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Series 5: Programme 3 (of 9) - 'Packing a Punch'

People Power – Malawi

In Malawi, 6.3 million people are defined as poor, which means that almost two-thirds of the country's population are unable to fulfil their basic economic, political, social, psychological, and physiological needs. Recently, however, communities in Malawi have established an effective way of improving their quality of life. The Community Score Card process is designed so that community members have the power to evaluate the provision of services such health care, and to ensure that high standards are upheld.

Pervasive Poverty

Poverty in Malawi is widespread, deep and severe. It is caused by a number of factors, including low levels of education, poor health status (including widespread HIV/AIDS), lack of off-farm employment, rapid population growth and gender inequalities. The country ranked 162 out of 175 in the Human Development Index (HDI) of the UNDP (United Nations Development Programme) Human Development Report 2003. The HDI measures achievements in terms of life expectancy, educational attainment and adjusted real income. The rural population are disproportionately affected by these problems, with 67 per cent of rural people below the poverty line compared to 54 per cent of those in urban areas. With 90 per cent of Malawi's population living in rural areas, and because poverty is more pervasive in rural areas, 91.3 per cent of the poor live in rural areas.

Dealing With Poverty

A household from Kumongo village, Lilongwe
Malikesi, of the Kumongo village, mentions that January and February are the worst months of the year because of food shortages and a scarcity of money. To cope with this situation he works harder in his firewood business. He makes two trips a day on his bicycle selling firewood in Lilongwe. If he is still unable to make ends meet, he seeks help from his relatives. If they are unable to help, he goes to his friends. Any amount he borrows has to be repaid in full – no instalments. His wife has reciprocal relationships with her neighbours. Salt is shared without having to return it. However, a bar of soap or a plate of maize flour has to be returned.

(Source: Shah et al., 2002)

Health problems pose a serious threat to the ability of the rural population to raise themselves out of poverty. Life expectancy at birth has been falling, reaching as low as 39 years in 2000. This is partly due to the HIV/AIDS epidemic, with an estimated 16 per cent of the population infected. Infant, child and maternal mortality rates are high by global standards. In 2000, infant and under-five mortality rates were estimated to be 104 and 189 deaths per 1000 live births. This is caused in large part by a lack of access to adequate health services, demonstrated by the fact that health workers attend only 43 per cent of births. Children in Malawi are generally malnourished. In 2000, almost half of the children under the age of 5 were found to have a low height for their age (stunted). The poor consume only 66 per cent of the recommended daily calorie requirement.

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Dealing with Disease

A household from Chilombo village, Lilongwe
Miriam is a 78-year-old widow who lives in Chilombo. In 1999 Miriam's daughter returned to the village because she was sick with AIDS. When her daughter came back to her she had already started losing weight and had been sick for some time. She suffered for another two months while she was with Miriam before she passed away.

Miriam looked after her daughter with the help of her granddaughters. In the process they had to seek medical help and buy medicines, which resulted in huge monetary debt. Since a lot of time was spent taking care of her daughter, she was not able to pay much attention to her garden and as a result her crops suffered. However, she mentioned that relatives were very helpful, and they used to bring her food and fuelwood whenever they came to visit her daughter. These relatives also brought food, cash, cloth and coffin for the funeral. However, Miriam added that there was no help from the church.
(Source: Shah et al, 2002)

Development in Malawi

Historical, geographical and political factors have combined to make the alleviation of these problems in Malawi an enormous challenge. The government reform programmes face problems of a rapidly growing population, a high HIV/AIDS infection rate, limited natural resources, high levels of inequality caused by years of elitist development strategy, and the corrosive effects of recurring droughts, poor resource management, and environmental degradation.

Over the past two years the government has implemented a growth-oriented reform programme, but results have been mixed. High interest rates and inflation during 2002 and 2003, combined with severe drought, means that Malawi still depends largely on aid from international financial institutions and individual donors.

The World Bank, the European Union and the United Nations are the major multilateral agencies active in Malawi, while Britain, Canada, Germany, Japan, the Netherlands and the United States are the major bilateral donors. Almost all donors are involved in various programmes in agriculture, infrastructure, finance, the social sectors and the environment, with a common aim of reducing poverty.

Community Empowerment

The first poverty reduction strategy paper (PRSP) for Malawi was published in 2002 and has directed development attention towards community participation and empowerment, achieved through increased accountability of local and national governance. Empowerment refers broadly to the expansion of freedom of choice and action. For the poor, that freedom is severely curtailed by their lack of voice and their powerlessness in decision-making processes that affect their lives. Thus, empowering poor people requires the removal of formal and informal institutional barriers that limit their choices and prevent them from taking action to improve their well-being.

> ‘Empowerment is the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affects their lives’.
>
> (World Bank, 2002)

For the empowerment of poor people to successfully facilitate their well-being, four key elements must be incorporated into strategies:

1. *Access to information*
   Informed citizens are better able to take advantage of opportunities and access to services, exercise their rights, and hold state and non-state decision-makers accountable.

2. *Inclusion/participation*
   Participation in decision-making is crucial to ensure that the limited public resources are used in line with local needs and wants.

3. *Accountability*
   State officials, public employers, and private actors must be held answerable for their policies, actions, and use of funds.

4. *Local organisational capacity*
   Organised communities that work together and mobilise resources are more likely to have their voices heard and their demands met.

Social Action Fund Project

To address the above four elements, the World Bank has initiated the Social Action Fund Project (SAFP). This has been designed to allocate resources to programmes aimed at the poor. Investment in health, nutrition and education are vital components of the project. In allocating these resources, the poor are involved in the decision-making process through project selection, preparation

and implementation. The project also allocates resources to strengthen monitoring and assessment of poverty in the country.

The Community Score Card Initiative

In rural Malawi, the ‘community score card’ initiative has been developed to facilitate the SAFP. Report cards achieve public accountability by facilitating the voices of communities on the quality, efficiency and adequacy of the services that are provided to them. User opinions are aggregated to create a ‘score card’ that rates the performance of the service providers. They also measure the overall satisfaction and perceived levels of corruption. The system gives the people a powerful voice. Citizens, individually and collectively, can signal to agencies that their performance should be improved.

The report card design originated in 1993 in Bangalore, India, in response to public concern over the quality of services. The strategy has since spread to the rest of India and to countries such as the Ukraine, the Philippines, Vietnam and now Malawi.

The success of a report card initiative requires the combination of four factors:

- Understanding the socio-political context of governance and the structure of public finance;
- Technical competence to design and analyse the survey;
- Media and advocacy campaigns to bring the findings into the public domain;
- Institutionalisation of the practices for community-involved actions.

What can it be used for?

- Local monitoring and evaluation of services;
- Tracking of inputs or expenditures;
- Creation of benchmark performance criteria;
- Comparison of performance across facilities/districts;
- Generating a feedback mechanism between providers and users;
- Strengthening the voice of citizens.

What does it tell you?

- How inputs or expenditures match with entitlements/allocations at the local level;
- How both the community and providers score themselves according to their criteria;
- Evidence on which scores are based;
- What the basis for an action plan for improvements should be.

Kasonga Village Heath Care Centre

In Kasonga, the community score card initiative has had an important impact upon the provision and take-up of health care. The score cards have helped raise awareness in the community. They are now aware that taking an active role in the assessment of local facilities, such as health care, can substantially benefit the quality of that service. They have also become increasingly aware of their rights of involvement in such initiatives.

Previously, publicly provided services and those donated by external organisations have lacked an element of public participation. This is largely because the local community has not been aware that such facilities actually belong to them.

The increased profile given to the health care centre has also helped in facilitating the provision of physical care. Not only are people being encouraged to attend the health centre as a result of the score card initiative, the cards are also enhancing the quality of the health provision. By making the providers of health care accountable to the community, standards are maintained. Therefore, the community can feel safe in the knowledge that when they do attend the centre, they are receiving the standard of care that they expect.

Mary Sefa's comments indicate that the score card has encouraged community participation:

> 'I never knew that this health centre belonged to us community members and this encourages me to play a role in the running of the health facility.'

Agnes Milanzi tells of how mothers used to give birth in the village without adequate health care, a problem that has been resolved by increased awareness of the centre:

> 'Now they know the importance of coming to the health centre through the kind of work we are doing, and as a result maternal deaths have been reduced.'

A Voice of Hope

Initiatives of community empowerment, such as the score card initiative, are opening spaces of communication for the voices of the poor. These voices are being given the opportunity to dictate their needs and wants to those providing essential services. In this way, services are more fully used and their quality is enhanced. Not only does this directly benefit the users of such facilities, it also has the indirect effect of letting the poor concentrate on tasks such as guaranteeing a good harvest.

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Further Information

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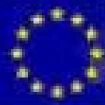

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