Exploring the Role of Aid in the Malawian and Zambian Health Sectors

To what extent does development assistance contribute to aid dependency in Malawi and Zambia?

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Abstract

Aid is an important topic in development sector current discussions are polarised thereby creating a need for further research. This essay assesses the role that Malawi and Zambia plays in realising its development outcomes including in the area of health. There is a need to appreciate the variables that contribute to the inability of most countries in sub-Saharan Africa to finance their domestic expenditure related to healthcare. In this situation, foreign aid which has received marked interest by scholars over the past decade and is used to supplement incomes of developing countries like Malawi and Zambia. Debate on the effectiveness of aid is polarised, while highly concerned scholars see aid as ineffective and a contributor to the poor performance of economies in developing countries, others see it as essential in the achievement of development outcomes. This thesis explores the extent to which development assistance contributes to dependency in Malawi and Zambia. It further examines the link between aid and the Malawian and Zambian health sectors. The study similarly considers the role of development assistance for health in realising outcomes related to maternal health in line with SDG 3.1. By identifying two countries in sub-Saharan Africa, this essay underscores the similarities between Malawi and Zambia analysed through a historical context, health systems structures, child and maternal mortality rates and health programme models. The essay concludes that social, political and economic barriers present challenges in financing healthcare in Malawi and Zambia. Aid contributes to dependency in the study countries.

Key Words:
Malawi, Zambia, Dependency Theory, Development Assistance for Health, Universal Health Coverage, Health Aid, Maternal Health, Sustainable Development Goals

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1. Introduction

1.1 Background

Aid is a common subject in international development discourse. In the early stages of operations relating to large-scale global development, aid was mainly focused on facilitating external functions of financing development which played a critical role in sourcing of additional resources for developing countries. Aid is a concept that has been generally used to fill in gaps within economies of developing countries and consequently enhancing the capital investments of the countries. Aid is considered to have boosted the economic development of the recipient nations and has also led to a decline in domestic savings of countries. It has also limited access to private capital markets for such countries. There is solid evidence to show that aid and assistance results in dependency by receiving countries in their approach to international development (UN ODA, p.162). Aid advocates have pointed out that development assistance can meaningfully contribute to the development outcomes of developing countries especially where it relates to poverty reduction (Sachs, 2014 p. 123). Aid however if inefficiently managed can also contribute to dependency.

An analysis conducted in sub-Saharan African countries similar to Malawi and Zambia observed that aid may be largely ineffective, especially where it relates to sustainable change in the countries under review (Moyo, 2009.p.44). Statistics examining the effectiveness of aid to such countries brought to light significant evidence that international aid has largely harmed the economies of most of such countries (Moyo, 2009 p.46). A number of studies illustrate that aid has only increased the bureaucracies of governments resulting in the enrichment of the countries' elite at the expense of national growth and development (Reddy & Minoiu, 2006, p.67). Most of the aid is given to countries with bad governance which has contributed to slow rates of development. Corruption has delayed development in most of these countries. Besides, some donor countries have been found to be unaccountable with high levels of neglect and mismanagement of the funds (Ferraro, 2008, p. 78).

Recently, there has been debate on why aid becomes ineffective in cases such as the ones illustrated above and ways in which to bring effectiveness in implementing development strategies especially those funded through aid (Ferraro, 2008, p.78). Financial aid received from various donors is often intended to spur economic growth and to bring about better strategies and objectives towards the realisation of the human development agenda (Gianetti et al., 2018 p. 101). Effective contribution of aid to development in most cases is wanting leading to several analysts' suggesting alternative methods of enhancing sustainable development through aid and ways in which to measure its effectiveness.

The issue of dependency in financing healthcare has gained more attention in the past decades. The Organisation for Economic Cooperation and Development (OECD) considers aid as integral to improving the world's development cooperation efforts. This definition asserts that aid is not a pointless measure, but assistance given to fringe countries to support their

development efforts. Although the OECD's definition points to aid as being cooperative in nature, this balance unless emphasised often leads to a disconnect between the ambitions of recipient countries and those of funding partners. In this way, aid may well contribute to shifting the development priorities of recipient countries or to dependency. This is so because recipient countries often prioritise donor outcomes at the expense of their own development outcomes that they often are unable to finance. In the case of health management and particularly maternal health, poorer countries depend on aid to support the realisation of these health outcomes. Most sub-Saharan African countries have traditionally depended on aid to finance their healthcare systems since their independence from European countries. ODA countries set the agenda for global development indicators and prioritise healthcare. This is evidenced by the prioritisation of health outcomes as key development indicators including in the millennium development goals (MDGs) under goals 1, 4, 5 and 6 and the eventual adoption of health improvement indicators into the sustainable development goals (SDGs) outlined under goal 3. (UN SDGs, 2020). Improvement of health outcomes require the concerted efforts of all stakeholders as they remain critical indicators of development. Developing countries including the study countries in this essay require external support to achieve these goals (UNSDGs, 2020).

In September 2000, world leaders set time-bound actions aimed at reducing extreme poverty by the year 2015 at the UN General Assembly and passed Resolution 55/2 adopting the United Nations Millennium Declaration (UNOHCHR, 2020). These goals became known as the Millennium Development Goals (MDGs). 8 MDGs were agreed with MDG5 targeting improvement of maternal mortality ratios (MMR). The target for the millennium was to reduce by three - quarters the MMR by the year 2015. And recording success in achieving universal access to reproductive health by 2015 (UN, 2014). By 2015, states in particular those from sub-Saharan Africa had failed to meet the MDGs leading into a new declaration to strengthen gains made under the MDGs and push into the future through the adoption of the sustainable development goals (SDGs). The SDGs are a fifteen-year plan that endeavours to respond to the world's challenges including SDG3 that speaks to health outcomes more broadly and SDG 3.1, which prioritises reduction in maternal mortality rate as a clear development indicator (UNSDGs, 2020).

Although both Malawi and Zambia receive substantial funding for maternal health improvement from donors and some improvements in maternal health were noted during the MDGs period, both countries failed to meet the target. This failure illustrates the challenge of health financing in most countries especially with regard to women and girls. In sub-Saharan African countries including study countries, social, economic and legal barriers exist that obstruct access to equitable health care for women and girls. These barriers contribute negatively to maternal health outcomes in the study countries. The World Health Organization (WHO) estimates that globally, more than 810 women die per day from preventable incidents during pregnancy, childbirth and the postpartum period (Human Resources for Health. 2010 n.p). Despite the existence of data and remarkable progress reported in Asia and Northern Africa towards the reduction of maternal mortality rates, sub-Saharan Africa however, remains

an area of great concern. An estimated 200,000 women die every year from maternal deaths (WHO, 2020).

While foreign aid has been used to bring about economic development, it has also been used to facilitate health support to nations such as Zambia and Malawi. Research shows that there are many implications and outcomes of health that reflect the economic development of a country. Most scholars underscore the importance of health improvement as a key indicator in sustaining the economic development of a country. These have also stressed the importance of funding in the improvement of the health sector (Gianetti et al., 2018 p. 109). Global statistics still indicate that many countries continue to lag behind on meeting this target while poverty and disease continue to prevail in these countries. Provision of aid has a primary strategy of reducing poverty in most developing nations. However, results show that instead of fostering development and minimising poverty, in most such countries aid has increased the gap between the poor and ruling elite (Lynch et al., 2004. p.88). There is need to assess how aid contributes to the expansion of income gaps in developing countries while broader development continues to lag behind. Therefore, understanding the effect of foreign aid and its implications on the social and economic outcomes as well as human development in recipient countries becomes even more important. In this case, maternal health improvement and reduction in child mortality rates are critical indicators.

While the OECD definition of aid evokes a cooperative element, Collins however defines aid as "money, equipment, or services that are provided for people, countries, or organisations who need them but cannot provide them for themselves" (Collins, 2014). This definition is limiting in that it references recipients of development assistance for health (DAH) as dependant and without agency because it depicts recipients of aid as helpless and in need of saving. DAH cannot be successful and sustainable if the recipient parties cannot 'provide for themselves'. This definition opens up assertions made by scholars like Moyo whom in her seminal book 'Dead Aid' states that 'Aid is dead' and contributes to continuing the legacy of poverty in Africa (Moyo, 2011 p.443). Taylor et al (year) however in 'The Impact of Official Development Aid on Maternal and Reproductive Health Outcomes: A Systematic Review in 2013' found that DAH contributed to improvements in maternal health although the paper critics the distribution and management of aid and calls for collaborative reforms towards sustainability of health outcomes (Taylor et al., 2013). Whether aid and in particular, DAH contributes to aid dependency in the management of maternal health in the study countries, various scholars identify that aid if not well managed may lead to dependency. This essay interrogates whether aid encourages dependency in Malawi and Zambia.

1.2 Aim of the Study

The aim of this essay is to investigate the extent to which development assistance contributes to dependency in Malawi and Zambia. It examines the link between aid and shifts in the health sectors in the study countries. The essay further examines the extent to which development assistance contributes to progress in maternal health and reduction in child mortality.

This essay relies on previously conducted research and is presented in a descriptive format supported by an analysis and concluding remarks.

1.3 Research Questions

Based on the above listed considerations, this essay considers the following research questions:

1. How has aid been used to improve health outcomes in Malawi and Zambia?
2. What actions have the governments of Malawi and Zambia taken to improve health outcomes including maternal health through international aid?
3. What are some of the evidence of dependency in relation to aid?

2. Literature Review

2.1 Introduction

It is generally agreed that the main goal of development is to see an improvement in the lives of the citizens of the world. The United Nations (UN), a leading multilateral institution on development continues to take the lead in realising this objective. The current global goals referenced in the SDGs seek to accelerate development in developing countries. Although significant progress has been reported on the successes of the MDGs mainly sustained by access to aid by developing countries, these global targets are yet to be met. This has led to increased concerted efforts by countries to accelerate progress towards the realisation of the global development targets outlined under the SDGs by 2030 (UN, 2020). Despite the success observed under the MDGs some donor countries have suggested that more targeted funding to developing countries will result in improvement of development outcomes in developing countries including in Malawi and Zambia, others feel that this is highly unlikely. There is, however, a general consensus that coordination of various strategies aimed at enhancing development requires good governance and transparency without which, these goals will not be realised (Gianetti et al., 2018. p. 160). Corruption, poor governance and a lack of transparency are some of the key barriers to realising development outcomes in most developing countries including in sub-Saharan Africa where the study countries are situated.

Empirically, foreign aid has generated criticism especially with regard to its effectiveness in meeting health outcomes and contributing to other sectors of the economy (Loxley and Sackey, 2008. p.172). Most research conducted on this topic has mainly focused on the effectiveness of the various forms of aid, particularly on development assistance for health although most of them have not considered an empirical approach to aid and how it affects dependency. It is crucial to point out that there is deficiency in data focusing on measurement of the rate of development as portrayed by key indicators of economic progress. (Loxley and Sackey, 2008. p.173). Some studies conducted previously have shown data on economic progress, nonetheless data consistency has not been achieved on a study analysis based on the past fifteen years. Most studies conducted to investigate the effect of aid on numerous healthcare systems as well as their economic impact has indicated varying results (Acharya and Martínez-Álvarez, 2012.p.6). This essay examines existing date to establish the

impact of development assistance for health in realising outcomes related to maternal health in line with SDG 3.1

This chapter describes several theories on aid dependency discussed in this essay. It considers these theories in relation to health financing in Malawi and Zambia. This thesis also considers the effects of foreign aid in the two countries and its effect on healthcare in the study countries. The assertions presented by Moyo (2009. p. 120), Easterly (2014. p. 110) will be the central theories that argue against aid, seeing it as ineffective, responsible for dependency and fostering corruption. Other experts like Sachs (2014 p. 123) and Stiglitz (2002 p. 49) provide an alternative position by supporting the continuation of aid and DAH albeit preceded by reforms to enhance performance and ensure that funds meant for the world's poor reach them.

Despite the contention between the scholars outlined above, all agree on reforms in the management of development assistance seeing it as useful in specific circumstances and contributing to globalisation and achievement of positive economic outcomes including poverty reduction. These central theories are presented in this paper to provide a pathway towards understanding dependency theory and its relationship to aid in particular development assistance for health provided to Malawi and Zambia to support maternal health outcomes amongst others.

2.1.2 Concerns with Financing for Health in Malawi and Zambia

Governments are responsible for funding their national budgets to achieve the promise of universal health coverage (UHC). The United Nations (UN) through SDG3 sets the minimum standards that countries should adopt to achieve health coverage for all. To achieve these health results, countries like Malawi and Zambia are required to allocate adequate resources to their national health budgets and; to instigate social and economic activities that support the progression of these outcomes (UNSDGs, 2020).

In the absence of policy coherence and national commitment to funding health coverage, health outcomes are unmet, and the lives of citizens particularly, the most vulnerable are compromised (WHO, 2020). Naturally, a strong international response in the form of Development for Health (DAH) exists and is directed at meeting the health needs of poorer countries including in the study countries Malawi and Zambia. To appreciate the structure of DAH this essay examines the health systems in the study countries and the limitations that DAH seeks to respond to in the study countries.

Malawi and Zambia have similar health systems models prioritising UHC but face challenges in the achievement of these priorities key amongst these challenges is the retention of human resources without which both countries are incapable to respond to health requirements (WHO, 2020). In the early 2000s Malawi and Zambia faced challenges in their healthcare systems, plagued by a shortage of healthcare professionals, inadequate health facilities and financial barriers to accessing healthcare by citizens. Both countries needed to

reprioritise their health systems strategies as well as to access critical financing to support the implementation of such strategies.

Notwithstanding these challenges, both Malawi and Zambia aspire to distribute equitable healthcare to all citizens and outline these aspirations in their national health care strategies. Attempts to remove all financial obstacles in accessing healthcare for citizens in Zambia has been largely unsuccessful (Achokia and Chansa, 2013). Malawi on the other hand has introduced a community based health systems structure that has seen remarkable success in delivering health care improvements. The country's constitution further prioritises UHC (USAID, 2017). Malawi is one of 11 countries in Africa that managed to achieve the MDG target of reducing child mortality rate by two-thirds between 1990 and 2015, it also managed to increase life expectancy for women by ten years under the same period (Chansa and Pattnaik, 2018).

Zambia likewise, has seen remarkable progress in this area as evidenced in the decline in the HIV infection rate from 14% in 2007 to 13.3% in 2014, while maternal mortality rate reduced from 591 deaths per 100,000 in 2007 to 398 in 2014, this progress is also seen in the child mortality rate from 195 for every 1000 live births to 75 deaths. These gains are reflected in the country's 2017-2021 National Health Strategic Plan (NHSP) that mandates the ministry of health to provide UHC for all (Bakyaita and Mweemba, 2018.p.g.9).

The measure of progress in implementing UHC in the countries under review includes monitoring their performance in the reduction of maternal and child mortality rates. While both Malawi and Zambia show remarkable improvements in providing UHC, integrated approaches at national level are critical. National strategic planning for health should prioritise collaboration and include ministries of health, labour and education for operational efficacy, while inclusion of finance ministries is essential to ensure funding allocations are available (Lynch et al., 2004. p.88). Further, cooperation between donor nations, donor institutions and recipient countries are a pre-requisite to implementing DAH in recipient countries. Ministries overseeing justice and law enforcement must be integrated to support development and implementation of policies or laws that address legal barriers that impede access to UHC for all including women and girls. The African Commission on Human and People's Rights (ACHPR) in its report acknowledges the contribution of human rights violations against women and girls in limiting the HIV response in Africa (HIV, the Law and Human Rights in the African Human Rights System, p.1).

In the results section, this essay considers if the health systems financing design of Malawi and Zambia exposes them to dependency on foreign aid for achievement of their health outcomes.

3. Theoretical Framework

3.1.1. Dependency Theory

To appreciate the link between dependency and health financing in Malawi and Zambia, this essay considers the circumstances under which periphery (underdeveloped) countries like Malawi and Zambia engage with centre (ODA) countries within the international development space. The dependency theory supports this essay in examining the structures and pre-set conditions that characterise engagement between donor and recipient countries and how this engagement may contribute to dependency especially in financing for health.

The dependency theory was first mooted in the late 1950s and is a mature concept without a clear articulation and appreciation of the concept. As Brown (1985.p.62) asserts, that no agreement on dependency exists although some theorists agree that there exist countries in the world whose development is tied to those of other countries. Despite this, it remains the most relevant theory to utilise when interrogating existing structures that perpetuate or enable dependency in relation to ODA countries and recipient countries.

Topik (1998, cited by Reinert et al., 2009 p.382) asserts that two schools of thought exist on dependency theory. Those that are steeped in Marxist theory and led by scholars like Paul Baran and Paul Sweezy (1966, cited by Margdoff, 1967 p.145) and developed by Andre Gunder Frank (1960) while the other is founded in structuralist approach through the work of Raul Prebisch and the team serving under the UN Economic Commission in Latin America and consolidated by Fernando Enrique Cardoso, Peter Evans and others. School of thoughts driven by scholars like Immanuel Wallerstein depend on world systems tradition.

Theorists holding Marxist, structuralist and world-systems traditions all agree that there exist two types of nations mainly developing nations (periphery) and developed nations (centre). And that trade between these countries is informed by unfair trading systems and exchange that has trapped developing countries in a dependency relationship with centre or developed countries. These unfair trading practices keeps the raw material exporting countries like Malawi and Zambia on the backfoot while centre countries become wealthier. Owing to this structure, periphery countries are unable to grow their GDPs and therefore are unable to fund all their development projects including healthcare. In this case, the existence of the unequal relationship outlined in these theories may contribute to aid dependency in the study countries.

3.1.2 Different Theories of Dependency

To examine the relationship between DAH and financial dependency in Malawi and Zambia, this essay relies on the dependency theory to provide a framework from which this relationship can be understood. As outlined above, Malawi and Zambia's health financing in general and maternal and childcare financing in particular is dependent on external financing received through DAH. Both Malawi and Zambia have for decades received an estimated 60% and 40%

DAH to meet their health targets. This chapter summarises the different dependency theories, the Marxist versus non-Marxist thoughts and finalises with financial dependency a topic that this essay is concerned with in relation to DAH in Malawi and Zambia.

Marxist traditional scholars examine the relationship between developed (centre) and non-developed (periphery) countries purely based on technological advancements and the international division of labour. Marxists assert that periphery produces raw materials in the form of minerals, oil, agricultural produce amongst others – these are exported to centre countries where they are processed and exported back to periphery countries at exorbitant prices. Marxists contend that the distribution of surplus earned from exports from periphery countries exposes the exploitative nature of the relationship between the centre and the periphery and maintains inequality (Frank, 1966).

In fact, this is worse when centre countries open businesses in periphery countries and transmit all their surplus to their countries as profit while periphery countries are left in poverty (Reinert et.al., 2009 p.g.382. The difference between the two theories is that structuralists argue that periphery countries can catch up with centre countries while Marxists contend that this is not possible as the entire development model is structured to ensure the success of the centre at the expense of the periphery (Jomo et al., 2005 p. 134).

Despite multiple arguments, it is generally concluded that there are internal and external drivers of under development that lead to dependency. While Marxists theorists lean more on external factors relating to the relationship between the centre and the periphery, structuralists argue that the causes were more internal and focused on political and economic drivers as presented by Cardoso and Faletto (1969 as cited by Reinert et.al., 2009).

Cohen (1996) considers the inability of periphery countries to borrow funds for development in their own currencies as the original sin of dependency. The international monetary system contributes to dependency as evidenced by the way currencies are valued with developed countries pitted against periphery countries. As earlier illustrated, the countries under review are both considered low income (periphery) countries with the inability to finance their own national health budgets due to many factors including low GDP. Malawi and Zambia both export minerals and agricultural produce at nominal prices to centre countries and are unable to exponentially increase their GDP percentage. In this way, they do not generate sufficient income to finance their health budgets and their efforts of reducing maternal and child mortality and depend on donor aid from centre countries for their interventions.

3.2. Criticism of dependency theory

Dependency theory is a contentious topic having born out of earlier Marxists thoughts and structuralists approach. It has attracted criticism from free market economy promoters who consider the theory as being limited in nature as it emphasises the external environment without examining the internal environment of periphery countries for their failure to develop. These

include the political and economic conditions that obtain in these countries including political stability, corruption, nepotism etcetera that render development almost impossible (Namkoong, 1996).

This is compounded by arguments presented by Smith (year) who describes dependency theory as an attempt by Marxists to unite periphery countries towards one ideology (Smith, 1979, p.83). Other scholars insist that contrary to Marxist views on dependency the current international development system was not designed as a model of manipulation of periphery countries by the centre and therefore, the arguments presented by dependency theorists do not hold (Agbebi, Virtanen, 2017 p.434).

3.3 Relevance of dependency theory

Dependency theory provides a necessary lens from which one can critic the limitation of the international political economy and a method to underscore under development in periphery countries. This also provides a method of appreciating these limitations in relation to aid particularly, development assistance that centre countries extend to periphery countries towards the improvement of development outcomes in their countries. In this chapter, the dependency theory is used to examine the question of aid dependency.

Aid dependency is often referenced to as the ratio of government expenditure, which comes from a foreign donor. In this case and owing to under development, the government of a recipient state usually depends on aid to finance some of her projects, such as in health or economic activities such as road and infrastructure development. Several factors influence dependency of any kind, but it is mostly caused by the length and strength of the donation period. Further, Clemens et al. (2012 p. 189) states that dependence takes place when a particular nation uses aid intentionally as the long-term technique the fund its projects or to initiate any form progress in their economy. Dependency is related not only to the donation of products but also to other technical skills brought by a donor to help in a particular project within a developing country. However, if this expertise is not followed appropriately by educating the local people, it creates a reliance on the donor. For this reason, any form of aid provided by a donor to a developing country should be monitored effectively to prevent it from developing to become a form of dependency.

Ferraro (2008) argues against aid and attaches the under development of periphery states to its existence. He further asserts that while developing nations supply cheap raw materials and labour, they are utilised as open markets for products centre countries do not need and do not benefit from profits made from the sale of their raw materials. This maintains the continued portrayal of countries like Malawi and Zambia as consumer markets with little development progress over the past decades. He concludes that aid that is given to periphery nations is not free as it intends to serve a purpose which includes the continued dependency of such countries for support from centre nations. (Ferraro, 2008 p. 132). This is demonstratable so especially that Zambia remains Africa's second largest producer of copper next to

Democratic Republic of Congo (DRC) but the majority of its citizens remain in poverty (MiningDotcom, 2016).

Moyo (2009) a critic of aid supports this position by stating that despite Africa having benefitted from the 'highest' amounts of development assistance during the years 1970-1998 the number of people living below the poverty line was over 55% and had not reduced significantly. According to Moyo, this proves that aid does not work and contributes to dependency including in the two countries under review. Malawi and Zambia obtained independence at the same time and has majority of citizens living below the poverty line (Moyo, 2010. p.g.45).

Sachs (2009) and Stiglitz (2002) however, assert that foreign aid is important and if properly managed can contribute to poverty reduction and to improved economic outcomes for all. They contend that although foreign aid's indirect contribution to poverty mitigation renders it relevant in the development conversation. Sachs (2009) cautions against theories advanced by (Moyo, 2010 and Easterly, 2014) who assert that aid is dead and harms periphery countries seeing them as being absolute in their determination without factoring in the contribution of aid to reducing poverty and concludes that aid is still relevant.

3.4. Aid is harmful to development

According to Zambian economist Dambisa Moyo, the provision of humanitarian aid to developing countries like Malawi and Zambia is at best ineffective. Moyo (2009), asserts that aid usually damages the growth of a recipient country's economy instead of bringing about development. In her seminal work in *Dead Aid*, Moyo discusses how foreign aid generally inhibits the social, political and economic progress of developing countries like Malawi and Zambia. Moyo further provides alternative solutions sustainable for development to these countries. Born and raised in Zambia with her primary, secondary and initial University education in the Southern African country, Moyo has first-hand experience of living in a recipient nation. A beneficiary if a US scholarship after her university was closed indefinitely due to a failed coup to unseat a sitting president. Moyo migrated to the US and has worked in various financial and development institutions including the World Bank (Moyo, 2009, p14).

Moyo (2009), asserts that developing countries like Malawi and Zambia experience significant challenges of corruption, poverty and an overdependence of foreign aid. They also share common health and infrastructure challenges. Further, Moyo argues that these countries have different resources, and the magnitude of aid offered should also be adjusted. The challenges of health care, poverty, and disease burden in these countries are almost the same; thus, policy makers in both study countries should endeavour to develop effective measures to realise permanent solutions. Moyo suggests that policymakers in these countries should investigate these challenges to gain an appreciation of their root causes. Understanding the root causes will support the formulation of target specific policies that would eliminate these vices. In so doing, development countries would flourish and end their dependency on foreign aid.

Moyo (2009) further states that although western countries, and other international firms, have donated more than $1 trillion to developing countries in the last decades, these donations are yet to show benefit for developing nations. Moyo argues that aid contributes to corruption and contributes to unmitigated economic challenges in developing countries (Moyo, 2009, p 49). Despite the availability of aid, life expectancy, as well as mortality rate, have also plunged in the last decades (compared to the 1960s). Moyo states that developing countries are alone in the fight against poverty worsened by a corrupt and incompetent leadership. In conclusion Moyo states that developing countries are primary targets of aid, that is obstructive to their development.

Moyo (2009) critics both vertical and horizontal aid programmes on the premise that they do not incorporate the needs of the recipients. The main criticism lies mostly with horizontal programmes where most of the aid is provided since the 2nd World War as a pathway to rebuilding different states through the Marshall Plan. These were aimed at reconstructing the global economies of Europe which were severely affected. These donations were different in nature however, in 1990 donors changed their formulae and started providing contributions to respond to various states' need to improve their health conditions (Moyo, 2009, p37).

However, Moyo (2009) states that developing countries cannot benefit from this type of aid as they are faced with high levels of corruption. Other factors include poor governance, inadequate implementation measures, and failure to understand the needs of beneficiaries. Moyo noted that corruption practices in these countries hinder the usefulness of aid and usually leads to corruption and enables individuals to practice fraud. According to Moyo (2009) 25% of aid goes directly into the pockets of corrupt state officials. Citing incidents in the DR Congo and Zambia where despite recorded embezzlements, both countries still benefitted from IMF loans (Moyo, 2009 p.53).

Moyo (2009) notes that most countries that receive donations and aid regularly experience a decline in growth rates and asserts that these declines emanate from corruption as well as consumption of aid instead as opposed to investing in programmes. Moyo (2009) further, states that since most of these planners typically support a top-down method, this creates a loop for accountability (Moyo, 2009, p 65). This is because project planners believe that they own the answers; hence their implementation is based on their grand plans but not in accordance with societal needs. Supporters of the top-down strategy believe that donations should be increased significantly to maximum development among these countries.

Still, Moyo (2009) argues that since these countries lack the extra resources to prop up donations, they are incapable of freeing themselves from the chains of poverty. For this reason, Moyo (2009) believes that aid is not the answer to developing challenges faced by countries like Malawi and Zambia. Despite countries like Malawi continuously receiving donations, they still record low growth rates (Moyo, 2009, p 50). To improve health outcomes and eradicate

poverty in developing countries through foreign aid, donors first need to investigate the needs of beneficiaries for effective implementation.

Scholars like Sachs (2009). assert that there exists a relationship between an increase in development assistance for health and child mortality rates. This is based on the assumption that an increase in donations result in a decrease in mortality rates. Sachs argues that Moyo fails to differentiate between the achievement of various health outcomes and their connection to overall economic growth.

According to Sachs (2009), an increase in foreign aid leads to improved health outcomes. Consequently, Moyo (2009) concludes that donor countries, and international firms confirm that an increase in the amount of aid given does not guarantee a significant improvement in health care. Therefore, the recommendation that to benefit from foreign aid and improve health outcomes, recipient countries should have efficient and well-governed management free from corruption

4. Methodological Framework

The research methodology identified in this research relies upon a qualitative literature study that uses two different countries as case studies. Secondary sources are used to appreciate existing data mostly published through previous research papers. Primary data is drawn on policy documents (e.g. publications, statements, declarations etcetera) by governments and multi-lateral agencies' including the UN. An analysis is done to appreciate the extent to which aid contributes to dependency in Malawi and Zambia. This thesis has the intention to deeply evaluate and further contribute to the debate on the concept of dependency and the health sector in Malawi and Zambia through the dependency theory lens.

The essay also presents current debates on health performance in the study countries especially in relation to achievement of health outcomes directed at improving maternal health and child mortality rates and its relationship to foreign aid. It also examines barriers to health care outcomes improvement while exploring existing financing structures by both the governments of Malawi and Zambia (study countries) and international development assistance partners. This thesis further seeks to appreciate the link between low child mortality rates and the general wellbeing of citizens in the study countries. A list of other factors contributing to maternal and child mortality rates are examined against the background of development assistance for health and its contributions to improving health outcomes in the countries under review. It further appreciates the theoretical questions presented on the efficacy of aid and its effect on the sustainability of health financing in the study countries.

A comparative case study will be used with the objective of comparing similarities as well as a framework for investigating whether external development assistance for health contributes to dependency in Malawi and Zambia. The essay further provides a context to the health systems in the study countries and considers maternal and child mortality as key

indicators in responding to the essay questions. The essay further provides a comparison of two types of programme implementation methods – vertical versus horizontal methods. While vertical methods are disease specific programme for example HIV/AIDS programmes funded by the US government while horizontal programmes are more long term for example cholera prevention programmes which are often underfunded. Th essay concludes with an analysis of the types of aid available in Malawi and Zambia and provides an analysis of the critic that aid does not work,

4.1 Limitations and Delimitation of the study

During the course of this study, a number of limitations have been noted. The internet is a reservoir of knowledge and a desk-based research can never appropriately cover all the existing research data from online sources. Language skills especially with English as a fourth language made it difficult for me to translate the texts into Swedish and understand them before using them.

New information on some multilateral organisations' websites such as the UN on key policies utilised in this essay is older than ten years and this is a missed opportunity to utilise new data. The reliability of data found on official websites of the governments of Malawi and Zambia may be compromised due to freedom of information issues in the study countries. Most statements are not backed up by peer reviewed papers or by civil society and the private sector. The study is also aware that the that statistics and numbers may be outdated or unrealistic. Due to the contentious nature of aid dependency, it is a challenge to find scholars that take a more neutral perspective as the debate is polarised leaning on two extremes. The results are also limited due to time constraints as I have been studying while working and had limited my movements due to the current COVID-19 epidemic's social distancing rules.

4.2 Qualitative Results

The results section presents findings of the desk-based research undertaken followed by a brief performance comparison of Malawi and Zambia in the identification and delivery of health improvement outcomes and the link to foreign aid. The thesis also focuses on maternal mortality rates and examines the conditions that exist in the study countries that hamper improvement in maternal health outcomes. It also considers barriers to improving maternal health and existing available financing structures by both governments and foreign partners.

5. Results

5.1 Context Analysis of Malawi and Zambia

In 2009-2012 figures indicate that Malawi's depended on over 50% official development assistance to fund its fiscal budget. In the year 2012 Malawi received support for more than 74% budget support in order to meet its internal fiscal obligations (World Bank,

2014). This means that the Malawian Health system depends largely on external financing. A WHO report shows that during the period 2006-2009 Malawi received between 57% -62% external assistance for health while the country contributed only 13.5%-22% (WHO, 2015).

Zambia's official development assistance in 2009 that was at 5.9% of Gross Domestic Product (GDP) although this reduced significantly to 3% the following year owing to reports of corruption and financial mismanagement as well as Zambia's graduation into a middle-income country. Zambia has largely depended on PEPFAR, Global Fund (GF) and Millennium Development Challenge (MDC) amongst others to meet its health obligations. However, despite the initial focus in the years 2011 – 2013 for the country to financing and Zambia sourced over 750 million through a Eurobond to finance its own domestic expenditure. Zambia depends on external financing to meet its development goals including SDG 3.1 (UNDP, 2013).

A further analysis proves that the total health expenditure in Malawi increased by 440% from US$123.9 million in 1999 to US$669.6 million in 2015. Its GDP expenditure for health rose from 7% in 1999 to 11.1% in 2015 but this budget is still 3.9% short of the 15% commitment made by the government during the Abuja Declaration in 2001. A close inspection of Malawi's financing structure for health confirms a dependency on donor funding at 63% and 37% is domestically sourced with government contribution at 23% (Chansa and Pattnaik, 2018 p.16). The situation is slightly different in Zambia with government expenditure on health averaging 38% during the period 2013 -2016 and donors at 42% in the years under review, a 20% consists income contributions from corporations and households (Chansa and Masiye, 2019 p.g.6).

Malawi and Zambia are both landlocked countries located in sub-Saharan Africa. The two countries have since independence from Britain faced similar economic constrains, with a greater section of their economies reaching near collapse after the structural adjustment programmes of the 1980s (Mohs, 1980). One of the most significant causes of the slow economic development in these countries has been closely associated with poor governance. The founding leaders and the economic programmes prevalent in the 1980s and 1990s contributed to the downfall of the economies of these countries. As a result of the economic strains, these countries have largely depended on foreign aid to support their UHC.

Malawi and Zambia are rich in natural resources, with Zambia having a wide range of minerals including copper, while Malawi is endowed with coal, limestone and other minerals. Yet, these countries remain amongst the poorest worldwide as indicated by the measures of the Human Development Index (HDI). Most of the citizens of these countries live in poverty with many burdened with diseases (Usher, A.D., 2015 p 520). Maternal and other related care in these nations becomes a challenge and the mortality index being relatively high. Universal Health Care (UHC) is a challenge with a life expectancy averaging 63% in both countries (World bank, 2017). Although significant progress has been made in reducing HIV incidents, UNAIDS (2018) reports that the HIV infection rate for Malawi and Zambia for the age of 15-49 years is 9.2% and 11.3% respectively. Increased poverty and health constraints experienced

in these countries contribute to challenges in maternal health care in these countries. In recent years the economic development of both countries has declined with an annual GDP of 3.5% and 3.8% for Malawi and Zambia respectively (World bank, 2018).

5.2 Analysis of Major donors in Malawi and Zambia

The proceeding chapter presents the true extent and contribution of donor funding to meeting the health outcomes in Malawi and Zambia. This is understood through an appreciation of the programmes models that are implemented these countries and their effectiveness. This presents opportunities for appreciating the relevance of these models in countries under review and how contribute healthcare outcomes or dependency.

Malawi and Zambia have a diverse array of donors that provide specific project or programming funding to the health sectors. There are three major categories of the donors in these countries notably global health initiative donors, multilateral and bilateral donors. Bilateral donors in this case mainly provide aid through national agencies like the ministries of health where governments receive aid from other governments based on bilateral agreements.

Some of the most common bilateral donors in these countries are the Swedish International Development Cooperation Agency (SIDA), the Canadian Development Agency (CIDA), the Netherlands and includes several other European nations and the United States Agency for International Development (USAID). The World Bank is also another common multilateral donor to the study countries. The governments of Malawi and Zambia have formulated a coordination method to sector aid in which governments get funded to meet the various demands in the health sectors through the National Health Strategic Plan (NHSP) developed every year. In the latter scenario, countries (like Malawi and Zambia) outline their health sector development plans and identify stakeholders to guarantee the effective execution of the plan in line with defined priorities through funding. This is a multi-sectoral approach to implementation that includes government, the private sector, civil society organisations (CSOs) and other actors in the sector actors.

Donors in this case make huge contributions for healthcare development in the study countries and their contribution relates to the needs identified in the national strategies and donor priorities. In this case, development partners support project implementation by pooling resources together to support the budgetary demands of health financing in said countries. The role of governments like Malawi and Zambia in this case is to provide oversight on strategy and expenditure by setting up independent strategies and mechanisms for resource distribution and implementation. At community level, these resources serve as general funding to support the delivery of UHC at municipal or district level. The central budget is usually managed by the ministries of health with support from the finance ministries in the respective countries.

The Global Fund (GF), PEPFER and The Gates foundation are some of Malawi and Zambia's largest health donors especially where it relates to treatment, prevention and care for HIV/AIDS, TB and Malaria. Other actors include the Swedish and Dutch governments who

fund more interventions focusing on Sexual Reproductive Health and Rights (SRHR) for women and girls and indirectly to improvement of maternal healthcare and reduction of child mortality rates.

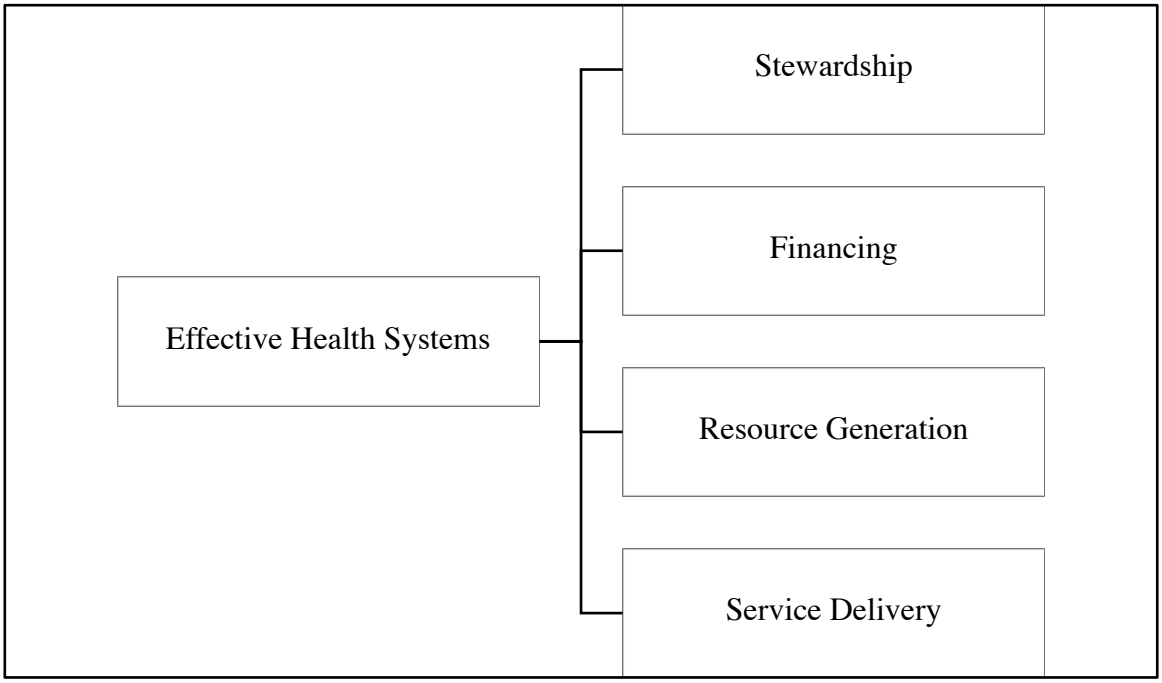
5.3 Similarities between Malawian and Zambian Health Systems

As early as the 1990s, the countries under review began implementing a series of health reforms. The general strategies of these countries were to provide equal, affordable and quality healthcare. The approach and targets in the National Strategic Framework (NASF) were to decentralise national health system so that services are offered close to communities while policy is directed at a national level (Ashraf et.al., 2016. p.4). Both Malawi and Zambia indicated that decentralisation is an effective way of improving health systems as it facilitates direct funding at the district level. This method has brought about efficiency at municipal level although significant positive outcomes are yet to be realised at national level despite an increase in health expenditure. The study countries have also proceeded to implement various cost-sharing mechanism as a key reform in their national health systems. One of the greatest contributors to the decline in health systems of both Malawi and Zambia is poor economic performance. Poor economic performance contributes to a reduction in national development, quality of life and healthcare provision. Decentralisation of health systems in the study countries has enhanced accountability, planning processes and fund allocation to various services in the countries under review. This approach is effective as it applies a "bottom up" approach to strategy development and implementation beginning at community level, district level, provincial level and up to national level.

It is important in this chapter to address the cost effectiveness of health systems in the study countries especially where it relates to the attainment of UHC and accessibility of funds for maternal and childcare improvements. According to the WHO Health Report (2017), an effective health system offers four major functions illustrated in figure 1 below notably providing stewardship through a centralised function responsible for coordination, policy direction and formulation while the financing pillar focuses on financial management, procurement of goods and services and others. These are complemented by resource generation focusing on skills uptake and service delivery through provision of services directly to communities (WHO, 2017). To achieve efficacy and efficiency in Malawian and Zambian health systems and improve health outcomes all factors related to effective health system management should be prioritised equally.

It is noted however, that since both Malawi and Zambia do not fund their health programmes and largely depend on vertical funding from ODA countries, it is seen that funders can come in with their own priorities and disrupt the matrix or support it. Whereas a funder like The President's Emergency Plan for AIDS Relief (PEPFAR) is interested in service delivery related to HIV/AIDS (Chin, et.al., 2015), the Swedish International Development Cooperation Agency (SIDA) is interested in funding the health economics of nations (SIDA, 2005).

Figure 1, denoting 4 pillars of effective health system management



Management Sciences for Health (2020).

5.4 Maternal Health

In the last decade, both Malawi and Zambia have been presented with challenges concerning women's health, especially those relating to Sexual Reproductive Health (SRH) including maternal and neonatal health care. Existing research confirms that the two countries under review experience poor outcomes in reproductive health services (RHS) and therefore, maternal mortality remains a challenge. Data utilised in this analysis indicate an absence of affirming comprehensive RHS for women and girls in these countries. This is worsened by the existence of legal barriers impeding the enjoyment of SRHR by women and girls in Malawi and Zambia. Several mechanisms exist offering comprehensive guidelines on the operationalisation of SRHR in Africa, the most important policy document related to this is the Maputo Plan of Action (MPoA) (2016) guaranteeing access to comprehensive SRH services in Africa as part of Agenda 2030 (MPoA, 2016).

The International Conference on Population and Development (ICPD) further consolidates the MPoA and provides guidelines to guarantee women's sexuality and asserts their autonomy over their own reproductive health including in their respective countries. Comprehensive SRHR are key to improving health outcomes and social-economic development factors including in Malawi and Zambia (UNICEF, 2016 n.p). Multilateral institutions, UN inter-agency reports amongst others identify the existence of legal barriers as

contributing to increased health disparities that weaken national health systems and contribute to increased maternal mortality rates. Other challenges impeding improvement in maternal health include high poverty levels, low literacy rates, lack of basic education especially in young rural women; unsafe abortions and the effects of Malaria and HIV (UNICEF, 2019).

To overcome the limitations identified in the previous paragraph and record improvements in maternal health, countries like Malawi and Zambia need to adopt a life course perspective prioritising the removal of barriers that impede access to SRH services for women and girls and prioritise their education and access to information on SRHR. This concept not only advocates for SRH during the motherhood period but also during the entire birth process, from conception and through pregnancy (UNICEF, 2016 n.p). To improve maternal health, countries like Malawi and Zambia need address all factors of safe motherhood and this includes eliminating the risks of dying during birth for both and child and the mother, or to disability in children.

In 2019 Malawi reported a maternal mortality ratio (MMR) of 439 maternal deaths per 100,000 live births (USAID, 2019) while Zambia (2018) reported 183 deaths per 100,000 live births (Gianetti et al., 2018). While there is a significant improvement in the MMR of both countries, the death toll is still high and contributes to the global MMR therefore putting immeasurable strain on the achievement of SDG 3.1. In 2017, sub-Saharan Africa alone accounted for 196 000 deaths of which according to the WHO, is 'roughly two-thirds' of the global death count (WHO, 2020). To extensively respond to the thesis statement, several factors contributing to maternal mortality in Malawi and Zambia are interrogated in the preceding chapters.

Poverty: The UN has raised their concerns about the worsening cases of poverty in Malawi and Zambia. Malawi and Zambia's are low income countries. There have been close association of poverty of these nations and the health, and this mainly affects the vulnerable groups. This is the reason for the adoption of the Millennium Declaration, by the UN, which eventually leads to the necessity of incorporating the Millennium Development Goals (MDGs). It is clear according to the WHO that health is a strategic tool to eliminate poverty in these nations and this has been proven by the potential effect of the four of the total eight MDGs to eliminate poverty, (MDG 3, 4, 5, and 6) (UNICEF, 2016 n.p). The third MDG emphasizes the equality, as well as women empowerment, while the fourth emphasizes the child mortality reduction.

The situations for a rural community is dire with little push or drive by politicians and policy makers to reduce the gap between the political class and the poor communities concentrated in the rural areas. The majority of the country's poor are women and girls, this is made worse by existing social, political and economic barriers that impede access to resources for women. Western province in Zambia for example accounts for 84% of the rural poor. According to the World Bank 58% of the Zambian population live below the poverty datum line (World Bank, 2019). Malawi is described as one of the world's poorest countries (World

Bank, 2019). These numbers are indicative of the challenges that both countries face in relation to maternal health as the majority of the world's poor are women and girls.

Education: Acknowledged as a major factor that contributes to increasing maternal mortality. Malawi and Zambia are patriarchal societies that do not prioritise the education of women and girls considered as second-class citizens. Boy children in these societies are given preference to attend the highest form of education while most girls are not encouraged. Although the governments of Malawi and Zambia have introduced deliberate policies of free education for all children up to secondary education, poverty plays a challenge in ensuring that children especially girls are able to access it (UNICEF, 2020).The education process is in accordance to the third MDG, which calls for women empowerment. There is need to readjust the net attendance rate of the female in these children, as a strategy to enhance education (UNICEF, 2016 n.p). The youth literacy in these nations has increased in the last three decades, but females still lag behind the scale, mainly because the education of the has not yet gathered enough popularity.

Early marriages: One of the key drivers of maternal mortality, a report released by UNDP in 2013 concludes that two out of every five girls in Zambia is married before the age of 18 years. Further, half of all marriages in Zambia are entered into with girls who have not yet reached the age of 13 years. (UNDP, 2020). UNICEF estimates that 20% - 30% of Malawi's maternal deaths occur in teenage pregnancy (UINCEF, 2020). The numbers demonstrate the contribution of early pregnancy to maternal health as a direct result of early marriages or child pregnancy.

Unsafe abortions: Access to comprehensive sexuality and services is a challenge. Both Malawi and Zambia criminalise abortion and therefore leading women to seek services elsewhere and succumb to harmful practices. In 2003 5,600 woman were treated for unsafe abortion complications and the number increased to 10,000 in 2008 although this number rose to more than 52,700 over the next few years meaning that more than 85% of women were treated for unsafe abortion complications than those who actually underwent safe abortion, this figure however, does not include those that did not make it to a health Centre on time and died doing the process. There's a lack of available data for women who die owing to unsafe abortion complications (Guttmacher Institute, 2009). While the numbers in Malawi are also high as Guttmacher reports that "complications from abortions" contribute up to 18% of maternal deaths in the country and recommends improved access to sexual reproductive health services (Guttmacher Institute, 2017).

HIV/AIDS and related Illnesses: Malawi and Zambia suffer a high disease burden of HIV/AIDS and related illnesses. 11.3% of Zambian adults (between 15-49 years) are currently living with HIV and out of this figure 58.3% are women (UNAIDS, 2018). Malawi reports a 9.2% prevalence rate of adults aged between 15-49 years with 59.75% being women (UNAIDS, 2018). Despite the high contribution of girls below 15 to the maternal death count segmented data on this demographic is not readily available. HIV/AIDS is a great challenge in

these countries, considering that there are an increasing number of pregnant women with AIDS. This translated to higher levels of HIV/AIDS transmission to children under the age bracket of 0 to 19 years (UNICEF, 2016 n.p). Additionally, there have been increased cases reported for children who have received antiretroviral treatment in the Malawi and Zambia within the age brackets of zero to fourteen years.

Malaria: A preventable and treatable illness accounts for a high percentage of maternal deaths in Malawi and Zambia. Prevention of Malaria is considered an extremely expensive exercise especially for the two countries' rural poor and involves a multi split approach that ranges from environmental control, spraying with pesticides as well as sleeping under an insecticide treated mosquito net (ITN) (Maternal Task Force, 2020).

Over the last decade the governments of Malawi and Zambia embarked on a robust programme to reduce Maternal Mortality by employing the following programmes notably improved use of contraception for birth spacing, prevention of early marriages, improved referral systems, provision and access to emergency obstetric care, deployment of more trained midwives and birth attendants, investing in mothers' education and nutritional status and investment in Malaria prevention and treatment for expectant mothers (UNDP, 2013, UNAIDS, 2012 and UNICEF, 2014).

Contraception for Birth Spacing: The two governments have partnered with UN Agencies like UNFPA and other stakeholders to improve access to cheap and affordable contraception to women and girls of reproductive age. Since both countries are deeply conservative Christian nations with large number Catholic populations, most women are shy to consider birth control as it is regarded as a 'sin'. Condom use is generally accepted although most men prefer not to use condoms within their marital households as the practice is generally frowned upon, thereby creating a high risk of transmission of sexually transmitted illnesses especially amongst couples as well as high incidents of unplanned pregnancies which inherently contributes to a high maternal mortality ratio.

Early marriages: Malawi and Zambia are conservative countries that adhere to patriarchal norms with most of national power vested in traditional leaders. Although both countries have legal provisions to prevent the rape and defilement of children, harmful customary practices especially in rural are the norm. Gender Based Violence (GBV) is prevalent in these countries and girls are married off to their abusers. Early childbearing has been dominating in these countries, with a great population of the females being parents before the age of 18 year (UNICEF, 2016 n.p). This not only leads to their inability to continue with their education but often to increasing maternal mortality due to complications arising as a direct or indirect result of pregnancy. This is also common in other countries in sub-Saharan Africa with Tanzania being the most extreme case and its sitting President, John Magufuli having recently banned pregnant girls from continuing their education or returning to school after pregnancy (Centre for Reproductive Rights, 2017).

Maternal care: Under this programme, the Malawian and Zambian governments together with several partners have embarked on specific programmes that focus on improved referral systems, provision and access to emergency obstetric care, deployment of more trained midwives and birth attendants both countries grapple with the number of available health care providers Further, accessibility of health centres, availability of essential drug lists required for obstetric care as well as transportation to referral centres remain some of their biggest challenges. (UNFPA, 2013). Maternal care is a diverse concept, that ranges from sanitation, nutrition, and healthcare provided during the maternal and new-born periods. A number of studies show that there is a low turn up for deliveries at healthcare facilities. Nutrition especially during pregnancy and after birth presents challenges in the health outcomes of these countries. Vitamin A is limited for children with breastfeeding presenting challenges including poverty and other related health problems including HIV/AIDS infection in mothers (UNICEF, 2016). The paragraphs compare the performance of Malawi and Zambia in relation to the thesis statement.

5.5 Child mortality

Development assistance for health is aimed at providing resources to effect change in developing countries such as Malawi and Zambia. UN IGME (2019) reports that Malawi and Zambia have an under-five mortality rate of 49.7 and 57.8 respectively (UN IGME, 2019). The primary drivers of child mortality are listed as preventable pneumonia and malaria with malnutrition also contributing significantly to infant mortality. In response to these deaths and reduce child mortality, UNICEF with the support of aid partners facilitated different forms of support including the distribution of mosquito nets, production of vaccines as well as provision of nutritional supplements (Wallerstein, 2011 p. 473). Further, UNICEF has increased its support to affected countries and initiated various campaigns directed at improving the health of children. The agency collaborates with governments to ensure that children and health providers are able to access relevant resources (UNICEF, 2020). Despite all these measures, meaningful reduction in child mortality rates in these countries still requires more dedicated resources including funding without which it is unmanageable.

Child mortality rate is indicative of the overall development performance of a country. To reduce the child mortality rate, it is important to appreciate its determinants. Wolfe and Behrman (1987) explore the determinants of child mortality in their regression analysis of overall household utility. They find empirical estimates of determinants of child mortality leading them to conclude that the level of urbanisation, amount of time for childcare (which depends on female employment), prenatal care, the level of education, number of children, caloric intake and access to clean water are significant indicators of child mortality. The research finds formal medical care or income as major predictors of child mortality. Given this data, achieving SDG3 should involve targeting improvement of determinants of child mortality rates within the general populations in the study countries.

Another study done by Lynch et al., (2004) establishes these primary determinants of child mortality as related to the general well-being of the population with income inequality being flagged as a key driver in developing countries. This thesis utilises child mortality rates in Malawi and Zambia as key indicators in the measurement of their failures or success in the provision of UHC. It also underscores the social, economic and environmental conditions of the study countries as children do not live in abstract and but exist within the confines of a family and or societal structure. Comparing child mortality rates in countries in several countries proves that the higher the income inequality, the higher the child mortality rate. The child mortality rates of the countries under review cannot be compared for example to those of Sweden and Denmark who have higher incomes and lower mortality rates in comparison to Malawi and Zambia who have lower incomes and higher mortality rates. Lynch, et al., (2004) therefore concludes that foreign aid reduces child mortality since the leading cause of most deaths are preventable illness which can be controlled through short term aid and donations.

The above arguments present a strong theoretical framework for a discussion and appreciation of the advantages and disadvantages of aid in relation to the study countries of Malawi and Zambia. It remains to be seen in the foregoing chapter how the theoretical frameworks presented supports the role that aid (if at all) plays in creating dependency or improving maternal health in the countries under review.

5.6. Implementation of vertical vs horizontal health programmes in Malawi and Zambia

The bulk of health programmes implemented in Malawi and Zambia are 'vertical' programmes which are disease specific and focus on short term turn arounds. Vertical programmes are often funded by 'vertical funds' and are a health financing mechanism with 'mixed funding' sources focusing on single issue like funding responding to the HIV/AIDS pandemic by funders like the Global Fund. These disease specific funds compete with system strengthening funds or 'horizontal' programmes that focus on UHC for all (The Global Fund, 2020).

The main focus of primary healthcare is to ensure health improvement for citizens especially those in developing countries. These improvements are realised through the provision of health education to people, prevention of outbreak for common diseases, consolidating their family planning mechanisms, and also by ensuring access to clean water and food. Further, primary care promotes overall societal wellbeing while crafting a pathway to self-sufficiency towards UHC (Oppong, 2014 p. 323). Investment in UHC besides improving the overall economies of countries through poverty reduction and also contributes to improved economic indicators and in the long term an increase in domestic financing for health.

Reddy and Miniou (2006) underscore this point by stating that, "the stronger the state's primary healthcare system, the higher the systems quality and cost-effectiveness and the greater its impact on general health." (Reddy & Minoiu, 2006, p.67). And thus their recommendation to integrate vertical and horizontal aid to prevent a detract related to primary health care.

While the structure that donor funded programmes take in Malawi and Zambia depend on the designs of the donor partners, Cruz et al., (2003) in an article published in the *Journal of International Development* considers in detail the merits and demerits of vertical and horizontal health programmes and the different forms of foreign aid (Oliveria et al., (2003). Promoters of 'vertical' aid argue that it is the best category of aid and that 'horizontal' programmes create challenges with human resources who are often underfunded and work as volunteers or community-based workers (Cruz et al., 2003, p. 72). The effectiveness of horizontal programmes is hard to measure as they are mainly long term and are concerned with multiple indicators and disease as opposed to a single issue. This is so because most horizontal programmes are long term and require huge expenditures to initiate which most recipient countries including Malawi and Zambia do not have while vertical programmes are easier to develop, implement and measure.

Proponents of vertical programmes also consider them as effective based in the way that they are structured with clear objectives that are easily measurable and are provide short term solutions which are achievable and require less funding (Cruz etal., 2003, p. 73). Additionally, most donors want to see that their donations are bringing immediate solutions to existing challenges; as such, they prefer vertical programmes. Besides, most of these donors usually live outside the countries they are donating towards and consider that an immediate use of their donations reduces the risk corrupt and mismanagement by national leaders. Further, most nations that provide development assistance for health want to ensure that their contributions bring about an immediate improvement as compared to long term projects (The Health Foundation, 2013 n.p). Some donors usually donate as a way of proving their societal worth and hence require direct results. For this reason and many others, most donors prefer funding vertical programmes as opposed to horizontal programmes since change is almost instant and their contribution to success is significant. Malawi and Zambia implement a number of horizontal healthcare programmes funded through DAH received mainly from the European Union, Dutch, Norwegian, Swedish and US governments to name but a few.

Nevertheless, several limitations can be brought against the use of vertical programmes as underscored by Cruz, et al., (2003) who assert that research on vertical programmes do not consider the specific needs of the community but respond to donor priorities. Vertical programmes mostly utilise a top-down approach as opposed to establishing a cultural relevance of their programmes to recipient nations (Cruz, et al.,2003, p.74). For this reason, these programmes facilitate for the continued dependency of recipient countries on foreign aid. Besides, the lack of connection between vertical programmes and countries that promote them results in such programmes destabilising progress that recipient countries have made in alternative programmes.

A given scenario in this study is where a recipient country may be struggling to promote overall primary care and donors ignore this and provide aid to bring about quick outcomes in the treatment of a specific disease like reduction of new HIV infections. This may lead them to overlook local specific information that could prevent future outbreaks of other medical

challenges. Cruz, et al., (2003) questions the effectiveness of vertical programmes as stand-alone in addressing health care challenge as this method is not sustainable in the long term. Although these programmes are perceived to be transparent and bring in various benefits, they should not stand independently. Further, failure to involve beneficiaries at programme design level results in a lack of local ownership which render such interventions unsustainable (Cruz, et al., 2003, p. 76).

Further, vertical programmes focused on diseases like HIV/AIDS funded through the USAID or PEPFAR in the study countries do not target the overall population who similarly face a plethora of health challenges. As a result, they end up creating other externalities since other citizens do not gain access to the kind of health care they require. The recent COVID - 19 pandemic may well illustrate the pitfalls of vertical programmes in achieving health outcomes as all health interventions presently are eclipsed as the world responds to one disease at the expense of others. The majority of citizens dealing with other health challenges are presently not able to access the health care they need. It is noted that health care outcomes experienced in any country are as a result of the economic, political and social conditions of a country.

On the other hand, vertical programmes may contribute to achieving specific short term outcomes, an example is how in Malawi and Zambia, the Global Fund project contributed to a massive recruitment drive for much needed health care professionals intended to support HIV/AIDS, Malaria and TB specific outcomes despite being structured as vertical programmes. By reducing HIV/AIDS, Malaria and TB incidents, vertical programmes now contribute to a reduction in maternal and child mortality rates in the countries under review (WHO, 2020). It should be noted however, that addressing maternal and new-born health in Malawi and Zambia requires an integrated health systems approach on the pathway to achieving the SDG goal on UHC. This may require a combination of both 'horizontal' and 'vertical' systems of programme development and implementation.

6. Analysis

There is not one agreement or perspective on whether health financing contributes to dependency structures and if there exists an unequal relationship between developed and developing countries. The debate continues with Moyo (2009) on one end insisting that *'Aid is Dead'* while Sachs (2009) underscores the relevance of aid. There are marked differences in dependency ideology espoused by those based in a Marxists foundation Frank (1966) and structuralist like Cardoso (1979) and Wallerstein (1975), all of them, however, hold that internal and external drivers contribute to dependency. Structuralists and world-system view scholars insist on transforming aid to support development outcomes while anti aid campaigners like Moyo (2009) insist that aid except that of a humanitarian or emergency nature should be abolished and this is noted in the writing of this essay.

This thesis found that both Malawi and Zambia share a historical context stemming from a shared colonial past that influences the set-up of its health systems and how these systems interact with the rest of the world including funding partners. A further analysis of the maternal and child mortality rates exposes vulnerabilities in the way that health programming is structured and considers how this exposes the study countries to continued dependency on DAH. One of the crucial findings of this report is that most developing countries including the countries under review did not retain and maintain readily accessible data.

During the course of this research, one of the observations made is that data collection is an important aspect of development. However, this is a huge step back for most developing countries since most of them do not focus on data collection nor its maintenance. Also, it was further noted that the institutions responsible for development in countries such as Malawi and Zambia do not have access to specific information based on freedom of information laws and this limits them from capturing specific data. Political instability and corruption in most developing countries is another factor that limits the collections of measurable data. According to the World Bank and WHO, administration and organisational management are common impediments to effective programme implementation for health in the study countries (WHO,2020).

As a result, donors funding countries like Malawi and Zambia continue to focus on establishing data assessment processes that will build on previous data from recent funding sources and existing plans in these institutions. As mentioned in the literature review, it is important to point out that several studies show a relationship between dependency and aid. Malawi and Zambia are case studies used to present the trends and outcomes of foreign aid on UHC improvements particularly in maternal healthcare. Analysis of the above data is based on consistent cases and data available. This thesis demonstrates a significant connection between aid and dependency in Malawi and Zambia. By so doing, this thesis demonstrates the link

between aid related dependency, improvement in maternal health and achievement of other health outcomes.

This study considers the question, to what extent does development assistance in Malawi and Zambia contribute to aid dependency? The result of the research supports the hypothesis that both Malawi and Zambia are dependent on foreign aid. Not only are they dependent on foreign aid but they are reliant on it to finance their health programmes including those relating to improving maternal health. The conclusion is based on testing the questions presented in the research questions notably, what actions have the governments of Malawi and Zambia taken to improve health outcomes including maternal health through international aid? This question sets to examine the priorities of both countries in health programme development and improvements while utilising maternal health and child mortality as indicators of any such performance. This question also supports the thesis in appreciating whether the study countries set their own health agenda and if, they are capable of financing the achievement of any such priorities.

Data collected in this research shows that both countries depend on significant funding from external partners who direct their health agenda and programming related to maternal health in line with the global development agenda. According to a 2010 survey published by the Zambian ministry of health, the sector faced financial challenges as a direct result of a 40% reduction in DAH following allegations of corruption at the ministry of health (Usher, 2015, p 519). The report further illustrates a decline in funding for maternal health and for other critical programmes including Malaria prevention and treatment amongst others.

The decline in health care service provision illustrated above was reported following the decision of the Swedish and Dutch governments to freeze funding for health in Zambia in response to allegations of embezzlement of funds involving top officials at the ministry of health. Data obtained further shows that, after the Swedish government and other donors reconsidered their decision and started to fund the Zambian government, there was a remarkable improvement in healthcare provision in the country. Statistics show that antenatal care increased by up to 70% while treatment of other diseases showed a marked improvement of about 40% (Usher, 2015, p. 519). On the other hand, Malawi also recorded a 40% drop in overall health care without aid but improved significantly after accessing external funding for health (Usher, 2015, p. 520).

It is clear from the scenarios presented in the preceding paragraphs that both Malawi and Zambia generally depend on external aid to sustain their health sectors. Further, this thesis proves that if the countries under review are not supported with aid, their health care services would deteriorate as shown in the percentages above. These findings also show that both the governments Malawi and Zambia remain under significant pressure to present results in order to continue benefiting from external aid. Consequently, it is correct to conclude that provision of aid to the countries under review results in dependency since the national health systems of both Malawi and Zambia cannot be funded without external aid.

Through asking further questions relating to the relationship between aid and maternal health in Malawi and Zambia, this thesis endeavours to appreciate progress made by the two countries towards the realisation of their health goals specifically those concerning SDG 3.1 whilst appreciating the role that development assistance plays in supporting this aspiration. The question further concerns itself with appreciating the performance of the countries under review in relation to actions taken to improve health outcomes including maternal health through accessing international aid. This thesis found that both Malawi and Zambia are dependent on external aid to finance their health and maternal health budgets in direct response to the main research question.

Further, the thesis aimed to find evidence to appreciate the extent to which both Zambia and Malawi depend on aid to improve their healthcare. This thesis found that the countries under review depend on external aid as a source of financing for their health budget. Moyo (2009) asserts that most aid recipient countries in sub-Saharan Africa (including the study countries) are corrupt and lack effective planning in terms of policy formulations. As a result, most of the resources generated and allocated by for development projects including health in the national budgets end up being embezzled by the greedy leaders hence leaving the country at the mercy of donors.

Additionally, lack of adequate policies similarly contributes to dependency as those formulating policies do so without conducting detailed research on community needs and thus render most interventions unviable. According to Moyo (2009), most strategies designed in the name of development are aimed at generating funds for the personal use of the political class in the study countries. On several occasions, politicians formulate policies in the areas that benefit them or allow them to steal. For this reason, the study countries can only demonstrate progress in the health sector through monitored donations. The preceding statement further proves dependence in the countries under review. Despite improvements in the provision of UHC in Malawi and Zambia, progress is slow and most of the population are still unable to access healthcare and incidents of corruption and theft have been reported in the subject countries. Despite this, this thesis found that the study countries continue to receive DAH without much consequence.

This thesis also sat to find out how foreign aid has been used to improve health outcomes in both Zambia and Malawi. Through the consistent evaluation of existing data, this thesis proves that aid contributed to the improvement of development outcomes in the study countries. Through DAH the countries improved their health conditions and control over several diseases including Malaria and HIV/AIDS and hence recording a significant decrease in maternal and child mortality. Therefore, it is correct to conclude that foreign aid has a substantial impact on the development of health in both Zambia and Malawi as presented by the data I generated.

This study found that, there was a correlation between maternal health improvements in Malawi and Zambia partly due to the availability of development assistance for health or foreign aid. While these improvements are remarkable, the study also found that although the countries have benefited by receiving development assistance for decades, this did not correlate with direct development in these countries nor translated into sustainable ways of financing for maternal health. Both Zambia and Malawi reported a dependency of 40% and 60% respectively on external financing for health meaning that both countries are incapable of meeting their health budgets.

Although earlier information shows how Zambia had initially taken steps to provide its own local financing for health in the earlier part of the last decade, progress shows that owing to rampant corruption and financial mismanagement, the country still remains dependent on development assistance. This scenario demonstrates the arguments presented by Moyo (2009). Improvements and gains made in the maternal mortality rate also consolidates Sachs (2014)'s argument that there is value in aid and that it supports the improvement of development goals in developing countries.

Moyo (2009) asserts that an unequal relationship exists between aid recipient nations and ODA nation and that foreign aid is given to recipient nations is attached with conditionalities and recipient nations have little control over what policies to implement as they adhere to the wishes of the funder. This is made clear in instances when African policy makers introduce projects/programmes that are to the detriment to Africa based on ODA countries' guidelines. An example is the structural adjustment programmes (SAP) that wreaked havoc on sub-Saharan African economies and were implemented with gusto by sub- African states at the bidding of the International Monetary Fund (IMF) and the World Bank. Oppong (2014). The results of SAP reveal that global institution often prescribe recommendations without proper needs assessment and or consultation with stakeholders and or/beneficiaries of the programme. Meaning that some solutions designed and implemented through development assistance are often top down and with little negotiation. It is also important to stress that most sub-Saharan African policy makers have neither the interest nor the political will to negotiate such conditions or interventions (Oppong, 2014).

Sachs (2014) however, states that aid is beneficial and this argument correlates to existing data on improvement in maternal health outcomes in Zambia and Malawi as a direct result of DAH. Benchani (2019) found that there was a significant improvement in maternal healthcare as a direct result of foreign aid to the countries under review (Benchani, 2019). This demonstrates that although the structure of aid is flawed and requires improvements, criticisms of aid advanced by Easterly (2014) and Moyo (2009) overlook the significant of aid contributions to the health sectors and maternal health in particular. The thesis also proves that healthcare in Malawi and Zambia deteriorates in the absence of DAH.

This research is significant as it seeks to understand the relationship between aid and dependency by interrogating different views on the matter while it analyses evidence presented

by leading academics on the subject matter. This thesis does not stop there as it further explores the evidence obtained from data sources to appreciate the relationship foreign aid and maternal mortality. Whereas other areas of work may be harder to measure, maternal health indicators are easier to measure, and the data is readily accessible. This provides clear evidence on the relevance or lack thereof of aid in the improvement of healthcare in the countries under review. The same cannot be said for example on work concerning key populations (KP) groups in sub-Saharan Africa with respect to the HIV/AIDS response as governments including in Malawi and Zambia are reluctant to work on these issues and reliable data is typically unavailable. In this case, external financing obtained by countries like Malawi and Zambia for KP programming from organisations like the Global Fund goes unreported and specific indicators are never fulfilled (Laar, A., DeBruin, D., 2017).

A discussion on progress towards realising maternal health outcomes improvements in sub-Saharan Africa in general and the study countries in particular, cannot be taken without interrogating the role of development assistance in promoting the achievement of immediate and short term outcomes often at the expense of long term programmes requiring the commitment of national governments to finance their national health budgets. A case in point is how African governments met in 2001 and committed to allocating 15% of their national budgets to health and almost two decades later, this milestone has not been realised (WHO, 2011). African governments further adopted the MPoA in 2010 in efforts to improve key milestones on SRHR in Africa and these are yet to be realised. Consequently, it is evident that both Malawi and Zambia are dependent on foreign aid to fund their health budgets. An example is mater maternal health where the former receives an estimated 60% DAH and the later 40%. The data illustrates above proves that the healthcare systems in the study countries deteriorates significantly without aid. This essay therefore concludes that the provision of DAH by external organisations and countries contributes to aid dependency in Malawi and Zambia.

7. Conclusion

This paper concludes that although the governments of Malawi and Zambia are responsible for improving the health conditions of their citizens, both countries fail to do so owing to social, political and economic barriers. Therefore, the international community in their quest to support the realisation of these outcomes including maternal health step in and offer conditional DAH to support vertical or horizontal health programmes. In so doing, development partners drive the UHC and maternal health response in the study countries through their partnership with national governments. The essay further concludes that Malawi and Zambia's decades-long dependency on aid has not translated into sustainable economies nor into a reduction in the number of people living below the poverty line. There is also no marked improvement in domestic financing of their national health budgets.

The data presented in this thesis confirms that positive intervention with aid has been mostly observed where it relates to maternal health improvement and reduction in child mortality rates, but it cannot be successfully proven for other interventions. Although Malawi and Zambia show remarkable improvement in addressing SDG 3.1 (specifically targeting maternal health improvement), they still have in place draconian laws that impede access to comprehensive sexual and reproductive health care for women including, access to abortion and related services. Unsafe abortion related complications remain one of the primary drivers of maternal mortality. Further, continued funding for maternal health improvements by external partners in the study countries demonstrates an increased dependency on external aid to support internal health outcomes coupled with a reluctance by the governments in the study countries to explore alternative sources of funding. Despite attempting to increase their own internal financing, the countries under review relapsed into corruption and mismanagement scandals while external partners continued to support their health budgets. This paper concludes that foreign aid without accountability worsens dependency in health financing in Malawi and Zambia (Moyo, 2009).

This paper therefore recommends that for aid to be effective and acceptable across all sectors, governments need to ensure that resources meant for the poor, actually reach the poor and translate into meaningful change through poverty reduction Easterly (2014). Strict conditionalities on accountability, good governance, corruption and embezzlement should be prioritised by donor nations although Moyo (2009) does not agree with this approach and calls for the discontinuation of aid except where it relates to humanitarian and emergency aid. This thesis found that whilst Malawi and Zambia performed badly in their accountability and corruption indexes, they still managed to access DAH. The appearance of China on the development partner in the study countries worsens the situation as China does not include human rights or good governance as a pre-requisite condition to accessing financing.

It is imperative therefore, that future research investigates the relationship between development assistance and dependency in modern times especially in the age of China as a superpower with considerable influence in sub-Saharan Africa including in Malawi and Zambia. Further qualitative research should be undertaken using communities' voices to measure national performance and hold national governments and development partners to account in a quest to reduce corruption and embezzlement of donor funds meant for the most vulnerable in the study countries.

Further, owing to the polarised nature of the debate on development assistance, finding neutral discussions proved to be complex and presented challenges in formulating the research questions. Although multiple research exists in this area of research, this paper relies heavily on theories presented by scholars like Moyo (2009) and Sachs (2014) who are both on opposite ends of the debate. Earlier research was either two old or outdated and leaned more towards driving a development agenda. This thesis also limits its exploration to whether or not Malawi and Zambia are dependent on external aid to finance and improve their healthcare performance including a reduction in the maternal mortality rate.

Several other essential questions found in the course of this research require further investigation. For example, my research focused on investigating the performance of Malawi and Zambia in relation to dependency, although a conclusive study on other sub-Saharan African countries in particular members of the Southern African Development Community (SADC) would be necessary to test the results. A further research utilising an alternative theory for example, the postcolonial theory to investigate the effect of foreign aid in another sector such as infrastructure development in relation to the overall economic performance of Malawi and Zambia would form a useful comparison. Conducting further research on this topic will significantly contribute to appreciating the relevance of aid to recipient nations and how it can lead to dependency.

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