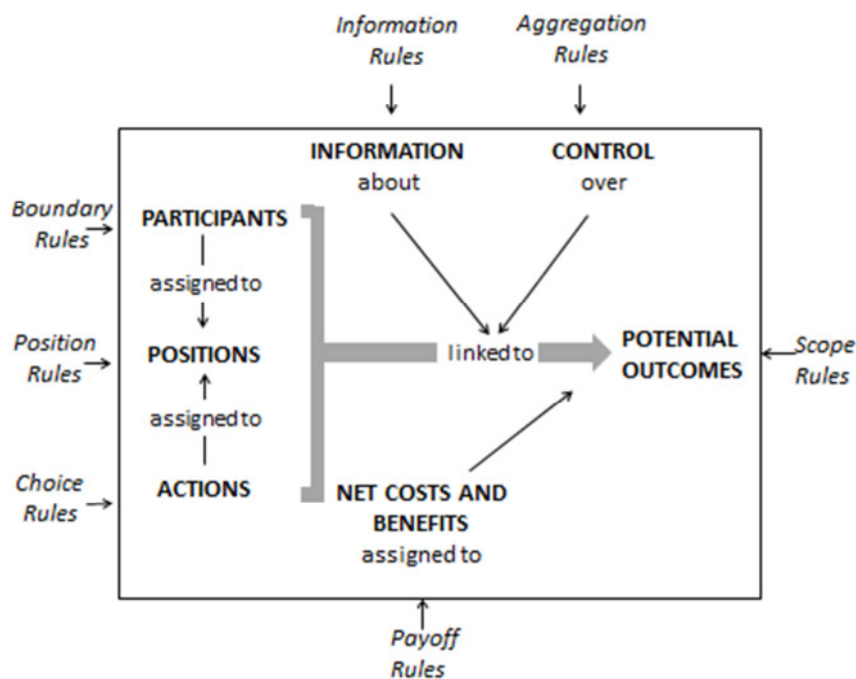


Figure 2: Structural components of an action situation

Source: Ostrom 2005, p. 189

Having established the action arena to be studied also allows the researcher to explicitly turn to its environment (Ostrom 2005, p.15). This refers to exogenous variables on the one hand (in this case the physical, social and cultural attributes of HRH and the larger community in which it is embedded), and to linked action arenas on the other hand (in this case situated at the collective choice and the constitutional level of the Malawian state as a polity).

3.4 SUMMARY: COMBINATION OF DATA AND METHODS

The different methods and data sources outlined in this chapter inform the results section (chapters 4 and 5) to a varying degree. The IAD framework (Ostrom 2005) not only provides analytical tools, but also offers an overall frame for analysis and synthesis.

Chapter 4 of this thesis is taking an overall health workforce perspective. Investigating the current status and context of the resource system provides the basis for evaluating chances of sustainability. Some institutional statements are identified which influence the incentive structures facing the health workers. The chapter evolves around institutions which are most relevant to the individual career, namely the professions and different types of employment status or work contracts. It also takes a closer look at organisations and agencies which act as employers or contractors in the in the Malawian health sector. The aim is to analyse the actors' general understanding of the link between the attributes of HRH on the one hand, and the rules applied to govern the resource appropriation and (re-)production on the other hand.

By establishing different categories of employers, the positions for organisations (composite actors) participating in 'co-ordinated planning' at district level are outlined. Ostrom (2005) defines positions as "the anonymous slots that are filled by participants and to which specific action sets are assigned at junctures in a decision process"(p.193). Hence the positions within a specific action situation form an important starting point for the analysis of the institutional statements governing this situation. In a field such as HRH, such institutions are likely to expand largely into time and space (Giddens 1984). Particular attention will thus be paid to the influences of

global health and of the Malawian history on the self-conceptions related to these positions.

Chapter 5 of this thesis is then dealing with HRH-related interaction and outcomes within the administrative unit of the health district. Furthermore, the chapter is exploring the question which action arenas exist regarding HRH, and how they might be linked to each other. It lays out the landscape of organisations operating in the Malawian health sector, referring to their activities at the point of the field research. The action arena 'health district' is circumscribed and its links with neighbouring arenas are specified. As such, the chapter may also provide readers with an initial overview if they are unfamiliar with the Malawian health system.

Interviewees are considered representatives of their type of organisation, as they are either managers or leaders at the district-level units within their organisation, or they are researchers or consultants deployed at that level on a freelance basis. Although the chapter focuses on health districts, it will not look into distinct organisational settings or projects, for reasons of anonymity. The action situations and institutional statements worked out here are rather abstractions from the concrete cases of collaboration found at the district level during field research. Three basic types of action situations, with different constellations and roles of the actors involved, will be outlined here. Most of the concrete cases found in the data contain elements of several action situations.

Besides possible shortfalls that lie at this operational level, Oakerson (1992) suggests to look at the rules that specify the conditions of collective choice among the actors, i.e. 'the rules determining how to make the rules'. Problems identified at the collective-choice level may again be rooted in the conditions at the constitutional level. Therefore, the second part of chapter 5 is looking at entry points for regulation and governance, to improve co-operation between Malawian and international composite actors in the field of HRH.

4 FINDINGS: HRH AS A CONTEXTUALISED RESOURCE SYSTEM

The present chapter deals with the composition and status of Human Resources for Health and its producers/appropriators in Malawi. It also reflects the socio-cultural attributes of the larger community in which HRH is embedded, namely the health sector with its international linkages, and the Malawian society at large. This is considered a necessary step to derive and contextualise the analysis of interaction among Malawian and international organisations, which will be presented in chapter 5. Insights in the general understanding of HRH in Malawi may also be used when trying to come up with modes of regulation.

By taking the historical and geographical context into consideration, the expansion of professional and labour-market institutions in time and space is disclosed (Giddens 1984; Layder 1993). The earliest historical accounts considered here refer to the colonial period, although concepts of health and healing in Malawi certainly date back much further. Traditional medical practice in Malawi forms part of the social system of kingship, in which herbal medicines, spirit worship and some elements of sorcery are applied to control diseases¹. However, an ethnographic study of traditional kingship structures and the colonial encounter comes to the conclusion that the shape of Malawian polity today owes more to the colonial institutions than to the pre-colonial ones². The traditional system continues to be influential, but it is not part of the present study, which is concerned with the provision of 'Western' medical services.

The structural data presented in this chapter provides the basis for assumptions about the conditions of development and change within the health occupations on the one hand, and organisations acting as employers on the other hand. Chapter 4.1 looks into the attributes of HRH as a resource system in Malawi, tracing its inner and outer boundaries along established occupations and professions. Furthermore, the status of HRH in terms of total numbers and distribution is described. Chapter 4.3 evolves around HRH appropriation and (re-)production. It is pointing out major composite

¹ Lwanda J (2005) Politics, Culture and Medicine in Malawi: Historical Continuities and Ruptures with Special Reference to HIV/AIDS. Kachere Theses no. 6. Zomba: Kachere Series

² Kaspin D D (1990) Elephants and ancestors. The legacy of kingship in rural Malawi. Doctoral Thesis, Chicago Illinois

actors (employers, organisations) in HRH in Malawi, different modes of employment in the health sector, and the influences of international funding on the supply of and demand for health workers. Each section starts by an outline of the situation at the point of the field research, i.e. referring to the most recent data. Major data sources for this purpose are the needs assessment study on HRH and capacity development compiled in 2007³, the draft HRH census report of 2008⁴, and the registry of the Council of Non-Governmental Organisations of Malawi (CONGOMA) issued in 2008⁵.

This outline of present configurations refers to the reconstruction of the internal context of the phenomenon under study (Lueger 2010), which in this case is the provision of personal and non-personal health services at district and community level. In a second step, the historical developments up to the conditions at present will be reconstructed for each section. This also includes developments at the national and international level (i.e. the external context of the phenomenon). However, comparisons with other resource systems which have developed under similar conditions (which is also suggested by Lueger 2010) cannot be covered within the scope of this study.

Instead, the reconstructed context is then contrasted with empirical findings from the interview data (chapters 4.2. and 4.4). These are the institutional statements that are being used by the interviewees themselves to characterise their profession or their employer. The most prominent HRH-related themes put forward in the respective narrative contexts will be presented here in the form of 'shared strategies' (see chapter 3.3.3).

³ MoH, Health SWAP Donor Group, GTZ (2007) Human Resources / Capacity Development within the Health Sector. Needs Assessment Study, Final Report: Republic of Malawi.

⁴ MoH (2008) Malawi Health Sector Employee Census. Final Draft. Lilongwe

⁵ CONGOMA (2008) Directory of NGOs in Malawi. Blantyre

4.1 HEALTH OCCUPATIONS AND PROFESSIONS

In the following, four different occupational groups will be outlined, oriented at those professions which are part of the core District Health Management Team (DHMT) in Malawi. They largely coincide with the groups established in the Health Sector Human Resources Plan of 1999⁶, but the technical support section is subsumed under general management and administration. For the purpose of this thesis, graduates from social sciences are also included in the latter group.

Annex 7.7 provides some relevant quantitative data from the HRH census 2008, in order to provide an overall picture of the situation at the point of field research. The tables in the Annex allow for comparison between the different occupations and will be referred to throughout this chapter. They also demonstrate the geographic distribution of health facilities and of staff by professional groups across the 28 health districts of Malawi. In 2008, rural dwellers made up for 84.7% of the Malawian population⁷. While 70.54% of all health facilities are situated in rural areas (see Annex 7.7.3), only 23.16% of all medical doctors, 26.57% of all clinical officers and 33.15% of all nurses/midwives work in such rural facilities (see Annex 7.7.1).

On behalf of the government, training and formal qualification of health professionals in Malawi predominantly takes place at the Malawi College of Health Sciences and at the University of Malawi (UNIMA). The constituent colleges of UNIMA are the Polytechnic, the Kamuzu College of Nursing (KCN) and the College of Medicine (COM). In addition, Mzuzu University was founded in 1997, which also hosts a Faculty of Health Sciences. As for church-related provision, the ten CHAM training institutions are engaged in the training of nurses, midwives, medical assistants and clinical officers⁸. To date, technical colleges that train students up to certificate and diploma level are the major contributors to the health workforce in quantitative terms. The 1980s and 1990s, however, brought a shift towards training at academic level. The different branches of UNIMA turned their diplomas into Bachelor Degrees and thus offered

⁶ MoHP (1999) Malawi National Health Plan 1999 - 2004: Vol. 3 - Health Sector Human Resources Plan

⁷ National Statistical Office (2010) Population and Housing Census Results 2008.

<http://www.nsomalawi.mw>

⁸ MoH, Health SWAP Donor Group, GTZ (2007)

possibilities for further upgrades of qualifications⁹. Compatibility with internationally established levels of qualification (Bachelor and Master) was achieved.

By contrast, more recent national HRH plans prioritise the expansion of training capacities at lower technical and educational levels, in order to produce more health workers within shorter time-frames¹⁰. The Needs Assessment Study emphasises the importance of the Malawi College of Health Sciences (MCHS) and the CHAM colleges, since they are training those cadres which are supposed to take over the major share of work in the provision of essential health services at district and community level. The MCHS consists of four faculties: Clinical Sciences, Medical Sciences, Nursing Sciences and Public Health Sciences. Within the scope of the EHRP, the college was supposed to double its student numbers from 700 to 1400. This required major investments in infrastructure and teaching staff, as well as curricula revision and respective alignment with the needs in the Malawian health sector¹¹. Mzuzu University receives little attention within the scope of these plans. As the disciplines taught there are not at the centre of this study, it is not further considered here.

History of health work in Malawi

Historical context information in this chapter refers to training institutes and internal qualification requirements. Occupations and respective training policies in the health sector often reach back to colonial times and have to be seen in light of expeditions and missions to South-East Africa. After independence these occupations constituted an integral part of state-building in Malawi. Throughout the 1970s and early 1980s, the Ministry of Health issued articles in its Health Extension Service Publication, to educate its own staff on political ideas and the occupational profiles of different cadres¹². After the endorsement of the Alma Ata Declaration by the Malawian government in 1978,

⁹ Ooto S N (1980) Health Manpower Problems in Developing Countries (Vol. 3). Medical Quarterly, 3: 6–8
Banda E E, Chimango J L (1993) Kamuzu College of Nursing: It's role in Malawi's Health Care Delivery System (Vol. 9). Malawi Medical Journal, 9(3): 2–3

¹⁰ MoHP (1999)

¹¹ MoH, SWAP Donor Group, GTZ (2007)

¹² Bomba W G (1971) The Health Assistant (Vol. 3). Moyo. A Health Extension Service Publication, 3(1): 2–5; Bomba W G (1981) Introducing a Primary Health Worker: A Historic Perspective (Vol. 13). Moyo, 13(11):2; Mackintosh A (1971) A Comprehensive Nurse (Vol. 3). Moyo, 3(3): 4–7; Matiti H M (1980) My job as I see it. District Medical Officer (Vol. 4). Medical Quarterly, 4: 19–20; Tembo K C (1981) Tasks of a Professional Health Educator in Malawi (Vol. 13). Moyo, 13(2): 4–7

the suggested role changes of professionals versus community volunteers are also reflected in domestic health care periodicals¹³. Tensions between preventive and curative approaches have appeared from the very beginning of colonialism. They are entangled with the question whether the general population or members of government services should be the primary beneficiaries of the health services. Respective inequalities persist in the gap of service provision between the rural population and the urban population.

Low levels of general education have long been a limitation to building a skilled health workforce, as until the 1950s no secondary school existed on Malawian territory. After independence, education - besides heavy investments into agriculture and transportation - was promoted as the backbone of national development¹⁴. Repeated surveys of the different health cadres were carried out with international support and were followed by specific training policies. This took place e.g. in preparation of the foundation of the College of Medicine¹⁵ or within the scope of the Emergency Human Resources Plan (EHRP) at the beginning of the new millennium¹⁶.

The regulation of health professions occurs through state authority. The Medical Council originates from 1926 and is in charge of registering doctors, paramedicals and allied health professionals¹⁷. The 1966 Nurses and Midwives Act provided for the establishment of a separate council for this professional group¹⁸. The councils oversee the development of courses at the different training institutions and take state examinations¹⁹. Since 2008, they are also aiming at regulating less formal continuing

¹³ Bomba (1981); Lungu G W (1984) Primary Health Care in Malawi - an introduction (Vol. 2). Medical Quarterly, 2(2): 47–48; Courtright P, Biggs-Jarrel B (1992) Village Health Volunteers: Key Issues Facing Agencies in Malawi (Vol. 8). Malawi Medical Journal, 8(2): 67–69

¹⁴ Kadzamira Z D (1977) Planning for Development in Malawi: 1954-1974 (Vol. 6). Journal of Social Science, University of Malawi, 6: 60–82

¹⁵ Lantum D N, Grillo T A I, Gilles H M (1981) Feasibility Study for the Foundation of a Medical School in Malawi

¹⁶ MoH (2008)

¹⁷ King M, King E (2007) The Story of Medicine and Disease in Malawi: The 150 Years since Livingstone. Fourth impression with added chapters on AIDS and the 1992-2007 period. Blantyre: MCC

¹⁸ Greenway E A L (1974) The Nurses and Midwives Council of Malawi (Vol. 6). Moyo. A Health Extension Service Publication, 6(5): 2–4

¹⁹ Muula A S, Misiri H, Chimalizeni Y, Mpando D, Phiri C, Nyaka A (2004) Access to continued professional education among health workers in Blantyre, Malawi. (Vol. 4). African Health Sciences, 4(3): 182–184; Government of Malawi (1987) Medical Practitioners and Dentists: Notice (Vol. 17). The Malawi Gazette, Gazette Extraordinary, 17

professional development (CPD) activities²⁰. Besides the regulatory bodies, professional associations were founded as quasi-governmental organisations under the Banda regime²¹.

4.1.1 MEDICINE AND CLINICAL OCCUPATIONS

Within the DHMT, medical doctors would either hold the position of the District Health Officer (DHO) or of additional District Medical Officers (DMO). For many decades, clinical practice in Malawi - especially in rural hospitals - has been largely a domain of domestically trained medical assistants (certificate after 2 years training) and clinical officers (Diploma after 3 years training and one year internship)²². On the basis of long-term work experience, clinical officers could be promoted to become DHOs. Medical doctors were scarce, as they had to be trained abroad. After the Malawian government established its own medical school in 1991, these posts are increasingly being filled by newly graduated medical doctors. However, Annex 7.7.1 shows that large parts of the clinical workload principally remain with the mid-level cadres. The ratio of doctors to clinical officers is 1:2.13 in urban health facilities, and 1:4.18 in rural health facilities. Moreover, medical assistants (n=479) clearly outnumber the clinical officers (n=186) in rural areas, while the opposite is the case in urban areas. The clinical occupations are dominated by males, with females only making up for 26.84% (n=51) of the medical doctors and 10.24% (n=65) of the clinical officers (see Annex 7.7.2).

The College of Medicine (COM) is the most recently founded college at the University of Malawi, situated in Blantyre next to the Queen Elisabeth Central Hospital. A Bachelor programme in Medicine and Surgery (MBBS) at the COM was started in 1991, when 14 medical students came back from the UK to complete the final year of their studies in Blantyre. The enrolment figure for the 5-year MBBS was 231 students in 2005, also including some from other neighbouring countries. As for clinical specialisation, the COM started preparations for a four-year Mmed programmes in

Government of Malawi (1993). Medical Practitioners and Dentists Act (Cap. 36:01): Paramedicals and Allied Health Professionals (Training) Rules, 1993. The Malawi Gazette: 268–279

²⁰ Medical Council of Malawi (2009). Continuing Professional Development. Lilongwe.

²¹ Tembo K C (1989) Evolution of Health Inspectors in Malawi (Vol. 26). Moyo, 26(3): 4–6

²² King, King (2007)

medicine and surgery in 2004²³. For other specialities it is still necessary to go to abroad, e.g. to South Africa. The Master of Public Health (MPH) course at the COM was the only health-specific postgraduate degree available at the point of the Human Resources Needs Assessment²⁴.

Qualitative research on the socialisation of medical students in Malawi reveals religious and nationalist motives as an important driving force to choose medicine as a profession, and notes that - unlike in the US or UK - the transition into clinical practice often goes along with a sensitisation for the adverse living conditions of their patients and increasing political consciousness²⁵. Furthermore, the principles of community medicine and basics of district health management taught at the College of Medicine are supposed to offer orientation to the graduates, with medical practice being based on profound knowledge of the underlying Public Health problems of Malawi²⁶. The programmes at the COM also include community-based teaching elements and to be backed up by a Research Support Centre for clinical research. The staffing solutions for the college are seen as innovative, but their sustainability is questioned²⁷. An article of 2007 states that the college still relies heavily on foreign teaching staff, with all eight positions of Associate Professors or Professors being filled by expatriates. While it is projected that positions can be gradually taken over by Malawian graduates, it is considered necessary for the foreseeable future that most senior teaching staff is externally provided on a technical assistance basis²⁸.

Registration with the Medical Council is apparently rather complete: 218 medical practitioners (including temporary and provisional) were registered²⁹, as compared to

²³ Zijlstra E E, Broadhead R L (2007). The College of Medicine in the Republic of Malawi: towards sustainable staff development (Vol. 5). Human Resources for Health, 5(10): 5 pages.

²⁴ MoH, SWAP Donor Group, GTZ (2007)

²⁵ Wendland C, Bandawe C (2007a) A Qualitative Study of Medical Student Socialization in Malawi's College of Medicine (1): Preclinical Training and Identity (Vol. 19). Malawi Medical Journal, 19(2): 68–71; Wendland C, Bandawe C (2007b) A qualitative Study of Medical Student Socialization in Malawi's College of Medicine (2): Clinical Crisis and Beyond (Vol. 19). Malawi Medical Journal, 19(2): 71–74

²⁶ College of Medicine and Medical Association of Malawi 2001

²⁷ MoH, SWAP Donor Group, GTZ (2007)

²⁸ Zijlstra, Broadhead (2007)

²⁹ Government of Malawi (1987); Government of Malawi (2008) Medical Practitioners and Dentists Act - Notice of Registered Health Professionals and Licensed Clinics (3,010: Vol. XLV). The Malawi Government Gazette, 3,010: Vol. XLV(50): 319–374

190 physicians which the HRH census found to be working in different kinds of facilities³⁰. The Malawi Medical Association dates back to 1926 and as such is the oldest professional association. Since 1980 it has been publishing its own journal³¹, the Malawi Medical Journal (formerly the Medical Quarterly), which is also connected to the COM. It considers itself a means for continuous professional development, promoting research in the country and striving for excellence³².

History of medicine in Malawi

The first western medical doctor to reach the territory of modern Malawi in 1859 was Dr. David Livingstone on his Zambesi Expedition. The different Missions established health facilities for missionary staff as well as local population and deployed their own expatriate doctors. The Colonial Medical Service was established by the government in 1891. It also pursued research on infectious and parasitic diseases and the possibilities of containment and prevention³³. Government hospitals and health facilities were partly vacated of their expatriate staff during the two World Wars, meaning that local auxiliary staff had to take over the services. In the following decades, training activities focused on these auxiliaries, in order to increase the coverage of health services especially in rural areas³⁴. By the time of Malawi's independence in 1964, the number of doctors (including administrators) is reported to be 41 in government service and 17 in the Missions. 18 persons were abroad for medical studies under government sponsorship and were expected to build up the domestic health services upon their return. Meanwhile, volunteers predominantly from the US and the UK contributed to the service provision³⁵.

In the early 1980s, the discourse in Malawian publications took up the PHC idea and was officially favouring the training of larger numbers of medical auxiliaries over

³⁰ Government of Malawi (2008)

³¹ King, King (2007)

³² Muula A S (2003) The changing faces in Malawi's health care landscape (Vol. 15). Malawi Medical Journal, 15(1): 2

³³ Baker C (1976) The Government Medical Service in Malawi: An Administrative History, 1891-1974 (Vol. 20). Medical History, 20(3): 269–311

³⁴ King, King (2007)

³⁵ Stevenson D J D (1964) The Health Services of Malawi: A Thesis presented for consideration for the degree of Doctor of Medicine of the University of Glasgow.

medical doctors, whose training is comparatively expensive³⁶. At the same time, however, the government of Malawi made a formal request to the WHO to send an expert mission and explore the feasibility of establishing a medical school. The underlying argument was that the health infrastructure had been greatly scaled up, but doctors trained abroad had difficulties to adapt to the conditions in rural Malawi and were often lost to the health services³⁷. Medical officers deployed in district hospitals were expected to work on their own, covering a wide range of specialties and supervising the health facilities in the district, without much supervisory support from headquarters or central hospitals³⁸.

4.1.2 NURSING AND MIDWIFERY

The District Nursing Officer (DNO) as part of the DHMT oversees the facility-based as well as the community-based nursing activities within the health district. A diploma in nursing takes 3 years and is complemented by a fourth year of midwifery. In order to prepare nurses for further tasks in management and comprehensive care, a Bachelor Degree in nursing was introduced in 1991 at the Kamuzu College of Nursing (KCN), with the entry requirement of at least two years of nursing practice. The second year of the degree course was dedicated to a research project in a chosen area of specialisation, which could be either management, education, community health, mental health, paediatrics, medicine and surgery or advanced midwifery³⁹. The Human Resources Needs Assessment study of 2007 found that the two KCN campuses at Lilongwe had 75 staff members, including five PhD-holders and 29 Master degree holders, and had the capacity for 300 students. Since training courses in Malawi are usually conducted as full-time on-site courses, hostel accommodation was a major limitation factor at that time⁴⁰.

³⁶ Msukwa L A H (1981) Meeting the Basic Health Needs of Rural Malawi: An Alternative Strategy: Monograph No. XII. Chapter VI and VII: Manpower Requirements and Summary of Main Recommendations.

³⁷ Lantum, Grillo, Gilles (1981)

³⁸ Matiti (1980)

³⁹ Banda E E, Chimango J L (1993) Kamuzu College of Nursing: It's role in Malawi's Health Care Delivery System (Vol. 9). Malawi Medical Journal, 9(3): 2–3

⁴⁰ MoH, SWAP Donor Group, GTZ (2007)

The CHAM training institutions train nurses up to technician level (2 years) or diploma level, hence they are also said to have a central role in the efforts to scale up staffing in the health sector. They are coordinated through the training board and follow joint curricula. Funding for operating costs such as salaries, accommodation, transport and student fees is provided by government, and the targets set by the MoH require CHAM colleges to at least double their student intake. However, problems are reported for the necessary investments in infrastructure as well as the staff motivation and availability of tutors. Due to specific funding arrangements, incentives to supplement salaries are not provided for, and overall donor funding is considered insufficient⁴¹.

Nurses constitute the largest group among the qualified health workers providing personal health care. According to Annex 7.7.1, there were 2,932 nurses/midwives and 968 nurse technicians working in Malawian health facilities in 2008. 37.79% of the nurse/midwives work in urban, 33.15% in rural and 29.06% in semi-urban areas. Among the nurse technicians, the share of those deployed in rural health facilities was highest (39.57%). As in most countries, the gender balance is very uneven, with 91.51% female vs. 8.49% male nurses/midwives (see Annex 7.7.2).

History of nursing and midwifery in Malawi

The first nurse training initiatives are reported from the missions in Malawi at the beginning of the 20th century. The Livingstonia mission pleaded for a national register of trained Nurses and Midwives, along with Medical Assistants, in the year 1914 already. Nurse trainings in several rural hospitals were started in the 1920s and were registered by the Medical Council since 1926. The first governmental medical training institution opened in Zomba in 1936 and provided training in nursing besides other health occupations⁴².

Midwifery is conceptualised as an additional qualification after basic nurse training. A Midwives Ordinance Board was introduced in 1947 and established the first midwifery courses, taught in English language. In 1966 a separate council for nurses and midwives was founded, which coincided with the opening of the National School of Nursing in

⁴¹ MoH, SWAP Donor Group, GTZ (2007)

⁴² King, King (2007)

Blantyre in 1965. The latter aimed at incorporating the sciences into nurse teaching and thus had higher entry requirements (General Certificate of Education) than previously established auxiliary training courses. It was expected that these nurses would be leaders in the provision of comprehensive nursing care in rural and urban settings⁴³. The higher entry requirements were also supposed to lay the foundation for clinical specialisation at academic level⁴⁴. At that time, more than 100 nursing students were still accomplishing their training abroad⁴⁵.

In 1979, the school was moved to Lilongwe and - under the name of Kamuzu College of Nursing - became a constituent college of the University of Malawi⁴⁶. From 1980 onwards, different one-year specialisation courses were offered, including Public Health Nursing⁴⁷. Public Health aspects and health education had already been introduced to the nursing curricula with the opening of a school for community nursing in Zomba in 1969, which was assisted by the WHO and had a focus on maternal and child health. However, resistance in the MoH against a separate cadre of community nurses led to the creation of the 'comprehensive nurse', who was supposed to be flexibly deployable in both urban hospitals and rural communities. Public Health thus became part of general nursing and of midwifery courses⁴⁸. Hence the PHC discourse was embraced by officials of the profession as being well suitable to the philosophy of nursing and offering a chance to comprehensive and autonomous professional practice⁴⁹. At the beginning of the 1990s, however, it was deplored that graduates of the college were still mostly being deployed in medical-surgical settings rather than in the community⁵⁰. Moreover, 18 years after the introduction of the Bachelor degree in nursing, a study from 2008 finds that graduates are usually employed as matrons or

⁴³ Sagawa S (1982) History of Nursing in Malawi (Vol. 9). Medical Quaterly, 9: 26–27

⁴⁴ Sagawa (1982)

⁴⁵ King, King (2007)

⁴⁶ Chigwenembe S S (1982) Courses Present and Projected for Training Manpower: In: The 1982 Papers presented by Heads of Sections Meetings held at the Headquarters in Lilongwe, Malawi from January to December 1982. pp. 10–16

⁴⁷ Sagawa (1982)

⁴⁸ Mackintosh A (1971) A Comprehensive Nurse (Vol. 3). Moyo, 3(3): 4–7; Zindawa, A. B. (1975). The National School of Nursing (Vol. 7). Moyo, 7(4): 6–11.

⁴⁹ Mwale T (1985) The role of the Nurse/Midwife in Primary Health Care. Medical Quaterly, : 48–49.

⁵⁰ Banda, Chimango (1993)

ward sisters in-charge. As such, they are facing a high administrative workload while often having little work experience⁵¹.

In terms of professionalisation, the Nurses and Midwives Act of 1966 marked another important step, whereby registration was separated from the medical profession. The Nurses and Midwives Council of Malawi was established as a regulatory body, which is also in charge of overseeing continued professionals development (CPD) for nurses⁵². Less formal CPD among nurses is mostly occurring through workplace activities (handover meetings, workshops), while the access to professional journals or to the internet is low⁵³. As a professional association, the National Organisation of Nurses and Midwives of Malawi (NONM) was founded in 1979. It is a member of Public Services International and claims the functions of a nursing-specific trade union.

4.1.3 PREVENTIVE SERVICES AND ENVIRONMENTAL HEALTH

The position of the Environmental Health Officer (EHO) at present requires a Bachelor degree, which can be acquired at the Polytechnic in Blantyre, a college within the University of Malawi. In the civil service, this is also the qualification needed to assume the managerial position of the District Environmental Health Officer (DEHO). Environmental health workers often have to cover extensive geographical areas. This is meant to be achieved through a network of outreach staff, structured in a hierarchical manner. DEHOs and their juniors are in charge of supervising the group of Health Surveillance Assistants (HSAs) in the district, whose numbers have been boosted in recent years under the EHRP. The Health Sector Human Resources Plan 1999-2004 finds an overweight of staff at leadership levels compared to the intermediary assistant level⁵⁴. Hence it does not give high priority to academic training of public health staff. However, problems in supervision are repeatedly highlighted for the environmental

⁵¹ Maseko F C, Msoma P, Phoya A, Muula A S, Kuntiya K (2008) What is required to retain registered nurses in the public health sector in Malawi? (Vol. 16) *Malawi Medical Journal*, 16(2): 30–32

⁵² Greenway E A L (1974) *The Nurses and Midwives Council of Malawi* (Vol. 6). Moyo, 6(5): 2–4

⁵³ Muula A S, Misiri H, Chimalizeni Y, Mpando D, Phiri C, Nyaka A (2004) Access to continued professional education among health workers in Blantyre, Malawi. (Vol. 4). *African Health Sciences*, 4(3): 182–184

⁵⁴ MoHP (1999)

health section. This is said to be partly due to a lack of coordination and concepts that also include the community-based activities beyond the health facility level⁵⁵.

The EH section comprises by far the largest number of health workers in the Malawian health sector (see Annex 7.7.1). The n=10,055 HSAs are almost twice the number of ward/hospital attendants (n=5,701), which are the second largest group, holding a similarly low qualification. HSAs are predominantly deployed in rural areas, where they constitute 44.98% of the total health workforce, as opposed to 7.93% in cities. The HRH census category of 'Public Health workers' (n=318), who are supposed to be their supervisors, is predominantly working in semi-urban areas (52.52%). While these higher cadres in the EH section are mostly male (89.62%), the gender imbalance among HSAs (61.56% male) is less extreme (see Annex 7.7.2).

History of preventive services and Environmental Health in Malawi

The Polytechnic in Blantyre has hosted the training of Public Health Officers at the Department of Mathematics and Science since its year of foundation. The first graduates from a domestic three year diploma course in this technical field started their work in 1969, either deployed in District Health Offices or at city councils. They were then called Health Inspectors, referring back to the position of the Sanitary Inspector (later: Public Health Inspector) in Great Britain, which was directly taken over by the colonial administrations. Before independence, these positions were filled by expatriates, while Malawians were supposed to become their subordinate Health Assistants with two years of training. Training Malawian Health Inspectors was therefore emancipatory from a political perspective, but still carried a colonial connotation of control and enforcement in the terminology, which was also contested from within the occupational group⁵⁶.

⁵⁵ Chamatambe G M (2007) Regularity and Quality of Supervision Provided to Health Surveillance Assistants in the South East Zone of Malawi: Operational Study. Zomba; Gallagher R (2002) Proceedings of the dissemination workshop for the study on 'the role of health surveillance assistants (HSAs) in the delivery of health services and immunisation': held on wednesday 19th june, 2002 at the Lilongwe Hotel, Lilongwe, Malawi. Recommendation for the way forward drawn from the open floor discussion, pp. 18–20.

⁵⁶ Tembo (1989)

The year 1969 also marked a reorganisation of preventive health services with a stronger focus on health education in addition to sanitary measures and food control, as the renamed Ministry of Health and Community Development introduced the Health Extension Services within the scope of rural development schemes⁵⁷. The interferences between the government and the institute can be seen in academic practice, as the programs at the Polytechnic have always comprised basic, upgrading and specialist training courses. For example, the examination of food inspectors was a joint task of teaching staff as well as senior officers from the MoH and city councils⁵⁸.

The training scheme at the Polytechnic was interrupted in 1980/81 because the need for this cadre was questioned, but then continued. The 1993 Medical Practitioners and Dentists Act finally introduced the official term 'environmental health'⁵⁹. However, at the point of this study, Environmental Health Officers in Malawi neither disposed of their own registration board, nor did they have their own professional association.

HSAs are the lowest cadre in the environmental health section, and they are recruited and trained locally. Yet they have to be distinguished from non-salaried community volunteers, who are often attached to non-governmental and church-based organisations⁶⁰. While the MoH has issued training manuals for Community Health Workers during the early phase of PHC and set up pilot districts, these workers received allowances from the MoH and were not sustained by the communities⁶¹. The HSA cadre originates from temporary staff that was recruited to vaccinate against smallpox and control cholera outbreaks in the 1970s and was then non-formally maintained to survey health risks among the population. Only in 1995, they became a permanent cadre with official options for further qualification and promotion in EH⁶².

⁵⁷ Matemba F S (1971) The Community Development Assistant (Vol. 3). Moyo 3(2): 2–5; Bomba G W, Tembo K C (1991) Historical Development of Health Education in Malawi from 1891- 1976 (Vol. 44). Society of Malawi Journal, 44(2), 43–46

⁵⁸ Tembo K C (1980) Training of Food Inspectors at the Malawi Polytechnique (Vol. 12). Moyo, 12(5): 1–4
⁵⁹ Government of Malawi (1993)

⁶⁰ Courtright P, Biggs-Jarrel B (1992)

⁶¹ Bomba (1981); Lungu (1984); Khosa B (1984) Initial stages in the introduction of PHC in a pilot district in Malawi (Vol. 17). Medical Quaterly, 17: 16

⁶² Kadzandira J M, Chilowa W R (2001) The Role of Health Surveillance Assistants (HSAs) in the Delivery of Health Services and Immunization in Malawi. Blantyre

They may be promoted to Senior HSAs and enrol in training schemes for health assistants, which are offered at the MCHS.

4.1.4 GENERAL MANAGEMENT AND ADMINISTRATION

District Health Administrators are the fourth category of health workers represented in the DHMT and usually start their career in hospital administration. As there is no specific qualification for this task, candidates could be graduates from various courses offered at the University of Malawi in the fields of management, administration or social sciences. Another pathway into health sector management could be through the Common Service, which deploys administrative personnel under various government ministries, including health. It has to be noted, however, that the sectoral ministries do not dispose of this Common Service staff, who could be posted away from the health sector at any time, to be deployed elsewhere.

The Chancellor College in Zomba is home to the Departments of Economics, Political and Administrative Studies and Sociology. The degree course in Sociology also contains modules on development and on health⁶³. Bunda College of Agriculture in Lilongwe hosts the Faculty of Development Studies, including a Department of Language and Development Communication. The Polytechnic in Blantyre offers studies in accountancy or business administration and management⁶⁴. Such graduates are of course also potential candidates for taking over management functions in health-related non-governmental organisations or as self-employed consultants. Monitoring and evaluation, but also research activities in a larger sense are included here.

Specific training in health management does not exist in the form of a diploma or degree programme in Malawi. The Malawi Institute of Management (MIM), a self-financing research and training institute, is occasionally running respective courses. Otherwise, management modules are offered as part of nursing or medical degrees and within the scope of the MPH programme. The latter is said to receive academic support in health management from the Queen Margaret's University College,

⁶³ University of Malawi - Chancellor College (2009) Sociology: (degree course outline)

⁶⁴ University of Malawi (2009) Welcome to the University of Malawi (UNIMA): (Official homepage of the university with sub-sites on the five different colleges). <http://www.unima.mw>.

Edinburgh, through the Scottish Malawi Initiative. The COM is also reported to plan a specific course in hospital management, to target hospital administrators and accountants. The Needs Assessment study, referring to insights from the work of Management Sciences for Health (MSH), recommends that health management should be prioritised in in-service trainings. Besides respective modules in the MPH course, funds should also be provided for specific health management courses⁶⁵.

Management staff has a considerable share (8.76%, n=2,931) among all health workers covered by the HRH census, ranking fourth behind HSAs and hospital/ward attendants, and just behind nurses/midwives. Accountants (n=782) are even enumerated in a separate staff category (see Annex 7.7.2). The male proportion of management staff is 80.08%, while it is 55.75% among accounts staff (see Annex 7.7.1).

History of management and administration in Malawi

Colonial administration was aimed primarily at containing the local population rather than developing local government structures. The chain of command was from the Provincial Commissioner to the District Commissioners, who were directly overseeing the traditional chiefs on the one hand, and a team of technicians and field staff on the other hand. Expatriate administrators were usually supported by subsidiary grades of African clerical and executive officers⁶⁶.

National development planning after 1964 endorsed rural development schemes, building largely on the inherited colonial administration structures. They were, however, complemented by local branches of the ruling Malawi Congress Party⁶⁷. Starting from 1969, Community Development Assistants were trained at the Magomero training centre, to be posted to villages and districts and work alongside technical outreach staff from the health department and others. They were meant to provide information from the communities to the district development council, and to

⁶⁵ MoH, SWAP Donor Group, GTZ (2007)

⁶⁶ Kadzamira Z D (1974) Local Politics and Administration during the Colonial Period in Malawi (Vol. 3). *Journal of Social Science, University of Malawi*, 3: 5–19

⁶⁷ Kadzamira Z D (1977) Planning for Development in Malawi: 1954-1974 (Vol. 6). *Journal of Social Science, University of Malawi*, 6: 60–82

teach and stimulate local leaders to engage in development activities⁶⁸. At the national level, the Department of Community Development was integrated into the MoH.

Within the scope of administrative and political decentralization initiated by the Muluzi government in the mid-1990s, new positions for managers and administrators have evolved in rural development. The Malawi Social Action Fund (MASAF) supports local communities in improving infrastructures for health and education for example. Also, as civil servants deployed at the district assembly, they might arrange for and implement health-related projects and become mediators between communities and external funders⁶⁹. The district level administration is also called upon to contribute to reaching the Millennium Development Goals, which includes implementing health-specific service packages and related monitoring activities⁷⁰.

⁶⁸ Matemba(1971)

⁶⁹ Van Donge (2004)

⁷⁰ Kalanda (2007); Kalanda, Mandala, Maoni (2008)

4.2 INTERVIEW DATA FROM THE PROFESSIONAL CONTEXT

Complementary to the structural data analysed in chapter 4.1, findings from the thematic analysis of interview data is presented in the following. Interviewees have made these statements in the context of talking about their own profession or other occupations in the health sector. The main themes of the interviewees were covered by the following codes (see Annex 7.6):

- training policies (category: institutional arrangements),
- career opportunities (category: availability)
- qualification and learning (category: knowledge)

The respective interview sequences were subsequently searched for shared statements, but also for divergences between different professions or occupations. Institutional statements (shared strategies, norms, rules) are considered as structuring the opportunities and constraints of individual health workers in Malawi. Thus they determine the incentives which influence individual decisions and actions regarding professional development. The institutional statements extracted from the data are presented according to their AIM-components, i.e. the action or outcome which they refer to.

Adequate stock of health workers (outcome)

On the background of overcrowded hospitals and difficulties to man remote health facilities, the mere non-availability of health workers is very prominent in the interviews. Most interviewees would presumably share the following statement:

Reaching at a larger stock of qualified health workers in the country is a matter of priority in the current situation of crisis.

Increasing the capacity and output of training institutions in Malawi is usually named as the first measure. However, it is also considered necessary to reduce attrition from the workforce, notably through by increasing the payment and improving the working and living conditions (Im3:47, Im5:78, Im7:181, Im15:172, If14:117). While the focus is usually on nurses as well as medical doctors, some interviewees also point out the

importance of clinical officers, who bear a major share of the clinical workload but are lacking perspectives of professional development (Im19:129-137, Im15: 187).

The environmental health section makes an exception here, as it includes the HSA cadre, which has been considerably enlarged in recent years. EHOs interviewed in this study therefore rather highlighted the issue of adequate supervision for these large numbers. However, the underlying problems are again seen in a lack of accommodation for supervisors within the community, the termination of training Health Assistants as an interim cadre, and weak supervisory concepts (Im16:55, If17:50, Im12:27, 65, 81).

While the HSAs relieve the community nursing services from some of their workload, the idea of task-shifting to lower qualified cadres is seen as an indicator of malfunction and a threat to service quality – especially by the nurses (If22:140-150, If21:98-99). Many interviewees highlight that there is also a lack of highly qualified personnel, which accounts for the clinical and the nursing field, for programme management as well as for research and teaching (If11:103, Im5:79, If14:113).

Attrition through emigration from the country occurs as an ambivalent aspect. As for themselves, most interviewees think that they can best fulfil their potential in their home country or that their own people should benefit from their qualification (If11:103, Im13:18). They would at best say that those who have been trained should carry out their duties (If14:117), but not call for a restriction of individual freedom of movement - despite all health worker scarcity (Im2:132). One interviewee even thinks that Malawi could export nurses if receiving countries would refund the Malawian government for training (If4:70).

Higher academic qualification (action)

The strife for further education and specialisation is characteristic for the biographic accounts of the interviewees. They would therefore subscribe to the following statement:

Malawian health workers who hold a basic qualification in any field pursue higher academic qualifications if they wish to advance their career.

After Bachelor degrees in nursing, environmental health, social sciences and administration had been introduced, in 2001 the Master of Public Health degree at the COM for the first time opened up the opportunity for health-related post-graduate studies within the country. About half of the interviewees from various backgrounds already hold an MPH or are in the course of completing it, although some still preferred to do a full-time course abroad (Im7:48, Im19:53, If4:17) or opted for distance learning (Im16:49-51). Even older interviewees, when asked for their future plans, state that they hope to complete a Masters degree so that they can advance their career (If17:22, 26-28; If22:29, 35-37). For younger study participants working in health research and teaching, an MPH appears to be an essential step (If14:100, Im13:14, 20), possibly to be followed by a PhD (If20:32). Older consultants or senior managers interviewed in this study also hold Masters degrees in other disciplines (Im1:37, Im5:16-17, Im6:37-39, Im15:21). One consultant, however, also highlights that you have to know your limits and refer to PH experts, e.g. when it comes to statistics and their interpretation (Im15:90-93).

The major barrier for the pursuit of further studies is the question of funding. In many instances, aspirants are successful in applying for a place on a course but not for a scholarship, so they have to retry over several years (Im4:17, Im19:51, If14: 33). As a consequence, Malawian medical doctors seem to 'leave it to fortune' which kind of further studies they will actually pursue. Specialisation in particular medical fields, which at the time of this field research were not yet on offer within the country, is the norm, but Public Health is often viewed as a good alternative (Im7:30, If23:46, If11:20). This high interest in MPH courses among doctors is now leading to restrictions of respective scholarship support by the MoH, to keep doctors working in the clinical field (Im6:21).

While at first view this seems to be directed against community medicine and preventive care, a related problem field is surfacing here: Public Health is often equated with management and administration. The same can be observed in the nursing field, where Public Health nursing is one option for a Bachelor degree at Kamuzu College of Nursing (KCN) besides Nurse Management and Nursing Education. Completing any such degree is connected to the expectation of moving to a higher

position, away from ‘hands-on’ nursing into doing administration (If4:51-52, Im3:14-16). This again is seen as a waste of resources among those who are concerned with the management of clinical services (Im2:127-132, Im5:78). They suggest to expand the opportunities for specialisation in clinical settings, for the medical as well as the nursing profession, and to back it up with respective career paths in the civil service.

As for Clinical Officers, such opportunities for further clinical training exist, but they are not generally perceived as career advancements or professional development. This may lead to choosing a different career all together, and possibly having to start from first-year studies to achieve a Bachelor degree (Im19:9-19). The introduction of degree-level qualifications has unfolded a considerable dynamic in a sense of competition between the different occupational groups and civil service cadres (Im13:123-125). This also means that professional bodies and academic institutes need to adapt their curricula to the changed job-market, as reported for the field of Environmental Health (Im13:94, 100).

From the individual perspective, a formal qualification in Public Health, notably an MPH, may still be seen as a career step in the original profession, e.g. nursing (If4:12). At the same time, interviewees from all backgrounds think that they contribute something to Public Health in Malawi, be it through research, policy making, training or service delivery – on the preventive or the curative side.

Specific and compatible training (action)

Besides formal academic training as outlined above, most interviewees report that they have participated in short-term trainings. The following statement can be derived from these accounts:

If they are facing new tasks or new technologies have been developed in their field of work, health workers participate in task-specific training or less formalised continued professional development.

Such courses are usually related to the current job, and thus may be either technical or managerial in nature. Topics mentioned were vector resistance monitoring, PH management (Im12:82-83), data analysis in SPSS, PH survey methods (Im15:33-41),

ART (If21:10), HIV/AIDS-related counselling (Im18:9), community home-based care (If21:10), or socio-economic impact assessment of HIV/AIDS (Im16:53). The official definition of the MoH is that short-term courses last up to six months (Im19:100). Often they take place in other African countries, but also the COM has started to offer summer schools, e.g. on management (Im7:96). Those interviewees who went on short-term courses to Western countries tend to say that it broadened their scope or even opened their eyes (Im16: 13), but they also mention limited transferability or relevance for their Malawian work context (If21:24-27). Nevertheless such experiences may trigger the wish to pursue further studies in this field and gain a formal qualification (Im7:44-45, If21:35).

While the range is wide and especially older interviewees indicate that they have participated in too many trainings to mention, it occurs that EHOs tell most about these courses in the interviews. This confirms an observation by one of the interviewees, who states that opportunities to travel are one argument for clinicians to shift to PH (Im3:14). By contrast, his organisation is emphasising HIV/AIDS-related clinical on-the-job training, which is offered for various cadres and entire work teams. Participants receive certificates, which he considers relevant for service improvement but not for career advancement (Im3:28-30).

The interviewees rarely mention that they participated in in-service trainings themselves, but some report that they engage in teachings staff members in their workplace or that they are a trainer-for-trainers in certain technical issues (Im8:108, If21:10). One interviewee even did systematic assessments of training needs in the EH field and developed practice-oriented trainings and coaching methods (Im16:11, 66-70). In this context of being in a leading function, they also report a number of personal informal learning processes. These include learning to plan and organise things (Im13:53-54, Im12:29-31), to make decisions and execute them (Im15:126-133), to lead people with very different qualifications and foster teamwork (If 14 55-57, Im19:62-65), or to manage a male team as a woman (If20:54-58). Regarding interaction and exchange with international partners coming to Malawi, they tend to see themselves as being in a position to provide a support system (Im1:207-209,

If17:38) and act as a cultural mediator (If14:92, Im13:108), while at the same time they can acquire new technical knowledge and work principles (Im15:51; If4:82).

Those interviewees who state that they would like to work in research often highlight the link with their current work in the health services. One doctor is thinking about how he could combine specialisation in internal medicine with research in the district setting (Im10: 31). One nurse is looking for a PhD format which allows her to do the data collection and analysis in Malawi and maintain her managerial position (If4:18-24). One EHO has observed the need for appropriate and low-cost environmental health technologies and would like to do a PhD on that subject (Im12:41). Applicability and relevance of research is highly valued.

4.3 EMPLOYERS AND WORK ARRANGEMENTS

The employers in the Malawian health labour market described in this chapter include the Ministry of Health, CHAM and NGOs. A fourth category comprises academic institutes and consultancy agencies (or individuals engaged in research and teaching), which often have direct contracts with international donors. In this study the focus for academic institutes is not primarily on their function as providers of training and thus as 'producers' of health workers. Instead, each type of organisation presented here is considered in their double function of appropriating human resources, i.e. making economic use of their labour, and of (re)producing human resources, i.e. providing them with experience, knowledge, supervision, training etc. The share of these two functions in the overall activities of organisations may of course vary considerably.

The HRH census of 2007 for the first time attempts to include all NGO and private sector employees, who are working at health facilities or are engaged in their administration and support⁷¹. It included questions about working and living conditions, as well as career paths. However, the published report provides little information that is disaggregated by the ownership of the facility. Housing conditions (water and electricity supply) on the average are worst for government and CHAM staff (p.73), probably because the majority of their health facilities is located in rural areas (p. 23). Promotions appear less frequently in the private than in the governmental sector (p. 85). Regarding the provision of in-service training, the picture is heterogeneous (p.83).

Details on the location and staffing by ownership of health facilities are provided in Annexes 7.7.2 to 7.7.4. These figures are also referred to in the following sections. Statutory organisations (military, police, public providers, municipalities) as well as private companies and clinics are included in the statistics for reasons of completeness and comparability (external structural data), but they are not further described as employers. According to the census, statutory organisations and private industrial companies, which are offering clinics for their employees, only play a minor role as appropriators of HRH in quantitative terms.

⁷¹ MoH (2008)

By contrast, the total number of health workers in private-for-profit facilities even supersedes the number of those working in NGOs (see Annex 7.7.2). A large part of these n=200 facilities are likely to be single practices: the 2007/2008 register of health professionals lists n=104 medical assistants, n=42 clinical officers, n=29 medical practitioners and n=19 medical specialists in private practice⁷². The expansion of this work arrangement was encouraged in the late 1980s, but it appears to be an opportunity which is especially used by clinical officers and medical assistants to earn an income after their retirement from government service⁷³. As such, the work arrangement of private clinical practice is not in the focus of this study. Other governmental bodies, e.g. the Office of the President and Cabinet (OPC) or the National AIDS Commission may also act as employers of highly qualified health workers. The same accounts for inter-governmental organisations and donors. Official figures on this sub-field are difficult to acquire. Apart from their political influence, in the scope of this study they are mostly considered as contractors of other organisations and of individual consultants.

History of paid labour in Malawi

The historical data presented in this sub-chapter is meant to illustrate the expansion of health labour market institutions in time and space (see Giddens 1984; Layder 1993). Paid labour and the principles of commerce were introduced to the territory of contemporary Malawi (then called Nyasaland) in the 19th century by missionaries and the African Lakes Corporation, who had a need for labourers such as porters⁷⁴. Over the decades, Malawians also entered the urban professions via mission-based school education. A historical-ethnographic study finds that while nationalist currents stemmed from the Southern estates in Nyasaland in the 1940s, its protagonists were increasingly separated from rural life and formed a new urban social class. The “ethos

⁷² Government of Malawi (2008)

⁷³ Ministry of Health (2008); Ngalende Banda E E, Simukonda H P M (1994) The public/private mix in the health care system in Malawi (Vol. 9). *Health Policy and Planning*, 9(1): 63–71.

⁷⁴ Coleman G (1973) *International Labour Migration from Malawi, 1875-1966* (Vol. 2). *Journal of Social Science*, University of Malawi, 2: 31–46

of the colonial elite over that of the rural African”⁷⁵ remained despite all anticolonial rhetoric and is still reflected in the centralist governance structures of modern Malawi.

The beginning of work migration of Nyasalanders also falls together with the introduction of the money economy⁷⁶. Traditionally, migration had been with permanent intent. Temporary migration started with the British protectorate and covered the whole Southern Africa, where payment was often higher. An increase in buyable goods, and the fact that taxes were collected, also put pressure on the population to seek work, e.g. in plantations. Work in the mines of Southern Africa also started around the turn of the 19th century. Those who had received school education were the most likely to migrate, and the rate of schooling in Mission School was comparatively higher in Nyasaland than in neighbouring regions. Estimates of Nyasaland migrants working abroad in the 1920s go up to one quarter of the adult male population. The author of the article concludes that the social, political and economic development of the newly independent Malawi are likely to be hampered by these large numbers and calls for “governmental efforts to make better use of Malawian labour within the country”⁷⁷.

National workforce planning that includes both the public and the private sector is seen as a challenge in Malawi⁷⁸. A report on the identification of critical areas for capacity replenishment proposes a ‘labour market information’ flow chart: data on the public sector from various district and national level offices would have to be combined with data from umbrella organisations in the private sector. This would then have to inform the activities of training institutions in a strategic manner. It becomes clear that workforce planning is considered a responsibility of the state. Trade unions (as well as employers’ unions) might come in here as so-called ‘umbrella organisations’, but historically industrial relations in Malawi are very weak⁷⁹.

⁷⁵ Kaspin (1990), p.84

⁷⁶ Kaspin (1990)

⁷⁷ Coleman (1973)

⁷⁸ MoH (1991) Strengthening of Health Services in Malawi: Report of a study on co-ordination and collaboration between the Ministry of Health and the Private Hospital Association of Malawi.

⁷⁹ Dzimbiri LB (2005) The State and Labour Control in Malawi: Continuities and Discontinuities Between One-Party and Multiparty Systems. *Africa Development* XXX(4): 53-85

Hence, the out-migration of health workers from Malawi, which rose after the fall of the Banda regime in the 1990s, is rooted in historical and geopolitical constellations. The regional and global demand for health workers certainly has to be considered as an influential context factor. Nevertheless, the focus of this study is not on migration but on the work opportunities and arrangements of health workers within Malawi, which are also influenced by international actors.

4.3.1 MINISTRY OF HEALTH AND ITS SUBORDINATE STRUCTURES

The public system of health service provision in Malawi is run by the MoH. The operational level of health services management lies in the 28 administrative districts of the country, each of which disposes of a District Health Office that is usually located closely to the district hospital. According to the HRH census of 2008, MoH-owned health facilities amount to n=575. Out of these, 82.96% were located in rural areas, 11.13% in urban areas and 5.91% in semi-urban areas (see Annex 7.7.3). The MoH is the largest employer of health workers in the country, with 22,542 people on its payroll (see Annex 7.7.2).

The management of the different services and programmes within the districts lies in the hands of District Health Management Teams (DHMT), which were established in the late 1980s⁸⁰. The core DHMT consists of the District Health Officer (DHO), the District Nursing Officer (DNO), the District Environmental Health Officer (DEHO) and the District Health Administrator (DHA). The extended DHMT comprises all the programme managers in charge of disease control programmes, e.g. for Malaria, Acute Respiratory Infection, Sexually Transmitted Diseases, Tuberculosis. The work of DHMTs is meant to be comprehensive, interdisciplinary and intersectorial. An account of a DHO published in 1980 provides an insight into his understanding of the job, demonstrating that multiple responsibilities were cast on this position⁸¹. Today, while the DHO is still the overall in-charge heading the team, the different tasks are shared among the DHMT members.

⁸⁰ MoH (1991) Strengthening of Health Services in Malawi: Report of a study on coo-ordination and collaboration between the Ministry of Health and the Private Hospital Association of Malawi, p.viii

⁸¹ Matiti (1980)

Supervision within the MoH structures used to operate through a three-tier system (national, regional and district level) for many decades. In the 1990s, the regional health offices were abolished under the argument of decentralisation and strengthening the district level, to be reintroduced as Zonal Health Support Offices (ZHSO) under the same argument in 2004/2005. However, the scarcity of staff qualified to act as supervisors in the ZHSOs remains a critical argument against these offices. No nation-wide regulation for supervision in the health sector existed in 2007, but international donors worked together with MoH to establish respective concepts and guidelines within the scope of the SWAp⁸². DHMTs are in charge of supervising activities at health centre level throughout their district. At the level of each health centre there is again a management team, which consists of nurses, medical assistants and Senior Health Surveillance Assistants (HSAs). They collect and discuss data from their services and catchment area and report it to the district level.

The prerogative for recruitment, appointments, promotions and disciplinary measures lies with the Civil Service Commission under the Office of the President and Cabinet. It creates and reviews human resource policies, regulations and staff establishments for all line ministries. Establishment warrants issued by the Ministry of Finance then provide for the funding. The creation of new posts first has to be accepted by the Cabinet Committee on the Economy. The Commission is directly overseeing senior and mid-level managers, as well as qualified staff from the level of Nurse Technicians, Clinical Officers, Assistant Environmental Health Officers and Assistant Statisticians upwards. The ministerial Appointments and Disciplinary Committees are responsible for technical staff, such as Senior Enrolled Nurses, Senior Accounts Assistants, Medical Assistants, Health Assistants and HSAs⁸³.

The capacity of the Malawian civil service was subject to a 2003 report published by UNDP and the Department of Human Resource Management and Development (DHRMD) in the Office of the President and Cabinet. The report assesses the staffing situation in various line ministries with a particular focus on the consequences of HIV/AIDS in this field. The body of staff of the MoH is the second largest after the

⁸² MoH, SWAP Donor Group, GTZ (2007)

⁸³ MoHP (1999), pp. 5, 19

Ministry of Education. The report states that weaknesses in planning and slow recruitment are an overarching problem. Yet the vacancy rate at the level of principal officers and managers is highest in the Ministry of Health, reaching 75% when comparing filled posts against the establishment. Looking at all professional and technical staff in the MoH, vacancies amount to n=6,018, with nursing having by far the highest vacancy level in absolute terms (n=3,922 out of 6,084 posts, 65.17 %) ⁸⁴.

The needs assessment carried out within the scope of the SWAp criticises that planning is not based on evaluation of previous plans or reliable base-line data, including workload analysis and job analysis. According to the authors, this indicates the lack of capacity at management level, but the relationship between technical staff and support staff is failed to be addressed in the HRH plans. The narrow definition of health workers so far applied in Malawi neither corresponds to the WHO definition nor the one adopted by the Ministers of Health of the SADC region, which include support workers and health managers. The report also highlights the complications of recruitment, deployment and strategic HR management. These are said to arise from unclear responsibilities between different authorities at the national level, but also between the national and the district level and between different departments within the MoH. Various attempts to set up national HRH plans and to rearrange the responsibilities have been made from 1999 onwards, not least as part of the SWAp. However, the report states that many planning tools and policies only exist in draft form or have been incompletely implemented, especially the Health Service Act of 2002 which was meant to establish the Health Service Commission. Duplication or omission of activities and further slowdown are said to be the consequences ⁸⁵. After all, the system of HRH recruitment and management in the public sector was still highly centralised in Malawi at the point of field research.

History of the governmental health services

A historical account of health services in Malawi states: “All the important policy threads of the past are still found in the current fabric” ⁸⁶, with its imbalances between

⁸⁴ Government of Malawi (2003) Human Resources for Health Emergency Plan, p. 8

⁸⁵ Ministry of Health, Malawi Health SWAp Donor Group and GTZ 2007, p.20-28

⁸⁶ Baker (1976), p.311

urban and rural facilities, services for government officials vs. the general population, and curative vs. preventive work. At the same time it is highlighted that some form of public health care provision existed on Malawian territory long before a national health service was established in Britain itself, as the colonial power.

Medical officers have formed part of the colonial administration in British Central Africa from its very beginning in 1891. While recurrent expenditures for health increased over time, these were to a decreasing extent spent on personal emoluments, but on infectious disease control measures to protect trade and infrastructure projects such as railway construction. In terms of expenditure, the medical department had become the second largest government department by 1910, being allocated about 8% of the annual government budget. Expectations rose to expand government medical services to the local population after African carriers had gained access to them during World War I. Also the economic advantages of a healthy population became increasingly recognised. Official health policy shifted from 'law and order' towards a development and social service approach, with an expansion of health facilities to rural areas and increased staffing levels. The majority of the hospitals at district health quarters had a sub-assistant surgeon or a doctor in post by 1935, and also the sanitation branch was strengthened⁸⁷. When in 1933 the native authorities were formally established, many of them engaged in sanitation and some deployed their own staff for this purpose. Also the number of African trained employees in hospitals and dispensaries is reported to have increased from n=47 in 1921 to n=487 in 1938⁸⁸. The period after World War II was marked by an air of progress and steady expansion of services, and was only interrupted by the creation of the Federation of Rhodesia and Nyasaland in 1954. From Malawian independence in 1964 to the mid-1970s, the MoH increased its numbers of staff by 50%, notably medical officers, specialists, nurses and clinical officers. The emphasis continued to be on curative services, making up for 80% of government health expenditure, while 12% were spent on administration and 8% on prevention⁸⁹.

⁸⁷ Baker (1976), pp.296-301

⁸⁸ Baker (1976), p. 302

⁸⁹ Baker (1976), pp. 304-309

National Health Planning began in the 1970s, with a first plan for 1973-1988 being supported by the WHO. It included the so called Miniplan, a 5-year vaccination campaign. The plan foresaw one health post per 2,000 population, which was supposed to be manned by a homecraft worker trained for 6 weeks⁹⁰. Several other National Health Plans followed, but the 1999-2004 plan claims for itself to be the first one to systematically consider staffing consequences, with a separate volume on human resources. It is formulated along the lines of management capacity, including adequate staff development and training, retention measures, performance management and decentralisation. The Health Sector Human Resource Plan makes detailed prescriptions for training and deployment priorities among different categories of staff. Foreign technical assistance has been engaged to set up this National Health Plan, which has been embedded in structural adjustment policies required by the World Bank and IMF. Respective civil service reforms have been aimed at rationalisation, following a functional review in all sectors. However, qualified health personnel have been identified as a priority area and thus exempted from the contraction (as opposed to industrial and sub-ordinate workers). The reforms have included privatisation measures and a change in the budgeting method within the scope of a Medium Term Expenditure Framework. The prescribed shift from establishment-based to activity-based budgeting meant that staffing levels would be tied to the planned activities and unfilled posts would not be paid for⁹¹.

4.3.2 CHRISTIAN HEALTH ASSOCIATION OF MALAWI (CHAM)

The Christian Health Association of Malawi (CHAM, formerly PHAM) is an umbrella organisation of health service providers from various denominations. As stipulated in its constitution, its major objectives are to improve the quality of health care and better cooperation between CHAM members and the government. The mutual dependence between the MoH and CHAM is considerable, as it has traditionally been running a large share of rural hospitals and health facilities in the country. According to its website, CHAM had 171 health facilities, 10 training colleges and 1 college of health sciences operating in the year 2009. The organisation has several internal technical

⁹⁰ Ooto (1980)

⁹¹ MoHP (1999), p.10.

committees, incl. one on Human Resources constituted by 10 persons. It is stated that they produce about 77% of the nursing personnel in the country⁹². The HRH census has found 147 CHAM facilities in total, 87.76% of which are situated in rural areas. The strength of CHAM lies in the secondary level of care (n= 42, 28.57% of CHAM facilities), compared to n=52 and 9.22% of government facilities. CHAM employs n=553 nurses/midwives and n=362 nurse technicians, which together make up for 23.46% of nurses in these two categories in Malawi (see Annex 7.7.2).

CHAM has been a signatory and major partner within the SWAp, which is aimed at delivering an Essential Health Package (EHP) to the Malawian population. This was built on a Memorandum of Understanding of 2002 between MoH and CHAM, establishing the so called Service Level Agreements (SLA). This basic mechanism aimed at ensuring that services could be delivered free of charge in CHAM facilities, which usually collect user fees⁹³. CHAM has received support for medical equipment, pharmaceutical and laboratory supply and facility development through the SWAP. In Pillar 1 on Human Resource Development (integrated with the EHRP), it has been included as a beneficiary in the area of pre-service training, vacancy filling and staff maintenance (incl. salary top-ups) and in-service training⁹⁴. The SWAP mid-year report 2009 indicates that parallel non-residential training courses were planned at CHAM facilities, but the developments were put on hold due to financial constraints⁹⁵.

History of CHAM

Mission hospitals and dispensaries are reported to have focused their services on the African population from the very beginning, while by 1911 the colonial government

⁹² CHAM: Christian Health Association of Malawi (2010)

<http://www.coldfusionwebhostings.be/ICCO/www/index.cfm?type=workprocedure&id=34&menu=Secretariat>. Accessed 1 April 2010

⁹³ Memorandum of Understanding between Government of the Republic of Malawi and Christian Health Association of Malawi (CHMA), dated December 2002, Lilongwe; Christian Health Association of Malawi and Norwegian Church Aid, 2009, Evaluation of service level agreements in Christian Health Association of Malawi (CHAM) hospitals: the views of the community, Lilongwe

⁹⁴ MoH (2004) A Joint Programme of Work for a Health Sector Wide Approach (SWAp): 2004-2010, Republic of Malawi.
http://gametlibrary.worldbank.org/FILES/466_Health%20Sector%20SWAp%20Malawi.pdf, pp. 81, 122

⁹⁵ MoH (2009) Agenda for the Joint Health Sector SWAP 2008/2008 Midyear Review: Crossroads Hotel, Lilongwe. 7th-8th April, 2009, p. 3

only ran 3 hospitals and two dispensaries for this target group. In some instances, church-based services were already so well established that the government later preferred to pay grants to the providers instead of setting up their own services, e.g. for the treatment of leprosy. The period of Malawian independence brought insecurity about such funding arrangements. However, external advisors recommended that the new Malawian government should continue to make use of the church-related structures and health personnel already in place. At the same time, small user fees were already being charged for these health services⁹⁶.

In 1965, a committee of the World Council of Churches advised on setting up an ecumenical umbrella organisation for the church-related health services. The aim was to coordinate their activities and co-operate with the Ministry of Health. The Private Hospital Association of Malawi (PHAM) was thus founded, with eleven sponsoring churches at that time. Its headquarters were located at the premises of the Ministry of Health. PHAM was registered with the Registrar General in 1966 as an association under the Trustees Incorporation Act. Such incorporation is required from all Malawian organisations that aim for a charity status. Co-operation with government is described as very constructive, with PHAM contributing to the government's 15-year-plan for health infrastructure development⁹⁷. The association also participated in the so called Miniplan, a five-year vaccination campaign, and other Public Health activities in the 1980s⁹⁸. However, due to decreasing subventions during the economic crisis of the 1990s, PHAM members also turned to local and international charities and churches for financial support.

The history section on the association's website informs about the development of internal governance structures: In 1976 they revised their constitution and enlarged the council, with 14 members each from protestant and catholic institutions. After movement of the government from Blantyre to Lilongwe, PHAM acquired its own headquarters building in 1989. The mother bodies changed the name to CHAM in

⁹⁶ Stevenson (1964)

⁹⁷ Niemer, H. (1974). *The Private Hospital Association of Malawi (PHAM) and its Activities* (Vol. 6). Moyo, 6(3): 7–9.

⁹⁸ Stack M (1987) *The PHAM Activities in Public Health* (Vol. 24). Moyo, 24(1): 5–7

1992, to reflect Christian identity. These are also reflected in the vision and mission statements and the core values proclaimed on the website⁹⁹.

The church-related health care providers thus hold a special position in terms of HRH planning and management, due to their close co-operation with government. A joint MoH-PHAM study of 1991 states that the association provides 28% of the country's health services and that the government grant makes up about 40% of the associations budget. The latter is mostly taking the form of a salary subvention for their health workers. The report is rather critical regarding the organisation's performance and collaboration: At national level, there is neither enough PHAM representation on programme boards nor enough MoH representation in PHAM boards. Internal PHAM governance structures are described as ineffective, as the boards of the different health facilities consist of Church representatives only. Also at district level, there is little cross-referral between PHAM and government facilities according to the study¹⁰⁰.

International financial support to CHAM declined in the early 1990s, while at the same time the government increased the salary levels for civil servants, which CHAM could not keep up with. As a result, many health workers left CHAM to join the civil service. CHAM facilities reacted by charging higher user fees, which led to protests in impoverished rural communities they were serving¹⁰¹.

The situation analysis in preparation of the National Health Plan 1999-2004 viewed staffing needs of MoHP and CHAM together. Figures are based on the 1998 Human Resource Development Survey, complemented by subsequent information from CHAM and MoH. It is stated that CHAM provided good data on posts filled against a set establishment, which is coordinated at headquarters level, although training data was considered insufficient¹⁰².

Eventually, CHAM and the MoH worked out a Memorandum of Understanding to establish new principles of partnership, which was signed in December 2002. While CHAM agreed to limit user fees to a minimum, the Malawian government assured the

⁹⁹ CHAM (2010)

¹⁰⁰ MoH (1991), pp. xi and 25)

¹⁰¹ Ngalande Banda, Simukonda (1994)

¹⁰² MoH (1999)

payment of salaries for all CHAM employees working in the health facilities¹⁰³. Service Level Agreements (SLAs) were included as an instrument by which the District Health Offices could reimburse CHAM facilities for the provision of essential health services which could not be delivered by the governmental facilities in sufficient quantity. To reduce the complexity and the volume of financial obligations, the focus was put on maternal and child health services. CHAM headquarters have developed standard costing schemes for their facilities to be used in the districts. Around 2008, several reviews of SLAs were conducted to prepare for an adapted Memorandum of Understanding¹⁰⁴.

International partnerships continue cover a large share of the CHAM budget. The CHAM website as of 2009 provided a list of 30 partner organisations, among which are churches and other religious associations as well as foundations, NGOs and bilateral donor agencies. Within the country, CHAM interacts with international partners in a voluntary working group of NGOs, interest groups, training institutions and health care providers on the issue of HRH. The members list of this so called HRH Action Platform as of June 2009 also included 4 representatives from the CHAM secretariat¹⁰⁵.

4.3.3 NON-GOVERNMENTAL ORGANISATIONS (NGOS)

Over the last three decades, NGOs operating in Malawi have multiplied. This trend is certainly linked to the political changes within Malawi, i.e. the introduction of a multi-party system, but also to shifts in international development policy. Nevertheless, the international links of such organisations are often hard to capture. Most NGOs are also small in terms of employees; the larger ones appear to rely on volunteering. In terms of health care provision, the NGO holding by far the largest number of health facilities is Banja La Mtsogolo (BLM). This organisation was established in 1987 with the objective to provide family planning services¹⁰⁶. According to the Medical Council's 'List of company clinics and private institutions' for 2007/2008, BLM made up for n=29

¹⁰³ Memorandum of Understanding between Government of the Republic of Malawi and Christian Health Association of Malawi (CHAM), dated December 2002, Lilongwe;

¹⁰⁴ Christian Health Association of Malawi and Norwegian Church Aid (2009) Evaluation of service level agreements in Christian Health Association of Malawi (CHAM) hospitals: the views of the community, Lilongwe

¹⁰⁵ Medecins Sans Frontieres Belgium (2009). Contact Details HRH Action Platform (unpublished)

¹⁰⁶ MoH (2008)

of the 130 facilities registered in this category¹⁰⁷. The HRH census data indicates n=70 health facilities under NGO ownership, which are concentrated in the districts of Lilongwe and Blantyre (see 7.7.4). The largest single category of employees in NGOs is management staff (n=232). The total number of researchers (n=8) is higher than with any other type of employer (see Annex 7.7.2).

If NGOs are newly founded or enter from outside to take up operations in the country, the Non-Governmental Organisation Act of 2000 requires them to become members of the Council for Non-Governmental Organisations in Malawi (CONGOMA) and subsequently register with the NGO Board. While CONGOMA is designated to represent and promote the collective interest of NGOs in the country, the NGO Board is supposed to monitor them on behalf of the government. The Non-Governmental Organisations Bill of 2000 regulates their status as follows¹⁰⁸: Organisations registered with the NGO are permitted to act as a corporate body, engage in public interest activities and public fund-raising, and enjoy fiscal privileges if they produce annual financial and operational reports. If an organisation fails to prove that it functions for the purposes it was constituted for, it will be cancelled from the registry. If it contravenes the provisions of the Act, it will be fined.

Beyond facility-based health care provision, there are few publications or documents which systematically cover health-related engagements of NGOs in Malawi. Therefore, the following section of chapter 4.3.3 takes a closer look at the data published by CONGOMA, before turning to the history NGOs.

Contemporary structural data on NGOs

CONGOMA is a members' umbrella organisation, which understands itself as a lobbying body regarding the improvement of service delivery and good governance for poverty alleviation and also supports member organisations in capacity building. Its directory of 2008 is meant for "providing profiles of member NGOs to market their activities to interested stakeholders"¹⁰⁹. Out of 334 local and international member

¹⁰⁷ The Malawi Government Gazette Vol. XLV No 50, published November 21, 2008, pp. 369-373

¹⁰⁸ SDNP (2015) Malawi Non-Governmental Organisations Bill 2000. www.sdn.org.mw/ngo (accessed 2015-01-13)

¹⁰⁹ CONGOMA (2008), p.4

organisations of CONGOMA in the year 2008, 127 state that they are working in the health field among others. Health thus ranks third among the fields in which NGOs engage, which of course has cross-linkages to many of the 21 other fields outlined. HIV/AIDS is the largest field of work in absolute terms (see in Annex 7.8.1).

The following analysis is based on a sample of NGOs from the CONGOMA registry which self-reportedly work in the field of health or HIV/AIDS or water&sanitation (WatSan), whereby one NGO could work in several fields. Detailed information was missing for 7 organisations, so that the sample in the following consists of n=227 NGOs.

Fields of work mentioned by the NGOs in the sample are distributed as follows:

- Health: n=123 (54.19%) yes, n=104 (45.81%) no
- HIV/AIDS: n=173 (76.21%) yes, n=54 NGOs (23.79%) no
- WatSan: n=75 (33.04%) yes, n=152 (66.96%) no

Cross-tabulations of the three fields show that n=80 (46.21%) of the HIV/AIDS organisations and n=45 (60.03%) of the WatSan organisations are also operating in the health field. Health NGOs show a slightly larger spectrum of fields that they engage in, with a median of 5 fields as compared to 4 fields among those NGOs that do not work in health.

Details on activities derived from the self-descriptions offer information about personal vs. non-personal health services provided. Among the explicit health NGOs, n=44 (35.77%) mention personal health care or clinical activities. This includes primary health care services, HIV counselling and testing, and administration of pharmaceuticals to patients. The same still accounts for n=12 of the NGOs (11.45%) that do not explicitly state to be working in health. As for research, n=12 health NGOs (9.76%) versus n=12 NGOs (11.54%) working in 'HIV/AIDS and/or WatSan only' report respective activities. 'Capacity development' or 'capacity building' is literally mentioned by n=45 health NGOs (36.59%) and by n=47 of the other NGOs (45.19%).

Years of operation in Malawi can be derived from the year mentioned as starting point of work in n=156 cases in the sample. The median duration of work in Malawi in

2008 was 9 years. The earliest starting date mentioned by a church-related organisation is 1860. The number of NGOs operating in Malawi has been growing significantly over time. International NGOs have mostly come to Malawi from the early 1990s onwards, e.g. Action Aid in 1990, Population Services International (PSI) in 1994, MSF-Belgium in 1998 and Norwegian Church Aid in 2001. Peaks were reached in 2001 and 2003, with 12 NGOs taking up their work. Goal Malawi and Concern Worldwide both started in 2002. They indicate in their self-description that the President invited the international community to assist after declaring a state of emergency due to famine.

Geographical foci of operation are revealed in the location of the NGOs' national headquarters. Most of them are located in Malawi's major cities: Lilongwe in the central-western zone (n=88; 38.77%), Blantyre/Limbe in the south-western zone (n=81; 35.68%), Mzuzu in the northern zone (n=10; 4.41%), Zomba in the south-eastern zone (n=8; 3.52%). Only n=40 (17.62%) NGOs are based in other locations. The mean number of districts that these NGOs are working in is n=6,97 (Std Dev: 6,76).

As for the districts of operation - which include the location of headquarters - a similar geographical bias can be observed: Lilongwe and Blantyre districts host the maximum (n=94 each) of NGOs working on health, HIV/AIDS and water & sanitation, while the minimum (n=34) goes to Likoma island (see Annex 7.8.2). The geographical distribution of NGO activities across the country resembles the distribution of health facilities found in the HRH census, regardless of whether they are run by government, CHAM or NGOs (see Annex 7.7.4). However, the absolute difference between the number of NGO-owned health facilities included in the HRH census and the number of CONGOMA-registered NGOs working in health, HIV/AIDS or WatSan in the same district is considerable. These differences are displayed in table 3, for the seven districts ranking highest on the numbers of NGOs operating there.

District (Zone)	NGO-owned health facilities (n, according to HRH census)	NGOs working in health, HIV/AIDS or WatSan (n, according to CONGOMA)
Lilongwe (CW)	15	94
Blantyre (SW)	13	94
Mzimba / Mzuzu (N)	4	79
Zomba (SE)	3	74
Mangochi (SE)	1	61
Dowa (CE)	4	61
Salima (CE)	3	59

Table 3: Number of NGO-owned health facilities and of NGOs working in health related fields, by district

Source: CONOMA registry 2008, HRH census 2008

Employment in NGOs plays a considerable role by 2008. This can be seen from the NGOs that report their numbers of employees in the CONGOMA registry (available for n=193 organisations from the three fields). The total amounts to 7,011 employees, although it is possible that some organisations have included volunteers in their figures. The mean number per NGO is 48.38 (Std Dev: 92.38), but the distribution is clearly skewed towards small organisations, as shown in figure 3. The frequency of organisational size (i.e. number of employees) is represented by the surface of the categories in the histogram. The last category with n=400 to <650 employees is mostly constituted by organisations that are not self-reportedly working in the health field in Malawi, but in HIV/AIDS or WatSan (World Vision Malawi: n=647 ; Lilongwe Islamic Movement: n=600; Wildlife and Environmental Society of Malawi: n=460 employees). However, they are followed by the family planning service provider Banja La Mtsogolo (BLM) with n=400 employees.

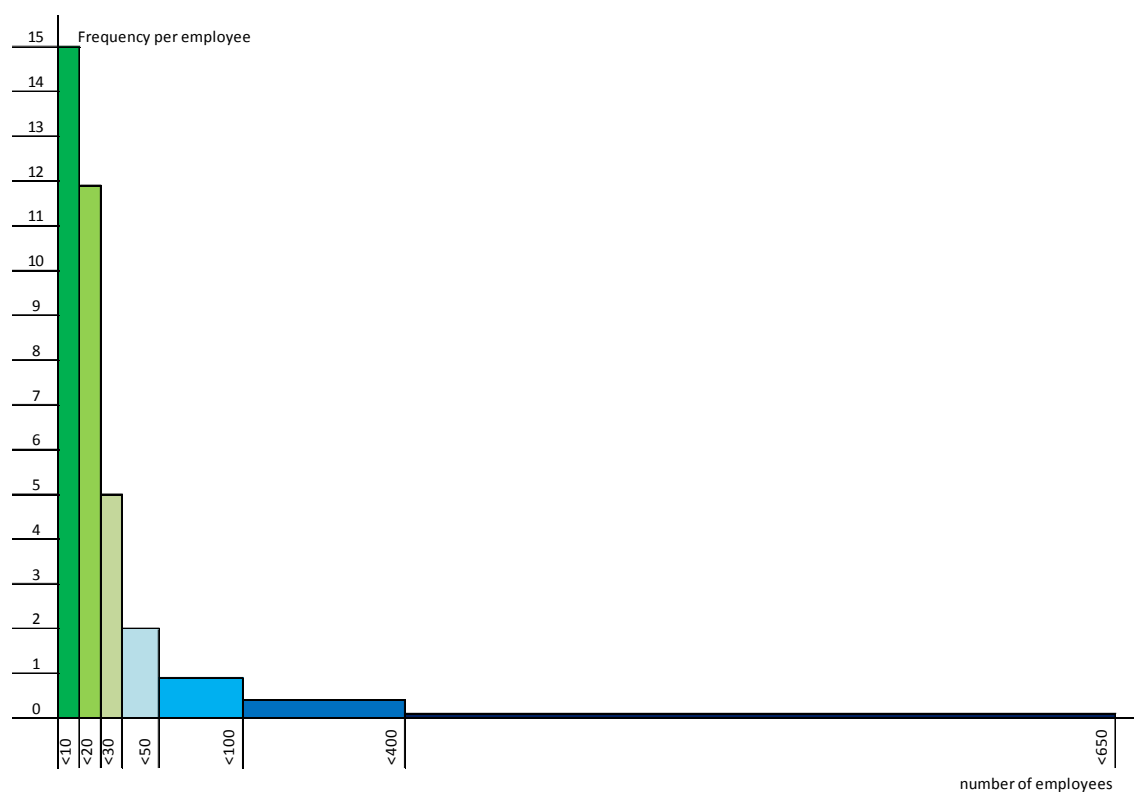


Figure 3: Size of employer (non-governmental organisation)

Note: includes NGOs working on health, HIV/AIDS or water & sanitation),
n=186 (excluding 41 cases with missing information)

Source: CONGOMA registry 2008

Methods of implementation pursued by the NGOs are also indicated, although information was missing in n=31 cases (13.25% of the sample). Many of the NGOs either have the function of an umbrella organisation with distinct members in various districts, or they implement their activities through partner organisations. Direct provision of services is declared by n=117 NGOs (50.02%), 'direct and through partners' by n=59 NGOs (25.21%), while n=15 NGOs (6.41%) say that they work through partners only. Implementation of activities through sectorial ministries (among others) was mentioned by n=5 NGOs (2.14%).

Sources of funding are only indicated by the minority of NGOs in the sample, with missing information in n=127 cases (54.27%). 15 organisations (6.41%) report that they rely on local or national funding, while n=76 (32.48%) indicate international funding, partly in addition to national sources. The status is uncertain in n=9 cases (2.85%).

Financial challenges are reported as an area of constraint by many NGOs in the CONGOMA registry.

History of NGOs in Malawi

Attempts to engage local communities in planned development date back to the early years of the Republic of Malawi, but the problems arising from the distribution of external resources at community level were already surfacing as well. A health extension service publication of 1969 speaks of a problematic understanding of ‘aid’ in self-help projects at the community level. While aid flows were supposed to be organised through district development committees, the population is said to often associate it with the appearance of Peace Corps Volunteers, or as an automatic consequence of forming local committees. The author recommends to keep information about possible aid under disclosure and to exclusively work through local leaders, who are then supposed to hold meetings and instruct their people what the aid is meant for and what their own contribution should be. This ‘method’ is stated to work well for avoiding common misunderstandings, e.g. that aid projects offer paid employment, or that the money may be used for personal enrichment¹¹⁰.

The role of volunteers is also prominent as a working principle of the Red Cross in Malawi. Being an offspring of the British Red Cross Society - Nysaland branch, the Malawi Red Cross Society was established in 1966 and joined the International Federation of Red Cross and Red Crescent Societies in 1971¹¹¹. An article about the Red Cross in the health extension service periodical introduce the goals and working principles of the International Federation of the Red Cross, highlighting that national societies are “auxiliaries in the humanitarian services of their governments” (p.15) but must remain autonomous. Readers are invited to become members and promote these principles as volunteers¹¹². Another article about the National Red Cross Training Centre indicates that volunteers were also meant to take over health education activities in rural communities, in the areas of child care, home nursing, hygiene and

¹¹⁰ Mphana D L (1969) The Abuse of Financial Aid to Self Help Projects (Vol. 1). The Messenger. A Health Extension Service Publication, 1(3): 18–19.

¹¹¹ International Refugee Rights Initiative (1990) <http://www.refugee-rights.org/African%20NGO%20directory/South%20Africa/Malawi-RC.html>, accessed 25/04/2013

¹¹² Rodges M (1974) The Red Cross Society in Malawi (Vol. 6). Moyo. 6(1): 13–16

first aid. The selection and sponsoring of trainees is carried out through “recognised organisations or government departments”¹¹³.

The Primary Health Care concept was adopted by the Malawian government in the early 1980s. Although PHC formally underlines the importance of non-governmental and community-based organisations, they are hardly visible in the Malawian documents available from that period – with the exception of CHAM¹¹⁴. The role of volunteers in the community was vividly discussed then, but again such volunteers were mostly recruited through governmental structures such as local development committees, or through the churches. Besides religious motives or sub-ordination to governmental authority, the hope for opportunities to move into paid employment is identified as a major motivation for volunteering¹¹⁵.

The instalment of a Council for Social Welfare Services in Malawi (CSWSM) in 1985 marks a recognition of the contribution of the non-governmental sector – often labelled ‘private sector’ at that time. Also the definition of such organisations, which had previously been based on membership within the communities, appears to have broadened. A publication from the Centre for Social Research on the public/private mix in the health sector points out a shift in the government’s development policy after 1986, when it formally sought to incorporate private sector resources in the health care field. The Medical Practitioners and Dentists Act of 1987 did not only aim at the registration of practitioners but also of health care facilities, thus allowing for an expansion of private practice. Since non-governmental providers including CHAM have always collected fees for service to at least partly finance their operating costs, the boundary between for-profit and not-for-profit providers is blurred. However, the authors state that for most ‘voluntary bodies’ the sources of income are – in descending order – the public sector, direct private payments and foreign aid, while private insurance schemes or private enterprises only have a minor share¹¹⁶. The

¹¹³ Chibambo C (1975) The Malawi Red Cross Society National Training Centre Dowa. *Moyo* 7(5): 8–9

¹¹⁴ Lungu G W (1984) Primary Health Care in Malawi - an introduction (Vol. 2). *Medical Quarterly*, 2(2), 47–48; MoH (1981) Primary Health Care in Malawi. A brief overview; Msukwa L A H (1981) Meeting the Basic Health Needs of Rural Malawi: An Alternative Strategy: Monograph No. XII. Chapter VI and VII: Manpower Requirements and Summary of Main Recommendations.

¹¹⁵ Courtright, Biggs-Jarrel (1992)

¹¹⁶ Ngalende Banda, Simukonda (1994)

Council for Social Welfare Services in Malawi (CSWSM) was changed into the Council of Non-governmental Organisations in Malawi (CONGOMA) in 1992, thereby widening its activities to various other development sectors.

4.3.4 RESEARCH INSTITUTES AND CONSULTANCY

An international donor agency maintaining a country office in Malawi is likely to staff it with expatriate managers. Still it might need highly qualified and experienced local staff, e.g. for generating country- and sector-specific information or for implementing tasks that require a good personal network. With regard to this target group, donor agencies are thus relevant as contractors of consultants, or at least as financiers behind positions offered by national organisations. For health workers who are holding higher academic degrees, consultancies within the scope of internationally funded programmes are an income opportunity which can be either adopted as a main occupation or to top-up their normal salary.

As for the Malawian health sector in particular, the UK with its Department for International Development (DFID) have traditionally been the major bilateral donor, followed by the US, Norway and Germany and more recently Sweden. Since its onset in 2004, the Global Fund to Fight AIDS, TB and Malaria (GFATM) has become the largest contributor to health funding in Malawi in 2008. In 2006, the engagement of the Global Alliance for Vaccine and Immunisation (GAVI) also rose to be among the eight major donors to the Malawian health sector¹¹⁷. Not all donors have joint the SWAp - only DFID and GFATM have actually implemented a pooled funding arrangement (sector budget support), which was mostly used for the Emergency Human Resource Plan (EHRP). Other members of the SWAp donor group included US, Japan, Germany and some UN agencies, which contributed through discrete funding.

The SWAp donor group has played a special role as contractors of consultants to carry out assessments and evaluations in the field of HRH. The HRH needs assessment study is a prominent example: it has been carried out by an international consultancy firm, but also comprises an analysis of existing technical assistance arrangements in Malawi. The expert panel called in for this study consisted of high level representatives of

¹¹⁷ DAC CRS database and WHO national accounts database, (see Pearson 2010)

Malawian institutions as well as Malawian and international consultants. The study was conducted in preparation of a Technical Assistance strategy, aimed at decreasing the reliance on expatriate technical assistants and at more self-determination of Malawian organisations in deciding which kind of technical assistance they require¹¹⁸. The GDC has also commissioned several studies on different HRH-related topics to individuals who were holding posts at academic institutions in Malawi, to Malawian agencies or individual consultants who had retired from high-level government service. Furthermore, the Centre for Social Research at the Chancellor College occurs as a major agency taking over consultancies in the health field (e.g. the HRH census).

As for the HRH census, academic institutes are included in the category 'statutory organisations', with a total of n=389 health workers. Among them are n=10 lecturers/tutors and n=2 researchers (see Annex 7.7.2). However, information on consultancies as a form of paid labour can hardly be derived from this source. Hence, the following section of chapter 4.3.4 provides an analysis of two other contemporary data sources: a database of consultants, and job advertisements in Malawian newspapers.

Contemporary structural data on consultancies

The National AIDS Commission (NAC) has put up a database for technical assistance¹¹⁹ - a task that was funded by UNAIDS and DFID and carried out by a Malawian consultant itself. It contains the profiles of n=107 individuals, 29 of which are running under consultancy firms. NAC has outlined the following priority areas, which consultants or firms can relate to in their profile:

- Prevention and behavioural change;
- Treatment, care and support;
- Impact mitigation (socio-economic and psychosocial);
- Mainstreaming, partnerships and capacity building;
- Research and development;

¹¹⁸ MoH, SWAP Donor Group, GTZ (2007).

¹¹⁹ National AIDS Commission Malawi (2007) Database for Technical Assistance for the National HIV/AIDS response in Malawi. CD-ROM. Lilongwe

- Monitoring and evaluation;
- Resource mobilisation, tracking and utilisation;
- National policy, coordination and programme planning;
- Crosscutting issues (gender, human rights)

Among the n=107 consultants listed, 12 are non-Malawian nationals, 8 of which are British. The majority holds a Bachelor or Masters degree, which in n=43 cases (40.18%) has been obtained abroad. The formal qualifications are mostly in non-health-specific fields, such as education, development studies, agriculture, environmental studies, economics, business administration, accountancy, information technology, statistics, social sciences, arts, psychology, theology etc. However, n=14 consultants in the database hold a health-specific or epidemiological degree. Academic institutes and also other employers such as NGOs are frequently given as a postal address, e.g. five consultants are employed at the College of Medicine. One agency, the 'Applied Statics and Epidemiological Research Group', has even been formally established under the Mathematical Sciences Department at Chancellor College.

Consultancies are regularly advertised in the major Malawian newspapers, along with other vacancies. They indicate influences of international donors within the job market for health professionals. In order to estimate the share of consultancies among all vacancies related to the field of Public Health, a job advertisement analysis was conducted. By screening the national newspapers of June 2008, a total of n=53 advertisements was identified. The details on the type of post and the qualification required are displayed in table 2, distinguished by the type of employer. Out of a total of n=72 positions offered, 47 are employment positions, 21 are consultancies and 4 are scholarships.

Type of employer	Number of positions advertised			Minimum qualification level required				total
	employment	consultancies	scholarships	diploma	degree	postgraduate	not specified	
Governmental bodies	2	18	0	0	5	12	3	20
Statutory bodies	3	0	0	2	1	0	0	3
NGOs (national / internat.)	31	5	0	9	17	7	3	36
CHAM (incl. members)	2	0	0	0	1	0	1	2
International / UN agencies	1	1	0	0	0	2	0	2
Trusts / Foundations	4	0	4	1	4	3	0	8
Private Companies	1	0	0	0	1	0	1	2
Total	44	24	4	12	29	24	7	72

Table 4: Health-related positions advertised in Malawian newspapers, June 2008, by type of employer

Source: Daily Times Archive, Blantyre

NGOs offer half of all positions in the sample, namely $n=36$, mostly in the form of employment ($n=31$). The second largest share falls to Governmental bodies with $n=20$ positions announced, out of which the majority were consultancies ($n=18$). The most relevant single employer here is the National AIDS Commission, offering $n=11$ consultancies and $n=1$ employment position. Thus Lilongwe is the dominant location of deployment ($n=43$), followed by Blantyre ($n=14$) and others ($n=10$), with 5 cases of missing information. The mean duration of the consultancies announced is 3.05 months (1 missing). Regarding employment positions, a time-limitation is not mentioned in most cases. The 5 temporary positions in the sample have an average duration of 13.2 months.

In most of the advertisements, an academic qualification is wanted: $n=29$ positions require a degree (Bachelor or MBBS) as a minimum, while $n=24$ even require a postgraduate qualification (Master, advanced degree). Diplomas are requested in $n=12$ cases, while in $n=7$ cases the qualification is not specified. The qualification level is highest for consultancies, with $n=17$ positions available for postgraduate degree

holders and only one for bachelor degree holders (3 missing). As for the field of qualification, Public Health (or similar fields such as community health, environmental health, health & development, health discipline, epidemiology) is mentioned in n=29 cases.

Although international funding agencies are only explicitly mentioned in n=8 advertisements, most of the advertising bodies are either internationally operating organisations themselves, or they are running large donor-supported programmes such as the National HIV/AIDS response. Regular recruitment activities of the MoH and CHAM for positions included in the establishment are not reflected in the job advertisements, since they are carried out through separate channels (Health Service Commission among others, see chapter 4.3.1).

History of research and consultancy in Malawi

Consultancies appear to be a very recent work arrangement within Malawi. None of the agencies listed in the NAC consultants database has been founded or registered before 1999 (dates provided for 9 out of 13 agencies)¹²⁰. Traditionally, externally commissioned studies and evaluations of development issues and programmes have been carried out by institutes belonging to the University of Malawi. Reports on such research activities by the Centre for Social Research were accessed during field research, covering the period of 1980 to 2002¹²¹.

¹²⁰ National AIDS Commission Malawi (2007)

¹²¹ Centre for Social Research - University of Malawi (2002). [Publications and project reports of the Centre for Social Research, 1995-2002] 10–17; Kahongwe P (1993-94) Research reports, evaluations and papers written and produced by the Centre for Social Research, 1980-96 (Vol. 16). Malawi Journal of Social Science, 16: 91–105

4.4 INTERVIEW DATA FROM THE ORGANISATIONAL CONTEXT

Statements of the health professionals interviewed in this study are presented in the following sections, to be related to the structural data in chapter 4.3. They stem from an organisational narrative context, meaning that the interviewees were talking about their own employer or other employers in the health sector. The following codes from the thematic analysis have been used (see Annex 7.6):

- Career paths (category: institutional arrangements)
- Functions for HRD (category: guidance)
- Work contracts and modalities (category: availability)

Institutional statements (shared strategies, norms, rules) determine the incentives which influence individual decisions and actions regarding a career within an organisation or across different organisations. They are structuring the opportunities and constraints of individual health workers in Malawi. The institutional statements extracted from the data are presented according to their AIM-components. Similarities and divergence between interviewees working in different organisations and contracting arrangements are pointed out.

Staff attraction and retention (outcome)

To stabilise the pool of health workers available in Malawi, the conditions of work in the health sector play an essential role. Given the heterogeneity in terms of backgrounds and current positions among the interviewees, the following basic statement provides common ground:

In a context of health worker scarcity and high turn-over, employers in the Malawian health sector increase their efforts for staff attraction and retention.

Interviewees in this study are managers within the scope of their organisation on the one hand and individual participants in the health labour market on the other hand. In some instances they have also worked for different employers. It becomes clear that comparative attractiveness of employers depends on individual preferences. Nevertheless there is high accordance about the advantages of working in the civil

service, as an employee in the non-governmental or parastatal sector, or as a freelancer respectively. The three major factors mentioned are remuneration, opportunities for further training, and the type and scope of the work.

A frequently mentioned perception is that salaries and incentive packages are higher in NGOs than in the civil service (Im19:107-109, If20:42-45, Im2:27-32). This statement is qualified by one interviewee, who thinks that the gap has considerably narrowed after the 52% salary increase in the governmental health service, which has been implemented within the scope of the Swap. Junior staff might still be attracted, but senior staff would not easily give up the security of their position in the MoH (Im7:164-170).

A major argument for working for the MoH – as opposed to CHAM, the NGO or private sector - is the medium-term prospect of further qualification and specialisation (If22:120-122, If4:18-24). Starting from 2006, the MoH has introduced remarkable improvements in order to attract young medical doctors in particular. The conditions for receiving a scholarship for specialisation are that they first work as DHOs for a period of two years (Im10:70-73). Besides formal qualifications, the MoH as an employer is also seen as offering learning opportunities in a greater range of fields and trying to keep staff updated with treatment policy changes (Im1:110-114, Im13:59-65, If21:92-99). By contrast, organisations in the private and non-governmental sector are said to be looking for readily qualified and experienced people, who are often contracted for a limited time-span (If4:60, Im13:103-106). Some few NGOs are reported to engage in performance management and quality improvement (If21:92-99).

As for the type and scope of work, it is mentioned that leading positions in NGOs often mean managerial and technical responsibility for a distinct process or unit (If14:47-50, Im5:63). In the public sector or CHAM, the division of work - but also the need to think in systems - are more pronounced (Im18:21, If23:61, Im5:63, Im7:111-114). In the clinical and nursing field, one participant assumes that the patient fees charged in the private and non-governmental facilities lead to more conducive work environments (If22:117-119). The private sector, especially the research and consultancy field, certainly offers less job security and is less family-compatible, but is also described as

more interesting and challenging (If20:14-16, 42-45, Im15:83-85). Rewards for good quality can be experienced more immediately than in the public or parastatal sector (Im15:19-20, 86, If20:46-53).

Despite the growth of other employers in the Malawian health sector, the competition for scarce personnel is hardly brought to the fore by interview partners working for the public sector. Health workers whose training was paid from a public budget and who decide to work for NGOs and private organisations are not condemned. A common justification is that these health workers are still serving the same nation (If22:123-127, If11:100-101), although there is some awareness that the accessibility of these services is limited by patient fees (Im6:53). One recommended option for organisations is to tie in-country scholarships with the obligation to work for this organisation for a certain period, but 'bonds' for people studying abroad are said to be ineffective (Im3:132-135). With regard to senior posts in country offices of international organisations such as the WHO, it is accepted that they require highly qualified staff, and those should rather be filled by Malawians than other Africans (Im 12:77-79, Im2:127-132). At the level of the MoH headquarters, it has been realised that a number of staff have resigned shortly after obtaining an MPH (Im6:18-19). Qualified health managers are also said to be very futile, as clinical occupations receive the greatest attention and support staff is not included in salary increases (Im6:59, Im5:21) Interviewees working in NGOs or as consultants acknowledge that it is difficult to recruit highly qualified staff, notably specialists and Masters degree holders (If14:93-96, Im5:49-53).

Shifting from the individual to the organisational perspective, however, there is some criticism of NGOs or private sector organisations. They are perceived as not contributing sufficiently to developing the overall pool of health workers, and the need for a policy to control salary levels and other incentives is pointed out (If4:60). Some interviewees think that NGOs working in the country should sign a Memorandum of Understanding with the MoH which could also cover HRH issues (Im2:127-132, Im6:74-75). Yet one NGO manager highlights the juridical sensitivity of recruitment policies that discriminate public sector employees from taking up a job in an NGO. He thinks that 'anti-poaching' policies have to remain unwritten (Im2:127-132).

Influencing one's own career (action)

Working in the civil service continues to be the standard for health workers in Malawi, while forms of private employment or self-employment are relatively new phenomena. Yet career expectations are changing now, and the continuum of individual autonomy and entrepreneurship could be covered by the following statement:

Within the scope of their work contract(s), health workers express their aspirations and influence decisions concerning their own career.

A classical career path in the MoH can best be seen in the EH section, the structure of which is very hierarchical (Im12:14-17, 23-30; If17:15-22). A similar hierarchy but greater variations of actual occupations can be found in nursing. The commonality between all cadres is the great anticipatory reliability of being promoted after having completed further academic qualifications (If22:13-19), although this is often connected to being posted to a different district. One nurse, who has been a civil servant for many years, views her career as a combination of being visionary and having been given opportunities for further training (If4:44-47).

However, when it comes to the speed of advancement, individual health workers have little influence. All they can do is to apply for scholarships and wait. For doctors wishing to specialise, there is still the alternative to leave the civil service and become a registrar at the Queen Margaret teaching hospital (Im7:16, 19, 21-25, 27-30, 35). The more senior health workers get and the more unique their position is within their organisation, the greater is the chance to return to that position after their studies or to adapt the work arrangements for the meantime (Im13:41-52, Im7:49-58, If4:21). Still, in the civil service, further promotion for senior staff remains very incalculable (Im7:84-85). Acquiring and maintaining a post at the highest levels within the MoH headquarters is then also a matter of political affiliation (Im2:41-42, Im1:143).

Civil servants have the possibility to request the MoH to be posted in a different location, but this again might slow down their career if higher positions are not free in the respective district (If17:17-19, 21). They may also request to be deployed in a different function, at least temporarily. For young doctors, this is particularly decisive

to fulfil the requirements for specialisation (If23:31-34, 42-47). At the same time, they express their irritation that working in a clinical position (e.g. as medical officer in a district or central hospital) would not be accepted to qualify for a scholarship (Im7:22-23). As a consequence, medical graduates are forced to take over a large share of administrative duties as a DHO, even if they would rather gain more clinical experience (If11:15-18, 19-23).

Retirement from the civil service, which is regularly possible after 20 years, marks an outstanding transition. Senior officers are often highly attached to the MoH and consider working there beyond retirement age - provided that they get into a higher management position. Otherwise they would also opt for similar positions in NGOs (If17:22-30, If22:32-37). One interesting case in this respect, however, is a senior clinical officer, who gained a PH certificate at a European university in anticipation of being promoted to DHO later (Im8:30-41). At the same time he is cautious to enhance and consolidate his clinical skills, because he wants to open up a private practice after retirement from the civil service (Im8:52-58). Such private practice has originally been pushed for by the Malawi Medical Association, as a measure of income diversification for doctors, and clinical officers followed their example. However, it is not commonly perceived a sufficient means to attract medical and clinical practitioners back to the country (Im3:52-55).

Private business in the form of consultancy is another option for the retirement phase (Im1:158-160). However, consultancies are also carried out by people who hold a regular employment contract or by civil servants. They may pursue such private economic activities when they are off-duty (Im5:55, If20: 28), although it appears that there is no official MoH policy regulating this issue (Im7:171-178). One interviewee who is working in the research field states that taking over consultancies counts as good professional development, yet she would prefer to do it only as a complementary activity besides her actual job (If20:24-30, 32-38). There seem to be many consultancies on offer due to the high interest of donors in the health field (Im15:86-89). However, for researchers and lecturers in a full-time position, the competition from consultancy agencies disposing of a range of specialists is said to be high (Im13:33-39). At the same time, full lecturers will only achieve further promotion through

research and publishing, which is difficult due to limited public research funding (Im13:14, 19-26).

In research and in the private sector, the practice of hiring staff on the basis of short-term contracts is predominant. Careers in this field usually start by a number of different contracts as a research assistant and later as a research supervisor (If14:11, If20:7-10, 17-20). With a certain level of experience, it is said to be relatively easy for graduates to find a job, but for higher positions again a Masters' degree would be required (If14:100). Difficulties might arise if a more steady income or work location is needed, e.g. for family reasons (If20:10-11).

Interviewees who have reached a senior position and now work in the private or non-governmental sector appreciate their autonomy as managers and decision makers (Im15: 42-49, 121-126). Those who used to be civil servants can make good use of their insider knowledge and contacts. At the same time they like the freedom of working 'with government, but not for them' (Im2:36-42). As country directors of an international NGO, they may even receive support from international headquarters to change business models and policies, thereby also customising them to their own work preferences and expertise (Im5:31, 35, 60-61).

Managing allocated staff (action)

The authorisation and possibilities to manage HRH differ in the various organisations considered here and obviously depend on the level at which a manager is positioned. The following, however, can be seen as an overarching statement:

Leaders at the operational level in the Malawian health sector manage their allocated staff by developing incentive structures within their available resources.

Within the structures of the MoH, the recruitment and dismissal of personnel is confined to the central level. District Health Offices may request staff for vacant posts and then have to wait for the allocation – or even 'lobby' for it (Im8:146-150). The deployment of available staff is seen as an administrative task (If11:90). Nevertheless it needs to be considered under the aspects of service quality and safety, e.g. when deciding which facilities are to provide basic emergency obstetric care (If11:63-67). As

for the non-governmental sector, the competences for staff recruitment may be similarly distributed, depending on the size of the organisation (Im18:16). In the field of research, managers at operational level are often in charge of putting together a team (If20:79, If14:51-54).

In the case of sub-standard performance within the MoH, disciplinary measures are first to be undertaken at district level by the principal officers or within a sub-committee of the DHMT. If severe consequences have resulted for a patient, the committee might recommend interdiction of practice to the headquarters (If17:41-42, Im8:140-145). However, the lack of a performance appraisal system is lamented by some DHMT-members; they would like to be empowered to enforce certain standards and to reward outstanding engagement (Im19:104-105, Im12:68-69). One DEHO has introduced an award for the 'cleanest health facility of the district' to promote hygienic standards (If17:24). By contrast, some of the NGO-based interviewees report to be involved in performance appraisal of individual staff members (If14:54, If21:86-87).

Although DHMT members perceive their role in HRH management and development as limited, many of their routine activities are in fact evolving around the motivation of staff. They frequently engage in knowledge and skills transfer, which practically serves to develop staff at a small scale (Im8:151-155, If11:93-97, Im10:33). A special form of this skills transfer can be found with consultants who work as technical assistants – they may even apply mentoring concepts (Im16:17, 72). Individual health workers can also be recommended for further training within the scope of an annual training needs assessment, although the procedure is criticised for being intransparent (If11:90, Im19:98-103). The assessment results are sent to MoH headquarters, where a training committee decides about who will receive long-term training (Im6:47).

District health management is a highly regulated action arena, with many rules and norms evolving around health management information (Im8:96-106). Formal reporting requirements and health indicators may serve as a resource for developing local approaches to supervision (If22:89-96). Yet supervisory structures often continue to be seen as 'chains of command' (If17:40); more supportive forms and combinations with training needs assessments are rare (Im16:72, If21:86-87). One interviewee mentions the importance of taking an overall approach to HRH development rather

than training selected individuals who are likely to leave soon afterwards: training needs mean skills and competences that are required by the organisation (If4:76). Another interviewee highlights the difficulty to manage employees and volunteers within the same organisation, with both sides having to be motivated and trained for their specific functions (Im18:11, 18).

Finally, some interviewees point out the entanglement of HRH management with the management of other resources. The improvement of working conditions, such as the availability of solar panels or radio systems may be provided for in the annual DIP (Im8: 157-159). A systemic view of district health with its different sub-systems is required for this (Im7: 109-110). One practical approach at the level of the DHMT can be to foster a team spirit and solve problems from different departments together (Im19: 64-68).

4.5 SUMMARY: COMPARISON OF STRUCTURAL AND INTERVIEW DATA

The idea of HRH in Malawi being a common-pool resource system is calling some attention to the different 'species' (professions / occupations) and different 'habitats' (employers or work arrangements) which characterise the resource. The perception of one's own professional group and employer in relation to other groups and employers is of interest for understanding the incentive structures for individual health workers. One very particular feature of HRH as a resource system is that the user community is actually the resource at the same time (see Hess 2011). Individuals as well as composite actors can be viewed as appropriators and producers of HRH, or skills respectively.

The demarcation and categorisation of HRH is difficult and lacks agreement among the stakeholders. The established MoH cadres continue to shape HRH in Malawi, but the shift to academic qualifications (Bachelor, Masters, Ph.D.) now seems to be overtaking the establishment in the civil service. It also appears to have increased competition between the professions and occupational groups. Whether continuing professional education and specialisation should take place at academic level is increasingly debated. In terms of training policies, the installation of the COM on the one hand and promoting cadres with lower qualifications can be seen as antagonistic trends. Also the practice of task-shifting to lower cadres is causing considerable irritation. There is a strong interference with the discourse on Public Health or management tasks (which are often equated) versus personal clinical/nursing care.

Although the HRH system in Malawi shows warning signs of depletion, few efforts are made to investigate what is happening at its boundaries. The attention is rather focused on the production of new health workers – which is largely seen as the government's responsibility. Those who leave the health sector or even the country are rarely tracked. Non-availability often results from attending workshops and trainings, or presumably from pursuing private economic activities in parallel to the actual job.

As the comparison of data sources in this chapter shows, employment opportunities in the non-clinical, non-governmental sector are on the rise. International funding for

projects to be carried out within limited time-frames is reportedly forcing NGOs to recruit highly qualified, English-speaking staff at high rates for the duration of the project. Staff development is said to be often neglected against this background, and employment security to be limited accordingly. The findings from the job advertisements also support this. In political terms, however, many of these organisations are also engaged in building the Malawian health workforce, e.g. within the scope of technical working groups or through funding arrangements for colleges. Asymmetries between Malawian and international actors are evident, in terms of their dependence on HRH and their relative autonomy in deciding to enter or leave the system. New governance arrangements and platforms for exchange are needed to deal with this phenomenon. Different types of composite actors (organisations) have been outlined for the Malawian health sector in this chapter, which will be drawn upon for the subsequent analysis at the level of the health district.

The regulations within the governmental health services provide the range of action within which the DHMT members can operate, i.e. their own capacity as managers and the career opportunities within their organisation. The low sensitivity for HRH at district level can be understood as a consequence of the longstanding centralised practices of HRH management and development in the MoH. Legacies of - and counter-reactions to - the authoritarian Banda regime can be found in a number of fields concerning HRH. This includes the idea that health workers are serving the same nation regardless of their employment arrangement, but also the great appreciation of a general freedom of movement.

The pursuit of a career with adequate compensation and opportunities for personal and professional development is becoming ever more important. Medical progress (e.g. the availability of ART) and general technological developments (e.g. mobile information technology) contribute to the rising expectations of health workers regarding their working and living conditions. These attributes of HRH interact with incentive structures that may be influenced by joint rule-making. Respective governance arrangements will be investigated in the following chapter

5 FINDINGS: INTERACTION OF HRH APPROPRIATORS/PRODUCERS

This chapter takes a closer look at the strategies of different national and international organisations (composite actors) in the Malawian health sector. Their patterns of interaction are examined to identify opportunities for regulation and to draw conclusions regarding the sustainability of the HRH system. For this part of the analysis, interviewees as managers and decision makers are seen as representing their organisations.

The action arena focused upon in chapter 5.1 is the health district in Malawi, populated by various organisations collaborating to a greater or lesser extent. Some institutional statements (shared strategies, rules and norms) underlying the interaction are abstracted from the interview data. An action situation establishes a link between optional actions (choice) and outcomes (scope). The three major influences on the action-outcome link are the level of information about other actors (information), the modes of control (aggregation), and the perceived costs and benefits of the actors' different options (payoffs) (Ostrom 2005, see chapter 3.3.3). As HRH are the major resource required for health service provision, the 'choices' of interest to this analysis are HRH appropriation and HRH production. Furthermore, approaches to joint decision- and rule-making between Malawian and international actors at the district level are analysed.

The health district is part of a multi-layered system, i.e. it is 'nested' within other action arenas. Chapter 5.2 therefore takes up interview statements that deal with decisions and policy options in these other arenas. As leaders in their organisation and in the field of HRH, interviewees might shift from thinking *within* the rule system of 'every-day' operations to thinking *about* these rules and how they could be changed for the better. The underlying assumption is that institutional support from other levels could be conducive to HRH management and coordination at district level and thus improve the overall HRH performance and sustainability.

Interview sequences carrying the following thematic codes are predominantly drawn upon in this chapter (see Annex 7.6):

- views of HRH (category: guidance)
- accountability relations (category: accountability)
- duties and rights (category: accountability)
- power differentials (category: ownership)
- donor involvement (category: ownership)

The interview sequences have been sorted by their narrative context – which is either ‘interactions at operational level’ (chapter 5.1) or ‘conditions of collective choice’ (chapter 5.3).

5.1 THE HEALTH DISTRICT AS AN ACTION ARENA

While in each of the Malawian health districts some engagement of national or international NGOs is found, the number of actors and the kind of their engagement varies considerably. So do the geographical and infrastructural conditions and the health needs of the population. The health district is the arena in which the following three action situations are located. Such an arena is mainly characterised by a specification of place and time (i.e. the Republic of Malawi in 2009), and by a set of possible actors.

Set of actors

Some general features of these actors and the historical background of their engagement in Malawi have been described in chapters 3 and 4. The following types of organisations, which have been derived from the interviews and the structural data, might fill the positions in the action situations below with their individual representatives.

- **District Health Offices:** Each of the 28 districts in Malawi has one District Health Office, with a district health management team (DHMT) consisting of the District Health Officer (DHO), the District Nursing Officer (DNO), the District Environmental Health Officer (DEHO) and the District Health Administrator (DHA). Any of those may represent a District Health Office in the analysis.
- **Donor agency/international governmental organisation (IGO):** Bilateral and multilateral governmental organisations, which often function as donors but also offer technical assistance. They are usually directed to the DHO through MoH headquarters, if they want to implement programmes in a district (pooled funding that goes through the government budget is not considered here). They often do not have programme units with their own staff at district level, but sometimes at zonal or regional level. (Examples: Unicef, WHO, gtz, USAID)
- **Non-governmental organisation (NGO):** These are not-for-profit organisations, which act as employers of health professionals. They could be either of Malawian or of international origin. They may be contractors of other organisations or donors, and they may contract out certain tasks to others,

including freelancers. Their work at district level is often directed from a national headquarter, but some also have project units in the district. (Examples: MSH, BLM, Concern Worldwide, Goal Malawi)

- **Community-based organisation (CBO):** A sub-group of non-governmental organisations, with the discriminatory feature of having their own membership base (often volunteers) and offices in the district. Still they could be part of a larger international network or umbrella organisation. They may act as contractors of other NGOs or donors. (Examples: Red Cross, faith-based organisations)
- **Freelancers:** Individual health professionals who might be employed elsewhere, but offer ‘knowledge services’ in the form of research, consulting, technical assistance or training. As self-employed professionals or technical experts, they are not an organisation in the actual sense, although they might sometimes join up in consulting agencies. They may be contractors of any of the organisations above.

Features of the action situations

For the following ‘abstract’ action situations, the minimum set of positions would be that of the District Health Office and an aid organisation with an international background intending to operate in a Malawian health district. This minimum set is enlarged by a third party in action situation number three. Hence the position and boundary rules are fixed, and the analysis concentrates on institutional statements concerning the action-outcome link (AIM-components: scope, choice, information, aggregation, payoff; see chapter 3.3.3). It should be noted that the rights of one actor generally mean duties to another actor; and the liberties of one actor are the exposure of his counterpart (see Ostrom 2005, p.105). Institutional statements could thus be formulated interchangeably from the perspective of different actors. Normally they would also require a backing-up by other statements. Due to the limited scope of this thesis, these details are spared in favour of a broader range of scenarios and AIM-components.

The duration of the action situation is one fiscal year in Malawi (from July to June) and is expected to be repeated at least once. Furthermore, international aid organisations

in the health field have different areas of technical expertise or priority areas of impact, which they will like to focus on when engaging in a district. It is assumed that activities in any of these impact areas contribute to the totality of personal or non-personal health services delivered to the population. As such, most activities are tied to the use of the HRH system: they imply either the appropriation or the production of human resources, or both. The overall outcome of interest for each action situation is the performance of the health workforce vis-à-vis the health needs of the population.

The regulation of interaction could be driven by prescribing certain actions, but it is also possible that the required outcome serves as a major source of orientation, leaving more freedoms to the actors as to how to achieve the outcome.

Three basic strategies of interaction

Any aid organisation which wants to provide health-related services at the district level is supposed to be integrated in the preparation, implementation and evaluation of the district implementation plan (DIP). The DIP procedures are carried out by the District Health Office (Im8:85). However, the collaboration of DHMTs and NGOs varies across the districts. This is concerning the frequency and framework of meetings, the attendance of NGOs or their contribution of NGOs to planning (Im7:141-149). The differentiated account of international co-operations provided by one interviewee served as a starting point for shaping the three basic action situations. She distinguishes between implementing partners, funders and intermediary organisations (If23:63-68). The major variable distinguishing the three situations presented here is the general working mode or strategy, which an international aid organisation intends to pursue when entering the action arena. It might either want to deliver the services itself, or work through other structures. The latter may either be the District Health Office, or some sub-contractor.

5.1.1 DIRECT IMPLEMENTATION BY THE INTERNATIONAL AID ORGANISATION

In this first scenario, an international aid organisation would enter the health district with the intention to implement projects or programmes itself, by means of its own

employees. These employees, who could be of foreign or Malawian origin, would deliver the personal or non-personal health services required to reach the objectives of the organisation's engagement in the district. The internal managerial structure of this organisation is thus oriented at service delivery and employment, most likely on a temporary basis, at least for lower cadres deployed in certain projects. In this competitive situation for HRH, the 'poaching' of staff from governmental services is a risk. While it might not be actively pursued, it can just be a consequence of the salary gap.

It is possible that different types of organisations fill this position (IGOs, NGOs and even CBOs), provided that they have an international background and funding base. The most common type in this position, however, is the international NGO. The organisation principally operates in parallel to the District health office, but the degree of collaboration may increase or decrease over time.

Collaboration or at least co-ordination is based on 'voluntary' mutual involvement. This might occur if overlaps of technical expertise and areas of responsibility between the District Health Office and the international aid organisation are recognised by both sides. Longer-term commitments would also foster such arrangements, which usually include the explicit objective of capacity development.

Institutional statements concerning HRH

Having outlined the [ATTRIBUTES] of the actors and the [CONDITIONS] of their interaction, the following sections are ordered by the [AIM] components of institutional statements found in this type of action situation. While each of these statements contains a [DEONTIC], i.e. an obligation, interdiction or permission for the actor, [OR ELSE] components are seldom found (see 'grammar of institutions' in chapter 3.3.3).

Statements aimed at scope and choice: The key actions or strategies that the aid organisation can pursue would be to recruit health workers and/or to develop members of their own organisation. If they recruit health workers who hold at least a basic qualification in the health field, they are competing with the District Health Office

for this scarce resource. While in-house HRH development might be possible for volunteers as well as other cadres, it is likely that basic or even academic entry qualifications are required, especially for more advanced positions. As a counter-measure in this competitive situation, it is possible to have a Memorandum of Understanding (MoU) at district level, regarding the poaching of government health workers:

NGOs must not poach staff from MoH.

While it is the employees' right to resign from government services first and then apply for other jobs, they cannot change employers directly under such a policy (If23:22-23, 74-76). Another option for an international aid organisation is to establish a 'no-poaching policy' as a voluntary and informal measure (Im3:85), to save the capacity of the governmental structures.

Writing a MoU can also serve as a learning point (If23:59). It is an opportunity to exchange about specific needs of the District Health Office on the one hand, and available resources of the international partner on the other hand as starting points of partnership (If22:81-82). Regarding the health services to be provided to the population, both sides should ideally work in a complementary manner, with the aid organisation at least 'filling gaps' that the District Health Office cannot cover in terms of geographical or technical areas. HRH should always be considered:

The District Health Office and the international aid organisation must include HRH as a cross-cutting issue of cooperation.

Such integration is required from the planning stage onwards (If21:78-83). HRH-specific fields of cooperation could be staff appraisal, training needs assessment, supervision or monthly joint meetings for all health workers, to discuss protocols and clinical chains. As supervision is the central HRH-relevant function of DHMT members, it lends itself to being an entry point for collaboration (If23:52). In the sense of capacity development, a shift over time needs to be agreed:

The international aid agency may gradually hand over core responsibilities and staff to the District Health Office.

As a prerequisite, the District Health Office would have to create new posts and taking staff on contract who have previously been employed by the NGO (If21:51).

Statements aimed at information and aggregation: Information flows constitute a particularly sensitive topic. For the international co-operation at health district level, this means providing mutual insights in the organisations' activities. Most DHMT members mention the DIP planning and evaluation mechanisms as the appropriate frame for this exchange (Im10:53-56):

District Health Offices and international aid agencies must regularly exchange information on fields of work, targets, available resources, planning time-frames and impacts assessed.

Problems and delays often occur when the District Health Office has completed its internal routine analysis and has to incorporate data from the NGOs working in specific fields (If11:70-74). In fact, many of the DHMT members interviewed are complaining about NGOs which keep information about their work plans and resources for themselves (If11:73, Im10:62, Im19:85-86). This is also referring to the 'packages' that these organisations are offering - a term that is generally used for staff remuneration and incentives (If11:75). Some deplore that the NGOs would not even attend the planning meetings (Im10:66). A duplication of activities and waste of resources in the district are named as potential consequences; at least impact would often be limited.

It is stated that the co-operation of NGOs in this regard often slacks after the initial phase of coming to the district. However, repeating the same reporting requests year by year sometimes shows a positive effect (Im19:87-88).

District Health Offices and international aid organisations usually pursue different ways of planning (If23:61). For the District Health Office, 'co-ordinated planning' means setting priorities while remaining open for suggestions from their partners. If considered important, these issues should then also be integrated in the District Implementation Plan, and resources and activities would have to be shifted accordingly (If23:62).

By contrast, integrated management and planning (If22:84) has the effect that the partner cannot start any activity without communicating it with the District Health Office, which also is a mode of control. With regard to management decisions about the actual allocation of resources, both sides nevertheless remain separate entities (Im12:44):

International aid organisation and the District Health office may each decide autonomously about their use of resources.

The DHO is proclaimed as a steward for the health district, who is supposed to set priorities and guidance on MoH policy to other actors (Im7:153-160). He or she is supposed to coordinate the different actors and their resources but has no actual sanctioning powers (If11:86).

Statements aimed at payoff: The general strategy for an international aid organisation to directly implement their projects has immediate consequences in terms of payoff:

The international aid organisation must take over the managerial costs and salaries for project implementation.

The managerial input in relation to other personnel cost would thus be higher than in case of indirect implementation. The benefit, however, is relative decision-making autonomy from the MoH with its extensive bureaucratic procedures. Furthermore, the intervention is rather confined, and the link with its reportable results appears as more clear-cut.

Integrated planning and implementation of activities between the District Health Office and the international aid organisation is time-consuming and only appears likely under certain conditions. Joint efforts should start as early as possible in the process (If23:52). The benefit for the District Health Office would be optimum complementation of their own activities, in addition to enhancing their own skills.

In case that duplication can be avoided but the aid organisation is still working in isolation, the District Health Office might be relieved from particular tasks related to population health and save some of its resources for a certain period of time. On the

other hand, it might lose its competencies in this particular area in the medium run (If11:52).

On behalf of international aid organisations, a phase-out mechanism is usually justified with the ‘empowerment of partners’ and ‘sustainability of services’. However, programmes that are expected to be taken over might retrospectively interfere with the priorities for the district (If11:82). The chances for the programme to be continued are not very high under these circumstances: The District Health Office is likely to be faced with high expectations among the community to continue the service at a comparable level, but may not have the necessary financial or human resources.

The international aid organisation must seek the transfer of skills to the District Health Office at an early project phase, or else the activities will not be continued after its exit.

There are no strong sanctioning mechanisms in place that would back-up co-ordinated planning, especially the exchange of relevant information and the consideration of the overall workforce performance in the district as an outcome. It seems that NGOs are ready to take information and even advice on MoH policies away from the quarterly meetings, but communication appears to be mostly one-way (Im8:135-139). One interview partner states that internationals often only ask for advice when they are facing problems (Im13: 107-112).

However, it is also admitted that DIP review meetings are time-consuming for the NGOs. Usually, local members attend these meetings, who are based within the district (Im8:131). This arrangement does not disturb too much the operational procedures or the self-image on either side.

Conclusion

The cooperation of the District Health Office and non-governmental agencies at this level is characterised by weak or unclear institutional statements. Rules, which according to Ostrom (2005) are backed up by mechanisms for enforcement, are very rare. Also HRH-related outcome variables are largely absent from the action arena at the level of the health district – except for ‘availability’. The availability of qualified personnel, be it with regard to particular posts or from a geographical and population

perspective, stands in the foreground of the discourse about HRH in the various action arenas outlined here.

In the governmental sphere, the approach has historically been very much centralised and control-oriented, but there is increasing sensitivity for aspects of staff motivation. The options that managers have in this respect depend on their own position within their organisation and its internal rules, but they range from staff development through trainings via physical workplace arrangements to financial incentives. Intense collaboration on HRH with an international partner may deliver ideas, know-how and additional resources in this regard.

5.1.2 IMPLEMENTATION THROUGH THE DISTRICT HEALTH OFFICE

This action situation is characterised by an international aid organisation intending to deliver personal or non-personal health services through governmental structures, which in this case is the District Health Office. Intergovernmental (bilateral or multilateral) organisations are most likely to pursue this strategy, at least in the larger part of their engagements, since their prime counterpart is the Malawian government. Managerial decisions concerning operations at district level are then usually made at the national headquarters (or in programme units within the MoH), with representatives being sent 'to the field' at specific occasions. But also NGOs could operate through staff of the District Health Office. Contracts are either made directly with the MoH headquarters and handed down to the districts for implementation, or they are negotiated at district level. As a third position in this action situation, consultants (freelancers, technical assistants) may come in.

Institutional statements concerning HRH

The following [AIM] components and [DEONTIC] may become relevant in this second type of action situation.

Statements aimed at scope and choice: With regard to outcome variables on HRH performance in this strategy of collaboration, again little is said by the interview partners. If recruitment and training measures are part of the collaboration, the

number of health workers trained and available for certain tasks may serve as a more proximate variable, e.g. 1 HSA per 1000 population (Im8:89)

With the introduction of new programmes and systems in the health sector, tailored training might be included. This is often happening within the scope of bilateral programmes, which then provide either training in clinical management or in more general management issues (e.g. finance, HR, transport, procurement)(Im5:19-21).

Making use of the infrastructure and the staff of the MoH already in place is a frequent strategy for international aid agencies, especially for interventions in rural areas. Most notably, HSAs are likely to be deployed for joint action, as they are the MoH cadre based at community level:

An international aid organisation which contributes to the training and remuneration of MoH staff may use the District Health Office's primary health care structures to implement its programmes.

In this case, the District Health Office operates as a coordinator between the aid organisations and the staff on the ground and integrates these health workers in their supervision activities (If17:34). This is reported to have been the common approach UN agencies, but they are now changing from subsidies to model projects (Im12:42-44).

Capacity development is an argument that usually accompanies this implementation strategy and can be seen as a quasi-outcome variable. District Health Offices are meant to be enabled to continue the service provision by themselves at the end of the funding period.

One example for capacity enhancement' in terms of clinical work is an on-site mentorship programme targeting government structures. This programme advises and practically supports health workers at their workplace in the districts regarding the treatment of HIV patients. Mentors make several follow-up visits after the target group has received some initial training in a central clinic (Im3:27-29).

Training or mentorship offered by the international aid organisation must be local and/or workplace-related.

Another approach often taken in the cause of capacity development is to post consultants within the MoH structures. These could be expatriates, but may also be of Malawian origin. At the district level, they would usually occur in a supervisory function. For example, staff and technical assistants deployed at the zonal health support office (ZHSO) has not been on government payroll at the time of field research, but has been financed by donors (Im7:134; Im16:35).

The international aid organisation may also appear as a donor agency, which is only offering financial assistance to the District Health Office to implement particular kinds of projects. Such funding organisations usually have been in contact with the MoH at the central level first, where they have stated what they want to support. They are then directed to the districts, but it is up to the District Health Offices to request the funding for a concrete purpose. Knowing about the impact area of the funder, the DHMT looks at the gaps that they cannot cover with the regular government (or SWAp) funds and writes a respective proposal to the donors which they consider suitable (If23:63-66).

Statements aimed at information and aggregation: UNICEF given as a good example of an organisation reliably providing annual work plans to the District Health Office (Im7:141-149). As for information flows, the action situation described in this section is usually characterised by reporting requirements, which may be substantiated in the form of a written contract.

The District Health Office, either being a direct partner in such a contract or reporting to the MoH headquarters, has maximum insight in the operations actually taking place, but naturally only passes on reduced information. At the same time, the District Health Office often faces intransparency regarding the status of collaboration and the time or the amount of payment. They have made different experiences with the reliability of funding organisations after having submitted proposals. It can take a year before they receive a response at all (If23:63-66). On the other hand, the contracts are tied to reporting duties, which are then difficult to keep (Im10:52):

Within the scope of funding applications and contracts, information must be provided timely and reliably, both ways.

By posting its own consultants within the MoH structures, the international aid organisation can gain additional 'insider' information. The same is true for a programme office which is directly installed at the MoH headquarter. Meanwhile, such posts are increasingly being filled by Malawians rather than expatriates:

An international aid agency may post technical assistants or install programme offices within the MoH structures, which may be staffed locally or internationally.

One example for information gathering would be a 'familiarisation tour', i.e. field visits conducted in a team to get acquainted with the people working at that level. Another one would be operational research, which better allows for communicating the results to the 'relevant authorities' (Im16:55). Apart from that, conduct regular meetings within the scope of supervision activities would generate relevant information (Im16: 63).

At first sight, technical assistants have little power to affect major changes in intra-organisational structures (Im16:65; Im3:52). Still, the longer-term deployment of Malawian consultants offers an opportunity for international aid organisations to 'silently' introduce new ideas. In the case of distinct organisations giving advice, this is at a greater risk of causing embarrassment or offense (Im3: 42). The communication with MoH headquarters regarding policy advice, e.g. based on research findings, is usually taken over by the Country Director of an international aid organisation (Im15: 58-65).

Other international aid organisations operate in a very flexible manner, in the sense of being a broker linking up the donor with the various Malawian agencies that need to be involved (Im5:36-43). Also the recruitment of staff and experts is done according to the programmes' requirements and remuneration is offered on a person-day basis (Im5:45).

For the District Health Office running distinct programmes or projects, the locus of control regarding HRH management basically lies with them as the implementing agent. However, external funding might also bring a shift in priorities to staff deployment at district level. If the donor is demanding the fulfilment of certain tasks, these might overrule other routine activities. (Im12: 50-55) This also accounts for

projects that the District Health Office applied for, albeit to a lesser extent if carefully planned. The provision of resources is usually being tied to specific policies on how the money should be spent. The opportunities for Malawian district health managers to make amendments which they consider useful or necessary are limited (Im12: 50-55).

The influence of the donor may also be hidden for the DHMT members, as intergovernmental agencies often have programme offices within the MoH headquarters. They use the regular vertical lines of policy making and implementation in the MoH, with policies within the district usually being derived from the national level. An outstanding example is the Unicef breastfeeding programme, which offers the certification as 'baby-friendly hospital' and requires the DHMT members to follow a very clear set of rules ('10 steps')(If22:58, 64)

Statements aimed at payoff: District Health Offices appreciate that many different intervention areas or tasks are covered by those partners, and that the office could identify areas of need and then apply for funding (Im8:85). In this kind of project arrangement, the DHMT would have to plan themselves for the necessary staffing measures.

The District Health Office must provide the management and administration of implementing the programmes, incl. HRH.

However, the disbursement of funds may be delayed by several months, while it is expected that programmes are carried out as agreed (Im10:52). Effective implementation and - as a consequence - reporting and evaluation are becoming difficult in those cases. Therefore larger external programmes in core areas of health care provision can be a risky undertaking for the District Health Office.

The District Health Office may write proposals to apply for specific funding and tailored support.

The administrative and managerial costs for proposal writing, information generation and planning also predominantly lie with the District Health Office (or with the consultant) as a contractor. Whether they receive any overhead as compensation remains unclear; also salary top-ups for civil servants managing the programmes are

not mentioned in the interviews. They take risks as to how much effort they should invest to eventually 'win the price'. Previous experience in managing international projects helps to be successful in proposal writing, since it invokes trust on behalf of the donors (If11:50).

Conclusion

The kind of contractual collaboration described here is prone to principal-agent-problems, meaning that agents at a lower hierarchy level are only passing on selected information to their principals. Information asymmetries even exist if both parties work in the same location. They increase if the reporting chain gets longer, involving national or even international headquarters. Given that the principals in this action situation would often be large multilateral agencies, this is likely to hamper adequate and timely decision-making on both sides. Even if consultants are working very close to the level of service provision and have extensive insights in the progress of the activities in question, they are at best catalysts for relevant decisions.

Shortfalls in the capacity of the MoH system may also be deliberately displayed in order to attract support. The DHMT just has to be flexible - up to the extent of adjusting its own plans to those of the aid organisation - to secure the aid flow. (If17:38-39). However, programmes which are aimed at the local level and offer funding upon the initiative of the District Health Office might also foster creativity and trigger local initiative.

5.1.3 IMPLEMENTATION THROUGH OTHER ORGANISATIONS/FREELANCERS

The third action situation presented here is characterised by the international aid organisation's strategy to implement its projects or programmes through partners other than the District Health Office. These could be NGOs, CBOs or consultants. If23 calls them 'intermediary organisations', since they usually apply for funding from larger donors but use other organisations' infrastructure and membership base on the ground. It is likely that they operate from a regional or national office. Principally, sub-contracts might also be given to consultants, e.g. to conduct community-based research.

From the perspective of the District Health Office as a coordinating body, this action situation is most limited. With regard to the local partners of the international aid organisation, the relationship is very similar to action situation number one, and they normally should be included in the DIP procedures. The organisational structure of this partner might be weak or at least scattered, especially in the case of volunteer organisations, or temporary, in the case of consultancy and research teams.

Collaboration with the District Health Office is thus officially required, but would rather occur in the form of loose coordination than in the form of a contract. There might be demonstration of goodwill, however, to avoid open conflict and maintain an image of being open and collaborative. The attention of the international aid organisation would mainly be on its interaction with the local partner organisation.

Institutional statements concerning HRH

Given the actors' [ATTRIBUTES] the [CONDITIONS] outlined above, the following kinds of statements might occur.

Statements aimed at scope and choice: Consultancies would normally be announced by an advertisement in the newspaper. These could include task such as surveys, water sample collection, or training impact assessment. The contractor would then be paid for organising staff and supervisors on the ground, while data analysis is usually done centrally (Im13:27-32, 73-78).

The international aid organisation may tender and contract out tasks to third parties, unless these tasks correspond to core functions of the District Health Office.

While such operations are often carried out from a distance, it is also possible to seek close cooperation with the District Health Office - at least in geographical terms. After all, this might offer advantages regarding the use of infrastructure and closeness to clinical and community-based activities, as in the case of the M&E officer working for the COM (If20:14). For the field of Environmental Health, one interviewee is telling about a failed proposal which aimed to establish a university study centre in a rural district (Im13:84-92).

HRH is unlikely to play a central role in the interaction between the District Health Office and these international aid organisations, even if there is an exchange of information about the resources being put into certain activities. This may be partly due to the greater role of volunteers or students/research assistants in such activities, who are not normally perceived as HRH.

The local partner would have to dispose of (or recruit) the necessary human resources to implement the envisaged activities. Some organisations might pursue the objective of enlarging the human resource base by training lay people and volunteers for their specific purposes, such as counselling or data collection (If4:41-43). If these human resources overlap with the cadres or professional groups employed by the MoH, there is a competitive situation for HRH. However, the international aid organisation is not directly affected in the sense of facing the short supply of HRH when trying to recruit qualified project staff. The contracting of local consultants makes an exception here:

The third party must assure that that its activities are not detrimental to the availability of core health staff to the District Health Office.

International aid organisations increasingly contract out smaller tasks within their larger programmes to Malawian health experts, different forms, e.g. carrying out studies and assessments, either as the consultant in charge or as member of a team from multiple organisations (Im5:36-43). For specialists in certain technical areas a short list is necessary. For such 'competitive' positions, they have to work with whoever is available at the required point in time. By contrast, 'non-competitive' short-term positions are advertised in the newspaper (Im5:44-53).

Statements aimed at information and aggregation: The decision of an international aid organisation to operate through non-governmental structures may have to do with their primary focus of work (e.g. research, counselling, advocacy), for which the DHO would not be the most suitable partner. They may also perceive the transaction cost of operating through the District Health Office as being too high, if administrative procedures tend to be obstructed. This may lead to the decision to 'bypass' governmental structures as far as possible.

Information exchange between the District Health Office and the international aid organisation in this action situation does not underlie any contract and has no respective sanctioning mechanisms. The international aid organisation and its sub-contractor in this situation might even perceive respective requests from the District Health Office as an illegitimate intrusion into their own affairs. However, information exchange appears as a centre piece in this action situation, given the rather loose linkages between the participants:

District Health Offices may actively seek information exchange with the intermediary international aid organisation or the third party, e.g. visiting each other's planning meetings, accessing research findings.

Arrangements for the co-ordination of activities are possible, but would require mutual goodwill and investment of effort. Personal contacts need to be established and nurtured (If23:68-69). These tasks can also be delegated to the district coordinators who are in charge of the respective impact areas that the organisations are working in, e.g. home-based care, PMTCT, breast feeding, malaria or TB. The regular interaction after the initial phase is thus with programme managers (Im23:71, Im19:80-85). They would then compile reports which are shown to the DHO and then passed on to the MoH headquarters.

As for authority in decision-making, the situation of the District Health Office here is similar to the first action situation above. The 'visitor's status' indicates that it can exercise even less influence on the international aid organisation or its partners, at least in terms of staff allocations. It can only try to adapt its own staff deployment to the activities of the other organisations. The office may instruct the other organisations on relevant MoH policies, which mostly refer to technical or clinical standards though (Im8:136-137).

However, CBOs may wish to make use of the extension workers that different sectoral ministries have in the communities, even if they have their own network of volunteers in the community:

Community-Based Organisations acting as third parties may seek to coordinate their community-based activities with the District Health Office.

The District Health Office could designate focal persons upon request, who would then participate in meetings and trainings, and they also follow up the project through the usual supervision mechanisms of the MoH (Im18:19).

Statements aimed at payoff: Voluntary co-operation may bring an image gain for the international aid organisation. The importance to align with government policies is being highlighted, which indicates the appreciation of such conduct by the membership of the organisation (Im18:11, 16-17).

The benefits for the District Health Office from maintaining close contact with such CBOs mostly lies in receiving additional information about what is happening in the communities. They may use this information to adapt their own activities and avoid duplication. At the same time they can demonstrate to the relevant authorities that something is being done, and that they are fulfilling their role as a link between the MoH and other stakeholders in the district. It may also be helpful for the fulfilment of DIP requirements, which include the comparison of HMIS data with other data – thus also research data would be of relevance (Im10:61-66).

For the District Health Office, leaving certain fields of work to other organisations does not necessarily have to mean that those are ‘filling the gaps’ which should normally be covered by public services. Emphasizing the complementarity of other organisations’ activities (while at the same time confining it as not being the major responsibility of the District Health Office) may bring moral relief.

On behalf of the CBOs, although volunteers would not receive salaries by definition, their longer-term engagement is usually remunerated in some form:

Community-based organisations must ensure that volunteers are adequately trained and motivated. This may include financial or in-kind incentives up to an agreed level.

Offering training to the volunteers can be seen as a sign of appreciation and an attempt to assure sustainability. It is recognised that volunteers usually stay in the community even after a project has finished and an organisation leaves (Im18:18). However, this may also be a source of intra-organisational conflict, because people do not understand why there should be paid labour and unpaid volunteerism in the same

organisation. Building skills among volunteers could thus also be read as an approach to appeasement.

Volunteer structures assure direct links to beneficiaries and help mobilise communities more easily. However, it appears that there is also competition with regard to community mobilisation through offering incentive, e.g. for the attendance of health education sessions. The work of community volunteers in this case is backed up by further resources, which is a cost to the CBO. It has been argued that this area of competition among organisations should also be regulated by a policy (If4:64).

Finally, consultants make a special case with regard to the payoff. As they usually operate on a short-term basis and offer highly specialised services, they need to be particularly trustworthy for their contractors, in the sense of being a reliable partner and delivering good quality (Im15:103-105; 134-139).

Consultants acting as third parties must build a reputation not only based on quality delivered but also on conduct regarding HRH.

Interviewees in this study have not mentioned to what extent information generated through consultancies actually reaches the District Health Office or the local communities researched. Respective contracting arrangements could be considered to ensure a larger benefit of these activities.

Conclusion

The authority regarding international collaborations in the health district is no longer restricted to the 'technocratic line', from the MoH headquarters to the District Health Offices. DHMTs are now operating in two different strands of political accountability. Most of the interview partners in this group are more comfortable with the hierarchical structures of the MoH, whereas the inter-sectoral collaboration at the district level (District Assembly/District Commissioner) bears uncertainties.

Apart from that, however, it has to be recognised that these coordination activities also require considerable managerial efforts. The common criticism that health workers spend too much time in meetings and carrying out administrative tasks should be taken seriously (Im15:174-184, Im5:78). It needs to be carefully considered whether

the improvements in general - and regarding HRH in particular - are really worth efforts that are required at district level. Given the general reluctance that can be observed in this regard, also the reporting and planning structures appear to be hindering better collaboration in the field of HRH.

With regard to consultancies, greater attention is to be given to the practice of issuing short-term contracts. For 'competitive' positions, these would normally be in addition to a regular work contract elsewhere. This is said to be a legal arrangement, if the contractors sign that they are available during the agreed time span (Im5:55-57). If these contracts come on top of an employment in the public sector for example, the competition for human resources is obviously shifted to the level of the individual professional's work-time.

On the positive side, contractual arrangements and agreements among actors in this third action situation also offer some innovative potential and learning opportunities. It stems from the variety and the resources of actors working on health and social welfare in the broadest sense.

5.2 LINKS WITH OTHER ACTION ARENAS

The action arenas presented here are linked to the level of the health district in one way or another. The nature of this linkage will be examined, to identify arenas in which discussions about underlying norms and rules take place and where relevant rule changes might be initiated (collective-choice and even constitutional level).

The landscape of composite actors relevant for the resource system HRH in Malawi is visualised in figure 4. The action arena ‘co-ordinated planning’ at district level, which has been dealt with in chapter 5.1, is thus put into context. Different colours the different types of organisations: the different bodies of central government are kept in blue, while the District Assembly (DA) as a body of local government is distinguished. The connecting lines and neighbouring clouds make clear that a number of decisions, which are of relevance to the action arena in question, are being made in other action arenas. Most organisations do not operate in one district only. The rules and norms within their respective organisation will thus determine the range of action that individual managers at district level have.

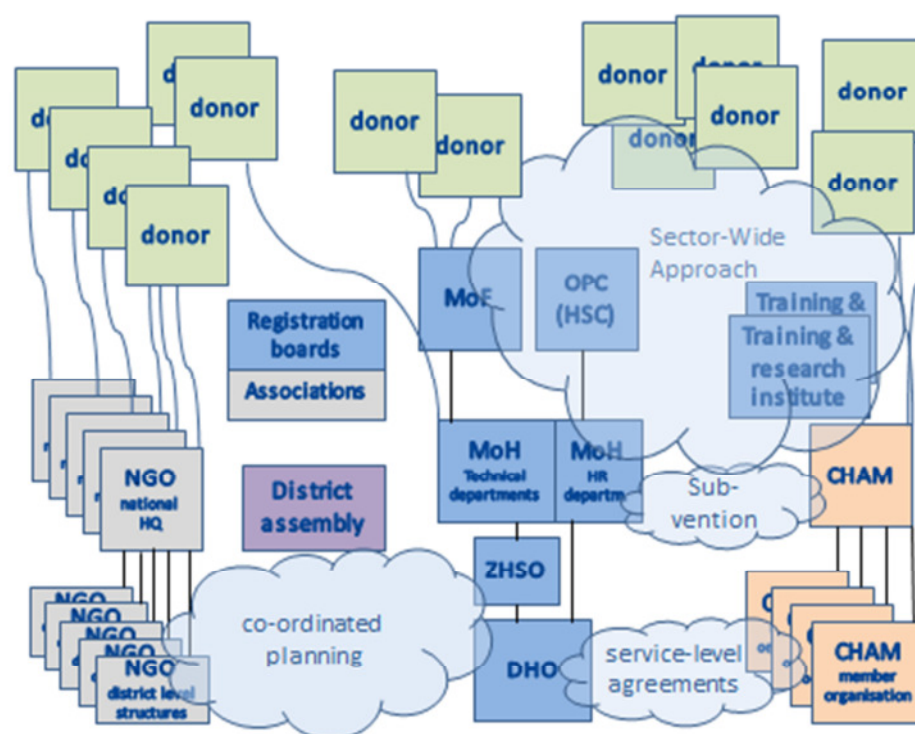


Figure 4: Actors and action arenas relevant to HRH in Malawi

According to the Local Government Act of 1998, the DA is supposed to receive a more active role within the scope of decentralisation, but councillors had not been elected yet in the year 2009. Malawi in fact has a history of emphasising rural development whilst taking an inter-sectorial approach. The installation of 'rural growth centres' to further decentralise the services available in the district, was also supported by German development aid. This support is being continued in technical assistance for building the local government structures. However, the recent decade has rather been characterised by sector-specific aid, e.g. within the scope of the health SWAp. This has also been very relevant for the District Health Offices in terms of financial and physical resources. Large numbers of HSAs have been recruited locally, as part of the EHRP. Furthermore, the Zonal Health Support Offices (ZHSO) as an intermediary structure have been introduced (see map in Annex 7.1).

Potentials and limitations at the district level have been worked out in chapter 5.1. The following three sub-chapters will pick up these aspects: They will deal with different options to enhance HRH management and development in Malawi in a context of international aid. Each focuses on a particular arena, namely the health zones (chapter 5.2.1), local communities (chapter 5.2.2) and the DA (chapter 5.2.3).

In contrast to the preceding results sections, the following sections will also present some original quotes from the interviews. This is to acknowledge that in various instances, individual leaders have made up their minds regarding the changes that they consider necessary to improve the HRH situation at the operational level. Thereby they shift to the conditions of collective choice. However, these statements are not necessarily shared by the wider community of health workers.

5.2.1 EXPERTISE, SUPERVISION AND MEDIATION

As pointed out in chapter 5.1.1, a major potential lies in the intense collaboration on HRH between Malawian and international actors. The SWAp as a form of international co-operation has not only increased the available resources at the district level (If23:65, If11:81). The MoH has also received technical assistance in order to build supervision and HRH management capacity. One particularly visible consequence are

the Zonal Health Support Offices (ZHSO), another one is the establishment of technical working group at the level of MoH headquarters.

Through the engagement of ZHSO staff in the technical working group on HRH, relevant expertise is supposed to be built and disseminated. One example is the initiative to develop joint terms of reference for DHMTs, based on operational research and piloting integrated supervision checklists. Supervision is thus the central function of the ZHSOs. It is deemed necessary to induce more systemic thinking through these activities. One step in that direction is the integration of disease control programmes into the regular services and therefore also into the supervision system (Im7:108-129, 78-80). Also the supervisory performance within the districts themselves is targeted. For instance, for local communities to benefit from the increased numbers of HSAs, improvements in the system of supervision are required (Im16:61).

At first glance the ZHSO does not appear as a direct partner of international aid agencies. These are reported to either interact with MoH headquarters or with the District Health Offices. However, there is some collaboration with WHO and Unicef outside the SWAp, where the ZHSO acts as a mediator for implementation of activities at district level. A joint programme of the Reproductive Health Unit in the MoH and the African Development Bank is being supported in a similar way: The ZHSOs help to make the programme known among the District Health Offices, assist with applications for funding and train people on the subject (Im7:130-131, 153-158). Other international aid agencies usually only deal with selected districts within a zone, but the ZHSO is in a position to compare modes of collaboration in different districts and also advise on this subject. Furthermore, it can bring together the DHMTs and other distinct players operating at supra-district level within zonal meetings, e.g. the regional medical stores, central hospitals or CHAM dioceses (Im7:140-146).

It has to be noted, however, that none of the interview partners from the DHMT-group has mentioned the support of the ZHSOs, except when explicitly asked about it. This indicates that this relatively new structure has still been very weak at the point of field research.

Strengthening ZHSOs as a structure

ZHSOs do not normally run international partnerships for the immediate provision of health services, but they constitute a 'joint venture' by themselves. Different international aid agencies have agreed with the MoH to finance the offices and their operating costs (including salaries), and to back them up with technical assistants. Their immediate interest lies in monitoring how the SWAp resources are being used within the districts. This is meant as an interim solution, until the MoH has affected that the posts at the ZHSO are included in the formal establishment and the staff is taken on the government payroll (Im7:130-138, 139-141). Hence, in 2009 the status of the offices has still been provisional. In addition, some of the posts have been vacated again because the MoH decided to deploy the respective staff in other (or additional) positions (Im7: 80-82).

Institutional back-up on behalf of the MoH therefore appears to be urgently required to secure the functions of the ZHSO in the longer run. At the same time, this new structure also bears some qualities which are worth safeguarding, as the following interview sequence illustrates:

MB: But would you like to work at the central level? // At the long term yes. But in the interim I think that being at the zone is quite a good opportunity also. Because I feel that it's one of the places where you are more or self-directed and you can indeed try to contribute to the development of the services. Of course following the Ministry's vision and aspirations, but you can be a bit creative in the way that you want to implement that development. So it's a decision of how creative you want to be to support the districts. Later at the central level it could be a bit of a contrast. (Im7: 86-88)

It is questionable whether a ZHSO with an in-line management function within the MoH would still have this innovative potential. One advantage lies in the possibility to try things out without being overly fearful to make mistakes. The need for such arrangements is also reflected in the following statement:

And sometimes you find that a lot of money is lying in the banks or has not been granted from donors because, at the end of the day we aren't able to implement. So, the major problem has been: do we have appropriate human resources in place. That's one thing that we did not attend to most of the times, because we are busy, you know, thinking that new knowledge in itself will solve problems. (Im1:118)

Thereby the interview partner is also referring to the fact that government officials spend a lot of time on attending workshops and trainings sponsored by international aid agencies. While these measures are usually justified as ‘capacity development’, they also reduce the worktime that can actually be spent on the implementation of programmes. Moreover, the statement indicates the ambiguity of international aid and inherent lines of conflict.

Providing platforms for dialogue

The relationship between Malawian and international actors is often portrayed as distrustful, characterised by disappointments and even by evaded control attempts. One example is that the HIV/AIDS crisis situation has been used by the MoH as an argument to deviate from agreements with donors regarding the deployment of health workers. Instead of providing community-based preventive services, they were concentrated in hospitals (Im6:33). Development aid that follows the capacity development paradigm is at risk of running into dilemma situations. This can be observed in the ambivalent that way the term ‘ownership’ is being used – even by Malawians themselves, who complain that leaders in the health sector are not personally committed to the programmes they are meant to implement. What surfaces here is the wish that donors should sometimes execute more direct pressure on the government (Im1:201-202).

In the case of disagreement and frustration, non-governmental actors might even be in a more favourable situation than governmental actors, e.g. bilateral donors and providers of technical assistance to the Malawian government. Donors are reportedly hesitant to bring up conflictual issues in the latter kind of arrangement, lacking the results orientation that they often proclaim (Im1:249, 258). By contrast, the following statement highlights the advantages - but also the limitation - of being an outsider to the system:

MB: [...] you and your team, are you trying to actually get involved at that political level? // Well, I'm not in that one now, you know, we're not in that one now, but all we can do is, really, advocate from outside. And then, we want to go in the College of Medicine courses. In the Ministry of Health we can only advise and that's all. And sometimes, if you are working as NGO, advice is taken as agitation. //MB: As what? // Agitation. That, you know - why are you causing

problems? So sometimes, it's sometimes better when you are not within the system and then you make noise. (Im3:35-38)

As for the field of HRH, however, the SWAp - or the respective technical working group - are suggested as the appropriate place to openly discuss policy suggestions. This may involve donors and recipients, governmental and non-governmental actors, even if they do not financially contribute to the SWAp. It is seen as an opportunity to arrive at unified approaches of all relevant players and at country-wide policies (Im7:161-163). The ZHSO as a part of the SWAp implementation system may offer respective platforms for exchange and critical discussion at the zonal level.

5.2.2 LOCAL RECRUITMENT AND RETENTION

The potential of community-based health workers for reaching broader service coverage has been widely acknowledged in Malawi (see chapter 5.1.2). Massive health worker shortages have been addressed by the MoH and international donors through the national EHRP and the SWAp from the year 2004 onwards (Im6:13). A special focus besides increasing the numbers of nursing and medical students, has been the recruitment and training of HSAs. Furthermore, the 52% salary top-up within the scope of the SWAp has taken some pressure off the district health system.

Salary levels are obviously out of reach of district level decision making. The more so, HRH are predominantly perceived as a management challenge rather than a responsibility that lies at district level. The recruitment of HSAs is an indicator for this phenomenon. It takes a special place in human resource management, since HSAs are not posted to but selected from their respective catchment areas. Yet District Health Offices do not necessarily claim a very active role in this, as the following interview sequence shows:

MB: Can you tell me more about the HSA training, how do you plan for that, how do you recruit the people, how do WHO and UNICEF get involved? // These people have already been recruited, and you identify areas where people cannot access services easily, and then you look for funds from WHO or Unicef, and then you train them. After training they start managing some minor things in their communities. Of course, HSAs have also been trained by [name of an NGO], funded by [name of a donor], to provide Depo Provera, which was given by the NGO. [...] And they also trained community distribution agents, these are volunteers from the communities. They are trained to provide contraceptives. //

MB: And who recruits the HSAs? // The MoH recruits them. The idea is to have one HSA per 1000 people // MB: So somebody comes from the national level, or they operate through the districts? // The advert comes from the Ministry, and then people apply and are recruited. Somebody from the MoH comes when they are conducting the interviews, and you also have local people from here, and independent people within the district, so that it's transparent. // MB: And also you as DHO have been sitting on that board? // Not necessarily, people have been delegated to do that. // MB: How have you been involved in their training as a DHO? // We only provide the trainers, they are already there. They have been trained by the MoH, they are local trainers. (Im8:86-95)

Given the involvement of so many different players, the principles of transparency, independence and local linkage are highlighted as particularly relevant. However, no consequences are derived regarding staff motivation and quality assurance, which might be handled differently in this cadre of health workers.

Reducing costs on behalf of the workers

Working close to home, and the possibility to engage for one's own community can be seen as critical factors in retention. Emigration, death, and premature retirement have been mentioned as major causes of attrition. The latter phenomenon is described in the following statement:

Im3: [...] because of these others we are losing off the system, because nobody seem to be keeping track of that people whatsoever. Yeah? I don't know whether they cannot get them, because of course you get the numbers of people who just - nursing particularly - who are just quitting their job because it costs so much to come to work that the salary is not enough. You know? You spend all that money only on transportation, so what's the point, you know, you have very open hours to start with, and then at the end of the day you spend three quarters of your salary on transportation, you know? So what is in it for me? So that say ah, stop working. So there's quite a good number of those, yeah (Im3: 48)

The underlying assumption is that there might be a pool of qualified health workers that could be tapped through more localised approaches to recruitment. Of course, highly qualified health workers are not likely to live in the most underserved areas. Yet community-based health care provision may offer some chances, as this interview statement shows:

Currently we want Ministry to give us home based care nurses. I know it's not in their establishment, but as a district we feel that if we can have that, it will help us, and through collaboration with COM, because I think they run those colleges in certain towns, they have their own home based care nurses, and the programme is running so well. So we're proposing to the Ministry to say can we take those nurses on our payroll? But we have to keep it solely for home based care component. So they have given us a go ahead that we have that establishment. So our role in HR is just to coordinate. (If11:91)

This example shows that local initiatives for HRH - and alliances of several actors in particular – can be successful. Some sensitivities about the deployment of this new cadre is surfacing in this account. On the other hand, the integration into the MoH establishment assures connectivity with other parts of the health system as well as the longer-term covering of the cadre.

Fostering autonomy

Additional advantages of locally recruited staff and especially of volunteers are often seen in better means of community mobilisation. This is of particular relevance when donor-supported projects are phasing out, as can be seen in this interviewee's account:

We should find alternatives, the community should find alternatives on how they can get these things on their own, without dependence. [...] What happens is that most of our strategies for sustainability, they are meant to convince our donors, so that they can see what we are doing is going to produce results, like we can leave behind and then people can continue. But most of them are academic. (Im5:67)

Sustainability here is described as being in conflict with immediate visibility. This is concerning the visibility of project inputs to the community at the early stages of the project, and the visibility of project outputs to the donors at the end of the project. He admits that the problem already lies in the project proposal: The sustainability strategy has a pacifying and legitimizing function for the donor and is thus essential for the approval.

Development committees at the district level are meant to provide such links with the community. Since in 2009 they were still populated by employees of the district administration rather than by elected representatives, these links are reportedly weak:

And within that district assembly we are supposed to have working committees, one on health and environment, one on agriculture, one on other things. So within this health and environment, we are supposed to have councillors, to look at all issues coming from health sector. //M: so they are like the chairmen of this working group then.// Yeah, they are supposed to be chairmen, without them this committee doesn't work. But the mandate of the zone, later on, is to orient these people on how best they can either support the plan and budget in the health sector, and also that there is indeed issues coming from the community. But from there, we are also supposed to support the decentralised structures through the area development committee, village development committee and village health committees, in coming up with the plans. And these are supposed to be tapped through these structures, where now the District Health Office can tap the initiatives from the people. But that thing is still like a dream, because the structures are weak. (Im16:37-39)

As an important step in that direction, he suggest to have a more intense and participatory planning exercise every three years instead of the current annual planning procedures (Im16:46). Expertise from the health sector with participatory planning is thus supposed to be fed back into the larger political structures. Meanwhile, the development committees can also be seen as a chance for the District Health Office to become part of coordinated action in the district (Im12:46-48).

Although Malawian leaders often call for a stronger donor engagement in varying sub-sectors of the health sector and appreciate concrete assistance, many of them are also sensitive about the issue of donor dependence. The idea that users should pay a flat rate or user fees to generate an income within the health sector therefore appears to be rather popular among the interviewees (Im8:79). At the same time they are aware that accessibility of community health services is better if there are no fees (If21:99). The uncomfortable feeling of being at the mercy of donors partly outweighs the awareness of poverty and constriction of autochthonous resources:

[...] we always say that your expenditures should be within your income. [...] if we have to think within our income, I think we can focus. But because we always think there will be somebody who'll come to rescue us, so we tend to take opportunities. We think somebody will come and give us some money, we'd say it's not enough, so we keep on dialoguing. Lots of time to try and mobilise resources. But if we were to spend within the income that we have, I think we can do it. (If4: 86)

For this interviewee, the performance of health services is thus not a matter of the overall resource levels, but a matter of focusing and maintaining a long-term perspective.

Of course, the major donor investments in the infrastructure and staffing levels of training institutions are also at risk of being discontinued. Even during the field research period, there have been signs of default regarding the financial flows that were agreed to flow into the CHAM colleges (Im2: 112). As for the issue of workforce development, it also appears necessary to foster the commitment of highly qualified staff to engage in training. Simply offering scholarships for Bachelor degrees in nursing education is doomed to failure, if the working and living conditions in rural nursing colleges are not accepted by the graduates (If22: 25). The following interview sequence highlights this potential:

[...] the maternal issues, I think there we're still having problems. Hm, that would mean in terms of human resource, in terms of how we manage our cases, in terms of our logistics. On HR, I'll say maybe there aren't enough nurse-midwives, but they conduct save deliveries in health centres. And also in terms of other specialties - for [name of her city], we don't even have one obstetrician that is trained that belongs to government. [...] I think also in [name of two other cities], most of them are visiting, they come here, they go, they come, they go. And in my own understanding, the way I feel, it's us guys that do really understand our health system, and it's also us that have to make a difference. Because if we can improve on our human resources, I think things would be better. Yeah, that's my suggestion. (If11:103)

It also shows that technical expertise as it can be gained through specialist engagement (e.g. in the form of technical assistance) is not sufficient to ensure the 'reproductive functions' of the national HRH system.

5.2.3 INTER-SECTORIALITY AND GOVERNANCE

The great variety of local, national and international actors operating in health and social fields at the district level is worth examining for potential benefits. Intersectorial aspects move to the foreground when assuming that many projects initiated by NGOs might not touch upon the core activities of the District Health Office (see chapter 5.1.3). The role of the district commissioners and the district assembly is of interest here. Within the scope of decentralisation, the district level is supposed to take over

greater political and also budgetary responsibilities, also for the health sector. At the point of the field research, DHOs already have to get approval the district commissioner for major management decisions (If23:83). Some see the involvement of the DA as narrowing the direct interface of international partners with the District Health Office, slowing down the processes and hindering health-specific collaboration (Im10:58). There is also a concern that these organisations would now only approach the DHO when they need further funding (If11:77, 86-88).

The referral procedures for NGOs that want to operate in the Malawian health sector are thus of particular interest. They first have to address CONGOMA, and also registration is required by law. When CONGOMA redirects the NGOs to the respective sector ministries, it is up to those ministries to negotiate how and where they could collaborate. These requests are then directed to the DHO in the relevant districts, where more detailed arrangements on the co-operation have to be made (Im6:66). The initial point is where the government can exercise most control, while authority is weakened after the NGO is admitted. This is illustrated by the following interview sequence:

[...] now with the SWAP meeting, it's called the SWAP annual review, where everybody comes, they are invited. //MB: Even the NGOs?// Yeah, NGOs are invited. And we also encouraged the districts to have meetings with all the NGOs within their own district; that they'll know what they're doing, that they're doing everything according to government policy or Ministry of Health policy. That was encouraged, yeah. Because some of them have very good programmes, we learn from them. // MB: But are there any Memorandums in place between the Ministry or NGOs?// Yes, there is usually - might be no Memorandum of Understanding, but usually the NGOs will seek permission from the Ministry to come into the country, to do a particular area, and we have to say yes, because we are giving the NGO status. But once they have come, it's still nice to get reports, what they're doing, how they're doing, what problems are there in a district. (Im2: 75-80)

Learning opportunities are mentioned here, but they need to be explicitly searched for. Registration requirements could be used as an entry point for HRH-related agreements, if staffing aspects were focused on at that point

Depending on the international aid agencies' self-perception or presentation of their profile, they might also go through other sectors' structures instead of the MoH. This

could be the case for projects in the field of HIV/AIDS, water & sanitation, nutrition, disaster preparedness and many others. Health-related activities might have considerable overlaps with the work of the Ministry of Agriculture or Ministry of Education, for example. Hence the District Health Office might not even take notice of new international aid organisations entering the district. Local government might take over a monitoring function regarding entry to and exit from the district, and inform the other players concerned, such as the District Health Office. This inter-sectorial approach is in fact more Public Health-oriented than a referral from the MoH headquarters to the District Health Office. While inter-sectoriality has also been a principle in earlier rural development schemes, the new challenge is rather to deal with a multiplicity of private and non-governmental actors.

Developing governance concepts

Official interaction with non-governmental actors in the health field has long been limited to a few larger agencies, notably CHAM. Co-operation usually took the form of budgetary support, i.e. subventions to provide health care in areas that were not covered by governmental services (Im1:127). With the arrival of so many international actors after the Millennium, new governance mechanisms are needed. Legal regulations or other arrangements for composite actors at the national level then also affect the space for stewardship and governance at district level.

Written contracts or Memoranda of Understanding about collaboration between government and NGOs are not common so far, as the previous interview statement has shown. Within the scope of the HRH needs assessment the MoH intended to prepare a standard memorandum that NGOs should sign, by which they agree that they will adhere to the policies of the ministry. However, it appears to have fallen off the agenda (Im6: 72-78). It is also indicated that regulatory policies regarding the movement and recruitment of health workers are not popular:

Unfortunately until now, there isn't really a policy that would be legally enforced. Although, what has been happening and continues to happen is they were saying that, okay, in the event that we have paid for your training you must sign a bond. But I think unfortunately, I've seen those documents, there's no legality to what happens if you don't comply to what you have signed. I mean, you find that after someone has finished their training they go and work in the private sector. And

then you have your bond paper here, the question is how do you enforce it?
(Im6:54)

This interviewee keeps it to the level of individual responsibility and civil service ethics. In his further argumentation he indicates that health workers who move to the private sector deprive poor people of their access to health care, if their salaries have to be financed from user fees. The following statement illustrates the contrary position, calling upon the responsibility of employers:

Yeah, they act as employers, NGOs take nurses, research institutions take nurses and so on and so, but can you blame the nurses? They are going there because they are paying a lot more money. So I do not hold any grudges for anybody. But I think that's unless - an institution comes to Malawi to set up, as I said before - there's a Memorandum of Understanding, and that what we are doing is benefitting the general public at large, then that's fine. When you take a nurse to come and maybe do some statistics instead of her treating patients, then that is waste of a resource. (Im2:128)

Both positions are often reconciled in the argument that keeping health workers in the country and in carrying out their actual job is preferable from losing them to other countries or sectors. Yet ideas of how this problem field could be tackled remain vague. Some more concrete suggestions are put forward in the following interview sequence:

[...] I've seen within the country - it's not necessarily from a specific international NGO, I look at all - in the way that we don't have a policy which controls what package we should be offering to the individuals who are employed by the international NGOs. And this has actually made all the capable, the ones who have skills, competences, from civil service to go into the NGOs. And then it leaves the civil service with no manpower. (If4:60)

The term 'package' refers to salaries plus additional financial or in-kind incentives, such as top-ups, transport allowances, credits, pension and housing schemes. What is notable in this statement is the clear outline of negative consequences, which should be considered by international aid agencies who recruit these health workers. The importance of a functioning civil service as a backbone for health sector development is highlighted.

Allowing for diversity

Clarity often seems to be hampered by the undifferentiated use of the terms ‘public sector’ and ‘private sector’. Organisations operating on a not-for-profit basis (including CHAM) are often subsumed under the ‘private sector’, while the role of profit-oriented organisations and private firms as employers of health workers is hardly mentioned explicitly. The term ‘NGOs’ is also frequently used for bilateral and multilateral agencies, which normally cooperate closely with the recipient government. Im6 tells about his activities in the field of public private partnerships and a presentation that he prepared for an international meeting. Categorisation of actors is certainly difficult in practice and should not be an end in itself. The central message is that health is not a prerogative of the MoH, and so other partners have to come in (Im6:56). However, the objectives and the modes of operation of different organisations deserve a closer look. This appears as a prerequisite for the MoH to develop a concept for interaction with these ‘others’, let alone to regulate their activities.

Also with regard to interacting with the general public, the heritage of the one-party system is surfacing. The MoH is trying to represent many different interests by itself and is increasingly targeted by criticism from the media (Im6:33). A higher degree of organisation among health workers, in terms of professional bodies and scientific associations, might help to avoid intra-individual and intra-organisational conflicts of interest. Such associations may get involved in curricula development, CPD activities and policy consultations (Im13:80). The identification with one’s own profession seems to bear great potential in terms of health worker motivation and performance, as the following sequence shows:

And when we go to national meetings, where we have presentations from all the districts’ environmental health, that issue is always mentioned: where are we in terms of the association? So we know that people are waiting eagerly. //M: But how it comes that people are so eager? // Maybe it has been a trend of issues now, most of the other professions they have associations, so they do have some ideas on the importance of those associations. So they know that in their profession something is lacking, and they are looking forward to have their own. //M: And why is it Environmental Health and not Public Health?// Eh okay, in fact we were Public Health Inspectors. But I know the Polytechnic and the other concerned parties, they thought that just making it Public Health would be generic. Because a nurse can do PH work, or a clinician can do PH work, we can

also do PH work. So to differentiate that, though it's PH work you have to differentiate on the professions. That's why they opted - that's my kind of thinking now - that's why they opted there. Of course we are all doing PH work, but somebody should at least have a known background, like nursing. Ours is environmental health. And the clinicians, maybe they do, clinical officers or medical doctors. So while ours, it was at least identified to be environmental health. PH is general, anybody can do PH as long as they are shifting the focus from hospitals to community based, that's PH. //M: But there is no other association or organisation who is lobbying in that more of overarching area?// There was a PH association, I know, but it's not active. But I think there should be an overarching body that could connect all the interested parties in the PH. I do agree that it's important to have that. Maybe it could be the same EH association that could lobby for that, since our main focus is PH. While our colleagues could be doing PH but could be registered with the Nurses Council of Malawi, doctors are with the Medical Association. While our main focus is PH, so we are in a better position to lobby for that. (Im12:100-107)

It becomes clear that this classical type of professionalisation has a competitive element and bears a risk of fragmentation. At the same time, the integrative potential of Public Health is highlighted, which offers aspects that most professions and occupations in the health field can identify with. The concepts of Public Health and HRH management and development are not commonly combined with each other, as far as the interviews in this study show. Increased interaction with non-health specific actors such as CONGOMA or trade unions might also be fruitful in this regard.

5.3 SUMMARY: MULTI-LAYERED HRH GOVERNANCE

Co-ordinated planning for the health services at district level in Malawi – and its larger conditions – have been the subject of this chapter. The DIP offers a frame of mind and a set of rules for the interaction with other stakeholders to the members of the DHMT. However, international partners would not necessarily be aware of the co-ordinating function that the District Health Office is supposed to take over. This is not only concerning HRH, but health service provision in general. What is missing is a joint understanding of the benefits of co-ordination and the need for negotiating the rules that are supposed to govern their interaction. The complaints mentioned by some interviewees regarding the large amount of worktime that coordination meetings consume, are an indicator of this.

Against this background, the limited awareness of the necessities and chances of joint HRH management in health districts is not surprising. As in any service industry, this can partly be explained by the fact that they rather constitute a means than an end in the economic processes of the health sector. Concerns of the DHMTs rather evolve around the maldistribution of resources and the continuity of services in general. HRH-related outcome variables probably play a role in co-operations that focus on training and capacity building (e.g. filling skill-gaps), but they are rarely mentioned by the interview partners. The overall health workforce performance in the district is not a common subject, let alone a point of orientation. However, being the most relevant resource in quantitative as well as qualitative terms, HRH needs to become a cross-cutting issue.

The absence of monitoring and sanctioning mechanisms in the accounts of the interview partners regarding the co-ordinated planning at district level is another striking finding of the above analysis. According to the IAD-framework (Ostrom 2005), these mechanisms require special attention to enhance the joint resource management. The [OR ELSE] component of an institutional statement largely determines the benefits and costs assigned to an action. At least – on a positive note – repeated interaction of the actors at district level throughout several annual planning cycles might play a role, as it offers the opportunity to build trust and a reputation.

This effect again depends on the duration of funding cycles among international aid organisation and on the rate of staff turnover.

While the District Health Office might shift resources within the scope of the DIP, it cannot recruit or dismiss health workers on its own behalf. On behalf of the international aid organisation, adaptations regarding HRH might also be limited, depending on the hierarchy level of the aid organisations' representative in the district and the tightness of its contracts with donors. In fact, recruitment policies and the balance between appropriation and production of HRH also have to become subject of intra-organisational negotiations, based on respective feedback from the operational level.

Tellingly, the interaction with CHAM at the district level is largely absent from the accounts of the DHMT members interviewed. Service Level Agreements (SLAs), which come closest to an inter-organisational contractual arrangement and standardised tool, are not mentioned at all. However, this might be grounded in the long history of cooperation between CHAM and the MoH, throughout which decisions have usually been made at the national level (e.g. salary subventions). It is also difficult to assign one of the three action situation to this cooperation, due to the special features of CHAM.

As for the 'co-ordinated planning' between the District Health Office and other international actors, however, some opportunities have opened up through recent changes in related national action arenas. Notably the SWAp has brought the installation of technical working groups and other platforms for exchange, including the ZHSOs. The EHRP with its emphasis on lower-qualified health workers has been a shift of attention to the communities and the potential of localised health service provision. Administrative decentralisation, albeit happening at a slow pace, allows for new inter-sectorial governance concepts to be developed at district level. Potential for HRH also lies in greater diversity, if health-specific (e.g. professional associations) and non-health specific actors (e.g. CONGOMA) are getting involved in this field. In the following discussion chapter, the issue of addressing collective and constitutional action problems for HRH will be further elaborated.

6 DISCUSSION: PERFORMANCE AND SUSTAINABILITY

The first decade of the 21st century has brought awareness of a crisis in the field of HRH to Malawi, followed by different initiatives in co-operation with international development partners. The present study has looked into some action arenas, which are often neglected in major interventions at the national level. The focus has been on the interaction of Malawian as well as international actors at the level of the health district. This chapter sets out with a brief summary of findings, which are then extensively discussed in the light of the research question and relevant literature (chapter 6.1).

Research and programme evaluations concerning HRH in Malawi, which have been published since the field research phase, have been gathered and screened after the completion of the analysis (see Annex 7.2). They cover the period of January 2010 to January 2015, complemented by newspaper articles documenting relevant further political developments. These documents are drawn upon for comparison and further critical discussion of the findings in the second part of this chapter (chapter 6.2).

The strengths and limitations of this study are then being laid out, taking into consideration both practical and methodological aspects (chapter 6.3). The integration of different theoretical concepts (economics, political science and development sociology) constitute a novel contribution to the field of Public Health.

The chapter – and the thesis – concludes with some prospects and recommendations for further research (chapter 6.4), arguing for the development of a Public-Health approach for making Human Resources for Health sustainable.

6.1 CRITICAL APPRAISAL OF MAJOR RESEARCH FINDINGS

The major findings from the chapters 4 and 5 are integrated and discussed in the following sections. Findings from other research will be also drawn upon.

- The health workforce in Malawi can be considered as a common-pool resource system consisting of multiple 'species' (professions / occupations). The system shows warning signs of depletion, as reproduction cannot meet the domestic demand and compensate for the attrition (migration, retirement, death).
- Appropriators of HRH are usually composite actors (organisations), who partially cooperate and partially compete for the resource. This appropriator community is characterized by striking asymmetries regarding their dependence on the resource and their autonomy in decision making, especially regarding entry to and exit from the system.
- At the operational level (health district) there is little awareness of the necessities and chances of joint HRH management. Existing arrangements attempt to avoid skill gaps, geographical maldistribution and disruptions of health services, but monitoring is difficult and offenses are weakly sanctioned.
- Decisions about recruitment/dismissal and remuneration of health workers continue to be highly centralised. Yet some opportunities for participation of health workers/leaders have opened up through the SWAp, thematic working groups and within some of the professions.

For the empirical study of a common-pool resource system, Oakerson (1992) suggests to first investigate its status and conditions, and then turn to questions of system design. This means reflecting on how decision-making arrangements can be better adjusted to the physical and technical features of the particular commons. Patterns of interaction between the resource appropriators might be modified to eventually reach better outcomes. These aspects are thus elaborated in chapter 6.1, against the background of the overall research question:

How can the cooperation between Malawian and international actors be regulated with regard to HRH appropriation and production, aiming at a well-performing and sustainable health workforce?

The discussion of findings and suggestions for adjustment are presented along the eight principles of robust governance ('sustainability criteria') put forward by Ostrom and colleagues (see chapter 2.4.2).

6.1.1 CLEARLY DEFINED BOUNDARIES

In order to meet the features of the health workforce in Malawi, specific institutional statements (rules) are required. The biophysical attributes of the resource as well as the availability of relevant technologies for its management need to be considered. HRH can be seen as a complex 'multi-species system' comprising different professions as well as volunteers. Using a renewable natural resource (e.g. a fishery) as a metaphor, it can be stated that the availability and distribution of the resource within the country depends on functioning (re)production as well as a favourable 'habitat'. The former refers to the training and continuing professional development (CPD) of health workers, while the latter refers to the working and living conditions. There are several cultural and economic arguments for viewing HRH as a commons, which are supported by the data presented in chapter 4.

Socio-cultural attributes of the larger community, such as shared values and norms, constitute important exogenous variables to the resource system besides the biophysical and technical conditions (Ostrom 2005). My study has demonstrated that professional practice and labour markets are rooted in missionary activities, colonial administration and state-driven development. Formal professional qualification and socialisation takes place within the national education system. The interviews have shown that the respective professions usually provide strong value systems and are oriented at public welfare. Among Malawian health professionals, such values are often interwoven with a notion of patriotism or at least 'civil service mentality'. For the purpose of analysis and policy-making, it makes sense to confine the territorial boundaries of the HRH system to the national territory, or the sub-units of health administration respectively, i.e. health zones and districts in Malawi.

One important prerequisite for the manageability of the resource according to commons theory is thus fulfilled, namely that it can be geographically circumscribed (Schlager 2004). Obviously, HRH are not a natural resource, but a historically grown

social system. Still, such man-made systems may be considered as commons, as Shivakumar (2005) has argued e.g. for the case of treasuries. In the following it will be discussed whether the economic attributes of the commons apply to HRH. These attributes have been said to be subtractability (or jointness), indivisibility and non-excludability (Oakerson 1992).

Subtractability is particularly relevant to personal and curative health care delivery: The deployment of a health worker in one health facility at a given time subtracts from his or her availability to other facilities and thus to other beneficiaries. Referring to the territory of Malawi practically means that health service delivery largely has to take place in rural areas, where the majority of the Malawian population lives. The mere non-availability of health workers in remote areas and understaffed health facilities are well-known problems in Sub-Sahara Africa (McAuliffe et al. 2008; Muula et al. 2007; Kurowski et al. 2007), and they also have been predominant in many of the interviews in this study. Subtractability in the scope of this study should not be understood as the resource being destroyed at the point of use. However, high aggregate levels of use by a community over a long period are likely to reduce its capacities for replenishment and eventually the yield of the resource system (Oakerson 1992). The wish of health workers for further professional training and qualifications is often incompatible with the large workload in a current job, as some interviewees explained. Official stop-gap measures in Malawi, such as after-hour private practice, locums and overtime work (Muula and Maseko 2006) are likely to contribute to the depletion of the HRH system as well. Careers in teaching and tutoring appear comparatively unattractive, especially at remotely located technical colleges, as one interviewee made clear. This is additionally hindering the scale-up of health worker training.

Indivisibility as an economic criterion mainly refers to the question whether the resource units could be submitted to private property instead of being treated as a commons (Oakerson 1992). In strictly biophysical terms, human resources for health are divisible into the minimal unit of individual health workers. While those might enter into work contracts, they will not be at the unrestricted disposal of their employer, however. Such contractual arrangements are prone to principal-agent-

problems – workers might well decide to use their time in other ways than their contract requires (Sesselmeier and Blauermeil 1998). In addition, work is not physically confined to a certain location. Workers can make themselves available and provide their skilled labour in very distant places with the help of modern transport and communication technologies, as found e.g. with the consultants in this study. Urry (1991) has pointed out that this flexibility of time-space-distantiation is a distinct feature of modernisation and globalisation in the thought of Anthony Giddens. The non-availability health workers is thus closely related to technologies at hand and to personal decisions about allocating time and attention. While health workers cannot be ‘owned’ by an employer, their knowledge and skills are seen as their own individual property in standard economic theory (Becker 2009). Their status regarding divisibility is therefore ambiguous.

Limited excludability as an economic attribute makes common pool resources vulnerable to overuse. In a market of private goods, exclusion usually occurs by withholding the good unless a certain price is paid, which is meant to at least cover the production costs. For a commons this means that the costs for the maintenance and reproduction of the resource system need to be shared among its beneficiaries (Oakerson 1992). My study has paid particular attention to the practices in ‘international development business’ regarding the recruitment, contracting and deployment of local personnel. The data shows that they open up opportunities for professionals to develop their individual capacities and increase their income at the same time (see chapters 4.3 and 4.4). The consequences for institutional capacity in the overall health sector have been debated under the term ‘internal brain drain’ (Ferrinho and Van Lerberghe 2000). As another metaphorical reference to natural resources, the negatively connotated term ‘poaching’ has been used by some interviewees to describe international agencies actively recruiting health workers from governmental services.

The findings of the study show that it is difficult to exclude potential employers from appropriating HRH in Malawi (see chapter 5.2.3). The national health system is now being populated by a great variety of global, national and local agencies. At the same time, cost sharing for training of HRH is rarely taking place. Also most of the

interviewees see the initial training of health workers as a task of the government and CHAM. Within the scope of the Emergency Human Resource Plan (EHRP), some attempts have been made by larger donor organisations to pool funds for enhancing training capacities. Thereby they are still adhering to the general principle of government provision, while the large majority of NGOs does not participate. Some NGOs provide for the tuition fees of individual health workers. However, the question remains how such cost-sharing can be systematically imposed.

Boundary rules would normally take the form of registration and respective membership duties. A major limitation of these registration requirements for international and non-governmental actors entering Malawi is that they are not being enforced in the first place. This indicates a free-rider problem: the resource system cannot effectively be defended from unauthorized appropriators. Participating organisations may also decide freely about exiting from the action arena, which restricts the power that other participants can exert over them (see Ostrom 2005, p.199, Gibson et al. 2005). However, related interview statements in this study also indicate a lack of transparency of juridical requirements. Even from the entries in the CONGOMA registry it is not clear under which legislation the respective organisations are established. CONGOMA membership and registration with the NGO board are apparently not congruent.

6.1.2 PROPORTIONAL EQUIVALENCE BETWEEN BENEFITS AND COSTS

Institutional arrangements for HRH development and management need to consider the features of the resource outlined above. Incentive structures for the resource appropriators result from the nature of the resource and from available technologies relevant for its use. The most striking feature, which surfaces in the literature on the health workforce crisis and in the data analysed, is the fugitiveness of the resource (see chapter 4.4). Many interviewees do not see a major problem in health workers opting for employment in the non-governmental sector as long as they still provide the services that they have been trained for and remain on Malawian territory.

Avoidance of attrition should therefore be in the focus of collective action between governmental and non-governmental actors in the health sector. This is referring to

attrition to other sectors (e.g. agriculture or commerce) and to foreign countries, but also illness and death due to HIV infection. However, the emphasis currently appears to be on scaling-up the production of the resource by fostering pre-service training. The employment and deployment practices, including the avoidance of overuse, are comparatively neglected. Contributions to (re-)production by smaller organisations appear most practicable in the field of continued professional development. In this respect, the Global Health Workforce Alliance (GHWA) has called for better integration of state-provided education, on-the-job training activities and supervision (Task Force for Scaling Up Education for Health Workers 2008).

It has been criticised that using the economic term 'human resources' depersonalises health workers, who should rather be seen as human beings with psycho-social needs and individual capacity for decision-making and action (Segall 2003). However, these individual human needs have to be systematically provided for in the workplace, which requires a managerial perspective (Simmonds 1989). The World Health Report 2006 lists four job-specific levers which may influence health worker motivation and performance: developing clear job descriptions, supporting norms and codes of conduct, matching skills to tasks and exercising supportive supervision. The importance of an enabling work environment is also highlighted, which includes the promotion of life-long learning, effective team management and combining responsibility and accountability (WHO 2006b). These will be discussed in the following as costs to employers in relation to the benefits which they derive from their employees.

Basic support systems, such as medical supplies and equipment, facility maintenance and housing, are needed to allow health workers to do their job at all. While this is not in the hands of the district level manager alone, some DHOs in this study indicated that they were sensitive regarding the hardships of health workers posted in remote areas. Within their decision-making range of devising rotation schemes and rosters, and of allocating physical resources such as solar panels or vehicles, they tried to influence the incentive structures for these health workers. Such non-financial incentives for retention in rural areas have been reviewed by Dambisya (2007) for example. He

concludes, however, that they need to form part of a longer-term strategic plan to unfold larger effects.

Supervision has usually been mentioned by interviewees in this study as their major HR-related activity (see chapter 4.4). In the governmental health services, as their accounts show, the emphasis in these activities continues to be on disciplinary control and on producing data for health reporting. While this might contribute to the adherence to norms, Segall (2000) maintains that a lot could be reached if supervision was provided in a more supportive manner, with managers listening and also attending to the problems of their sub-ordinates. Manafa et al. (2009) have shown that health workers in supervisory positions in Malawi – besides their limited numbers and problems of geographical coverage – are often not sufficiently prepared and trained for this. Hence, they do not see the motivational potential of feedback on performance.

Professional development – or the lack of respective opportunities – are frequently mentioned as a major demotivating factor to adhere to a certain job (Manafa et al. 2009). While managers at district level interviewed in the present study lament that their recommendations of staff members for further training often remain unheard in the MoH, they frequently initiate activities in this regard in their district (see chapter 4.4). In-service trainings and joint discussions of practical cases during ward rounds are just a few examples, from which they often benefit themselves in terms of job satisfaction and gaining professional experience. Awareness of different modes and options of CPD – other than formal training - need to be risen among staff members and managers alike, to make full use of its motivational potential (Muula et al. 2004).

Teamwork is not only a matter of optimal utilization and combination of available skills (Zurn et al. 2004). A team approach to problem solving can also foster social cohesion at the workplace, as Becker (2009) explains. Among the interviewees in my study, the idea of interdisciplinary collaboration does not appear to be widespread - with the exception of the work within the DHMT as such. Instead, thinking along the lines of the established cadres within the MoH with their distinct technical tasks is still very prevalent. Not only the clinical and non-clinical staff members appear to be poorly integrated; there also seems to be little appreciation of the contributions which

community-based health workers (and also volunteers) can make in health care provision to a given population. On the other hand, the insufficient level of qualification of health workers regarding the enormous tasks they are effectively facing is scarcely mentioned as a matter of concern (see chapter 4.2).

It becomes clear that there is still much room for improvement in terms of HR management within organisations. On the other hand, this also requires a longer-term perspective of employers for their operations within Malawi. If an NGO is predominantly working on a project basis, the short-term benefits of employing highly skilled health workers are in the foreground, and often higher salaries can be paid for a limited time period. If it cannot ensure the continuance of its activities in a certain field, it should make sure that it cooperates with steady players such as the MoH or CHAM in HRH development. Considering the acute shortage of labour supply, the question arises whether there are modes of HRH usage that allow for the MoH and other agencies benefiting from the same health worker. A prominent approach mentioned by the study participants are research and management consultancies, which health workers and experts are officially allowed to carry out during their leave. Such consultancies usually include some field work or other physical involvement, which require geographical mobility and transport, but data analysis and report writing can be done on a personal computer at any place and time within a given time frame. In the literature, various examples of 'sharing' human resources among employers can be found. Muula and Maseko (2005) or Israr et al. (2000) name part-time work for different organisations, or 'moonlighting' in private practice.

Marketable expertise is becoming ever more important in a country like Malawi in the context of international development aid. For the implementation of complex capacity development strategies, donors rely heavily on experts and technical assistants from the donor countries. Stubbs (2003) explains that they often link grants and credits with technical assistance and make sub-contracts on the basis of competitive tendering. He assumes that this has given rise to the plethora of consultancy agencies, NGOs and other non-state actors operating locally and transnationally. As I also found during my field research, donors are now increasingly referring to local academic institutions or individual researchers when contracting out assessment and evaluation studies (see

chapter 4.3.4). This appears to be in accordance with the envisaged self-reliance of recipient countries within the paradigm of capacity development. The fact that higher academic qualifications such as the MPH degree at the COM are usually designed to prepare graduates for management and administration, or research and teaching positions respectively, is likely to support this development. Yet in this respect graduates from social sciences and business administration may also qualify, which enlarges the pool of available HR for such tasks considerably.

Income levels appear to be the critical point at first view. From the perspective of the individual health worker, the most acute problem is the insufficiency of income in relation to the cost of living and of making themselves available at the workplace. Interviewees name higher salaries as the most important factor for health workers to seek employment with an NGO or private clinic (see chapter 4.4). Yet again, the cost-and-benefit-calculation of taking up and adhering to a particular job would include not only the immediate financial and material compensation. As Steinwachs (2006) has pointed out, the possibilities of maintaining contacts with the family and of accessing other sources of income – either in parallel with the on-going job or afterwards – also have to be considered. According to Anders (2002), this explains why health workers might decide to remain in the civil service despite very low salaries, but they are often busy with generating other income during their work-time. Especially in the health sector, civil service positions offer long-term job security together with relevant ‘business contacts’, including international aid agencies and NGOs (Ferrinho and Van Lerberghe 2000; Israr et al. 2000; Muula and Maseko 2006).

Clinical specialisation is still in its beginnings in Malawi. Nevertheless, employment in research positions within NGOs, international trusts and universities is on the increase. A number of internationally funded clinical research projects are carried out in the country, often in collaboration with the University of Malawi, and predominantly focused on HIV/AIDS. In the international discourse on ‘brain drain’ (Kupfer et al. 2004), such approaches have been proposed as a possible means to retain academically qualified staff in the country and re-attract scientist who went abroad. Zijlstra and Broadhead (2007) expect that this will also contribute to the capacity and sustainability of HR production by the College of Medicine, with Malawian staff

gradually taking over the teaching positions from expatriate experts. This would match the career expectations of the younger clinicians in this study very well (see chapter 4.2).

Community-based health workers are also of interest, as an alternative to formally qualified employees. Task-shifting to volunteers or cadres with minimal qualifications is often criticised from the governmental as well as from the professional side, and partly from trade unions. This is regarding unsolved questions of quality assurance and claims for higher remuneration (Lehmann et al. 2009). A large pool of workers with minimal qualifications and without prospects of further occupational development could be tempting organisations to save on the salaries. It has been argued that paid and qualified labour should be referred to wherever possible (Health Alliance International 2009; Lehmann et al. 2009), which would increase the impact of development aid on the national economy. Proponents of voluntary approaches have countered that the commodification of services may not only erode value systems, but may also have landslide effects and lead to ever increasing financial demands on behalf of the providers.

CHAM and CBO representatives in this study have highlighted the importance of community volunteers as HR in order to carry out their work, but also as a matter of humanistic or religious principle (see chapter 5.2.2). A local membership base can play a vital role regarding the penetration, continuance and reach of services. This does not mean that incentive structures are disregarded – the interviewees consider offering small material allowances to the volunteers as useful. Also, investments in training are said to remain an important aspect in volunteerism. One interviewee views training and education as the most suitable and also long-lasting rewards that his organisation can offer to its volunteers. This indicates how in an impoverished community with low levels of general education, volunteering provides access to some kind of income and possibly of a ‘career’, albeit in very modest terms.

Permeability and connectivity with the formal education and qualification system appears essential for all kind of health occupations as well as for volunteers. These are often not given for intra-organisational and task-specific training systems for volunteers. The Malawian government has taken a different approach, by assimilating

Health Surveillance Assistants (HSAs) as a formal MoH cadre (see chapter 4.1.3). Thus HSAs may acquire senior positions and – at least in theory – opt for further qualification in the environmental health section. With the focus on the delivery of an essential health package to the communities, this cadre is carrying a large share of the workload and the number of newly trained HSAs has starkly increased. It has been highlighted by interviewees in my study, though, that this has not been backed up by adequate supervision and that intermediary positions with a supervisory function are even being reduced and respective training schemes in Malawi are suspended. As McAuliffe et al. (2009a) have found out for mid-level providers such as clinical officers, career paths which turn out to be blind alleys can become a major source of demotivation. Supervision and further training thus also need to be taken into consideration if international aid agencies want to make use of low-qualified cadres and volunteers. The health district in general appears to be the appropriate arena for respective cooperation. Rules and regulations agreed at this level can influence the incentive structures for resource appropriators and thus the patterns of interaction.

6.1.3 COLLECTIVE-CHOICE ARRANGEMENTS

The various practices of topping-up income mentioned above contribute to an increasing intransparency regarding the actual incomes of health workers. This is of concern for employers, health policy makers and fiscal authorities alike. It is also widely assumed that these practices subtract from the time and effort that health workers put into their actual public sector jobs and thus constitute a form of internal brain-drain (Ferrinho and Van Lerberghe 2000). On the other hand, it has been stated that the non-governmental and private sectors are here to stay, and ways must be found to deal with them. In the absence of adequate remuneration and acceptable working conditions, which are prevalent in the public sector of many developing countries, moralising would be of little use (Van Lerberghe et al. 2002). Opportunities for income top-ups may help to retain highly qualified health workers in public employment and within the country. However, this also requires greater transparency and clearer rules, which should be discussed in the professional and international community. Those organisations which are considered legitimate appropriators of HRH

in Malawi thus have to make inter-organisational efforts in HRH management and governance.

District level arrangements for joint decision-making, and how these might affect the structure of incentives for the actors, have been in the focus of this thesis (see Oakerson 1992). Chapter 5.1 suggests that it would take some form of contracting - in the broadest sense - to regulate HRH utilization in Malawi. Contracting in this field needs to be oriented at priority health needs of the population. Speaking in terms of the IAD framework (see Ostrom 2005), rules need to be confined on how HRH in a specific setting may be appropriated, and who is a legitimate user of the resource. Perrot (2006a) sets out a typology of contracting by governmental health authorities, in which he distinguishes contractual relations based on (a) delegation of responsibility, (b) an act of purchase and (c) cooperation. The category (c), which applies here, is characterized by a framework containing respective aims and means of the cooperation. It is further divided into weak and strong organizational interpenetration agreements, the difference lying in the degree of autonomy that each party maintains in its practical operations. He emphasizes that contracting is actually much more diverse than a contract in its legal sense, and that contracting is not to be equated with privatization (Perrot 2006b).

Given the long-standing oligopoly of the MoH and CHAM regarding health service provision and their highly centralised approach to HRH management, it is not surprising that the system is disturbed with the arrival of so many potential employers. So far, experiences with inter-organisational contracting for health service provision appear to be limited in Malawi. The most prominent examples are probably the Service Level Agreements (SLA), by which District Health Offices are meant to buy in essential health services from CHAM facilities within the same district. Yet they were only mentioned by one interviewee and no published literature about this issue could be found, let alone on contracts between international NGOs and local providers. This does not come as a surprise, however, since such arrangements are usually handled confidentially.

Organisational interpenetration of the stronger kind is only possible with a limited amount of partner organisations, though. Unger and Paepe (2007) have argued that

for disease control interventions on specific ailments such as HIV/AIDS, malaria and tuberculosis, particular attention needs to be paid at integrating them with general health care provision in the public sphere. Otherwise these strands of health care would not only compete for scarce resources, but also risk insufficient levels of service utilization. For other types of interventions, especially non-personal health services, Boelen et al. (2007) suggest that a coordinated approach by rather autonomous organisations could be expected. Of course, the procedures of District Implementation Planning (DIP) principally do provide an arena for negotiation and joint decision making of discrete actors, i.e. contracts of cooperation. This may involve the allocation of various kinds of resources, including health workers (see chapter 5.1). According to a manual by Görden et al. (2004), annual district health planning should ideally cumulate in a document accepted by all parties, which include local community or municipal authorities, MoH, donors and NGOs. Tellingly, their commitment to the plan is included under 'risks and assumptions'. Competition for HRH is not mentioned in this manual, although staff allocation is supposed to be given central attention in the planning process.

As described in chapter 5.1, international aid agencies might choose different strategies for implementing their activities within health districts, i.e. the intensity of cooperation with the District Health Office. Besides managerial strategies, it is also necessary to look into possible modes of HRH appropriation and (re)production, and what 'shared use of HRH' between different organisations might look like. The rules concerning HRH, which are agreed upon at the district level, may include arrangements on salary levels (and possibly salary top-ups for health workers in local services), coordinated planning and deployment of staff, as well as joint training frameworks and supervision. Indirect implementation through consultants or CBOs is likely to increase against this background. The mode of HRH utilization that the agencies predominantly pursue, i.e. the work contracts or agreements made with individuals, also need to be considered. These might differ between the professional cadres or the level of qualification of the health workers. A further increase in knowledge work is likely, taking the form of consultancy contracts. Organisations searching for consultants should carefully choose between health professionals in the narrower sense and individuals holding other qualifications.

Decentralisation of public services, including health care, has been stipulated in the Malawian Local Government Act of December 1998. At the point of my field research, the consequences of decentralisation were noticeable for the interview partners. The responsibility of directing NGOs to where they are needed had been officially shifted to the District Assembly, and budgetary decisions had to be counter-signed by the District Commissioner (see chapter 5.2.3). In the absence of local elections it is questionable whether this constitutes a democratic gain. (In this respect, Bach (2000) is differentiating between political and administrative decentralisation.) Some members of the DHMT experienced it as a loss of control. However, it may be useful for integrating health with the broader district development and keeping an eye on neighbouring work fields such as education, HIV/AIDS, nutrition or environmental preservation. According to Schroeder (2000), various sources of funding are expected to be made available to the District Assemblies, in order to back-up the Local Government Act. This included the devolution of budget funds from the central Malawian government as well as the Malawi Social Action Fund (MASAF). In 2009, the budgetary devolution had not been fully enacted yet for the health sector.

From the perspective of the District Health Office, the DIP procedures require that the District Assembly participates, together with other stakeholders in the field of health. This could provide a starting point to establish an arena for negotiating rules of cooperation between domestic and international actors, with regard to HRH and other resources. As for the Kenyan health system, which has a very similar administrative structure to the Malawian system and is also subject to a decentralisation policy, Owino et al. (2001) call for establishing a stakeholders' forum at district level. According to the authors, this could serve to integrate the efforts of local government, donors, NGOs, the community and the private sector, with the District Health Management Board being the node of interaction. They expect that such a forum could lead to "the formal unification of each stakeholder's health care inputs e.g. plans and budgets at the district level", and that interactions could "build up to a threshold that would guarantee continuity and sustainability of programmes" (Owino et al. 2001, p.25). They admit that substantive policy interventions are required for this and outline some of the laws to be reviewed. However, the actual scope of this endeavour, and the incentive structures for stakeholders to join in, remain unclear.

Inter-sectorial development approaches at district level may in fact bear some advantages for NGOs over a narrower health-sector specific approach. As shown in chapter 4.3.3, health usually constitutes but one of several fields of activity for these organisations, with varying emphasis. Defining inclusion criteria for NGOs to join a health-specific development forum would be somewhat arbitrary. It might unnecessarily exclude well-resourced stakeholders from making an input. Where broader environmental, economic and social determinants of health are to be taken into consideration, it would even be counter-productive. International aid organisations or intermediary NGOs wishing to start operations in a district need to go through initial registration procedures and acquire allowance by the District Assembly anyway. They should be requested to join a multi-sectorial forum at this point, if the aim is to pool external resources in order to produce public goods. However, the HRH system is facing somewhat different challenges, namely depletion caused by unrestricted access of appropriators, which is often described as the 'commons dilemma' (Dietz et al. 2003).

Inter-organisational collaboration on HRH at district level can only evolve if the boundaries of the system are regulated. One option for the point of entry would be for the District Assembly to request insight into the staffing profile of organisations or their projects and screen them for formal health qualifications. District Health Offices should be informed if these qualifications are named in the profile (even if the positions are filled by expatriates). They may use this standard situation to enter into further negotiations, e.g. regarding skills transfer, supervision, payment schemes or secondments. Such a boundary rule would raise awareness for existing HRH problems and also provide incentives to possibly refer to staff qualified in other areas. Interaction could be institutionalised in the form of contracts or memoranda of understanding which explicitly contain rules for HRH governance, as an action variable or outcome variable in terms of the IAD-framework. Introduction at a later stage, as the different players will settle into their individual modus operandi, might be difficult but not impossible. Negotiations should also include rules for exit from the arena, e.g. what is to happen to local employees when a project ends. The inter-sectorial collaboration at the district level bears some uncertainties for DHMT members, but placing a monitor at the District Assembly to specifically watch over entry and exit

could also relieve the DHMT from some of its vast monitoring duties. This will be discussed in the following section.

6.1.4 MONITORING

The increasing numbers of NGOs and private-for-profit organisations operating in Sub-Saharan Africa have been accused of fragmenting health care delivery (Pfeiffer 2003; Barber and Bowie 2008). For example, the short-termism inherent in project-based operations often does not allow for proper skills transfer. However, Pfeiffer (2003) reports the development of local codes of practice for NGO interventions in the health sector of developing countries, which he counts as an indicator of a growing awareness among development workers themselves.

A voluntary code of conduct has also been developed in the international NGO community and launched at the first Global Forum on HRH in Kampala in 2008 (Health Alliance International 2009). It is offering some guiding principles to reduce unintended harm to national health systems, starting with the recognition that the presence of foreign NGOs in developing countries is temporary. In article 1, it condemns direct hiring of health workers from public services and recommends the following:

“In places of scarcity, on rare occasions when NGOs hire health staff already working in the public sector, NGOs pledge to do so in coordination and with the consent of local health authorities. This coordination will be accompanied by a commitment to expand overall human resource capacity in the public sector through pre-service training, salary support and/or other means. Governments and NGOs should work collaboratively to address the chronic underpayment of health workers in all sectors.”
(Health Alliance International 2009, p.5)

The code indicates a number of possible rules with specific reference to HRH performance and sustainability as an outcome. For example, financial support of NGOs to colleges and universities training health workers could be considered a kind of ‘user fee’ for the national HRH system. In the terminology of the IAD framework, this would

constitute a choice rule. However, further details on the governance and management options at local level are not given, except for the option of salary support.

Adherence and default of organisations regarding such codes and memoranda of understanding subsequently need to be monitored. According to the IAD framework, monitoring should be regular in order to effectively back up the set of rules. In robust governance systems, the monitor would rather be selected and/or hired by the participants. Another option is that all participants engage in mutual monitoring. It is deemed important that the monitor is familiar with the local conditions of the resource system and is accountable to all appropriators (Ostrom 2005, p.265/266). In the case that HRH is actually picked as an explicit focus of cooperation and rule-setting, the existing MoH regulations point to the District Health Office as the 'natural monitor'. Given the principal position of the District Health Office and its interests as a major resource appropriator, it would benefit from taking over the monitor's role in terms of acquiring relevant management information for its own operations and reporting duties (see chapter 4.3.1).

Information flows regarding the provision and use of resources within districts, however, have been highlighted as a major problem by the interviewees (see chapter 5.1.3). This might be explained by underlying fears of non-governmental partners - who also have other contractual obligations such as project funding agreements - that their own interests will be neglected. Problems are likely to arise from the triple function of the District Health Office: provision of health services (i.e. appropriation of HRH), coordination of actors in the district (i.e. leading function) and monitoring the overall performance of these actors (i.e. health reporting). With regard to reaching the best possible deployment of health workers to improve population health within the district, these functions may be conflicting. It is debatable whether the District Health Office is the most suitable participant in the action arena to monitor the cooperation and execute sanctions. It should be considered whether such functions could at least partly be taken over by NGOs, or by external players such as the District Assembly.

HRH-related indicators – in terms of data quality and availability – are a related problem field, as shown in chapter 4. NGOs and international aid organisations often operate in an indirect way, e.g. through consultancies, funding and sub-contracting.

Hence, they play an increasingly important role as employers or contractors of health workers, but exact quantification is difficult. For example, among the six categories of composite actors in HRH which can be identified from official Malawian documents, the assignment of international aid organisations (governmental or non-governmental) remains unclear. Increasing the level of information available to the appropriators of HRH is an important prerequisite for joint sustainable resource management (Schlager 2004). Such information would have to include the status of the resource system and the actions taken by the other appropriators.

At the national level, the 'HRH Action Platform' provided a small, but task-specific forum for national as well as international actors at the point of field research (see chapter 5.2.3). This forum included individuals as well as representatives of organisations. While it had no explicit function in Malawian health politics, it had multiple links with the operational level within Malawi as well as with international arenas (e.g. WHO). The negotiation and enforcement of information rules could still be a major function of this arena in the Malawian context. Such a forum may back-up change processes in the Malawian HRH system with knowledge and information from both sides, which means to incorporate the principles of multi-layered and global governance (Bartsch and Kohlmorgen 2005; Hein et al. 2007; Dietz et al. 2003). In considering HRH as a multi-layered system, where actors (leaders in particular) are moving between related action arenas at the local, zonal, national and even global level, the advantages of large-scale and small-scale approaches can be combined. It has to be noted, though, that the 'HRH Action Platform' constituted a collective-choice arena with a low degree of institutionalisation at that time. To upgrade the scope of action for such an arena, e.g. to turn it into a monitoring board, it would be necessary to initiate changes at the constitutional level (Ostrom 2005).

6.1.5 GRADUATED SANCTIONS

The question of sanctioning in case of detected rule breaking is even more difficult for the District Health Office than the question of monitoring. An example of such default would be an NGO enticing a qualified health worker away from a governmental health facility despite a 'no-poaching-agreement'. As the cooperation at this level remains

quasi-voluntary, the District Health Office would have to fear the exit of the offender (i.e. the NGO) from the arena, probably with negative consequences for the overall resource input into the district. Despite all difficulties of interaction, the large majority of DHMT members interviewed have highlighted the importance of these resources. Such dilemmas may lead to ineffectiveness of existing memoranda of understanding.

Quasi-voluntary commitment to rules for common-pool resource management also needs to include monitoring and sanctioning arrangements which all parties are committed to. Ostrom (2005) points out that such commitment may not only bring image gains, but help organisations to be sure that they sustain the joint basis of health care and that their actions are not detrimental to their partners. If an alliance regarding the issue of HRH is achieved at district level, it might increase the moral pressure on non-cooperating organisations. First-time sanctions could come in the form of notification and publication of the default; harder measures would be announced in case of repeated default. According to Ostrom (2005, p. 267), such graduated sanctions signalise to the defaulter that the other participants in the action arena still extend their trust and would appreciate continued cooperation. In the absence of coercive mechanisms, as it is the case in the Malawian health sector, individual approaches to sanctioning are necessary to build mutual trust and accountability.

Value systems and norms are already well established in the field of health (see chapter 4.1). Some professional boards and associations have long existed (e.g. the Malawi Medical Association or the Council of Nursing), to guard professional standards. New associations, e.g. in the field of environmental health, are now being created. Although a broader and interdisciplinary approach among health workers is still missing among these associations, community medicine and Public Health have found their way into the curricula of various occupations and professions. Public service values - in the sense of a strong loyalty to the MoH as an employer - could also be observed in this study, most notably among the older interview partners (see chapter 4.4). This might partly be due to their socialisation under the strong discipline and indoctrination by the Banda regime. In addition, they apparently have not been victims of the civil service reforms and staffing reviews during the period of political

transition and economic liberalization, which were driven by the IMF and the World Bank (Anders 2002). Among the younger interviewees, especially doctors trained at the COM, the benefits of civil service enrolment were again highlighted. Besides career prospects, serving the Malawian population was frequently mentioned as a value. Such public service ethics, rooted in professional standards and intrinsic motivation, have been said to outweigh any external incentive schemes (Segall 2000; Gilson et al. 2005; Pangu 2000). However, these authors also warn that values may be eroded by adverse conditions such as the prevailing under-funding of health systems.

Action situations in which District Health Offices and international actors can negotiate their own rules should draw on this moral capital. The organisations need to re-consider the costs and benefits connected to the different choices of HRH appropriation and HRH reproduction and the strategies they want to pursue. A greater awareness of the threat of HRH depletion, and possibly their own contribution to it, would be a primary result. This can be drawn upon when it comes to modes of sanctioning. Hence, it seems possible to share the burden of HRH-specific monitoring and sanctioning among the different participants within a health district.

6.1.6 CONFLICT RESOLUTION MECHANISMS

Boundary rules regulating the entry and exit to the arena require special attention. The same is true for conflict resolution mechanisms in case of dispute over rule interpretation. The potential of the structures that have already been created or revitalised in the course of decentralisation in the Malawian health-sector, notably the Zonal Health Support Offices (ZHSO), should be considered for HRH governance.

Highly centralised systems are a heritage from former colonial administrations in many African countries, and governments adhered to this structure after independence to ensure political stability and economic development. According to Bach (2000), such systems have often been criticised for being too distant from service users and too insensitive to local labour market variations. The private sector, where management competencies are usually located closer to the operational level, is believed to be more adaptable and thus more efficient in this regard. Consequently, Bach (2000) states, decentralisation has been an important component of donor-driven structural

adjustment reforms. At the point of field research in Malawi, the provisions of the Local Government Act of 1998 were slowly gaining momentum, with first observable effects on the district health system (see chapter 5.2.3).

HRH management competences, however, continue to be centralised at the MoH headquarters in Lilongwe. This study has found that decision making competencies of individual leaders at the district level regarding HRH within their own organisational context are usually limited (see chapters 4.4 and 5.2.1). Similarly to the situation in Kenya, staffing schemes as well as recruitment and dismissal are in the hands of authorities at national level, i.e. the MoH and the Public Service Commission. Owino et al. (2001) have recommended in their Kenyan study to devolve these competencies to the provincial and the district level, depending on the grade of the health workers. This would include performance appraisal and promotions, continued professional development and disciplinary measures. Respective plans were also discussed for Malawi at the time of field research, as lengthy recruitment procedures at central levels were perceived as a major bottleneck for more adequate staffing levels in the health sector (Ministry of Health et al. 2007). With regard to HRM, great expectations of the international community are also put in establishing an autonomous status to central hospitals.

From the perspective of public sector managers, the issue of decentralisation is often ambivalent, as McIntyre and Klugman (2003) explain: While they principally appreciate greater autonomy, it also means that their workload increases and new intra-organisational conflict lines open up with regard to authority and resource distributions. Pangu (2000) states that studies on decentralisation from a range of African countries have shown dissatisfaction and resistance of civil servants regarding these reforms, as they mean a loss of power and predictability to the individual health worker. Furthermore, sector-specific administrative decentralisation requires enhanced management capabilities at remote levels, which are often lacking.

Supervision and advice to the District Health Offices are the major task of the ZHSO team in their geographical zone, while the in-line managerial function within the MoH was still weak at the point of research (see chapters 4.3.1. and 5.2.1). Regarding the cooperation with private and non-governmental employers of health workers,

particularly international agencies, the ZHSOs may still have a role to play. Each of these offices is in charge of several districts, which might coincide with the districts of operation of an NGO or international aid organisation. Therefore the ZHSO would lend itself to developing nodes of expertise in HRH management and development, to advise the DHMTs as well as other organisations.

Mediation between the central and the district level is another function of the ZHSO. While a ZHSO does not usually maintain its own partnership with international aid agencies, it often facilitates the implementation of national level agreements (see chapter 5.2.1). Meetings at the zonal level may involve agencies such as the regional medical stores, CHAM dioceses or central hospitals, which are otherwise excluded from exchange platforms. ZHSO staff is also in a position to compare the working cultures and modes of operation in different districts. Hence, they could also become a conflict resolution arena in case of conflict between two organisations in a district, or between an organisation and the designated monitor. Such mechanisms are considered essential in common-pool resource governance (Dietz et al. 2003). The presence of donor-funded technical assistants in the ZHSOs may increase the confidence of international agencies, as perspectives might be more balanced.

It has to be noted that in 2009 the technical assistants were waiting for their MoH counterparts to be posted to the ZHSOs in several instances. This may indicate a mere lack of personnel, but also some resistance of individuals at higher levels of the bureaucracy to be posted away from the urban centres (Van Lerberghe et al. 2002; Pangu 2000). Even the backing through salary support by donors (see Van Lerberghe et al. 2002) in this case does not seem to provide sufficient incentives. Of course this puts into question the longer term success of the ZHSOs. On the other hand, enhancing their advisory function and their responsibilities in terms of conflict resolution might also contribute to their acknowledgement.

6.1.7 MINIMAL RECOGNITION OF RIGHTS TO ORGANISE

In order to achieve active coordination and joint rule setting, leaders at district level need to work together on a quasi-voluntary basis, albeit within the scope of their job. Hess (2011) has pointed out that the rule systems created and maintained by such

joint action are a public good by itself. This means that individual participants' investments of time and effort hardly pay off directly, since potential users or beneficiaries are hard to exclude, and 'consumption' is not subtractive. Health workers and experts may voluntarily share their knowledge and skills for a common purpose, e.g. on the basis of professional values or feeling accountable to the local population. Work-time arrangements and contracts should give some leeway for information exchange and knowledge sharing, coordination and joint action. Employers and contractors of health experts and leaders could support the self-governance of the HRH system this way.

Threats to such voluntary engagement come from two sides: First, an authoritarian or paternalistic state is likely to limit the influence of other associations or organisations. Second, there is a risk that this motivational potential is undermined by the contracting practices of the consultancy business. Insecurity within planning processes leads to an unbroken demand for expert advice. Knowledge is being commodified in this context; it is produced within a market logic and thus underlies organizational or personal interests (Evers et al. 2003). For example, a competitive spirit impedes efforts to improve the quality of health reporting for a particular geographical area and population, as information and knowledge may become 'commercially sensitive' (Bach 2000).

Post-modern working conditions have arrived in the field of HRH in Malawi (see Brose 2000). Private and non-governmental organisations are taking an increasing share among the employers, often offering time-limited work contracts under international funding. These have been conceptually linked with an ideology of 'professionalism' which is detached from the classical professions. Such post-modern professionalism neither refers to organizational hierarchies nor to autonomous control by professional bodies, but it operates through internalisation of market-orientation by the workers themselves (Evetts 2006; Kuehl 2009). My study has shown that private practice and consulting in Malawi are on the increase. This indicates that individuals market and manage their skills on an ad hoc basis to maximise their income through self-employment.

Separating the resource from its appropriators is often not possible in the case of HRH. Employer representatives and leading managers are usually health workers themselves, which is a logical difficulty of applying commons theory to the system HRH. The more so, arenas for exchange and reflection are needed to find ways of integrating the collective perspective of organisations providing health services and the individual perspective of achieving a decent livelihood and a professional career. Values such as sustainability and equitable health service provision, which were mentioned in the interviews, should inform managerial as well as personal career decisions. The concepts of leadership development, as they can be found in the broader development literature (UNDP 2003; James 2003) and in the field of health (Flahault and Roemer 1986; Schiffbauer et al. 2008), might serve to bridge the two perspectives.

Labour relations in the classical sense have not been picked out as a relevant theme by the interviewees in this study. This might also be due to the difficulties of Malawian civil service unions, which according to Dzimhiri (2005) are not being fully recognised by the government. He explains that public and economic policy of the national government after Malawi's independence did not allow for industrial relations to unfold. In the civil service, trade unions were interdicted or turned into parastatal bodies, such as the Teachers Union. Even after the introduction of a multi-party system and the Labour Relations Act of 1996, the state remained hostile towards the newly founded or re-registered unions and effectively exercises much control over the workforce. Dzimhiri assumes that after some increases in membership levels and strike activities in the 1990s, frustration has spread among the Malawian workforce. In addition, if civil service unions are not sector specific, improved conditions and salaries in one sector can also trigger respective claims in the others. As a consequence, governments are often reluctant to increase salaries in one field, or instead they refer to a rather intransparent system of additional allowances (Bach 2000).

Association building on the grounds of an affiliation with the health sector, and regardless of the employment status, appear to be a more promising approach. The role of the health professions as composite actors is crucial to preserve HRH as a resource system. However, professionalisation in the health sector is often imitating

the classical approach of the medical profession. Public Health professionals are not principally different in this, although a clientele relationship (as a core element in theories of professionalization according to Freidson (2001)) cannot be easily established with collectives and populations. Interviewees in this study have indicated that new discipline-specific associations are now being established, e.g. in Environmental Health (see chapter 5.2.3). Differing professional values, notably regarding curation vs. prevention, are reflected in this approach. While it is laudable with regard to the development of a diverse civil society, it might continue to be hampered by small membership figures and could be vulnerable to the same divide-and-rule tactics of the government which have been observed in industrial relations (Dzimhiri 2005). Certain professionals such as nurses and doctors are particularly short in supply, but insular solutions will not be successful in the long run. This is due to the interconnectedness of professions within teams at the facility levels and within the health sector at large (see chapter 4.4). As one interviewee in this study pointed out, a holistic approach is needed to avoid that one cadre is jeopardising the improvements achieved for another one.

Associations need a broad membership so that they can negotiate rules with other composite actors such as political authorities or umbrella organisations of employers (see Hess 2011, ch.9). For the health sector in Malawi, it appears necessary to find new ways to instill a population orientation as a value in health professionals, as the hierarchical influence of the MoH is dissolving. Segall (2003) explains that population orientation means to identify and meet the priority health needs, basically following the principles of equity and efficiency. In the light of 'predatory behavior' and internal brain drain that can be observed among health workers subjected to adverse working conditions and chronic underpayment, Van Lerberghe et al. (2002) have suggested that professionals as well as aid organisations should seek a more open and non-moralising exchange about such practices. While there are no easy solutions in sight for a country like Malawi, it is to be hoped that such an exchange might bring greater sensitivity regarding the professional values in question, and would spark attempts for joint action at the constitutional level. Health professionals and experts need to become aware of the political preconditions and consequences of their practice.

A collective identity of health workers needs to be fostered, regarding their status as the central resource in the health system. One approach could be to join different professions under the common goal of meeting priority health needs of the population. This should also lead to enhanced efforts regarding the ‘reproduction functions’ of the health workforce, with the different professions reconsidering how respective training schemes and curricula can be adapted to better meet the populations’ health needs (Boelen et al. 2007). Moreover, as Ijsselmuiden (2007) highlights, it is necessary for the professions and educational institutions to think in systems. They need to consider how they can support respective health policies to be issued by other players, notably the government.

6.1.8 NESTED ENTERPRISES

While commons research and theory development have started from rather small and localised natural resource systems, they are now also being applied to global resources. A prominent example is the establishment tradable environmental allowances for greenhouse gases to save the atmosphere (Dietz et al. 2003). The concept of ‘nested holons’ (Ostrom 2005) allows for looking at the larger picture of mutually linked action arenas and thus for governance at multiple levels. The Joint Learning Initiative (JLI), a predecessor of the GHWA, has been talking of “workers as a global health trust” (Joint Learning Initiative 2004, p.26). The dynamics of HRH policy making that evolve between the local and the global level deserve further attention. Country leadership and global solidarity, as major claims in Global Health Policy, need to work together in practice at the country and district level.

Accountability to the local population remains a major source of legitimation for organisations working in the health sector. In order to orientate health services at the needs of the population, it is necessary to find ways to involve people in the planning processes. The relationships within society and the quality of interaction are considered important in achieving social sustainability (Littig and Grießler 2005). The PHC concept has always emphasised the importance of community participation as well as the contribution of qualified health workers and the responsibility of governments. In Malawi, the DIP procedures issued by the MoH arrange for the

consultation of community leaders. However, as some interviewees in this study have pointed out, meaningful participation would require more efforts by the District Health Offices and longer planning time frames (see chapter 5.2.3).

Community health workers therefore deserve even greater attention when it comes to policy dialogue, especially in the light of diversification of organisations providing health care. Rather than just engaging in educative measures and provision of basic services, Shukla (2008) suggests that their role could be enhanced to become counsellors and advocates for local communities. While HSAs are at least selected at a local level and work in their own communities, their role in Malawi as found during the fieldwork for this study is still far from this (see chapters 4.1.3 and 4.2). Training and supervision would have to be adapted to empower them for such tasks. Volunteers might be suited here just as well, but they also need to be given a forum to voice their ideas and demands. Again the district level appears appropriate to establish such fora. Subsequently, links are also needed to the national and international level.

‘Civil society’ promotion has occurred as a political alternative to supporting government health budgets since the 1990s. On the grounds of supporting democratization and improving accountability in developing countries, some donors opt for non-state actors as implementing agencies and health service providers. DHMT members interviewed in this study have reported particular difficulties in coordinating their health planning with such organisations (see chapter 5.1.1). As Hein (2003) states, global players such as philanthropic foundations nowadays often directly intervene at the community level, thereby bypassing the state or taking over its responsibilities. This is running contrary to the idea of 'ownership' by national governments, which has been emphasised in the Paris Declaration (High Level Forum 2005). Also the declarations of the WHO in terms of HRH and health systems strengthening generally emphasise the overall responsibility of national governments to provide sufficient health services to their populations (WHO 2007a, 2007c).

Moreover, Stubbs (2004) has criticised that ‘civil society’ in this context is commonly confused with user-led approaches, since most activities by NGOs are in fact professionally led. As such, they are not principally different from governmental interventions. He calls for paying greater attention to “the lived experience of welfare

subjects”, and “the demands of oppressed groups” (Stubbs 2004, p.190). However, many social and political movements and human rights groups in the health field have strong academic or professional connections as well – either with regard to their membership base, through projects such as university and hospital co-operations, or in maintaining their own ‘think tanks’ for advocacy work (Birn et al. 2009). This casts some doubt on the idea that user-led and professionally led approaches can be clearly distinguished in practice. On a similar note, research on PHC programmes from various African countries shows that even where communities are regularly involved, the decision making power remains in the hands of the professionals (El Ansari et al. 2002; Barker and Klopper 2007). To a certain extent, this might reflect the values and self-perception of community members, as a study from Guinea indicates (Haddad et al. 1998). The authors were asking lay people about quality criteria in health care, and found that the expectations were largely centred on professionals, their (mainly curative) technical competencies and the personal client-provider interaction.

Arenas for collective decision making of composite actors concerned with HRH at the national level were still lacking in Malawi in 2009. The SWAp offered the potential for collective choices on HRH between the Malawian Government and some international donors, which appears to be an important first step. However, the coordination of support to HRH strategies through SWAPs has not worked well in the past - Schmidt-Ehry and Lauckner (2001) presume that this is due to the wider cultural and structural factors involved in health labour markets, which go beyond the scope of health sector planning. In the Malawian health SWAp, which was at its mid-term during my field research, I also found that the segment of internationally funded non-governmental actors was factually excluded from relevant political arenas. Many other actors had a visitor’s status in the SWAp arena at best (see chapter 5.2.1). Assuming that organisations would subscribe to the overall aim of comprehensive and sustainable health care delivery to the Malawian population, they need to be given the opportunity to negotiate the rules of co-operation to reach that aim.

Most of the health professionals interviewed in this study still assume a rather reactive role as implementers of health policies made by their employers, notably the MoH headquarters (or international agencies behind it). By opening up action arenas

focusing on HRH, they could get more engaged in policy dialogues. Instead of undifferentiated 'civil society promotion' by donors, Lachenmann (2003) proposes to create a public sphere and foster a critical trans-national health community, which can be a platform for negotiations between policy makers, epistemic communities, professionals and user groups.

In some cases, harmful managerial practice in aid organisations can also be seen as a consequence of the rules of 'global development business': Unger and Paepe (2007) have pointed out that budgetary subsidies of basic governmental health services principally violates article 1.3.c of the General Agreement on Trade in Services (GATS). Politicians and managers might therefore shy away from strong organisational interpenetration between public and non-governmental entities. Pfeiffer (2003) argues for organisations working in this field to join up and advocate for more favourable terms and conditions in aid provision on a global level. In the terminology of the IAD-framework (Ostrom 2005, p.59), this would mean to seek meta-constitutional action arenas and form global social movements which affect the constitutional level of nation states and their political economy.

6.2 POLICY EVALUATIONS AND RESEARCH ON HRH IN MALAWI SINCE 2009

At the time of field research in 2009, the EHRP and the SWAp Programme of Work in Malawi were already in their second half. With the large-scale donor engagement and the major policy changes which these approaches implied, they can be considered a 'natural experiment' of rule change in the Malawian health sector. Aware of the complexity inherent in such situations, Ostrom (2005, p. 242) warns that the attempt to design optimal sets of rules is to be doomed to failure. Rather, devising rules is based on expectations about their outcomes and the distribution of these outcomes, which requires a monitoring process that feeds back into continued adjustments. While this study has not been focused on the effects of the EHRP and the SWAp, it is worthwhile looking at how the major players have evaluated it. The political consequences – or at least the further political developments concerning HRH in Malawi – are also of interest. These are outlined in Annex 7.2, together with a review of recent reports and scientific papers published between January 2009 and January 2015. This also appears as a necessary step to reach meaningful conclusions of this thesis and to formulate recommendations that are relevant to the contemporary situation.

The EHRP has been picked up as a positive example of scaling-up health worker training and using less qualified cadres to meet the rising demands for health care (see Dayrit et al. 2011, Brugha et al. 2010), but accounts of the Health SWAp in Malawi are hard to find. A few news items point to 'underperformance' under the SWAp as perceived by the donors, with the UK and Norway holding back final payments and demanding an audit. The formal end of the SWAP, originally dated at 2010 but prolonged until 2011, fell into a period of increasing tensions between donors and president Bingu wa Mutharika, over issues of governance, accountability and human rights. In 2011, most major donors to Malawi decided to refrain from general budget support for these reasons. Britain as the largest bilateral donor also withheld pool funding for the health sector and shifted aid to non-governmental channels.

When Vice-President Joyce Banda took over from late president Bingu wa Mutharika in April 2012 and introduced economic reforms, international relations eased again. The

'Health Sector Strategic Plan 2012-2016' succeeded in attracting pooled funding from donor governments including Germany and Norway. For Malawian citizens, however, the reforms (including currency devaluation and price liberalisations) meant stark losses of spending power. From September 2012 onwards, civil servants and workers in various industries have started go on strike for salary increases. As development aid previously made up about 40% of the government budget, the withdrawal of general budget support also led to increasing gaps in sectorial budgets, particularly in the health and education sector. The next shockwave occurred with the major corruption scandal 'Cashgate' in September 2013, uncovering that large amounts of money had been diverted from the public payment system. Although President Joyce Banda had not been subject to corruption charges herself, she lost the elections in April 2014 to her predecessor's brother, Peter Mutharika. The strikes continue to gain momentum, with health workers threatening to go on a nationwide strike at the turn to 2015. The government is arguing for a harmonisation of pay scales after the country will have recovered from economic crisis.

These recent developments in Malawi dramatically demonstrate how much the field of HRH is indeed entangled with other sectors and public policy at large, and how vulnerable it is to external economic influences. In addition to the global economic recession, Malawian health workers have been hit hard by the fraudulence of their own government and consequential shifts in donors' policies (see Gopinathan et al. 2014, Cammack 2011). This does not only mean economic hardships and a degradation of workplace infrastructure and supplies, resulting in increasing migration pressures for qualified health workers. What might be even harder to reconcile is the loss of trust among the different actors involved, which according to Ostrom (2005) is fostering egoistic behaviour and jeopardising joint efforts in managing HRH. The challenge of securing the successes of the EHRP through improved retention and performance of the health workers in place has become greater than ever.

Similarly to what Gama (2013) has highlighted for Service Level Agreements (SLAs) as a presumably donor-driven policy, international donors are facing a 'Samaritan's dilemma' here (see Gibson et al. 2005, p.38). In this classical constellation, the provider of aid is better off choosing to help, regardless of how low the efforts of the recipient

may be to improve the situation. In repeated interaction, the incentive structures inherent in this situation would lead to ever greater incapability and dependency of the aid recipient. With regard to fraud and corruption of Malawian government officials, an additional 'moral hazard problem' has occurred, which stems from the principal-agent-relationship of donors and recipient governments (see Gibson et al. 2005, p. 42). Assuming that it would be difficult for the donor to gain knowledge of singular fraudulent payments, government officials have taken ever higher risks, which amounted to the 'Cashgate' scandal. Donors are now in a situation where they face losses in credibility from two sides: By withdrawing their budgetary support they are letting down the health workers which they have previously supported. By continuing their support they invite ever greater audacity on behalf of Malawian government officials. On top of that, regardless of the option they chose, they risk that social unrest among workers destabilises the Malawian state.

Many of the donors, notably the UK, have turned to administering their aid through non-governmental structures. However, this is no panacea against corruption, but brings along other difficulties in monitoring and controlling. It also creates a competitive situation regarding the authorisation to provide services to the public, which in post-independent Malawi has traditionally been the monopoly of the state (see Cammack 2011). Although CHAM is holding a strong position in this field, its relationship with the government is still being characterised by sub-ordinance. This constellation has apparently not been a fruitful ground for gaining experiences in negotiating contracts and rules for producing a public good (see Cammack 2011; Gama 2013). Nevertheless, considering the large numbers of NGOs operating in Malawi by the year 2015, joint efforts and respective contractual arrangements are urgently needed. The challenge for donors is to not divide Malawian society into governmental employees on the one side and 'civil society' on the other. The local elections, which were successfully carried out in April 2014, open up new chances for cooperation at the district level, including international cooperation. A first step could be to open up District Health Offices for information and knowledge exchange among the various types of organisations operating in the health field (see Vollmer LeMay and Bockock 2012).

On a separate note, the recent escalation of strikes in Malawi shows that the neglect of industrial relations on behalf of the Malawian government is now repulsing (see Dzimbiri 2005). Conflict resolution mechanisms also need to be developed in this classical policy field of labour and human resource issues. As for a country like Malawi, respective regulations would have to take into account the new forces in the labour market that have arisen with the proliferation of NGOs and the permeability with international labour markets. As such, it is also a task that the international HRH community should address itself to.

6.3 LIMITATIONS AND STRENGTHS OF THE STUDY

This section reflects the underlying reasons and the implications of having chosen an institutionalist research framework within a political science tradition. However, owing to a qualitative social research paradigm, it also contains some reflections about the role of the researcher in her field of research. Limitations and strengths of this thesis often appear as ‘two sides of the same coin’.

6.3.1 PRACTICAL AND METHODOLOGICAL CHALLENGES MET

The research strategy that I envisaged at the outset of the field research in 2009 was to conduct qualitative field research and collect various types of primary and secondary data. With this idea of inductive, theory-generating research, theoretical sampling appeared to be the suitable approach to data collection. This mode of sampling is an element of the Grounded Theory methodology, stipulating that the next step of data collection is always informed by the analysis of previously collected data (Przyborski and Wohlrab-Sahr 2008). However, as my period of stay in Malawi was determined to be only 6 months, it soon turned out that most of the data analysis would have to be saved to the time after the field research. Therefore, I chose a ‘grid sampling’ approach for the interview partners, following criteria derived from the obvious organisational and occupational structures of the Malawian health system. Such an approach also lends itself to a combination with quantitative methods of data collection and analysis (Przyborski and Wohlrab-Sahr 2008).

In addition, the original plan to conduct open, narrative interviews with a biographical focus proved to be unsuitable for the interview partners selected. As health professionals in leading positions, they were usually time constrained and had previous experience with being interviewed as experts on technical concerns of health care. Consequently, I developed a semi-structured interview guideline to conduct expert interviews, which still aimed at triggering narrative expert accounts. According to Meuser and Nagel (2005), these narrations are essential for reconstructing the ‘insider knowledge’ that characterises an expert. It is often not revealed through direct interrogation.

A strong concern of the founders of Grounded Theory has been that data might be forced into a particular direction if preconceived theories and hypotheses are used in the process of data collection and analysis. Instead, they argued for letting the theory emerge from the data (see e.g. Glaser 1978). Layder (1993) argues that the separation between theory testing and construction is often artificial, however, and many social research projects mix both approaches with each other. A dialogue between emerging and general theory throughout the research process is a possible strategy to make 'grand theory' more fruitful for empirical research activities. According to Kelle (2005), so called 'grand theories' can be a useful tool to organise the data. Since they have low empirical content, the danger of forcing the data remains limited.

My study has evolved around personal accounts of study participants regarding their globalising working context. Hence I was looking for an analytical frame to integrate the aspects of globalisation and international aid on the one hand, and professional biographies and local action on the other hand. Layder (1993) emphasises that the multi-layered nature of social activity should be theoretically accounted for when designing and conducting research projects. He recommends that special attention be given to general theories which attempt to integrate the macro and the micro level. Even if the focus of a research project is on the meso-level, the researcher should consider the embeddedness of particular settings in macro-structures as well as the role of individual agency in producing and reproducing social institutions. In this respect, Layder (1993) points out the Theory of Structuration by Anthony Giddens, which offers an approach to the analysis of power and constraint.

Giddens (1984) sees humans as voluntaristic and reasonable beings, capable of reflexivity and self-reflexivity. The latter is divided into practical and discursive consciousness – which fits well with the methodology of expert interviews (Meuser and Nagel 2009). The concept of practical consciousness emphasizes the knowledge and competences of people (while also acknowledging their limitations) and is therefore central to Giddens' understanding of human agency. Discursive consciousness constitutes what agents say or could say about the social coherences in which they live, including the conditions of their own actions. Practical consciousness is not 'discursive', meaning that agents usually do not reflect their actions because

they see no need for it (Giddens 1984). However, the use of the Theory of Structuration has been limited for my field of study. The interviews were neither conducted in my own mother tongue, nor in the mother tongue of the study participants, although health-related university courses in Malawi are all held in English. Furthermore, the period of fieldwork was too short to gain a broad understanding of Malawian culture. An in-depth analysis of underlying sense structures in the interview data therefore proved to be problematic (see Przyborski & Wohlrab-Sahr 2008, pp. 308-309). I had to focus on the more manifest content of the interviews and orientated myself at institutionalist approaches in the political sciences.

As for organisational research, the old institutionalism has been criticised for its preoccupation with values, attitudes and norms. This is seen as abidance in utilitarian thought, and in models of intentional action or rational choice. Calling upon a new institutionalism, Powell and DiMaggio (1991) state that institutions are rather made of sub-conscious scripts, rules and classifications. These are conceived as less emotionally loaded but the more normative for individual action. This Consequently, new institutionalists also distance themselves from political scientists in the game-theoretical tradition, who focus on the 'rules of the game'. The underlying assumption is that institutions can be changed deliberately, as they merely reflect preferences and power of the actors involved (Powell and DiMaggio, p.7-8). By contrast, neo-institutionalist organisational research is concerned with how informal social relations and cultural forms become institutions, and how such institutions are constraining the decision-making by and within an organisation. Professions, industries and nation-states constitute the relevant environment from which such institutions originate (p. 27).

My decision for the IAD framework (Ostrom 2005) as a rational choice-based research approach has not only been the consequence of the above mentioned practical and linguistic limitations, though. The research question for this study is establishing a highly organized and political arena as the research field, and the value-loaded concept of sustainability as the envisaged outcome. As Mayntz and Scharpf (1995) have pointed out, the particularities of political organization require attention not only for the embeddedness of organisations in their environment. It is also necessary to look

into actor constellations and rules governing their interaction. This is especially relevant for sectors such as health care, which are proximate to the state, and where analytical interest lies in sectorial steering and self-regulation. Admittedly, coming from a background of game-theory and individual decision making, Ostrom (2005, p. 39) hesitates to apply the IAD framework to composite actors. Treating organisations as quasi-individual participants in an action situation means short-cutting the internal processes which lead to the external organisational behaviour. The same accounts for treating leaders as representatives of their organisations. Referring to the work of Scharpf (1997), however, she states that such simplifications are permissible in case that individuals have joint up as an organisation to pursue a common goal. Moreover, for corporate actors, the individual preferences of members are assumed to be neutralized to a certain extent by their employment contracts.

The IAD framework still caters for the connection between the micro- and the macro level by the concept of action arenas as 'nested holons', and the multilevel nature of rule-making (Ostrom (2005). Individual actors may shift from one arena or one level to another – in thought or action. The framework's value for empirical social research also lies in the emphasis on 'working rules', i.e. rules-in-use rather than written rules-in-form. While they may become internalized and habitual, it is still possible for participants to explicate those 'working rules' when asked to explain their actions (Ostrom 2005). A thematic analysis of the interview data as a first step was therefore justifiable.

The fact that I have researched Public Health as my own professional field – albeit in a foreign country – might be criticized from an ethnomethodological stance. The risk lies in not questioning certain behaviour because the researcher is too familiar with it. Biographical and cultural proximity also make it difficult for the researcher to explicate his or her understanding of the study participant (Przyborski and Wohlrab-Sahr 2008). A related constraint was my association with the German Development Cooperation (GDC) in Malawi on the one hand, and the College of Medicine on the other hand. While these were essential prerequisites for my access to the study field and interviewees, they may have triggered strategic or even opportunistic answers. Sensitised for these aspects, I have emphasised my linkages selectively and highlighted

that I am not carrying out an evaluation of any specific programme or activity. I put special emphasis on the independence of my research and the strict confidentiality in handling the data. At the same time, I have made efforts to reflect the personal interaction with my interview partners. I have been asking myself how differences or similarities in age, gender, professional status, wealth, citizenship etc. have been influencing the course of the interview. In a sense, the interview situations were small arenas of international cooperation in Public Health, and as such they have sometimes been very revealing. Stubbs (2002) has highlighted that the interaction in the context of international aid provision might reproduce certain power relations. However, these processes are complex and sometimes contradictory, and professionals on either side often have a distinct role to play in them.

Finally, the conception of my research as a single-case study is certainly limiting the generalizability of the findings, in the sense of transferring specific recommendations to other countries and actor constellations. With the time lap of the analysis, even in Malawi the political situation has changed significantly since 2009, so that the findings cannot be applied as immediate policy advice. However, ex-post comparison of the study findings with HRH-related publications from 2009 to 2014 has allowed for some validation and critical discussion.

6.3.2 CONCEPTUAL INTERGRATION AND OWN CONTRIBUTIONS

The IAD framework (Ostrom 2005) and earlier methodological concepts for the empirical analysis of common pool resource systems (Oakerson 1992) have provided me with an overall concept to capture the complexity of HRH as a research field. This comprised different organisations, different modes of employment, professions and individual experts, in the context of a larger health system. Moreover, this systemic approach was supposed to incorporate aspects of globalization, i.e. the connection between the local and the global level. Finally, the historical, cultural and socioeconomic embeddedness as well as physical and technical aspects of HRH had to be considered as contextual factors. On the basis of such a theoretical concept capturing the multi-layered nature of society, Layder (1993) recommends to make “as many analytical ‘cuts’ into the data at one’s disposal as possible” (p.108). However, the

next challenge was to integrate the different types of qualitative and quantitative data collected during my field research. These included interviews, observations, textual documents and secondary statistics.

The practical methods that I have eventually chosen for the analysis, after the stage of data screening, organisation and preparation, are oriented at the work of the Austrian sociologists Ulrike Froschauer and Manfred Lueger. The 'thematic analysis' applied to the interview data and related field notes is an aggregative method of content analysis, by which previously selected themes in the data can be investigated (Froschauer and Lueger 2003). The 'structural data analysis', which I used for the documents collected, is a method to explore the context of the social phenomenon under study, and to reflect on its conditions (Lueger 2010). Both methods are actually conceptualized by the authors as preliminary or complementary analytical steps to generate theory within a social research framework. The combination of the two allowed to integrate not only primary and secondary data, but also qualitative and quantitative data, and therefore suited my requirements very well.

The underlying methodological principle for this integration is 'constant comparison' – another principle which has first been proclaimed in Grounded Theory (Przyborski and Wohlrab-Sahr 2008). As discussed above, I am not comparing the Malawian HRH system, which is defined as the overall case in this study, to other national systems. However, the study contains multiple internal comparative aspects, e.g. between different professions or different types of organisations. As for the quantitative data, the main analytical tool are basic cross tabulations indicating the interrelation of certain variables (Glaser and Strauss 1979), which then feeds into the constant comparison process. Hence the data is utilised for the purpose of theory generation and therefore does not underlie the same quality criteria as for hypothesis testing. Data quality is frequently questioned for health-related statistics in Malawi, and the limitations became obvious when I was plotting the HRH census data. With secondary data, the researcher has no influence on the circumstances of data collection and on the data validity and reliability. Therefore, documents are rather seen as a 'natural manifestation' of an empirical phenomenon at their time of origin (Lueger 2010)

As I have outlined above, my research has gradually shifted from a qualitative sociological approach to a political science approach. After all, HRH has emerged as a global policy field during the recent decade. The publications of the Joint Learning Initiative (JLI) mark a starting point (Chen et al. 2004). The political and scientific activities on this subject have further unfolded when this initiative was transferred into the Global Health Workforce Alliance (GHWA) under the umbrella of the WHO. A look at its website (<http://www.who.int/workforcealliance/en/>) reveals a wide range of related topics being worked on. A great variety of members from all over the world are using modern communication technology as well as physical meetings, to jointly act on HRH issues. Many publications that I have cited in this study have been produced within the scope of GHWA or have been subsequently linked up with the alliance.

Although the GHWA as a policy network has not been the actual subject of my research, its existence is supporting my decision to take a political science perspective. The global increase of activities in the field of HIV/AIDS has attracted the attention of political scientists. It has given rise to a research field labelled 'Global Health Policy', rooted in the discipline of international relations (see e.g. Hein et al. 2007). A more economic approach has been pursued by Smith et al. (2003), focusing on the nature of health as a public good. Coming from the field of social policy research and development studies, Deacon (2007) has established the term 'Global Social Policy'. The journal of the same title dedicated an issue to the topic of health worker migration in 2008 (see Loewenson 2008). However, to my best knowledge, the global political activities on HRH as such have not been subject to larger empirical studies to date. Similarly to the proponents of 'Global Health Diplomacy' (see Kickbusch et al. 2007), I argue that Public Health researchers and practitioners working on the topic of global health would benefit from adopting a political science perspective. Thereby they would take into consideration the larger political-economic influences on population health.

This study also constitutes a first-time application of Commons Theory and of the IAD framework to a national HR system. The framework has proven useful to capture the highly normative nature of health care work, which is ridden with prerequisites. Taking an institutionalist approach to interactions in this social field allows for identification

and abstraction of more general mechanisms. At the same time it is acknowledging that institutions are man-made and therefore changeable. It offers a way to link up the perspectives of different stakeholders and to counteract the fragmentation of health systems. As such, it is in line with the initiative “Towards Unity for Health” (see Boelen et al. 2007). This initiative calls policy makers, health managers, health professions, academic institutions and civil society to join under the shared goal of meeting the priority health needs of a resident population. I go further to argue that in order to build strong alliances reaching from the local to the global level, a new understanding of the health workforce is required. It needs to be valued as a vital resource system in need of protection (Schlager 2004), which constitutes a prerequisite to producing or maintaining health as a public good.

This research has started from the quest for sustainability, which is omnipresent in the discourse on development and international aid. The conceptual connection between HRH and the capacity development paradigm seemed to lie at hand: the UNDP concept of capacity is relying heavily on human resources to eventually achieve human development that is self-determined and that can be self-sustained (see UNDP 2010). However, human resources (in the sense of incorporated knowledge, skills and competencies, see Becker 2009) occur both as an input and an outcome within the UNDP framework. This made it difficult to apply to HRH, which has been the research subject in this thesis. I could still use the framework for deriving thematic categories for the interview analysis, as it also puts great emphasis on institutional arrangements and accountability mechanisms. These are conceived as supra-individual features of a social system in the UNDP framework. Nevertheless, taking a Commons Theory perspective proved to be more suitable for the research subject, and for meeting the practical requirements of social research. It also allowed me to link up health-related work with theoretical conceptions of social sustainability (Hans Böckler Foundation 2001; Littig and Grießler 2005).

Sustainability has become a buzzword in the international development community. Littig and Grießler (2005) state that while there is increasing consent that the concept is linking the environmental and the social sphere, the quality and direction of these links is usually not further discussed. I take up their argument here that human needs

are the driving force behind social behaviour and societal institutions. Health workers are making important contributions to meeting such needs, vis-a-vis a large range of environmental threats to human health. Hence, strengthening HRH as the central component of health systems is not an end in itself. But what criteria might be applied to ensure that these contributions of health workers are themselves sustainable? I have looked into the notions of professionalism, participation and welfare production for this purpose. The idea of HRH as a common-pool resource can contribute to sustainable health workforce performance, and thus to overall social sustainability. The governance changes suggested in this chapter are informed by insights regarding the 'goodness of fit' between the resource and the rules applied (Oakerson 1992).

Features of HRH and of the resource appropriators have been examined in this thesis, to reach a conclusion on the likeliness of cooperation and joint governance (see Schlager 2004, p.151-15). Putting a halt to the deterioration of HRH in Malawi seems to be generally feasible - domestic training institutes exist and are being massively supported by international donors to increase their output. Efforts are also being made to generate indicators on the status of the resource system (e.g. through the HRH census). Admittedly, data quality and updating of information as a routine activity remain a challenge. In order to oversee the pool of health workers and optimise their deployment, it appears as a good step to shift more autonomy in overall resource planning to the district level. In addition, a number of studies have been conducted during recent years to learn about factors affecting retention or attrition of health workers, such as the intention to migrate. Considering the strife for further academic qualification and specialisation found among interviewees in this study, domestic solutions need to be found – with the participation of health workers themselves.

The features of the employers, i.e. the resource appropriators, indicate that the challenges in this area are even greater. Any kind of health-care providing organisation is of course dependent on HRH. Yet the time horizon differs considerably between the MoH and CHAM on the one hand, and NGOs (especially international ones) on the other hand. NGOs working on a project basis with international funding have a much higher discount rate from buying in available experts and releasing them after the project is over. Long-term staff development is left to be looked after by the

government or the individual health worker. A common understanding of HRH as a resource system urgently needs to be enhanced, including the awareness among employers of their own positive or negative contributions.

Insecurity and overburdening among MoH officials in charge of HRH planning can be observed. It seems to hinder greater autonomy of actors in the districts to develop their own governance mechanisms and initiatives. To some extent, this is certainly rooted in the history of the one-party system in Malawi, so that there is a lack of experience with self-organisation under local leadership. Mutual trust between actors on the governmental and non-governmental actors, and between Malawian and international actors is difficult to build. It is additionally being eroded by repeated corruption scandals in Malawi. However, the right for stakeholders to organise at various levels in a self-determined way bears the greatest potential for the governance of 'globalised resources' (Dietz et al 2003, p.1910). Therefore it requires special attention. The changes suggested in this study are expected to affect the patterns of interaction of HRH appropriators in Malawi and other parties involved - on a larger scale and in the longer run. In sensitizing employers and contractors for the risk of overuse and depletion, common-pool resource theory provides a starting point for devising HRH-specific sustainability criteria (see Oakerson 1992, p. 54). Following the principle 'do no harm', international aid agencies might orientate their own HRH-related practices and advocacy work at such criteria.

Without doubt, the HRH system in Malawi is exposed to global forces and contextual factors which lie beyond reach of individual health managers. Rapid contextual change and influences of international donors have been identified by Ostrom (2005) as being considerable threats to sustainable governance of common-pool resources. It remains open to what extent material and non-material incentives provided at organisational level can compensate for insufficient remuneration, to retain health workers in their jobs. A study by Mackintosh (2003) found that inadequate remuneration was still the single most important factor for midwives in Malawi to leave their public-sector or CHAM position. Nevertheless, if the depletion of the HRH system is to be avoided at all, problems have to be tackled at various levels, including the operational level of health service provision.

6.4 CONCLUSION AND PROSPECTS

The conditions and logics of the HRH system in Malawi, which were found during field research and which also surface in recent political developments, call for an outlook: What will HRH development in Malawi have to provide for in the future? There will be increasing demand due to epidemiological and demographic factors, thus the quantitative aspect of HRH development is likely to remain in the foreground. However, it is also necessary to establish a (self-)critical transnational community on HRH, to pay attention to the qualitative aspects and the systemic inter-dependencies.

District Health Offices are principally well situated to connect international assistance with local needs and resources. This is also due to the relative stability and continuity of the governmental system as a provider of health care, despite all shortfalls. High staff turnover on all sides endangers the cooperation, of course. The first generation of graduates from the College of Medicine were filling the posts of District Health Officers (DHO) at the time of field research. Medical graduates who opt for the civil service are obliged to serve in this position for at least two years before they are allowed to proceed to specialisation. As the respective interviews have shown, the position of the DHO is therefore often viewed as a passage, and the strife for subsequent specialisation is strong. It appears necessary to stabilise the District Health Management Teams and assign greater value to the work that is done at this level.

The MPH course at the College of Medicine has been designed to qualify professionals for this kind of activity. However, comparatively few doctors enrol on this course - and those who do are unlikely to continue working as a DHO. It should therefore be considered whether the DHO position could be opened to persons with a background in nursing, environmental health or health administration. The MPH and experience at district level would be prerequisites. For Clinical Officers, it appears necessary to keep this career path open as well, as these mid-level providers are particularly disadvantaged regarding further professional development (McAuliffe et al. 2009a). Young medical doctors might fulfil their two years of rural service as District Medical Officers instead.

Greater stability of leadership and team constellations would also open up possibilities to develop and establish local approaches to managing specific health problems. According to Shivakumar (2005), local action arenas are the places where development essentially takes place, in an institutionalist sense. The scope and decision-making competencies for those working in district health management has already been increased during recent years. Besides the outcomes of health interventions, the kind of procedures pursued can play an important role for job satisfaction. The term 'procedural utility' has been suggested by Frey and Benz (2004) to signify the payoff that individuals derive from 'the way things are done'. They thus introduce a new category of utility which values procedures as being more than an adjunct of the instrumental outcome. Instead, respective human needs such as autonomy, relatedness and competence receive a greater weight in institutional analysis. Procedural utility is conceptualized as increasing the well-being of the actor and a positive sense of self.

Equity and efficiency are often proclaimed as overall goals or principles for setting priorities in health care delivery. However, resource allocation mechanisms at national level are generally fraught with difficulties, as conflicting values are involved. Segall (2003) therefore suggests to move away from fixed formulas and decentralise decision making again. He argues for leaving it to the considerations and consultations of health professionals at the operational level. As for Malawian DHMT members focused upon in my study, procedures that allow for these principles – especially equity and community participation – may contribute considerably to job satisfaction. On the other hand, it also places a considerable burden on them, as they are meant to be accountable to the local population and to the MoH as well (McIntyre and Klugman 2003). The resulting frustration needs to be taken seriously; collegial exchange and supportive supervision appear to be essential in this.

The year 2015 marks the evaluation date of the MDGs, a Post-2015 Agenda is currently being devised. HRH issues have proven to be central to poverty reduction and human development and therefore need to remain on the agenda. Further research connecting Public Health to the sustainability discourse is recommended, to contribute the interdisciplinary competencies and scientific approaches of Public Health. The

sustainability discourse has brought some new attention to the role of work as a mediator between nature and society, as Littig and Grießler (2005) have pointed out. Based on their concept of social sustainability, they argue for remodeling work to meet the diverse physical and psychosocial needs of humanity in a sustainable manner. One result of the 'Work & Environment Interdisciplinary Project' (Hans Böckler Foundation 2001) is the appeal for a new working hour policy. This should allow for combining different forms of work (paid labour, voluntary engagement, care work), according to the needs and abilities at different biographical stages of the individual. The project was focused on (Post-)Fordist working conditions, so that the results are not directly transferrable to developing countries. Nevertheless, they bear interesting starting points for reconsidering the role of public sector work in this part of the world.

New perspectives for individual decisions regarding career and work-time allocation are needed. Involving health workers personally in the discussion of staff coverage and equitable health care provision might open up such perspectives. Health workers who remain in the country signalize their understanding for those who leave, although they are facing an ever increasing workload. Innovative division-of-labour and work-time models are thus urgently required, which provide for the needs of health workers as well as impoverished population groups. For example, Bach (2000) has pointed out that voluntary organisations play an important role in the health sector, but do not fit into the simple dichotomy of public vs. private providers. Also Stubbs highlights that the range of parties involved in the production of welfare is diversifying, which he calls an 'extended welfare mix' (Stubbs 2004). Households and kinship deserve some attention in this, especially in the African context. Individual health workers and volunteers are part of a larger kinship network, within which different forms of income are distributed, in exchange for socio-economic support at younger or older age (Steinwachs 2006). The distinction of the private sphere and official employment has never been as clear-cut in African societies as it has been in industrialised countries, anyway (Anders 2002).

In the face of poverty, environmental and epidemiological challenges to mankind, 'health work' appears as a key contribution in the strife for sustainability.

7 ANNEXES

7.1 MAP OF THE MALAWIAN HEALTH ADMINISTRATION



Source: Author's own compilation (graphic design: T.Bredehorst)

7.2 RECENT POLITICAL DEVELOPMENTS AND HRH-RESEARCH

This annex outlines HRH-related developments in the political and scientific domain, which have occurred since 2009 the year of my field research. The exact period covered is January 2010 to January 2015.

As for political developments in Malawi, I have searched the Database NexisLexis as well as online services and newspapers. I predominantly rely on the UK-based online newspaper Nyasa Times (<http://www.nyasatimes.com/>), complemented by articles from BBC World News (<http://www.bbc.com/news/world-africa-13881367>) and the Integrated Humanitarian Information Network (IRIN) by the United Nations (<http://www.irinnews.org/country/mw/malawi>). Furthermore, the country-related websites of selected international aid agencies concerned with HRH in Malawi have been referred to, to find out about the outcomes of completed programmes and about ongoing activities. These include the WHO, UNDP, GFATM the World Bank, and OECD-DAC as multilateral agencies, and GIZ, DFID and NORAD as European bilateral agencies. The articles or news identified have been fed into the basic timeline of events presented below.

As for scientific publications and grey literature dealing with HRH in Malawi, I have used the Bielefeld Academic Search Engine (BASE) and the Meta-Search function of Bielefeld University library for (covering the databases JADE, Social Sciences Citation Index, CINAHL, Medline and EconLit). For these searches I have applied very broad search terms, using the key words “Malawi*” AND “Health*” or “Malawi*” AND “work*” or respective variations. The most relevant publications are listed in chronological order in the second part of this annex.

7.2.1 TIMELINE OF EVENTS 2010-2015

2010-12: Country evaluation of the Paris Declaration for Malawi published, stating that the health sector attracted stronger donor support than any other sector (almost a 'donor-led' sector), high rating on Paris Declaration principles in health due to SWAp arrangements (source: OECD)

2010-03-10: Malawi contributes a country presentation at the 1st meeting of the WHO Health Workforce Information Reference Group in Switzerland; limited computer literacy at district level and incomplete integration of HMIS and HR information system are mentioned as constraints (source: WHO)

2010-06-22: Final Report "Impact Evaluation of the Sector Wide Approach (SWAp), Malawi" published (source: WHO)

2010-07-02: Publication of Final Report on Malawi's Emergency Human Resource Programme (2004-2010, as a pillar of the SWAp); total number of workers in priority cadres increased by 53%, but only four of eleven cadres have met the targets (source: DFID)

2011: Onset of the second Malawi Growth and Development Strategy for 2011 to 2016, names decentralisation of administrative structures as essential for rural development (source: GIZ)

2011-01-25: Second Global Forum in Bangkok, Thailand; VSO presents "Development of a human resources Management Information System for the Malawi Ministry of Health" and "Highlighting health workers' concerns through focused research: supporting studies in Malawi, Cambodia, Uganda and Sierra Leone" as projects for the HRH awards (source: WHO)

2011-03: Major donors to Malawi stop disbursements due to concerns about governance and freedom of press. Since rule of law and subscription to human rights are underlying principles of budget support, the "Common Approach to Budget Support" (CABS) group of donors - including France, Germany, Iceland, Ireland, Japan, Norway, UK and US - issues a respective statement (source: BIZ community)

2011-04-20: Health SWAp Program of Work has been extended for a year (originally 2004-2010), but Norway and UK withhold some of their funds and demand an audit (source: BBC)

2011-05: Malawi expels British High Commissioner because of a leaked diplomatic telegram criticising president Bingu wa Mutharika's autocratic leadership style, but also indicating that some civil society leaders attack government because of their own political ambitions (source: BBC)

2011-07: Protests against the government in Malawi lead to 19 deaths. Britain as Malawi's major bilateral donor suspends £19 million of aid; 39% of British aid goes to health (source: BBC)

2012: Onset of the Malawian "Health Sector Strategic Plan 2012-2016", continuing focus on Essential Health Package (EHP) delivery (source: GIZ)

2012-01: Start of UNDP "Public Sector Capacity Development Project" (until Dec 2016), based on the previous National Decentralization Programme (2001), Comprehensive capacity assessment of the public service/administrative common service (2007), Capacity Development for Public Sector Management Programme (2008-2011) (source: UNDP)

2012-04: President Mutharika dies of a heart attack and is succeeded by vice-president Joyce Banda (source: BBC)

2012-05: President Banda devalues the currency (Malawian Kwacha) by 49% against the US\$ and removes the bond with the US\$, which leads to further devaluation. With other demands of the IMF also being followed, (e.g. price liberalisations for fuel, water and power), and repressive media laws being annulled, donor trust in economic policy is gradually re-established over the following months (source: BBC)

2012-05-15: Start of DFID "Health Sector Support Programme" (until Mar 2016), focusing on supply of drugs and therapeutic feeding, equipment to train health workers, and service delivery through CHAM. Britain adheres to the suspension of budget support from 2011, but talks of a "fresh development partnership", offers

technical and financial assistance for coping with currency devaluation (source: EU news)

2012-06-05: Extensive column on ethical aspects of health workers' strike in Nyasa Times, first accounts of strikes in Queen Elisabeth Central Hospital (source: Nyasa Times)

2012-06-30: End date of GFATM Round 5 Grant "Health Systems strengthening in Malawi" (from July 2009), performance rating B2, i.e. "inadequate but potential demonstrated" (source: GFATM)

2012-07-03: German Government announces 14 Million Euro of pooled funding for health, which was held back at the beginning of 2011 (source: Nyasa Times)

2012-07-08: Norway contributes 180 million Norwegian Kroner to Health Sector Pool Funding (source: Nyasa Times)

2012-09: Strikes for salary increments in various Malawian industries and public services are discussed as a reaction to the 49% currency devaluation, government and economists argue against it (source: Nyasa Times)

2012-09-22: Malawian Minister of Finance tries to raise additional funds among donors because of a large gap in the 2012/2013 government budget, but donors refuse. CABS speaker states that all Malawians - including the privileged - need to make sacrifices in times of economic crisis and patience is required for recovery. German ambassador remarks that effectiveness of budget support is being questioned globally (source: BBC)

2013-02-01: The Civil Servants Trade Union in Malawi announces strikes for mid-February, doctors and nurses say they will join (source: Nyasa Times)

2013-02-09: Malawi government considers the strike announcement to be unprocedural, since not all communication channels have been exhausted (source: Nyasa Times)

2013-02-18: Health workers at Dedza hospital go on strike although the National Organisation of Nurses and Midwives called them to wait for a two weeks ultimatum to end (source: Nyasa Times)

2013-06-21: Germany releases 5 million Euros of budget support for the pursuit of the economic reform agenda and the 'zero-corruption-policy' (source: Nyasa Times)

2013-07-09: Health workers in Northern districts go on strike because their salaries are delayed (still ongoing in October), Ministry of Health and Ministry of Finance blame each other (source: Nyasa Times)

2013-09: The major corruption scandal "Cashgate" is unveiled, after budget director Paul Mphwiyo (who was tasked with anti-corruption measures) has survived an assassination attempt. Extensive action on the public financing system follows, with 70 people arrested. According to a first audit covering recent months, US\$ 15 million were diverted from April to September 2013. The majority of donors to Malawi decide to withhold general budget support, which previously made up for 40% of the government's budget. Other forms of aid are tied to stricter conditions. (source: NORAD)

2013-10-24: "Cashgate" is said to undermine Malawi's public health system, with depleted budgets for equipment and supplies, and health workers being demoralised (source: IRIN)

2013-11: President Banda dismisses the cabinet on the background of corruption allegations (source: BBC)

2013-11-10: Third Global Forum on Human Resources for Health in Recife, Brazil focuses on identification of systemic interventions pathways along the Universal Health Coverage Framework AAAQ (availability, accessibility, acceptability and quality). Malawi stipulates HRH Commitment Action Plan, among others: Supporting capacity building for MoH managers at all levels, Enhancing mutual accountability between Health Workforce with local community and stakeholders including civil society organisations, decentralising HRH administration from central level (source: WHO)

2013-11-20: Nurses announce strike activities to press for the implementation of a presidential directive upgrading nurses and midwifery technicians to registered nurses and midwives (source: Nyasa Times)

2013-12: German government increases its aid for improving public finance management in Malawi; saying that suspended General budget support will be discussed again between January and March 2014. Britain has not only stopped general budget support, but also sector budget support - which principally allows more donor control over the accounts (source: Nyasa Times)

2013-12-09: Norway and UNDP sign cost-sharing agreement to maintain 28 of 44 UN Volunteer doctors in Malawian hospitals. Programme started in 2001 and will phase-out until Dec 2014 (source: Nyasa Times)

2013-12-18: World Bank Support to Malawi Social Action Fund (MASAF) Round IV approved; round I had started in 1996 (source: World Bank)

2014-01: Beginning of the first court trials for people arrested in the “Cashgate” affair (source: BBC)

2014-02-04: About 500 employees of World Vision Malawi go on strike for the first salary increase in 6 years, demanding 80% (source: Nyasa Times)

2014-02-25: Workshop “Countdown to 2015 – Maternal, Newborn & Child Survival” in Nairobi, within the overall scope of the MDG pursuit. Malawi conducts a case study on District performance variation, expected in March 2015 (source: WHO)

2014-04-14: Malawi makes commitments to WHO’s “One million Community Health Workers” Campaign at a national planning workshop in Tanzania (source: WHO)

2014-04-29: Germany decides to stop general budget support to the Malawian government and gives up its full membership in the CABS group, becoming an observer (source: Nyasa Times)

2014-05-20: First local elections after 13 years are held (after two postponements), together with parliamentary and presidential elections. The voter participation of 70%

provides strong mandates to those elected. Peter Mutharika, brother of the former president, wins presidential election (source: GIZ)

2014-05-25: Germany releases 3.5 million Euros for the Local Development Fund after the condition of successful local elections has been met. 2014 marks the end of GIZ programme “Promotion of democratic decentralisation”, which started 2003 (source: GIZ)

2014-07-31: Malawian government struggles to put up a budget for the fiscal year 2014/15; attempts to raise US\$ 500 million to close the budget gap for the health sector are rejected by donors (source: Nyasa Times)

2014-10-11: President Peter Mutharika promises to recover the money lost in “Cashgate”, which is a requirement of German government to resume general budget support. Germany funds a forensic audit to quantify the amount misappropriated during the period of the 2009 to 2012 rule of the Democratic Progress Party (audit to be carried out by Price Waterhouse Coopers). It is estimated that about 30% of the countries budget may have been diverted over a decade (source: Nyasa Times)

2014-10-24: Britain says it will resume budgetary support after the completion of the public sector reforms, meanwhile channels US\$ 100 million through the non-governmental sector (source: Nyasa Times)

2014-11-10: Health workers in Zomba district strike for removal of the allegedly corrupt DHMT (source: Nyasa Times)

2014-11-14: For the period up to 2015, Germany donates 58,3 million Euro to Malawi for education, health and private sector development, which includes a results-based programme on maternal and child health. GIZ programme “Sustainable structures for the health sector” started 2004, ends in 2015 (sources: GIZ, Nyasa Times)

2014-11-24: The “Cashgate” audit commissioned to Price Waterhouse Coopers starts, but is only to cover the period of 2009-2013. According to the Malawian Auditor General, funds to conduct an audit for 2005-2009 still need to be raised (source: Nyasa Times)

2014-12: Claims for salary increases and strike activities by employees in the judiciary, the University of Malawi, the National Assembly and the Anti-Corruption Bureau (ACB) gain momentum (source: Nyasa Times)

2014-12-17: Representatives of doctors and nurses reject Malawi government's plea to postpone salary reviews until the economy has recovered, announce plans to go on a nationwide strike (source: Nyasa Times)

2014-12-18: Minister of Finance is threatening the ACB employees with withholding December salaries unless they end their strike (source: Nyasa Times)

2014-12-21: President Mutharika, in his 'state of the nation' address, urges civil servants to consent to salary harmonisation instead of adhering to the diverging pay scales that have evolved since 1998. He also highlights the risk of rising inflation and interest rates, and that wage containment is a requirement of the IMF (source: Nyasa Times)

2014-12-31: The Malawi Human Rights Commission states that the legality of some of the strikes is questionable, as they take place outside of negotiation. Moreover, the right to withdraw labour is limited for those who are providing essential public services, (e.g health services, according to a government directive). The Commission recommends clarification whether the judiciary falls among these services, as incapability of juridical action erodes the principle of the separation of powers (source: Nyasa Times)

2015-01-08: Civil Servants Trade Union, National Organisation of Nurses and Midwives and Malawi Doctor's Union issue a seven day notice to government to resume negotiations on salaries and allowances (source: Nyasa Times)

7.2.2 RECENT SCIENTIFIC PUBLICATIONS

Articles and evaluation reports published between 2010 and 2015 are reviewed here under three main aspects: global policies influencing HRH in Malawi, approaches to improved retention of health workers in the country, and efforts to decentralise governance in health and other sectors.

Global policy on HRH

The outflux of health workers from sub-Saharan African countries has long been identified as a major factor inhibiting workforce development. A study published by Mills et al. (2011) substantiates this insight, quantifying the returns on investment lost to sending countries, whose domestically trained medical doctors migrate to the US, the UK, Australia and Canada. Although the costs of training in Malawi are low in comparison to other countries from the region, the average investment lost per doctor are estimated at 51,238 US\$ (32,926 US\$ in Uganda - 127,221 US\$ in South Africa). The authors argue that such calculations of human capital may support the policy debate about aid from receiving to sending countries.

The global discourse on the negative effects of overseas recruitment of health workers has also led to more restrictive immigration policies in the UK from 2006 onwards. Adhikari and Grigulis (2014) find a connection to the subsequently reduced numbers of Malawian nurses entering the UK and assume that – at least in Malawi – nurses have found alternatives to public sector employment in the expanding NGO sector. However, those who still find alternative routes to the UK experience deskilling and find themselves shut in due to visa uncertainties, impeding their original intent to return home.

The policy discourse has also fed into several WHA resolutions and the WHO Code of Practice for the International Recruitment of Health Personnel issued in 2010. Dayrit et al. (2011) state that related global action plans have not led any of the 57 countries identified in the WHR 2006 out of the state of HRH crisis so far. They admit that the medium term strategic plan 2008-2013 (resolution WHA60.11) was based on very optimistic assumptions about the political and economic developments in support of

building up HRH. However, they identify eight countries which provide positive examples on which to base policy advice, each in different aspects of HRH development. Based on the results of the EHRP evaluation (DFID 2010), they commend Malawi for an 83% increase of its health worker stock from 2004 to 2009, due to expanded pre-service training and retention schemes for rural areas. However, the health worker density of 1,61 per 1000 population was still below African average (1,91 per 1000) in 2009.

However, Gopinathan et al. (2014) point out the influences of the overall health system on the health workforce, which might undermine the effects of large-scale HRH programmes, but also changes in the HRH field may lead to shifts in health policies and service delivery. Also Mueller et al. (2011), who have examined constraints to the implementation of the Essential Health Package. Having interviewed health workers and managers at various levels of the Malawian health system, they identify the shortages in staff and drugs supply as key factors and conclude that those should have priority over the design and implementation of fundamental reforms such as EHP implementation. Notably, they have found that among clinical staff only 48% of expected man days were available, with more than half of the absences in health centres being due to meetings and trainings.

Global Health Initiatives have been criticised as vertical programmes fragmenting and distorting national health systems. As a response, Round 5 of the GFATM was directed at Health systems strengthening, which in Malawi contributed to pooled funding for the EHRP. Brugha et al. (2010) state that on top of routine outpatient services, ART delivery could be substantially increased due to the Malawian policy of particularly expanding lower-trained cadres shifting HIV/AIDS related tasks to these cadres. By contrast, the simultaneous intervention of GFATM and PEPFAR in Zambia is thought to have inhibited a coordinated workforce response. However, Smith et al. (2014) highlight the consequences of task-shifting and prioritization for HSAs in Malawi. In their focus group discussions and interviews, HSAs have indicated that they feel overloaded and troubled by competing demands, while at the same time they lack training, supervision and adequate remuneration. The authors call upon policy-makers

to reconsider the division of HSAs' roles (prevention versus curative care; community versus centre-based activities) and possibilities of specialization for this cadre.

HRH management and retention in Malawi

As for the topic of health worker retention, number of studies have been carried out in recent years. Silvestri et al. (2014) have investigated the career plans of medical and nursing students in eight countries including Malawi. 28% of final year students still wanted to work abroad, with the intention to leave the country being more widespread among nurses. The likelihood of aiming for a rural post (18% of participants) increased with years previously spent in rural areas. As these intentions existed before matriculation, the authors recommend to shift admission standards in favour of such candidates. Mandeville et al. (2012) have specifically researched the career plans of Malawian medical graduates and traced them within the country as well as abroad. Out of 256 persons graduated between 2006 and 2012, 79,2% were still working in Malawi, but the odds of emigration doubled with each year after graduation (odds ratio = 1.98). As most doctors leave Malawi in strife for specialisation, offering in-country post-graduate training is considered an important measure. However, as Sawatsky et al. (2014) point out, there are mixed views among Malawian medical students regarding the specialisations already on offer, and most of the 21 interviewees still desired to go abroad for this purpose.

Other research has focused on job satisfaction of health workers deployed in rural health facilities. Blaauw et al. (2013) have conducted a questionnaire survey of various cadres, comparing Tanzania, Malawi and South Africa. According to this study, 71% of Malawian participants are satisfied with their job, as compared to 52.1% of South African and 82.6% of Tanzanian participants. Fogarty et al. (2014) go one step further, devising a multivariate model of job satisfaction and testing it for different countries. Other than for Afghanistan, their model only explained 9.8% of variance in job satisfaction and 9.1% of variance in intention to stay in Malawian health workers. They conclude that features of the workplace (resources, performance recognition, financial compensation, training opportunities, safety) need to be covered in more detail to learn about the relative importance of different determinants in different contexts. On

this basis, tailored interventions for health worker retention and performance may be designed.

A qualitative study on 'critical incidences' which made health workers consider leaving their job has been conducted by Chimwaza et al. (2014). The accounts mostly dealt with unfair or disrespectful treatment, personal efforts not being recognised, issues of payment, obscure promotion criteria, and dying patients. The authors highlight that better management practices and more transparent policies might well address a number of factors underlying these incidents. Bradley et al. (2013) have interviewed DHMT members in Malawi and their equivalents in Tanzania on human resource management issues. Malawian participants were found to be focused on inspection and control, while Tanzanians rather put forward a more positive and supportive approach. Again, policies to foster the understanding and skill of supervision are called for by the authors. Especially in rural health districts, where a large share of the workload is met by mid-level cadres with a lower degree of institutionalisation, guidelines for supervision are needed to improve staff retention.

Decentralised governance

The importance of utilising health management information at district level for decentralisation of decision making competencies is widely acknowledged. However, Kasambara et al. (2014) find the functioning of the Health Management Information System (HMIS), which was introduced in Malawi in 1999, being limited because respective staff members at district and community level lack the appropriate qualifications. Out of ten HMIS-Officers interviewed in southern districts, only one was meeting the qualification stipulated in the job description by the MoH. Besides the need for training and refresher courses, the authors assert that a review of indicators and a harmonisation of data collection tools are required. Vollmer LeMay and Bocock (2012) also see problems in the upward as well as the downward flow of health information and knowledge within the Malawian health system. They have conducted a qualitative study on information needs among health workers regarding reproductive health and HIV/AIDS issues in three districts and the capital Lilongwe. With a weak culture of clinical and technical knowledge exchange, standardised information

compiled at the national level was found to be mostly disseminated through technical meetings and working groups. Only few health workers in the districts have access to these structures, notably those working in NGOs. The authors suggest developing District Health Offices as information hubs and learning centers, providing internet access for health workers, libraries and spaces for mutual knowledge exchange. More suitable formats of information (e.g. in local language) are especially needed for HSAs. Information provided at the district level should be both clinical and programmatic for use by clinical providers and district management staff.

Gama (2013) has studied the Service Level Agreements (SLA) as a form of contracting between governmental and CHAM facilities in Malawi, from the perspective of principal-agent-theory. Although he asserts some positive contributions of SLAs in terms of maternal and child health care and protection of service users against financial risks, he sees few considerable improvements in quality or efficiency. One underlying reason, he assumes, is the focus on the demand side (user charges), while the supply side (resources, materials and infrastructure) is largely neglected in SLAs. Thus he is also critical of assigning the already scarce and stretched health workers with enforcement, governance and accountability within such contractual arrangements. Problems do not only arise from lack of knowledge about the managerial procedures and intended outcomes, but also from perverse incentives for both contracting parties. Development agencies come in as a third player, so that the field is characterised by multiple agency relations and plural modes of governance. Gama states that “the actors reshape each other’s incentives through various mechanisms such as bureaucratic systems, unpredictability of financial flows and capacity problems” (2013, p. 183). He is cautious of SLAs being a donor driven idea that is in conflict with the historically and socially determined relations between the Malawian government and CHAM, and that SLAs therefore might not be sustained in the absence of donor support.

The provision of public goods through local governance structures in Malawi is investigated by Cammack (2011), looking at the examples of safe birthing, market management, and public safety. He also finds that jurisdictional overlaps and uncertainties, plus a lack of capacity and resources, are undermining coordination. In

addition, he points out the politicisation of public services as a historically grown phenomenon. While any transformation comes along with conflicting rules and problems of enforcement, donor-induced policy shifts may aggravate the situation. He observes that collaborations of citizens, local leaders and officials in Malawi generally remain feeble and do not last for long.

The relationship of governmental and non-governmental, local and global agents remains controversial. Cohn et al. (2011) have found positive perceptions of GHIs among civil society organisations in four receiving countries (Kenya, Malawi, Uganda, Zambia). This is concerning GHIs' impact on the availability of special services such as ART, but also on the larger health system. At the same time, they criticise that GHIs' engagement does not provide sufficiently for the participation of and capacity building among grassroots organisations. Bisson et al. (2014) see a tendency of CSOs seeking greater influence on policy making for the health workforce, e.g. regarding the recruitment in rural areas. In their Report of the Health Workforce Advocacy Initiative (HWAI) for Malawi, Senegal and Uganda, they look into the Country Commitments made within the scope of GHWA. They acknowledge progress in Malawi, such as the 2014 audit of civil servants working in the health field, or trainings for DHMTs. Still they see room for improvement of coordination between governmental and non-governmental agencies, particularly in the field of HRH monitoring.

7.3 FIELD RESEARCH PHASE

I arrived in Malawi on the 19th February 2009. Lilongwe as the capital and centre of activities in international cooperation has been the geographical starting point. The first weeks were used for clarifying the requirements for ethical clearance and the preparation of the proposal, but also for document and internet research. After linking up with the Department of Community Health at the COM, I submitted the proposal to their Research and Ethics Committee (COMREC).

In March and April I also had the opportunity to participate in a meeting of all GDC health staff, an internal meeting of the Ministry of Health (MoH) on technical assistance and in the SWAp mid-term review meeting in Lilongwe. I met key informants at the MoH, the Malawi College of Health Sciences and the CHAM headquarters and carried out three pilot interviews. I requested and later obtained access to the Human Resources for Health census data from the MoH.

After a revision and resubmission, the COMREC gave its ethical approval on 6th May, which enabled me to officially start the field research. After three more interviews in the capital and participating in a 5-day cultural course in Mua Mission, I moved to one of the zones, where I visited several districts and interviewed several participants.

In June I participated in a meeting of the HRH advocacy platform in Lilongwe, which is a network of training and health service providers concerned with human resource issues, focusing on nursing. I then spent three weeks in Blantyre, doing document research at the College of Medicine, the Society of Malawi and the Daily Times newspaper archive. Moreover, some interviews were conducted surrounding districts.

I continued the field research in Zomba, where I interviewed some participants in surrounding districts and searched for documents in the National Archive, the Centre for Social Research and the Library of the College of Nursing. Afterwards I shifted to another zone for some more interviews.

In August I finalised the data collection for the analysis of job advertisements from the Daily Times Archive, with the assistance of two Malawian students. After debriefing meetings at the GDC, I departed to Germany on 13th August 2009.

7.4 CONSENT FORM FOR INTERVIEW PARTNERS

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Mobile phone: 0884487486

Blantyre, in June 2009

Consent for participation in research project

Dear Sir / Madam,

Thank you very much for your interest in my current research project. This field research in Malawi is part of my doctorate at the School of Public Health, Bielefeld University, Germany, carried out in cooperation with the Department of Community Health at the College of Medicine in Blantyre.

The project deals with human resource development within the field of public health, particularly with Malawian health professionals in leading positions. By means of qualitative interviews and participation in the work setting, my aim is to embrace the perspectives of the professionals as agents within the Malawian health system. The focus is on professional biographies, work arrangements and the meaning of international collaboration and geographical mobility.

My request to you is your personal consent for participation in this research project. Please find below the related information on confidentiality and data handling.

I would greatly appreciate if you agree to participate by signing the form below (see overleaf).

Thank you very much in advance.

Yours sincerely,

Maren Bredehorst, MPH

Statement of consent

(Please cross out non-applicable statements, if any)

Hereby I agree to participate in the research outlined above, which will include giving an open qualitative interview and receiving Maren Bredehorst as a participant observer in my workplace.

I have been informed that any material gathered from me, either in the form of interviews, observation or unpublished documents, will be treated with strict confidentiality and will only be processed anonymously (names of persons and places as well as distinct dates will be masked).

I am also aware that I have the right to refuse the answer to any of the interview questions, to withdraw at any point of the research or to ask for the non-utilisation of certain data sequences after the data collection is completed.

I agree that the interview will be recorded on a digital recorder, to facilitate the research documentation and correct transcription.

Date:

Signature:

7.5 INTERVIEW GUIDELINE

1) Initial stimulus

“As I have told you, I am interested in the professional biographies of Malawians working in the field of public health and health systems development. So I would like to ask you to tell me your personal story: What is your background, what education and training have you pursued, which different stages and experiences have you gone through, and how did you come to work in your current position?”

(followed by probes on missing details, sequences that remained unclear or interesting references indicated (particularly on work or training in international context))

2) Further questions:

Own career:

- How common is this kind of career for people with your training background?
- What are your ideas and wishes for your further career?

Leadership:

- At what point in time did you start to take over leading functions, and what were they?
- Since then, what are the most significant things that you have learned, where have you personally improved as a leader?
- Which human resource management tasks do you have in your current position?

Public health work activities:

- Can you describe the processes of health policy making and implementation that you are involved in, please?
- Have you ever been doing commissioned research or consultancies, and what were they?
- What is your understanding of Public Health, and where do you see your personal contribution to it?

International interfaces:

- Where do international contacts occur in your everyday work? Please describe these encounters a bit more, and what they mean to you.
- You have mentioned different engagements with international organisations. How do you perceive your role as a Malawian interacting with those agencies?
- Looking at the various international aid agencies working in the Malawian health sector, which different employment practices do you see? What effect do these practices have for human resource development in health?

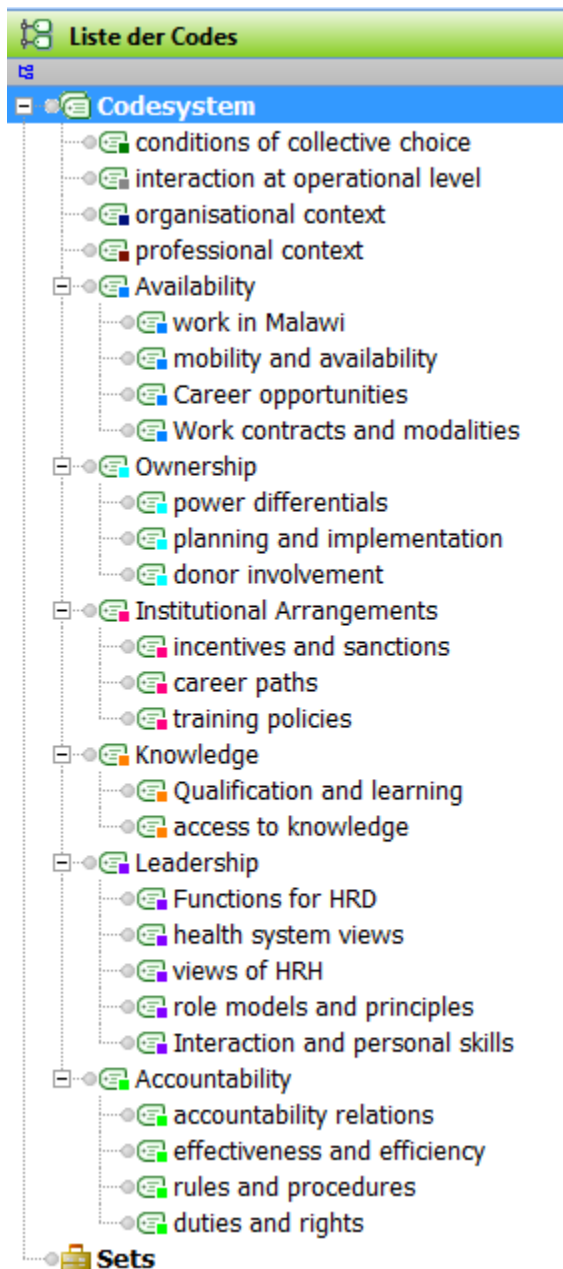
Malawian health system:

- What would you say is the biggest problem of the Malawian health system?
- What motivates you to work here in Malawi?
- Which do you consider the most important issues to tackle in order to achieve a sustainable and well-performing health workforce?

7.6 CODE SYSTEM FOR THEMATIC ANALYSIS

List of codes used in MAXQDA:

The first four codes were used for double coding of interview segments, to mark the narrative context in which the statements were made.



7.7 HRH CENSUS DATA ON THE MALAWIAN HEALTH WORKFORCE

The tables in this Annex have been derived from published tables based on the HRH census. It was carried out as a nationwide survey by the Centre for Social Research in Zomba in 2008.

Source: Government of Malawi - Ministry of Health (2008) Malawi Health Sector Employee Census, Final Draft. Lilongwe

The following original tables from the HRH census have been transferred to MS Excel, cross-checked and rearranged:

- Table 9: Distribution of staff in the health sector disaggregated by location of work (Annex 7.7.1)
- Table 11: Distribution of staff in the health sector according to ownership status of the facilities (Annex 7.7.2)
- Table 3: Distribution of facilities in Malawi disaggregated by facility ownership status, regions, location and zone;
Table 2: Number of facilities in Malawi disaggregated by Zone and level of care (Annex 7.7.3)
- Table 5: Distribution of health facilities in Malawi disaggregated by district and ownership status (Annex 7.7.4)

Population data for Annex 7.7.4 was taken from the Statistical Yearbook 2008, referring to the 2008 Household and Population Census. (The authors of the HRH census report had still been using figures based on the previous census in 1998)

Source: National Statistical Office (2010) Malawi Statistical Yearbook 2008. Tables for chapter 2. <http://www.nsomalawi.mw/publications/statistical-yearbooks/87-statistical-yearbook-2008.html>, accessed 03-01-2015

7.7.1 HEALTH WORKER DISTRIBUTION BY LOCATION OF WORK

Location of facility Profession	Urban			Rural			Semi-Urban			total	
		col %	row %		col %	row %		col %	row %		col %
Physicians	117	1.47	61.58	44	0.25	23.16	29	0.37	15.26	190	0.57
Clinical Officers	250	3.14	35.71	186	1.05	26.57	264	3.38	37.71	700	2.09
Medical Assistants	94	1.18	13.30	479	2.70	67.75	134	1.72	18.95	707	2.11
Nurses/Midwives	1,108	13.94	37.79	972	5.49	33.15	852	10.92	29.06	2,932	8.76
Nurse Technicians	249	3.13	25.72	383	2.16	39.57	336	4.31	34.71	968	2.89
Auxiliary Nurses	131	1.65	30.61	26	0.15	6.07	271	3.47	63.32	428	1.28
Public Health Worker	73	0.92	22.96	78	0.44	24.53	167	2.14	52.52	318	0.95
HSA's	694	8.73	6.90	7,967	44.98	79.23	1,394	17.87	13.86	10,055	30.04
Management Staff	1,185	14.90	40.43	866	4.89	29.55	880	11.28	30.02	2,931	8.76
Lecturers/Tutors	69	0.87	56.10	47	0.27	38.21	7	0.09	5.69	123	0.37
Researcher	18	0.23	100.00	0	0.00	0.00	0	0.00	0.00	18	0.05
Laboratory Technicians	191	2.40	40.38	176	0.99	37.21	106	1.36	22.41	473	1.41
Dentists	85	1.07	40.28	77	0.43	36.49	49	0.63	23.22	211	0.63
Pharmacists	119	1.50	40.61	122	0.69	41.64	52	0.67	17.75	293	0.88
Physiotherapists	7	0.09	77.78	2	0.01	22.22	0	0.00	0.00	9	0.03
Opticians	5	0.06	62.50	1	0.01	12.50	2	0.03	25.00	8	0.02
Orthopaedician	41	0.52	56.94	4	0.02	5.56	27	0.35	37.50	72	0.22
Radiographers	45	0.57	44.12	21	0.12	20.59	36	0.46	35.29	102	0.30
Anesthetists	25	0.31	30.86	12	0.07	14.81	44	0.56	54.32	81	0.24
Ophthalmologists	7	0.09	41.18	1	0.01	5.88	9	0.12	52.94	17	0.05
Semi-skilled Workers	25	0.31	7.51	273	1.54	81.98	35	0.45	10.51	333	1.00
Ward/Hospital Attendants	1,381	17.37	24.22	2,760	15.58	48.41	1,560	19.99	27.36	5,701	17.03
Accounts Staff	344	4.33	43.99	251	1.42	32.10	187	2.40	23.91	782	2.34
Secretaries/Typists	137	1.72	56.61	50	0.28	20.66	55	0.70	22.73	242	0.72
Kitchen Staff	188	2.36	44.34	81	0.46	19.10	155	1.99	36.56	424	1.27
Messengers/Cleaners	555	6.98	41.73	470	2.65	35.34	305	3.91	22.93	1,330	3.97
Security Staff	359	4.52	17.54	1,271	7.18	62.09	417	5.34	20.37	2,047	6.12
Ground Labourers	173	2.18	13.32	848	4.79	65.28	278	3.56	21.40	1,299	3.88
Other Staff	220	2.77	38.80	221	1.25	38.98	126	1.61	22.22	567	1.69
Not mentioned	56	0.70	52.83	25	0.14	23.58	25	0.32	23.58	106	0.32
Total	7,951	100.00		17,714	100.00		7,802	100.00		33,467	100.00

Source: Malawi Health Sector Employee Census 2008, Table 9

7.7.2 HEALTH WORKER DISTRIBUTION BY OWNERSHIP OF FACILITY AND BY SEX

Ownership of Facility	Government	CHAM	Private				Total	Sex			
			NGO	for Profit	Statutory org.	Company		Male	row%	Female	row%
Physicians	97	48	7	33	3	2	190	139	73.16	51	26.84
Clinical Officers	409	118	68	77	10	18	700	635	90.71	65	9.29
Medical Assistants	492	107	15	66	4	23	707	585	82.74	122	17.26
Nurses/Midwives	2,004	553	146	140	63	26	2,932	249	8.49	2,683	91.51
Nurse Technicians	530	362	26	38	8	4	968	148	15.29	820	84.71
Auxiliary Nurses	374	29	15	10	0	0	428	96	22.43	332	77.57
Public Health Worker	287	18	8	0	4	1	318	285	89.62	33	10.38
HSAs	8,333	1,559	48	32	9	74	10,055	6,190	61.56	3,865	38.44
Management Staff	1,746	762	232	102	64	25	2,931	2,347	80.08	584	19.92
Lecturers/Tutors	51	62	0	0	10	0	123	61	49.59	62	50.41
Researcher	6	1	8	0	2	1	18	7	38.89	11	61.11
Laboratory Technicians	208	155	29	51	24	6	473	403	85.20	70	14.80
Dentists	123	75	0	13	0	0	211	168	79.62	43	20.38
Pharmacists	158	105	11	15	0	4	293	178	60.75	115	39.25
Physiotherapists	4	1	3	1	0	0	9	8	88.89	1	11.11
Opticians	4	3	0	1	0	0	8	6	75.00	2	25.00
Orthopaedicians	63	4	2	3	0	0	72	64	88.89	8	11.11
Radiographers	69	29	1	3	0	0	102	95	93.14	7	6.86
Anesthetists	61	17	1	2	0	0	81	63	77.78	18	22.22
Ophthalmologists	16	1	0	0	0	0	17	14	82.35	3	17.65
Semi-skilled Workers	91	226	14	2	0	0	333	29	8.71	304	91.29
Ward/Hospital Attendants	3,944	1,523	53	96	9	76	5,701	2,150	37.71	3,551	62.29
Accounts Staff	368	276	23	95	19	1	782	436	55.75	346	44.25
Secretaries/Typists	137	56	13	15	20	1	242	23	9.50	219	90.50
Kitchen Staff	274	105	13	13	19	0	424	305	71.93	119	28.07
Messengers/Cleaners	511	443	71	237	52	16	1,330	677	50.90	653	49.10
Security Staff	1,187	605	98	100	53	4	2,047	1,941	94.82	106	5.18
Ground Labourers	744	474	25	33	10	13	1,299	1,191	91.69	108	8.31
Other Staff	181	166	204	7	5	4	567	353	62.26	214	37.74
Not mentioned	70	8	20	6	1	1	106	56	52.83	50	47.17
total	22,542	7,891	1,154	1,191	389	300	33,467	18,902	56.48	14,565	43.52

Source: Malawi Health Sector Employee Census 2008, Table 11

Note: The cross-check in MS Excel revealed some inconsistencies in the sums presented in the original table.

Corrected fields in this version are:

- Nurses/Midwives in Government and NGOs
- Other staff in CHAM.

As a result, the grand total in this table is n=33,467 health workers, instead of n=33,470 as displayed in the HRH census report.

7.7.3 OWNERSHIP OF FACILITY BY ZONE, BY LOCATION AND BY LEVEL OF CARE

Ownership status	Government			CHAM			NGO			Private f. profit			Statutory			Company			Total	
	575	col %	row %	147	col %	row %	70	col %	row %	200	col %	row %	20	col %	row %	47	col %	row %	1059	row%
Zones																				
North	114	19.83	60.96	23	15.65	12.30	9	12.86	4.81	31	15.50	16.58	4	20.00	2.14	6	12.77	3.21	187	17.66
Central East	80	13.91	59.70	20	13.61	14.93	13	18.57	9.70	17	8.50	12.69	0	0.00	0.00	4	8.51	2.99	134	12.65
Central West	129	22.43	50.19	34	23.13	13.23	19	27.14	7.39	67	33.50	26.07	5	25.00	1.95	3	6.38	1.17	257	24.27
South East	116	20.17	56.04	45	30.61	21.74	9	12.86	4.35	22	11.00	10.63	2	10.00	0.97	13	27.66	6.28	207	19.55
South West	136	23.65	49.64	25	17.01	9.12	20	28.57	7.30	63	31.50	22.99	9	45.00	3.28	21	44.68	7.66	274	25.87
total	575	100.00	54.30	147	100.00	13.88	70	100.00	6.61	200	100.00	18.89	20	100.00	1.89	47	100.00	4.44	1,059	100.00
Location																				
Urban	64	11.13	27.35	11	7.48	4.70	31	44.29	13.25	103	51.50	44.02	14	70.00	5.98	11	23.40	4.70	234	22.10
Rural	477	82.96	63.86	129	87.76	17.27	14	20.00	1.87	88	44.00	11.78	6	30.00	0.80	33	70.21	4.42	747	70.54
Semi-Urban	34	5.91	43.59	7	4.76	8.97	25	35.71	32.05	9	4.50	11.54	0	0.00	0.00	3	6.38	3.85	78	7.37
total	575	100.00	54.30	147	100.00	13.88	70	100.00	6.61	200	100.00	18.89	20	100.00	1.89	47	100.00	4.44	1,059	100.00
Level of care																				
Primary	493	85.74	54.72	96	65.31	10.65	56	80.00	6.22	196	98.00	21.75	13	65.00	1.44	47	100.00	5.22	901	85.08
Secondary	53	9.22	53.00	42	28.57	42.00	1	1.43	1.00	4	2.00	4.00	0	0.00	0.00	0	0.00	0.00	100	9.44
Tertiary	5	0.87	83.33	1	0.68	16.67	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	6	0.57
Others	24	4.17	46.15	8	5.44	15.38	13	18.57	25.00	0	0.00	0.00	7	35.00	13.46	0	0.00	0.00	52	4.91
total	575	100.00	54.30	147	100.00	13.88	70	100.00	6.61	200	100.00	18.89	20	100.00	1.89	47	100.00	4.44	1,059	100.00

Source: Malawi Health Sector Employee Census 2008, Tables 2 and 3

7.7.4 OWNERSHIP OF THE FACILITY BY DISTRICT

Zone	District	Population	Government	CHAM	NGO	Private for profit	Statutory organisation	Company	Total
North	Chitipa	179,072	11	1	0	1	0	0	13
	Karonga	272,789	17	1	2	3	1	0	24
	Rumphi	169,112	15	4	2	7	0	1	29
	Mzimba	853,305	51	13	4	17	3	2	90
	Nkhatabay	213,779	19	1	1	3	0	3	27
	Likoma	10,445	1	3	0	0	0	0	4
total	1,698,502	114	23	9	31	4	6	187	
Central East	Kasungu	616,085	24	3	2	3	0	2	34
	Nkhotakota	301,868	14	6	4	2	0	2	28
	Ntchisi	224,098	11	1	0	1	0	0	13
	Salima	340,327	14	4	3	5	0	0	26
	Dowa	556,678	17	6	4	6	0	0	33
total	2,039,056	80	20	13	17	0	4	134	
Central West	Mchinji	456,558	14	3	2	7	0	0	26
	Lilongwe	1,897,167	61	13	15	57	5	3	154
	Dedza	623,789	27	8	1	1	0	0	37
	Ntcheu	474,464	27	10	1	2	0	0	40
total	3,451,978	129	34	19	67	5	3	257	
South East	Balaka	316,748	8	8	2	2	0	0	20
	Mangochi	803,602	29	12	1	6	1	1	50
	Machinga	488,996	20	4	1	6	0	0	31
	Zomba	670,533	31	12	3	2	1	1	50
	Phalombe	313,227	10	5	0	0	0	0	15
	Mulanje	525,429	18	4	2	6	0	11	41
total	3,118,535	116	45	9	22	2	13	207	
South West	Thyolo	587,455	34	7	2	5	0	9	57
	Blantyre	999,491	36	7	13	46	8	9	119
	Chiradzulu	290,946	13	3	2	3	0	0	21
	Chikwawa	438,895	23	3	1	4	1	3	35
	Nsanje	238,089	13	3	0	2	0	0	18
	Mwanza	94,476	9	0	1	1	0	0	11
	Neno	108,897	8	2	1	2	0	0	13
total	2,758,249	136	25	20	63	9	21	274	
Malawi	13,066,320	575	147	70	200	20	47	1059	

Source: Malawi Health Sector Employee Census 2008, Table 5

7.8 CONGOMA DATA ON HEALTH NGOS IN MALAWI

7.8.1 SECTORAL STRUCTURE OF THE NGO REGISTRY

The following table displays the self-reported fields of work among n=227 NGOs in Malawi (indication of multiple fields was possible).

Note: Ranking by number of organisations engaging in the sectors (author's own calculations)

Rank	Field of work	NGOs engaged (n)
1	HIV/AIDS	180
2	education	128
3	health	127
4	agriculture and food security	120
5	orphan care and children's affairs	114
6	capacity building/technical skills training	109
7	gender/women development	87
8	water and sanitation	80
9	human rights, democracy and governance	70
10	environment, land and natural resources management	68
11	advocacy and lobbying	61
12	disaster management	54
13	micro credit / finance and enterprise development	50
14	youth	47
15	counselling	41
16	construction and infrastructure	30
17	social rehabilitation	23
18	disability	15
19	media/development communication	12
20	drug and substance abuse	6
21	unclassified sectors	6
22	energy	1

Source: CONGOMA (2008) Directory of NGOs in Malawi. Blantyre

7.8.2 DISTRICTS OF OPERATION

The following table shows the district-level activities reported by health NGOs and by NGOs working on HIV/AIDS or water & sanitation. The 28 Malawian districts are ranked by the total number of NGOs working in them (in the field of health and in the fields of water&sanitation, HIV/AIDS)

Note: Organisations working in health – among other fields – are counted as health NGOs.

Zone	District	Sum health NGOs	Sum NGOs in water & sanitation, HIV/AIDS	total	Rank out of 18 (according to total)
North	Chitipa	25	23	48	13
	Karonga	27	26	53	11
	Rhumpi	26	23	49	12
	Mzimba	45	34	79	2
	Nkhata Bay	26	28	54	10
	Likoma	18	16	34	18
Central East	Kasungu	29	29	58	7
	Nkhotakhota	25	23	48	13
	Ntchisi	22	23	45	16
	Salima	36	23	59	5
	Dowa	34	27	61	4
Central West	Mchinji	22	25	47	14
	Lilongwe	53	41	94	1
	Dedza	30	26	56	8
	Ntcheu	27	28	55	9
South East	Balaka	25	28	53	11
	Mangochi	32	29	61	4
	Machinga	28	28	56	8
	Zomba	38	36	74	3
	Phalombe	20	26	46	15
	Mulanje	28	27	55	9
South West	Thyolo	28	31	59	6
	Blantyre	46	48	94	1
	Chiradzulu	25	24	49	12
	Chickwawa	31	27	58	7
	Nsanje	23	26	49	12
	Mwanza	22	22	44	17
	Neno	25	20	45	16

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Declarations

Ich versichere, dass ich die Arbeit selbständig verfasst und keine anderen Quellen und Hilfsmittel als die angegebenen benutzt habe. Die Stellen der Arbeit, die anderen Werken entnommen sind, habe ich unter Angabe der Quelle als Entlehnung kenntlich gemacht. Das gilt auch für die verwendeten Tabellen und Abbildungen.

Ich versichere, dass die vorliegende Arbeit nicht anderweitig in dieser Form als Prüfungsarbeit für eine staatliche oder andere wissenschaftliche Prüfung eingereicht worden ist.

Ich versichere zudem, bisher keine weiteren Versuche zur Promotion unternommen zu haben.

Marburg, den 11. April 2015

Maren Bredehorst