Global Health Donor Proliferation and Effects in Malawi: Perceptions from Development Agency Leaders

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A proposal for a capstone project submitted to the faculty of Radford University in partial fulfillment of the requirements for the degree of Doctor of Health Sciences

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Abstract

The proliferation of donors providing aid to the health sector brings intended and unintended consequences associated with increases and iterations of funding. Well-documented contributions alongside concerns from scholars and critics draw attention to a need for country-specific studies on positive and negative effects. Conducted in Malawi, a low-income country, this qualitative study utilized key informant interviews (KII) to explore real-time perceptions from longstanding bilateral and multilateral development agency leaders and counterpart recipient government leaders. Findings from KII offer different views on positive and negative effects of Malawi's global health donor proliferation environment as well as development agency leaders and government insights.

Objectives: The purpose of the study was to examine perceptions of bilateral and multilateral key development agency leaders and central government leaders to provide first-hand effects on global health donor proliferation in Malawi.

Methodology: The Pallas and Ruger (2017) framework guided the global health donor proliferation lens applied to this project. The qualitative study consisted of a two-part process: a rapid Malawi literature and document review followed by KIIs to examine the effects of global health donor proliferation in Malawi. Learnings from peer-reviewed literature informed the KII questionnaires used with bilateral, multilateral, and government leaders to address pertinent issues. In phase two, the researcher conducted 10 of the 15 targeted KIIs then examined findings using the Dedoose web-based application. The researcher also organized, coded, and analyzed the KII responses before identifying themes and recommendations to present in the final project.

***Findings*:** Major and minor positive effects emerged from the KII on i) longstanding partnerships, ii) health outcomes, iii) dedicated financing, iv) health workforce support, and v)

the Health Sector Strategic Plan III guidance. Major and minor negative effects included i) bypassing local systems and structures, ii) donor dependency, iii) domestic resource mobilization gaps, iv) information systems proliferation, and v) time and management burdens. Most development agency leaders were concerned about the future.

Conclusions: Accounts from bilateral agencies, multilateral institutions, and central government leaders suggest opportunities for improving global health donor proliferation. More attention should be devoted to inter-ministerial leadership and cooperation, improved coordination of financial and programmatic investments, and harmonization of human resources for health and health management information systems. Efforts to operationalize the Health Strategic Plan III remain critically important and need to better align donor-supported strategies with national priorities. Implementing change among development agency leaders and the Government of Malawi requires commitment to action.

Keywords: donor proliferation, global health, U.S. government, Global Fund, Malawi, effects, impact

Dedication

This Capstone is dedicated to Tembile and Asanda, my main support system, and Sihle, my son, on our journey of professional self-discovery. Tembile, your sacrifice and the encouragement coupled with physical separation when needed most pushed me along the many long days and nights. *Ekosi kakhulu*.

Dr. Sallie Beth Johnson, a scholar and my guide, this research was also made possible due to our special collaboration. You knew where to prop me up and when to pull back when I needed to take the reins. Thank you.

Finally, for Malawians, my study forms part of a 60+ year dialogue about genuine and transformative global health partnership. I dedicate this work to the warm heart of Africa where development agency leaders share responsibility to serve others first, second, and always. *Zikomo kwambiri*.

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List of Abbreviations

Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Malawi
HSSP3	Health Sector Strategic Plan Three
KII	Key Informant Interviews
MOH	Ministry of Health
NCD	Non-Communicable Diseases
OECD	Organization for Economic Co-operation and Development
ODA	Overseas Development Assistance

List of Definitions

Bilateral aid – the direct transfer of capital, goods, or services between a donor and a recipient country

Bilateral donor – a government (often a developed economy) that provides funding to a developing economy or country

Donor proliferation – increase in the number of entities involved in the financing and delivery of official finance; increased influx of funding and increase in providers of official financing in recipient countries

Donor fragmentation – increased number of donor-funded activities

Multilateral aid – the direct transfer of capital, goods, or services between a multilateral organization and one or more recipient countries

Multilateral donor – three or more nations (governments) that form an organization typically established through an agreement between members states that provide funding to a developing economy or country

New entrants, new donor countries – countries (governments) that lie outside the official membership of the Organization for Economic Co-operation and Development's Assistance Committee

Health Sector Strategic Plan – a multi-year (often 5 or more years) that identifies key reforms, priorities, and actions that aim to propel Malawi towards attainment of universal health care

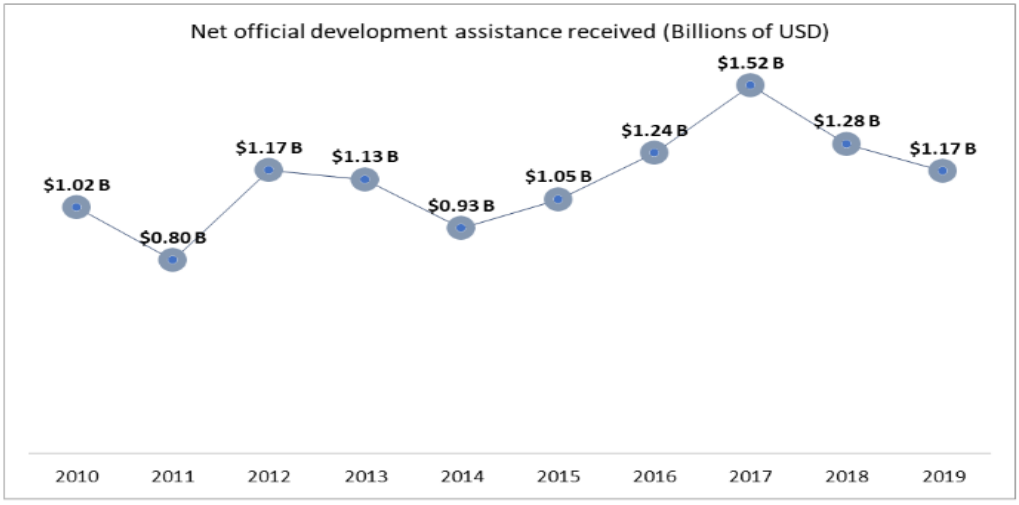
Chapter 1

Introduction

Donor proliferation is commonly defined as an increase in the number of donors and inflows of aid funding to a country (Organization for Economic Co-operation and Development [OECD], 2021; World Bank Group, 2022)**.** According to the OECD's Development Assistance Committee 2021 database on donor countries and multilateral agencies financial reporting, least developed and low-income countries received 94% of their financing from foreign assistance. This multi-country trend coincides with the situation in Malawi. A correlation analysis using World Bank data, Figure 1, shows a strong positive correlation between the years and overseas development assistance (ODA) across all sectors. In Malawi from 2010 to 2019, the results of the Pearson correlation analysis revealed $r = .926$, $p < .001$. The increased funding level that supports key sectors is one illustration of how external assistance contributes heavily to the Government of Malawi (GoM).

Figure 1

2010-2019 Development Assistance, All Sectors



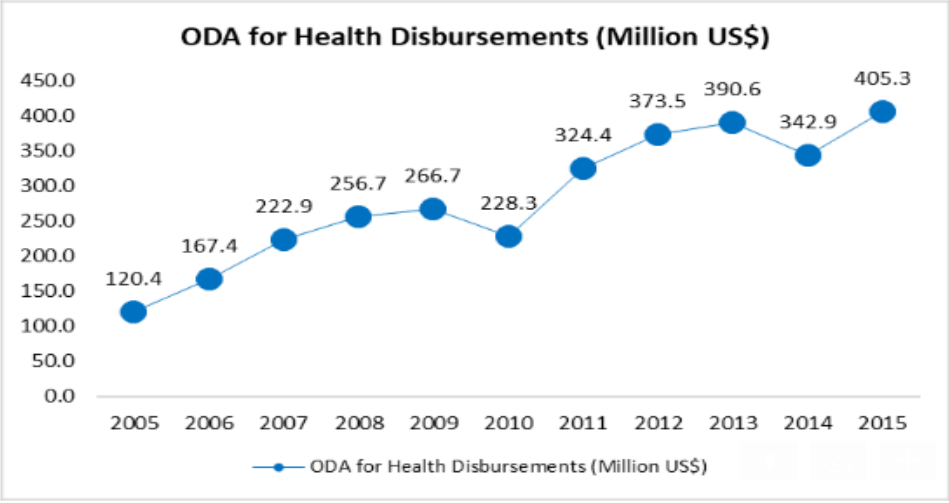
Note. From World Bank Data Portal (2019)

This macro-view of financial support, however, masks the resource allocation shifts in the health sector. ODA for health alone is isolated on the next page through a look at historical funding from 2000 through 2015, where complete data is available.

The ODA for health disbursements in Figure 2 shows a strong correlation between years and funding; the results of the Pearson correlation analysis revealed $r = .942$, $p < .001$. The largest disbursements historically and to date come from bilateral and multilateral donors. The leading global health donors since 2014 have been the United States and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund). Both continue supporting the national health response, dominating the number of disbursements at 944 in one year. These statistics signify multiple approaches for implementing projects, programs, and initiatives through which funds are allocated or disbursed (Overseas Economic Cooperation and Development, 2021).

Figure 2

2005-2015 Development Assistance, Health Disbursements



Source: Overseas Economic Cooperation and Development, 2021

The Malawian government's resource mapping confirmed funding of $3.09 billion in 2019-2020, up from $1.80 billion in 2017-2018 from external assistance (Government of Malawi, 2022). For prior years, the HIV/AIDS programs alone had over a three-fold increase in available financial resources, from U.S. $5 million in 2003 to U.S. $19 million in 2013 (Yoon et al., 2021) and currently U.S. $176 million in 2023 (U.S. Government, 2023). These increases across different points in time illustrate the expansion of global health donor support over the last decade—a recurrent phenomenon with inflows and dynamic disbursement activity.

Within this financial backdrop, there is an abundance of literature on the mixed effects of bilateral (government to government) and multilateral (more than a single government and/or funding entity) donor proliferation (Chasukwa & Banik, 2019; Duran & Glassman, 2012; Page, 2019; Samy & Aksli, 2015; Sweeney et al., 2014). While bilateral assistance takes the form of funding flows from a developed economy to a developing economy, multilateral donor assistance gets distributed from a bilateral donor to multilateral organizations that then disburse funds to the developing economy (Biscaye et al., 2016; World Bank Group, 2022). In the case of Malawi, the rise in development agencies funding disease prevention and treatment and the strengthening of health systems is important. Equally important is the analysis of both the documented and perceived impacts of the increase in global health donors.

This study provides a deeper examination of the positive and negative elements within Malawi's health funding environment. By examining a wealth of studies on traditional and new donors operating in this country and in Africa (Hasselskog, 2022; Overseas Development Institute, 2020; Samy & Aksli, 2015; Silcock & Nilima, 2020; Swiss & Gulrajani, 2018), this capstone adds to the body of knowledge on effects of donor proliferation in the health sector, with a focus on in-country perspectives from development agency and government leaders.

Purpose and Research Questions

The purpose of the capstone project is to conduct a qualitative study on the perceptions of key development agency leaders and explore their first-hand insights on global health donor proliferation in Malawi. Examining effects of global health donor proliferation included key informant interviews (KII) with bilateral, multilateral, and Government of Malawi (GoM) leaders. Rather than embrace the mainstream negative view of donor proliferation, the student researcher sought to understand diverse perspectives. Using the foundational Pallas and Ruger (2017) Conceptual Framework on Hypothesized Effects of Donor Proliferation on Health and the Malawi document review literature, the following research questions guided the project:

i) What effects of global health donor proliferation in Malawi are reported in the literature?
ii) What positive effects of global health donor proliferation in Malawi do key development agency leaders identify?
iii) What negative effects of global health donor proliferation in Malawi do key development agency leaders identify?

Hypotheses

Three hypotheses were assessed in the KII findings:

i) More primary effects than secondary effects will arise in KIIs derived from the Pallas and Ruger framework.
ii) Major positive effects will include better health outcomes and recipient control.
iii) Major negative effects will include inter-donor parallel systems and increased corruption cases.

Chapter 2

Literature Review and Malawi Document Review

Background

New and generational donor investments and partnerships with central governments toward health sector goals demonstrate positive evidence of opportunities for market-based or collective agency bargaining power, resource pooling and leveraging of funding resources, interagency coordination for complimentary goals, and multi-disease-related benefits to populations (Acharya et al., 2006; Biscaye et al., 2016; Knack & Rahman, 2007). These promising possibilities have immediate and far-reaching effects for the recipient country. They enable governments and communities to tackle pernicious public health threats utilizing external support. In Malawi, notable successes attributed to increased donor funding channels are higher life expectancy, higher undetectable viral load for people living with HIV at lower risk for transmission, and reduced costs of drugs for adults and children (Ministry of Health, Malawi, 2021).

Harmful, unintended, and suboptimal results from donor proliferation in the health sector have also been reported (Easterly & Williamson, 2011; Fuchs et al., 2015; Hasselskog, 2022; Moyo, 2009). These concerns can arise depending on the local conditions such as heightened vulnerability within lower-income countries, high dependency on external assistance (Moyo, 2009), and inter-donor competition and burdens placed on local governments exacerbated by the time required to manage numerous aid channels and interagency relationships (Knack, 2014; Leiderer, 2015; Samy & Aksli, 2015; Sjostdet, 2013. The adverse effects of independent management units and parallel procurement systems mandated by select donors can compromise national autonomy and institutions.

Severe challenges in Malawi have led to donor arrangements that can disempower local governance structures, which occurs when their authority is circumvented (Chasukwa & Banik, 2019; Knack, 2014; Moyo, 2009) as global health development agency leaders vie for dominant roles and recognition in a crowded donor space. Such competition involves maneuvering amid power dynamics and politics (Page, 2019; Pallas & Ruger, 2017). Practices exhibited to enhance a government or country's international standing (also referred to as donor ambition) are not new nor seen as nefarious (Devex, n.d.; Swiss & Gulrajani, 2018).

Conceptual Framework

The Pallas and Ruger (2017) framework guided the global health donor proliferation lens applied to this project as its contents analyze a range of positive, negative, and potentially bi-directional effects situated within the health sector. This global health-specific framework provided a distinct pathway to see health as part of broader development, which signaled theoretical and practical significance. Currently donor proliferation is associated with seven primary effects that influence individual variables: i) aid value, ii) inter-donor competition, iii) recipient (country government) control over aid, iv) donor poaching of country staff, v) transaction costs and parallel systems, vi) donor sense of accountability for overall outcomes, and vii) aid fragmentation, in lieu of health programs.

Alongside these individual areas, Pallas and Ruger (2017) postulated five secondary effects: i) price of aid, ii) innovation and diversification, iii) information hoarding, iv) monitoring of aid use, and v) disbursement volatility. Whether an individual effect or multiple effects act as an enabler or detriment to progress remains contingent on an interplay of factors such as the context or conditions in the country. In this study, the researcher examined how the

macroeconomic environment, local capacity, and corruption levels interact, assessing whether development agency leaders' perceptions on the subject of study are positive or negative.

Key dimensions of global health donor proliferation that underpin the Malawi document review were dynamic: inter-donor competition, country control over aid, donor poaching of country staff, transaction costs/parallel systems (Biscaye et al, 2016; Pallas & Ruger, 2017). The full list of hypothesized effects of donor proliferation (Pallas & Ruger, 2017) related to country conditions, performance determinants, and health programs (coupled with population health outcomes) can be found in Appendix A.

Findings in the background literature informed how the student researcher selected Malawi-specific documents and maintained neutrality and openness in the project scope. An exploratory approach was taken, which involved adopting an investigative mindset. This was based on evidence that showed that global health donor proliferation can be both beneficial and problematic in low-income settings (Dijkstra, 2018; Keijzer & Black, 2019; Pallas & Ruger, 2017). In the data analysis section, the student researcher provides common and distinct themes that surfaced.

Working papers by Overseas Development Institute and the World Bank explained some of the tensions and debates within the discourse. Longstanding health donor interactions are constantly being navigated with other donor activity in the same fiscal and program space. The crowding of different donors involving new inflows of funding (Swiss & Gulrajani, 2018) alongside traditional development agency leaders' increased resource allocations can disrupt and duplicate local health program activities. While some global health donors persist with their programs in Malawi, the mix of new and changing health initiatives often results in duplicated efforts for the GoM. Conversely, this situation could also present an opportunity for the GoM to

reassess and reprioritize its health agendas, potentially benefiting from alternative funding sources. The dynamic nature of the health sector makes it difficult to isolate dominant factors at play within a single framework or analysis (Overseas Development Institute, 2020), which is consistent with how Pallas and Ruger (2017) depict the landscape of effects in the framework.

Appendix B further details findings from eight studies that outline characteristics and concerns within the global health donor proliferation landscape in Malawi. This Malawi document review summary draws attention to diverse issues associated with central and subnational oversight, planning, and service delivery as well as multi-disease program performance (Borghi et al., 2017; Bridges & Woolcock, 2017; Chasukwa & Banik, 2019; Martineau et al., 2022; Marty et al., 2017; Ochalek et al., 2018; Walsh et al., 2021). Other studies highlighted complex yet interconnected incentive structures (Borghi et al., 2017; Bridges & Woolcock, 2017; Chasukwa & Banik, 2019) with tentacles reaching organizational, agency influence, and operating environment levels.

While the Pallas and Ruger (2017) framework organized the effects in a linear and multi-pronged fashion that informed the research approach to mapping out key factors, the need for further investigation is critical. The effects of global health donor proliferation in Malawi varied significantly across studies. This variability was influenced by key factors identified by Pallas and Ruger (2017), such as primary to secondary effects of global health donor proliferation, recipient conditions, determinants of performance at intermediate stages, and health performance and outcomes. Studies indicate that a deeper analysis of these variables is necessary to understand their relationships and impact fully.

Gaps

Gaps in Methodological Approaches

The literature and document reviews also revealed the persistence of gaps in standardization and a lack of agreed upon methodologies (Marty et al., 2017; Nunnenkamp et al., 2020). The student researcher encountered a multitude of methodological challenges described across studies. Recent research articles drew attention to constraints of data access (limited large data sets), contextual factors, and metrics (Duran & Glassman, 2012; Easterly & Williamson, 2011; Marty et al., 2017). These methodological challenges suggest that to examine global health donor proliferation effectively, there is opportunity for authors to improve on approaches undertaken and find common ground on how to manage an expansive and conflicting evidence base. Alternatively, the debate on global donor proliferation needs to be grounded in specific country case studies and district level data with more recognition of the limitations in large scale or global studies.

Aid critics, health, economic, and other analysts pursued efforts to understand the negative (and positive) associations, implications, and effects of global health donor proliferation, yet very few assert direct causality. An analysis of qualitative studies, including interviews, surveys, and issues mappings, alongside cross-sector systematic studies based on political, administrative, and judicial empirical evidence (Dijkstra, 2018), and desk reviews of select major policy or program areas (Borghi et al., 2018; Keijzer & Black, 2019; Nunnenkamp et al., 2020, yielded mixed positions. Evidence confidence varies as numerous factors, often referred to as “noise,” tend to show only slight certainty that rising funding levels directly cause one or more specific outcomes.

Gaps in Consensus on Indicators

Scholarly works were predominately led by academic and research institutions that gathered stakeholder information and analyzed global health donor proliferation, often from a focused rather than a multidimensional lens. The student researcher came across two think tanks whose work looked at more comprehensive indicators tied to the impact of donor effectiveness and proliferation. The Center for Global Development produces the Quality of Overseas Development Assistance report, and the Overseas Development Institute released the first Principled Aid Index report (World Bank Group, 2022). Indicators worth noting include level of untied aid, predictability of funding, use of country financial systems, and core support to multilaterals (Center for Global Development, 2021). In the second report, other indicators identified to monitor activities likely to impact donor proliferation and aid fragmentation directly were country-based pooled funds, levels of untied (unrestricted) aid, and core support to multilaterals (Overseas Development Institute, 2020). Measuring and assessing the increase of donors in the health sector, often linked to other sectors, presents challenges. The variety of methods available makes it hard to compare different sources and determine which one has the most significant impact.

Despite a limited number of studies initiated by donors (Borghi et al., 2018; Marty et al., 2017) and an absence of research led by heads of development agencies, there were ample opportunities for ongoing analysis of the immediate impacts. A detailed examination of the increase in donor agencies and implementing organizations, including their effects and the actual conditions in recipient countries (Pallas & Ruger, 2017; World Bank Group, 2022), was particularly significant. These recent findings on gaps in this chapter suggests that the project stands to contribute 2023-2024 global health development agency leader perspectives in Malawi where such data is currently absent.

Chapter 3

Methods

Study Design Overview

The project, a qualitative study, encompassed two parts. Phase one included the Malawi document and literature review followed by phase two, KIIs. Guided by the 2017 Conceptual Framework, Hypothesized Effects of Donor Proliferation (Pallas & Ruger, 2017), the research approach identified primary effects alongside those ascertained from reviews of additional documents (e.g., reports, policies, multi-year strategies, and media articles). The qualitative approach to explore real-time perceptions as compared to documented evidence of effects of global health donor proliferation formed the core element of the study design. The student researcher's knowledge of the Malawian context was imperative to leverage a respectful and trusting rapport during KIIs with i) development agency leaders and ii) central government.

Phase 1: Malawi Document Review Overview

A review of recent frameworks, relevant journal publications, professional association working papers, government websites, and international and development partner commentaries focused on Malawi constituted the bulk of phase one of the capstone. Recognizing that viewpoints on optimal and suboptimal effects of donor proliferation represent a subset of stakeholders, the student researcher included additional works that covered geographical (central and district levels), policy (national and donor-driven plans and strategies) and geopolitical (fragile, stable, and crises state) considerations. The review of literature, however, produced time and context-bound data, distinct from a historical or longitudinal evidence base. The inclusion and exclusion criteria explain the search and decision-making process in the next section.

Inclusion and Exclusion Criteria

The keywords "donor proliferation," "donor fragmentation," "Malawi," and "global health" plus "aid effectiveness" were used with the following databases to search for relevant studies via Radford University McConnell Library (Cinahl, DynaMed, Elsevier, Health Business Elite, Medline, ProQuest, Pubmed, and JSTOR); and Google Scholar. Using confined search parameters of 2017-2023 helped to focus on the most recent literature while ensuring a broader lens than the COVID-19 period. However, selection criteria of literature most relevant for the global health donor proliferation study required discernment and discipline. A subset of articles was identified that fit the following study settings: country case study at national, district and/or policy levels, with several published earlier years. See Table 1 for an overview of search results and actual literature reviewed.

Table 1

Number and Type of Documents Reviewed

Location	No. of documents reviewed	Type of document reviewed
Scholarly Databases	23 of 979	journal articles, literature reviews, commentary, critiques
Google Scholar	18 of 53	journal articles, case studies, working papers, assessments
Other Sources	9	websites, conference presentations, country archive reports
Malawi-specific	15	journal articles, policy reviews, working papers (think tanks, analysts' reports)
Government Portal	6	multi-year strategy, plans and reports
Total	71	*(991 excluded or did not meet search criteria)*

Narrowing this search was critical to isolate current Malawi-specific findings reported as positive effects, negative effects, or mixed outcomes in relation to the substantial global health funding flows noted in data sources. Inclusion of highly cited GoM reports was a complimentary

addition from the 2017-2023 period as well as critiques of the global health donor proliferation country situation such as working papers and media commentaries.

It is also worth noting other areas where sources were excluded. First, the term "donor" yielded numerous results related to organ donor and donor proliferation related to blood banks and organs. Next, research was excluded that focused heavily on nontraditional donors, new donor entrants, nongovernmental organizations, given the focus on the pre-selected development agency leaders. Last, where literature was devoid of a detailed examination of actual effects, associations, and or causal relationships in relation to donor proliferation, the work was excluded.

Data Collection

At the outset, the document review examined the primary effects of donor proliferation. The researcher became familiar with the body of research and, most importantly, evidence-informed practice, to develop the approach and instruments that allowed the researcher to conduct key informant interviews. Findings from the various databases were complimented by Malawi-specific country studies at national and sub-national level. Alongside journal articles, this second element of global health donor proliferation research on Malawi relied on grey literature: government, development agency, and academic institution reports and assessments.

The researcher lastly entertained the likelihood that during the study period, there may be additional research released. The significance and saliency of the topic meant that global, Africa-regional, and Malawi-specific literature could be recommended or identified on an ongoing basis. Two such works referenced for the researcher to review by key development agency leaders included the 2023 final report, The Lusaka Agenda: Conclusions of the Future of Global

Health Initiatives (2023) and the NGO Sector Report, fourth edition, produced by Malawi's NGO Regulatory Authority (2023).

Data Analysis

Combining Thematic Areas for the Interview Questionnaires. The student researcher examined multi-source information to identify recurrent themes on positive and negative aspects of global health donor proliferation. An overarching cataloguing of dominate categories generated from the literature reviewed resulted in Table 2, below. Pallas and Ruger's Hypothesized Effects of Donor Proliferation (2017) were captured alongside overlapping themes in seven Malawi-focused articles. KII questions informed by the various themes and research findings were an in product of phase one.

Table 2

Common Themes in Global Health Conceptual Framework and Malawi-Document Review

	Borghi et al.	Bridges & Woolcock	Chasukwa & Banik	Martineau et al.	Marty et al.	Ochalek et al.	Walsh et al.
Select Hypothesized Effects of Donor Proliferation (Pallas & Ruger, 2017) Categories examined in the Conceptual Framework salient in Malawi Documents							
Growth in Number of Donors vs Volume of Aid Flow Tensions	X			X			
Donor competition & cooperation tension	X	X		X			X
Govt. & Country Control of Aid Debate		X	X				X
Loss & Departing of Govt. Staff			X	X			X
Parallel administrative systems for aid mgmt.		X	X				
Dispersed & Diffused Accountability for health/development outcomes		X	X		X	X	X

Table 2 (Continued)

Common Themes in Global Health Conceptual Framework and Malawi-Document Review

	Borghi et al.	Bridges & Woolcock	Chasukwa & Banik	Martineau et al.	Marty et al.	Ochalek et al.	Walsh et al.
Select Hypothesized Effects of Donor Proliferation (Pallas & Ruger, 2017) Categories examined in the Conceptual Framework salient in Malawi Documents							
Fragmentation with small share of total aid with each donor			X				
Transaction Costs & Market Distortions		X	X				

Source: Pallas & Ruger, 2017; Borgi et al 2017; Bridges &Woolcock, 2017; Cashukwa & Banik, 2019; Martineau et al., 2017; Marty et al., 2017; Ochalek et al., 2018; Walsh et al., 2020

This study goes from the broader literature or hypothesized effects to Malawi-specific studies identified described in the subsequent Results section on dominant themes and considerations.

Phase 2: Key Informant Interviews

Study Design Overview

The KIIs comprised of selection of development agency and GoM leaders. As described subsequently, key activities involved the development and refinement of the recruitment strategy, administering of consent and related participation forms, and conducting the interviews with permission provided for recording or self-note taking. The researcher ensured alignment with the two institutional review board requirements and recommendations at each step. The upcoming sections provide further details on the selection criteria and U.S. and Malawi-based reviews. Chapter 4 findings delve into results in relation to actual study population, setting, recruitment, and data collection with final instruments and KII analysis activities.

Inclusion and Exclusion Criteria

In terms of development agency leadership composition, the United States remained the largest health sector donor at 28%, providing 1/3 of support to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The United States Government, second largest at 16%, was also through bilateral support. Other funders, such as the United Kingdom at 5% (Ministry of Health, 2020; World Bank Group, 2022), provided additional contributions. See Table 3 for the inclusion and exclusion factors for the target development agency leaders.

Table 3

Study Populations Selection Criteria

Inclusion	**Exclusion**
Long standing health sector donors OECD Countries Prominent Bilateral agencies supporting multi-disease programs Main Multi-laterals supporting multi-disease programs Health sector-centric National Government and Health Independent Body	New donors Non-OECD (China) Smaller Bilaterals (Norway, Japan) Multi-laterals focused on specialty areas (World Bank, African Development Bank) New Taskforces/Clusters (COVID, cholera, cyclone) Other line Ministries

In addition to development agency leaders, involvement of central government leadership as mentioned represented the other KIIs. The student researcher sought to gather GoM perceptions from ministries of health, planning, and finance, as well as local government. However, the Ministry of Health (MOH) was the focus.

The student researcher purposively selected a target of 15 proposed key informant interviewees. Of the individuals identified and contacted, 10 responded. For the KII study

population, directors within Malawi's health and planning directorates, key bilateral development agency leaders (the United States and United Kingdom), and multilateral development agency leaders (The Global Fund to Fight AIDS, Tuberculosis and Malaria and United Nations AIDS agencies) participated. Germany did not respond to their two invitations, and only one of the two donors providing funding from the United Kingdom participated.

Of the 10 interviews conducted from December 18, 2023, through January 15, 2024, the U.S. government agencies that took part in the study included the Centers for Disease Control and Prevention (two leaders), the United States Agency for International Development (one) and the U.S. Department of State (one leader). The United Kingdom participated through the Foreign, Commonwealth and Development Office (one leader). For the multilateral agencies, the participation consisted of the Joint United Nations Progamme on HIV/AIDS (UNAIDS) and the Global Fund. The above participants represented a total of five leaders from one U.K. and three U.S. bilateral agencies, and two leaders from two multilateral agencies, so six donor agencies overall.

The GoM participation constituted three leaders from the MOH. The central government representative from the Department of Planning, a representative from the Project Implementation Unit, and a former Secretary for Health were senior officials spanning three departments. As stated in the recruitment results section, the Department of HIV and the National AIDS Commission and district level leaders did not respond to the request to participate. Considering leadership shifts and vacancies, GoM leaders were excluded from the National AIDS Commission and Ministry of Local Government. See Appendix D for background information on the key leader participation (n = 10).

Of the 10 total study participants, five were female and five were male. Education levels were split evenly as well, with half graduate degree holders and the remaining with doctoral degrees. In terms of nationality, six leaders were Malawian citizens, two were Americans, and the other two were citizens of Gambia and the United Kingdom. Most interviewees stated they lived in Lilongwe, Malawi as permanent residents (six). Development agency leaders who resided in Malawi (two) were on 2-year assignments, and the remaining leaders were based in the United States (one) and Europe (one). Three bilateral, two multilateral, and two government respondents reported being active members of a donor group. The two development agency leaders that were not members gave reasons for not joining the health donor and HIV and development partners donor groups, because the need for adequate representation had already been met.

Most of the participants opted to meet the student researcher under a five-mile radius from their individual offices or at the home of the student researcher. The Global Fund leader based in Geneva, Switzerland joined and completed the KII via Zoom video, as did the State Department leader based in Washington, DC.

Recruitment Strategy

The recruitment approach entailed outreach to senior multilateral (up to four), bilateral (up to eight), and GoM (up to five) participants. Two recruitment strategies were used to contact key development agency and GoM leaders: purposive targeting of key and known health and development leaders and elicited leader recommendations. Communication included official letters by email signed by the student researcher contained in Appendix E, the Letter of Invitation. Follow-up WhatsApp messages sent yielded a response with delays in email replies from five of the 10 participants. Scheduling the interview times was guided by the participant's

preferred time and location, and each person was offered $10 USD, required by the Malawi Social Science Committee, of which seven declined.

The final aspect of recruitment procedures was alignment with feedback from the two institutional review boards. Information was provided in more detail about volunteerism, people to contact should a complaint arise, and the option to opt out of participation and recording at any time. The researcher remained flexible and responsive in refining the recruitment strategy to account for any changes. The next section provides approval details for the U.S. and Malawi processes and study reviews.

United States and Malawi Institutional Review Boards

The Radford University Carilion Institutional Review Board (IRB) provided expedited review of the study before initiation. The student researcher met university requirements and received approval October 3, 2023, for the study protocol IRB 2023-095. An application was also submitted to the local IRB in Malawi for their review of the study protocol following the Radford University process. The Malawi Committee on Research in the Social Sciences and Humanities approved the proposal as November 23, reference number NCST/RTT/2/6, following two rounds of researcher feedback on the study budget and a compensation offering requirement for study participants. See the official letter in Appendix F.

Instruments

Following IRB approval, several instruments were finalized to carry out KII effectively: the Demographic Survey, Consent Form, and Interview Guides (Questionnaire A and B). The student researcher administered a pre-interview demographic survey where development agency leaders were asked to provide details. These forms were also re-explained after an overview of the study objectives and time commitment were provided. A voluntary consent form (Appendix

G) was emailed for individuals who participated or recommended a colleague. With a focus on bilateral, multilateral, and government-specific questions on Malawi's global health donor proliferation experience, the student researcher utilized the interview guide previously referenced in Appendix C. All instruments were revised and re-branded following guidance from the Malawi IRB recommendations.

Chapter 4

Findings

Phase 1: Malawi Document Review Results

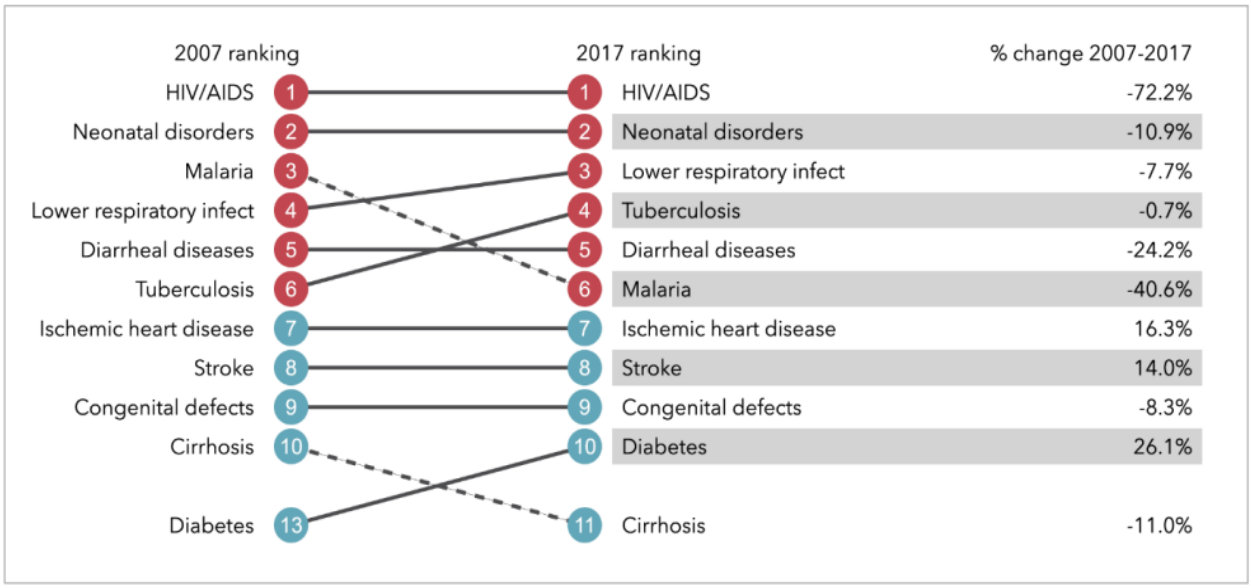
Research question 1: What effects of global health donor proliferation on Malawi are reported in the literature?

Gains made in access to public health services are cited as a byproduct of partnerships between GoM, bilateral, and multilateral partnerships (Kavanaugh & Chen, 2019; Marty et al., 2017; World Bank Group, 2021; Wandjowo, 2020). With respect to specific indicators and care improvements—mother and newborn health, HIV/AIDS, and malaria—complementary data demonstrates how lifesaving investments and interventions flow from global health donor support (Ochalek et al., 2018). Substantiation of this claim largely stemmed from the 9.3% of the national budget spent on health (2020-2021) by the central government that has yet to increase despite domestic resource mobilization commitments set in the 2023-2030 National Health Financing Strategy (Government of Malawi, 2022b).

Recognition and shared responsibility were openly cited in local news with respect to the need to meet regional health financing goals (Mzungu, 2021). The external funding assistance amidst Malawi's constrained fiscal and socioeconomic prospects presents another illustration of the significance of global health donor assistance partnerships, which links to beneficial aspects of proliferation. The high percentage of funds from donor agencies serve as key financiers of program, project, and personnel-related costs (Ministry of Health, 2020) with varying support in the 28 districts, hence communities as well as populations reached (Marty et al., 2017). The Ministry of Health (2020) released a brief on changes in the leading causes of death from 2007 to 2017, where the national response was almost entirely donor funded. Figure 3 depicts gains and persistent challenges by disease and rankings in the causes of death as well as changes in these over a 10-year period.

Figure 3

Leading Causes of Death in Malawi



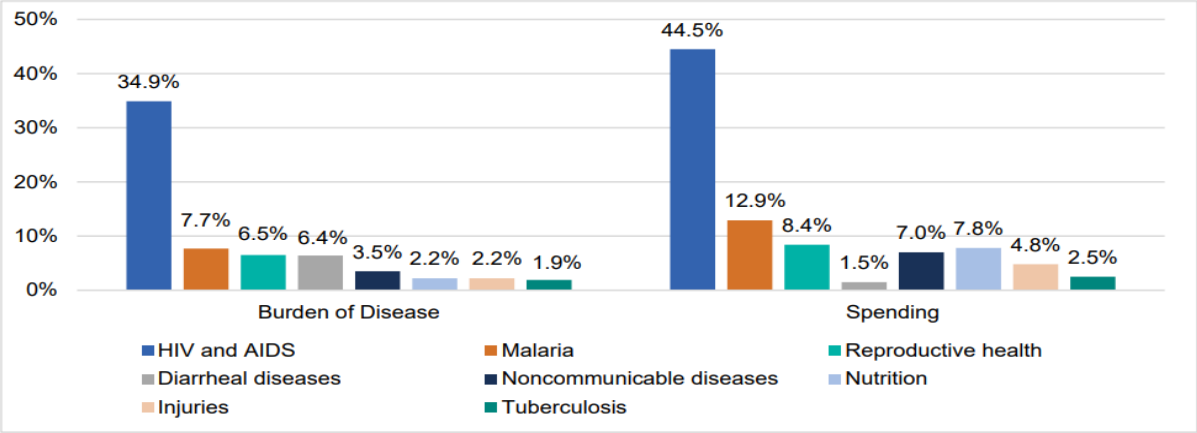
Source: Institute for Health Metrics and Evaluation, 2017

Improvements in health outcomes associated with global health donor proliferation have demonstrated contributions toward the wellbeing of many Malawians; however, some of the population is still dying from preventable diseases. Uneven progress is visible as data reveals gaps in financial and service delivery support to address the fastest growing causes of death: diabetes and other non-communicable diseases (NCD). Figure 4 lays out resource allocations by burden of disease as compared to spending level (Ministry of Health, 2020). When compared with overall per capita health spending, the analysis of gains reveals areas where funding did not meet the anticipated needs, to a certain degree. For example, diarrheal diseases constituted 6.4% of the burden of disease, yet spending on that area was limited to only 1.5%, a major under-allocation. The comparison of disease programs below highlights the need for detailed analysis of increased funding beyond the overall sum to accurately identify where there is a growth in

global health donations for specific diseases within a country, and where such growth is absent or is still needed.

Figure 4

Burden of Disease Compared to Percentage of Total Health Expenditure, Malawi



Source: Ministry of Health, 2020

Funds allocation for multiple health threats and combatting persistent ones like malaria remained priorities for donors in the form of support of NCD and malaria diagnosis, prevention and reduction targeted hard to reach areas, high volume health facilities, and for patients living with multiple diseases. Two notable benefits were improved basic health infrastructure and parasitic and infectious disease control across both wealthy and less wealthy districts in Malawi (Marty et al., 2017). The combined examples of higher life expectancy and quality of care for clients receiving preventative and curative public health services (Government of Malawi, 2022; Kavanaugh & Chen, 2019) initially suggests positive effects of global health donor proliferation in the study country's low-income setting. However, further examination is needed at the district, oversight, and stakeholder levels to gain a more comprehensive understanding.

Health Governance

While progress made in combatting multiple diseases in Malawi can be attributed in part to global health donor or external financing, larger health governance-related effects have been documented (Armstrong et al., 2019; Keijzer & Black, 2019). From the vantage point of government-specific benefits, it is important to delineate differences that touch upon bilateral and multilateral donor considerations in addition to that of the national-recipient government. The U.S. government and the Global Fund, for example, expanded support in Malawi through various special initiatives, such as programs to reach young and vulnerable populations and to strengthen health information systems and respond to health threats such as pandemics (Armstrong et al., 2019; United States Government, 2022). These initiatives have created new platforms for collaboration, as the Government of Malawi develops and updates multi-year strategies. Within these platforms, donors have the opportunity to contribute to and shape both policy and implementation efforts (Fuchs et al., 2015; Nunnenkamp et al., 2016; Walsh et al., 2021). As interactions and financial contributions have not waned, increased donor cooperation and stakeholder consultations remain a work in progress (Lundsgaarde & Engberg-Penderson, 2019; Martineau et al., 2022; Walsh et al., 2022).

Other effects of donor proliferation tied to the GoM specifically coincided with competing elements of relationships. On the one hand, a subset of analysts adopts the position that the MOH stands to gain disproportionately from increased funding flows (Adhikari et al., 2019; Yoon et al., 2021). Positive aspects include areas of flexibility in how ministry departments guide health sector priorities, redirect any cost savings, formulate plans, and use evidence-informed decision making. Recent articles that document oversight roles of coordination, development of service delivery packages, and management of human resources for health (Martineau et al., 2022; Ochalek et al., 2018; Walsh, 2021) demonstrate the active

roles that the MOH plays in leveraging inflows of resources to do more. These advantages, however, do not detract from the dynamic and evolving environment that involves navigating multi-global health donor restrictions and influences (Walsh, 2021).

Financial Oversight

Alongside government ownership considerations, the larger fiscal space to operate with external resources indicates an undeniable reality—increased policy and program driven stakeholder engagements. Donor proliferation enables more in-country planning, meetings, services, and implementation activities to flow and flourish, put simply (Bridges & Woolcock, 2017 Martineau et al., 2022). Even where global health donor agencies are known to exert inputs or make shifts affecting national priorities, the central government has the autonomy to determine the appropriate scale, site, and "best buys" in annual and multi-year health programming. Ministry units and directors also serve as the driver and custodian of service and program appraisal modalities while leading on the determination of age-specific service delivery packages (Kavanaugh & Chen, 2019; Ochalek et al., 2018).

Perhaps the most powerful illustration of effects of donor proliferation associated with health governance remains tied to financing. In GoM's public sector budget, investments in health have stagnated between 9-9.5% (Chansa et al., 2020; Ministry of Health, Malawi, 2020). The upshot of this prolonged historic underinvestment has meant access to other funding sources. Bilateral and multilateral development partners plug some of the health financing gaps in response to strategic plans that have costed out need by disease intervention (Chansa et al., 2020; Government of Malawi, 2023; Ministry of Health, Malawi, 2020). This health sector aid truism in the donor proliferation landscape in Malawi gets promulgated in different forms. For instance, the $55 million cost of Malawi's Health Sector HSSP3, as reported by the Government of

Malawi in 2023, lacks a clear statement on major public sector funding, highlighting a common practice (Government of Malawi, 2023).

Like predecessor health sector strategic plans, the HSSP3 included calls for reinvigorated support with less focus on strategies for domestic resource mobilization (Chansa et al., 2020; Walsh, 2021). Consequently, a steady stream of external support flows in from both long-standing and new donor countries, eager to stake their claim and contribute to disease programming. This trend might reflect a tacit approval of the existing situation. Given that Malawi has outperformed other regions in global health achievements with one of the lowest per capita spending levels, especially when compared to other low-income African countries (Chansa et al., 2020; World Bank, 2022), this scenario suggests both a benefit and a challenge of dependency. Global health donors and the GoM appear to mutually favor ongoing external support to address the health needs of the population, particularly in light of the country's enduring macroeconomic difficulties (Government of Malawi, 2022; Government of Malawi, 2023; Kavanaugh & Chen, 2019).

Negative Effects/Concerns in Relation to Global Health Donor Proliferation in Malawi

Local Structures. Understanding global health donor proliferation warrants attention from the perspective of its unintended consequences. A focus on effective management of funds, for example, necessitates special staff and procedures designated to help ensure the success of programs. These resources, however, arguably also lead to bypassing local institutions and systems (Chasukwa & Banik, 2019). Creating parallel management and procurement systems not only has a cost component, but both may weaken accountability (Easterly & Williamson, 2011; Klingebiel et al., 2016; Page, 2019; Pallas & Ruger, 2017). Global health donor efforts aimed at safeguarding resources to better reach Malawians are widespread, ranging from investments in

subject matter experts and information technologies to independent auditing and reporting services (Keijzer & Black, 2019; Kiendrebeogo & Meesen, 2019). In many cases, donors must meet requirements as part of the terms for receiving support, but these requirements can result in leadership and bandwidth challenges. Articles highlighted that the GoM's capability for oversight and their direct access to central managers responsible for driving programmatic, financial, and other priorities—including direct implementation—was frequently and significantly hindered (Asongu & Nwachukwu, 2016; Chasukwa & Banik, 2019).

Tension and Complexity of Multi-Layered Effects. Focusing solely on the weakening of bureaucratic authority associated with global health donor proliferation and the ways in which it undermines the GoM is problematic. The view of GoM's control in their role as custodians of their population's health should be entered into with caution. An oversimplification of a bidirectional (recipient government to donor government) problem should be avoided and replaced with multi-stakeholder inputs and experiences within the broader landscape. Various works emphasize the need to recognize concepts and modalities of shared ownership across a range of actors, which takes government out of the center (Keiijzer & Black, 2019; Lundsgaarde & Engberg-Penderson, 2019). In addition, understanding traditional global health donors alongside civil society, new donors, and ramifications in a changing environment raises important questions about the limitations and legitimacy of data. Where financial, program, and/or disease specific data is deemed as a static property rather than one that comes with several nuances, there is an opportunity to complement findings with real-time and real-world inputs from a specific operating environment.

There are well-documented tensions between control at the central, sub-national, and community levels. There is a need to expose where existing studies neglect the layered, dynamic,

and relational aspects of donor proliferation and cooperation within the global health sector (Nunnenkamp et al., 2020 Walsh et al., 2019). The debate often revolves in circles regarding who possesses and upholds the authority to convene discussions, develop policies, enact reforms, and ensure accountability, especially when examining these issues through a lens of balancing risks and rewards. Power and authority bestowed in certain ministry level decision-making structures gets re-negotiated and shared often across entities (Walsh et al., 2019) and the detriment to national ownership may stem from different directions: internally and externally with multiple stakeholder self-interests (Keijzer & Black, 2019).

Funding Misappropriations and Abuses. The story of corrupt practices associated with global health-related (and development) funds in Malawi runs the gamut from subtle or small scale to egregious. In mainstream media, references were made to misuse of GoM position and resources in the health sector and special pandemic response initiatives (Kachinziri, 2022; Mzungu, 2021). The widely covered 2013 “Cashgate” scandal, where roughly $32 million in misappropriation of funds occurred, continues to be referenced today, serving as a poignant reminder of gross abuse and corruption when accountability chains were weak and broken (Adhikari et al., 2019; Bridges & Woolcock, 2022). Several recent analysts also point to deepening indications of GoM and global health donor community friction and fragmentation resulting in harm that affects the very projects, people, and policies intended to be served, especially at subnational level (*Lusaka Agenda*, 2023; Bridges & Woolcock, 2017; World Bank, 2022). While some literature asserts the far-reaching impact of aid volume on development outcomes, the relationships with counter effects of spillage and corruption remain blurred.

Reduced accountability took the form of diverting funds for program use in other ways. Development agency leaders may require tasks and interventions poorly suited for the context,

with pressure to spend money and show impact (Caselli & Presbitero, 2020; World Bank Group, 2022). Ministries of health can also divert essential resources through overuse and abuse of their roles such as with daily subsistence allowances tied to travel, conferences, and site and supervision visits (Soreide et al., 2012). The lack of concerted action among the donor community to improve the perverse incentive structure found in the long-standing allowance-seeking culture arose as a historic and current issue.

Areas of Bi-directionality and Contention. The merits of literature continue to be situated within competing concerns and bi-directional evidence of mixed effects of donor proliferation in the health sector. The dichotomies at which to delineate the positive and negative or unintended effects depend on the unit of analysis. Four dominant themes in the form of debates were noteworthy: i) disparities in global health donor allocations at individual agency and geographic channels (Martineau et al., 2022; OECD, 2021; Page, 2019), ii) limitations of aggregate or national results as compared to district level results, iii) tensions between accountability structures and incentives across donor country government and GoM (Fuchs et al., 2015; Chasukwa & Banik, 2019; Overseas Development Institute, 2020), and iv) complexities in assigning benefits over an extended period of time given transactional, sociopolitical, and other dynamic environmental considerations (Biscaye et al., 2016; Pallas & Ruger, 2017).

Assessing effects of increased global health donor activities on population health proved to be contentious. Select literature revealed no consistently defined association between changes in health finances and health outcomes (Borghi et al., 2017; Nunnenkamp et al., 2016). For an aid analyst or critic to disentangle the effect of global health donor proliferation from the reverse effect is extremely difficult. Variables and results depend largely on “samples, data, time periods and estimation methods” (Dijjkstra, 2018, p. 231). Although there is a wealth of evidence

showcasing a range of successes and failures, it often comes with numerous caveats regarding the uniqueness of country-specific situations, which limits its generalizability and applicability to different contexts.

Beyond the scholarly literature and working papers identified, Malawi-specific case studies demonstrated that the effects of donor proliferation shift in a pendulum-like manner. These case studies focused attention on a lack of project-based aid coordination and related deterioration of bilateral and multilateral global health donor-funded projects (Nunnenkamp et al., 2016). Alongside these concerns, positive considerations were documented that point to spillover effects of multi-donor assistance (Dijkstra, 2018; Kavanaugh & Chen, 2019). Spillover effects refer to benefits that impact non-health sectors such as education, planning, local governance, and other domains due to the interwoven nature of health and development efforts (Dijkstra, 2018).

Recent studies have shed light on the significant limitations of cross-national research, highlighting how such studies often overemphasize negative outcomes (Dijkstra, 2018; Marty et al., 2017). There is also a recognized need to gain a more detailed understanding of how a single country contributes to the widespread adoption or "use proliferation" of certain practices (Word Bank Group, 2022, p. 6). Aggregate data often masks complexities in understanding drivers of negative outcomes and undesirable health outcomes. For example, depending on a given district, global health donor proliferation may not be widespread in terms of growth in new programs and activities. Gaps in support where urban and wealthier districts are highly prioritized and rural districts deprioritized were identified as undermining progress. In studies that focus on data at central level, these disparities become less apparent (Chasukwa & Banik, 2019; Marty et al., 2017).

For the final step of phase one, the student researcher identified several effects of donor proliferation and integrated those effects into the KII instruments. Some of these integrated effects revolved around the perceptions on global health donor proliferation by development agency and government leaders, tensions created by competition and cooperation, and outcome related queries related to administration, management, and human resources. See Appendix C for the KII questionnaires. Given the different positive and negative effects of global health donor proliferation found in the literature and Malawi document review, the student researcher selected only a subset of topics to stay within allotted time for KIIs and for project feasibility.

Phase 2: Key Informant Interview Results

Data Collection

Actual interviews were carried out based on schedules communicated and within time allotted for each bilateral, multilateral, and GoM participant. Most interviews provided data over a 60-minute period with one up to 84 minutes in duration. The 84-minute discussion was with a development agency leader (multilateral) and the shortest, 46 minutes, was with a development agency leader (U.S. bilateral). Table 5 provides an overview of participant details following completion of the 10 interviews, breaking down study participant type, date of interview, consent decision, and duration of interview. One development agency leader declined the request to record the interview, so data collection relied on handwritten notes only. This same bilateral leader opted out of responding to the questions on multilateral donors. She cited inadequate information on the topic and a time constraint. The other nine KIIs completed questionnaires with data collection instruments.

Table 5

Key Informant Interview Schedules and Consent Register

Study Participant	Interview Date	Consent Decision	Interview Duration

Government 1	12/15/2023	Accepted	61 minutes
Government 2	12/20/2023	Accepted	57 minutes
Government 3	1/15/2024	Accepted	54 minutes
Bilateral 1	12/18/2023	*Accepted except Recording	46 minutes
Bilateral 2	12/19/2023	Accepted	65 minutes
Bilateral 3	1/3/2024	Accepted	62 minutes
Bilateral 4	1/4/2024	Accepted	50 minutes
Bilateral 5	1/11/2024	Accepted	57 minutes
Multilateral 1	12/12/2023	Accepted	65 minutes
Multilateral 2	1/15/2023	Accepted	84 minutes
**One study participant declined to be recorded and chose no for that option on the Consent Form.*			

In-person interviews included a brief welcome and introduction followed by an overview of the purpose of the study and a request to record the interview. Responses were documented through handwritten, a voice recorder application, and Zoom transcription application. The general mood or tone of the discussions, jotted down at the time they occurred, was universally friendly, open, and communicative.

Scanned hard copies of interviews were thereafter typed to prepare final versions for transcription. A summary of key details captured as part of data collection consisted of final interview count, key demographic profiles of respondents, and completion status with specific start and end times. This post-interview data collection step with use of voice recorder for the first three interviews was disrupted by poor quality of transcription of various African accents so the researcher had to return to audio and re-capture key responses. In the interest of time,

transcription relied on a mix of handwritten notes and segments of recording where there were major gaps.

Data Analysis

Key informant interview data and responses were analyzed by the student and faculty researcher (Dr. Sallie Beth Johnson) using Dedoose, a web-based application to support qualitative data organization, coding, and major theme identification for a subset of KIIs. Deductive coding was applied to map interview a core set of responses for the word map and isolating aspects of major themes. Descriptors for Dedoose analysis included types of development agency, leader membership on donor coordination structure, years of residence in Malawi, and country office presence.

Categories of effects of global health donor proliferations—positive, negative, mixed, and recommended—fed the analysis of key themes, minor themes, and quotations captured in a detailed document. Major themes encompassed responses identified by seven or more study participants. Minor themes were characterized by accounts made by five or less participants during KII. For the hypothesis two and three investigation, more detailed mapping and synthesis of positive and negative effects by group and frequency were undertaken in comparison with the Pallas and Ruger (2017) Framework of Hypothesized Effects of Donor Proliferation in the Health Sector. This last stage of analysis re-assessed a sort of ranking in the most common or major themes, secondary or minor themes, and "other" data such as recommendations associated with global health donor proliferation in Malawi.

Overarching Key Informant Interviews' Results

The study identified study participant profiles, demographics, as well as themes and recommendations from the donor and central government's responses to donor proliferation in

Malawi. Major themes emerged from the KII revealing both positive and negative effects of global health donor proliferation in Malawi in relation to health outcomes, financing, workforce, infrastructure, as well as time and management-intensive burdens. Minor themes described donor and central-to-local-government relationships and inequities in multi-disease programming, time and management burdens, and coordination. Most development agency leaders expressed concern about the future. In addition to study participant-specific data, the results section also includes select quotations on perceptions, observations, and experiences. Where present in seven or more study participants, these responses were categorized as major themes; if raised by five or less participants, they were deemed as minor themes.

Results of the Study – Positive and Negative Themes

Research question 2: What positive effects of global health donor proliferation in Malawi do key leaders identify?

Positive Effects

The major themes from study respondents included a recognition of positive effects of global health donor proliferation. Five themes extracted from accounts comprised of beneficial elements: i) longstanding partnerships; ii) improved health and health-related outcomes; iii) dedicated resources for health financing; iv) investments in human resources for health; and v) the Health Sector Strategic Plan three. While not exhaustive, topics are multi-dimensional and interconnected with some of the concerns articulated. The web interwoven mirrors the image of coexisting positive and negative respondents reflected upon in each interview.

Longstanding partnerships cited described the United States as the trusted partner with continuous support that predated many bilateral donors and outlasted a range of them. Malawi was said to be able to achieve increased years in life expectancy, decrease in maternal and child

deaths, and effective prevention and treatment of HIV/AIDS and malaria, in part due to the leadership and funding from the United States. The various quotes that follow illustrate the special attention to health-centric gains and the gratitude for this single bilateral donor, the United States, and some of the intricacies of global health partnerships:

- "The US was there when budget support was flowing and also there when there was no budget support." (Female Bilateral leader)
- "…the investments and contributions in treatment and antiretroviral medications, systems strengthening, human resources for health – PEPFAR areas. The number of new infections have gone down from 110,000 in 1992 in Malawi to 15,000 in 2023; 70,0000 AIDS related deaths down tied 12,000 and this would not have been possible without the reliable and predictable commitments of multiple donors." (Male, Multilateral Leader)
- "It is insane the number of donors because the donors don't come as a single entity...they're like maybe a thousand pieces that come with us so it's not actually just labeling it the US government, it is the US government, it's agencies, the agencies, contractors and partners that it interacts with…. It's a sign of capability on the recipient country side that they want to question this approach." (Female, Bilateral Leader)

In addition to the role of partnerships and contributions to reach communities and improve their health, health sector financing was perceived as a major effect of proliferation among key donors. Respondents described how multiple global health donors provided funding that could be directed to addressing multiple diseases and needs. Multilateral leaders especially

also stated that with Malawi's low-income status, and economic and fiscal challenges, the central government depended on its allies—bilateral and multilateral partners—to procure essential drugs, commodities, technical assistance, as well as other investments. Other investments described span health service delivery projects, workforce support, and community systems strengthening, for example, referenced in KII with government.

Accounts of how important and significant human resources investments were in Malawi spanned every key informant interview. Respondents suggested that, even if donor-supported staff are mobile, leave and start new positions, or get different compensation, they are a part of the success story in global health. In efforts where global health donors have affected change, funding for community, facility, and Ministry of Health-based workers benefit the country at different levels. Such assertions also pointed to genuine risks in distorting of the salary market when donors pay exorbitantly more in their human resources for health budgets while recognizing that retaining these health professionals through those measures are better than losing them to neighboring countries and/or Europe. A number of development agency leader respondents described the effects of multi-donor funding for human resources and across health threats:

- "From a human resources perspective, global health donor resources are building capacity of Government of Malawi counterparts and working to make programs stronger especially for HIV, malaria and TB programs. Sometimes it gives rise to opportunities for the Government to relax which is a concern." (Female Malawian, Bilateral Leader)
- "I will highlight NGOs not the ministry positions. There are an increased number of NGOs….Donors benefit from Malawian staff movement from Government to NGOs

ad NGOs implement. Low government salary is an issue and with….imposed austerity measures and effects on the wage bill, Government's hands are tied, not able to increase civil service salaries." (Female Malawian, Bilateral Leader)

- "[Ministry] Secondments are short term attempts and often not done properly so building support of people while they are in positions is key. Secondments cannot end up doing everything on their own." (Male Malawian, Bilateral Leader)
- "Significant multilateral effects…. Arrival of new funding sources through World Bank and GFF have been significant in terms of resources like $200 million for primary health care that has kept the health systems on its feet during a very turbulent fiscal time." (Male, Multilateral Leader)

Respondents described the HSSP3 as a guiding force and priority related to the global heath donor proliferation issue in Malawi. The HSSP3 was referenced by eight of the 10 interviews using different terminology. Reasons for how donors and the GoM interact, assess gain and gaps in disease programs, as well as how they lead interventions, were linked to elements on the HSSP3 and its multi-stakeholder development. In addition to this national five-year strategy, bilateral, multilateral, and government leaders agreed that global commitments contained in the Sustainable Development Goals and Millennium Development Goals, for example, help countries to make progress toward the journey to universal health care. Even respondents who had previously registered negative or mixed effects on donor proliferation in Malawi's health sector referenced the significance of operationalizing the HSSP consistently. Multiple comments demonstrated the overarching value of the contents of the HSSP3:

- "I think you know the focus should be on the One Plan and how best we can calibrate the systems of accountability before you move onto One Budget." (Male, Multilateral Leader)
- "The HSSP pretty much lays out a responsible roadmap and a lot of the work has been done in prioritization. What should take precedence over what needs de-prioritization, what is incremental verses what are whole sum gains, all need attention and clarity." (Male, Multilateral Leader)
- "Malawi has been good at guiding donors and the national health plans, HSSP one, two three and now four." (Female, Bilateral Leader)
- "If committed to the HSSP3, we need to engage the Ministry of Finance such as in the detailed implementation plan, force and pick at, reveal and assess activity-level support and contributions, meaningful commitments that get evaluated for impact." (Female, Government Leader)
- "The good thing is that when we're developing this strategic plan [HSSP3]…it was an all inclusive process and in Malawi we have what is called the health donor group, the part of the team that worked with ministry to develop this strategy so it's our document. We're now in the implementation stage. I'm hoping that we will be in it together and follow the same priorities we have." (Male, Government Leader)

A summary of major and minor positive themes captured responses to research question two. These build on findings from the background literature review and the Malawi document review that addressed research question one. Whilst not meant to be exhaustive in content derived from the 10 KIIs, Table 6 summarizes select recurrent statements and accounts identified by the researcher.

Table 6

Summary of Positive Themes

Major Themes	**Minor Themes**
Long standing health sector donors	Shared Global Goals and Indicators
Life expectancy & community health	Reliability of Funds
Health Sector Financing	Competition and Cooperation
Human Resource Investments	Inter-Donor Contributions and Complementarity
Health Sector Strategic Plan Mandates	Multilateral institutions' new funding *(World Bank,*
National Government and Health Independent Body	*African Development Bank, Global Financing Facility)*

Research question 3: What negative effects of global health donor proliferation in Malawi do leaders identify?

Negative Effects

Other themes were elucidated from KIIs that demonstrate negative effects of global health donor proliferation in Malawi. Qualitative data collected from the respondents revealed several adverse findings for research question two: i) bypassing local systems and structures, ii) donor dependency, iii) domestic resource mobilization gaps, iv) information systems proliferation, and (v) management and time burdens. The high frequency of these areas warrants further details provided in the subsequent section on these major negative effects.

Local Systems and Structures. A major theme among Government respondents was how multiple donors over-utilize external systems. Outsourcing and direct agreements for procurements, implementation, and contracting were dominant vehicles for projects, for example. Donors themselves and government leaders described ways in which global health work bypassed national structures and local systems. The statements offered revealed a dominant

concern in the lack of genuine attempts and decisions to identify and imbed a larger proportion of global health work within government-established structures or indigenous or Malawian-led organizations. Development agency leaders and GoM perceptions of these negative effects were illustrated in several statements:

- "Some partners don't use the national system. They are going according to the priorities they have set and that brings problems. And also there is an issue of looking at specific programs and supporting them, supporting them heavily and yet others are suffering." (Male Malawian, Government Leader)
- "Government of Malawi has to manage multiple partners and for example districts ability to reallocate funds is the biggest challenge and limited flexibility to change priorities. In many cases, you partners just going to partners. Its more than a proliferation issue….the sheer number." (Male Malawian, Government Leader)
- "Many donors bypassed Government of Malawi systems and supported NGOs, for example. Then when resources go missing by the NGO, donors then come start asking government to be accountable for this part of that deal." (Male Malawian, Government Leader)

Reasons referenced for not going through local and public sector vehicles with donor funding were associated with lingering effects of the 2012 Cashgate financial scandal in Malawi. This scarred period of corruption and the historical introduction of daily allowances driven externally by donor-funded partners competing amongst themselves arose in several KII. One particular development agency leader and two GoM respondents stated:

- "What is visible for me is the changes after CashGate, the indirect budget support. Here many donors stopped giving direct support to the Government and shifting to

having funding go through to third party implementers which continues to an extent today." (Male, Bilateral Leader)

- "With the history of Cashgate, likely that each donor will have additional mechanisms to develop and use in Malawi." (Male, Government Leader)
- "….a number of these NGOs and partners….fighting for the same health worker, told them, we'll give you a daily subsistence allowance….10 Malawian kwacha payment. The other one is trying to offer the same health workers [more] kwacha on the support side so that's in a way a competition…after some time professionals got addicted to that and jumping from one meeting or training to another." (Male, Government Leader)

The disparities in funding going from central level to district level were also mentioned. Bypassing district structures was also highlighted by government leaders as missed opportunities to have more locally led oversight.

Donor Dependency. Respondents communicated a range of concerns in relation to excessive donor dependency in Malawi among bilateral and multilateral leaders. The KIIs included references to a dominant mindset or expectation that global health donors, "our friends," would always be there to assist. Consequences of donor dependency were viewed as Government being compromised in its reliance on external assistance. The inaction and lack of funding allocated for their national health response represented a recurrent theme. All respondents described a form of dissatisfaction or lack of urgency with domestic resource mobilization. Bilateral leaders were quite vocal in constructive criticism of the mix of large, small, and very small donors that contribute to proliferation, but multilaterals also expressed their concerns in the resources available that provide the environment for donor dependency.

These quotations capture some responses on different aspects as well as complexities of donor dependency:

- "At some point, some sort of relaxation by Government of Malawi happened as they were not throwing their weight. You have to recognize that external funding accounts for 80-90% funding by partners. Then development partners came with earmarks tied to their support…, fragmented service delivery and at district level, a lot of fragmentation." (Female Malawian, Bilateral Leader)
- "Over the last years, there has been an increase in donors, so I feel that can be a good thing for Malawi and also it can take away from the responsibility of Government to take on health financing and explore the best local options." (Male Malawian, Bilateral Leader)
- "The partnership with the private sector is underutilized. Often we focus on getting their money rather than tapping their expertise in innovation." (Male Non-Malawian, Multilateral Leader)

Multiplicity of Administrative and Data Systems. Another major commonality from KIIs described the proliferation of health information and related systems. The major theme took different forms from data, reporting, administrative investments, and other "hardware" intended to manage, track, and inform global health programs. A multiplicity of systems in the eyes of one leader was the single biggest challenge she witnessed with project-specific quality improvement systems affecting the health workforce and clients. The time and costs associated with start-up of electronic and paper reporting systems, maintenance of these and close out of that system with each project, were viewed as problematic even if required by each donor. Select development agency and GoM leaders described their experiences.

- "When one partner ends, there is proprietary information to each system: the US, Japan and United Kingdom. There is no uniformity for the Ministry of Health to cost and determine which we should accept." (Female, Bilateral Leader)
- "From a financial perspective, multiple systems have implications. First each donor spends, each has differing fiscal years, varying reporting deadlines with different requirements, for serving the same people, Malawians." (Female, Bilateral Leader)
- "There are quite a lot of data and management systems. Both involve spend, more on administration and administrative human resources costs….trying to replace any gaps they see in the government system. Most donors will go and source from their side that capacity which increases costs." (Female, Central Government Leader)

All 10 leaders among bilateral, multilateral, and GoM expressed concerns about the volume of existing and new data systems, and the lack of integration when funding ends. Two examples detailed the common practice of each donor, partners and projects introducing indicators tied to a specific health facility, community-based and central level site with individualized health management information systems. These investments across donors were described as even more problematic when tailored for HIV, tuberculosis, malaria, and other single diseases rather than feeding into national data infrastructure and multi-disease initiatives. The plethora and ongoing creations of such parallel activities affect not only the government ministries, but often place burden on health workers and other civil servants to be trained and to use them. Related negative effects are revealed in statements below:

- "Malawi has tried to advance the way it tracks… There is duplication in systems and each donor wants to bring in own administrative systems…..Sometimes we go on our own and that has happened quite a lot especially if the response system is slow….or

you have to report and we have to meet strict deadlines or be accountable…the leadership of government is key in this environment [to] make it conducive enough for people to come together willingly." (Male, Multilateral Leader)

- "There is proliferation of human resources like the proliferation in different systems that causes a lack of continuity for technical advisors (TAs). This means staffing is not well organized as some have too many TAs and no sustainability of these. Some TAs are championing a specific agenda and not approaching their work in a holistic way. Many though are trying to lead service delivery, pre-service and in-service so overall there has been a benefit but it could be better coordinated." (Female Malawian, Bilateral Leader)
- "There is quite a lot. Both [administrative and data systems] involve spend, more on administration and administrative human resource costs, trying to replace any gaps they see in government system. Most donors will go and source from their side that capacity which increase costs. I make this comment because both management costs and administrative costs can skyrocket." (Female, Government Leader)

Inter-donor risk management was cited as the core reason for having so many of these often fragmented, project-derived, and expensive administrative inputs. In relation to oversight of these multiple activities and their related resources, 10 of the KIIs (100%) cited the time, management, and personnel burdens in not only being responsive to risks but also in addressing inter-donor requests. These requests become exacerbated by diverse leadership and communication styles, different reporting cycles and fiscal years, and many donors vying for credit and access to GoM ministry leadership. Accounts of this major theme on "burdens" were described best through voices of select development agency leader respondents:

- "…both [bilaterals and multilaterals] are pulling on the same Government person and taking a car to each site when figuratively speaking three or four could have gone in one vehicle and saved resources." (Female Malawian, Bilateral Leader)
- "There are so many donors vying for credit like for example the concept of launching, Its such high frequency here, I have never seen this many launches in other countries where I have worked….it's harder to have credit shared and attribute a single donor to effects." (Female, Bilateral Leader)
- "The challenge is totally aligned with different entities support, different histories, and different experiences. Also seeing a multiplicity of small initiatives, these take up to much time. Managing that 10% can take a lot of Government capacity. Personally for small initiatives, these should be taken up at district and municipality level." (Male, Multilateral Leader)
- "The increase of donor proliferation is only a problem due to the multiplicity of processes, of demands. Ten partners with each a procurement plan, oversight mechanism, financial management mechanism. Do we have to deal with introduction and iteration after iteration? It depends." (Male Malawian, Government Leader)

A full summary of major and minor negative themes captured responses to research question two. Table 7 highlights recurrent development agency leaders and GoM responses identified by the researcher.

Table 7

Summary of Negative Themes

Major Themes	**Minor Themes**

Bypassing of Local Priorities and Structures	District-level Inequities
Entrenched Donor Dependency	Lack of Flexibility in Donor Funding
Limited domestic resource mobilization	Multi-disease Programming Disparities
Reporting and Data System Proliferation	Central Government Infighting and Coordination Gaps
Management and time burdens	Local market distortions *(Donor and NGO-elevated Compensation)*

Investigation of Hypotheses

Hypothesis Statement 1: More primary effects than secondary effects will arise in KIIs derived from the Pallas and Ruger framework.

The KII demonstrated diverse commonalities in primary effects in the Pallas and Ruger (2017) framework and the literature then secondary effects of the framework. The research only gleaned five of the seven primary effects and two of the five secondary effects from analysis of leaders' responses and data reviewed to characterized sentiments as described in the Discussion section. The hypothesis that primary effects would dominate was evidenced by seven or more (70%) of KIIs overlapping themes.

Hypothesis Statement 2: Major positive effects will include better health outcomes and recipient control.

Respondents described and many ranked the positive effects of improved health outcomes in Malawi as a major effect of global health donor proliferation. This theme of benefits by population, select disease prevention and treatment programs as well as life expectancy were consistent across 10 of the KIIs. As provided earlier in the Results section, leaders' statements (100%) fully aligned with the hypothesis statement that anticipated positive effects would highlight progress in health indicators as a priority theme.

For the other two aspects of hypothesis two, there was not enough information tied to i) recipient control to assess leaders' perceptions and ii) too few number of responses for multilateral institutions. The distribution of study participants of five bilateral leaders as compared to only two multilateral leaders did not provide for a robust way to weigh whether multilateral leaders identified more positive effects.

Hypothesis 3: Major negative effects will include inter-donor parallel systems and increased corruption cases.

Various KIIs in detail described the existence and growth in the number of inter-donor parallel systems as a major negative effects of global health donor proliferation in Malawi. Bilateral, multilateral, and government leaders (100%) expressed concerns specifically naming administrative, data, and reporting systems and related issues with duplication from program, personnel, and cost perspectives. While 10 of the 10 leaders identified these negative systems-level effects, only three of 10 leaders, explicitly mentioned corruption. The topic of corruption among respondents got described in the context of "Cashgate," "reform," and "risks," as opposed to more common global terms. Therefore, the hypothesis in relation to donor proliferation associated with increased cases reported about corruption was not aligned with the majority statements from inter-donor and government leaders.

Sentiment

Commonalities Across Respondent Sentiment

A mapping of responses across bilateral and multilateral donors as compared to GoM examined select areas where Malawian and non-Malawian leaders felt similar sentiments. Two themes were extracted that the researcher identified as noteworthy: perceptions about risks and

outlooks on the future. Findings show recognition of reasons for certain practices and current vulnerabilities within the context of global health donor proliferation.

Outlook on Risks

Amongst leaders, there was a widespread mention of bilateral and multilateral partners needing to manage risks, hence expected rigidity in certain requirements. Across government key informant interviews, risk management was cited as a core reason for having various fragmented, project-derived, and expensive administrative inputs. Recognition of these, however, did not translate to acceptability of practices going unchanged. One senior leader referenced alternative or additive ways to also address fraud, waste, abuse, and other risks:

- " …..countries have supreme audit institutions. I've noticed that quite a number of our bilateral partners don't use our national system to audit the accounts….the national institutions play a special role to be keeping an eye, monitoring those exposed. When things go wrong, for example, you find that donors bring in another institutions when local institutions could be used. You find that because they didn't use the local institutions, some of those agreed management actions are not kept to. While if we'd used the national institutions, it would be different." (Male, Government Leader)

Outlook on the Future

There were not significant differences in Malawian as compared to non-Malawians, or donor as compared to central government leader responses about the future if global health donor proliferation persists. The majority of respondents expressed concerns about the years ahead in relation to changes in the status quo or the donor-GoM operating environment. Seven of the 10 leaders were pessimistic in their view of the future. See Appendix I, Parting Thoughts From

Study Participants, which delves into the closing reflections of doubt, concern, fear, and difficulty in leading change and the few glimpses of hope.

Only two respondents (development agency leaders) expressed an optimistic sentiment. One neutral statement from a GoM leader ended with a specific charge to change "the Malawian mindset" or vertical way of doing things. All respondents conveyed that what lies ahead is contingent on the role that Ministry of Health leadership should play in shared vision (e.g., better collaboration, less competition, and internal disputes), and implementation and multi-donor coordination of contributions toward the HSSP3.

Discussion

Theoretical Framework Iintegration

Primary Effects Resonated. An overlay of themes from the Pallas and Ruger (2017) framework of hypothesized effects on donor proliferation on health emerge within different leader responses. These include overlapping opinions in 50% or more KIIs regarding aid volume, inter-donor competition, transaction costs and parallel systems, donor sense of accountability, and aid fragmentation. Five themes arose through divergent statements that describe pros and cons of how bilateral and multilateral funding affects the environment from a costs-benefit, market, and community health lens. The researcher derived several "doubts" and "worry" regarding the extent to which government and donor group actors will formulate and act upon change rather than employing the same practices despite knowledge of course corrections (e.g., advancements in coordination, cooperation, and harmonization and localization agendas). Both have to demonstrate and follow through on commitments to minimize negative effects and sustain positive effects of proliferation in Malawi.

In contrast to the above commonalities, two of the remaining primary effects—recipient control over aid and donor poaching of recipient staff—were discussed. Under half of respondents made statements about "control" of financial and human resources specifically unprompted. Statements revealed more complexity than a monolithic position. Two of the three government leaders described how Government, communities, and local leaders cannot solely be responsible for "controlling aid" that comes into the country with the donor directives, restrictions, and issues around lack of predictability of funds.

Secondary Effects Debated. Minor themes noteworthy that coincide with other areas of the literature review were also identified. From Pallas and Ruger (2017), the price of aid, innovation/diversification, and disbursement volatility were recurrent threads debated, of the secondary effects of global health donor proliferation. A subset of respondents drew attention to the varying perspectives on the scale of global health proliferation, evidence of high funding concentration, and differences in bilateral and multilateral footprints or investments. For example, the United Kingdom arose as a bilateral donor that had significant shifts in its funding support to Malawi, in half of the KIIs. One key informant described the shift as "abrupt" driven by policy shifts commensurate with allocating less resources to Malawi and more "back home." It appears KIIs re-emphasized that some donors had political and social drivers that did override prior commitments (Benn & Luijkx, 2017; Swiss & Gulrajani, 2018), heavily linked to the macro level financial crises globally. Two interlinked secondary effects in the Pallas and Ruger (2017) framework resonate, the "price of aid" and "disbursement volatility" that should be explored further.

Respondents also articulated some of the implications of high funding concentration among two entities across KII. The U.S. government and the Global Fund support for over 80%

of health financing was heavily cited. Several respondents challenged the premise that global health donor proliferation was at an aggregate level and instead directed the researcher to consider layers such as project, activity, NGO, and systems level proliferation and consequences of new entrants. The reality of having finite number of large and many small donors with highest volume of resources coming from the United States and increases influx of funding coming from Global Financing Facility, Africa Development Bank, and World Bank suggests perhaps a value add in separately looking effects of one bilateral and one multilateral institution rather than multiple entities.

Lastly, the perceptions on what are necessary and sufficient conditions to enhance coordination, competition, and cooperation were noteworthy. Most respondents stated there was a healthy side of inter-donor (and to a less extent inter-governmental) competition in Malawi. A subset of leaders, in turn, described trust as a prerequisite for coordination and cooperation, acknowledging that trust can be built and/or broken among colleagues, decision makers, stakeholders, and in donor to government relationships. Select KIIs alluded to the shortcomings of individual lawmakers, regulators, the foreign ministry, and market influencers to redirect and require changes in how actors have worked for decades, on the one hand. On the other hand, requirements and conditionality tied to agency headquarters and boards remained as constant drivers within global health partnership and innate power dynamics that can undermine trust.

Tensions between past and current aid effectiveness principles, the attribution paradox of who takes credits for results, and bi-directional responsibility and accountability (as compared to solely Government-owned) must be dealt with directly. Competition and ownership of results, programs, client and service-derived targets, as well as directedness of funding will continue to cause conflict without inter-ministerial agreement and solutions to guide better coordination and

course corrections in how donors pursue the work. These felt challenges are not unique to Malawi or low-income settings, as evidenced by country case studies in the global health donor proliferation literature (Overseas Development Institute, 2017; Pallas et al., 2015; Pallas & Ruger, 2017; Swiss & Guirajani, 2018).

Recommendations

Perceptions from development agency leaders were diversely rich; however, three recommendations to address negative effects and sustain positive effects are worth highlighting.

- Bolder GoM leadership should identify and mobilize domestic resources, and better direct and coordinate development agencies, projects, and partners.
- Government, development agency leaders, and communities should define and start to operationalize the HSSP3 systematically with actual tracking of funding against results and progress toward universal health care goals.
- Development agency leaders should increase use of local structures and systems and reduce parallel systems with immediacy.

Changes in the global health ecosystem contained in the recent Lusaka Agenda (2023)—on governance, common metrics, aligning with and using government systems, transparency around funding flows, and sustainability mindsets—hold great potential to point researchers to reexamine fundamental shifts needed for longer term transformation toward domestically financed health systems in Africa that lead to the attainment of universal health care. As we grapple with the longstanding issues in the donor-recipient government of global health programs, further research on different modalities for partnerships will be important to respond to known concerns articulated across study participants, in transformative ways.

Study Limitations

Several caveats and limitations exist with respect to KII and the study overall. Three noteworthy include i) the small number of interviews, ii) potential bias and human tendency for respondents to give socially desirable answers, and iii) time and geographical constraints. Despite the candor and overall level of comfort observed across KIIs, the issues inherent in participants' self-selection and the researcher's (relational) leadership role cannot be overstated. KII responses may have been subject recall bias. Also taking into account the study participant size and geographical implications, it is not possible to know the views of those outside of Lilongwe, such as district leaders and other donors that might have contributed. Findings should not be viewed as generalizable and other studies in low-income and resource-constrained countries form better options for comparison rather than global application.

Conclusion

Global health donor proliferation as a unit of study will continue to vary: by the share of resources directed at diseases-specific programs, by the time period and policy directives, and by place and locality delineations. Further research should examine these salient issues. While the study participant cohort (n = 10) of bilateral, multilateral, and government leaders revealed how positive and negative effects co-exist at central, district, and partner levels, there is much more to unearth as global health leaders routinely navigate financial and nonfinancial inputs aimed at improving the lives of populations meant to be served.

Accounts from bilateral agencies, multilateral institutions, and central government leaders suggests opportunities for more attention to intergovernmental leadership and cross-ministerial cooperation, improved coordination of financial and programmatic investments, and harmonization of human resources for health and health management information systems, yet to

be realized. Efforts to operationalize the HSSP3 whilst ensuring multi-donor strategies better align with national priorities requires concerted action and change from the status quo.

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Appendix A

Conceptual Framework of Donor Proliferation's Hypothesized Effects

(Pallas & Ruger, 2017)

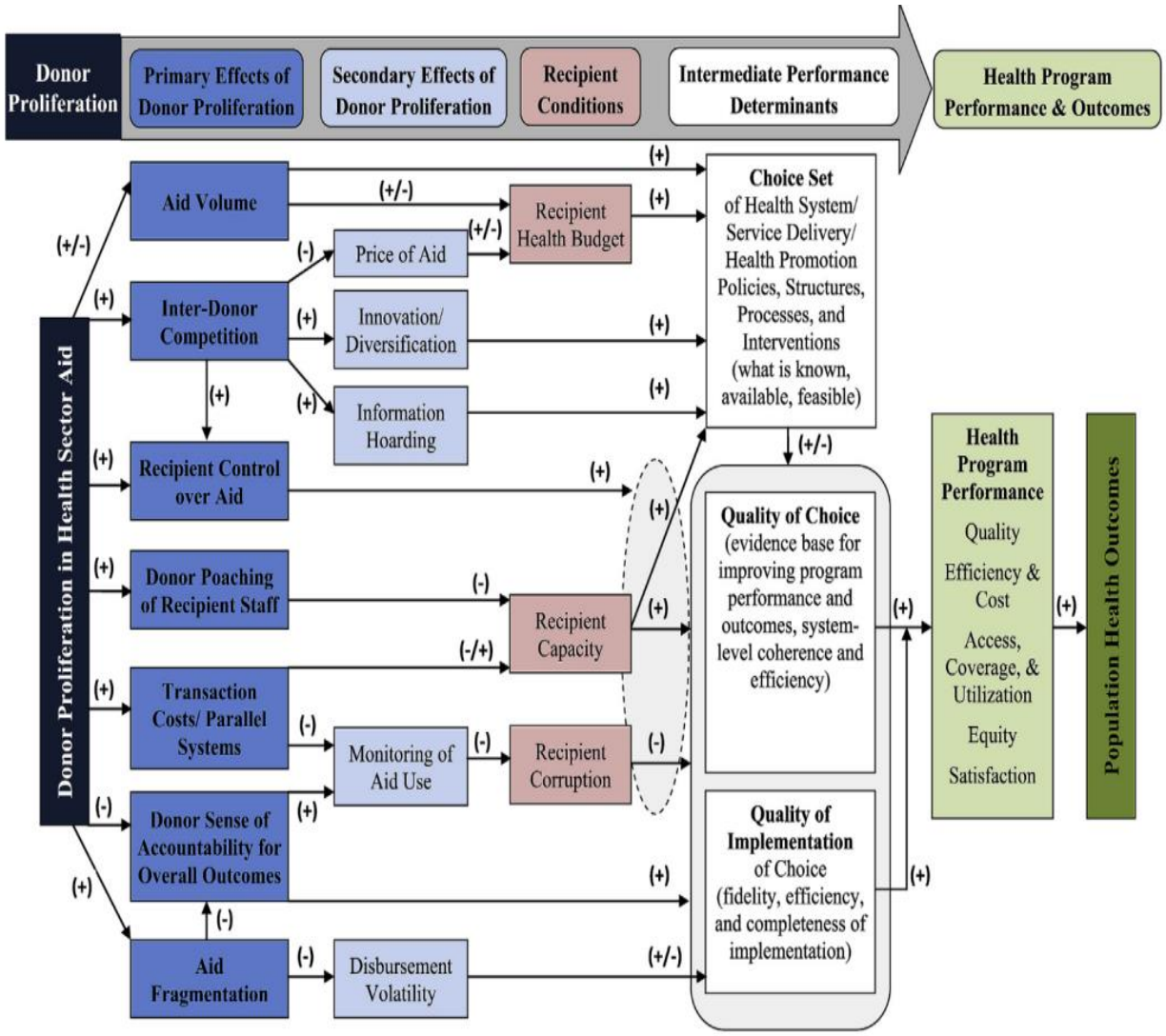

Fig. 2. Conceptual framework of donor proliferation's hypothesized effects on health program performance: detailed view of individual effects.

Appendix B

Literature Sources and Key Findings

Study	Author Affiliations	Themes	Assertion/Findings	Effects
Armstrong et al, 2019	**Academia** Univ. of KwaZulu Natal South Africa	Global Fund Donor competition HIV programs investments Donor funding dependency	Complex, competing priorities for limited resources increasingly strain processes for inclusive deliberation. Of concern, expansion of HIV treatment programs relies on external funding sources for support. LocalGlobal Fund-supported governance structures need to ensure critical decisions regarding priorities for national HIV programs are country led and more domestically funded.	Mixed
Borghi et al, 2017	**Academia** Univ. of London Univ. of Malawi National Statistics Malawi	Sub-national resource tracking District level funding outcomes and time periods Reliance on external assistance due to delayed receipt of funding common at sub-national level Substantial district level financing benefits to primary care, specifically pregnant women and children under five	District level and powered studies needed to fully understand global health donor proliferation effects. Funding allocations need to be commensurate with health needs and better dispersed from wealthier to non-wealthier districts Per capita spending across districts from 2006-2011 varied with no association	Negative Inconclusive Positive

			changes in financing and outcomes,	
Bridges & Woolcock, 2017	**Multilateral Institution** World Bank	Donor self-interests, professional credibility vulnerabilities Disbursement pressures Perverse donor and organizational incentives toward costlier projects and solutions Negative implications for donor-driven solutions	More reform-minded donor and client government mindset and action needed Broader stakeholder engagement key for addressing incentive structures, organizational cultures within Malawi's economic environment Known Best practices prove to be difficult to implement with "give government what it wants " (22) environment	Negative
Chansa, C., Pattnaik, A. (2018).	**Multilateral Institution** World Bank	Malawi Universal health External assistance Millennium Development Goals	Investment in the health sector over the years has led to an increase in population coverage, financial protection, and improvements in health outcomes. Low out of pocket spending compared to neighboring countries.	Positive
Chasukwa & Banik, 2019	**Academia** Univ. of Malawi Univ. of Norway	Local institutions Weakening of governance	Multilateral and bilateral donors bypass national structures.	Negative

		(ministries and policy space) Aid fragmentation Coordination gaps Fragile national structures		
Martineau et al, 2022	**Academia** Univ. of Oslo Liverpool, Friends of Waldorf Education Germany, Kamuzu Univ. Malawi	Human resources for health and national structures Donor support and technical expertise, HRH systems strengthening	Country ownership, credibility of (donor) coordination mechanisms. Gaps and lack of specialists knowledge despite funding Benefits not sustained	Positive Negative
Marty et al, 2017	**Academia** College of William and Mary	Central and district level variability Health aid and measurable improvements in health outcomes Geographical Targeting under examined Inefficiencies and attenuated impacts	Beneficial global health beneficiary effects even with inefficiencies. Subnational data add value. Contributions to reduced malaria, better quality of care, parasitic and infectious disease control most notable. Limited empirical evidence on ongoing and point in time impact of health donor dollars	Positive Mixed
Ocheck et al, 2018	**Academia, Local Government** Univ. of York, UK Univ. of London Ministry of Health Ministry of Agriculture, Irrigation and Water	Health benefits package and donor support Health outcomes and improvements Health opportunity costs and resource allocations	Set of interventions that represent “best buys” Costs of donor conditionality and broader objectives and gains beyond population health	Positive Mixed

	Development Malawi	Donor-funded programs, intended and unintended consequences		
Walsh et al, 2020	**Academia** Univ. of Heidelberg Germany	Country Ownership Donor Capture Health Sector Strategic Plan Contextual elements	Ministry of Health ceded some ownership in policy formulation to development partners	Negative
Nunnenkamp et al, 2016	**Research Institutions** Kiel Institute for the World Economy Germany	District and Central level disparities Sector nuances Donor division of labor deterioration	No compelling evidence of increased aid specialization Donors respond to aid flows by increasing their own aid flows	Mixed
Global Partnership for Effective Development Co-operation (2018)	**Research Institutions** Global Partnership for Effective Development Co-operation	Cooperation and conflict co-exist Donor and government motivations vary and evolve		Mixed

Appendix C

Study Participant and Leader Profiles

Study Participant/Leader	Sex	Education Level	Malawian In-country base	Member of Donor Groups
Government 1 Program Manager	M	PhD	Yes 40+ years	Yes Multiple Groups
Government 2 Director	M	PhD	Yes 40+ years	Yes Multiple Groups
Government 3 Senior Minister	M	MD	Yes 40+ years	No
Bilateral 1 U.S. Division Chief	F	MD	Yes 40+ years	No
Bilateral 2 U.S. Senior Advisor	F	MPH	Yes 40+ years	Yes, former Health Donors
Bilateral 3 UK Advisor	M	MPH	Yes 40+ years	
Bilateral 4 U.S. Country Director	F	PhD	No 2.5+ years	Yes, former Health Donors
Bilateral 5 U.S. Senior Leader	F	PhD	No	No
Multilateral 1 Country Director	M	MPH	No 2.5+ years	Yes Multiple Groups
Multilateral 2 Senior Advisor	M	MPH	No	Yes HIV Donors

* U.S. agencies included Centers for Disease Control and Prevention; U.S. Agency for International Development; U.S. Department of State
** U.K. agency included Foreign Commonwealth & Dev. Office
*** Government of Malawi included Ministry of Health

Appendix D

Recruitment/Letter of Invitation Email

RADFORD UNIVERSITY

Subject: Perceptions on Donor Proliferation – Interview Request from Doctoral Student Researcher

From: uroxo@radford.edu

I hope this email finds you well.

This letter is to request 45-minutes of your time to participate in an in-person semi-structured interview on global health donor proliferation in Malawi. The study is being conducted by me, the student researcher as part of my Doctor of Health Sciences requirement with support from my faculty researcher, Dr. Sallie Beth Johnson. The Radford University Committee for the Review of Human Subjects Research approved this study, a 2023 Capstone Project.

The purpose of this study is learn about different perceptions and perspectives on the effects of global health donor proliferation in Malawi. The topic is near and dear to me professionally and personally and your participation as a key informant interviewee will contribute to a better understanding of key and current issues.

Please reply to this email at your first convenience if interested. I will reach out to schedule a time on your schedule before mid-August 2023. Feel free to recommend a senior leader of your team if you are unavailable. Within that timeframe and follow up email, the attached a Consent Form will be recirculated for your review and signature. *As required by Malawi's Institutional Review Board, you will be offered $10 usd for any costs associated with your participation in this interview.*

Warmest Regards,

Uchechi

Doctorate of Health Sciences Candidate

Radford Carillion University

Appendix E

Donor Interview Guide Informed by Malawi Document Review Findings

Thank you for taking the time to speak with me today. Our discussion will explore the topic of **Donor Proliferation,** an increase in the number of donors and aid funding channels in a country. There are different perspectives on what effects an increase in the number of global health donors has in low-income countries. My doctoral study focuses on the perceptions of donor agency leaders and examples of the positive and negative effects of donor proliferation. The study looks specifically at bilateral donors (United States, United Kingdom, and Germany) and multilateral donors (Global Fund, UNAIDS, and the World Bank).

We will go through questions to hear your views; all responses will be kept **confidential and anonymized for the study.** I estimate our interview will last approximately 45 minutes.

May I have your **consent to record** our discussion? I appreciate your willingness to voluntarily participate and your permission to begin. (Note start time, then end time).

Introduction

Malawi's **2023-2030 Health Sector Strategic Plan** cites "roughly 166 financing sources and 264 implementing partners" contributing to combat disease programs where roughly 10 agencies fund 97 percent of the health sector. This statistic provides context and a recognition of the existing donor proliferation dialogue underway in the country.

1. Opening: In your leadership role (state position title), how is your work affected by the increased number of bilateral and multilateral global health donors in Malawi?

2. How do you feel about the increased number of global health donors?

3. What, if any, changes do you see directly linked to donor proliferation in Malawi? Probe: positive and negative in nature

The next questions will focus on experiences and observations in relation to the key global health donors by type. We will first discuss bilateral donors followed by multilateral donors.

Bilaterals

4. What do you view as the most significant effects of the growth in **bilateral global health donors in Malawi?** Probe: (United States, United Kingdom, and Germany)

5. From an engagement perspective, what do you see as the relationship between **donor proliferation and competition**? Probe: factors such as vying for credit for global health successes, for reputational gains, for health program resources in Malawi

6. What are your thoughts on key factors that contribute **to bilateral global health donor cooperation among the US, UK and Germany**? Probe: influence on national policies (Health Financing Strategy, Health Sector Strategic Plan), global policies (United Nations Sustainable Development Goals, Paris Declaration), health sector wide strategies, pooling of funding

Multilaterals

7. What do you view as the most significant effects of the growth in **multilateral global health donors in Malawi**? Probe: the Global Fund, UNAIDS, World Bank, other entity

8. From an engagement perspective, what do you see as the relationship between **multilateral donor proliferation and competition**? Probe: factors such as vying for credit for global health successes, for reputational gains, for health program resources Malawi

9. What are your thoughts on the factors that contribute **to cooperation among global health multilateral donors**? Probe: influence on national policies (Health Financing Strategy, HSSP3), global policies (UN Sustainable Development Goals, Paris Declaration) health sector wide strategies, prioritization of funding

The next questions focus on both bilateral and multilateral global health donors, specifically investments and implications of management systems and human resources.

Both Bilateral & Multilateral

10. How would you characterize the **multiple administrative systems and management structures for health programs** that arise with the increase in global health donors in Malawi? Probe: efficient vs inefficient, opportunity for streamlining vs donor-driven requirements, interoperability vs duplicative

11. From a human resource perspective, what are some effects of changes in the MOH workforce in the context of increased global health donors? Probe: “brain drain” or loss

of **Government of Malawi staff that creates workforce gaps or gains in the number of Government of Malawi staff (e.g. seconded advisors)** that fill workforce gaps

12. From an oversight perspective, how do you see the expansion of bilateral and multilateral donors affecting **levels of responsibility for overall development outcomes**? Probes: if donor proliferation is seen to **weaken** individual donor accountability, please give examples. If donor proliferation is seen to **enhance** individual donor accountability, please give examples.

Closing

13. Looking ahead to 2030, the last year of the Heath Sector Strategic Plan 3, how do you feel about the future if bilateral and multilateral global health donor proliferation continues to occur in Malawi?
14. Any other additional comments?

Government Interview Guide Informed by Malawi Document Review

Thank you for taking the time to speak with me today. Our discussion will explore the topic of **Donor Proliferation,** an increase in the number of donors and aid funding channels in a country. There are different perspectives on what effects an increase in the number of global health donors has in low-income countries. My doctoral study focuses on the perceptions of donor agency leaders and examples of the positive and negative effects of donor proliferation. The study looks specifically at bilateral donors (United States, United Kingdom, and Germany) and multilateral donors (Global Fund, UNAIDS, and the World Bank).

We will go through questions to hear your views; all responses will be kept **confidential and anonymized for the study.** I estimate our interview will last approximately 45 minutes.

May I have your **consent to record** our discussion? I appreciate your willingness to voluntarily participate and your permission to begin. (Note start time, then end time).

Introduction

Malawi's **2023-2030 Health Sector Strategic Plan** cites "roughly 166 financing sources and 264 implementing partners" contributing to combat disease programs where roughly 10 agencies fund 97 percent of the health sector. This statistic provides context and a recognition of the existing donor proliferation dialogue underway in the country.

1. Opening: In your leadership role (state position title), how is your work affected by the increased number of bilateral and multilateral global health donors in Malawi?
2. How do you feel about the increased number of global health donors?
3. What, if any, changes do you see directly linked to donor proliferation in Malawi? Probe: positive and negative in nature

The next questions will focus on experiences and observations in relation to the key global health donors by type. We will discuss bilateral and multilateral global health donors.

Bilaterals

4. What do you view as the most significant effects of the growth in **bilateral global health donors in Malawi?** Probe: (United States, United Kingdom, and Germany)
5. From an engagement perspective, what do you see as the relationship between **donor proliferation and competition**? Probe: factors such as vying for credit, for reputational gains, for health program resources in Malawi
6. What are your thoughts on key factors that contribute **to bilateral global health donor cooperation among the US, UK and Germany**? Probe: influence on national policies (Health Financing Strategy, Health Sector Strategic Plan), global policies (United Nations

Sustainable Development Goals, Paris Declaration), health sector wide strategies, pooling of funding

Multilaterals

7. What do you view as the most significant effects of the growth in **multilateral global health donors in Malawi**? Probe: the Global Fund, UNAIDS, World Bank, other entity
8. From an engagement perspective, what do you see as the relationship between **multilateral donor proliferation and competition**? Probe: factors such as vying for credit for global health successes, for reputational gains, for health program resources in Malawi
9. What are your thoughts on the factors that contribute **to cooperation among global health multilateral donors**? Probe: influence on national policies (Health Financing Strategy, HSSP3), global policies (UN Sustainable Development Goals, Paris Declaration) health sector wide strategies, prioritization of funding

The next questions focus on experiences and observations in relation to both bilateral and multilateral global health donors, specifically investments and implications for management systems and human resources.

Both Bilateral & Multilateral

10. How would you characterize the **multiple administrative systems and management structures for health programs** that arise with the increase in global health donors in Malawi? Probe: efficient vs inefficient, opportunity for streamlining vs donor-driven requirements, interoperability vs duplicative
11. From a human resource perspective, what are some effects of changes in the MOH workforce in the context of increased global health donors? Probe: “brain drain” or loss of **Government of Malawi staff that creates workforce gaps or gains in the number of Government of Malawi staff (e.g. seconded advisors)** that fill workforce gaps
12. From an oversight perspective, how do you see the expansion of bilateral and multilateral donors affecting **levels of responsibility for overall development outcomes**? Probes: If donor proliferation is seen to **weaken** individual donor accountability, please give examples? If donor proliferation is seen to **enhance** individual donor accountability, please give examples?

Closing

13. Looking ahead to 2030, the last year of the Heath Sector Strategic Plan 3, how do you feel about the future if bilateral and multilateral global health donor proliferation continues to occur in Malawi?

14. Any other additional comments?

Appendix F

Key Informant Interview Consent Form

RADFORD UNIVERSITY

You are invited to participate in the qualitative research study, "Global Health Donor Proliferation Perceptions." The study is being conducted by Uchechi Roxo, student researcher as part of my Doctorate of Health Sciences requirement with support from faculty researcher, Dr. Sallie Beth Johnson. The Radford University Committee for the Review of Human Subjects Research approved the 2023 study.

The purpose of this study is to examine the effects of global health donor proliferation in Malawi through key informant interviews that explore perceptions among longstanding donor-government leaders. Your participation as a key informant interviewee will contribute to a better understanding of different effects of global health donor proliferation in Malawi. The discussion will take about 45 minutes.

There are no anticipated risks from participating in this interview. The student and faculty researcher will protect your data to the extent permitted by technology. Demographic profiles and interview responses of participants will be kept during the data collection phase for subsequent analysis. Access to the data will be limited to the student researcher and faculty with information de-identified in the final dataset and report.

Your participation as a key informant is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time without consequence. For any questions that arise, please call or WhatsApp Uchechi Roxo at (088) 129-1211 or send an email to uroxo@radford.edu. Thank you.

If you agree to participate, please tick here: Yes ____ No _____

Appendix G

Malawi Institutional Review Board Approval Letter

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY
Lingadzi House
Robert Mugabe Crescent
P/Bag B303
City Centre
Lilongwe
Tel: +265 1 771 550
+265 1 774 189
+265 1 774 869
Fax: +265 1772 431
Email:directorgeneral@ncst.mw
Website:http://www.ncst.mw

NATIONAL COMMITTEE ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES

Ref No: NCST/RTT/2/6 **23rd November 2023**

Uchechi Roxo,

Email: uroxo@radford.edu

Dear Ms Roxo,

RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR PROTOCOL NO. P.10/23/811: PERCEPTIONS ON GLOBAL HEALTH DONOR PROLIFERATION IN MALAWI

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research in the Social Sciences and Humanities (NCRSH) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee and the Commission with a final report of the study. The committee reserves the right to carry out compliance inspection

of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

Wishing you a successful implementation of your study.

Yours Sincerely,

Yalonda .I. Mwanza

NCRSH ADMINISTRATOR HEALTH, SOCIAL SCIENCES AND HUMANITIES DIVISION

Committee Address: Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw

Appendix H

Reflections and Recommendations from Development Agency Leaders

Study Participant	Closing Remarks about the future outlook for Malawi
Bilateral 1	"To the extent to which the HSSP3 goals are met, I have doubt. This is because of how the government receives funding and there's a lack of flexibility built into the document. One does not want to compromise."
Bilateral 2	"The HSSP3 is a strong document in managing proliferation and laying out what should happen at national and at district level. It's embraced decentralization but districts should take charge and do a donor mapping. We have performance indicators in HSSP3 so we must see where we are doing well and not."
Bilateral 3 Non-Malawian	"if increase continue, my worry is a very ambitious strategic…in the next five to ten years without a proper framework to monitor and track, we will end up back where we were before the ambitious plan. Government needs a clear strategy on how they will manage an increase in resources. Donors will continue to find ways to achieve objectives but Government will lose in the end. Government of Malawi needs to be able to understand and track issues and proliferation year end."
Bilateral 4 Non-Malawian	"…my worry is [about] a very ambitious strategic plan…..in the next five to 10 years without a proper framework to monitor and track, we will end up back where we were before the ambitious plan. Government needs a clear strategy on how they will manage an increase in resources. Donors will continue to find ways to achieve objectives but Government will lose in the end…[and] needs to be able to understand and track issues and proliferation…..[and] fully tracking link to outcomes. "
Bilateral 5 Non-Malawian	"..if we get together, we're coming to country, who will own this [HSSP3], 12 months ago you came and you put your strategy out there…. I think that looking for areas where we can settle on a little bit, can we work on this piece? Like even the digital stuff, it's like, is there something that we can all rally around and say, can we improve this piece? Can we improve your leadership oversight and accountability of this piece?. I'm willing to take a take a risk with you [if areas get genuine attention].
Multilateral 1 Non-Malawian	"I think we need to approach the future with a certain level of optimism because when we started support in the health sector most of you know the investments were driven because of the emergency agenda and we've come to a level of stability. Of course in a way still half of the time goes to disease outbreaks in our efforts to end pandemics but it still doesn't negate the fact that you know, Malawians are actually healthier now."
Multilateral 2 Non-Malawian	"For future outlook, this one is hard, really hard, the hardest. So Malawi is really suffering from volatility and the international level, the whole climate. There is no foreseeable change or dimension within this larger economic situation in Malawi and the nature of how things are going….. A main determining factor for Malawi is the extent to which Malawi can make some of its own investments toward underlying elements of the health system."
**More than half of development agency leaders were concerned about the future in Malawi with global health donor proliferation and the Health Sector Strategic Plan three.*	