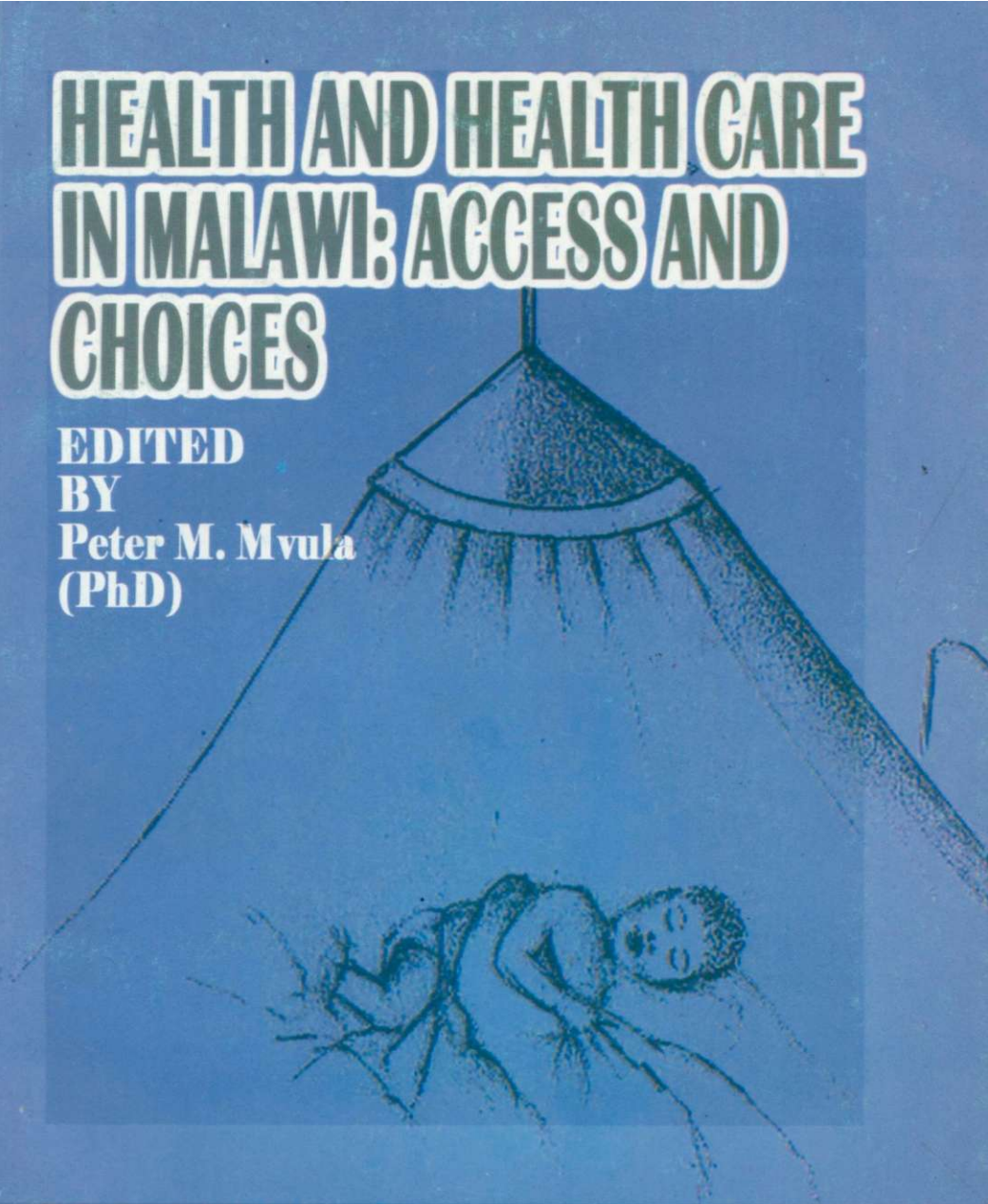


HEALTH AND HEALTH CARE IN MALAWI: ACCESS AND CHOICES

EDITED
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Foreword

The Organization for Social Science Research in Eastern and Southern Africa (OSSREA) Malawi Chapter, organized a research dissemination workshop on 14th July, 2004. The main aim was to share findings of studies in the areas of health and education with policy makers and academia and demonstrate the role Social Scientists can play in analysing Social Policy. What came out clearly during the forum was the need for increased dialogue between researchers, policy makers and implementers so as to generate effective interventions. This is in line with OSSREA's belief that research for research sake is futile unless it is disseminated to end users. At that dissemination meeting, participants hailed the principle of creating and strengthening the interface between research and policy as a target that we should all strive for.

A number of papers were presented. The papers published here are those whose manuscripts the authors managed to review to take into account comments made by workshop participants and other reviewers.

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I am also very grateful to the authors. A number of papers were presented at the workshop but only a few persevered and did more work on their papers. For their diligence and the time they put into the production of the papers, I say, thank you.

Without the technical contribution of the Chancellor College Publications, this book would not see the light of day. I am also very much indebted for the services of Mr Kingsley Jika, their editor; Mrs Linda Saka, their designer; and the rest of the members of staff at Chancellor College Publications. We also give credit to Eva Chikabadwa who designed the cover for this work.

Peter M. Mvula (Editor)

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Making Therapeutic Choices in African Societies

Alister C. Munthali

Abstract

In African societies, a range of therapeutic alternatives are available to which people can resort during illness episodes - they may choose to use the services of herbal concoctions or western pharmaceuticals; consult herbalists, diviners and faith healers of the African Independent Churches or they may go to modern health facilities which comprise dispensaries, clinics and hospitals. There are also the *malamai* (Islamic scholars) who practice medicine based on the use of Arabic texts and the healing power of Allah. This paper, which is based on a literature survey, explores the different factors that determine therapy choice in African societies.

Introduction

Biomedical health services were introduced in Africa by missionaries and the colonial administrators. Missionaries and their missions established hospitals, trained African medical personnel and dealt with chronic illnesses and epidemics until the period between the 1930s and 1960s when colonial (or independent) government medical services reached rural areas (Vaughan, 1991). The introduction of biomedicine in African societies has led to the curbing of many African illnesses though colonial incursion was also blamed for the introduction of measles and whooping cough and the exacerbation of the spread of smallpox as a result of, among other factors, the movement of people as porters, labour migrants and troops (Ranger, 1992:260). Missionaries and colonial administrators denounced the magico-religious character of African medical systems, and consequently the Witchcraft Suppression Acts, which were passed by the colonial states, banned witch-finding and witchcraft (Waite, 1992:229). Missionary medicine in a way was perceived as a tool to convert or draw the African patient to the love of God. Long-term

periods of hospitalisation afforded the missionaries opportunities for evangelism and Vaughan claims that some patients were coerced to stay in hospital even after getting cured, in order to win their souls (Vaughan, 1991). In some cases after demonstrating the superiority of European medicines, children wearing amulets were denied biomedical treatment (Ranger, 1992) as a way of coercing parents to accept Christianity and abandon the traditional forms of religion and their perception of various diseases.

After Independence the new African leadership inherited the colonial health delivery machinery and expanded it to the rural areas. It is this machinery which is recognised and supported by African governments, though in some countries such as Zimbabwe, there have also been attempts to professionalise traditional medicine (see Chavunduka, 1994). This review describes the different therapy options that are available and determinants for therapy choice in African societies.

Herbalists and diviners

In African societies, there exist different forms of traditional healing. First, there are herbalists, whose healing prowess is wholly founded on their knowledge of the medicinal functions of particular plant and animal species (Ingstad, 1989). These people may practise traditional healing as a part-time profession, and may have other sources of livelihood. The term "herbalist" is, however, a misnomer, as it implies that the "practitioners" only make use of herbal pharmacopoeia. Chavunduka has criticised the use of this term citing as the reason, their "use of other ingredients, as well as animal, insect and birds" (Chavunduka, 1994:8). Unlike diviners or spiritual healers, herbalists are not guided by any spirit either in their administration of therapeutic regimens, or in their choice of plant and animal species, but they acquire medicinal knowledge through informal learning from a close family member, or the inheritance of a father's trade or that of other relatives (see for example du Toit, 1985). Like clinicians in modern health facilities, herbalists administer their medicines based on symptomatology; and when this fails or is insufficient, people try to identify (through divination) the cause of the symptoms (see Reynolds-Whyte, 1998:321).

Diviners are called to the profession through a dream or (serious) illness after which they undergo apprenticeship as diviner/herbalist (Morris, 1985; Ulin, 1979:244) and that they may draw their powers from the ancestral, family and foreign spirits (Reynolds, 1996:2-3). Diviners are involved in those illnesses which are generally severe in nature. They are particularly more concerned with disease agents. One of the challenges facing illness episodes in African societies is to determine the agent responsible for such illness. Without knowing the responsible agent, even if therapy is sought and administered, the patient may not get well because the root cause of the illness has not been addressed. After determining the cause of the illness, diviners then recommend the right therapeutic course to be taken.

The nostrums used by both herbalists and diviners consist of concoctions of plants (leaves, roots or barks), stems, bulbs, fruits, flowers and animal parts to cure illness, and sometimes the power of these medicines can be released by invocation. These medicines can also contain *chizimba*¹ which is an activating agent and this substance is usually hard to find. The patient can take these medicines through the mouth, apply as lotions on the skin, rub as powder into skin cuts, through inhalation or as enemas, (see for example Ransford, 1983:33).

While herbalists and diviners can be consulted during illness episodes, people in both rural and urban areas possess a wealth of medical knowledge about medicinal plants, and they are often able to treat themselves and members of their families. Every adult person has some knowledge of herbal remedies or western medicines that they can use to cure certain diseases. Hence, for minor illnesses, they are more liable to self-medicate without necessarily consulting other therapeutic alternatives (see Alland, 1970; Morris, 1985; and Westerlund, 1989).

¹In Central Africa it is called *chizimba*, but in Igbala it is called *ayibo*: it activates medicines and is responsible for the release of the power therein. Without *ayibo* the medicines will not work (see Boston, 1971). The definition of *chizimba* as given by Friedson i.e. that it is a witchcraft base which gives witchcraft its efficacy (Friedson, 1996:55) is in itself restricting, as *chizimba* can be an activating agent for any medicine.

The healing powers of the African independent churches (AICs)

"the Zionist Churches recruit large numbers as a result of their prophetic healing activities" (Daneel, 1970:12).

Although not necessarily a component of the initial African traditional healing culture, the 19th century saw the establishment of the African Independent Churches. These churches are very popular among Africans because they have incorporated elements of traditional forms of healing into the church. It has been argued that the large numbers of people who, for example, thronged Prophet Kimbangu's meetings in the Congo was presumably because of the healing of the sick rather than the gospel (Daneel, 1970:16). As Ingstad points out, the prophets (*maprofiti*) in these, base their healing practices on concepts of sickness and misfortune which to a large extent are traditional ones (Ingstad, 1989). Although some healers in the Zion African Church may use herbal remedies, in most cases, they heal by laying hands on the patient, washing with or drinking blessed (holy) water and through prayer and sacrifices (Ingstad, 1989; du Toit, 1985). The prophets draw their source of revelation from the Holy Spirit (Chavunduka, 1994). For those who use herbal remedies, there might be need to activate them by religious rituals and faith (du Toit, 1985).

Although there are reports that other AICs use herbal medicines, Daneel reminds us that the use of medicines for example in the Reverend Samuel Mutendi's Zionist Church in Zimbabwe is not allowed and visits to the hospital for medication are considered "as a lapse in the spiritual life (*kuheduka*), a form of infidelity" (Daneel, 1970:53). Healing is therefore an important element in these AICs.

The use of pharmaceuticals in self-medication

Apart from using herbal remedies, people also use (western) pharmaceuticals as a way of self-medication. These pharmaceuticals can be obtained from pharmacies, personnel of medical institutions, shopkeepers, hawkers travelling from village to village, or market vendors. One of the reasons why people go to (informal and formal) pharmacies is the general shortage of medicines in public hospitals and health centres. In most cases

official pharmacies are situated very far from rural villages, as a result, people resort to the informal sector for access to western medicines. The informal sector is, in general, within reach, available 24 hours a day and medicines are even sold one tablet at a time, something not possible with official pharmacies (van der Geest, 1985). In addition to this, the services offered are quick, the social distance between the provider and the client reduced and it is less stressful as traders are usually acquaintances (Wolf-Gould, 1991:83-89). In addition, customers also buy what they want without asking questions (Wolf-Gould et al, 1991; Cocks and Dold, 2000). People also resort to pharmacies in order to save time over seeking the free but time-consuming services offered by public health care (Wolfers, 1987 quoted in Cocks and Dold, 2000). Adults may also resort to self-medication with western medicines if they feel that the disease they are suffering from is shameful and embarrassing (van der Geest, 1981), especially for sexually transmitted illnesses.

Despite the fact that they do not have any formal training in pharmacy, informal traders stock a wide variety of pharmaceuticals (Wolf-Gould, 1991:83-89), including analgesics, antibiotics, laxatives and antimalarials (see van der Geest, 1985). Although some of these medicines are supposed to be by prescription only, they are purchased over the counter in the informal sector. The major problem with the widespread misuse of pharmaceuticals is the development of resistance strains (see van der Geest, 1985) of microorganisms. A number of such cases have been reported in the developing world; for example, the development of chloroquine resistance parasites has been the consequence of misuse of chloroquine. Wolf-Gould et al posit that drug misuse is a result of:

"false or insufficient promotional material, corrupt or insufficient drug supply, poor prescribing practices by the doctors and the sale of drugs by unqualified individuals" (Wolf-Gould et al, 1991:83-89).

While there are disadvantages surrounding the sale of drugs by the informal sector especially in developing countries, academics have argued that the informal sector for drug distribution in developing countries "meets community needs and that realistic reforms should not aim at its liquidation" (van der Geest, 1985). While community needs such as healing and protection against

diseases may not actually be met (the consumption of wrong medicines cannot cure a person), what actually is met in this context is the community's easy access to (cheap) medicines which are very expensive in formal pharmacies and are not usually available in government health facilities.

In conclusion, while western trained medical personnel may be available, the widespread use of medicines rather point to the fact that people seem to have placed more confidence in western medicines than in western trained doctors (see van der Geest, 1981:280-283).

Modern (Biomedical) health care services

In addition to consulting herbalists, diviners and *maprofiti* in the African independent churches and purchasing western medicines from both the formal and informal sectors, people in different countries in African societies also resort to modern biomedical facilities for treatment when sick. While these services have contributed so much to the containment of disease in the region, the delivery of modern health care services is, however, severely hampered by, amongst other factors, lack of funds, poor quality of patient care, nurses' negative attitudes, shortage of vital drugs and limited availability of specialised care (LeBeau, 1999:124) In the rural areas poor or inadequate transportation limits rural people's access to the limited health care services provided for them (Ademuwagun, 1979).

From the above discussion on the different health care options available to people in Sub-Saharan Africa, it can be observed that there exists a pluralistic medical system which comprises not only:

"multiple choices of therapy, but also multiple categories of healers, multiple conceptions of disease and illness" (Slikkerveer, 1990).

In such pluralistic medical systems, patterns of resort, which Young defines as "the paths people make as they pick and choose their ways from one sector of the medical system to another, in pursuit of diagnosis, cures, and other medical services", can either be simultaneous or sequential (Young, 1983:1205-1211). There is, therefore, a need to discuss the determinants of patterns of resort during illness episodes.

Factors affecting decision making in choosing therapy in African societies

When examining the therapeutic alternatives that are available in African societies a question that arises immediately is: what determines the choice of a particular therapy? One of the factors that researchers have identified is the cost of the therapeutic intervention. If the cost of treatment is high, people will try to avoid that form of therapy and only resort to that alternative when everything else has failed. Unlike in other countries where state health services are largely free of charge, for example in Malawi (see Chilowa & Munthali, 1999), in most African countries, user fees have been introduced as cost sharing measures. Offiong's informants in Nigeria indicated that:

"Hospitals and clinics charge too much money and drugs are not available because Nigeria's "Big Men" steal drugs from government hospitals and clinics and sell them at very expensive prices" (Offiong, 1999).

This is given as an explanation on why people resort to traditional healers (Offiong, 1999) who are sometimes considered cheaper. A number of researchers have agreed that the introduction of user fees bars the poor from "appropriate" care since they cannot afford to pay (Devisch, 1999). In Zambia it was noted that one of the reasons for the decline in national hospital attendance rate was the introduction of user fees in state delivered health services (Chabot, 1998:159). The choice of therapeutic alternatives based on cost, and only resorting to the most expensive alternative when everything else has failed, is what Young calls "cost-ordering" (Mathews, 1998:188).

While cost is indeed one of the factors leading to the low utilisation of modern health facilities, recourse to traditional medicine and other forms of therapy may also be as a result of the unavailability or long distances to modern health facilities, unavailability of appropriate or essential medicines at the health facilities, and the poor treatment of patients by the health workers². Long queues

Dennis and Harrison quote a traditional healer who told them that "western medical practitioners get angry too easily and are too impatient. They do not understand the villager; then the villager gets angry and does not cooperate. Thus the western medical practitioners do not gain his confidence and the villager returns to his zo (meaning medicine man) (Dennis and Harrison,

(resulting in long waiting times) at state run facilities also force people to resort to other means of therapy. In their study in Lusaka, Zambia, Frankenberg and Leeson found that some of the *ng'angas* (traditional healers) in Lusaka were being consulted because they were near, that their service was private and available without queuing (Frankenberg and Leeson, 1976). Although researchers have argued that better utilisation of modern health facilities can best be achieved by increasing the quality of services provided (Kloos, 1990), quality is, however, not the only factor as resort to other forms of therapy can also be influenced by other factors including the cultural definition of the illness and what is perceived to be the efficacious therapy.

While a number of studies have shown that cost is one of the impediments in seeking modern health care at hospitals, clinics and pharmacies, other researchers have also demonstrated that traditional medicine is not all that cheap as well. Heap and Ramphele have shown that, as much as people may desire to utilise traditional medicine, the cost of pursuing such a therapy is sometimes prohibitive (Heap and Ramphele, 1991:117-126). Distance to the health delivery centres may not be a deciding factor for therapy seeking, as the availability of high quality services at the clinics may offset or mute the variable of distance (Devisch, 1999; see also Csete, 1993:1285-1292). In addition, cases are known whereby therapy seekers bypass a nearby hospital or clinic for a traditional healer miles away (Offiong, 1999). This is in line with what Senah wrote about Ghana, saying that though biomedical health services might be available, "prevailing social and cultural values render biomedicine an inappropriate option for many illnesses" (Senah, 1995).

Some studies which have correlated variables such age, sex, literacy and wealth with patterns of health care have shown that people:

"who are more acculturated to western standards (younger, wealthier and more highly educated) will be more likely to use western medical facilities than will individuals who are less acculturated ... i.e. older, poorer and less well educated" (Mathews, 1998:125).

Mathews argues that though such correlational studies are important, they are nevertheless not very useful in explaining why people choose western medical facilities (Mathews, 1998:125). The professional, after all, is also a kinsman and, though educated and acculturated to western standards, the persistence of illness may force him to accept the decision-making process of the therapy management group (Janzen, 1978:90-100). Janzen reaches this conclusion with reference to a professional health worker in Zaire, who, after the consumption of antibiotics did not cure him, had to succumb to the decision making process of the therapy management group. Often times those educated may use the traditional healers as the last resort, especially where physicians have failed to cure the illness (Dennis and Harrison, 1979). Ranger adds that while individuals may be Christians (Christianity being one of the attributes of westernisation), in instances of serious illness, it is a person's *jamaa* (kinsmen) who determine how he/she should be treated, regardless of his/her Christian stance (Ranger, 1992:270).

What is observed in many studies is that minor illnesses such as colds, coughs, headaches etc are treated in the home, either using herbal concoctions or medicines bought from the nearby shops. When these illnesses do not respond to these therapies, people go to the hospital or traditional healer (Morris, 1985; 1986; Chavunduka, 1994). The choice to go either to a traditional healer or a hospital largely depends on what is perceived to be the aetiology of the illness (LeBeau, 1999:154) and their previous experience of the efficacy of various healing systems (Heap and Ramphela, 1991; LeBeau, 1999). Like Morris (1985) and Chavunduka (1994), LeBeau's study has also shown that:

"[For] the most universally recognised symptoms, patients first go to western health care, unless the illness has a social/spiritual aetiology or western medicine has been unsuccessful" (LeBeau, 1999).

The seeking of therapy at government health facilities and its subsequent failure, as Feierman argues, can also be a form of diagnosis. The hospital's failure to cure an illness is on the part of the patient a reassurance or a confirmation that the illness is sorcery induced; hence a decision is made to pursue other forms of therapy (Feierman, 1981). Cases abound in which patients have been secretly taken out of the hospital to seek traditional medicine

upon advice from medical personnel (see Offiong, 1999). As Frankenberg and Leeson found in Lusaka "the *ng'anga's* patients tend to be a population of survivors: the patient and the illness have survived western medicine" (Frankenberg and Leeson, 1976) for a relatively long time.

Scholars have classified diseases into those which can be cured by recourse to traditional medicine (African illnesses) and those which can be cured by using European medicines (western diseases)³ (LeBeau, 1999). This classification, however, is not all that water-tight because, as we shall see later, people move from one form of therapy to another in search of a cure. The initial choice of treatment may also depend on where people themselves perceive the probability of cure to be high (Mathews, 1998). For those illnesses that are considered "African", it does not make much sense to seek treatment in modern hospitals because as far as Africans are concerned the probability of cure is either non-existent or low. As we shall also see later in this chapter, even some aspects of what are referred to as African illnesses need to be treated by western medicines in order for a cure to be effected as traditional medicines alone might be viewed as inadequate. The classification of illnesses into western and African has been criticised because it tends to bypass the herbal aspect of the traditional healers especially the herbalists (see Morris, 1985). The active ingredients contained in some herbal cures/medicines are very effective in the cure of some diseases. All those diseases that people suffer from as part of the natural order (namely natural illnesses) can be classified as western diseases. These diseases can effectively be treated using herbal or European medicines found in hospitals and clinics (see Morris, 1985; Yoder, 1981). The herbal medicines that are used to cure these illnesses are believed to be potent in themselves and effective, hence no need for a ritual (Ngubane, 1977:23). However, if the disease persists after receiving treatment, then it can be

³Feierman calls them hospital illnesses (Feierman, 1981) while the Bushmen classify diseases into Bushmen diseases which are caused by witchcraft, and European diseases which are new organic ailments such as tuberculosis (Westerlund, 1989). In some other countries for example Botswana there is a distinction between European illnesses and Tswana illnesses. Tswana illnesses were known to Tswana people and their doctors before the arrival of Europeans, while European diseases are of more recent origin and outside the scope of traditional medical knowledge (Ulin, 1979:244)

reclassified as originating from witchcraft or such other occult forces; hence they become African illnesses. Hence, the duality (African/Western illnesses) is not all that exclusive as reclassification may occur in the course of seeking treatment.

In terms of causality, "African" illnesses are those that people perceive to be caused by sorcery, witchcraft, curses, the breaking of societal taboos and the wrath of the ancestors. All these at one level relate to bad relationships. As Morris points out, the use of herbal medicines in such circumstances is deemed unnecessary or secondary because the most urgent thing is "the ritual procedures that seek the underlying aetiology of a disease or misfortune" (Morris, 1985; also see Ashforth, 2000). It is important that in such circumstances diviners should "detect these illnesses and counteract the power of witchcraft and remove objects sent into the body" (Yoder, 1981). In the case of diseases caused by displeased ancestors, while (herbal/medicinal) cures are important, they are not adequate on their own as there is need for the restoration of a balance in supernatural relations and this is best achieved through sacrifices (du Toit, 1985).

While this dichotomisation of diseases into African and Western diseases is helpful in understanding therapy seeking in African societies, it, however, distorts the true picture of how therapy is sought. In some cases patients simultaneously use both traditional and western medicine in what LeBeau calls "double consumption" (LeBeau, 1999:155). For example, in the case of sorcery, Yoder argues that herbal or biomedical drugs are taken to relieve the symptoms while the traditional healer addresses the ultimate cause by "extracting sorcery instruments from the body" (Yoder, 1981; see also Alland, 1970) a point that LeBeau also raises (LeBeau, 1999).

While people are indeed free to choose therapy depending on factors explained above, in some cases government and religious institutions may restrict the choices that people are able to make during illness episodes or epidemics. For example, during major threats to public health, such as cholera and tuberculosis therapy, managers do not have the freedom to choose their own label for the condition or their own treatment (Feierman, 1981), as government may move in to control or direct the therapeutic process. The administration of traditional medicines may thus have to be done very secretly and Offiong (1999) and Janzen

(1978) give examples of cases in which traditional medicine is smuggled into the hospitals to be given to patients who are admitted there.

In the case of African independent churches such as the Zion, du Toit argues that:

"Decision making during illness episodes is taken away from the members as Zionists are expected to behave alike and follow the guiding precepts of their leaders" (du Toit, 1985).

"Mainline" Christianity only allows for the consumption of herbal and western medicines. Herbal concoctions where invocation, or what Feierman calls "the spoken formula" is involved, are usually not allowed by the church (Feierman, 1981). Although mainline Christianity disavows some aspects of traditional medicine, some studies have shown that in reality Christians turn to ritualistic medicines when biomedicine fails (Spring, 1985) and, even when biomedicine has not failed. The rebuke of those Christians who turn to ritualistic medicines attracts responses such as that it is not their (i.e. the patients') responsibility to determine which treatment options to pursue as the decision-making process is made not by them, but by their relatives (Ranger, 1992:271).

In Islamised areas such as Hausaland in Nigeria, the use of pre-Islamic medicine is condemned because it centres around spirits and spirit worship (which are considered as *sihr* (magic) hence *hararn* and reprehensible in Islam)⁴ which contradicts basic principles of Islam. The invocation of supernatural beings like spirits to effect a cure infringes on the fundamental belief in Islam which requires that prayer can only be made to Allah and to him alone (Abdalla, 1985).

While people might indeed choose traditional healers for therapy, in some cases it is traditional healers who at the end of the day may advise patients to seek care at the hospital, for several reasons either because they have failed or the disease requires hospital treatment, or the fear of the police if the patient dies on their compounds (see Frankenberg and Leeson, 1978).

⁴See Abdalla, 1985)

Conclusion

This paper has in general discussed the process of seeking therapy in Sub-Saharan African societies. What we therefore see is that therapy seeking is not a straightforward issue. There are many factors that determine the course of therapy and among these, as discussed above, are cost of the therapeutic intervention, distance to the health facility, perceived quality of care, religion, the therapeutic management group, perceptions about aetiology of the illness and past experiences in dealing with disease.

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SOURCES OF RISKS AND VULNERABILITY AMONG MALAWIAN HOUSEHOLDS AND COMMUNITIES¹

John Mandoloma Kadzandira²

Abstract

Between 1997 and 1998, the Government of Malawi through the National Statistical Office (NSO) conducted an integrated household survey (IHS) as part of the poverty monitoring system. Following this, a series of surveys on a panel of roughly 750 households drawn from the IHS sample were conducted between 2000 and 2003 so as to determine the nature and trends of poverty in the country. The findings from these surveys indicated that in general, Malawi's poverty was more chronic than transient. It was therefore decided to conduct a qualitative survey which would provide some in-depth understanding of the sources of risks and vulnerability among most Malawians so as to guide policy formulation concerning poverty reduction. A series of qualitative research tools were used in 19 different sites across the country involving over 950 respondents.

The findings from this qualitative survey indicate that perpetual food insecurity and finance-related poverty constitute major risks trapping poor people in rural Malawi into the poverty web and/or pushing others into it. Food insecure households, with virtually no financial and material savings at all, are finding it tough to participate in the modern market-driven society amidst escalating prices of farm inputs, low produce prices, non-availability of farm credit, unreliable markets, frequent diseases and deaths, weather upheavals, land constraints, declining soil fertility and un-

¹The study was conducted with funding from the Poverty Reduction Group of the World Bank, Washington D C.

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protecting societal policies. Labour constrained households (such as those headed by poor females and males, the elderly, orphans and the chronically ill) are even more vulnerable than their counterparts because of their low capacity to carry out productive work. The degree of sensitivity and resilience to a stressing event has been found to be significantly correlated with the timing of the occurrence, its frequency or repeated occurrence, relative household wealth and social factors such as gender, age and position in society. On risk management, reactive survival strategies (to avert destitution and deaths) predominate the range of strategies being employed by the poor masses as opposed to adaptive and accumulation strategies.

This paper calls for a two-stage process of addressing the poverty that exists in Malawi, the first being to build the capacity of the poor Malawians to a level where they can participate in the market-driven economy on their own with deliberate and protective policies including massive investments in farm inputs, protective and reliable markets and promotion of capital investments. The second phase should include providing mechanisms to protect the Malawians from dropping back into the poverty trap, specialisation in the donor interests and massive investments in rural development (road networks, rural electrification, communication facilities, water supplies and health services).

Introduction

Malawi is a small land locked country located in Southern Africa, bordered by Tanzania to the north, Zambia to the west and Mozambique to the south and south-east. The total area is 118,000 square kilometres of which 20% falls under water resources, the major one being Lake Malawi. Administratively, the country is divided into three regions namely: Northern Region (6 Districts), Central Region (9 Districts) and Southern Region (12 Districts). In 1998, the population was estimated at 9.9 million giving a population density of 105 persons per square kilometre (NSO 2002). At regional level, the highest population density was recorded in the Southern Region at 146 persons per square kilometre while the Central and Northern Regions had population densities of 114 and 46 persons per square kilometre, respectively. Population densities for the Districts from which the study sites were sampled are presented in Table 1. The Table also presents the

%,

estimated population, number of households and average household sizes for the Traditional Authorities (T / As) which were sampled. As would be observed from the table, the population density for Malawi is characteristically very high. Being an agriculture-based economy with over 86% of the population living in rural areas (and dependent on subsistence farming), the high population density has serious implications on the livelihood status of the population.

Table 1: Selected social indicators for the sampled districts and T/A's

	Infant mortality rate**	District Population Density**	TA or Chiefin sample	T/A Population*	T/A Households*	Average household size
MALAWI	125	105		9933869	2310202	4.3
NORTH	103	46		1233560	243060	5.1
Rumphu	91	27	<i>Chikulamayembe</i>	45510	9170	5.0
Nkhatabay	103	40	<i>Kabunduli</i>	30130	6718	4.5
Mzimba	105	59	<i>Cliindi</i>	94250	18451	5.1
CENTRE	131	114		4066340	908943	4.5
Kasungu	134	61	<i>Cluilu</i>	43327	7861	5.5
Dowa	129	135	<i>Kayembe</i>	61484	13256	4.6
Nkhotakota	136	54	<i>Mnlangaciiizi</i>	41501	9401	4.4
Salima	126	113	<i>Karonga</i>	42498	9484	4.5
Lilongwe	129	219	<i>Knbiiditln</i>	80531	17435	4.6
Ntcheu	125	108	<i>Makwanguwla</i>	66339	15159	4.4

SOUTH	126	146		4633968	1121834	4.1
Balaka	123	115	<i>Msamaln</i>	145048	34410	4.2
Mangochi	123	97	<i>Nankumba</i>	79419	19248	4.1
Mangochi	123	97	<i>Chowe</i>	83204	20878	4.0
Zomba	124	212	<i>Kumtumanji</i>	61076	14928	4.1
Zomba	124	212	<i>Chikowi</i>	45650	11329	4.0
Chiradzulu	131	308	<i>Nchemba</i>	27542	6862	4.0
Chiradzulu	131	308	<i>Likoswe</i>	46527	11160	4.2
Mulanje	148	208	<i>Mthiramanja</i>	34688	8581	4.0
Mwanza	123	60	<i>Nthache</i>	31296	7397	4.2
Chikwawa	131	75	<i>Kasisi</i>	25362	6340	4.0

Source: * - NSO & IFPRI 2002: Malawi: An Atlas of Social Statistics

** - NSO 2002: 1998 Malawi Population and Housing Census: Analytical Report

Poverty in Malawi

Poverty in Malawi is pervasive. In April 1998, 64% of the population was living on less than 41 U.S. cents per person per day while 36% was living on less than 25 U.S. Cents. This situation is continuously raising concerns about the country's prospects to move out of the bundle of least developed countries in the world. The country's social indicators are also generally very poor. Infant mortality rate is estimated at 125 deaths per 1000 live births (NSO 2002). Available statistics also reveal that about 34 percent of underfive children in Malawi are underweight, 48.3 percent are stunted and 7 percent are wasted. Over 54 percent of pregnant women and over 70 percent of children below five years of age are anaemic and 27 percent of school children in severely affected iodine deficient Districts have goitre. It is also estimated that nearly the whole population of Malawi is at marginal risk of Vitamin A deficiency (GoM 1996,1997,1998).

In 1994, the government of Malawi launched a comprehensive 'Poverty Alleviation Programme (PAP)' with the core aim of reducing the pervasive poverty among poor Malawians. As part of the poverty monitoring system, the government, through the National Statistical Office (NSO) conducted an integrated household survey (IHS) between 1997 and 1998 which was followed by a series of surveys on a panel of roughly 750 households drawn from all the regions in the country. These surveys were conducted on the same households over a period of more than one year so as to determine the nature and trend of

poverty that exists in the country as either transient or chronic. Owing to the persistent finding from these surveys and other nationally based surveys that Malawi's poverty was more chronic than transient, a decision was made to conduct a qualitative survey which would provide some in-depth understanding of the sources of risks and vulnerability among most Malawians so as to understand the conditions forcing them to remain poor while making others join the wagon. The survey, whose findings form the bulk of this paper, was therefore commissioned as a follow-up to the complementary panel surveys (CPS) which were conducted as part of the poverty monitoring system (PMS) in the country.

At the time when the survey was designed, the CPS was being implemented in 19 rural T/As across the country. It was therefore decided to conduct the qualitative survey in at least one village from each of the 19 T/As. A series of focus group discussions (FGDs), Key Informant Interviews (KIIs) and case studies were conducted with over 950 people including men, women and the youth. Core issues in the various discussion sessions resonated around sources of risks and vulnerability for various groups of households and individuals (*idiosyncratic risks*) and their communities (*covariate risks*), their coping and risk management strategies along with information regarding social norms and local legal practices that affect the disposition of household assets in the event of divorce or death of a spouse. Another fundamental element of this survey was its ambition to capture regional variation in risk management and coping mechanisms as well as variation across the two predominant family systems in Malawi (patrilineal and matrilineal). However, being a rural-based survey, the survey lacked the dimension of urban vulnerability to poverty and how poor urban families and individuals respond to urban risks and shocks of life.

Definitions of Risks, Vulnerability and Risk Management: Literature review

In order to better understand why many Malawians continue to live in poverty, there is need to change the discussion of ex-post poverty to ex-ante poverty i.e. from discussing "who are the poor or vulnerable?" to discussing "what causes vulnerability to poverty". Vulnerability is the opposite meaning of security. It refers to people's exposure to contingencies, stresses and shocks

that push them to a state of being defenceless, making them remain in the ranks of the poor. Households are vulnerable if a shock is likely to push them below (or deeper below) a defined welfare threshold. In an agrarian economy (like Malawi), vulnerability is closely tied to being susceptible to shocks that affect factors of production (such as land, labour, inputs and weather) and if they affect the fruits from the agricultural sector. Scarcity of land and labour, declining soil fertility, high prices of farm inputs, bad weather, low produce prices, diseases and frequent deaths all constitute the major risks that lead poor farmers in poor countries to welfare loss and to being trapped in a web of poverty.

Risky events may be looked at as expected and unexpected events that disrupt the ability of a household to generate income or force it to allocate a certain portion of that income to an area not included in its established economic portfolio, thus reducing the share available for regular production and consumption activities (Wright et al 1999). According to Devereux (1999), the concept of vulnerability is more complex than that of poverty, being determined partly by risk factors that are *generic* to groups of individuals or households who are linked either geographically or by some shared risk characteristic (joint 'exposure'), and partly by risk factors that are *specific* to each individual or household (idiosyncratic 'sensitivity' or 'resilience'). Although the entire community might face equal exposure to a threat such as drought or price rise, resilience is differentially distributed across households depending on their relative wealth (savings, asset holdings) and access to alternative income sources, including support from extended family and social networks (Devereux 1999). As Lipton and Maxwell (1992) put it, vulnerability, is more dynamic and better captures change processes as people 'move in and out' of poverty. As such when defining vulnerability, two dimensions must be considered: *sensitivity* (the magnitude of a system's response to a risky event and *resilience* (the ease and rapidity of a system's recovery from stress).

We should look at risks and vulnerability in terms of a 'risk-chain' consisting of risks, risk responses (risk management) and outcomes. Risk management comprises all actions that are taken to respond to risks, shocks and adverse outcomes that are generated in the process and these actions can be taken before the shock

materialises (*ex ante* risk management), or after it has already taken place (*ex post* risk management or coping with a risk). The shock, together with the responses that are taken to deal with them, leads to an outcome (being changes in people's welfare).

Risk management actions could be looked at from four levels in a continuum: accumulation strategies, adaptive strategies, coping strategies and survival strategies. Devereux (1999) reminds us that poor households survive by pursuing a mix of livelihood strategies that seek to increase their income flows or stocks of assets (accumulation strategies), to spread risk through livelihood adjustments or income diversification (adaptive strategies), to minimise the impacts of the shock (coping strategies), and, in *extremis*, to prevent destitution or death (survival strategies). Among poor people in Malawi, accumulation strategies include cultivation of the high valued barley tobacco and cotton and participation in non-farm small scale businesses. Accumulation and adaptive strategies are either taken with prior knowledge of an impending risk such as from an old experience (experiential reasoning) or as part of people's desire to improve their welfare. Where it becomes difficult is how to classify a particular action such as casual work (*ganyu*) as being an adaptive or a coping or a survival strategy. It would be argued that where a household is involved in *ganyu* to earn money to supplement its income portfolio as in diversifying its income sources, such an action is 'adaptive' but where the *ganyu* is being done to meet urgent food needs, the action becomes a 'survival' strategy - but it is usually difficult to draw this line with any certainty or rigour. The transition between accumulation/adaptation strategies and survival strategies is often not clearly understood considering that poor people in Malawi live 10 months of each year without food stocks and depend on *ganyu* for them to live. As rightly argued by Devereux (1999), in what sense are poor people in Malawi coping if they cut their consumption to one meal a day when they are already malnourished? It is thus important to understand the risk management chain so as to properly intervene at upper levels before people move from adaptive and coping strategies to survival strategies. By the time people get into survival strategies, destitution and hopelessness grows and they tend to resign their fate.

When planning to improve the capacity of households to deal with risks, it is also important to characterise risks and shocks in terms of their magnitude as either idiosyncratic or covariate where the latter concerns risks that have wide coverage such as District, Region or Country. Idiosyncratic shocks affect individuals or individual households such as diseases, deaths, accident and divorce. Other important aspects of risks and vulnerability concern the timing of the occurrence, the frequency and variability that occurs in terms of the impact and responses once a shocking event has materialised in a household or community. When the sick member is the father, his labour contribution and his skills are lost. The mother withdraws from most activities. If this shocking event happens at the start of the rainy season or during the peak labour periods (weeding, banking, fertilisation etc), the household suffers more than when the same happens when people are harvesting.

This study provides a unique opportunity to understand the main shocks and risks that contribute to entry into (or deeper into) the ranks of the poor in Malawi. The findings also highlight various strategies which are being employed by the poor in response to the shocks. To readers and policy makers, it is also important to learn two things from this study: First, what subsets of these strategies are leading to virtuous movements out of poverty and what others perpetuate poverty? Secondly, what can the government and all the development agencies do to enhance the risk management capacity of the households - do we intervene when households are employing adaptive/coping strategies or when they have gone into survival strategies?

Findings

The findings from this survey suggest that perpetual hunger (food insecurity) and poverty constitute major risks trapping poor people in rural Malawi into the poverty web and/or pushing others into it. Food insecure and poverty stricken households spend most of their time in survival strategies instead of accumulation strategies because they have to solve their immediate food needs and other basics. Poor households and communities are finding it tough to effectively participate in this modern market-driven Malawi amidst escalating prices of farm inputs, low produce prices, non-availability of farm credit, frequent diseases and deaths, weather upheavals, land constraints and declining soil

fertility. The Role of Agricultural Development & Marketing Corporation (ADMARC) in ensuring a steady market for people's produce and in ensuring cheaper source of farm inputs and food in times of need has been highly demonstrated. Low produce prices (which do not match with high input prices), escalating commodity prices, price volatility and unreliable markets constitute major risks/shocks affecting the income flow of the rural population in Malawi, consequently leading them into (or deeper into) perpetual financial poverty and food insecurity. In areas which used to enjoy proximity to ADMARC but could no longer due to one reason or the other, the gap that has been created due to ADMARC's withdrawal has not been adequately filled by the private traders and vendors.

While all households may be affected by a particular shock, findings from this survey indicate that labour constrained households (such as those headed by poor females and males, the elderly, orphans and the chronically ill) are more vulnerable to food insecurity and financial poverty because of their low capacity to carry out productive work. The findings have also shown that the degree of sensitivity and resilience to a stressing event is significantly correlated with the timing of the occurrence, its frequency or repeated occurrence, relative household wealth and social factors such as gender, age and position in society.

In terms of risk management strategies being employed, the findings from this survey suggest that due to the perpetual food insecurity and poverty existing among most of the rural populations, reactive survival strategies (to avert destitution and deaths), predominate the range of strategies being employed by the rural masses as opposed to adaptive and accumulation strategies and that the poorest households (households headed by females, orphans, the elderly and the chronically ill) are more likely to employ survival strategies than their counterparts. The findings have also shown that temporary rural/urban and rural/rural migration in search of casual work (*gartyu*) is on the increase both as a coping and survival strategy and this is increasingly becoming a major livelihood resource for the rural masses.

On land ownership issues, the findings seem to suggest that the customary law which bars households from selling or longitudinally renting out their land protects such households

against eventual loss of ownership thereby enhancing their ability to avert further vulnerability (after being made landless). The findings have also shown that regardless of the predominant family system, land usufruct rights are vested in each household which makes independent decisions except where it concerns selling or longitudinal renting out of such land. Across family systems, the findings seem to suggest that due to the land constraints which are common in the Southern Region where the predominant family system is matrilineal, divorced men and widowers in such places are more likely to face critical land problems upon their return to their mother's homes compared to returning females in patrilineal societies particularly in the Northern Region.

On marriage formation and dissolution, the findings seem to suggest that men are more likely to ask for divorce when their wives are discovered in extramarital affairs, or when their wives are suspected to be impotent, when they do not sexually satisfy them, when they are lazy and due to bad behaviours (such as being too talkative, jealousy/gossipy, hatred for spouse's relatives and disrespect for the husband and parents). On the other hand, women are more likely to ask for divorce because of household poverty and persistent food insecurity, domestic violence, spouse laziness, lack of sexual prowess, spouse irresponsibility and alcoholism. At a glance, it is unarguable to say that women therefore take risky choices for not being very ready to divorce their husbands for extramarital affairs especially when the prevalence of HIV/AIDS is very high in the country. Regarding the aftermath of divorce or death of a spouse, the findings seem to suggest that women become more vulnerable to poverty and food insecurity because of the increased responsibilities especially where children have been left in their custody and also because they stay considerably longer periods before remarrying than their counterparts.

Recommendations

Based on the findings from this survey, it is recommended that the Government of Malawi, through its Poverty Alleviation Agenda, should consider formulating a comprehensive integrated programme aimed at reducing and breaking the vicious cycles of perpetual food insecurity and financial poverty. A two-stage

process would work better for Malawi where the first is sorely aimed at raising the status of the households to a level where they can procure their own inputs and produce their own food and cash crops. This could be achieved if the Government and development agencies intervened when households are coping rather than wait for the time they go into survival strategies. Among the interventions that could be looked into are: general emergency food distribution especially during the farming season, economic empowerment for households faced with multiple or frequent shocks such as parentless households and elderly-headed households. The Government should also reconsider the issue of farm inputs and alternative produce markets for the farmers. Other alternative marketing systems must be consultatively identified if the options provided by ADMARC could not be sustained.

The study also recommends the introduction of community based insurance schemes to help the affected households in their efforts of cushioning the effects of such shocks as diseases and funerals, rethinking the issue of farm input provision as evidence has shown that in their current perpetual poverty situation, poor farmers in Malawi would not afford them even if the prices were maintained at their current levels, and promotion of irrigation schemes.

The study also recommends that in order to achieve the goal of breaking the vicious cycles of food insecurity and poverty, 'specialisation' in donor interests must be instituted. This implies that the World Bank, for example, should pull all its resources towards one sectoral area and develop it for 5-10 years or even more rather than have a 'piece-meal' approach where one donor comes with 5-15 areas of support.

In order to address the shocks affecting the income flow of the farmers, it is recommended that the roles of the 'triad: state, markets and farmers' be re-scrutinized and enhanced for a balanced economic system learning from the Asia experiences which enabled them to improve from being food insecure in the 1970/80s to food exporters in the 1990s.

On cultural issues, it is recommended that the culture surrounding funerals has to be re-looked into and where possible, modified accordingly through civic education, and that customary laws regarding land ownership and usufruct rights need to be revisited
protect children, divorcees and widows/widowers upon

marriage dissolution. Lastly, the study recommends that women need to be empowered through civic education to claim their right to seek divorce particularly in cases where their spouses are involved in extramarital affairs which can expose them to great risks (sexually transmitted infections and HIV/AIDS).

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Targeting the poorest of the poor for public health goods: The case of insecticide treated nets (ITNs)

James Milner and Maxton Tsoka¹

Introduction

This is shortened version of the report submitted to UNICEF in December 2004 following UNICEF funding to Centre for Social Research (CSR) to undertake the research in 2004. This paper focuses on the major findings of the research from secondary and primary sources and proposed strategy on the basis of the findings.

Background

It is recognised and known that (i) malaria is a serious health problem in Malawi, (ii) ITNs are effective at reducing the incidence of malaria and (iii) ITNs ownership and utilisation rates are very low in Malawi. Further, it has been recognised by Malawi Government that there is need to scale up ITN availability and accessibility, especially to the vulnerable groups regardless of their ability to pay. UNICEF, therefore, requested the Centre for Social Research to undertake a study that would guide it and other stakeholders in designing a programme that would make ITNs accessible to the poorest of the poor who are seemingly left out in the current scenario where ITNs are considered too expensive for the poor.

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Objectives of the study

The overall objective of the study was to design ways of identifying and targeting the poorest of the poor with ITNs. The specific objectives were firstly, to review and evaluate existing methods for identifying the poorest of the poor and secondly, to design, or recommend (if already existing), an effective method to identify the poorest of the poor in a programme situation, particularly with regard to targeting public health goods and thirdly, to produce a strategy to enable the identified group to best have access to public health goods such as bed nets.

Study methodology

To achieve these objectives, study visited key stakeholders, reviewed literature, visited NGOs with experience in targeting and/or ITNs and visited safety nets beneficiary communities. The study used three data collection tools in the communities visited, namely: key informant interviews, focus group discussions and household level questionnaire. Eight NGO projects sites and their benefiting communities were visited; two in the North (Nkhata Bay and Mzimba), three in the Centre (Ntcheu, Lilongwe and Mchinji) and the three in the South (Zomba, Thyolo and Phalombe). Projects were selected to maximise diversity of project type and location.

Paper outline

The paper has six chapters. Following this introduction is a literature review as chapter 2. Chapter 3 reviews and analyses methods used to identify the poorest of poor in Malawi while chapter 4 presents the proposed method to be adopted for the identification of the poorest of the poor. Chapter 5 presents a proposed strategy to be adopted for the provision of ITNs to the poorest of the poor. Concluding remarks are in chapter 6.

Findings

Literature

Malaria and ITN study

To inform the scaling up process, UNICEF funded a nationally representative survey to determine, among other parameters, the coverage and utilisation of ITNs. This section attempts to present some of those findings as a basis for the proposed strategy and programme.

Knowledge of the malaria risk and its prevention

According to the survey, 87.3% of Malawians know that mosquitoes transmit malaria and 73.1% know that sleeping under an ITN can prevent malaria. Just over half know that pregnant women and under-five children are the groups that are at risk of malaria the most. This knowledge is a good foundation for building a strong ITNs distribution scaling up programme. Further civic education would be needed to make the other half understand why pregnant women and under-five children are particularly targeted.

ITN Coverage

On the basis of the estimated net population of 1,803,900 and proportion of 66.7% for ITNs, there are 6 people for every net and 10 people per every ITN. In terms of households, 42.9 percent of households own a net. This is a significant improvement from 13% found in 2000 under the Malawi demographic and Health Survey.

Net ownership and welfare status

Ownership was found to be highly correlated with wealth status. While 88% of households assessed owned at least a net, only 31% of the poorest group owned at least a net. Likewise, less households headed by females (33%) owned at least a net as opposed to 45% for male-headed households. However, even the poorest of the poor own purchased (and not free) nets. This possibly supports the idea that ITNs should not be provided free even to the poorest of the poor unless it is proven that the 69 percent that do not own at least a net are the poorest of the poor.

²Kadzandira, J and A Munthali. 2004. The Coverage and Utilisation of insecticide Treated Nets and Malaria Prevention and Treatment Practices at the **Community** Level in Malawi. Centre for Social Research

So far there is no evidence that this nationally representative sample selected the 'better-off poorest of the poor or defined the poorest of the poor in such a way that the worse off poorest of the poor would be left out.

The major reason given for not owning a net was the price of the nets being too high for them (70.4%). As expected the poorest cited the price of the nets as their main reason. Close to a quarter of the rich (23%) also blamed their lack of ownership on price of the nets. Honest ones said that the nets are not a priority to them (13.2%). This was mainly true for the wealthiest. Ignorance of ITNs also cited as a reason and the rich 'jumped' for this reason. Close to half of the rich (45%) blamed it on pure ignorance as opposed to less than 10% of the poorest.

Utilisation of nets

Just like under coverage, there was a significant rise in the net use. In 2000 the overall utilisation rate was 6% and this went up to 34% for pregnant women and 38% for under-five children. Encouragingly, the most vulnerable groups in households with ITN used the nets more than in households with non-treated nets. ITN use was 31% and 54% of ITN users the previous night were pregnant mothers and under-five children, respectively. There are two important lessons here. The first is that net utilisation is increasing and the second is that more of the vulnerable groups are sleeping under ITNs. This may mean that households are using 'right' prioritisation of ITN usage. Of course it would have been much better if the proportions of the pregnant women and under-five children were higher considering that most of the ITNs are sourced from Maternal Child Health clinics which target these two groups

Sources of nets

The survey found that 57% of the nets were sourced from a health facility. According to the national framework, MCH clinics have been used to target pregnant women and children. This means that there is, sometimes, 'misallocation' of resources within the household. This should, of course, be understood in light of the fact that just half of the households 'correctly' mentioned pregnant women and under-five children as the most vulnerable. Probably more encouraging is the fact that close to a third (33%) of nets were procured from shops. Community Based Organisations (CBOs)

and NGOs are not yet a significant source of nets because only 5% and 4%, respectively, mentioned them.

Leakage

Leakage of subsidised ITNs was estimated at 10%. This is not a worrisome level considering that ITNs have positive externalities. This means that the current targeting of ITNs, although not very efficient, is good enough to tackle the problem of malaria.

Other studies

This literature review is meant to draw lessons from international and national experiences on ITNs and targeting of poorest of the poor. The lessons are meant to inform the design of a methodology for identifying and targeting the most deserving group.

Poor health, vulnerability and poverty

Generally, poor health is both a cause and effect of poverty. As a cause of poverty, illness in a household has both direct costs (spending on prevention, care and cure) and opportunity costs (lost income or schooling while ill) and as an effect, it strikes the **rich** and poor - but not alike because the poor are generally hit harder. (**World Bank 2001:Paras 5.15/16**). This point that poverty causes ill health is yet to be empirically proven in Malawi. According to the analysis of the 1997/98 IHS data, morbidity is weakly linked to welfare status. What has been found is that the poorest (the ultra-poor defined as those below 60 percent of the poverty and the poorest 20 percent) reported fewer cases of falling sick than the wealthier ones³. See **NEC 2000**. The bottom line, though, is that a sick person demands household and national resources away from productive use but fails to contribute effectively towards household and national wealth creation. Poverty reduction requires healthier workers. Reducing incidence of illness among the population is a key poverty reduction strategy.

³This being counter-intuitive, the explanation given was that the poor have a higher threshold in regards to feeling out of sorts before they classify themselves as 'ill'. Consequently, the illness of the poor may not be directly comparable to the illness of the non-poor. The fact that the ultra-poor have even lower levels of morbidity than the poor as a whole lends additional support to the point"

The case for ITN safety net

It has been established that malaria prevention is a legitimate poverty reduction strategy. It has also been established that used correctly, ITNs are effective means of malaria vector control. Experience in Malawi shows that ITN marketing programmes will achieve little if financial limitations of the intended beneficiaries are ignored. When the prices of ITNs were reduced between 2000 and 2002 in Malawi, ITN coverage increased tremendously. This proves the point that prices of ITNs should be low enough to enable the beneficiaries to acquire some using subsidy supported by a voucher system to minimise possible negative impact on the blossoming ITN market.

Target groups

What literature indicates is that the poorest of the poor generally fail to acquire nets for their protection because the opportunity cost of acquiring the nets is higher than the perceived benefits. Further, there are some groups known to be vulnerable to malaria and these include children below the age of five years and expectant women. Malaria is a leading cause of morbidity and mortality in children below the age of five years and also pregnant women and that over 40 percent of deaths in children below the age of 2 years are caused by malaria. Children below the age of five years are reported to suffer on average 9.7 malaria episodes per year. See Table 1.

Table 1. Estimated number of malaria deaths and clinical attacks in Malawi

Age group	Morbidity (attacks/person/year)	Mortality (rate per 1000)
0-4 years	17,532,461 (9.7)	17,984 (9.9)
5-9 years	12,049,811 (8.0)	3,269 (2.2)
10-14 years	8,786,306 (7.0)	1,004 (0.8)
15 years and older	33,382,967 (6.1)	711 (0.1)
Total	71,51,545 -	

Source: CPAR Malawi, 2000:25

Geographical targeting

Although malaria is a national disease, the prevalence of the malaria vector, mosquitoes, in Malawi is not uniform. Mosquitoes are generally known to be endemic in lakeshore and warm areas

and during the wet season. According to 2002/03 HMIS Annual Bulletin⁴, districts with high malaria prevalence include Ntchisi where malaria new cases are 57 percent of the population, Karonga (52%), Mwanza (46%), Nsanje (43%), Nkhatakota (41%), Mangochi (41%) and Chikwawa (41%). Moderately affected districts include Salima (39%), Balaka (38%) and Nkhata Bay (35%). Following these are Ntcheu (34%) and Rumphu (32%). While Karonga, Nkhata Bay, parts of Rumphu, Nkhatakota, Salima and Mangochi are all lakeshore districts; Balaka and part of Ntcheu lie in the valley and are close to the lake and Chikwawa and Nsanje lie low and have high temperatures coupled with a slow moving Shire River, Mulanje (34%), Mwanza (46%) and Ntchisi (57% and highest) fail to fit the bill.

Using under-five morbidity data from the recent national sample survey by CSR, the worst hit districts do not necessarily correspond with those from the facility-based rates. The five worst hit districts include, in descending order, Kasungu (57%), Phalombe (54%), Ntcheu (51%), Nkhata Bay (50%) and Thyolo (48%). Apart from Nkhata Bay, there is no serious collaboration between the two lists. This could prove the argument that malaria is a national (and not area-specific) problem. This poses a problem for geographical targeting based on actual cases of malaria. If geographical targeting is considered, though, the malaria prevalence data at both facility and community levels cannot be ignored.

Distribution channels

In general, channels of ITN promotion and distribution include government agencies like hospitals, NGOs, existing private sector commercial outlets and assisted private sector (social marketing). The distribution points can either be centrally located (facility and district based) or locally located (community or household based). The distribution modalities can be continuous or fixed day (date) based. The most commonly used distribution channel for ITNs for the general public worldwide is private sector commercial outlets. Of late, due to the slow progress made, social marketing has been introduced to assist private sector sales of ITNs. However, for special groups like under-five children and pregnant mothers,

⁴This generally understates prevalence as some patients choose not to visit

formal health facilities.

health facilities are the commonest distribution points. Literature advocates the use of a combination of distribution channels based on country context with the private sector as ultimate channel in the long run.

Community partnership

To achieve even greater success, there is need for what experts call 'a sociological interface of the community's knowledge of the disease (i.e. health education) and understanding of intervention' (UNICEF and USAID, 1991). There are knowledge and attitudinal problems that still dodge the efforts being undertaken. Some households do not have nets not because they cannot afford but because they do not take ITNs as a priority. Again, some who have nets do not sleep under them. Another problem is that a good number of net owners do not value the insecticide and as such, they rarely, if at all, re-treat their nets. All these problems, although increasingly declining, judged by the recent findings, call for community level awareness campaigns employing techniques that would use the community members in internalising the devastating effects and impact of malaria and the simplicity of controlling malaria using an ITN. Experts call upon intervention implementers to ensure that community members are full partners in ITN distribution by harnessing their human and financial resources (CPAR Malawi, 2003). This is possible when community members are involved right from problem analysis. Others recommend that all programmes should contain a social analysis of community needs, demonstrate equal partnership, mobilise community interest and assist communities in the use, maintenance and commitment to bed nets, curtains and sheets (UNICEF and USAID, 1991)

Sustainability of ITNs interventions is reported to be determined by a host of factors. Some of them are the provision of affordable bed nets and re-treatment kits at community level; incorporation of cost recovery elements; reinforcement of community and individual KAP (for effective and efficient use of bed nets and other anti-malarial measures) and community involvement in the planning, implementation and monitoring of an intervention. These must be complemented by equity considerations and annual meetings of key players at a sub-regional level. On equity considerations, the intervention should be designed in such a way that the poorer segments are supported either through internal

mechanisms like community support or programme interventions like direct assistance to poor families. **(UNICEF and USAID, 1991)**

Why target?

In responding to this question, there is need to first consider what needs to be transferred. ITNs are for malaria control and malaria is endemic in Malawi. Almost everyone would benefit from ITNs. However, considering the cost of a universal transfer programme and the variable risk factors of different population and age groups as well as population areas, it seems more benefits would accrue if the most at risk are targeted first before others are considered.

Who are the poorest of the poor?

Who is the poorest of the poor? Is it in terms of financial resources, social factors like participation, inclusion and exclusion or vulnerability to malaria? If it is according to the vulnerability to malaria then the question has been answered. However, if it is in terms of income poverty then there is more that needs to be done. According to the poverty profile produced for 1998, about 65% of the population was estimated to be poor (below a poverty line) and 29% ultra-poor (below an ultra-poverty line that was 60% of the poverty line) (NEC, 2000:10 & 14). Using relative poverty profile, the poorest 20 percent of the households are also be classified as the poorest of the poor.

How can the poorest be identified?

These can be identified using either individual or group indicators. In some cases, the poorest can also identify themselves by choosing to participate in a programme that is designed for the poorest of the poor. The use of an individual indicator or individual targeting uses a cut off point. All individuals or households outside the cut-off point are excluded. However, to objectively and accurately determine the indicator, there is need to measure the indicator for the entire population. That process is expensive and time consuming. The use of group indicators avoids the need to measure the indicator throughout the population. Group characteristics rely on proxy indicators. The indicators are generally easy to identify. The downside is that they are not always exclusive to the target group and can also exclude some members of the target group as not all display the group characteristics.

Given that the poverty profiles define the poorest, do we have proxy indicators that can be used to identify them? The Profile of Poverty in Malawi 1998 does not provide poverty proxy indicators for the ultra-poor. It only provides proxy indicators for the poor. However, the related publication, A Relative Poverty Profile of Malawi, 1998, provides some as follows:

- Poorest households in rural areas are more female-headed than the wealthier ones in general
- Poorest households have the least educated adults
- Poorest households have generally the most malnourished children
- Poorest households have the least access to agriculture land

- Members of the poorest households are less likely to report having fallen ill
- Members of the poorest households are less likely to be formally employed and get a monthly income
- Members of the poorest households are mostly in primary industries and self-employment

As can be seen, these proxy indicators are potential carriers of errors of inclusion and exclusion. For example, not all female headed households in rural areas are poor just as not all male headed households are well to do. Again, not all households with limited access to farming land are poor and not all with large tracts of farm land are rich. Owing to these possible errors, experts propose that proxy indicators should be easy to use but difficult to manipulate. They state that these should be adopted after thorough consultation with beneficiary communities.

In the case of ITNs in Malawi, proxy indicators can be viewed as those that characterise the most vulnerable (pregnant women and children below the age of five) and the poorest of the poor. Clearly the most vulnerable can objectively be identified using individual indicators as well as group characteristics. The poorest of the poor group, according to what literature indicates, cannot be objectively identified without heavy cost (if individual targeting is used) or huge errors of inclusion and exclusion (if proxy indicators are used without community vetting). It is, therefore, important that and use of proxy indicators be subject to community participation and vetting. In fact, any programme that needs to use proxy indicators should be prepared to have community specific proxy indicators developed and applied by community members themselves if it is to minimise the errors.

As already indicated, individual targeting requires information regarding the beneficiaries. In Malawi, the first time there was a national registration of beneficiaries at a national level was under the Starter Pack Programme. The Starter Pack Programme was a free inputs distribution programme that targeted all farm families. Since the programme was universal, the register contains close to all subsistence farmers. Theoretically, other programmes can use the starter pack register, to narrowly-target sub sets of the smallholder farmers like the groups targeted by the subsequent Programme, Targeted Input Programme (TIP). TIP was meant to

target the most vulnerable to household food insecurity. These included the elderly without support or households headed by them, child-headed households and households headed by persons with disabilities. Practically, such a register, becomes almost obsolete because of rapid changes in household composition, apart from cheating by those who are entrusted to register the poorest of poor. Community-drawn lists ought to be vetted by the community otherwise they are bound to contain some element of bias.

There is also a case for self-targeting in a possible ITN programme. This is on the basis that the malaria risk is idiosyncratic. Self targeting is possible when ITNs, subsidised or otherwise, are made available for sale in cash or kind or work to whosoever is willing. Experts emphasise that for self targeting to achieve the intended results, the programme should ostensibly be available to all but should be designed to discourage the participation of the non-poor or unintended beneficiaries. In the case of ITNs, it would be imperative to design the ITNs for the self-targeting to be inferior for the unintended beneficiaries but attractive enough for the intended beneficiaries to acquire. Once this condition is not true, the less vulnerable who may be even wealthier would 'flood' the self-targeting market and crowd out the intended beneficiaries. In the case of Malawi where the practice of self-targeting is already in place and a market for commercial ITNs is also developing, stocking the 'self-targeting' market with just as good ITNs would suffocate the commercial ITN market. This is particularly negative if the ITNs in this 'self-targeting' market are subsidised. Probably with the current low levels of net ownership hurting the nascent market a little could do more good than harm for the malaria control programme.

Methods used to identify project beneficiaries
Indicators used for identifying beneficiaries in different programmes

The study has found out that in general, most NGOs had their own "administrative" criteria of targeting beneficiaries before they start interacting with any community. However, when they get to the community they would ask the community to come up with their own "community" targeting criteria which would complement the administrative criteria. The following targeting criteria under different interventions were found:

Nutritional interventions: In most cases, anthropometric indicators were used in order to identify the severely malnourished and moderately malnourished for nutritional rehabilitation. These indicators are usually utilised at the health centre level where the severely malnourished are treated with therapeutic feeding and the moderately malnourished are provided with supplementary feeding. In some cases, pregnant and lactating women whose mid-upper arm circumference is less than 21.5 cm are targeted for nutritional interventions as well.

Insecticide treated bednets: A number of NGOs such as Nkhoma CCAP Synod, Canadian Physician Aid and Relief (CPAR), Africare and World Vision have been involved in the distribution of ITNs at subsidized prices in the communities. The criterion for this distribution has been similar as they target pregnant and lactating women as well as children under five who can access ITNs at a price of K50/net. At the community level, members of the community can buy the nets from village health committees at a slightly lower level of subsidy i.e. K100net.

Agricultural activities: For agricultural interventions such as extension and provision of inputs and loans, the NGOs had various criteria to identify beneficiaries such as:

1. resource poor households e.g. shortage of land
2. female-headed households
3. child-headed households
4. households whose harvest does not last 3 months
5. households whose food availability does not suffice for the whole year
6. elderly people
people with no relatives to help them e.g. widows
8. Boys and girls who dropped out of school.

In some cases, NGOs target both vulnerable and well-to-do households. This is because if the most vulnerable are targeted there is no impact in the medium to long term. For example CPAR targets both the vulnerable and non-vulnerable in its food security Program. However, Catholic Development Commission (CADECOM) targets the well-to-do or individuals in groups for its small-scale irrigation component whereas small livestock (poultry and rabbits) are targeted at the poorest of the poor.

Relief activities: The recent food crisis situation in Malawi was responded to by the formation of the Joint Emergency Food Aid Program (JEFAP). This is a collaboration by the Government of Malawi, donor organizations, the World Food Programme and the NGO Consortium with the objective of providing general food distributions to the most vulnerable and food insecure households in Malawi in a transparent and accountable way.

JEFAP came up with a number of criteria for targeting beneficiaries as follows:

- Households caring for orphaned children less than 18 years old (where both parents have died)
- Child-headed households
- Elderly-headed households (more than 60 years old)
- Chronically ill/HIV-AIDS affected members
- Female-headed households
- Households with two or more years of successive crop failure
- Households with children receiving supplementary or therapeutic feeding

However, some JEFAP partners notably Goal Malawi, were of the view that the JEFAP criteria were too broad and could not be used in the community as everybody qualified as being vulnerable. It is for this reason that most NGOs ended up refining the criteria or involving the community to come up with other criteria. At the same time, those NGOs which did not have any guidelines before, found the JEFAP guidelines as a good starting point citing the reason that without any clear guidelines, wrong beneficiaries may be targeted.

Targeting for HIV/AIDS interventions: Targeted beneficiaries for these activities include the chronically ill, orphans, the youth, households affected by or infected with HIV/AIDS and home-based care providers. The youths are targeted for sensitisation of HIV/AIDS as a problem and empowerment with information to pass on to their fellow youths. The chronically ill may be those who have been discharged from hospitals, TB patients receiving treatment and who need care or the elderly who need psycho-socio assistance. The home care includes physical nutrition and drugs.

Approaches and proxy indicators used at community level

There are different approaches used by the NGOs to identify beneficiaries of various interventions. However, in general the approach may take any of the following forms:

1. *Baseline survey:* Most NGOs start by carrying out a baseline survey using participatory methods to assess community problems as well as the poverty situation in the area of interest. They then engage the communities to identify the poorest of the poor using the community's own criteria and/or that prescribed by the NGO. One of the methods used is wealth ranking in which the community will define poverty and then use that definition to identify the poor.
 2. *Initiation period:* Some NGOs, e.g. World Vision, go through what they call "initiation period" in which they look at incidences of poverty using PRAs, establishing and training village committees for various activities. During this period, they learn the community's definition of poverty which they use to identify programme beneficiaries.
 3. *Using church based institutions:* For church-based NGOs, identification of beneficiary areas is done by going through the church structure e.g. a Village CADECOM Committee would identify problems which it presents to a parish. The parish reports to a diocese which will then submit a proposal to the national CADECOM office. This is also the case for Zambezi Evangelical Church and the CCAP Church where local churches submit their requirements to their Relief and Development arms.
 4. *Working through existing structures:* NGOs also utilise existing structures at the community level when it comes to entering the community and identifying beneficiaries. For example, village committees, church structures, local leaders and members of district assemblies are involved in the identification of vulnerable areas and/or members of their society. In some cases, the NGOs facilitate the election of the community committees.
-)"Government operations: The government uses the Vulnerability Assessment Committee to identify geographical areas for relief operations. However, according to the Disaster Preparedness and Relief Act, there are

supposed to be Civil Protection Committees which are yet to be set up and provided with terms of reference. The community is still supposed to identify vulnerable members of their areas.

In almost all of the projects visited, communities are involved in beneficiary identification. In some cases, the entire community is involved in designing the selection criteria by providing their own definition of poverty or the poorest of the poor. Yet in others, implementers work with traditional leaders (village heads, for example) and/or community committees to develop the selection criteria. Implementers, in most cases NGOs, rely on the criteria provided by the communities or traditional leaders or committees during project implementation. Since each community or project area is free to define its beneficiaries, it is conceivable that each community would have different indicators used to identify beneficiaries.

However, going through the various proxy indicators developed and used by various communities, the following list provides an array of indicators used to identify beneficiaries.

1. Absence of or insufficiency of assets like bicycles, rented and/or productive land, shoes and clothes, livestock etc.
2. Presence of orphans in the family or household
3. Absence or insufficiency of remittances from other relatives
4. Large family size
5. High dependency ratio
6. Presence of household member infected or affected by HIV/AIDS
7. Food insecurity
8. The use of desperate coping strategies; including sale of assets
9. The aged
10. Female headed households
11. Malnourished under-5 children
12. Child-headed households
13. Single-parent households (including the widowed)
14. Poor condition of shelter
15. The physically challenged
16. Chronically ill (i.e. more than 1 month)

One would notice that the community-developed criteria are really a refinement of the implementer-developed criteria. Further, the criteria developed by the community help to identify beneficiaries more narrowly than the implementer-developed criteria thereby minimising inclusion and exclusion errors. Therefore, most NGOs use the community's criteria to their own advantage as well especially in the face of limited resources.

Apart from assisting in designing the selection criteria, community representatives like traditional leader or an elected committee are used by implementers to actually identify the beneficiaries. Again, this approach is said to minimise inclusion and exclusion errors. It is, nonetheless, still subject to some problems. One problem is that local leaders and committee members are 'tempted' to include their relatives as beneficiaries and consequently exclude deserving ones to create room for their relatives. Most NGOs, after noting this problem, go through a verification exercise using their field monitors and/or facilitators. With a working verification exercise, the temptation to include non-deserving beneficiaries is kept in check.

Implementers perceptions about targeting mechanisms

Views on community targeting

Most of the NGOs visited consider community targeting as the best method. Regarding the designing of the selection criteria, they are of the view that implementers should first define the criteria and that criteria should further be refined by the community to minimise errors. Further, implementers are of the view that the selection of the beneficiaries should be done by communities themselves using mostly committees or village headmen because these know deserving beneficiaries. Implementers are also of the view that inclusion of non-deserving beneficiaries or exclusion of deserving beneficiaries is mostly deliberate as non-deserving relatives or committee members are included. To check this Malpractice, implementers are of the view that the implementer should conduct some verification exercise before delivery of benefits.

Another problem is that committees once elected or appointed are not accountable to the community. This leaves the community powerless and angry. Although implementers provided no solution to this problem, it needs to be addressed. A more difficult Problem cited by implementers is political influence in the

targeting process. Again, implementers did not provide a solution for this problem. However, this is more prevalent if the selection of beneficiaries is undertaken by outsiders. The undue pressure of a politician in a community setting is minimised because of power relations - traditional leaders are generally respected even by politicians and politicians are voted into office by community members. It is rather risky for a politician to exert undue pressure on fellow community members or traditional leaders. Political pressure can be minimised with the use of community representatives.

Views on handouts

Some NGOs consider handouts as dis-empowering to beneficiaries and does not engender commitment. Further views indicate that handouts generate the feeling of rewarding what some may consider laziness. Over time and for a long-term project with no exit strategy, handouts will generally encourage some non-poor to 'become' poor in order to 'enjoy' the benefits as well.

Beneficiaries perceptions about targeting mechanisms

The development of the criteria for selecting beneficiaries

Except in very few cases, respondents mentioned the agency that was responsible for benefits delivery as the one that developed the criteria used to target beneficiaries. In fact about 70 percent of the respondents mentioned the agency as the one that developed the criteria. In some cases traditional leaders (5%), government (4%) and committee (3%) were said to have developed the criteria. Only in very few cases did the agency work hand in hand with the community (3%) or traditional leaders (2%) to develop the criteria.

Criteria for selecting beneficiaries

Although criteria varied from project to project, there were mainly three criteria that were used to identify beneficiaries. The commonest was to target the poorest (27%), the aged (15%) and orphans (12%). While it is possible that some implementers used self targeting as a criterion and that community members could not understand it, the high prevalence of the perception of 'no criteria' in several projects raises some concern.

Again, what is of interest is that some projects were viewed as having varied targeting criteria. While that is true for some projects, this is a reflection of insufficient knowledge on the part of the community which in turn would mean insufficient effort on the

part of the implementer to transparently inform the community. According to what implementers said, some of the criteria mentioned by respondents were not true but nonetheless presents the perception of some beneficiary community members.

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Three main institutions were identified as key players in the actual selection of beneficiaries. These include community level committee or volunteers (42%), traditional leaders (16%) and implementing agency (13%). In some cases, the implementing agency selected the beneficiaries in conjunction with a community committee (3%) or traditional leaders (1%). There were also some cases where a community committee did the selection in conjunction with traditional leaders (6%) and community (3%). Yet in others the traditional leader and the community selected the beneficiaries (3%). Overall, it is noteworthy that the selection was done largely by the community or its representatives (69%). Further, most of the committees that were used to select beneficiaries were appointed by the community (36%) or a community committee (12%). In some cases, the appointment of the committee was facilitated by the implementer (7%) or traditional leader (7%) or implementer and traditional leaders (3%). However, in some cases a traditional leader (9%) or an implementing agency (3%) or a combination of the two (3%) appointed the committee.

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The majority of the respondents (67%) were satisfied with the **criteria** used to select beneficiaries because it generally targeted the right beneficiaries (51%) and that they were not biased (14%), everybody can get assistance from the project and that the project provided the right type of assistance (9%). Those that were not satisfied cited the 'Malawi is poor' reasons like 'everybody was supposed to benefit' (23%) or 'everybody would like to benefit' (17%). Strangely, though, those who said everybody would like to benefit were from three project areas: Concern (50%), ELDP (33%) and Nkhoma CCAP (17%) and those that said everybody was Opposed to benefit were from ELDP (44%), Blantyre CCAP and Catholic Aid Relief and Development (CARD) (19% each) and Nkhoma CCAP (13%). As many as 16 percent of those that were not satisfied said the selection was biased and over half of those (55%) were in the Action Malawi (AAM) project area while 18

percent were from Evangelical Lutheran Development Program (ELDP) project area.

As expected, the most frequently mentioned preferred criterion for those that were not satisfied was that 'everybody should benefit'. This was mentioned by 55 percent of those that were not satisfied with the criterion used. Almost one in ten (9%) proposed that households should be investigated for eligible beneficiaries. Perhaps related to the type of assistance provided, 13 percent of those that were not satisfied said only children should benefit. This was mostly voiced in the Blantyre CCAP (60%), CARD (20%), Nkhoma CCAP (10%) and ELDP (10%) project areas. Very few mentioned the poorest (4%), orphans (4%) and pregnant mothers and others (4%). This in general indicates that some community members, although not in majority, are not in favour of narrow targeting or targeting the vulnerable only.

Selecting institutions

Just like in the case of selection criteria, two-thirds of the respondents said they were satisfied with the selecting institution. The main reason given for this is that the institutions follow prescribed criterion (76%). Other frequently mentioned reasons included 'the institution was appointed by the community' (6%), 'there was cooperation between the institution and the community' (5%) and 'the institution was free to choose proper beneficiaries' (5%). Those who were not satisfied mentioned reasons like biasness (75%), rudeness, i.e. insulting beneficiaries (6%) and exclusion of rightful beneficiaries (4%). Corruption (3%) and self-enrichment (3%) were rarely mentioned. Interestingly few blamed the selecting institution for sticking to the implementer's criterion rather than the community's (3%). Those not satisfied with the selecting institution were divided when asked to mention their preferred institution for selecting beneficiaries. The most frequently mentioned institutions were implementing agency (30%), new committee (18%), village head (14%) and committee (10%). Most likely that a tried one institution wanted to try another. Those who still had faith in a committee or those who thought they cannot do without a committee thought electing a new one would assist the situation.

Errors of inclusion and exclusion

In almost all the project sites, there were errors of inclusion and exclusion. As many as 43 percent of the respondents thought there

were eligible beneficiaries that did not benefit and 27 percent thought the project provided benefits to ineligible beneficiaries. The major reasons given for the errors of exclusion were biasness (37%) and inadequacy of benefits (33%). Some did not know (12%) the reasons why some were excluded. The key reason given for including those who did not deserve to benefit was favouritism (78%) i.e. favouring certain segments of the population. Corruption (or getting bribes from beneficiaries) (6%) was mentioned as a possible reason while just as many thought they were included just to set an example. Others did not know (6%) the reasons.

Views on provision of ITNs from implementers

Geographical and beneficiary targeting

There is need to come up with district profiles to identify malaria prone areas and then look for specific verifiable criteria to identify the poorest of the poor e.g. bicycle ownership to be verified by traditional leaders.

Impact of ITNs

Those who had malaria control components and were involved in ITN distribution, indicated that there were reductions in incidences of malaria and recommended that ITNs should further be promoted and access to them by the vulnerable ensured. Although the ITNs Guideline suggests free distribution to the most vulnerable, there were suggestions that payment for ITNs should continue and there should be some flexibility in terms of payment.

Misuse and problems of ITNs

There is some anecdotal evidence that in some cases the nets are being used for fishing especially in lakeshore areas or for making wedding veils. In some cases, fathers or husbands and not the intended household beneficiaries (under 5 children or mothers) use the nets. There were also some fears that the nets might cause infertility. In addition, some agricultural activities such as tobacco curing are being done in houses to avoid thefts and this is creating problems of lack of space for hanging nets. Further, most ITN projects sideline the chronically ill yet these are just as vulnerable as under-five children and expectant mothers.

Pricing of ITNs and treatment of special groups

The price of ITNs is crucial in determining demand. The pervasive poverty generally sidelines the purchase of ITNs as priority unless the price is reasonable. Implementers noted an increase in demand

of ITNs when the price of the subsidised ITN dropped from K110 to K50 per net. Some poor people had previously accessed ITNs by paying in instalments or in kind e.g. crops and/or livestock. In some cases community members have contributed to the cost of ITNs. Thus those vulnerable who cannot pay are given the opportunity to pay in instalments in kind⁵ and when they do not have anything to exchange the ITNs for, communities were encouraged to support or assist them. The chronically ill should be considered as one category of the vulnerable. Where all the options above are not available to the vulnerable, i.e. paying in cash or in kind and being assisted by community members, there should be some consideration for free distribution but only to the most vulnerable. In the case of free distribution, implementers' view is that identification of beneficiaries should be undertaken by NGOs which, in turn, would use their various committees to undertake assessments. Most probably the committees are made of community members who, once elected, are trained by the NGOs to conduct the assessments.

Promotion and distribution of ITNs

The use of the Ministry of Health structures is not the best for the promotion and distribution of ITNs. There is a feeling that the government health facilities are overworked and may not effectively handle large scale ITN promotion and distribution. District Health Officer (DHO)s' mobile clinics do not work efficiently as nurses do not spend enough time in the field usually because they get allowances on the same day they are going to the field and usually this is late in the day. Sometimes DHOs' vehicles are not working. Again, it was said that's PSI is poor at sensitising communities about ITNs. Their extensive use of the radio only manages to get to urban populations and some few with radios in rural areas.

Grassroots-based organisations like NGOs, CBOs and church-based organisations should instead, be used for promotion and distribution of ITNs. Where they exist, civil protection committees could be used. So far it is observed that there is more impact and accountability where there are NGOs implementing ITN projects

⁵This applies to ITNs distribution by CBOs and, to some extent, NGOs. Where VHCs are responsible for selling nets, the instalments would be managed by them.

than otherwise. The possibility of working through district assemblies (and traditional leaders) should also be explored where there are no liable NGOs and CBOs. Although health facilities are not the best, in terms of promotion and distribution, these should still be used

Furthermore, there is need to bring ITNs very close to the communities. Efforts should be made to ensure that there is community-based promotion and distribution. Government structures should be used to support the community-based distribution structures in terms of surveillance, growth monitoring and sometimes distribution. In particular, the structure for distribution of nets at the community level should be a committee comprising two members representing traditional leadership, two members from the Village Health Committee and one Ministry of Health official preferably the Health Surveillance Assistance (HSAs). For this to work, Government should build the capacity of HSAs as well as fully support them to ensure that they concentrate on their working in their designated areas.

It should be noted that these views coming from NGOs could be biased somewhat considering that the bulk of ITNs distribution in Malawi is undertaken by PSI and health facilities. This could mean that they feel that the current system works against their development or expansion. The national framework, however, provides the role for NGOs and CBOs. As long as health centres concentrate on their usual 'customers', the issue of capacity has limited arguments. Health workers are not necessarily overworked and NGOs are not crowded out as long as the health centres concentrate on visitors to MCH clinics. Again, if PSI is not doing a good job on popularising ITNs, CBOs and NGOs should take that component up.

Who should benefit from targeted ITNs

There were various suggestions on who should actually benefit from free or subsidised ITNs. Overall, expectant women and under-five children (variably defined) were clearly the target groups for both free and subsidised ITNs. Surprisingly the aged, which are not necessarily vulnerable to malaria, were considered as a target group by the implementers. Table 2 indicates the criteria suggested and the frequency from project management visited in the field.

Table 2. Criteria on who should benefit from an ITN targeted programme

	free ITNs	subsidized ITNs
Criteria	frequency	frequency
U-5 children	5	4
U-5 orphans	4	3
U-5 from poorest and female-headed households	1	1
Single mothers with U-5 children	1	1
Expectant women	6	5
Lactating women	1	1
female-headed	1	1
Child-headed	1	1
disabled-headed households	2	1
The aged	4	3
The weak	1	0
Chronically ill patients	1	0
Everybody	0	1
Everybody classified as poor	0	1

Identification of beneficiaries

On who should identify beneficiaries, project implementers suggested that health workers should identify women and U-5 children during MCH visits. They further suggested that orphans and the aged should be identified by the village health committee by going door to door to verify their economic status when ITNs are to be distributed through CBOs like VHCs and NGOs. They further recommended that the chairman of the Village Health Committee (VHC) should be responsible for actually certifying that a particular beneficiary should buy a subsidized ITN. Others suggested that a village committee chaired by Health Surveillance Assistants (HAS) and the village head should identify the beneficiaries. On how beneficiaries can positively be identified, Table 3 below indicates the various suggestions that project management gave. The table indicates that some of the methods were suggested for both.

Table 3. Beneficiary identification methods for free and subsidized ITNs

Free	Subsidised
<ul style="list-style-type: none"> • A quick survey capturing people's economic status, conducting social mapping to come up with a list of the poorest of the poor which VHCs should be using • Through awareness meetings and Participatory Rural Appraisal (PRA) in order to hear the general problems of a particular community. After the meeting, people should select a committee responsible for registering beneficiaries. • The expectant women and under-five should be identified at the Health Centre by using cards. • Beneficiaries can be positively identified through medical/clinical certification that a particular person is pregnant or under five years of age. <ul style="list-style-type: none"> • Key informants in the community should do the wealth ranking exercise helped by management staff in order to reduce errors of inclusion and exclusion. Staff should also do the verification of beneficiaries. 	<ul style="list-style-type: none"> • Identifying other people as the poorest of the poor might be seen as discriminatory and from experience, it is difficult to identify the poorest of the poor due to rampant problems of errors of inclusion and exclusion especially for free items. To avoid such errors, there is need for people to be given a piece of work before any hand-outs i.e. self-targeting • Through awareness meetings and Participatory Rural Appraisal (PRA) in order to hear the general problems of a particular community. After the meeting, people should select a committee responsible for registering beneficiaries. • The expectant women and under-five should be identified at the Health Centre by using cards. • Beneficiaries can be positively identified through medical/clinical certification that a particular person is pregnant or under five years of age. • Key informants in the community should do the wealth ranking exercise helped by management staff in order to reduce errors of inclusion and exclusion. Staff should also do the verification of beneficiaries. • The nets are accessed after production of maternal and under five cards. • Identification of such beneficiaries should involve a combination of groups; the VHC, VDC, HSA and the traditional leader but only the poorest should be targeted.

Civic education and promotion of the use of ITNs

There is need for the community to value nets for sustainability. One of the solutions is IEC. As a start, there is need for intensifying IEC about malaria and how to prevent it including the use of ITNs. The same civic education should be used to clear misconceptions about the use of ITNs and combat the misuse of ITNs for fishing and making wedding veils. This education should start with traditional leaders and their councillors. The traditional leaders should also sensitise their communities using every chance they have including during funerals.

Multi-sectoral and multi-stakeholder approach

The fight against malaria requires a multi-sector and multi-stakeholder approach. All institutions that work at community level should be involved throughout the whole process. These institutions include the district assembly, district health office, district social welfare office, traditional leadership and police. Further, communities themselves or through a community-elected committee should also be involved from initiation to implementation as well as monitoring and evaluation. Committee members should be trained and given appropriate support including transport, accommodation and meals whenever need arises.

Views from community members

ITN background of communities visited

In response to the question 'does your household use ITNs?' 36% said 'Yes'. Those that said their household does not use ITNs gave a multitude of reasons but the major ones were the high prices of nets (47%) and their non-availability in their areas (17%).

Encouragingly only 3 percent were not of (or did not see) the value of net use and 99 percent of those who do not use ITNs said they wished they could acquire them. Further, almost all respondents excluding two said would be sleeping under an ITN given the chance and only 5 percent knew somebody who would not be willing to be sleeping under an ITN. Major reasons given included 'ITNs not effective', 'ITNs make one feel hot', and 'do not know

benefits of ITNs'. Each of these three reasons was given by 23 percent of the respondents. Other reasons included the perception that ITNs cannot be used on a mat (18%), reduce fertility (9%) and make breathing difficult (blocks free flow of air). Thus, in general, communities have a positive attitude towards ITNs.

A quarter of the respondents said that ITNs are available in their area. For those that said ITNs are available in their area, there are three main places where they are stocked and these are health facility (93%) by far the commonest, area shops (25%) and project office (17%). Only few 1.5 percent mentioned individual as a source and 4 percent mentioned other sources. The most expensive ITNs are those from shops, averaging MK268.82 and the cheapest are from health facilities with an average price of MK62.30. See Table 4 for more details. It should be noted that this does not correspond to current figures reflecting the situation on the ground.

Table 4. Availability and average prices of ITNs

Source	Availability for respondents	Average price (MK)
Health facility	93.0	62.30
Project office	17.4	101.83
Village Health Committee	8.7	116.43
Shop (vendor/trader)	25.0	268.82
Individual	1.5	166.67
Others	3.8	100.00

Clearly the views from the community members contradict those of implementers. In fact, these views are closer to the findings of the national representative survey. As already said, it is possible that the implementers views were biased by their wish to 'get more of the cake' or simple lack of knowledge.

Selection criteria for subsidised and free ITNs

There was varied opinion on who should be targeted for subsidized ITNs. Of course the under-five children (18%) and expectant women (16%) topped the list. Other notable targets were 'all interested and able to purchase' (15%) and 'the poorest' (12%), the aged (11 %) and poor (11%). Note the similarities with

the list from implementers. The aged also appear as target group. There were two main reasons given for their choice of targets. The first was that of low immunity (34%) and then failure by the target group to afford unsubsidised nets (33%). Further analysis shows that those who mentioned immunity had under-five children (39%), expectant mothers (31%) and the aged (12%) as the target groups. Respondents were unable to link chronically ill (HIV/AIDS) patients with low immunity⁶. Those that mentioned affordability had poorest (24%), the poor (18%), the aged (16%) and orphans (10%) in mind. Expectant mothers were also mentioned as targets for affordability reasons by 11 percent of the respondents. People with disability and female headed households were not featured highly for both reasons. There were few cases of 'missed target', though. See Table 5 for more details.

Table 5. ITN Target groups and their justification

	Immunity	Affordability
Under-5 children	38.5	9.2
Expectant mothers	30.7	11.3
The aged	11.7	15.8
Wealth status	4.4	1.7
Persons with disability	3.9	6.7
The poor	3.4	17.5
Chronically ill	2.4	1.3
Lactating mothers	2.0	0.8
Self targeting	1.0	2.1
Orphans	1.0	9.6
Female headed household	0.5	0.4
The Poorest	0.5	23.8
Total	100	100

⁶Immunity was defined as the ability of the body to withstand infections. Responses related the ability of the body biologically by the respondents were grouped under immunity by the analysts.

There is some difference when the ITNs are to be distributed freely. The top five target groups are the poorest (27%), the elderly (18%), under-five children (13%) and expectant mothers (10%). The major reasons, of course, are the same: cannot afford (46%), have low immunity (22%) and not able to work (16%).

Beneficiary selecting institution and ITN distribution channel

In line with earlier findings, the village head and committee were the preferred selecting institution and health personnel came third. There were suggestions of combinations: committee and village head, implementer and village head, community and village head, implementer and health personnel. In any case, the village head alone is the most preferred selecting institution (41%) followed by a committee (28%) and health personnel (11%). The combination of a committee with village head was mentioned by 9 percent of the respondents. Only 3 percent suggested that community members should be responsible for selecting beneficiaries. The major reason given for their choice was that the institution so chosen knows the status of every household. Other reasons included transparency and natural or traditional responsibility. In fact going through the list of reasons given, one has the impression that selection of beneficiaries is the responsibility of traditional leaders.

When it comes to distribution, the preferred distribution channels are committees (35%), village head (25%) and health personnel (14%). The basis for their choice included 'will choose eligible beneficiaries' (56%), 'will sell at the recommended prices' (17%) and 'are responsible for this kind of work' (16%). Strangely all the three institutions were selected for almost the same reasons. Overall, all the three have similar trust among community members although the village head is more trusted in selecting the right beneficiaries and the committee in selling at the recommended prices but all the three are thought to be responsible for this kind of work. Of course, the health personnel have an edge on knowledge of malaria incidence and place for stocking nets. Table 6 provides the reasons for the top three institutions.

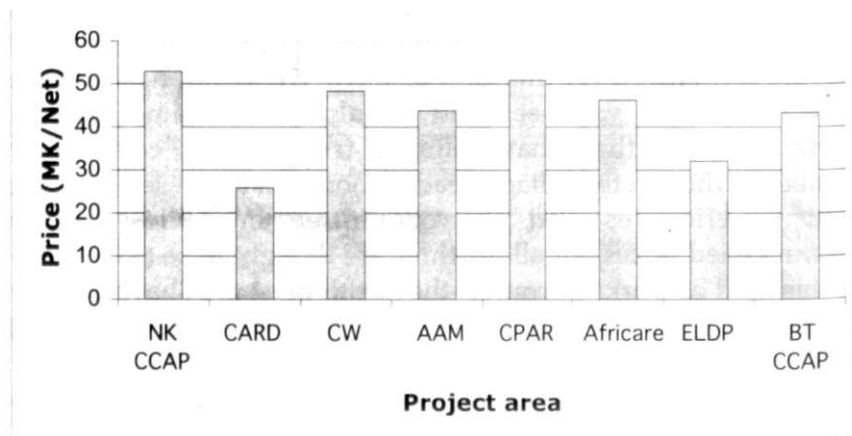
Table 6. Preferred distribution channel for subsidised ITNs and their basis

	Committee	Village head	Health staff
Will choose deserving beneficiaries	56.5	62.2	38.6
Very cooperative and hardworking	5.1	4.1	5.3
Have a good place for stocking nets	0.7	5.1	12.3
They know malaria incidence	1.4	1.0	15.8
Will sell at recommended price	24.6	17.3	15.8
Responsible for this kind of work	16.7	16.3	15.8
Others	2.2	0.0	0.0
Total	100	100	100

Recommended ITN price

The average price of an ITN the respondents would be willing to acquire was MK43.04 while that of a re-treatment kit was MK20.55. The average prices ranged from MK26.02 in the CARD project area to MK52.79 in the Nkhoma CCAP project area. In fact except for ELDP and CARD, all the averages were above the national average of MK43.04 per net. See Figure 1.

Figure 1: Recommended Average ITN Price



As expected there were no major differences in the preferred selecting institution and distribution channel between subsidised and free ITNs and for the same reasons. Clearly the difference was

in the target groups for the two products. This then emphasises the point that free ITNs are simply subsidised ITNs at 100 percent. It is encouraging to note, therefore, that community members would not undervalue a free ITN.

Identifying the Poorest of the Poor

Community perceptions on identifying the poorest of the poor

Characteristics of the welfare groups by household respondents

The poorest are characterised by lack of assets and basic necessities. The major characteristics of the poorest are: absence of household livestock (25%), vulnerability (19%), lack of food (12%), lack of housing (11%) and dependency on piece work or '*ganyu*' income (11%). Table 7 below presents the characteristics of the various welfare categories and the relative importance attached to each by the community.

The table shows some quite interesting issues. For example, *ganyu* and illness are mostly featured among the poor and poorest while businesses, even micro-enterprises are only run by the non-poor. Again, while the rich may run several medium as well as small enterprises, the moderately rich run small scale businesses like hawkers and can sometimes have insufficient food. They buy and apply fertilizer and improved varieties and use labour services of the poor and sometimes the poorest in their farms to cultivate and apply the modern technology. Meanwhile, the poor and the poorest have no fertilizer and improved seeds to apply and even time to work in their smallholdings.

Table 7: Welfare status and their characteristics

Characteristic	The rich n=401		The moderately rich n=28		The poor n=1332		The poorest n=645	
	Type/ Qty	%	Type/ Qty	%	Type/ Qty.	%	Type/ Qty	%
Housing	Good	24.7	Good	3.6	Poor	22.3	Poor and no	13.9
Livestock	Different	17.0	Few	32.1	Few	12.2	None	24.7
Livestock					None	3.8		
Food	Sufficient	18.6	Sufficient	25.0			Lack	12.4
Food			Insufficient	17.8	Insufficient	17.9		
Dressing	Good	10.0	Good	3.6	Poor	16.2		
Employment	Good	5.1					Lack	7.6
Self-employment	In business	5.9	Small scale	7.1	Ganyu	6.9	Ganyu depend	11.2
Agricultural inputs	Enough	5.9	Enough	3.6				
Luxuries	Have	4.8	Few	3.6				
Durable goods	Have	2.8	Few	3.6	None	4.4	None	5.3
Business	Several	2.8			Small scale	7.1		
Vulnerability					III health	4.1	Generally	19.1
Health status							Chronically ill	2.8
Basic necessities					Insufficient	2.7		
Others		2.4				2.4		
Total		100		100		100		100

Welfare groups and their characteristics from FGDs

Views from Focus Group Discussion (FGDs) are more concretised than those from households since the groups had the chance of thrashing out the issues. However, there are a lot of similarities. Food security, housing, sources of income, dressing and possession of assets still help define the welfare categories. FGDs only had three categories: the rich, the poor and the poorest. Just reflecting the pervasive nature of poverty, the FGDs just like household respondents, were more articulate in characterising the poor and the poorest.

The rich

Food security was the most frequently mentioned characteristic of the rich. Seven FGDs during feed-back sessions mentioned (or confirmed what the male and female FGDs already pointed out) availability of food throughout the year or enough food. This was followed by ownership of different types of livestock which was mentioned by five groups. Good housing, mentioned by three groups, seems to be one other important characteristic of the rich. Others mentioned include good clothing (2 groups), availability of money (2 groups), possession of assets like cars (2 groups), bicycles (1 group), ox-cart (1 group), fishing nets (1 group) and grocery shop (1 group); and possession of household items like sofa sets and beddings. One group mentioned 'smooth bodies' as another characteristic while another 'alleged' that the rich are characterised by their non-participation in development work. Given this and the findings from the household respondents, it is possible to select key indicators that would assist in identifying who is not poorest in a community.

The poor

There is more convergence on the characteristics of the poor. Food security still tops the list. However, quality and variety of clothing has a similar importance. Seven groups mentioned that poor households have insufficient food supplies to last a year and poor and/or inadequate clothing. Poor shelter was mentioned by six groups while five mentioned having only one type of livestock. Probably what is striking is the source of income for the poor. Piece work commonly called *ganyu* was mentioned as a characteristic of the poor by four groups. It is said that the poor's only asset is their ability to work throughout the year for their survival. They have no or just few of one type of livestock to depend on (3 groups) and

they do not have meaningful assets (1 group) including even a bicycle (1 group) and blankets (1 group). The poor have, in general, no stocks of basic necessities (2 groups) and have therefore inadequate resources (1 group) and money (1 group).

The poorest

The most striking feature of the poorest is their inability to work to earn a living (five groups). Further, they have no external support. Special groups of people are naturally in this category. For example the aged (living alone or with orphaned grandchildren) were mentioned by five groups, physically challenged (PWD) were mentioned by five groups, children (under the age of 11) living without parents mainly orphans (3 groups) and the chronically ill (3 groups). As some groups said, the poorest of the poor are people who are unable to do any type of work because they are weakly or sickly. Their life is described as miserable as they have no money and are forced to dress poorly having only one cloth (one group), sleep on sacks and go without food in most cases (4 groups) and soap for bathing or washing (two groups). Their dressing is described as very poor (two groups) and sometimes they have no house at all and when they have one it is in very poor state (3 groups) and they are said to have very poor beddings, if at all (2 groups). As expected the household of the poorest have no livestock (one group) and there is always someone who is sick in the household or put it differently household members easily fall ill (2 groups). Despite being weakly, the household survives on *ganyu*.

It is interesting to note, however, that neither household respondents nor FGDs raised the issue of landholding size or quality of land as a welfare determinant. This is also true for female-headedness. With so many households headed by women, both poor and rich, and so many households being poor regardless of sex of the head, community members generally view the sex of the head of the household as of no consequence. This is more so as the majority of the population is governed by the matrilineal system whereby women have some power including in matters of land ownership.

Identification of the poorest of the poor

Community representatives are considered to be the best placed to identify the poorest of the poor. The village head is again, the most favoured institution to select the poorest of the poor. Forty-six

percent of the respondents mentioned the village head as the rightful institution to identify the poorest of the poor in a project scenario. This was followed by a committee (21%) and a combination of the village head and committee (17%). Others suggested village head and clan leaders (3%), village head and community (3%) and the community as a whole (2%). A few (less than 10%) mentioned that there is stigma attached to being identified as the poorest even in a no-benefit scenario. This echoes the cry that 'every one should benefit' and very few would be 'ashamed' to be termed 'the poorest' as long as there is some benefit attached to the 'name calling'. In fact, 55 percent said there would be some negative reactions by those excluded in the category of the poorest in a project scenario.

The attitude of the communities whereby some would want to be included as the poorest even when they clearly know who the poorest are leaves few options for programme development. It is incumbent upon project implementers to be vigorous in the identification or verification of identified beneficiaries. The advantage is that the community members know who is poorest and they would not get surprised if only the poorest are included. Excluding the relatively well off and some marginal poorest would not be queried although some of those excluded would still feel jealous of those who would rightly benefit. It is most likely that a well targeted project implemented over a long period would slowly send a message to the non-deserving community members who would still want to benefit. However, any errors of inclusion (not exclusion), in such a project scenario would not instil confidence in the targeting mechanism but continue to provide fuel for the urge to benefit even when one is not deserving. The issue would be 'why not me when such and such who are just as good as I am or better benefit?'

It is sobering to note that the results from FGDs were more concrete than those from households. Of course in almost all the project sites visited they said their communities have a lot of the poorest of the poor. Asked whether it would be possible to identify them all, FGDs were affirmative and said that traditional leaders or a committee would easily do so. Other groups suggested the use of outsiders to identify the poorest of the poor. As a possible indication of possible problem of exclusion, some group proposed that the poorest should be identified from different parts of the

village. This is similar to the call from some households' respondents that proposed the use of family clan leaders so that each clan leader identifies the poorest in his/her clan thereby spreading the benefits in the village.

Again, all FGDs indicated that there is no stigma if one is identified as the poorest of the poor. Some group, however, mentioned that one would be disappointed if no benefits are attached to being identified as the poorest of the poor. The majority of the FGDs said they would be happy if a project identified the poorest of the poor for assistance since these people need assistance anyway. Some group, nonetheless, said that some community members would not be happy to be left out simply out of jealousy

One other thing is the overwhelming support community representative have on issues of targeting (only one FGD that called for outsiders to identify the poorest). While this is a good sign and a lesson to implementers, it does not mean that community institutions are foolproof. It is therefore important to use monitors and beneficiary verification as a check of even the most trusted targeting mechanism as proposed by implementers visited.

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It has been established above that it is not possible for outsiders to identify the poor because of imperfect knowledge. It has also been established that community targeting minimises targeting errors but still carries some risks. However, there is some convergence on critical indicators that can assist in identifying the poorest of the poor in a community. Considering what the literature proposes and what communities and implementers said during the community survey, we propose the following as a way of identifying the poorest of the poor for any generic programme

targeting the poorest of the poor with transfers that have no work requirement⁷.

- (a) Use of proxy indicators
- (b) Refinement of proxy indicators by communities before a programme/project is implemented
- (c) Use of the village head in conjunction with a relevant village committee in identifying the poorest of the poor. If such a relevant committee is not in place the committee should be elected by the community before stage (b) above. It is important that the village head and committee take part in the refinement of the proxy indicators.
- (d) The implementing agency should use its structures to verify the genuineness of the identified beneficiaries using its staff or trained volunteers. The volunteers should be trained together with the village heads and committee members. The joint training would assist in developing a common understanding of the agreed criteria for selecting the poorest of the poor by the selecting institutions and 'inspectors'. While trusting the integrity of the local leaders, this verification will assist in minimising the practice of deliberate errors of inclusion and exclusion. In this case the volunteers should also be mandated to investigate possible cases of erroneous exclusion by 'putting their ears to the ground'. Once verification exercises are conducted objectively, the selecting institutions would want to be more objective as well.
- (e) The implementing agency should ensure that there is community feedback on the programme. The frequency and timing would depend on the programme/project period. The objective of the feedback sessions would be to provide the status of the project including how beneficiaries have been selected and possibly who. Such a session should give chance to the community to voice their views on how the

⁷ It is our considered opinion that any transfer targeted at the poorest of the Poor should not have any work or payment requirement. As already seen above, the definition of the poorest of the poor hinges on their inability to work for their own survival. Further, the poorest of the poor have close to nothing and cannot be required to pay for a transfer that is considered fit for them.

programme is performing *vis a vis* its intended objectives as outlined before its implementation. The possibility of a feedback session and its actual taking place is likely going to instil some discipline in the selecting institution.

We feel it is important to have a short list of proxy indicators that should be used to identify the poorest of the poor in general. The proposed proxy indicators are considered common in all parts of Malawi and they are not area-specific. However, they may not be comprehensive enough to take care of area and programme or project specifics. It is therefore proposed that this list be treated as starting point for any generic programme targeting the poorest of the poor. Further, these indicators are at a household level. Considering the family structures and social organisation in Malawi, we feel it is imprudent to zero in on individuals in a household⁸. Here below is the list

- (a) Households headed by a child and with no known external support
- (b) Households headed by the aged with orphaned dependent children and with little or no known external support
- (c) Households which are chronically food insecure for at least three quarters of the year
- (d) Households headed by poor chronically ill parents
- (e) Households headed by highly physically challenged persons who mostly rely on begging and handouts

These indicators should be supplemented by poverty manifests proposed by the community itself. As a start, communities would be required to verify whether the proxy indicators characterise the poorest households in the community. Secondly, the community would be required to consider poverty manifests. Examples of poverty manifests include poor or no housing, poor or no beddings, poor dressing, no livestock, perpetual engagement in

⁸ For example, we feel it is imprudent to target orphans being kept in a household, without considering the children of the household. In such a scenario, it is impossible to improve the lot of the orphans as long as the orphans are in the household. Furthermore, it is impractical to talk of AIDS orphans when orphans are orphans regardless of how their parents died.

low paying piecework and begging. The poverty manifests will have to be developed by the community. The poverty manifests could differentiate between the poor and the poorest households displaying similar proxy indicators.

Once the full selection criteria are developed, a community committee should actually identify the poorest of the poor. The list produced should then be verified by an independent assessor appointed by the implementer. The assessor can be a person or group of people. Government front-line staff (teachers, HSAs and community development assistants) is considered more independent than community members unless the whole community is used. In any case, the proposal is that the implementer should be responsible for selecting the assessor.

Providing ITNs to the Poorest of the Poor

We have found that ITNs are gaining ground as a means of malaria control among Malawians but more specifically the most vulnerable groups (expectant women and under-five children). They are, however, rarely targeted at the chronically ill which is another vulnerable group. We have also found that poverty in Malawi relegates the purchase of ITNs down the list of household items to buy even at subsidised prices. It is, however, our considered opinion that social marketing of ITNs should continue with more use of community representatives like village heads and health committees and politicians in civic education. This social marketing should target the population at large, poor or rich. With political will and technical commitment, ITNs can become common household items in the near future.

We have also found that efforts at making ITNs accessible to vulnerable groups have had some positive impact. Subsidised ITNs are available in most areas. Implementers and community members alike call for more availability of subsidised ITNs at community level. Indeed there are two problems that plague the accessibility of ITNs. The first is the price and the second is availability. These are mutually exclusive problems. Solving either of the problems will likely increase the accessibility of ITNs and solving both will certainly boost the fight against malaria in the country. Our proposal on the issue of making subsidised ITNs more available and accessible to the most vulnerable groups is as follows:

- i. Government should prioritise an ITN-supported malaria prevention programme by committing its own funds. Interested donors should come in to support the subsidisation of ITNs. The subsidy should be large enough to maintain the current price of MK50. This is close to the community's recommended price of MK43.
- ii. The highly successful health facility distribution should be complemented by multiplication of CBOs and community-level distribution channels working with the DHOs. This will increase the horizon from only the most vulnerable to those at malaria risk. Community-level distribution channels are meant to show ITNs are not 'hospital drug' but an essential household asset. On the basis of the experience so far gotten and views of communities and implementers, village heads and village health committees supported by HSAs would carry this message forward. The HSAs should be trained in social marketing techniques to effectively support the community institutions in marketing the ITNs.
- iii. Like-minded NGOs should be used in the distribution of the ITNs to the community-level institutions. These NGOs should themselves be trained in social marketing which in turn should train HSAs in their areas of operation. Where NGOs do not exist, the Ministry of Health (MOH) and district assemblies should take upon themselves to work through their structures to work with the community institutions in making ITNs available at community level. Even in such cases, the relevant MOH and DA staff including HSAs and Traditional Authorities should be trained in social marketing.
- iv. The current national institutional arrangement for the ITN scale up should be implemented to the full because it offers a good chance for coordination and collaboration.
- v. Districts that are known to have high malaria prevalence should be targeted first. On the basis of the current information, we propose the following areas: Lakeshore districts (Karonga, Nkhatabay, Nkhotakota, Salima and Mangochi), Lower shire districts (Chikwawa and Nsanje) and mosquito prone areas (Rumphi-Mlowe, Ntchisi, Bwanje-Valley (covering lower Ntcheu and Dedza and parts of Balaka) and Mwanza).

As for the most vulnerable groups, we propose that the subsidised ITNs be narrowly targeted at all under-five children and pregnant women in the designated areas regardless of welfare status. These groups can easily be identified at community level. Expectant women should be eligible for the purchase of ITNs after three/four months of their pregnancy if they are not medically certified as pregnant by health professionals. Certified chronically ill, regardless of their welfare status, should also have access to the ITNs.

So far, we have been dealing with full cost and subsidised ITNs. Provision of free ITNs would need a different approach. Firstly, provision of free ITNs would require even narrower targeting; it would require the combination of vulnerability and welfare status. Secondly, it would require more rigorous verification process. Thirdly, provision of free ITNs would require functioning community-level selecting institutions in order to minimise targeting errors. Our proposal is as follows:

- i. Just like in the case of subsidised ITNs, the provision of free ITNs requires even more political will. Prevention of malaria should first be prioritised if the NMCP is to be given enough support. Government and interested donors should underwrite the cost of the ITNs.
- ii. Free ITNs should be distributed only in the districts where Malaria is endemic using a voucher system.
- iii. Only certified expectant women, under-five children and the chronically ill in the poorest of the poor households should be given the free vouchers.
- iv. The HSAs should be responsible for selecting beneficiaries because the criterion is biological. HIV/AIDS would need to be certified.
- v. The ITNs should be stocked in shops, nearest health centres or NGO project offices. Selected beneficiaries should get the ITNs in exchange for the vouchers.
- vi. Each free ITN should have three-year stocks of re-treatment kits. These should be transferred to the village head and his/her committee when getting the ITNs from the health centre or project office. However, they should be stocked at the community level (village head or any member of the committee with enough space) to be given to the

beneficiaries after every six months to ensure that the nets are re-treated.

- vii. The programme should run for at least ten years in order to have some impact. Our preference, is it should run as long as there are expectant women and under-five children without ITNs.

It is our considered opinion that with this narrow targeting, the numbers of free ITNs will not be so large. If the targeting is objectively done and beneficiaries sufficiently engaged to ensure that they make proper arrangements to ensure that the nets are used, the value of the free nets will not be too low as to make the beneficiaries care less for them. The constant follow-up (for re-treatment) will remind the beneficiaries that the ITNs are valuable and that somebody else has a keen interest in seeing that they are properly treated.

Assumptions underlining the proposals

The proposed method for identifying the poorest of the poor is dependent on the honesty of communities and community representatives. It is our assumption that in refining the proxy indicators, communities will not deliberately broaden the selection criteria to ensure that as many people are included as the poorest of the poor.

The strategy for providing ITNs to the poorest of the poor has been based on the fact that there will be a three-pronged approach in the ITN-supported fight against malaria. The first is that well-designed and attractive full cost recovery nets will continue to be advertised and marketed vigorously. It is assumed that commercial outlets will be used to sell these but with Government supporting social marketing.

The second approach is that subsidised nets will be available throughout the country with emphasis in malaria-prone areas. The current distribution channels will have to be used with more emphasis on CBOs and NGOs. Again, Government is expected to underwrite social marketing as well. HSAs are expected to work hand in hand with communities in popularising ITN use. It is alleged that HSAs are either overworked or unsupported. However, the proposal assumes that HSAs are simply

unsupported and not overworked. If it turns out that they are overworked, then their proposed role will be compromised.

The third approach requires commitment from health centres. Health centres will be required to stock the ITNs and re-treatment kits and provide the ITNs to those with bonafide vouchers. Further, the health centres would need to request for re-stocks. This assumes that the health centre staff has time and staff to perform these roles. It is known that health centres are thinly staffed. However, our assumption is that some NGOs will come in and take the responsibility of distributing the free ITNs and that the use of health centres will be limited.

In all this, the major assumption is that there will be political will and donor support. Without these two, all that has been proposed will amount to nothing.

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Political and fiscal sustainability of social policy: the case of Malawi¹

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Kutengule²*

Introduction

The paper focuses on the (i) determinants of Malawi's social policy; (ii) political sustainability of social spending; (iii) fiscal sustainability of social spending; and (iv) government's funding of the social policy. As a start, it sets the parameters for the analysis in relation to theory and practice. On this basis, it discusses whether or not Malawi's social policy is sustainable, politically and fiscally. The paper then presents some data on government spending on the basis of an adapted fiscal sustainability framework.

Malawi social policy

There has been no explicit social policy in Malawi. Implicit social policy is drawn from pronounced policy statements, initiatives and level of expenditure on social sectors (education, health, social welfare and, to some extent, water and sanitation). To provide a historical perspective, the paper has attempted to briefly go as far back as the early 1960s when the independent Malawi was in the making. Given that there is no implicit social policy, the paper mainly relies on public expenditure as an indicator of the level of emphasis the government was putting on social policy. However,

¹ This is a short-version of a research report prepared under a broader collaborative study between the Institute of Development Studies (IDS) at the University of Sussex and the Centre for Social Research of the University Malawi titled "Social Policy in Southern Africa: the Case of Malawi".

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before dwelling on public expenditure, this paper starts with a presentation of factors that have shaped government social policy overtime.

Ideology and political conflict: the cabinet crisis

Dr Banda, the Prime Minister, and the powerful members of his cabinet differed on political ideology. The difference in ideology made the determination of the social policy at the time rather difficult. Dr Banda leaned towards capitalism while the cabinet leaned towards socialism. Dr Banda preferred introduction of user charges for social services while his cabinet preferred free services. Dr Banda preferred gradual localisation of the public service and the cabinet preferred immediate localisation. Dr Banda preferred to recognise the capitalist China (Taiwan) and the Cabinet, socialist China. In line with the last point, Dr Banda worked with white Mozambique, Rhodesia and South Africa while his cabinet wanted to work with the independence movements in those countries. These differences led to a fundamental rift during a cabinet meeting. Dr Banda won the day and fired the dissenting ministers.

Dr Banda's triumph had a lasting effect on the nature of politics, national development policy in general and social policy in particular. It meant that capitalism won over socialism. It reinforced his position of taking social services as subsidiary to the economic sectors. This is why there was limited investment in the social sectors in Malawi unlike Tanzania and Zambia that adopted more socialist ideology. Although no user charges were imposed in the health sector, the sector was barely funded. In education, user fees continued. There was no free or universal or compulsory basic education. As will be seen later, the education sector was used to produce the bare minimum for the gradual localisation of the public sector and budding private sector.

Socio-economic status of the population

Malawi has always been poor before and after Independence. The idea of improving this status has pre-occupied politicians and Policy makers. The Malawi Congress Party's (MCP) social-economic fight from 1961 up to 1994 was against poverty,

ignorance, and disease. MCP Government, however, gave lip service to education (fight against ignorance) and health (fight against disease). Its fight against poverty also faltered since it neglected the smallholder concerns. All the three problems continued over the MCP's rule. Thus poverty, ignorance and disease also confronted the United Development Front (UDF) Government as it took over in 1994. The UDF Government launched the Poverty Alleviation Programme (PAP) in 1994 with free primary education as its flagship policy. The policy framework for PAP emphasised, among others, the provision of social services (education, health, water and sanitation) and safety nets as a means of poverty reduction. Within the social sectors, the PAP zeroed-in on the provision of basic social services (BSS).

The situation did not change Malawi's socio-economic status much. Malawi formulated the Malawi Poverty Reduction Strategy (MPRS). The MPRS, which is both a policy and expenditure framework, put a lot of emphasis on social sectors as well. For example, cost estimates for the two major social sectors of education and health were close to 50 percent of the total cost estimates of all pro-poor expenditures in the MPRS.

The level of public financial resources and their allocation

The level of public resources limited what the Government could do in the social sectors. Social sectors received low priority in the 1960s and 1970s in terms of public expenditure. This was in spite of the Government's express goal of fighting poverty, ignorance (education) and disease (health). Malawi's first and third development plans state:

"Their (social sectors') demand on a nation's resources is insatiable and no country in the world has so far succeeded in meeting all the demands for education and health services" (GoM 1962: 5).

"The Government revenue position does not permit expenditure on both the minimum acceptable level of treatment as well as on major preventive schemes: it is for this reason only that preventive health must for the time being be given a low order of priority" (GoM 1971: 5).

More importantly, Government concentrated its meagre public resources on Dr Banda's preferred dream projects, most of which were relatively costly. These included the construction of the lakeshore road, the construction and running of a modern university and the move of the capital from Zomba to Lilongwe. These significantly influenced public expenditures in the late 1960s and 1970s. In particular, the move of the capital to Lilongwe was clearly an expensive project whose socio-economic viability had been questioned seriously by donors. The opportunity cost of these projects, in relation to foregone investments that could have been made in the social sector, was considerable. This resulted in poor funding of the social sectors, especially basic education and health care.

Public expenditure and investments in the social sectors were justified more in terms of their contributions to economic growth than seeking to address longer-term human development concerns, which would still contribute to broad-based, and even more sustainable economic growth and development. In education, the focus was on meeting manpower requirements for economic growth and the localisation of positions held by expatriates in the public service and not so much a concern for general attainment of the population. This required an expansion of the process of producing highly skilled managerial and/or administrative cadres and specialist professionals. This expansion entailed investing in substantial secondary and tertiary educational facilities, among the various competing priorities. The University of Malawi was therefore established from 1965 to address the problem of lack of these cadres of staff. The supply of required human resources crowded out the provision of education as an essential aspect of improving the basic human capabilities and the quality of life for the majority of the population. The financing of the costly university and its required secondary education, meant reduced effort in expanding access to primary education and improving literacy and numeracy levels.

In health, the focus was on health improvements aimed at increasing the productivity of labour. In particular, the emphasis was more on a campaign against disease in terms of expanding access to curative services than preventive or primary health care services that would promote more general improvements in the health status of the population. Tertiary curative health services,

which are concentrated in urban areas, received the more funding than any other level. Likewise, Government focussed on limited low cost urban housing justified as a means of contributing to the prevention of disease among urban-based workers so as to avert possible decline in the productivity of labour.

Since the government had inherited poor health infrastructure from the colonial administration, the focus was on the construction of health centres and hospitals and the training of health care personnel to provide curative services. This meant the neglect of preventive or primary health care services considering that the Government had resource limitations. Faced with the difficult choice between curative and basic health care investments, the Government explicitly and deliberately gave low priority to social services. This, once again, was in line with the Government's strategy of increasing the productivity of the labour force to attain rapid economic growth. Owing to the nature of curative services, public spending on curative health services continued to take up the lion's share of the health budget than preventive health services.

The emphasis on tertiary services at the expense of primary services shaped most of the planning and programming to an extent that the country is struggling to re-focus its approach in the social sectors. Currently, major orientation has been proposed under the MPRSP. The MPRSP has proposed policies and expenditure patterns that emphasise primary as opposed to tertiary and secondary services. In education, the idea is not only education for white and blue-collar employment but also self-employment and innovation. In health, MPRSP emphasises the provision of an essential health package that promotes critical preventive and curative services for the entire population and not only for the working class.

Donor and international influence

Malawi's social policy has also been influenced by external forces. International bodies like the UN, World Bank and IMF and friendly governments have played major roles in shaping the countries policies, including those on social sectors. Malawi's poverty, low levels of public resources and the general poor management of public resources has left the country open to

international pressure. It is probable that the social sector spending policies in the early years of the country was influenced by the British Government bearing in mind it even funded most of the recurrent budget. Likewise, the development budget has always been financed by donors; with an average of only 20 percent being funded from internally generated resources. Thus apart from the Government's expressed low priority accorded to social sectors, the donors also had a hand in the low social spending in the years up to 1990.

In fact, SAPs of the 1980s negatively influenced Malawi's social spending in order to stabilise the economy. While it is true that the stabilisation and structural adjustment policies were necessitated by the Government's failure to manage its resources in the 1970s, it is also true that donors watched by as the Government was forced, under the heavy-handed conditionalities, to cut back expenditure on pro-poor social services, introduce cost recovery in health services and increase user fees in the education sector. Cost recovery in the era of worsening economic conditions limited the access to these services by the poor. Donors watched by as social services deteriorated and poverty increased in the name of restoring stability, laying foundation for broad-based economic growth and economic restructuring. And this had been the case until NGOs and international bodies like UNICEF forced them to change in the late 1980s and early 1990s.

In particular, the 1987 publication by UNICEF entitled "Adjustments with a Human Face", which argued for the protection of public expenditure on social services during the structural adjustment process, changed the orientation of donors including the World Bank. In response to this, UNDP in 1990 launched its poverty-focused Human Development Report and the World Bank's 1990 World Development Report focussed on poverty. In the same year, World Bank conducted a first-ever Malawi-specific study on poverty. The study underlined the need for substantial investments in the social sectors, including safety nets, as an important strategy for reducing pervasive poverty in the country. Later in 1992, the UN System in Malawi, in collaboration with Government, produced the "Situation Analysis of Poverty in Malawi", a publication which highlighted the Pervasiveness of poverty in the country. Through this publication, the UN Agencies started to put the issues of poverty and poor

access to basic social services at the centre of debates on Malawi's economic and development policies. These publications assisted in shifting the social spending policies in Malawi.

Extra positive international influence also came from Malawi's participation in UN-sponsored summits including the WHO's Alma Ata World Conference on Primary Health Care in 1987, UNESCO's Jomtien World Conference on Education for All in 1990. These were later re-enforced by the Copenhagen World Conference on Social Development held in 1995. This Summit emphasised the need for poor countries, such as Malawi, to invest in basic social services, to develop human capabilities thus increasing chances of attaining sustainable economic growth and development, as part of their strategies for reducing poverty.

The Millennium Summit held in 2000 also emphasised human, social and economic development and these hinge on human capital development. Recently, the Enhanced HIPC Initiative had brought with it the idea of a Poverty Reduction Strategy Papers (PRSP) for benefiting countries. The preparation of PRSP as a conditionality for accessing High Indebted Poor Country (HIPC) resources has been promoted by donors. Again, PRSP highlight the need to focus on poverty and by extension on social spending for human capital development. The use of PRSP ensures that the country continues to prioritise social sectors in its policies and investment programmes in the next few years although the sustainability of this commitment to social sectors is likely to depend on continued donor support for poverty and social development concerns.

Absence of a coherent social policy

Malawi's economic and development policy in the post-independence era was driven by a complex combination of both internal and external political and economic factors and the need to maintain some balance between economic and social sectors spending. The swings between economic and social sectors even in the era of PRSPs also reflect the difficulties of maintaining a sustainable balance between the two sectors. While the country has been building its capacity to develop its economic policy formulation and management capacity, there are no equally significant parallel efforts to develop capacity to prepare and

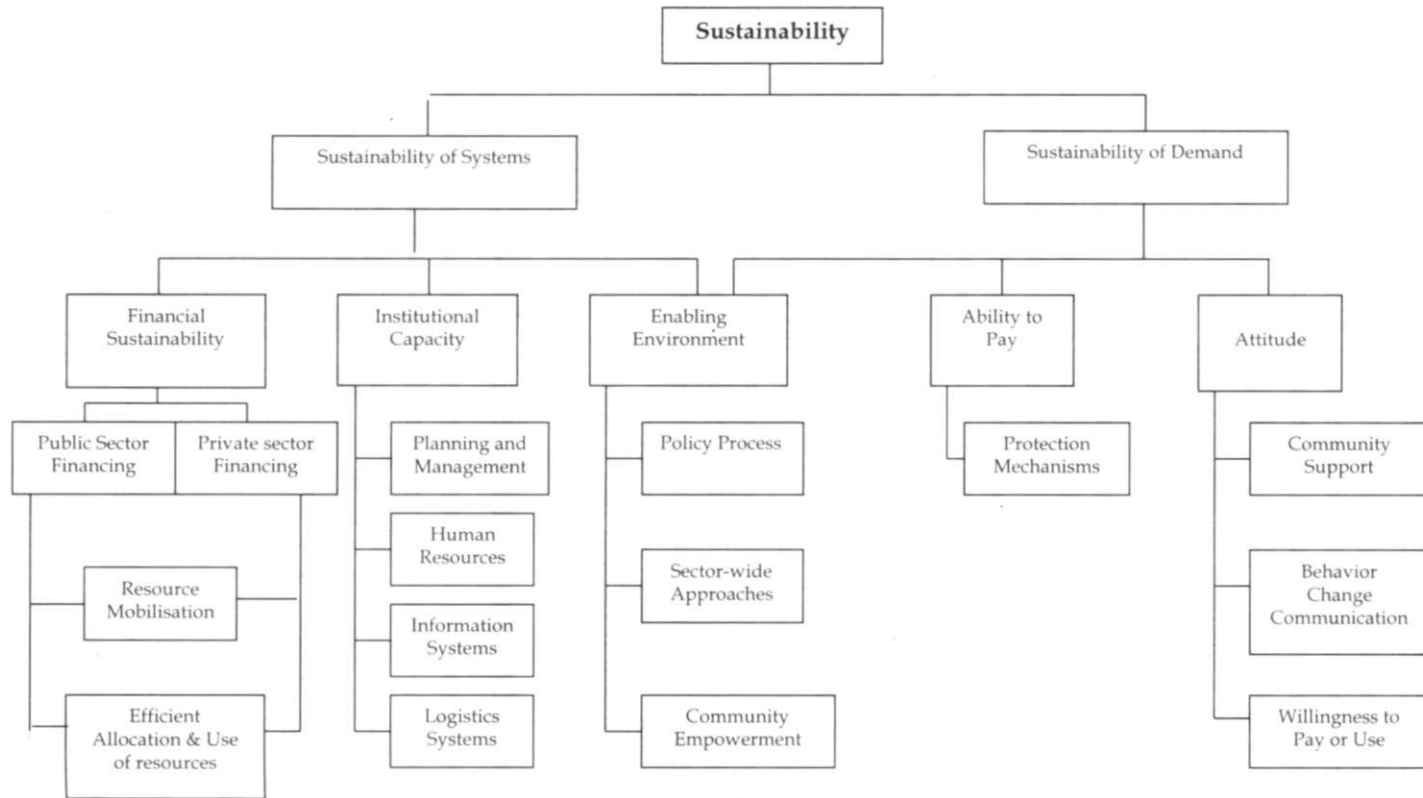
manage a coherent social policy. The absence of a coherent social policy leaves policy makers with no guide. Thus, the provisioning of social services is left to the whims of policy-makers of the time, hence the swings in social spending.

The notion of sustainability

Sustainability relates to the continuity of systems, operations, and activities over a longer time horizon. It has two linked components: sustainability of demand and sustainability of systems. See Figure 1. Political sustainability falls under sustainability of demand (ability to pay, willingness to pay, policy processes, community empowerment and community support). Fiscal sustainability falls under sustainability of systems through financial sustainability. Linking these two are external factors referred to as enabling environment in the figure. The enabling environment refers to political and socio-economic environment both of which have some influence on both financial and fiscal sustainability of operations and systems. These external factors are a collection of contextual factors that contribute to sustainability and these include country's level of economic development, availability of resources for supporting social services and level of decentralization (which has a bearing on the quality of resource mobilisation, allocation, and utilisation) (USAID 1999:9).

Concept of political sustainability

According to the conceptual framework presented in Figure 1, the involvement of the community and users of social services is vital for political sustainability. Popular participation is required in policy processes to garner popular support. Further, the users should be willing and able to pay, if fees are charged for the services. In general, community support and community empowerment are necessary to achieve political sustainability. Political sustainability encompasses a number of issues among them: (i) popular acceptability of the social programmes; (ii) citizen participation; (iii) removal/reduction of the social programmes' political threats; (iv) links between the social policy and political popularity of the government; and (v) consensus between ruling and opposition sides on the social policy and programmes.



Fiscal sustainability

Fiscal sustainability of social services in the context of the general sustainability refers to the sustainability of public spending on social services. Fiscal sustainability of social policy refers to the ability of Government to support its public spending on its social policy from its internally generated revenue in the medium to long term. It excludes donor, community and public support but includes user charges.

Fiscal sustainability (the sustainability of public sector spending) is thus just one aspect of financial sustainability. Financial sustainability means *"having enough reliable funding to maintain current social services for a growing population to cover the costs of raising quality and expanding availability to acceptable levels (USAID 1999:9)*. In the longer term, such funding should be generated from a country's own resources such that local resources gradually replace donor funding as it declines or is withdrawn.

Public sector financing consists of internally generated revenue and donors' budget support and project financing. This poses a feasibility question regarding fiscal sustainability in the medium and long term. For a long time, over 10% of the recurrent budget and three-quarters of the development budget are funded by donors in good donor years. Further, the role of out-of-pocket expenditures and private health insurance in the private sector financing is minimal. However, there is substantial financing by non-governmental organisations (NGOs) and private-for-profit providers in education and health. Notwithstanding, most of the NGOs are also donor funded. Of late, there have been mushrooming of private-for-profit providers in health (pharmacists, private practice clinicians, and traditional healers) and education (private pre-school, primary and secondary schools and post-secondary colleges and institutions).

Resource mobilisation encompasses the mechanisms that are used to generate financial and related resources. Resource mobilisation and efficient allocation and utilisation of resources, whether public or private, affect the sustainability of both public and private sector operations, including those relating to basic social sectors.

Political sustainability of Malawi's social policy

The question therefore is: has Malawi ever had a politically sustainable social policy? Although Malawi does not have a coherent policy, its bits and pieces fail to meet the political sustainability principles. The Malawi's social policy in its form has rarely been debated. It has always had political threats and opposition some of which were crushed by the undemocratic government. Further, the notion of 'social contract' implicit in the definition of political sustainability is foreign to Malawians. Despite being provided for in Section 13 of the Malawi Constitution, there is practically no demand for social contract. This is made worse by the absence of the recall provision, impeachment procedures and senate in the constitution.

Malawi did not enjoy democracy as envisaged since Independence. Dr Banda, the then Prime Minister, nipped the first genuine debate on the bits of the social policy by Cabinet in the bud. This was even before the debate was widened to the population. Following the cabinet crisis, all sympathetic to the fired ministers or their views were persecuted and silenced. By 1971, Malawi was a full blown dictatorship - no popular acceptability could be objectively obtained, no citizen participation was possible, no democratic means of removing political threats, no link between social policy and political popularity of the government, and no consensus between ruling and opposition sides on social policy since there was no opposition. This continued up to 1994 when the MCP government was removed from power.

The removal of the MCP Government itself is a manifestation of how unsustainable its social policy was politically. It did not appear suicidal in 1971 to state explicitly that public investment would avoid expansion of social services, especially primary education and health care. It was seemingly realistic but it planted a time bomb. The one-party political dictatorship was able to proclaim then its advocacy for purely economic growth-based policies and programmes. The explicit proclamation of the relatively low priority of social sectors could be made due to the excessive power vested in the one-party political structure that was capable of stemming dissenting views on this policy stance. The poor watched by as their poverty continued and their welfare

Political and fiscal sustainability of social policy:...

status deteriorated in the face of growth in the 1970s and economic stagnation in the 1980s. As it emerged later, the neglect of social sectors could not be sustained in the long run, even under dictatorship. By early 1992, Malawi Catholic Bishops wrote a landmark Pastoral Letter attacking the poor socio-economic status of the population. This started a move that culminated in the defeat of the one-party system in the 1993 referendum and MCP government in the 1994 general elections.

The UDF Government increased social spending. However, it did not consider the five components of political sustainability. Riding at the back of a seemingly docile population, the UDF government never bothered to put its social policy to the popularity test. Consensus and citizen participation was not used in its policy formulation. Sheer numbers instead of consensus building were used in parliament to get things done. Where numbers from their ranks were not enough, other means other than consensus building were used. By 1999 general elections, its popularity had dwindled. Since it has not changed its approach, it is likely that its popularity will dwindle even more in the 2004 general elections. It seems that the docile population speaks with its vote.

In summary, there has been no political sustainability of Malawi social policy. As a start, there is no coherent social policy. Even the absence of the social policy is not debated. Secondly, the bits and pieces that constitute social policy are not put to the test of political sustainability. Consequences of this have been obvious in genuine elections. The governments have been unsustainable, including the democratically elected UDF Government. Its neglect of the principles of political sustainability of policies has been the main cause.

Fiscal sustainability of Malawi's social policy

Analysis of the fiscal sustainability of the social policy in Malawi leans towards the analysis of social spending in line with a sustainability analytical framework³. This analytical framework is linked to the 20/20 Initiative through the provision of basic social services which is common in both frameworks.

³ This is modified from the USAID's health sector financing. The concepts are applied to social sector in general and education, water and sanitation sectors in particular.

The sustainability framework

The sustainability framework provides a set of indicators of sustainability under resource mobilisation, allocation and utilisation as follows:

Resource Mobilization

1. Public spending as a percent of GDP
2. Percent of public spending financed by donors
3. Total per capita expenditure on social service
4. Sources of financing for social sectors and their relative shares of total expenditure
5. Percent of total social spending recovered through various mechanisms of cost sharing
6. Percent of cost sharing revenues retained at a point of service
7. Percent of facility budget programmed at facility level

Efficient Allocation and Use of Resources

1. Percent of public expenditure budget allocated to basic social services
2. Percent of public expenditure budget directed to basic social services
3. Personnel expenditure as a percent of total social sector expenditure

The framework does not provide the recommended levels of the proposed indicators to assist in the assessment whether or not the provision of a particular service is sustainability or not. In the absence of such, international norms that are generally acceptable are used. A comparison of these indicators and those used to assess a country's commitment to the 20/20 initiative⁴ shows a lot of similarities. Grinspun (2001:178) proposes the use of the equation below to compute the share of GDP that is spent on BSS.

⁴ The 20/20 Initiative proposes that in order to achieve universal coverage of basic social services, 20 percent of budgetary expenditures in developing countries and 20 per cent of aid flows should, on average, be allocated to basic social services. The Initiative is based on the conviction that the delivery of basic social services is one of the most efficient and cost-effective ways of combating poverty.

$$\mathbf{BSS/GDP = BSS/SS \times SS/PE \times PE/GDP,}$$

Where

- BSS/GDP refers to 'human expenditure ratio' or the macroeconomic priority assigned to basic social services;
- BSS/SS refers to 'social priority ratio' or the allocation within social spending to basic social services;
- SS/PE refers to the 'social allocation ratio' or the fiscal priority assigned to social spending; and
- PE/GDP refers to 'public expenditure ratio' or the potential volume of resources available to government for allocation.

The ratios in the equation are developed when assessing a country's commitment to the 20/20 Initiative in relation to a country's specific socio-economic environment (and therefore constraints), namely the size of the national economy, the ability to raise funds from internal and external sources and non-discretionary (statutory) expenditure obligations in the form of debt service payments. What is of importance is that these ratios are similar to the critical fiscal sustainability indicators under resource mobilisation (the first three) and all the three indicators under efficient allocation and use of resources.

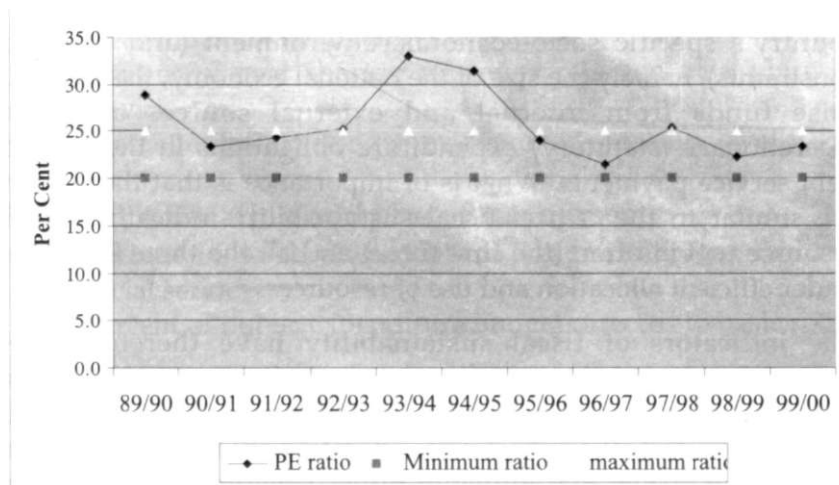
The indicators of fiscal sustainability have therefore been consolidated with the BSS equation indicators to form the analytical framework. The combination of the measures of resource mobilisation and efficient resource allocation are harnessed to form a key set of factors that influence public spending on basic social services.

According to the 20/20 Initiative, the level of public spending on BSS is determined by three factors: (i) the level of aggregate public expenditure in relation to the size of the national economy; (ii) the fiscal priority assigned to social sector spending in public expenditure; and (iii) the level of spending on basic social services within the total social sector expenditure. On this basis, we will use the 20/20 Initiative framework to assess fiscal sustainability of the public spending on social policy, in particular basic social services.

Macro economic priority assigned to public expenditure

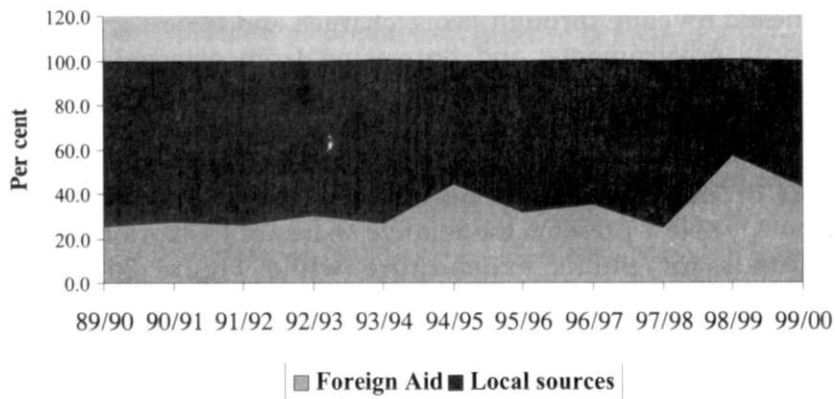
Macro economic priority of public expenditure is analysed using the public expenditure ratio. This ratio gives an idea of the potential volume of resources available to government from the national cake of resources for allocation. It is gauged that ratios in the range 20 to 25 percent are achievable for developing countries. Figure 2 gives the trend of this ratio for Malawi.

Figure 2. Trend in Public Expenditure



As can be seen, the public expenditure ratio has always been above 20 percent. However, the ratio has rarely been over 25 percent. Given that the GDP itself is relatively low, the absolute levels of public expenditure are generally low. Further, given that on average 36 percent of the national production (1994-2000) comes from smallholder agriculture and government services where revenue generation is limited, scope for increased expenditure is also limited.

Figure 3. Role of Foreign Aid in Public Expe



Clearly, the role of the foreign aid has generally been increasing over the period; 27.1 per cent in the 1989/90-1993/94 period and 39.1 per cent in 1994/95-1999/2000 period. If the trend continues talk of fiscal sustainability, in terms of reduced donor dependence, should be considered unattainable.

Fiscal priority accorded to social spending

The fiscal priority assigned to social spending is measured by the social allocation ratio that is the proportion of expenditures on social services in total public expenditure. Considering that BSS is a part of social services, the social allocation ratio ought to be significantly higher than 20 percent if Malawi is to allocate enough resources to BSS to achieve its social policy goal of universal coverage of BSS. Table 2 presents inter sectoral allocation of public expenditure over the years while Figure 4 shows the trend in the social allocation and public debt ratios.

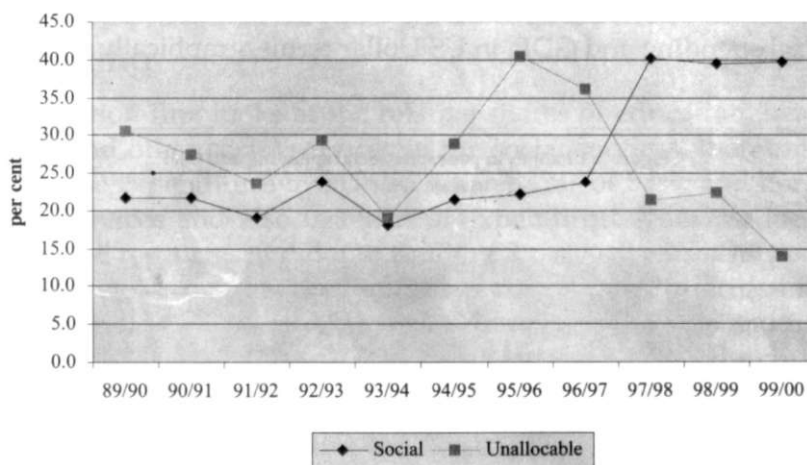
Malawi has shown commitment to social spending since 1994/95. Since then the social allocation ratio has been increasing. In the last three years, the ratio has apparently stabilised at around 39 percent. The decline in the public debt ratio is also encouraging. However, the bottom line is that there is little scope for inter-sectoral budgetary restructuring given that other services, including public debt have reduced their role over time. What

remains, it seems, is efficient utilisation of the resources allocated to the social sectors.

Table 2. Inter-sectoral Allocation of Public Expenditure since 1989/90

	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
General Services	16.7	27.0	24.8	25.8	38.1	26.7	21.9	4.0	25.6	25.0	25.0
Social Services	21.8	21.7	19.1	23.8	18.0	21.3	22.2	23.9	40.2	39.5	39.7
Economic Services	30.8	23.8	32.4	21.0	25.0	23.0	15.4	12.0	12.7	13.1	21.3
Unallocable Services	30.7	27.5	23.6	29.4	18.9	28.9	40.4	36.0	21.5	22.4	14.0
Total	100	100	100	100	100	100	100	100	100	100	100

Figure 4. Trends in Social and Public Debt Ratios



One of the measures of fiscal sustainability of social policy is the per capita expenditure. There are no standards set for social spending since there is more than the level of spending that determines the effectiveness of public spending. However, there is some standard for the health sector. According to USAID (1999) a Per capita expenditure of US\$21 is considered minimum for a

developing country. Table 3 presents the per capita expenditure on social services in general and the two key sectors of education and health.

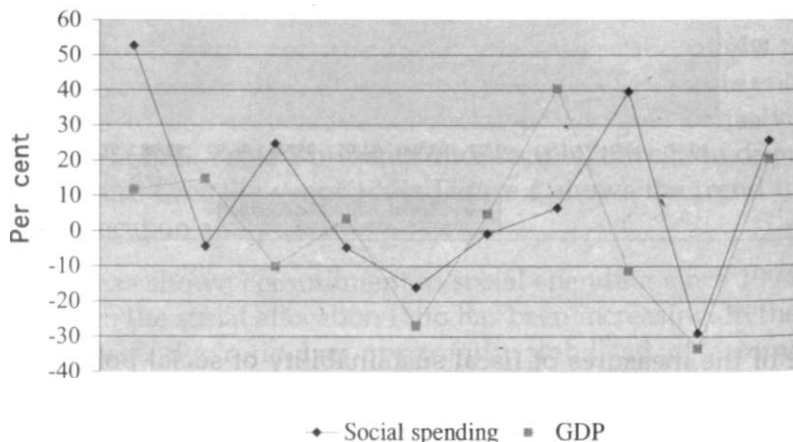
Table 3. Per capita Social Spending and GDP

	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
Social Spending (MK)	25.0	38.9	38.5	61.5	71.6	123.3	207.1	221.0	550.8	659.1	917.2
GDP(MK)	530	602	714	821	1,038	1,553	2,750	3,861	6,120	6,869	9,164
Social Spending (US\$)	9.3	14.3	13.7	17.1	16.3	13.7	13.6	14.4	20.2	14.3	18.0
GDP (US\$)	197.7	220.9	253.9	228.0	235.9	171.9	180.0	252.5	224.2	149.0	179.6

Source: Economic Report, Various Issues

Clearly, the per capita expenditure, in dollar terms, is far from the ideal. Given that the current levels of social spending is already so high for any meaningful increases, achieving even US\$21 per capita would mean serious neglect of other public services. Since the US\$21 is not given in the context of socio-economic environment, we present the trends in the changes in per capita social spending and GDP, in US Dollar terms, graphically in Figure 5.

Figure 5: Changes in per capita social spending and GDP
(1990/91-1999/00)



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As can be seen from the graph, the growth of the economy generally dictated the level of social spending, at least since 1994/95. Government seems to have pursued a policy of setting expenditure levels in tandem with the movements in the national economy. In fact, apart from the efficient utilisation of the resources in the social sectors, reasonable per capita expenditures can be achieved with increased donor aid. The role of donor funding is even more pronounced in the funding of capital budget. For example, in the year 1998/99, foreign aid funded 80.4 percent of the social sectors' development expenditures.

Increased donor support is, unfortunately, a 'negative' for fiscal sustainability of the social policy. Thus fiscal sustainability of the current social policy, in its true sense, is 'further away down the road'. Fiscal sustainability would also require radical economic structural change (not adjustment) and sustained high levels of economic growth.

Intra-sectoral analysis of social sector spending

This section first looks at the relative shares of education, health, water and other social services in the social services, then breaks down the expenditure in each sector in terms of basic and non-basic services and also in terms of expenditure from the locally generated resources and donor funding. Lastly, all expenditures on basic services from national resources are summed up to estimate total spending on basic social services from which macro and fiscal priority ratios are calculated. The fiscal sustainability of the current BSS expenditure and the ideal 20 percent ratio are discussed thereafter.

Relative shares of education and health in social services

As expected, the Free Primary Education programme significantly raised the relative share of the education sector immediately after it was launched in 1994/95. However, since 1996/97 the share has been declining steadily. A similar trend is seen for the health sector. However, water supply (in others) gained in prominence since 1996/97. The increase in water supply services has made health and water supply register similar shares over the period 1994/95-1999/2000. See Table 4, Figures 6 and 7. The average

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shares of education (14% of total expenditure) and health (4%) are below the shares found for the 17 countries that were 15.3 percent and 6.2 per cent, respectively.

Table 4. Relative Shares of Education and Health in Social Spending

	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	Average (194/95-99/00)
Total Social	100	100	100	100	100	100	100	100	100	100	100	100
Education	42.1	51.0	47.3	49.9	49.4	53.3	57.1	44.8	46.0	37.8	36.9	46.0
Health	33.0	31.3	34.7	33.7	30.1	37.5	32.4	24.2	18.7	26.4	21.5	26.8
Others	24.9	17.7	18.0	16.4	20.6	9.2	10.4	25.4	35.4	35.8	41.6	26.3

Figure 6: Trends in Social Sectors Spe
(1989/90-1999/00)

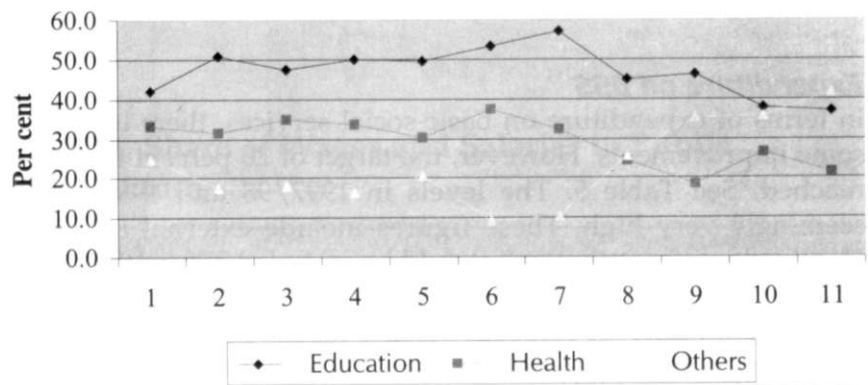
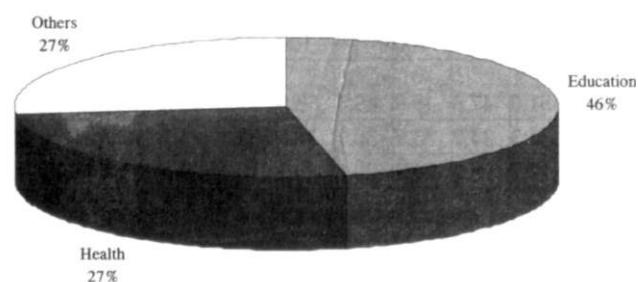


Figure7: Average Shares in Social Sp] (1994/95-1999/00)



Expenditure on BSS

In terms of expenditure on basic social services, there have been some improvements. However, the target of 20 percent is still not reached. See Table 5. The levels in 1997/98 and 1998/99 are seemingly very high. These figures include external resources. Ideally, donor contributions should be excluded. Given that donor funding of public expenditure (pe) averaged 39 per cent in the most recent years, the respective shares for the BSS/PE are 10.8 per cent and 8.4 percent. These low levels mean that if the country is to achieve the target of 20 percent for BSS, there will be need to re-allocate resources from administrative and tertiary services.

Table 5. Shares of Basic Social Services spending in Public Expenditure

	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99
Education									
BSS/PE	3.8	3.8	5.8	4.4	4.5	6.4	6.7	13	9.0
Health									
BSS/PE	0.6	0.5	0.6	0.5	0.6	0.7	0.5	4	2.9
Water									
BSS/PE	1.9	2.5	4.5	3.2	1.3	1.1	0.4	0.7	1.8
BSS/SS	29.0	35.6	46.2	45.0	30.0	36.9	31.8	44.0	34.7
BSS/PE	6.3	6.8	11	8.1	6.4	8.2	7.6	17.7	13.7
BSS/GDP	1.9	1.9	3.5	3.3	2.4	2.9	2.3	3.8	3.2

Source: MOF, Tsoka (ed.) 1998 Table 4.5.2

Tertiary and administrative services take up, on average, over 60 per cent. Thus, even without substantial increases in resource allocation to social sectors, there is scope for intra-sectoral allocation towards basic social services.

The relative share of personnel costs in public expenditure

In general, if the proportion of expenditure on personnel costs is too high to leave very little for goods and services then that expenditure is considered not as efficient. At the macro level, the economic classification of the public expenditure gives an idea of how much goes to personnel. As can be seen in Table 6, wages and salaries took up less than a quarter of the national cake in the period 1994/95-1999/2000.

Table 6. Share of Wages and Salaries in Public Expenditure

	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	Average
Recurrent*	21.3	22.4	24.3	25.4	33.3	20.1	26.7	25.3	31.7	24.8	33.3	27.0
Develop- ment	5.5	8.2	8.2	8.9	5.7	5.9	17.8	10.5	7.6	11.7	2.5	9.3
Total	17.8	19.2	20.2	21.7	28	17.7	24.9	22.3	28.4	20.6	21	22.5

Source: Ministry of Finance

However, the picture is different for social sectors. For example, in 1998/99 about half of the expenditure was on personnel costs leaving the other half for goods and services as well as fixed capital formation. Within the social sectors, personnel costs vary by sector and between levels of service. For example, in primary education, an average of 75.9 per cent was spent on wages and salaries. In secondary education, the proportion was 46.4 per cent in the latter part of 1990s. At the primary education level under the revenue account, 74.3 per cent and 68.4 per cent were spent on personal emoluments in 1997/98 and 1998/99, respectively. The high share of wages and salaries at primary education level leaves very little room for teaching and learning materials.

Likewise, in district and rural hospitals, an average of 47.7 percent was spent on wages and salaries in the period 1994/95-1996/97. In 1998/99, this proportion increased to 55.5 percent. Again, little resources are left for the rather expensive drugs and medical supplies. At Central hospital level the respective shares for the 1994/95-1996/97 and 1998/99 periods were 28.3 percent and 39.0 percent.

A recent analysis of the Government's public expenditure titled 'Public Expenditure Review' by Government and the World Bank found that expenditure on wages and salaries crowded out expenditure on non-salary basic social services, especially in education (teaching and learning materials) and health (drugs and medical supplies).

It is no wonder that most recent perception surveys find that Malawians consider the health services inadequate and ineffective because of lack of drugs. In fact, many of the sick prefer to do nothing (choose not to visit a health facility) until the condition becomes very serious⁵.

It should be noted, however, that wages and salaries and personal emoluments in general are an incentive in service sectors like education and health. Primary school teachers have been complaining of low salaries. Likewise, paramedics also complain of too low incentive packages. The result has been poor services despite the high proportion of resources devoted to these services.

The free primary education has increased pupil-teacher ratio notwithstanding the high increase in the number of teachers. The high pupil-teacher ratio is considered too high. To reduce this ratio, there is need for an increase in the number of teachers. An increase in the number of teachers would increase the expenditure on personal emoluments. Thus even with the current number of primary school teachers, there is need for an increased level of spending on personal emoluments and teaching and learning materials. What if the number of teachers increased to reduce the pupil-teacher ratio? What if that increase in the teachers were done

⁵ The Centre for Social Research has been conducting a panel survey called 'Complementary Panel Survey' under the Poverty Monitoring System and just completed a 'Social Policy Survey' under the Social Policy in Southern Africa: the Case of Malawi.

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together with an increase in the expenditure on teaching and learning materials? What if similar improvements were thought of in the health and water supply sectors? The next section attempts to present what it would mean to move towards achieving the 20/20 Initiative targets.

Budget Restructuring Issues

The poor socio-economic status of the average child, mother and Malawian in the country clearly shows that there is need for additional provision of social and economic services to the population. Government being the main provider of public goods is called upon to do something. So far, as we have seen, government has stretched its resources to the limit to ensure that its social policy embedded in the Poverty Alleviation Programme is implemented. Donors have also risen to the challenge and have generously contributed to this noble cause. Clearly, there is political commitment to the social policy by the national government as well as donors. What could be problems are technical in nature. The two topmost problems are the size and structure of the economy and technical commitment towards decentralisation.

The Size and Structure of the Economy

Macro economic priority ratios calculated in the preceding sections show the national commitment to the social policy. The ratios could be high yet the resources allocated to the social sectors could be inadequate due the level of the GDP, the denominator. Assuming a constant public expenditure ratio, absolute resources could increase with an increase in the size of the national economy. In terms of the level of GNP in dollar terms, Malawi ranks among the lowest ten countries in the world. This is worse in terms of per capita GNP because of its large population.

- The size of the economy also determines the domestic revenue base. The use of cash-budgeting system which the Government adopted since 1994 means that, by and large, the level of public expenditure is determined by the level of revenue collected at each point in time. The international 'recommended' revenue-GDP ratio is 20 percent. Over the period 1994/95-1999/00, the revenue ratio average 16 per cent. This is high considering the structure of the economy. The taxable economy is small. Sectors like manufacturing and distribution contribute about 30 per cent while

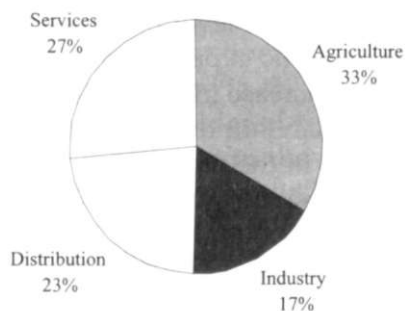
estate agriculture contributes 8 per cent, on average. In fact, the economy is dominated by smallholder agriculture (25%) and services (27%) most of which are low value services and difficult to extract revenue from. See Figure 8.

While an increase in the revenue ratio cannot be overruled, it should be noted that the few sectors that produce 'taxable' income are generally over-taxed. Going beyond the current levels may result in increased defaults or reduced effort. In fact most of the tax burden in Malawi is borne by consumers. A solution to this fix is radical structural change whereby most of the value added in GDP comes from industry and high value agriculture and services.

Inter-sectoral budgetary restructuring⁶

It has been argued over and over that there is little scope for inter sectoral budget restructuring. The reason given has been that the social allocation ratio is already high. However, on the basis of the issues raised under the size and structure of the economy, the structure of the economy cannot change without some serious move by the government. This means that there is need to allocate more resources to economic services.

Figure 8. Average Sectoral Shares in GDP 1994-2000



⁶See Tsoka (ed.) 1998 for detailed budget restructuring proposals.

Re-allocation of resources to economic services means reducing allocation from general services, social services and public debt. Clearly, there is no justification for a reduction in the allocation to social services. Allocation to general services has always been prominent (Table 2 above). The proportion of general services to total public expenditure, the bulk of which is general administration, averaged 25.4 percent as opposed to 16.3 per cent to for economic services in the period 1994/95-1999/00.

The high expenditure on general services is due to a top-heavy public service. According to the latest public expenditure review, 'headquarters' expenditures of key ministries consumes as much as three-quarters of the allocation to them. With decentralisation most of these excesses would be reduced. Currently, there is more reason to decentralise. Talk of capacity constraints at district level, as an excuse, is simply 'hiding behind one's palm'. Provision of services would be more efficiently done if resources were concentrated at the district level. Too many 'middlemen' in the provision of goods and services is inefficient.

The other option of reducing public debt servicing depends on the success of the HIPC-II Initiative. Currently, Malawi has started benefiting from the Initiative. More benefits are likely to follow with the completion of the MPRSP. Again, the draft MPRSP has prioritised expenditures on basic social services.

Intra-sectoral restructuring

The lower than 20 per cent social priority ratio over the period 1994/95-1998/99 means that there is still scope for increased allocation to basic social services. If indeed Government is interested in the provision of basic services, spending 20 percent of public resources to basic social services makes a lot of sense. However, it is not as simple as it sounds. What is encouraging is the trend. Over time, Government has been increasing resources towards social sectors. What needs to be emphasised is the allocation to basic social services. This is where technical commitment towards the 20/20 Initiative comes in. Analysis of this can only be done within the social sectors separately.

Intra-sectoral restructuring in education

Expenditure on BSS in education is high, averaging 8 per cent in the period 1994/95-1998/99. On average, at least three-quarters of this expenditure on basic education is on personal emoluments. Within education, basic education also takes up the lion's share, averaging 65 per cent in the period 1994/94-1996/97. With this scenario, there is a limited scope for increased expenditure on basic education. Yet there are inadequacies at this level. Given that salaries and wages are sticky downwards and that teachers are agitating for increased personal emoluments, there is some reason to think of reallocation to basic education away from secondary and tertiary education. The question is how can this be?

First, a decision has to be made that there should be increased cost sharing at the secondary and tertiary levels of education, never mind the level of poverty and the current drop out rates at secondary level due to the increased user fees. This would free a lot of resources for basic education. With these resources, both personal emoluments and goods and services could be increased. The final mix of personal emoluments and teaching and learning materials would be worked out after making other policy changes.

Intra -sectoral budget restructuring in health

Unlike in education where there is little scope for intra-sectoral budget restructuring, health sector has the potential to increase its allocation towards primary health care services away from tertiary and administrative services. About half of the health expenditure, on average, was spent at district and rural levels of health services since 1994/95. There is, therefore, a possibility of increasing allocation towards rural health facilities and services. Again, with the relatively low proportion of personal emoluments in expenditures on health, there is a feasibility of recruiting and/or re-allocating more personnel to beef up both curative and preventive health services in rural areas.

Concluding Remarks and Recommendations

Government and the international community agree that the provision of basic social services is one sure way of reducing poverty in the country. Likewise, demand for social services received from Malawians at political rallies, 'consultations with the poor', surveys; and observed through long queues at health

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facilities, overcrowded classrooms and long lines of 'tins' at water points imply that there is need for massive increases in social spending. There are currently high levels of political commitment to this which may still change depending on shifts in priorities in the international development discourse and what donor agencies perceive to be their priorities.

The size and structure of the economy pose constraints on the level of public expenditure. The sources of value added are limited and most of them are difficult to tax due to their nature. This leaves very few tax handles for the government to rely on. Currently, there is little scope for increasing the revenue ratio. Government has to invest in economic services first to jump start a radical economic structural change process and not merely advocating superficial or cosmetic economic reform policies, as it did under the structural adjustment programmes of the 1980s.

Where do the resources to support economic services come from? To begin with, the relatively high social allocation ratio implies that there is little scope for inter-sectoral budget restructuring. The little hope here is on the expenditure on general services, mainly general administration. An accelerated decentralisation process would free up resources that would be put in such economic sectors as tourism, mining, light manufacturing industries and others that have a significant potential to generate high value added. HIPC-II resources would then be devoted to poverty-reducing priority public expenditure areas.

There is some scope for increased expenditure on basic social services especially in the health sector. In both education and health, there is need to boost the morale of the staff, that is, teachers and paramedics. This can be in the form of increased personal emoluments, provision of basic inputs like teaching and learning materials for teachers and transport (push and motor cycles) and essential drugs for frontline health personnel like HSAs, drugs and medical supplies for paramedics. In both sectors and especially in education, the quality can improve even further with an increase in the number of trained teachers and paramedics, respectively.

Fiscal sustainability with minimum donor assistance is currently far from a reality in Malawi. Currently, donor funding is critical in

social sectors. In fact, there is need for more donor support considering the heavy demand for social services and the need to radically change sources of GDP in the country. The current sources of financing of public expenditure are not sustainable. Grants, foreign loans and domestic borrowing are all not sustainable. Possible donor fatigue, evident in some years even in Malawi, and the crowding out effect of government borrowing are good signs of the non-sustainability of these sources. The heavy taxing of the poor through surtax and indirectly through import duties cannot continue without political and economic ramifications. Likewise, the heavy taxing of the few that are working through the PAYE system is likely to force people to reduce labour supply or switch to non-salary packages to avoid the heavy tax. Unless the structure of the economy changes drastically so that it provides the Government with more tax handles, sustainable poverty reduction, let alone eradication, will be a mirage (and not a vision) because the incidence of poverty in the country is likely to increase in the foreseeable future.

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