LEVEL OF DECENTRALISATION IN THE DELIVERY OF HEALTH SERVICES IN BLANTYRE DISTRICT AND PERCEPTIONS ON ITS EFFECT

MASTER OF BUSINESS ADMINISTRATION DISSERTATION

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UNIVERSITY OF MALAWI

THE POLYTECHNIC

March, 2017

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Submitted to the Department of Management, Faculty of Commerce, in partial fulfilment of the requirements for the Degree of Masters of Business Administration (MBA)

University of Malawi

The Polytechnic

March, 2017

DECLARATION

I, the undersigned, hereby declare that this research report is my own, unaided work. It is being submitted in partial fulfilment of the requirements for the degree of MBA in the University of Malawi, and it has not been submitted before for any degree or examination in any other University.

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Date : _____

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CERTIFICATE OF APPROVAL

We, the undersigned, certify that we have read and hereby recommend for acceptance by the University of Malawi a thesis entitled '*Level of Decentralisation in the Delivery of Health Services in Blantyre District and Perceptions on its Effect.'*

Dean – Postgraduate :

Signature :

Date :

Main Supervisor :

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Date :

Head of Department :

Signature :

Date :

DEDICATION

I dedicate this work to my dear wife Florence and son Lonjezo who stood firmly by me throughout the thick forest of the long and cumbersome journey. To my mum who has always wished me the best. To my dear late young brother who was a source of inspiration to me. May his soul rest in peace!

ACKNOWLEDGEMENTS

This dissertation would not have been successfully produced and completed without contributions from various people. I am particularly grateful for the immense technical and intellectual help and encouragement, which I received from my supervisors – Associate Professor Nancy Chitera and Mr. Save Kumwenda for their continuous guidance and constructive comments on the earlier drafts.

Many thanks and profound gratitude should also go to Holmes Banda, Beth Dunbar and Lila Kerr for their contributions and constructive insights. I also thank staff members of Blantyre District Health Office, the District Commissioner's Office and health workers for all health facilities in the district where data collection exercise was conducted for sparing their valuable time and participating in the research. I would also like to convey my appreciation to my wife and children for missing my company during the research process and for their untiring encouragement in spite of the many hurdles and demands that accompanied the production of this dissertation.

The research process involved many organisations and individuals in Blantyre who, because of space, I am not able to list individually; instead, I wish to offer my appreciation for their support.

Above all, thanks be to the Lord God, the Almighty for making me what I am.

Having said all this, I, alone am responsible for any errors and omissions that may have arisen in the process of producing this dissertation.

ABSTRACT

As one way of improving the quality of services in the country, government adopted the decentralisation policy in 1998. The policy acted as a vehicle through which the reform can be implemented at the local level. This was after approval by cabinet in 1996 and subsequent enactment of the Local Government Act by parliament in 1998 which advocates for the implementation of the policy.

Decentralisation is the transfer of power and authority from the centre to the peripheral. In the health sector, decentralisation means the transfer of power and authority from the Ministry of Health to the local councils. This is so because Malawi adopted devolution as a form of the Public Administration Framework of decentralisation to improve health service delivery at the local level.

The main objective of the study was to assess the level of decentralisation in the delivery of health services in Blantyre District and perceptions on its effect. The study was based on both quantitative and qualitative methods of data collected and analysed. The data was collected in sampled health facilities of Blantyre District.

While decentralisation has taken place, the results reveal that there is partial implementation of the policy in the district. This has rendered the reform ineffective and inefficient. Despite its wide application, the Public Administration Framework has had its diverse effects in different organisations including Blantyre. These can be categorised into positive and negative effects. Though decentralisation has improved people's access to health services at the local level, the reform has also produced its adverse effects. Key to this is an increase in corruption at the local level due to abundant resources meant to improve service delivery. These issues, especially the effects on corruption are even higher in cases where there is no political will to implement the policy in full.

To address problems associated with the reform, the study recommends that decentralisation must be implemented in full, by enforcing the decentralisation policy. The rationale is to build mechanisms that can adequately mitigate the effects of decentralisation on health service delivery and indicator performance.

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	-	Antenatal Clinics
ARI	-	Acute Respiratory Infections
ART	-	Anti-Retroviral Therapy
CBDAs	-	Community-Based Distributing Agents
CCM	-	Community Case Management
CHs	-	Central Hospitals
CHAM	-	Christian Health Association of Malawi
CMST	-	Central Medial Stores Trust
DDC	-	District Development Committee
DHMT	-	District Health Management Team
DHO	-	District Health Office
DIP	-	District Implementation Plan
EHP	-	Essential Health Package
HAC	-	Health Advisory Committee
HCAC	-	Health Centre Advisory Committee
HCMCs	-	Health Centre Management Committees
HIV	-	Human Immunodeficiency Virus
HMIS	-	Health Management Information System
HSAs	-	Health Surveillance Assistants
HSC	-	Health Service Commission
HSSP	-	Health Sector Strategic Plan
HTC	-	HIV Testing and Counseling
IEC	-	Information, Education and Communication
IMF	-	International Monetary Fund
Med/Surg	-	Medical and Surgery
M & E	-	Monitoring and Evaluation
MNCH	-	Maternal and Neonatal Child Health
MOH	-	Ministry of Health
MOLGRD	-	Ministry of Local Government and Rural Development
NCDs	-	Non-Communicable Diseases

NGOs	-	Non-Governmental Organisations
NTDs	-	Neglected Tropical Diseases
Obs&Gynae	-	Obstetrics and Gynaecology
ORT	-	Other Recurrent Transactions
PHC	-	Primary Health Care
QECH	-	Queen Elizabeth Central Hospital
RHOs	-	Regional Health Offices
SBAs	-	Skilled Birth attendants
SPSS	-	Statistical Package for Social Sciences
TBAs	-	Traditional Birth Attendants
TB	-	Tuberculosis
VHC	-	Village Health Committees
WHO	-	World health Organisation
ZHSO	-	Zonal Health Support Office

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents an introduction to the study of the level of decentralisation in the delivery of health services in Blantyre District and perceptions of its effect. The Chapter has been divided into six sections. Section 1.1 covers the background to the study. This is followed by section 1.2 which provides the problem statement. Section 1.3 gives objectives of the study and section 1.4 presents the research questions. The justification of the study is discussed in section 1.5. Finally, the chapter ends with an outline of the whole dissertation in section 1.6.

1.1 Background to the Research Problem

After about thirty years of a highly centralised one party rule in Malawi, a radical political transformation occurred in 1992 following a wind of political change sweeping across Africa. Since then, a number of reforms such as decentralisation designed to institutionalise this new political freedom and improved governance have been taken and slowly democracy is taking roots in Malawi (Malawi Decentralisation Policy, 1998).

Mills, Vaughan, Smith and Tabibzadeh (1990) define decentralisation as "the transfer of authority, or dispersal of power in public planning, management and decision-making from the national level to sub-national levels or more generally from higher to lower levels of government"(p.7).

Therefore, as part of consolidating democracy in Malawi, cabinet directed that a comprehensive review of all decentralisation initiatives including that of district focus for rural development be undertaken. This was followed by enactment of the Local Government Act (1998), which advocates for decentralisation to the local level.

The Alma-Ata Declaration on "Health for all by the Year 2000" marked the turning point in the process of decentralisation of health services in Malawi and the world as a whole as countries embarked on prioritising primary health care as a vehicle through which the burden of diseases can be reduced (Alma-Ata Declaration Report, 1978). Decentralisation reforms therefore gained a

special status during the earliest Primary Health Care Reforms initiated by the World Health Organisation (WHO). This declaration emphasises that community participation is a crucial ingredient for the development of responsive health care system in the world.

In Malawi, the Decentralisation Policy came into being in October 1998 after a comprehensive review of all decentralisation initiatives. The policy states that:

All administrative and political authority of the Central Government shall devolve to the district level and that all government agencies at the district and local levels shall be integrated into one administrative unit through the process of institutional integration, manpower absorption, composite budgeting and provision of funds for the decentralised services (Malawi Decentralisation Policy, 1998, p.20).

The underlying principle of the Policy is to place local councils at the centre of planning and implementation of district-specific projects. The concept of decentralisation has long been used to mean the transfer of power and authority from the centre to the periphery (Tambulasi & Kayuni, 2006). However, Rondinelli, Nellis and Cheema (1989) provide a broader and deeper definition of decentralisation as:

the transfer of responsibilities for planning, management, and the raising and allocation of resources from the central government and its agencies to field units of the central government, semi-autonomous public authorities, regional authorities, or non-governmental, private or voluntary organisation (p.5).

The two definitions clearly envisage that decentralisation aims at transferring authority and power from the centre to the local level. Hence, the policy is aimed at promoting citizenship-participation in decision-making at the local level.

1.1.1 Decentralisation of Health Services in Malawi

Bossert (1998) argues that the main form of decentralisation of health services in developing countries is deconcentration. However, with reference to Malawi, Kress, Cripps, Olson and Ross (1998) contend that Malawi adopted devolution as a form of decentralisation to replace deconcentration which resulted in the dissolution of regional health offices in 1999. Health services management in Malawi is therefore in line with the Local Government Act of 1998,

which entails devolving health service delivery to local councils (Malawi Health Sector Strategic Plan [HSSP], 2011).

It should however be indicated that health services delivery in Malawi is implemented through the provision of Essential Health Package (EHP). This is a set of 13 minimum and basic health care services that are provided free of charge at the point of delivery (Malawi HSSP, 2011).

During a meeting held at Sunbird Capital Hotel in Lilongwe, Malawi between 12th and 14th October 2010, a decision was made to re-define the EHP in line with decentralisation of health services and the emerging evidence (EHP Handbook, 2004). Based on the University of Malawi - College of Medicine's burden of disease study, it was agreed that the following should constitute Malawi's EHP:

(i) HIV/AIDS
(ii) Acute Respiratory Infections (ARI)
(iii) Malaria
(iv) Diarrhoeal diseases
(v) Perinatal conditions (Adverse Maternal and Neonatal Outcomes)
(vi) Non Communicable Diseases (NCDs) including trauma
(vii) Tuberculosis (TB)
(viii) Malnutrition
(ix) Cancers
(x) Vaccine preventable diseases
(xi) Mental illness and epilepsy
(xii) Neglected Tropical Diseases (NTDs)
(xiii) Eye, ear and skin infection

The idea behind EHP is to select only those cost-effective interventions which when devolved and delivered at community level would improve the health status of the people (EHP Handbook, 2004). Such a package is expected to be cheaper to deliver because the interventions share the same technology, are delivered by multi-skilled health workers and share the same facilities at

the local level (EHP Handbook, 2004). For the patient, this means that at one visit, it is possible to access more than one service. For instance, postnatal care for the mother, immunisation for the baby and the management of other childhood interventions for a child under the age of five years would be accessed at one visit. With the above understanding, it is believed that the family would save on transport and other costs and thus be able to undertake other chores that contribute to family welfare.

Considering two EHPs namely: *Perinatal conditions* (Adverse maternal and neonatal outcomes) and *HIV/AIDS* that form Millennium Development Goals No.5 and 6, this study is grounded on health services delivery and two indicators of the aforementioned EHPs (HSSP, 2011).

These indicators are major pillars because they are considered to be crucial in determining the health status of the people at district and national levels. This argument is echoed by Chiweza (2010) who observed that decentralisation is essential as it is expected to improve the delivery of public goods and services at the local level.

1.2 Problem Statement

Although the health sector in Malawi was devolved along with other sectors in 1998 (Kress, Cripps, Olson & Ross, 1998, p. 20), there are still observed problems with perinatal conditions and HIV/AIDS in the district. The rate of maternal deliveries by skilled birth attendants (SBAs) is not increasing and that the HIV prevalence rate among the 15-49 age group is increasing. This is seen in Table1.1. Now, one wonders as to the effectiveness of decentralisation in the district; whether the implementation of decentralisation in the health sector has been effective or not considering the indicators.

In spite of availability of the policy on decentralisation, it is observed that there is no improvement in the two health indicators as seen from the table. But why is the trend like that? This research therefore would like to establish reasons as to why health services and indicators are not improving despite implementation of the policy in the District.

Table 1.1: Two indicators identified for the study

Essential Health Package (EHP) Indicator	Trend over the years						
	Before Decentralisation			After Decentralisation of Health Services			Target
	1996	1997	1998	2012	2013	2014	> 2020
Maternal Health Deliveries Rate of Maternal Deliveries by Skilled Personnel	78%	80%	80%	63%	46%	43%	80%
HIV/AIDS HIV Prevalence Rate among the 15-49 age group	33%	29%	28%	13.2%	14%	17.8%	0%

Source: Adapted from Blantyre District Health Management Information System (2014)

1.3 Research Objectives

1.3.1 Main Objective

The main objective of this research was to investigate the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect.

1.3.2 Specific Objectives

In particular, this study was intended to:

(i) Identify people's views about the state of decentralisation of health services in Blantyre.

(ii) Examine functions that have been decentralised and those that have not been decentralised.

(iii) Establish factors for the decline in health indicators in the district in relation to decentralisation

(iv) Identify challenges associated with decentralisation of health services in the district.

(v) Examine the level of decentralisation in the delivery of health services and perceptions on its effect.

1.4 Research Questions

The study was guided by the following research questions:

(i) What are the people's views about decentralisation of health services?

(ii) What are some of the functions that have been decentralised and those that have been retained by the Ministry of Health?

(iii) Which are the contributing factors to the decline in health indicators in Blantyre?

(iv) What are the challenges associated with decentralisation of health services in Blantyre?

(v) How does the level of decentralisation in the delivery of health services affect performance in the district?

1.5 Justification of the Study

Decentralisation is the suitable reform that developing countries and organisations undertake to improve service delivery. In the context of health, decentralisation is assumed to improve health service delivery and indicators as services are brought closer to the people. However, despite implementing the reform, health service delivery and indicators in the district are not improving as expected. This study therefore undertakes to establish why decentralisation has not satisfactorily improved health service delivery and indicators despite its implementation.

Limited district-based researches on the level of decentralisation in the delivery of health services and indicators have been conducted in the country. Results of this research work can therefore contribute to literature that may form a basis for further research study in the future.

Finally, the study intends to be a source of information to both government and the private sector. This information is necessary as it can be used by planners in strategic decision-making. It can also give management some food-for-thought and opportunity to reflect on some issues that may crop-up in the research.

1.6 Outline of the Study

This dissertation is divided into six main chapters. Chapter one has presented the background information to this study. It included the problem statement, objectives, research questions and justification of the study.

Chapter two covers literature review with a focus on the operational definition of health services and people's views about the implementation of decentralisation in the district. It also presents devolved and retained functions of the Ministry of Health; arguments for and against decentralisation of health services and the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect. The Chapter also presents gaps in literature and

effectiveness of the Public Administration framework of decentralisation. Additionally, organogram for Blantyre District Health Office and frameworks of decentralisation are also presented in the chapter.

Chapter three provides the methodology that was used in this study. In particular, issues of research design and study approach, research strategy, sampling and sample size, the approach to data collection, data analysis, validity and reliability are presented. The chapter also presents issues of ethical considerations and limitation of the study.

Chapter four presents research findings based on the study objectives. The chapter dwells much on the demographic information of participants and people's views about the implementation of decentralisation in the district. It also presents devolved and retained functions of the Ministry of Health; state of decentralisation of some health indicators; challenges associated with decentralisation of health services and the level of decentralisation in the delivery of health service in the district.

Chapter five presents a discussion of the research findings. This is followed by chapter six, which is the final chapter. The chapter gives a summary of the study findings; lessons drawn from the study; recommendations; suggested areas for further study and conclusions.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter establishes the basis for the study of decentralisation of health services in the District. It further provides a discussion on the theories of decentralisation of health services as expounded in literature and the appropriate theory for the study in the district. The chapter has been divided into ten sections. Section 2.1 discusses the operational definition of decentralisation of health services. This is followed by section 2.2 which presents people's views about decentralisation of health services. Section 2.3 provides an outline of devolution of health services and levels of healthcare delivery system in Malawi. The chapter also presents arguments for and against decentralisation of health services in section 2.4. The level of decentralisation in the delivery of health services and perceptions of its effect is covered in section 2.5. While section 2.6 discusses theories of decentralisation of health services in the district, section 2.7 provides gaps in literature and effectiveness of the Public Administration Framework of decentralisation. Section 2.8 gives the organogram for Blantyre District Health Office and this is followed by conceptual and theoretical frameworks of decentralisation of health services presented in section 2.9.Finally, the chapter ends with a conclusion in section 2.10.

2.1 Operational Definition of Decentralisation of Health Services

Decentralisation is defined as a socio-political process that transfers authority and responsibility in planning, management and decision-making from central government to local councils (Collins & Green, 1994; Rondinelli, Nellis& Cheema, 1989). This is motivated in part by the desire to bring politicians and policy-makers closer to clients (World Bank, 2004; Peckham, Exworthy, Powell & Greener , 2005), and to make health systems more equitable, inclusive and fair (WHO, 2008) as well as developing services to be more efficient and effective (World Bank, 2004).

Tambulasi and Kayuni (2006) define decentralisation as "the transfer of power and authority from the centre to the periphery" (P.3). With reference to this definition, various perspectives with different arguments have been given with regard to decentralisation in both the public and private sector. One argument asserts that decentralisation brings public services closer to people

who have more opportunities to participate more actively in decision-making process of local policies and activities than in centrally decided ones (Saito, 2001).

This participation in turn contributes to improve accountability of public services because people can scrutinise local governments more closely than central governments. The services are also delivered more speedily than in the case of a centralised administration since decentralisation reduces often lengthy bureaucratic procedures. Much of the interest in decentralisation is based on the notion that it can improve fairness through the delegation of administration and/or devolution of governance from central government to local communities and thereby help address the goals of an organisation.

Decentralisation is believed to be one of the essential institutional reform efforts pursued in developing countries. This is often implemented by donor agencies, especially the World Bank and the International Monetary Fund (IMF), and usually packaged together with attempts to minimise state interventions into economic activities and to liberalise markets by privatisation and deregulation[1].However, decentralisation in public service management continues to invite controversy and debate. Opponents of decentralisation consider it the road to wrack and ruin (Tanzi, 1996), whereas its advocates see it as a panacea for reforming the public services in developing countries (Shah, 1998a).

For at least the last two decades, decentralisation has been considered a key means of improving the performance of the health sector and generally promoting socio-economic development (World Bank, 1993;Peckham et al., 2005) contributing to equity, social justice and the end of exclusion (WHO, 2008). Decentralisation is also considered to be essential for the effective implementation of the Millennium Development Goals, a road map set out in 2000 by 147 heads of state and governments to achieve universally accepted human values and rights such as freedom from hunger, the right to basic education, the right to health and a responsibility to future generations by 2015 at the grassroots level (Mookherjee &Bardhan, 2003; United Nations, 2008). It is viewed as an essential component of the overall process of decentralisation because it tackles and ultimately eliminates the problems of centralisation such as bureaucracy, corruption and failure to develop inter-sectoral health approach (Collins, Omar &Adhikari, 2004).

[1] Decentralization :A Sampling of definitions -Working paper prepared in connection with the Joint UNDP-Government of Germany evaluation of the UNDP role in decentralization and local governance:1999,P.6

For purposes of this study, however, decentralisation is defined as "the assignment of fiscal, political and administrative responsibilities to lower levels of government occurring worldwide for different reasons, at different paces, and through different means" (World Bank, 1998, as cited in Fernando, 2002, p.118).

2.2 Views about Decentralisation of Health Service Delivery

Health services decentralisation has long been advocated as a desirable process for improving health systems and more recently, it has been seen as an integral part of broader health reforms to achieve improved equity, efficiency, quality and financial soundness (Bossert, 1998). Literature also shows that decentralisation of health system structures and management is a key issue for many countries in the achievement of *Millennium Development Goals* and in the development of primary health care (World Health Organisation, 1993).

Decentralisation reforms gained recognition after the Alma-Ata Declaration on "Health for all by the Year 2000". It obtained a special status during the earliest Primary Health Care Reforms initiated by the World Health Organisation following the Alma-Ata Declaration (1978). This declaration emphasises that community participation is a crucial ingredient for the development of responsive health care system.

Health sector decentralisation appeals to many policy-makers and academic analysts because of its perceived advantages (Conn, Green &Walley, 1996; Mills et al., 1990). Experiences from different countries, such as Ghana, Zambia, Uganda and the Philippines (Bossert& Beauvais, 2002), Botswana, Mexico and The Netherlands have highlighted problems in different spheres (Mills et al., 1990). The issue of distribution of power between different levels of government has shown that potential "losers" are often reluctant to hand over power to those who stand to gain from the process, resulting in considerable tension between the centre and the periphery (Mookherjee &Bardhan, 2003; Dahal, 2005; Adhikari, 2006).

A common aim of decentralisation is to make the government responsive to public needs and encourage community involvement by service delivery reform (Mills, 1994; WHO, 2008). However, community representatives may face several problems in making their voice heard by Central Government representatives who use their professional power to override others' views. Moreover, when community representatives gain influence at the local level, it does not guarantee the use of authority in the best interest of the community (Mills et al., 1990). Indeed,

increased community participation may actually increase inequality (urban areas for example may attract more resources than rural areas because of different socio-political interests); it can also exacerbate two other negative influences on equity: local demands that conflict with the achievement of national equity, and weaknesses in the central planning capacity (Green, 1992).

Two case studies on equity carried out by Gonzalez-Block, Leyva Zap Ata, Loewe and Alagon (1989) in Mexico and by Bloom and Xingyuan (1997) in China, showed that national inequity increases with decentralisation. Bossert (1998), however, argues that the process of decentralisation is one of selectively broadening the "decision-space", or range of choice available to local agents, within the various spheres of policy - management, finance, and governance. This approach is based on a "principal-agent" relationship in which the centre, acting as the principal, voluntarily transfers formal authority to the agent in order to promote its policy.

In a study conducted by Larbi (1998a) in Ghana, decentralisation of health services delivery moves from the vertical top to the bottom of healthcare delivery and promotes hierarchies that are flatter, more flexible and more responsive governance structures. In agreement to Larbi (1998a), Grindle and Thomas (1991) observed that the increased emphasis on decentralisation should see citizens as active participants engaged in making and shaping social policy and not only as users or consumers. This involvement ensures fair processes and creates better decisions in addition to bringing fulfilment and understanding among those involved.

Grindle and Thomas (1991) further argue that policy prescriptions made by central institutions weaken the autonomy of the lower implementing parties to chart their own course. Therefore, it is appropriate that an enabling environment for autonomous decision-making and policy formulation be created for the health sector to ensure effective and efficient health service delivery.

2.3 Devolution of Health Services and Levels of Healthcare Delivery System in Malawi

The devolution of health services in Malawi was effected in 1998 following the launch of the National Decentralisation Policy and subsequent enactment of the Local Government Act (Kress et al, 1998, p. 20). Since then, the country has experienced devolution of some functions to the

local level and retention of some at the Ministry level. The devolution of health services is also marked by the levels of healthcare delivery system in Malawi.

2.3.1 Devolved and retained functions of the Ministry of Health

The Malawi Decentralisation Guidelines (2005) point out that six core functions of health services delivery were identified for decentralisation to the lower levels of health service delivery and these are health planning, budgeting and resource allocation, district implementation plan, monitoring and evaluation, human resources management and research.

It is also observed that there are other non-core functions that were devolved to the lower levels of health service delivery during the implementation of decentralisation. These include procurement of cleaning materials, stationery and general stores (The Malawi Decentralisation Guidelines, 2005). Regarding the retention of functions by the Ministry, Dulani (2009) argues that the Ministry of Health retained some functions at the inception of decentralisation and these are policy formulation; health legislation and its enforcement; inspectorate and establishment of standards; international representation; regulation of the sector and donor coordination; resource mobilisation; budget review and analysis just to mention but a few.

2.3.2 Levels of Healthcare Delivery System in Malawi

Malawi's health care delivery system is specifically organised at various levels namely: Community, Health Post, Dispensary, Maternity Unit, Health Centre, Community Hospital, and District Hospital including CHAM, Central Hospital and the Central Ministry of Health (MoH). However, there are three main levels of health service delivery namely: primary, secondary and tertiary. These different levels are linked to each other through an elaborate referral system that has been established within the health system (HSSP, 2011).

(i) Primary Care Level

The Primary Level consists of community initiatives such as health posts, dispensaries, maternities, health centres and community hospitals. At community level, health services are provided by community-based cadres such as Health Surveillance Assistants (HSAs), Community-Based Distributing Agents (CBDAs), and Village Health Committees (VHCs) and other volunteers from Non-Governmental Organisations (NGOs). HSAs provide promotive and preventive health services including HIV testing and Counselling (HTC) and provision of immunisation services. They are also involved in community case management (CCM) of acute

respiratory infections (ARIs), diarrhoea and pneumonia among under five children. Services at this level are conducted through door-to-door visitations, village clinics, mobile clinics, or at manned or unmanned health posts. Community health nurses and other health cadres also provide health services through outreach programs. VHCs promote Primary Health Care (PHC) activities through community participation and they work with HSAs to promote preventive and promotive health services such as hygiene and sanitation. At primary level, health centres support HSAs and some health centres have Health Centre Management Committees (HCMCs) which ensure that communities receive the services that they expect in terms of quantity and quality through monitoring of performance of health centres in collaboration with VHCs. Health centres are responsible for providing both curative and preventive Essential Health Package services. Community hospitals that were formerly known as rural hospitals provide both primary and secondary care services. They have admission facilities with a capacity of 200 to 250 beds (HSSP, 2011).

(ii) Secondary Level

District hospitals constitute secondary level of health care. They are referral facilities for both health centres and community hospitals and have an admission capacity of 200 to 350 beds. They also service the local town population offering both in-patient and out-patient services. CHAM hospitals also provide secondary level health care services (HSSP, 2011).

The provision and management of health services has since been devolved to the local government following the Decentralization Act of 1998. The district or CHAM hospitals provide general services such as PHC services and technical supervision to lower units. District hospitals also provide in-service training for health personnel and other support to community based health programs in the provision of Essential Health Package (EHP). Health services at district level are managed by the DHMT. The DHMT receives direct technical support and supervision from the Zonal Health Support Office (ZHSO) (HSSP, 2011).

Meanwhile, Blantyre District does not have a district hospital. As such, many of its secondary services are provided by Queen Elizabeth Central Hospital (QECH), CHAM and private hospitals such as Mlambe, Mwaiwathu and Adventist. Recently, a new facility called gate-way clinic was opened a stone-throw away from the District Health Office to act as a conduit through which patients from the surrounding area can be referred to QECH. Apart from Blantyre, other districts

that do not have district hospitals are Phalombe and Zomba in the South and Likoma in the North.

(ii) Tertiary Level

The tertiary level comprises of central hospitals (CHs). These provide specialist referral health services to their respective regions. Specialist hospitals offer very specific services such as obstetrics and gynaecology (Obs & Gynae). There are currently 5 central hospitals namely: Queen Elizabeth CH in Blantyre, Kamuzu CH in Lilongwe, Mzuzu CH in Mzimba and Zomba Central Hospital in Zomba with admission capacities of 1250, 1200, 300 and 450 beds, respectively. Tertiary care is also provided by Zomba Mental Hospital. Queen Elizabeth and Kamuzu Central Hospitals are also teaching hospitals because of their proximity to College of Medicine and Kamuzu College of Nursing campuses. Central hospitals, however, also provide EHP services which should essentially be provided by district health hospitals. The CHs are also responsible for professional training, conducting research and providing support to districts (HSSP, 2011).

2.3.3 Role of the Ministry of Health in the Decentralisation of EHP in Malawi

The MoH Headquarters is responsible for the development, review and enforcement of health and related policies for the health sector; spear-heading sector reforms; regulating the health sector including the private sector; developing and reviewing standards, norms and management protocols for service delivery and ensuring that these are communicated to lower level institutions; planning and mobilising health resources for the health sector including allocation and management; advising other ministries, departments and agencies on health related issues; providing technical support supervision; coordinating research; and monitoring and evaluation (HSSP, 2011).

Previously, the MoH used to provide its services from central level through the regional health offices (RHOs) to the district level. It was noted during the review of the third Malawi National Health Plan that health care delivery had not caused a lot of impact despite a lot of activities and input from the government and donors. This was evidenced by increasing maternal and child mortality rates (Ministry of Health and Population, 1999). The maternal mortality rate increased from 620 to 1120 per 100,000 live births while the child mortality rate increased from 159 to 189 per 1000 in 1994 and 1999 respectively. There was also a notable decrease in the life expectancy

from 43 to 39 during the same period (Malawi Demographic and Health Survey, 2000). One of the contributing factors to ineffective delivery of services that featured highly in this forum was the centralised health service delivery that was characterised by vertical programmes that lacked coordination between financiers and implementers.

In an effort to address this issue, it was resolved that health service delivery be reformed through decentralisation in line with the Malawi Government decentralisation policy, and that the DHMTs should be expanded and strengthened. This was planned in 1999; the guidelines were put in place in 2004 and implementation was scheduled to start in 2005 (Ministry of Health and Population, 2005). However, due to failure to hold local council elections in the country, donors pulled out their assistance and this delayed the implementation till 2008 when it actually took-off.

According to Sakyi (2007), management decentralisation and health sector reform enable governments to provide high quality services that the citizens value. This is because the decentralised sectors involve the local citizen in planning and policy formulation, such that the locals are allowed to shape the services into designs that would benefit their community. In agreement to this, the Government of Malawi through Ministry of Health in its fourth national health plan forecasted that the District Health officer, who would be the head of the DHMT, should be a member of the District Executive Committee, which is a body that provides technical advice to the District Development Committee (DDC) on health matters. The DDC is comprised of chiefs, political leaders and members of parliament who bring issues from the grassroots. In such a way, it would be easy for the district team to identify areas that need specific intervention and incorporate the ideas of members of the community.

In addition to that, since the DHO is the head of the health sector at district level, all the health care activities conducted in the district by non-governmental organisations, the private sector and other technical groupings would be coordinated by his office (Ministry of Health and Population, 1999). This would ensure collaboration such that there cannot be duplication of activities and that activities would be equally distributed according to the needs of the communities.

2.4 Arguments for and against Decentralisation of Health Services

2.4.1 Objectives of Decentralisation of Health Services

Decentralisation is pursued for technical, political and financial reasons. On the technical side, it is recommended as a means to improve administrative and service delivery effective (Bossert &

Beauvais, 2002). Politically, decentralisation usually seeks to increase local participation and autonomy, redistributes power and reduces ethnic and regional tensions. On the financial side, decentralisation is used as a means of increasing cost efficiency, giving local units greater control over resources and revenues as well as sharpening accountability. In the health sector, where decentralisation has been pursued for technical reasons, it has been a major component of performance improvement efforts (Bossert & Beauvais, 2002).

2.4.2 Factors for Decentralisation of Health Services

Decentralisation brings public services closer to the people who have more opportunities to participate more actively in decision-making process of local policies and activities than in centrally decided ones (Saito, 2001). This participation in turn contributes to improve accountability of public services because people can scrutinise local governments more closely than central governments. The services are also delivered more speedily than in the case of a centralised administration since decentralisation reduces often lengthy bureaucratic procedures for decision-making and implementation at the centre and limited public resources are more efficiently and effectively utilised at the peripheral.

In my view, this line of argument parallels to that of participatory development because encouraging people's participation in entire development processes ensures more effective and sustainable development outcomes since people can feel the ownership of activities in which they are participating.

Accordingly, decentralisation is a version of seeking a balance between top-down and bottom-up communication between the centre and the peripheral in order to reach good governance. By shifting more responsibilities and functions from the central government to sub-national governments, an adequate division of functions and responsibilities between different levels of government is considered to be established. Therefore, this can enhance good governance, which in turn improves the delivery of health services to the local people.

2.4.3 Factors against Decentralisation of Health Services

Critics of decentralisation, on the other hand, contend that decentralisation leads to soft budget constraints, macro-economic instability, clientalism and enlargement of bureaucracies and fosters more local loyalty to regional identities than the national identity and this may encourage more

autonomy from the central government and even a territorial secession in multi-ethnic and multi-religious societies (Fallet, 2004). This puts the national integrity itself at risk.

One of the main arguments against decentralisation was put forward by Chiweza (2010), who argues that the effectiveness of decentralisation depends on the political will of the government of the day. Chiweza (2010) further argues that holding of Local Government Election should be treated as a matter of priority as the elected councillors act as a conduit through which citizenship-participation and decision-making at the local level are enhanced. This in turn improves service delivery.

Saito (2001) further asserts that newly created autonomy as a result of decentralisation may be manipulated by local elites for seeking their narrow personal benefits at the cost of the general population who are in dire need of improved livelihood. This view is in line with assertions by Bossert (1998), who claims that officials at the local level, who are at the centre of implementing decentralisation initiative, tend to seek personal gains out of the initiative. In my view, this suggests counter-productivity as it negatively affects the efficiency and effectiveness of the reform.

Decentralisation may increase corruption at the local level and thus, this would not improve accountability (Saito, 2001). Commenting on the local Malawian scene, Tambulasi and Kayuni (2006) agree with Saito (2001) by arguing that decentralised local governance in Malawi has enhanced corruption among the local councils in relation to their election, awarding of contracts and other related acts. This has consequently led to, *inter alia,* financial mess in local councils, loss of citizen and donor trust as well as low quality infrastructures as it was the case in Malawi in 2013 with the '*Cash-gate Scandal'*, where local contractors siphoned tax-payer's money to the tune of K1.5 billion at Capital Hill and local councils for contracts and projects that never existed (The Daily Nation: October 31, 2013).

However, though critics of decentralisation argue that it weakens the national government, promotes corruption and therefore should not be pursued, I am of the view that decentralisation improves access to basic services, quality of care and efficiency as the services are brought closer to the people. This view is in line with what Bossert (1998) argues when he said "Decentralisation has long been advocated as a desirable process for improving health systems".

2.4.4 Challenges associated with Decentralisation of Health Services

Several challenges may follow decentralisation of health services. Firstly, lack of organisational control and co-ordination of efforts may hamper the implementation of the policy (Bossert, 1998). This may be due to poor leadership styles or lack of political will. While too much top control may reduce initiative and creativity, a decentralised organisation's ability to release creativity may have limits. Thus, innovations at higher levels and innovations requiring inputs from different kinds of expertise may require some centralisation of intellectual capacity (Pascale, 1990).

The spread of power among several hands may lead to conflicts due to an unclear division of authority and the exercise of personal ambition (Pascale, ibid). In this regard, defence of one's own territory by departmental heads may be seen. With greater spread of power within decentralised organisations, the result may be that some departments tend to pursue goals other than those of the health system decentralisation depending not only on overall government political and administrative structures and objectives, but also on the pattern of health system organisation prevailing in the particular country (Mills, 1990).

2.5 Level of decentralisation in the delivery of health services and perceptions on its effect

Healthcare decentralisation is a complex phenomenon embracing a number of political, fiscal and administrative dimensions. It therefore follows that a precise measure of the level of decentralisation in the delivery of health services is difficult to develop (Jimenez& Smith, 2005).Thus, there is little evidence to support the idea that countries with a more decentralised health system have better outcomes.

So far, only a limited number of studies have attempted to measure the magnitude of the level of public sector decentralisation in the delivery of health services and indicator performance. On the whole, these studies found some beneficial effects of decentralisation on indicators of health outcomes.

In line with the above argument, Banting and Corbett (2002) as cited in Jimenez and Smith (2005) challenged that the core question is to what extent health care policy is decided centrally or locally for its effect to be measured. In this vein, results of the econometric estimates for Canada suggest that decentralisation has had a positive and substantial [effect] on the

effectiveness of public policy and indicator performance as there has been a substantial improvement in health service delivery in the country (Jimenez &Smith, 2005).

In summary, literature suggests that decentralisation has had substantial effects on health service delivery in countries where it has been implemented effectively. Where the reform has not been implemented fully and effectively, the effects have not been satisfactory.

2.6 Theories on Decentralisation of Health Services

Theory is defined as "*a* set of inter-related abstract propositions about human affairs and the social world that explain their regularities and relationships" (Brewer, 2000, p.192).

On the other hand, Denscombe (1998) define theory as *"*a proposition about the relationship between things" (p. 240).

Thus, theory is a coherent set of general propositions used as principles of explaining relationships of certain observed phenomena. Theories are used to understand and predict phenomena. They can be looked at in two levels: abstract level and empirical level. At an abstract level, elements of a theory are *concepts* and *propositions* while at empirical level we have *variables* and *testable hypothesis*.

However, it should be noted that our understanding of the two levels at which theory operates determine the research approach (deductive ie. testing a hypothesis or Inductive ie. building a hypothesis) and subsequently the research strategies.

With reference to decentralisation of health services, Bossert (1998) reviewed four major theories of decentralisation that have been used by authors to address problems of decentralisation in the health sector and these are: *Public Administration*, *Local Fiscal Choice*, *Social Capital* and *Principal/Agent Theory*. However, this study applies the public administration theory to investigate and establish the impact of decentralisation on health services in Blantyre.

2.6.1 Public Administration as a feasible framework for Decentralisation of Health Services in Malawi

This is the most prominent framework of decentralisation in that it focuses on the distribution of *authority* and *responsibility* for service delivery within a national, political and administrative structure (Bossert, 1998).The theory tends to assume that decentralisation brings public services closer to people who have more opportunities to participate more actively in decision-making

process of local policies and activities than in centrally decided ones (Saito, 2001). This participation in turn contributes to improve accountability of public services because people can scrutinise local governments more closely than central governments. The services are also delivered more speedily than in the case of a centralised administration since decentralisation reduces often lengthy bureaucratic procedures for decision making and implementation.

The study therefore uses the Public Administration Framework developed by Rondinelli in 1981 because it is in line with the objectives of the reform in Malawi and Blantyre in particular.

Broadly speaking, the Public Administration Framework may be categorised into four types and thee are a*dministrative decentralisation*, *political decentralisation*, *fiscal decentralisation and market decentralisation* (Rondinelli, Nellis & Cheema, 1984). Specifically, this approach has developed a well-known four-fold typology of decentralisation namely "*deconcentration, devolution, delegation and privatisation"* (Rondinelli, Nellis & Cheema, 1984, p.13).

(i) Administrative Decentralisation

According to Rondinelli et al. (1984), administrative decentralisation focuses on the different responsibilities that might be transferred from central (national or provincial/state) government bureaucracies to actors within smaller political units. These responsibilities often include the administration and delivery of social services such as education, health and social welfare. It is of two forms namely*: deconcentration* and *delegation.*

Deconcentration is defined as "The handing over of some amount of administrative authority or responsibility to lower levels within central government ministries and agencies" (Rondinelli, 1983, p.18). In other words, it is the transfer of administrative and service delivery functions within a given public body to one of its own regional or field offices and where primary policy-making responsibility is retained by the head office though defined managerial responsibilities for delivery may be delegated to the manager of the delegated entity. It entails the shifting of the workload from centrally located officials to staff or offices outside of the national capital. For example, the transfer of administrative responsibility from the Central Ministry of Health to a District Health Office can be termed as deconcentration.

From the above definition, deconcentration entails establishing local management with clearly defined administrative duties and with a degree of discretion that would enable the local officials

to manage without constant reference to the MOH. It has been the most frequently used form of decentralisation in developing countries including Malawi since the early 1970s.

Delegation, on the other hand, refers to "The transfer of authority and responsibility from central agencies to organisations not directly under the control of those agencies" (Hutton, 2003, p.3).

Rondinelli *(1983)* also defines it as "The transfer of authority to make operational decisions by a principal to an agent or subordinate authority while the principal retains full responsibility for the performance of the functions delegated" (p.19)

It involves the transfer of managerial responsibility for defined functions to the organisations that are outside the central government structure and only indirectly controlled by the MOH. Ultimate responsibility remains with the MOH, but its agent has broad discretion to carry out its specified functions and duties (Mills et al., 1990). Commenting on the same, Rondinelli (1981) asserts that delegation is the transfer of managerial responsibility for specifically defined functions to organisations that are outside the regular bureaucratic structure and that are only indirectly controlled by the central government. For example, the Central Ministry of Health can delegate its responsibilities to an autonomous Christian Health Association of Malawi (CHAM) Hospital to implement these responsibilities on its behalf.

Thus, delegation implies that a sovereign authority creates or transfers to an agent specified functions and duties, which the agent has broad discretion to carry out. However, ultimate responsibility remains with the sovereign authority. In developing countries, responsibilities have been delegated to public corporations, regional development agencies, special function authorities, semi-autonomous project implementation units, and a variety of parastatal organisations (Rondinelli, 1983).

(ii) Democratic/Political Decentralisation

Political decentralisation (also known as *devolution*) is "The legal transfer of authority and power to make decisions, plan and provide services from central to local level" (Rondinelli, 1983, p.24).

On the other hand, Ferguson and Chandrasekharan (2004), define devolution as "The transfer of governance responsibility for specified functions to sub-national levels, either publicly or privately owned, that are largely outside the direct control of the central government" (p.3).

In other words, it is the legal transfer of power to locally elected political bodies (local government) that are substantially independent of the national level with respect to a defined set of functions (Mills et al., 1990; Conyers., 1981). They are rarely 'completely autonomous' but are bodies largely independent of the national government in their areas of responsibility, for example, raising revenue and staff appointment. The policy function is usually the only function retained centrally. It transfers electoral capacities or political authority to sub-national and/or local governments. This is usually accompanied by constitutional amendments and/or electoral reforms. In some cases, though not always, political decentralisation involves describing the legislative powers of sub-national/local governments and how they can raise revenue for their day-to-day functions.

Under devolution, local units of government are autonomous and independent, and their legal status makes them separate or distinct from the central government. As an example, this may involve the transfer of responsibilities from the Ministry of Health Headquarters to the local government authorities (Hutton, 2003, p.3).

(iii) Market Decentralisation (Also known as *Privatisation*)

Privatisation is regarded as *"*the selling out of public enterprises to the private sector" (Tambulasi & Kayuni, 2006, p. 20). It involves the transfer of government functions to private, profit-making or non-profit making or voluntary organisations with a variable degree of government regulations[2].

However, many commentators do not see privatisation as true decentralisation. They argue that it is not a form of decentralisation but it clearly meets the definition of devolution given above. Despite Rondinelli's claim for privatisation as a radical category, its inclusion is also a problem, as not all privatisations are decentralisation (Peckham et al., 2005). In fact, privatisation may occur centrally or in decentralised units and it may or may not involve a transfer of power or authority, depending on the nature of the market or contractual relationship that is established.

(iv) Fiscal Decentralisation

Fiscal decentralisation is regarded as the central government's transfer of influence over budgets and other financial powers either to local governments or to their own regional/local offices

[2] Definition from "Management of Decentralisation of Health Care: Report and documentation of the Technical Discussions held in conjunction with the 39th Meeting of CCPDM (WHO), 2002, P.19.

(Rondinelli et al., 1984). It is considered to be one of the most important components in achieving more effective health services delivery as it can either be political or administrative or both, but its distinctive feature is that it has a financial responsibility and authority component.

It is a two-dimensional policy institution that involves either decentralisation of a tax instrument, where local governments have the power to raise taxes, or decentralisation of expenditures and where local governments bear the responsibility for implementing expenditure functions (Porcelli, 2009).

2.7 Gaps in Literature and Effectiveness of the Public Administration Framework of Decentralisation

Although the public administration framework of decentralisation has long been advocated as a desirable process for improving efficiency, equity, quality, financial soundness and the health status of the people, its effectiveness has been questioned by many authors and that there is scanty information on decentralisation of EHP Indicators in the literature (Bossert, 1998). However, though the effectiveness of the public administration framework has been a subject for debate over the years, the Malawi Government took the initiative to decentralise the EHP in 2004 to ensure universal access to quality EHP services which consist of promotive, preventive, curative and rehabilitative services to all people in Malawi in general and Blantyre District in particular (HSSP, 2011).

Drawing from the literature studied on decentralisation of EHP and the strategies employed by Blantyre District Health Office, there exist a lot of unanswered questions about why there is a high HIV prevalence rate among the 15-41 age group despite decentralisation of health services in the district. There is also a gap created by what is happening on the ground in terms of maternal health deliveries by skilled personnel and what the literature advocates. Literature advocates that decentralisation of EHP services improves health services delivery (Saito, 2001) but efforts to decentralise EHP in the district are providing results that are contrary to the expectation of the people. This mismatch therefore calls for the researcher to find out the effectiveness of decentralisation of health services in Blantyre.

2.8 Organogram for Blantyre District Health Office

According to Mullins (2005), an organisation is "a collection of people brought together for a purpose". Katz and Kahn (2004) also define it as a system which is composed of a set of sub-

systems. Typically, the organogram, which is in the shape of a pyramid, shows people and the intended structure of an organisation. It reflects on the power structure of the organisation. It also shows the person in charge at the top. Below then are the clustered subordinates, usually in progressive smaller order. The organogram is therefore a chart depicting the complete structure of an organisation, or division of an organisation, or a campaign body, including all its committees. It also demonstrates how the various sections of the organisation relate to one another.

Figure 2.1 shows the reporting lines of authorities and responsibilities and how the EHP is implemented. It also shows hierarchies and the span of control for each superior. From the organogram, it can be argued that the organisation itself is relatively flat as there are at least three management levels. With fewer layers of management, one would expect decentralisation to

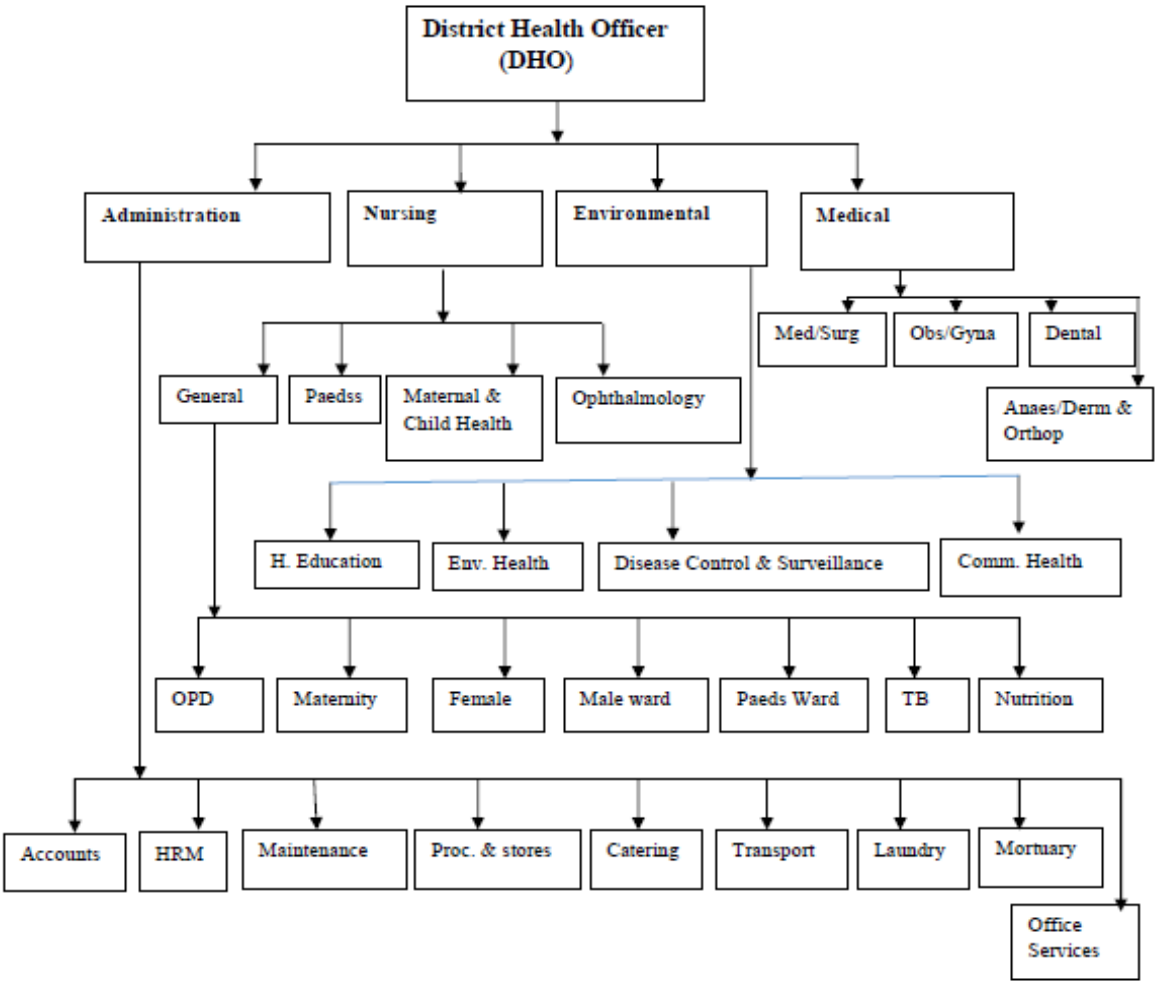


Figure 2.1: Organogram for Blantyre DHO

improve service delivery as the passage of information from one layer to the other is fast. However, in spite of all this, there is an inverse relationship between decentralisation and the EHP in the district.

2.9 Conceptual and Theoretical Frameworks for Decentralisation of Health Services in Blantyre

A '*conceptual framework'* is an explanatory device "which explains either graphically or in narrative form the main things to be studied - the key factors, constructs or variables - and the presumed relationships among them" (Miles & Huberman, 1994, p.18). Commenting on the same, Khan (1999) defines it as the researcher's own position on the problem and gives direction to the study. While the theoretical framework is the theory on which the study is based, the conceptual framework is the operationalisation of the theory. It may be an adaptation of a model used in a previous study, with modifications to suit the inquiry. Apart from showing direction, the researcher can also show the relationships of the different constructs that he wants to investigate through the conceptual framework.

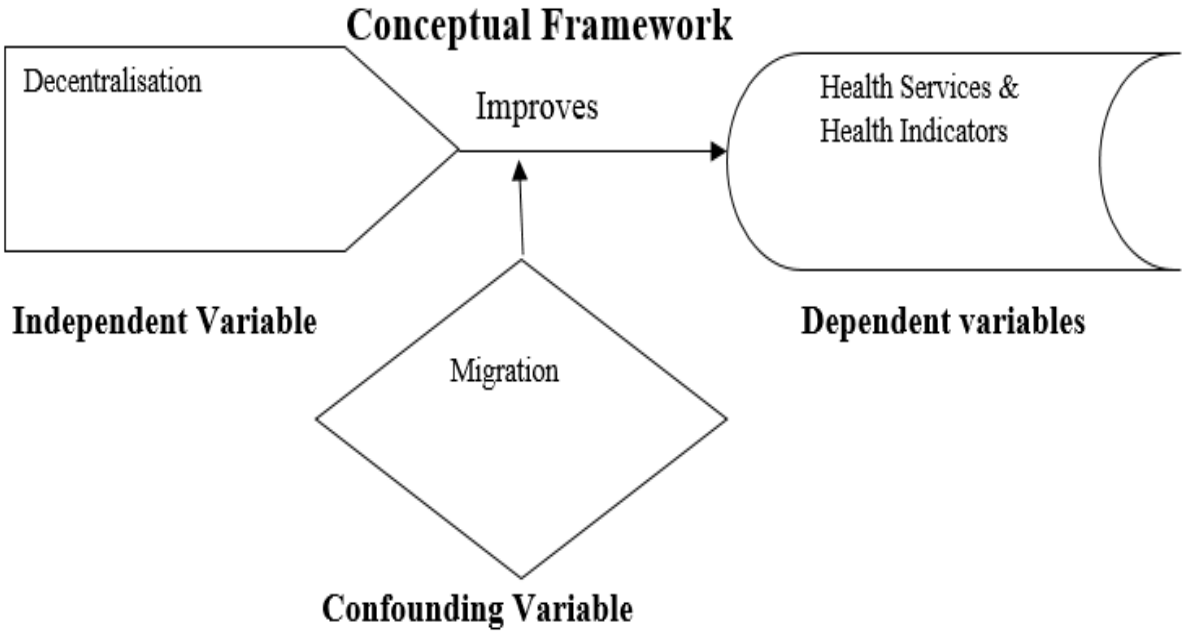
A good conceptual framework identifies and labels the important variables in the situation that are relevant to the problem (Sekaran, 2003). It logically describes the inter-connections among these variables. The relationships among the independent variables, the dependent variable(s), and if applicable, the confounding, moderating and intervening variables are elaborated.

In Figure 2.2, the dependent variables are health services and indicator performance. The dependent variable is the variable of primary interest to the researcher (Sekaran, 2003). The researcher's goal is to understand and describe the dependent variable, or to explain its variability, or predict it. In other words, it is the main variable that lends itself for investigation as a viable factor. Through the analysis of the dependent variables (i.e., finding what variables influence them), it is possible to find answers or solutions to the problem. For this purpose, the researcher is interested in quantifying and measuring the dependent variables and other variables of influence.

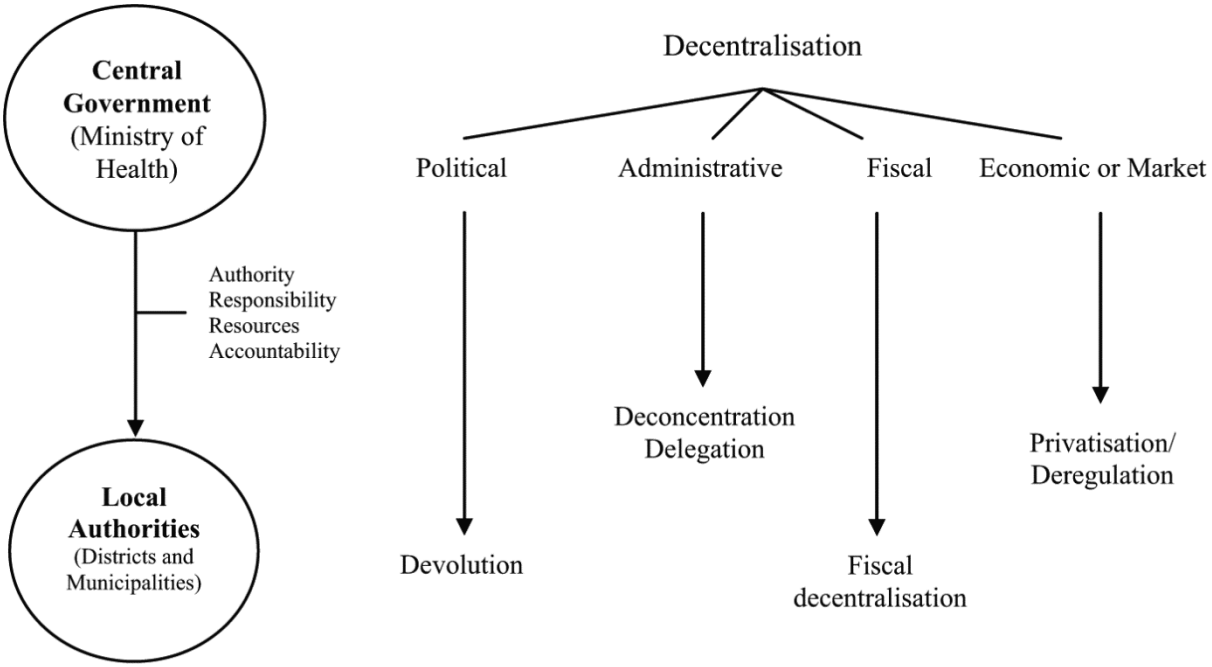
The conceptual framework above further shows that the independent variable is "decentralisation of health services". The independent variable is the variable that when manipulated, influences the dependent variable(s) positively or negatively (Sekeran, 2003).

Confounding variable is an extraneous and often unexpected variable which brings about a biased or distorted result due to constant error (Langdridge, 2004).In other words, confounding variables (aka third variables) are variables that the researcher failed to control, or eliminate thereby damaging the internal validity of the research.

They can adversely affect the relation between the independent variable and dependent variable. This may cause the researcher to analyse the results incorrectly. The results may show a false correlation between the dependent and independent variables, leading to an incorrect rejection of the null hypothesis.



Theoretical Framework



Source: Modified and adopted from Litvac *et al.* (1998) and Ribot (2002)

Figure 2.2: Conceptual and Theoretical Frameworks for Decentralisation of Health Services

If we had expected an effect from this variable, then we could have either included it in our study as another independent or controlled it for its effect through the careful design of our study. However, no matter what, we may sometimes discover the confounding effect during the course of our research.

In this study, our confounding variable is migration of people in Blantyre and this variable is eliminated through randomisation and sound operationalisation process. Once the conceptual framework has been determined, the next step for the researcher is to determine what research methods to employ to best solve the research problem through the proposed framework.

2.10 Conclusion

This chapter has reviewed the available literature on the impact of decentralisation on health service delivery and indicator performance. The chapter has explored theoretical concepts regarding decentralisation and concentrated on the Public Administration paradigm. It has also

looked at peoples' views about decentralisation and functions that have been decentralised to the district. The chapter has also looked at factors for and against decentralisation; the level of decentralisation in the delivery of health services and indicator performance and challenges associated with decentralisation of health services.

Decentralisation of health services is a major political reform that has been promoted by many international agencies and by national governments to improve health service delivery. The chapter has established that though there are problems in the use of Rondinelli's Public Administration framework, there is no single perfect framework that can be applied in all circumstances and the study therefore uses the theory as a basis to investigate the level of decentralisation in the delivery of health services.

Having reviewed the relevant literature that has provided the conceptual and theoretical framework of the study, the next chapter presents the methodology used to conduct this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

As indicated in chapter one, this study investigates the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect. Chapter three therefore discusses the research methodology based on the objectives of the study. It starts with section 3.1 which presents the research design and approach. Section 3.2 provides the research strategy. This is followed by section3.3 which covers sampling and sample size. Section 3.4 provides the approach to data collection. Data analysis is covered in section 3.5. A presentation on validity and reliability is covered in section 3.6.The chapter also outlines ethical considerations in section 3.7 and limitation of the study in section 3.8. Finally, the chapter ends with conclusion in section 3.9.

3.1 Research Design and Approach

Research design is the general plan of how one goes about answering research questions (Saunders, Philip & Thornhill, 2009). Burns and Grove (2001) conceptualise it as a series of defined structures within which a study is implemented.

The research approach for this study is both quantitative and qualitative using deductive reasoning. Quantitative research explains phenomena by collecting numerical data that are analysed using mathematically based methods (Gunderson & Aliaga, 2002). In this study, quantitative approach is used to analyse the qualification, experience and study response rate of participants with regard to the level of decentralisation of health services in the district. The approach further seeks to obtain data on views as to whether decentralisation has been implemented fully or not and the state of decentralisation of health indicators in the district.

Qualitative research on the other hand, studies things or objects in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them (Denzin, 1994).The study therefore uses the approach to gather data for analysis through actual interaction with participants and through actual face-to-face method.

The use of two approaches is necessary because it maximises flexibility of the research and takes care of the shortfalls associated with the use of only one approach. Considering the nature of this study therefore, qualitative and quantitative approaches are deemed to be appropriate.

3.2 Research Strategy

The study used a survey as a strategy for data collection. This strategy was used because it involves going into the field to interview participants to collect data.

3.2.1 Field Survey

In this study, the researcher visited the sampled facilities in the district and the operating bases of other remaining participants to collect data through the use of questionnaires or face-to-face interview. Survey research method was used for this study through the distribution of copies of questionnaire with clear instructions to collect necessary information from respondents.Questionnaires with clear instructions were emailed to the sampled participants and others were sent through courier mail delivery and office drivers.

Data were also collected through face-to-face interview with participants. In this regard, the researcher engaged participants by asking them interview questions that address the specific objectives. These interview questions were written on an interview guide that reminded the researcher during questioning time. Clarity of the questions was made instantly as the face-to-face interview allows for that. The researcher was also able to probe interviewees in cases where the answer given was unclear.

Survey research method was used for this study through the distribution of copies of questionnaire to collect necessary information from respondents.

3.3 Sampling and Sample Size

3.3.1 Study Area

The study was conducted in sampled health facilities of Blantyre District. The district is bordered by Chiradzulu District to the East, Chikwawa District to the South, Thyolo District to the South East, Neno District to the North West, Zomba District to the North East. It is in the South West Health Support Zone together with Nsanje, Chikwawa, Neno, Mwanza, Thyolo and Chiradzulu districts.

Blantyre is one of the districts in the country with the highest HIV prevalence rate perching at 17.8% against the national rate of 10% (Blantyre Health Management Information System, 2014). This in part is due to the high rate of migration as people constantly trek down from rural areas into the city in search of employment and other economic activities. This behaviour has exacerbated the transmission of HIV Virus to the city dwellers, hence the high HIV prevalence rate in the district.

The district also experienced one of the lowest rate of maternal deliveries by skilled birth attendants that was at 43% against the national target of 80%. It is these factors that compelled the researcher to conduct the study in the district.

3.3.2 Study Population

The study population is a totality of cases that conform to some designated specifications (Churchill and Lacobucci, 2002). The study population comprises of 27 public health facilities spreading across the district. This is shown in Figure 3.1.These facilities were identified through the Health Management Information System of the District Health Office. It should also be noted that private facilities are not part of the study because they are only concentrated within the city of Blantyre. Many rural communities of the district do not have private facilities. Therefore, including them in the study could have compromised the quality of data because of lack of representativeness on the part of participants for some areas of the district. In addition to that, private facilities are also left out because decentralisation of health services is mainly implemented in the public sector in the country.

3.3.3 Sampling Techniques

Basically, there are two major types of sampling techniques namely random or probability sampling and non-random (non-probability) sampling (Saunders et al., 2009). The goal in sampling is to produce a representative sample, that is to say, a sample that is similar to the population in all aspects. In this study, the researcher used purposive sampling as a form of non-random sampling.

3.3.3.1 Purposive Sampling

Purposive or judgemental sampling is a non-random sampling technique in which the researcher uses judgement to select cases that best enable him/her to answer research question(s) and meet research objectives (Saunders et al., 2009). It is often used when working with very small

samples such as in case study research and when one wishes to select cases that are particularly informative (Neuman, 2005).

Purposive Sampling is used because it captures important participants that could have been left out in the study should the other sampling techniques were used. In this regard, Patton (2002) argues that the logic for selecting participants for purposive sampling should be dependent on the research question(s) and objectives. In this study, purposive sampling was used to choose health facilities that are judged to be a representation of all the health facilities in the district. Furthermore, the study employed purposive sampling to draw key participants from the population.

All participants were purposively selected on the basis of their willingness and potentiality to respond to the interests of this study. The sampled participants were surveyed using the Interview Method, Focus Group Discussion and Questionnaire to collect data of interest.

3.3.4 Participants' Sample Size and Selection

The study draws a sample of 9 facilities from a population of 27 public health facilities. It also uses a sample size of 61 participants drawn from a population of health workers and non-health workers purposively selected across the district as shown in Table 3.1.

The World Health Organisation (WHO) defines 'Health worker' as "a person engaged in actions whose primary intent is to enhance health" (WHO, 2009, p.2). Thus, a health worker can be a health professional or a non-health professional who engages in contributing towards the well-being of a patient directly or indirectly. Non-health workers, on the other hand, are individuals whose primary objective is not to enhance health (WHO, 2009). They carry out duties that are not directly or indirectly related to health.

The participants were purposely selected in order to capture data on decentralisation from all corners of the district. The health workers include District Health Management Team (DHMT) members, Zonal Health Officials, Clinicians, Midwives and Health Surveillance Assistants (HSAs). On the other hand, non-health workers include District Council Officials, Traditional Birth Attendants (TBAs), Health Centre Advisory Committee (HAC) members and guardians/patients.

On the part of health workers, responses to questionnaire items were sought from 6 DHMT members because they hold key strategic information on decentralisation of health services at district level.

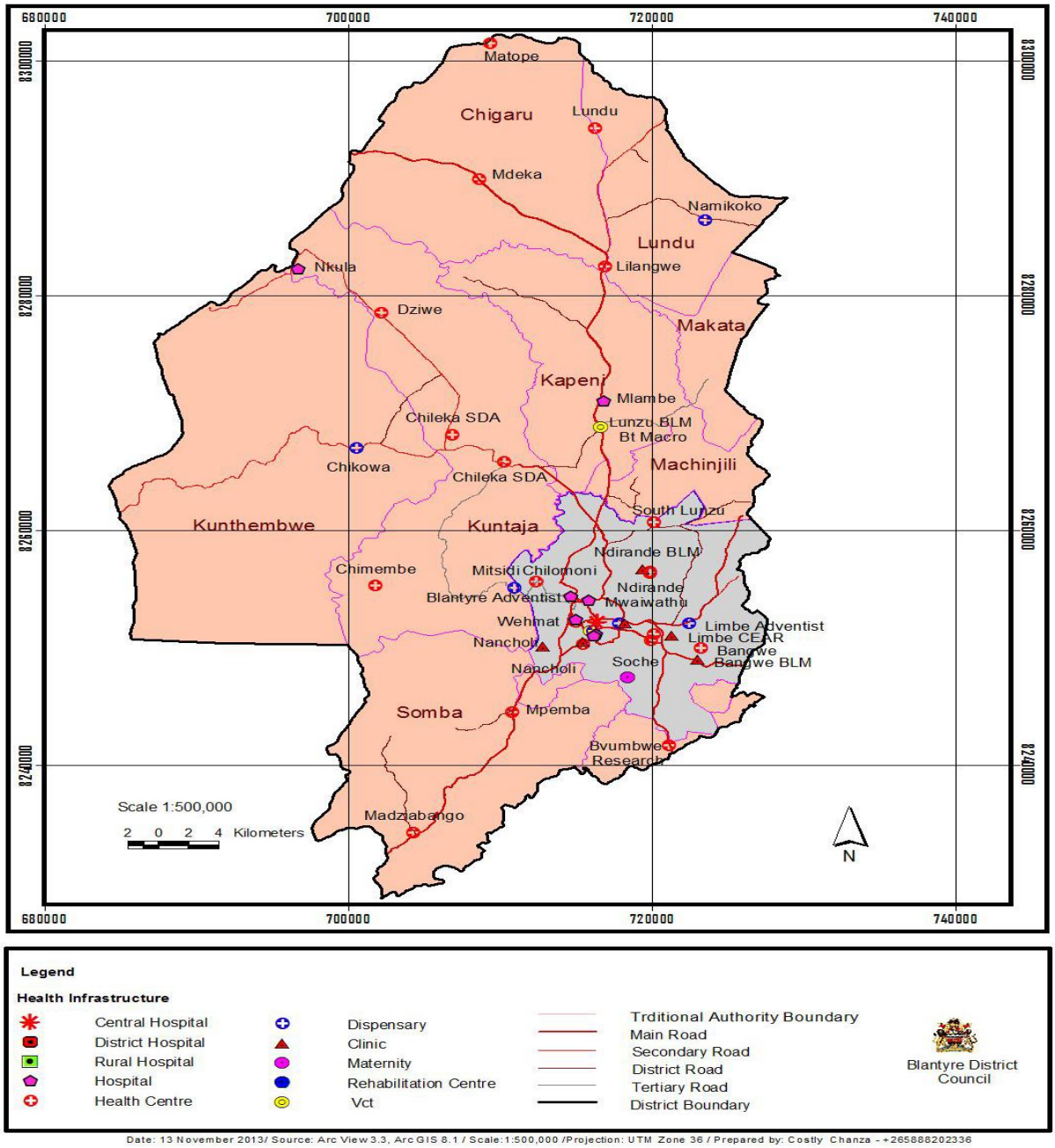


Figure 3.1: Map of Blantyre District showing the location of both urban and rural health facilities

Four Zonal Health Support Officers were involved in the study to provide answers to questionnaire items because they form part of management at the zonal level. They also provide policy guidance and technical support in the delivery of health services across the district. Nine clinicians, nine mid-wives and nine HSAs were drawn from the sampled health facilities for equal representation. This is shown in Table 3.1.

The study also used non-health workers for data collection purposes and these are 4 District Council officials namely Director of Finance, Director of Administration, Director of Planning and Development and the Human Resources Management Officer.

Table 3.1: Summary of the study sample.

CATEGORY	**NUMBER**
Health Workers	
District Health Management Team (DHMT) Members	6
Zonal Health Officials	4
Clinicians	9
Mid-wives	9
Health Surveillance Assistants (HSAs)	9
Non-Health Workers	
District Council Officials	4
Traditional Birth Attendants (TBAs)	4
Health Centre Advisory Committee (HAC) Members	4
Parents/guardians	12
Total	**61**

All these were purposively selected as key implementers of decentralisation at District Council Level. Four Traditional Birth Attendant (TBAs) were purposively selected from each of the four health zones of the district. This was done to allow representation of each zone. Two Health Facility Advisory Committee (HAC) members were selected from urban and two from rural areas of the district for representativeness. The study also involved 12 patients/guardians to collect data from the community about decentralisation and health services delivery in the district.

3.4 The Approach to Data Collection

3.4.1 The Mixed–Method Approach

Saunders et al., (2009) point out that the Mixed-Method Approach is a general term used when both quantitative and qualitative data collection techniques and analysis procedures are used in a research design. The approach uses quantitative and qualitative data collection techniques and analysis procedures either at the same time (parallel) or one after the other (sequential) but does not combine them. However, although the mixed method approach uses both quantitative and qualitative world views at the research methods stage, quantitative data are analysed quantitatively and qualitative data are analysed qualitatively.

It should be noted that the study uses the mixed-method approach in order to mitigate the gaps that go with the use of only one approach. This allows for the opportunity to compensate for inherent method weaknesses and capitalise on inherent method strengths to off-set inevitable method biases (Greene, 2007). It also provides an insight not possible when only one approach is used and this leads to greater confidence being placed on the researcher's conclusions.

3.4.2 Data Collection Methods

Different data collection methods were used to collect both primary and secondary data. The study depended much on primary data because it is reliable and first- hand- information. Secondary data was used in cases where primary data were not available.

3.4.2.1: Primary Data

Primary data was collected through in-depth key informant interviews, focus group discussions and structured questionnaires. An interview guide was also administered on key informants to collect primary data. The questionnaires sought to collect general information on the surveyed key informants. Furthermore, primary data were also collected through focus group discussions where participants gave first-hand information through a moderated discussion.

3.4.2.2: Secondary Data

Secondary data on levels of decentralisation of health service delivery were gathered from print and electronic media from both published and unpublished sources available in the form of books, journal articles, proclamations, policies, laws, regulations and pertinent academic theses.

Three data collection methods were used and these are Key Participant Interview, Focus Group Discussion and Questionnaire.

(i) Key Participant Interviews

An interview is 'a conversation with a purpose' (Kahn & Cannell as cited in Marshall & Rossman, 2007). In this study, an in-depth interview of key participants namely TBAs and HAC members was conducted to collect primary data on the level of decentralisation of health services delivery in the district. The researcher used this method in order to get in-depth information from participants.

An interview guide was used by the researcher to collect data from participants. By using the guide, the researcher intended to ask participants interview questions to capture primary data from the research questions. Interview questions were semi-structured and open-ended. Each participant was interviewed for a maximum of 10 to 12 minutes. This gave participants enough time and freedom to decide on their choice of responses to the questions. The researcher himself was involved in a face-to-face interview of the sampled TBAs and HAC members. Since participants were scheduled to provide the researcher with first-hand-information, primary data was expected to be collected. Primary data were collected through audio recording to avoid missing some important points. Furthermore, participants were told that they were being recorded to obtain their consent.

(ii) Focus Group Discussion

Focus Group Discussion is defined as "an interview composed of a small number of participants facilitated by a 'moderator' in which the topic is defined clearly and precisely and there is a focus on enabling and recording interactive discussion between participants"(Saunders et al., 2009, p. 592).

In this study, focus group discussions involved the researcher, 9 clinicians, 9 mid-wives, 9 HSAs and 16 patients/guardians. There were five focus group discussions comprising of 6 and 9 participants in each group. Three focus group discussions comprising of 9 clinicians, 9 HSAs and 9 midwives were conducted. In addition to that, two more focus group discussions were conducted with patients/guardians drawn from an urban facility and rural facility. The researcher used this method because it provides the opportunity for a flexible, free-flowing format for members. Furthermore, Focus Group Discussions are relatively inexpensive and can provide

fairly dependable primary data within a short time frame (Sekaran, 2003).The unstructured and spontaneous responses were expected to reflect the genuine opinions, ideas, and feelings of members about the topic under discussion.

Focus Group Discussions were conducted at each of the sampled facilities after the questionnaires were administered. They involved clinicians, mid-wives, HSAs and patients/guardians. The selection of participants at each facility was done using purposive sampling technique in order to identify potential participants with specific set of characteristics required by the researcher. Data for FGD were captured by audio recording to avoid missing some important points during the discussion. The audio-recorded data were transcribed and recorded to produce useful information. This was done by identifying participants on each day of data collection.

Qualitative primary data on what participants know about decentralisation were obtained during the discussions. Also captured were data on how the health workers and patients/guardians feel are the impact of decentralisation on health service delivery and indicator performance in the district.

(iii) Questionnaires

Questionnaires were used in this study to collect quantitative data on the education qualification, experience and study response rate. They were also used to collect primary data on people's views about the level of decentralisation in the district and decentralisation of some health indicators. These questionnaires were designed to target 3 categories of participants namely District Council Officials, South-West Zonal Health Officials and DHMT members.

A total of 14 questionnaires were administered to 14 respondents as follows: 4 District Council officials, 4 Zonal Health Support Officials and 6 DHMT members. Furthermore, the questionnaires were administered through email, delivery by trusted office drivers and courier. As for physical mail deliveries and courier, money was sent to participants to enable them to send the questionnaires back to the researcher without delay. This served to reduce cases of non-response rate.

Questionnaires consisted of close-ended and semi-structured questions. These were used to survey participants on the level of health care delivery before and after the decentralisation

process. These questionnaires were administered to participants in order to allow them to answer questions at their own free time.

The researcher used office drivers to distribute questionnaires to respondents with clear instructions. Among the challenges encountered were difficulties in mobility of the motor vehicles since the distribution was done during the rainy season. The roads in rural areas become impassable during this time of the year. This made the questionnaire distribution very challenging. In cases where the motor vehicle could not reach some health facilities, HSAs with motor cycles were used to distribute the questionnaires.

3.4.3 Pilot testing of the questionnaires

Saunders et al. (2009) argues that a questionnaire, just like any other data collection tool, needs to be pilot-tested and amended as necessary. This is so because such piloting process is of paramount importance as it helps to avoid a possible second chance of collecting incorrect data and also provides possible amendments to the data collection tools. The questionnaire for this study was pilot-tested to 9 purposively selected participants in order to establish its validity and reliability. These are not part of the sampled 61 participants for the main research project.

A number of issues came out after the test. One of the issues was that some of the questions were double-barrelled and ambiguous since they had double meanings. In this regard, the ambiguity was corrected by paraphrasing and modifying the questions accordingly. Another issue that was also identified was that many questionnaires were not returned by the participants because participants were not given money to use in sending back the questionnaires to the researcher. In view of this, the researcher made sure that money was sent to the participants together with the questionnaires to make sure that the questionnaires are back to the researcher after answering the questions. Hence, the questionnaires were more reliable after pilot-testing than before because errors and issues that were identified during the test were duly corrected before conducting the actual research.

3.5 Data Analysis

Data in the study were analysed both quantitatively and qualitatively, depending on the type of data and the analytical purpose intended. Lecompte and Schensul (1999) define *data analysis* as the process of reducing large amounts of collected data to make sense of them. Patton (1987) indicates that three things occur during analysis namely:

- data are analysed
- Data are reduced through summarization and categorisation
- Patterns and themes in the data are identified and linked.

In this study, data were analysed using both statistical techniques and content analysis. Both descriptive and inferential analysis were used. Descriptive analysis was used to determine the general characteristics of the data while inferential analysis was used to infer characteristics of the population from the sample.

3.5.1 Qualitative Data Analysis

According to Saunders et al., (2009), qualitative data analysis is the approach that describes phenomena. In this perspective, audio-recorded data from key informants were transcribed from field recordings into themes that answered the research questions to determine the impact of decentralisation on health service delivery. The transcribed data from audio-recordings were coded and analysed using thematic content analysis. Content analysis is defined as a "systematic and replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding" (Philipp, 2014). The study used content analysis to analyse data because it allows the researcher to sift through large volumes of data with relative ease in a systematic fashion. The analysis predominantly involved categorising responses according to the recurrent themes emerging from the data collection exercise.

Transcription of semi structured interviews was done by the researcher, where only sections that are important to the research were transcribed. Saunders et al., (2009) sees transcription as conversion of the audio recordings into written words, thus the written words are a mirror of the audio recordings. To ensure validity of the transcription, the researcher listened carefully to the interviews at least three times before starting the transcription.

3.5.2 Quantitative Data Analysis

The administered questionnaires were edited to ensure that all the required information is properly recorded. A coding frame was developed to capture all structured and semi-structured responses. Cleaned data was coded into the computer using SPSS software package (version 16.0) and Excel Software. Both descriptive and inferential statistics were used. Descriptive Statistics focused on the background of the participants. Frequency tables were generated and re-

organised to form various combined tables with significant statistical information to address specific research objectives. This is shown in appendices 6 and 7. For the purpose of meaningful analyses, response categories of categorical variables for some questions were collapsed into three or four response categories depending on the similarities and nature of collected data.

3.6 Validity and Reliability

3.6.1 Validity

As provided by Miles and Huberman (1994), validity of an instrument as used in this study is the "extent to which items in the instrument measure what they are set out to measure." On the other hand, Saunders et al, (2009) define it as "the extent to which data collection method or methods accurately measure what they are intended to measure" (p. 603). The validity of the questionnaire and interview guide was established through the critical assessment of items by the credible review audience that reviewed the instruments before actual administration to the study sample to assure their validity. The researcher spent a day with this team analysing each item to make sure that it is in tandem with objectives of the study.

3.6.2 Reliability

According to Saunders et al. (2009), reliability "is the extent to which data collection techniques or analysis procedures yield consistent findings" (p.156). Miles and Huberman (1994) define it as "the extent to which the items in an instrument generate consistent responses over several trials with different audiences in the same setting or circumstances" (p. 48). In this context, copies of the questionnaires were distributed to the respondents and the process repeated after sometime.

The researcher used the Cronbach's Alpha Coefficient measure to show the reliability of the instruments. According to De Vellis (1991), Cronbach's Alpha is interpreted as a coefficient Alpha and its value ranges from 0 to 1. In this regard, Sekaran (2000) advises that when calculating Cronbach's reliability coefficient, reliabilities less than 0.6 are considered poor, reliabilities within 0.7 ranges are considered acceptable and those coefficients over 0.8 are considered good. In this study, the questionnaires were reliable because using the same respondents and instruments several times, the Cronbach's Alpha of 0.8 was generated.

Besides the Cronbach's Alpha Coefficient and the constructive suggestions from credible reviewers, the reliability of the questionnaire and the interview guide was established following a pre-test procedure before their use with actual research participants. The questionnaires for health

workers were pre-tested among the health workers working in various health facilities in Blantyre District. Similarly, the interview guide for the patients and/ or their guardians was administered by the researcher to patients who came to health facilities for treatment. The pre-testing of research instruments assured validity and reliability of the research because the instruments were able to generate data that could be linked to the research questions.

The use of reliability and validity is common in qualitative research and now it is considered in the quantitative research paradigm. The use of the various approaches (questionnaires that would generate some quantitative data, and qualitative methods based on interviews and document analysis) provided a suitable basis for the triangulation of data, which, as Guba and Lincoln (1985) argue, strengthen the reliability of the data captured.

Although some researchers have argued that the term validity is not applicable in the qualitative research, Creswell and Miller as cited in Golafshani (2003) suggest that validity is applicable in both qualitative and quantitative research. This study therefore tried to seek evidence from a wide range of sources and comparing the findings from those different sources in the process called *triangulation*. This was done to maximise the validity of the findings.

3.7 Ethical Considerations

The study pursued ethical considerations that Burns and Grove (1999), and Saunders et.al. (2009) uphold in social science research, namely: permission to collect data, the right to self-determination, right to privacy, right to anonymity or confidentiality, the right to fair treatment and informed consent of the participant.

3.7.1 Consent to collect data

During this study, various participants were approached and their permission to participate and/or provide information appropriately elicited. The process proceeded by informing them of the intents of the study, as well as their right to participate and abstain or withdraw from the study. For this study, permission to collect data was sought and obtained from all participants in writing as shown in appendix 2.

The researcher also observed other principles required in the research process:

3.7.2 The right to self-determination

The right to self-determination is based on the principle of respect for persons, and indicates that humans are capable of controlling their own destiny (Burns & Grove, 1999). In this research, participants were treated as "autonomous agents" who have a freedom to conduct their lives as they choose without external controls namely:

- Informed about the research study.
- Allowed to choose to participate or not in this study.
- Allowed to withdraw from the study without fear of any penalty.
- No coercion or deception will be practiced as all participants will be fully informed.
- Information would be given to participants in the language of their preference.

This is shown in appendix 2.

3.7.3 The right to privacy

Privacy is the freedom an individual has to determine the time extent, and general circumstances under which private information is shared with or withheld from others (Burns & Grove, 1999). In this research, participants were protected in that data collected were only shared with those involved in the research study and these are supervisors and a statistician who helped in analysing the data..

3.7.4 The right to confidentiality and anonymity

Confidentiality is the management of private information shared by a subject. Anonymity is the right to "assume that the data collected will be kept confidential" (Burns & Grove, 1999, p.163). In this research, anonymity of informants was maintained by the fact that the names of participants did not appear on the questionnaire.

3.7.5 The right to fair treatment

The right to fair treatment is based on the principle of justice which states that people should be fairly treated and should receive what is due to them or owned by them (Burns & Grove, 1999).In this research, the researcher ensured fair treatment by the following:

- Participants were treated fairly and carefully.

- The researcher had a high regard for any harm or discomfort that may be experienced by participants, hence, made a special attempt to ensure that all participants were comfortable.

3.7.6 The Right to protection from discomfort and harm

This right is based on the ethical principle of beneficence, which states that one should do good and above all do no harm (Burns & Grove, 1999). The researcher took special precautions to ensure that participants were not harmed.

3.7.7 The right to informed consent

Informed consent is the prospective participants' agreement to participate in the study as a subject. Informing is the transmission of essential ideas and content from the researcher to the prospective participants (Burns & Grove, 1999).In this research, every prospective informant was given the opportunity to choose whether to participate in the research or not. The following information was given to the participants namely:

- The purpose of the research.
- The objectives of the research.
- The duration of the study.
- The type of participation expected from the participants.
- How results would be published.
- How confidentiality, anonymity and privacy would be ensured.
- Identity of the researcher, research assistant and supervisors of the study.

This is shown in the consent form in appendix 2.

3.7.8 Research benefits

All participants, including traditional birth attendants and health centre advisory committee members were informed that they would receive no monetary benefits from the study.

3.8 Limitation(s) of the Study

The researcher saw the following as potential limitations of the study:

3.8.1 Attitude of some participants

Some participants such as patients/guardians cooperated well with the process of data collection even though others were sceptical at the beginning. It was however disappointing that some officers at the District Council (the focal point of decentralisation) were unwilling to respond to the questionnaires. Their attitude towards giving information was poor as some of them were not ready to respond to the questions. Others delayed the interview process thereby postponing the schedule all the time with the excuse that they were busy or were travelling. However, health workers in selected health facilities readily received the researcher and granted to be interviewed.

3.9 Conclusion

This chapter has presented a detailed outline of the study methodology by including the processes that were used in gathering and analysing data. The study collected data through the use of questionnaire, interview guide and focus group discussion.

A mixed method approach was used in the study and a combination of various methods such as individual and key participants' interview and self-administered questionnaires served as the means of obtaining the primary data needed. The chapter looked at the strategies that were used to enhance the validity and reliability of the research study.

The chapter has also presented the data collection and analysis tools among other things. It has further looked at ethical considerations regarding participants' consent and privacy. The chapter again has touched on the limitations that were experienced in the process of carrying out the research.

Accessibility of hard-to-reach areas to obtain the data was a major barrier to the researcher as the majority of the earth roads to the health facilities where data were collected were rendered impassable during the rainy season, a period the researcher was scheduled to collect the data.

CHAPTER FOUR

DATA ANALYSIS AND RESEARCH FINDINGS

4.0 Introduction

This chapter presents findings of the study based on the research questions and objectives as provided in Chapter one. The main objective of this study was to investigate the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect. Therefore, in this chapter, Section 4.1 presents the demographic information of the study participants. Section 4.2 provides peoples' views about the implementation of decentralisation in Blantyre. This is followed by section 4.3 which covers functions that have been devolved and those that have been retained by the Ministry of Health. The state of decentralisation of some health indicators in the district is given in section 4.4. The chapter also presents challenges associated with decentralisation of health services in section 4.5.The level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect is covered in section 4.6. The chapter ends with conclusion in section 4.7.

4.1 Demographic Information of Participants

This study has different participants from various backgrounds that are categorised into health workers and non-health workers. Sub-section 4.1.1 covers the demographic profile of health workers while sub-section 4.1.2 presents the demographic profile of non-health workers.

4.1.1 Categories of participants

(i) Health workers

In this study, there are six groups of health workers and these are District Health Management Team (DHMT) members, Zonal Health Officials, Clinicians, Mid-wives, Health Surveillance Assistants (HSAs) and Traditional Birth Attendants (TBAs). Figure 4.1 shows the number of people who participated in the study.

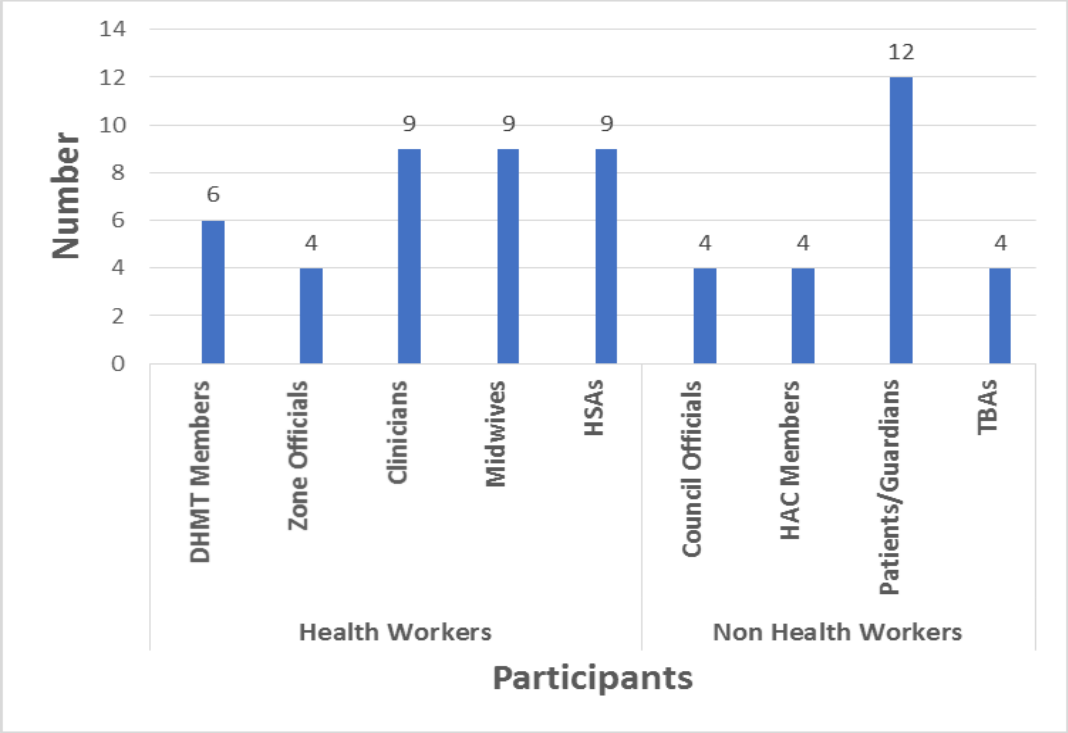


Figure 4.1: Categories of study participants

(ii) Non-health workers

There are four groups of non-health workers who participated in this study and these are District Council Officials, Health Facility Advisory Committee (HAC) members, TBAs and patients/guardians. Figure 4.1 shows the number of both health workers and non-health workers who participated in the study.

4.1.2 Education qualifications of the study participants

(i) **Qualifications of health workers**

An assessment of the qualifications of health workers was made and findings of the study reveal that the health workers involved in this study have adequate and suitable education qualifications that form an important ingredient of the necessary requirements for the efficient and effective delivery of health services. The qualifications range from Masters, Bachelors, Diploma Certificates and Malawi School Certificate of Education (M.S.C.E.).This is shown in Figure 4.2.

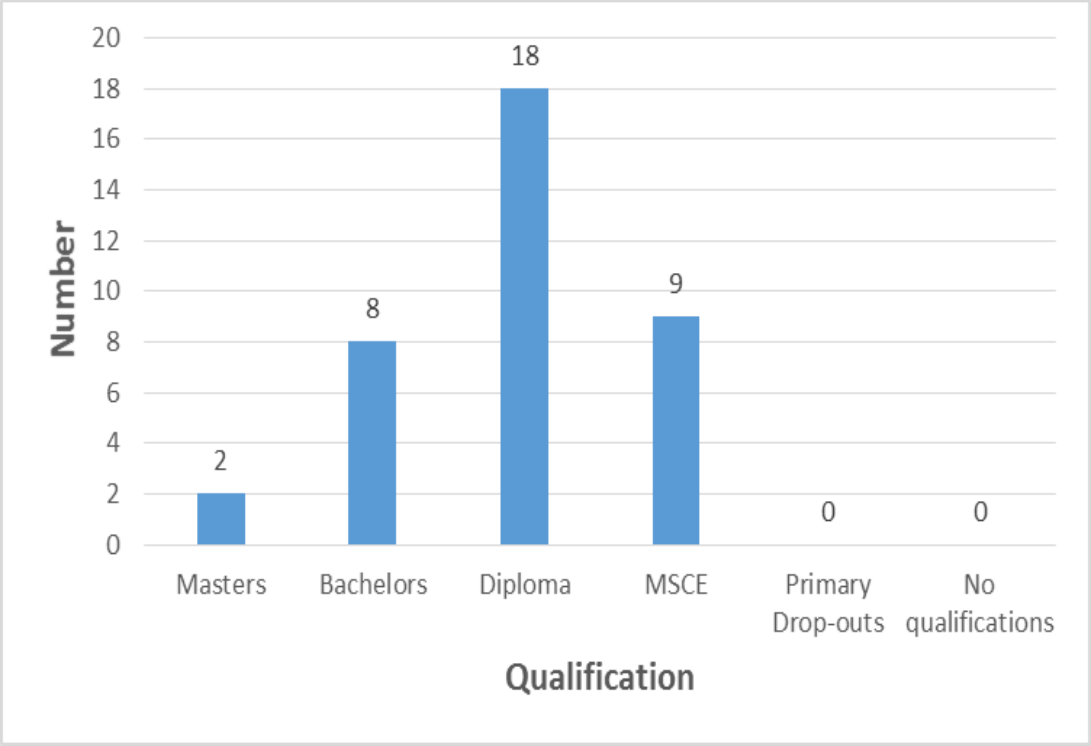


Figure 4.2: Bar graph showing educational qualifications of health workers

The study also revealed that the educational level of participants is directly related to their level of success. In this case, participants mentioned that the higher the level of their qualification, the greater the success and the lower the level of their qualification, the less the success.

(ii) Qualification of non-health workers

As for education qualification of non-health workers, those without qualification form the largest group of this category. This is explained in that their parents/guardians in most cases did not go to school. Few others had Masters, Bachelors and Diploma Certificates. The one with an M.S.C.E. qualification form the least number of this category. This is seen in Figure 4.3.

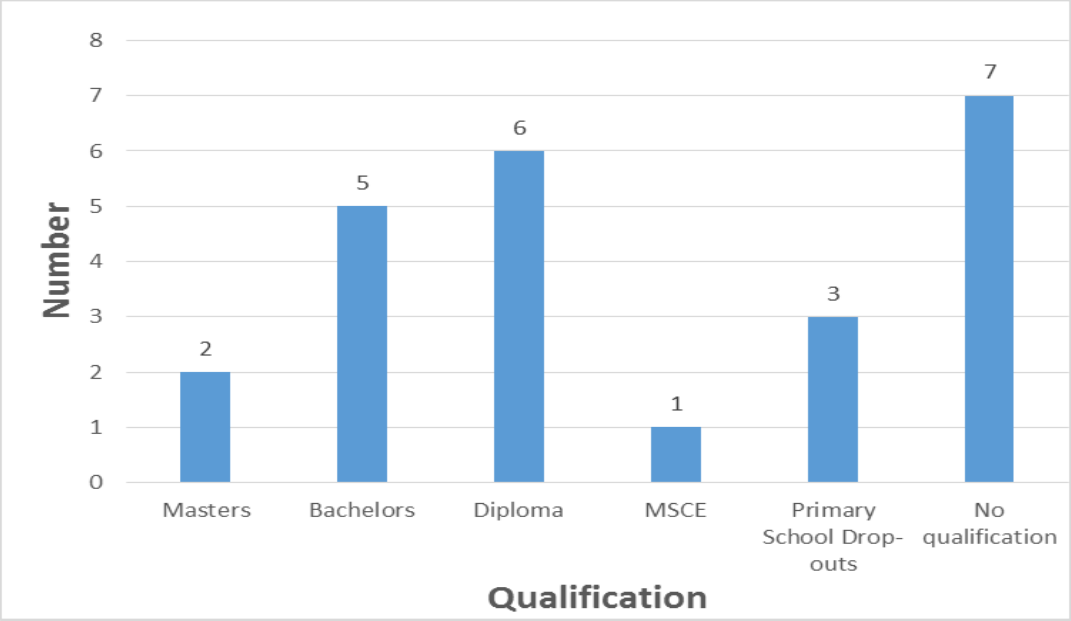


Figure 4.3: Bar graph showing educational qualification of non-health workers

4.1.3 Experience of Study Participants

The analysed data indicate that the majority of health workers interviewed through a questionnaire or face-to-face had worked in their various capacities for a period of at least 1 year and at most 50 years as shown in Figure 4.4

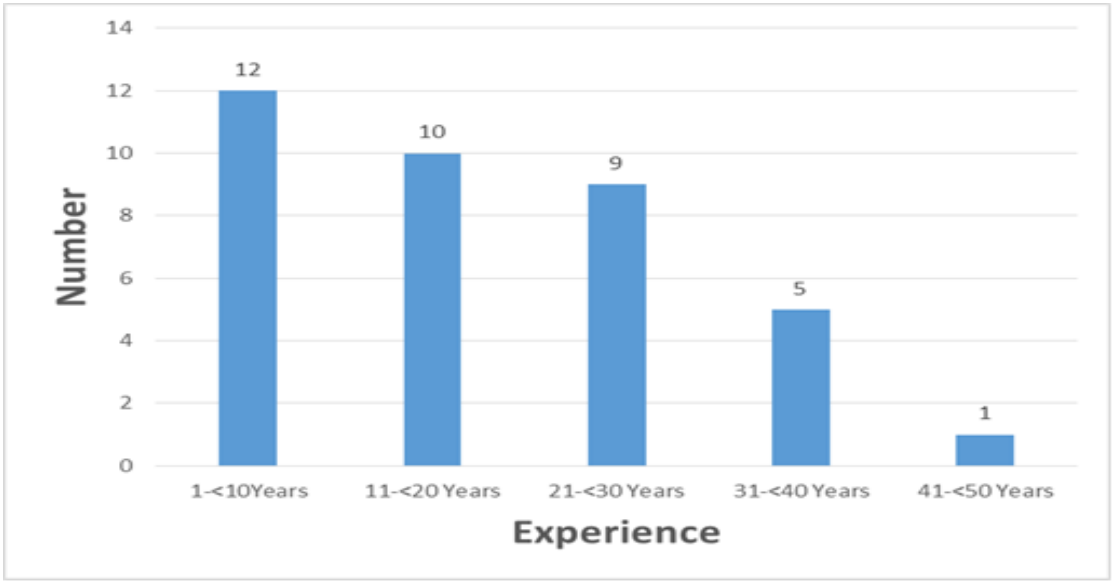


Figure 4.4: Bar graph showing the experience of health workers

On the part of non-health workers, the majority had served in their various capacities for at least 1 year except for few participants who were unemployed including TBAs. This is shown in figure 4.5. It should, however be observed that TBAs went through formal training for two weeks on how to help pregnant women during delivery. But their role was changed by government in 2012 to that of referring pregnant mothers to health facilities for safe delivery.

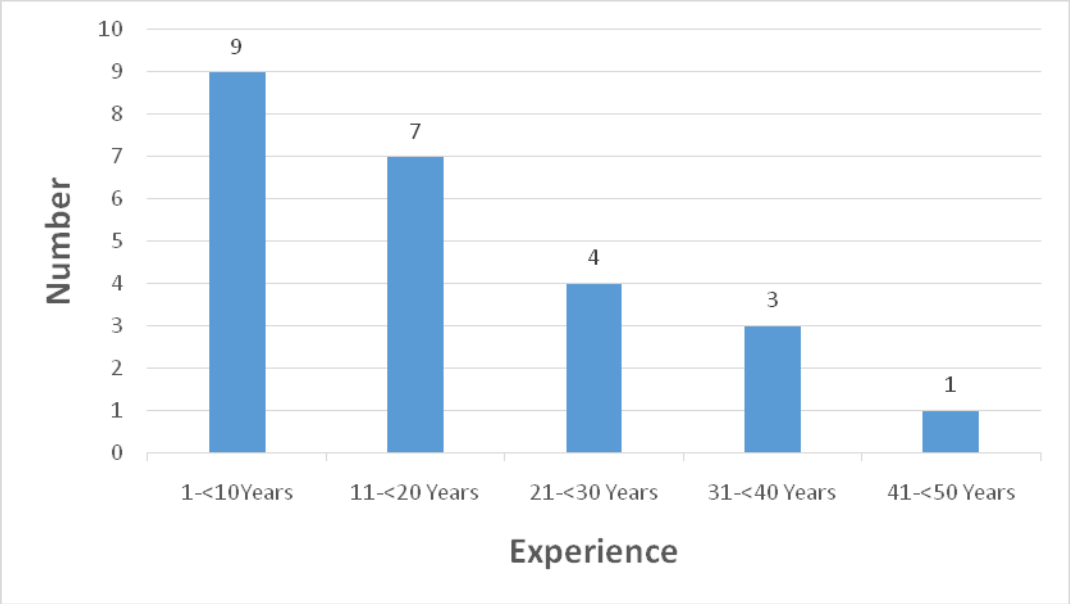


Figure 4.5: Bar graph showing experience of non-health workers

4.1.4 Study response rate

The study shows that out of 61 participants, 52 provided responses for both categories representing a response rate of85.2%. Three cadres of participants namely HSAs, TBAs and patients/guardians fully participated in the survey giving a response rate of 100% for each cadre. This is shown in figure 4.6.

The non-response rate is explained due to a number of reasons. Firstly, some prospective participants were not around on the day of the interview. Secondly, they were busy with patients on the day of the interview. Lastly, participants demanded monetary incentives to fill the questionnaires.

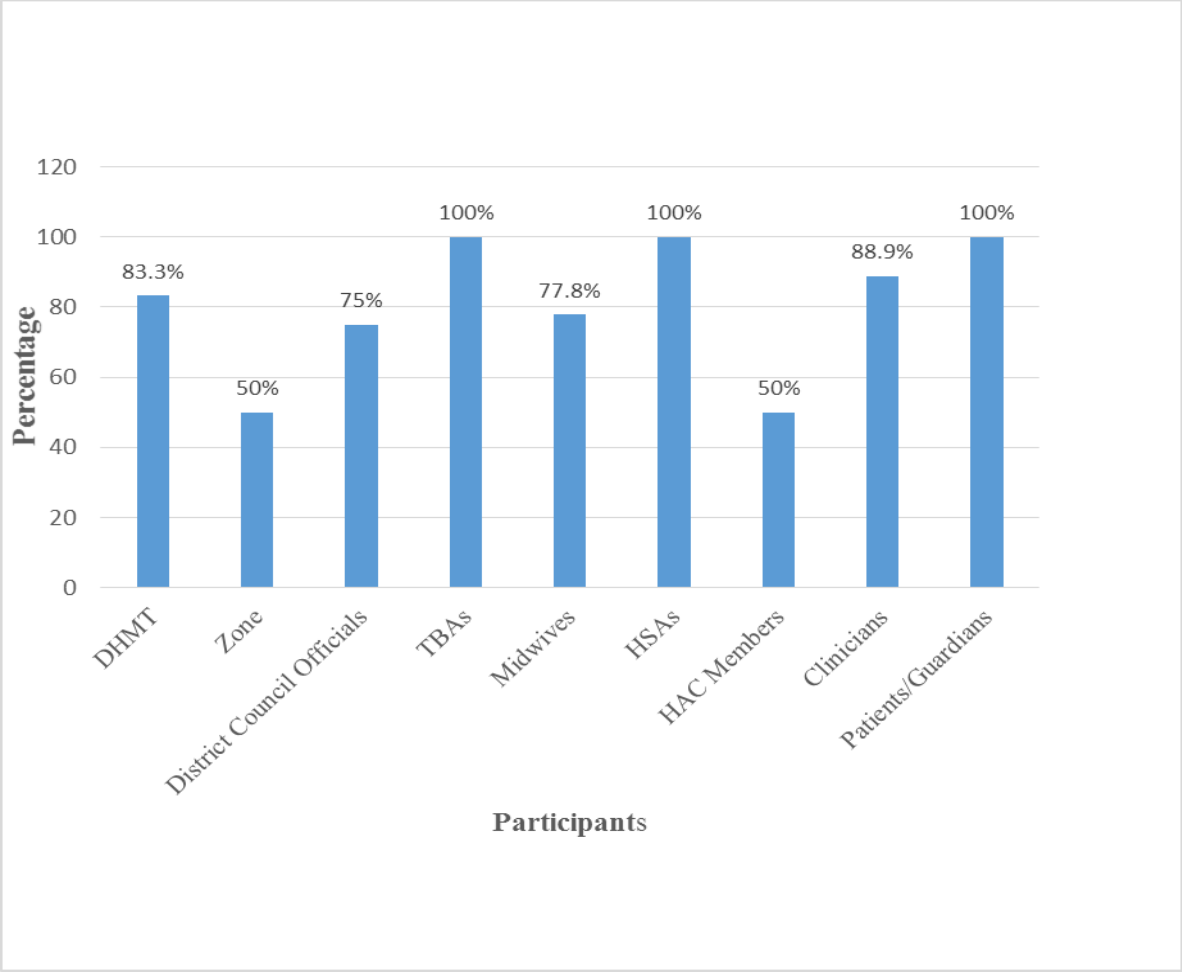


Figure 4.6: Participants' study response rate

4.2 People's views about the Implementation of Decentralisation in Blantyre

This section presents results on people's views about the level of decentralisation in the delivery of health services in the district and perceptions on its effect. The section has two subsections. Subsection 4.2.1 provides views on whether decentralisation of health services has been implemented fully or not. This is followed by subsection 4.2.2 which covers views about who is responsible for the implementation of decentralisation in the district.

4.2.1 Views on whether decentralisation has been implemented fully or not in the District

There are mixed results on the implementation of decentralisation in the district. While a few participants indicate that decentralisation has been implemented in full, others were of the view that the reform has been implemented partially. Thus, from the data collected, the results indicate

that 24% agree (6% strongly agree while 18% agree) that decentralisation has been implemented in full in the district. On the other hand, 76% disagree (71% strongly disagree and 5% disagree) that decentralisation has been implemented in full in the district. This is shown in Figure 4.7.

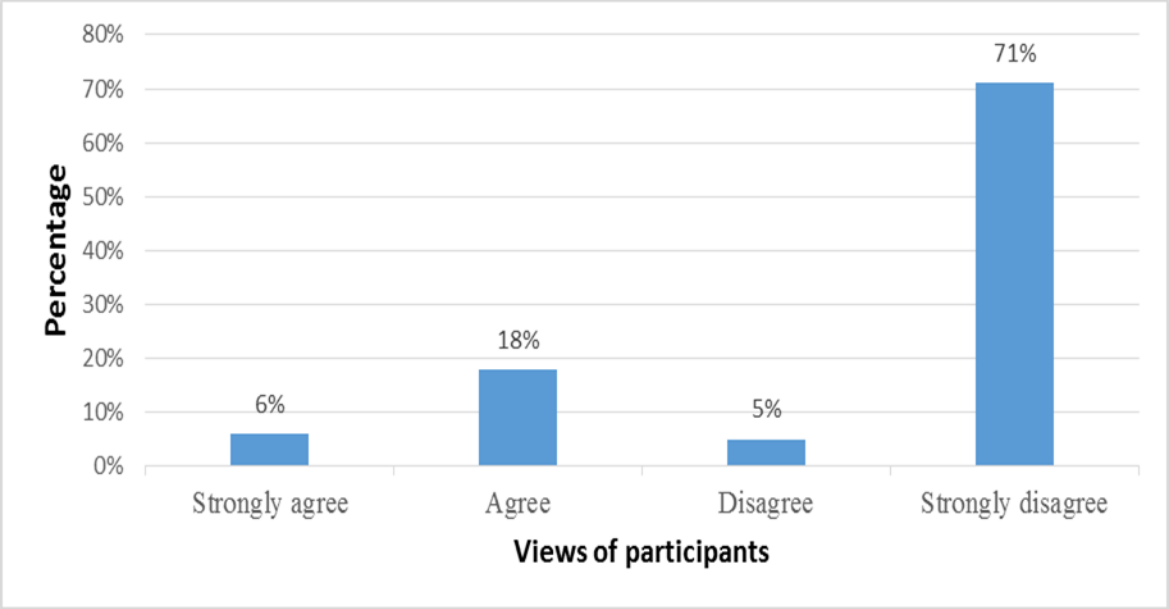


Figure 4.7: Views on whether decentralisation has been implemented in full in the district

4.2.2 Views about who is responsible for the implementation of decentralisation of health services in the District

Results of the study indicate that the DHO and his management team (DHMT) are responsible for the implementation of decentralisation in the district. Participants mentioned that the DHMT is assisted by the Health Centre Management Team (HCMT) in running the day-to-day affairs of the health centre in providing health services in the district.

From the results, it is however important to note that the DHO has a dual reporting relationship as he reports to the District Commissioner (DC) who is the head of the Council Secretariat and also the parent Ministry of Health through the Zone Health Support Office. Participants also mentioned that this reduces powers of the DC as a controlling officer. The two Ministries at times provide different information meant for the same thing to the district, a thing which brings

conflict in the implementation of the policy. This was accentuated by a participant who articulated that

Extract 4.1

"One cannot serve two masters at a time. The DC is just powerless without full implementation of the policy. The DHO tends to take instructions more from the parent Ministry of Health than the Ministry of Local Government".

4.3 Functions that have been devolved and those that have been retained by the Ministry of Health

This section presents functions that have been devolved and those that have been retained by the Ministry of Health. Sub section 4.3.1 covers decentralisation at the Ministry of Health Level. This is followed by decentralisation at the district level which is presented in subsection 4.3.2. Subsections 4.3.3 and 4.3.4 provide decentralisation at the health centre and community levels respectively.

4.3.1 Decentralisation at the Ministry Level

From the document analysis, this study reveals that the Malawi Government introduced decentralisation reforms in 1998 and that the health sector embraced the reform in 1999. In agreement to this, participants also mentioned that at the inception of the decentralisation policy in 1998, the Ministry of Health planned to retain the following ten functions within the implementation of the framework:

(i) Policy development, review and enforcement.
(ii) Regulation of the sector and donor coordination
(iii) Resource mobilization, budget review and analysis.
(iv) Human Resources planning and development.
(v) Quantification and national procurement of essential drugs, supplies and major equipment.
(vi) Epidemiological surveillance and compilation of national health statistics.

(vii) Development and enforcement of treatment protocols, standards and norms for service delivery.

(viii) Health legislation and its enforcement.

(ix) Provision of high level technical support to the operational level.

(x) Fulfilling obligations to international health and liaising with international donors.

The document analysis also showed that under the decentralisation policy, health services delivery was devolved to the District Council through the District Health Office with the District Commissioner (DC) as a Controlling Officer. The documents also revealed that six functions were identified for devolution from the Ministry of Health to the district level. This arrangement was meant to improve efficiency and effectiveness. This was confirmed by the study participants who indicated that at the inception of decentralisation, six functions were identified for devolution to the district level and these are:

(i) Health Planning

(ii) Financial Management, Budgeting and Resource Allocation

(iii) District Implementation Plan (DIP)

(iv) Monitoring and Evaluation

(v) Human Resource Management

(vi) Research

4.3.1.1 Functions that have been devolved at the Ministry Level

Results of the study show that health planning; financial management, budgeting and resource allocation; district implementation plan (DIP) and supervision, monitoring and evaluation have either been fully or partially decentralised from the Ministry to the District Level.

The results further indicate that besides those functions that were identified for retention, the Ministry of Health has further retained some of the functions that were identified for devolution and these are research and human resource management. This implies that not all functions that were identified for devolution have been decentralised in totality, hence partial decentralisation of services in the district.

(i) Financial management, budgeting and resource allocation

The study indicates that before decentralisation, planning, budgeting and financial management was done by the Ministry of Health and the district was only mandated to implement the plans initiated by the Ministry.

After the introduction of decentralisation, budgeting and expenditure under this function have been partially devolved to the district level through the district council. The DHMT is given monthly funding from the treasury to implement planned activities at the district level. In addition to that, the DHMT is also mandated to determine how to use available resources allocated to the district basing on the district needs. However, the study participants pointed out that determination of budget ceiling is still centrally controlled by the Ministry of Health as the function has all along been done by the Department of Planning at the Ministry without consultation with the district on the need and requirements of the district.

(ii) Health planning

The second function that has been decentralised is planning. The findings of the study indicate that before decentralisation, the district was not involved in planning as it was only responsible for implementing activities planned by the Ministry of Health. After the introduction of the reform, planning has been decentralised where the district is given a template to guide them as well as a ceiling of budget which their planning has to be based on. This implies that the DHMT is able to prioritise and plan activities to be implemented in the district within a particular financial year.

(iii) District Implementation Plan (DIP)

Findings of the study show that before decentralisation, the top-down approach to decision-making was employed by the Ministry of Health in making plans for the district. The District Health Office was only responsible for implementing plans crafted at the top without considering the needs of the district.

After the introduction of decentralisation, the health system in the district embraced the bottom-up approach to decision-making where the DIP annually begins by a situation analysis to identify the needs of the local people. This was revealed by a member of the DHMT who remarked that

Extract 4.2

"Ever since decentralisation was introduced in the district, the bottom-up approach to decision-making has been adopted to identify the needs of the local people before embarking on implementing any activity. The present approach is need-based as DIP activities are tailor-made to address the needs of the people".

This initiative has improved the delivery of health services as citizenship participation has accorded the district to take part in decision-making regarding the health needs of the people.

(iv) Monitoring and evaluation of health service delivery

Participants indicate that before decentralisation, the Ministry of Health was responsible for supervision and monitoring of activities at the district level. After decentralisation, supervision is partly decentralised implying that not all projects done at district level are supervised and monitored by the DHMT. The Ministry of Health still supervise some district projects that could have been supervised by the DHMT members such as the supervision of Umoyo Housing Project whose objective is to construct houses for health workers. This project is supervised and monitored by the Ministry of Health at times without the knowledge of the DHO and DHMT. However, minor district projects such as construction of toilets are monitored and supervised by the DHMT at that Level.

(v) Procurement of cleaning materials and general Stores

Another area that has been fully decentralised to the district is procurement of cleaning materials and general stores. Participants mentioned that this function was initially identified for retention by the Ministry. However, the function has been devolved to the district level after the introduction of the reform. This is clearly envisaged by the fact that the DHMT is now able to allocate funds to procure these items. In the same vein, participants also pointed out that stationery has been fully decentralised as it is done at district level. This is shown in Table 4.1.

4.3.1.2 Functions that have not been devolved at the Ministry Level

Results of the study indicate that two functions that were identified for decentralisation have not been devolved to the district level. These are human resource management and research.

(i) Human Resource Management

The decentralisation reform in the Health Sector that started in 1998 saw the retention of human resource activities by the Ministry of Health instead of devolving them to the district as planned. In this regard, findings of the study show that before decentralisation, those responsible for running the affairs of the district had no control at all in critical human resource issues such as hiring and firing. Participants highlighted that power and authority to hire and fire lied in the hands of the Ministry of health. This is shown in Table 4.1.

Table 4.1 showing devolved and retained functions at the Ministry of Health

Function	**Activity**	**Fully Decentralised**	**Partially Decentralised**	**Not Decentralised**
Maintenance	Monitoring of construction projects			✓
Procurement	Drug procurement			✓
	Other Procurements eg. Cleaning materials and general stores	✓		
Governance	Size and composition of DHMT			✓
	Planning		✓	
	Supervision		✓	
Human Resource	Firing and Hiring			✓
	Promotions			✓
	Salaries			✓
Finance	Allocation of expenditure	✓		
	Determining District Budget ceiling			✓

This trend continues even after the introduction of the reform. This is so because the onus to hire and fire still lies in the hands of the Ministry of Health in conjunction with the Health Services Commission. The DHMT has only the mandate to recommend to the Ministry as to who should be disciplined. Participants articulated that the only area where the DHMT has authority over is the discipline of junior staff but again this requires the final say of the Ministry.

Participants mentioned that the Ministry of Health still controls the promotion of employees despite the introduction of the policy. In line with this, the DHMT has no influence on promotions and trainings despite being people who monitor performance of workers on the ground. This has compromised the efficiency and effectiveness of health service delivery in the district

Commenting on the size of the DHMT in the district, the study reveals that the decision to determine the size of the DHMT is still not decentralised to the district as the DHO is just dictated as to who should be a member of the DHMT. This was evidenced by circulars that directed DHOs to include certain cadres such as human resources personnel and spokesperson into the DHMT. The circular, however, was silent on whether the DHMT members could co-opt some individuals into the management. Participants felt that these limit the DHO to take people who can be of help into the DHMT, hence it has a negative impact on the decentralisation of health services in the district.

As for the control of employee remuneration in the district, the study shows that before embracing the policy at the district level, salaries were controlled by the Ministry of Health. However, despite decentralisation being in place and management of finance being decentralised to the district, salaries for health workers in the district are still centrally controlled by the Ministry of Health. This clearly shows that human resource management as a function has not been devolved to the district even after the introduction of the reform.

(ii) Research

This is one of the functions that were identified for devolution to the district level. The function has been controlled by the Ministry of Health before and after the introduction of the reform. In this vein, participants mentioned that the Ministry carries research coordinated at the national level without involving the district health office. Hence, the function has not been fully decentralised to the district level to date.

(iii) Drug procurement

The study observes that drug procurement did not form part of the *six functions* that were identified for decentralisation to the district level. The function was planned for retention by the Ministry of Health. Therefore, before decentralisation, the duty to procure drugs solely depended on the Ministry of Health as the district did not have a capacity to procure huge quantities of drugs for the district. The function was however devolved to the district level after the introduction of the reform and enactment of the National Procurement Act (2003).

Participants further mentioned that since 2012, procurement of drugs was re-centralised to the Ministry due to challenges surrounding the district health office. These challenges include irregularities in the procurement procedures, the '*commission syndrome'* whereby those responsible for drug procurement opted to go for a private drug supplier in order to get a commission and over-purchase of drugs in order to receive more commission. The result implies that drug management is now centrally controlled by the Ministry of Health leaving the DHO's office only with the responsibility of placing orders for drugs from Central Government Stores Trust (CMST). This is a body entrusted with the responsibility to procure drugs for all public health facilities in the country.

4.3.2 Decentralisation at the District Level

From the results, only supervision, monitoring and evaluation of health service delivery have been fully decentralised from the District Level to the Health Centre Level. The rest of the functions have been retained by the district.

4.3.2.1 Function (s) that have been devolved at District Level

(i) Supervision, Monitoring and Evaluation of Health Service Delivery

The findings reveal that before decentralisation, supervision and monitoring of all minor projects was done by the DHMT. However, after decentralisation, the function has been devolved to the Health Centre Level. Minor projects are now supervised and monitored by the Health Centre Management Team. This is seen in Table 4.1.

4.3.2.2 Functions that have not been devolved at the District Level

The study shows that three functions have been retained at the district level. These functions are health planning; financial management, budgeting and resource allocation; and District Implementation Plan (DIP). The retention of these functions means that decentralisation has not been implemented in full in the district. Full decentralisation would imply decentralisation of all functions to the local level.

4.3.3 Decentralisation at Health Centre Level

After the District Level, the next level of health services delivery is Health Centre Level. Findings of the study reveal that the head of the health centre is the Medical Assistant (MA) and that he leads in the implementation of health services delivery. The results further indicate that the Health Centre Level has retained some function(s) like supervision, monitoring and evaluation.

4.3.4 Decentralisation at Community Level

The study established that this is the last level of health service delivery in the district. In this perspective, participants mentioned that before decentralisation, this level did not have well organised structures to enhance the provision of health services delivery.

After the introduction of decentralisation in 1998, a number of structures such as VHCs were put in place to help in the efficient and effective provision of health services. This effectively improved health services delivery in the district.

4.4 State of Decentralisation of some Health Indicators in the District

This section presents the implementation of decentralisation in line with health indicators in the district. The section has five sub-sections. Subsection 4.4.1 covers the state of maternal health deliveries by skilled birth attendants while sub-section 4.4.2 presents factors for the decline in rate of maternal health deliveries by skilled birth attendants. Sub-section 4.4.3 provides the state of HIV/AIDS in the district and sub-section 4.4.4 provides factors behind the high HIV prevalence rate among the 15-49 age group. The section ends with section 4.4.5 which gives the state of HIV related deaths in the district.

4.4.1 State of maternal health deliveries by skilled birth attendants in the District

Results of the study show that before decentralisation, the rate of maternal deliveries by Skilled Birth Attendants (SBAs) was the same as the national target of 80%. This implies that more deliveries were conducted at health facilities than those at home. As a result, participants mentioned that less maternal complications were experienced during deliveries at various health centres in the district.

After the introduction of decentralisation and subsequent passage of time, the results show a decline in rate of maternal deliveries by SBAs. The district registered 63% against the national target of 80% in 2012. The results show a further decline in deliveries by SBAs from 63% in 2012 to 43% in 2014.This is shown in Figure 4.8. Additionally, 88 % of health facilities in the district conduct deliveries by SBAs. The remaining percentage of health facilities does not conduct deliveries by SBAs because of shortage of SBAs. This implies that maternal mothers in those catchment areas go for TBAs for deliveries.

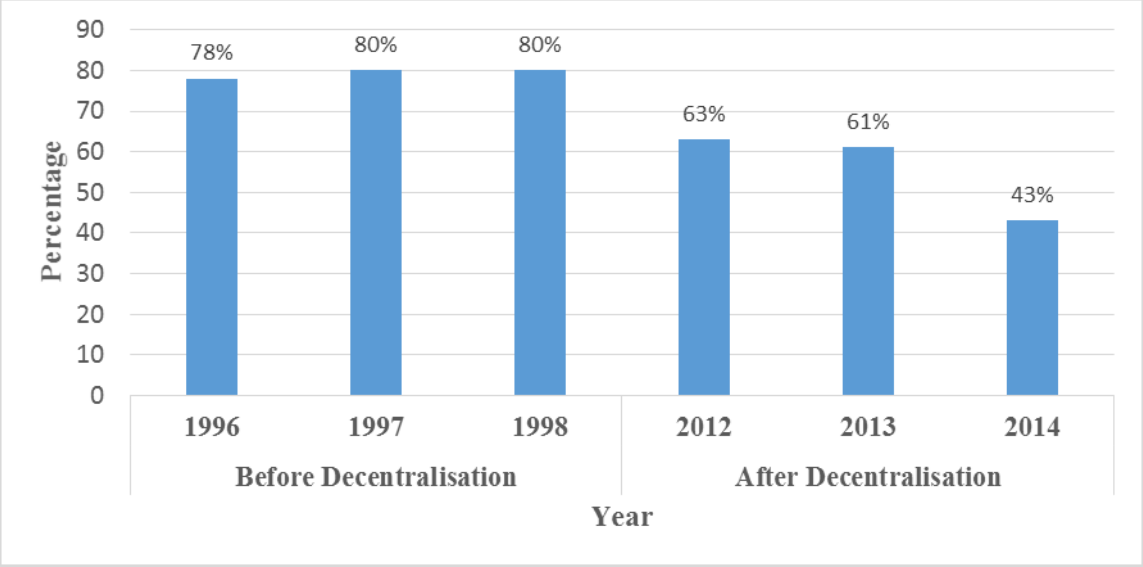


Figure 4.8: Graph showing the rate of maternal health deliveries by skilled birth attendants before and after decentralisation

4.4.2 Factors for the decline in maternal health deliveries by SBAs in relation to decentralisation of health services in the district

From the findings, the rate of maternal deliveries by SBAs before decentralisation was far much better than it is after the implementation of the policy. Participants attributed this to a number of factors. These include ill-treatment by some mid-wives, the mushrooming of TBAs, lack of health facilities within a reasonable walking distance and shortage of SBAs in the district.

In this context, the study reveals that 60% of participants attributed the decline to ill-treatment by some mid-wives, 20% by the mushrooming of TBAs, lack of health facilities and shortage of SBAs each contributed 10%. Participants further mentioned that decentralisation was introduced without considering these factors in the district. In other words, decentralisation was introduced in isolation and this may have contributed to its negative effects in the district.

Some participants, however, revealed that the existence of TBAs provide an alternative to mothers who get ill-treated by some mid-wives. An interview with a pregnant mother revealed that maternal mothers opt for TBAs because of the empathetic way in which they handle pregnant women. It was further added that some mid-wives do not have empathy in handling pregnant women. One TBA corroborated this in extract 4.2:

Extract 4.3

"*They say that some mid-wives pour insults on them and sometimes leaving them unattended to when they need help*".

Participants also pointed that maternal mothers opt for TBAs because of bad behaviours by some mid-wives. As one maternal mother remarked in extract 4.3:

Extract 4.4

"*We, pregnant women are subjected to torture and abuse by some mid-wives who utter all sorts of abusive words during delivery. They even go as far as demanding us to call for our husbands to see for themselves the results of their bed activities. With that mistreatment, some of us have no choice but to go for a TBA to avoid being subjected to that torture"*.

This was under shared by one HSA who claimed that:

Extract 4.5

"There is no improvement in terms of maternal deliveries by skilled birth attendants especially in rural areas. Many pregnant women complain that they get ill-treated by some mid-wives during delivery. Hence, women resort to going for TBAs for help. You can also see that the distance that pregnant women cover to reach health facilities is long".

Some clinicians interviewed also concurred with mid-wives that some of their colleagues are at times rude to pregnant women and this forces them to look for other alternatives. As one clinician accentuated:

Extract 4.6

"There is no improvement in terms of maternal deliveries by skilled birth attendants in Blantyre. The ratio of a mid-wife to pregnant women is still very high. You see, there are some facilities with only one mid-wife. This implies huge work-load on the part of the mid-wife and this compromises performance. This is also aggravated by the distance factor. When pregnant women realise that it has to take them long distances to travel to a health facility, they just opt to go to a TBA nearby".

In summary, the low rate of maternal deliveries by skilled birth attendants is due to ill-treatment of pregnant women by mid-wives; inadequate number of mid-wives; distances that maternal mothers cover to reach a health facility and availability of TBAs as an alternative to qualified mid-wives.

4.4.3 State of HIV/AIDS in the District

Findings of the study show that before decentralisation, the HIV prevalence rate was declining in the district. However, after the introduction of the policy, there has been an increased trend against the assumption that decentralisation improves service delivery (Chiweza, 2010).

Participants mentioned that the HIV prevalence rate among the 15-49 age group in Blantyre is 17.8%. This is against the national rate of 10% (National AIDS Commission HIV/AIDS Estimates, 2014). Of greater interest is the fact that the trend is picking up again from 2012 instead of declining. This is shown in figure 4.9.

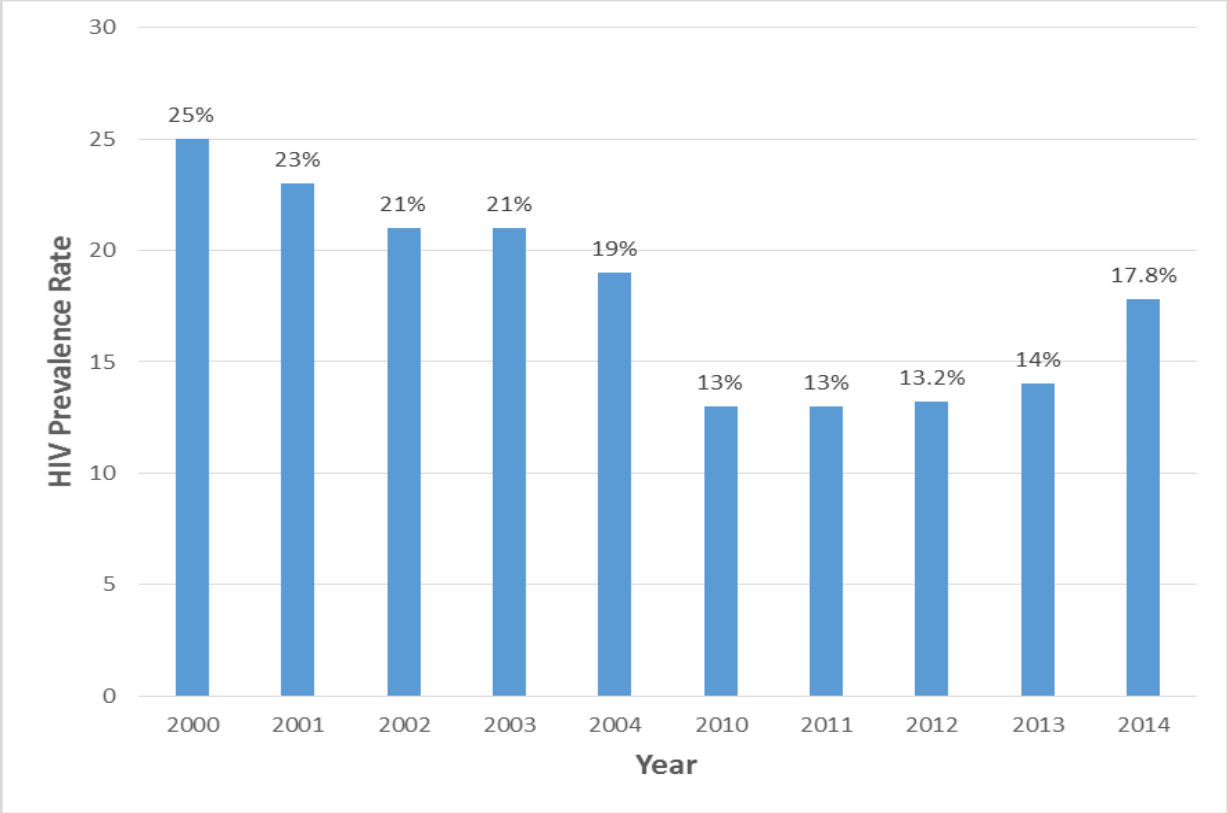


Figure 4.9: Graph showing the HIV Prevalence Rate in Blantyre before and after decentralisation

4.4.4 Factors behind the high HIV prevalence rate among the 15-49 age group in the District

From the results, the HIV prevalence rate was above 25% before decentralisation. This is shown in Figure 4.9. The trend has been going down over the years to 13% as of 2010. The study also shows that there are other factors responsible for the high HIV prevalence rate in Blantyre apart from decentralisation and these are migration, poverty, unprotected sex and lack of civic education. Additionally, the results show that migration is the leading factor with lack of civic education as the least as indicated in Figure 4.10.

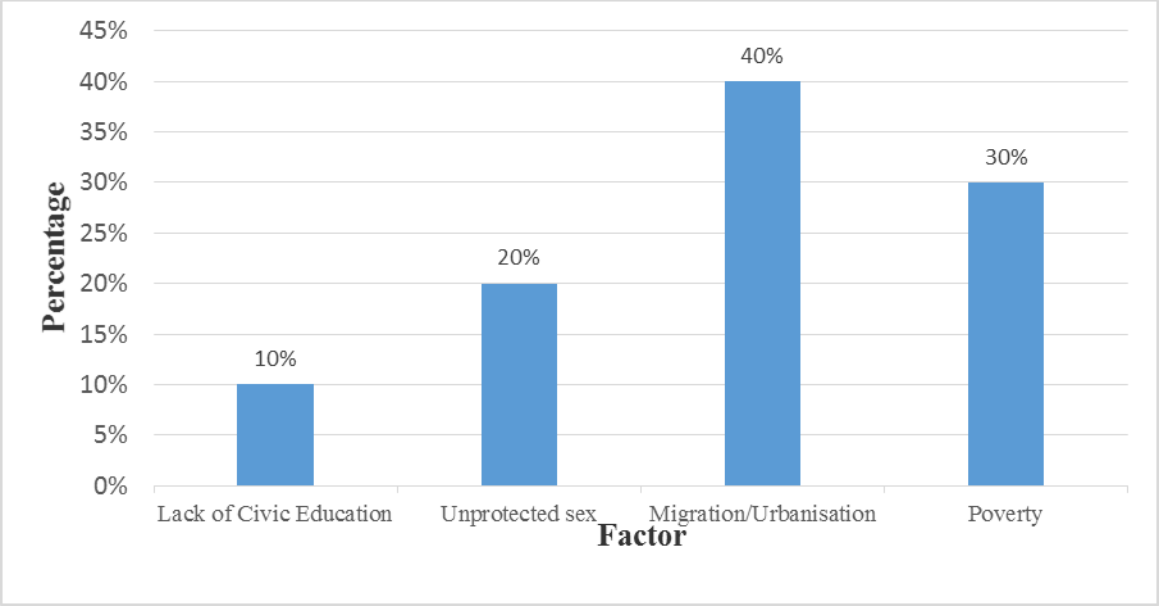


Figure 4.10: Factors behind the high HIV prevalence rate among the 15-49 age group in Blantyre

(i) Migration/Urbanisation

An interview with a clinician reveals that HIV prevalence rate is still very high in Blantyre despite implementation of the policy. Another clinician underscored this point by highlighting that:

Extract 4.7

"Urbanisation of Blantyre city is the main cause of the high prevalence rate in the district as many already infected people move into the city in search of economic activities. These may transmit the virus as they engage in unprotected sex with their multiple partners"

These remarks were also echoed by a mid-wife who observed that:

Extract 4.8

"Blantyre has a very high HIV prevalence rate as compared to other districts partly because of availability of job opportunities as compared to the other districts".

(ii) Poverty and unprotected sex

A DHMT member who gave the researcher an interview had another view despite acknowledging that migration has contributed more to the high HIV prevalence rate in the district. He suggested that poverty is one such factor which cannot be ignored and this is highlighted in extract 4.7.

Extract 4.9

"Yes, urban poor high density suburbs of Blantyre are full of men and women who cannot fend for themselves because of poverty. If you talk of women, they end up selling their bodies for money for their daily living. At times, their clients demand to sleep with them without protecting themselves. As if that is not enough, they satirise that using a condom is just like eating sweets that are wrapped in a paper."

(iii) Lack of civic education

The study also shows that lack of civic education is one of the factors behind the high HIV prevalence rate in the district. This was echoed by a HAC member who remarked that:

Extract 4.10

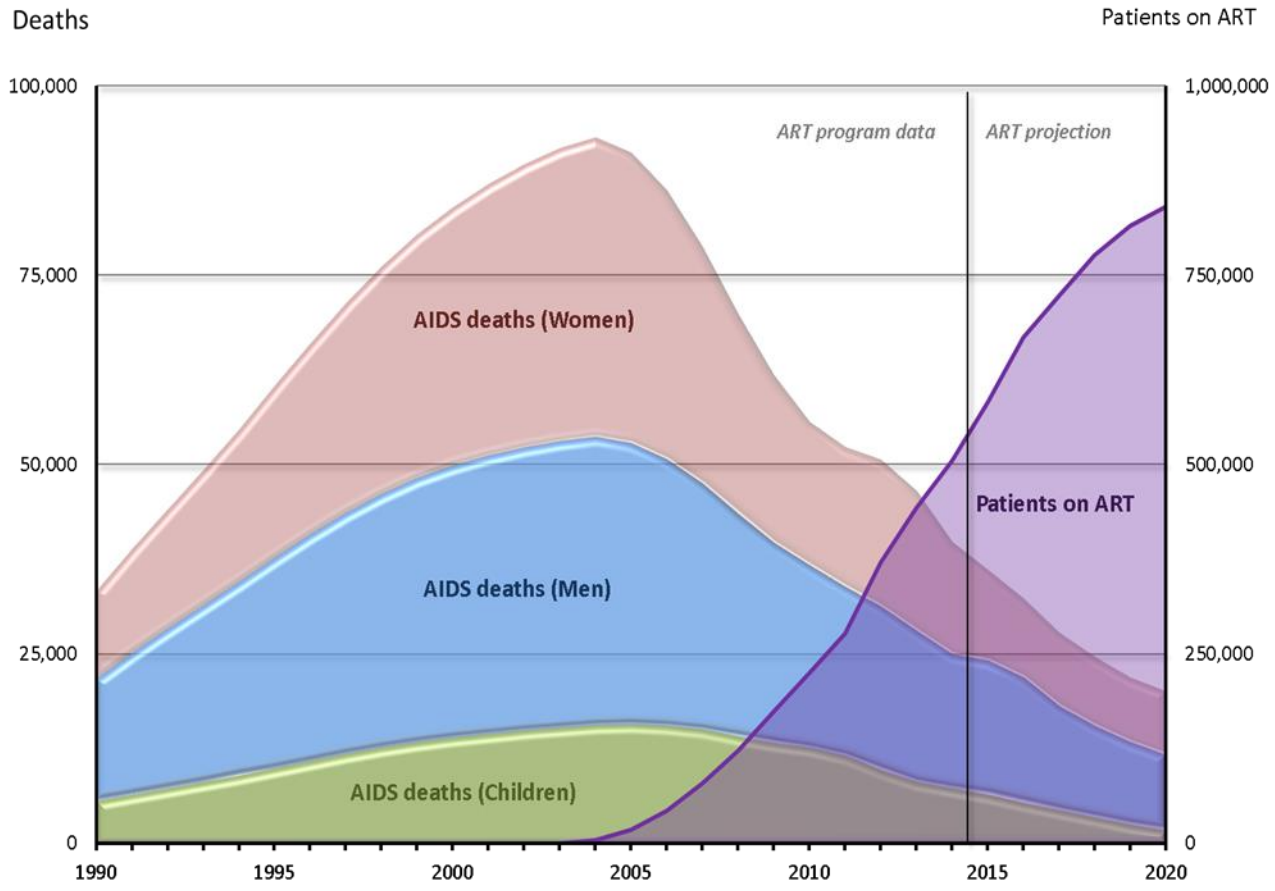
"The available civic education bodies in the district have lost their sense of direction. Instead of prioritising on telling people the dangers of contracting the HIV Virus, they are busy preaching that having sex with multiple partners is not a problem so long as one uses a condom. They even encourage boys and girls to condomise implying that they are very safe to have multiple partners so long as a condom is used. This gives a very bad impression to boys and girls who do not fear to sleep around with multiple partners".

In summary, results suggest that urbanisation of Blantyre has largely contributed to the high HIV prevalence rate among the 15-49 age group as people migrate into the city in search of employment. Furthermore, poverty and use of unprotected sex are the major factors for the high HIV prevalence rate in the district. Decentralisation has not been effective in the district because it has been implemented in isolation. To be effective, implementation of decentralisation needs to go hand-in-hand with other factors such as poverty reduction and use of safe sex.

4.4.5 State of HIV related deaths in the district

An interview with participants established that before decentralisation there was an increase in HIV related deaths in the district as 0.9% of the total population of the district used to die of the disease every year. Participants however revealed that after the introduction of decentralisation, the rate of death declined to 0.3%.

This finding is corroborated by the Annual Health Sector Performance Report (2014) which asserts that there had been a reduction in HIV related deaths soon after the introduction of decentralisation. The report argues that the decline is attributed to an annual Anti-Retroviral Therapy (ART) scale-up in 2004 in the district, which in turn has critically reduced the HIV related deaths and profoundly mitigated its effects. This trend applies to all the districts of the country and this is shown in Table 4.11



Source: Annual Health Sector Performance Report

Figure 4.11: Estimated AIDS Deaths (2014 Spectrum Model) and ART Scale-up (MOH Program Data up to Mid-2014)

4.5 Challenges associated with decentralisation of Health Services in the District

It was critical for this study to look at the challenges associated with decentralisation of health services in the district. Therefore, this section presents the findings about the challenges that the district faces and these are inadequate staff, partial decentralisation, governance problems, inadequate funding, inadequate managerial skills and mis-procurement of drugs.

4.5.1 Inadequate staff

Findings of the study show that there is huge shortage of staff in the district and this compromises effective implementation of the policy.

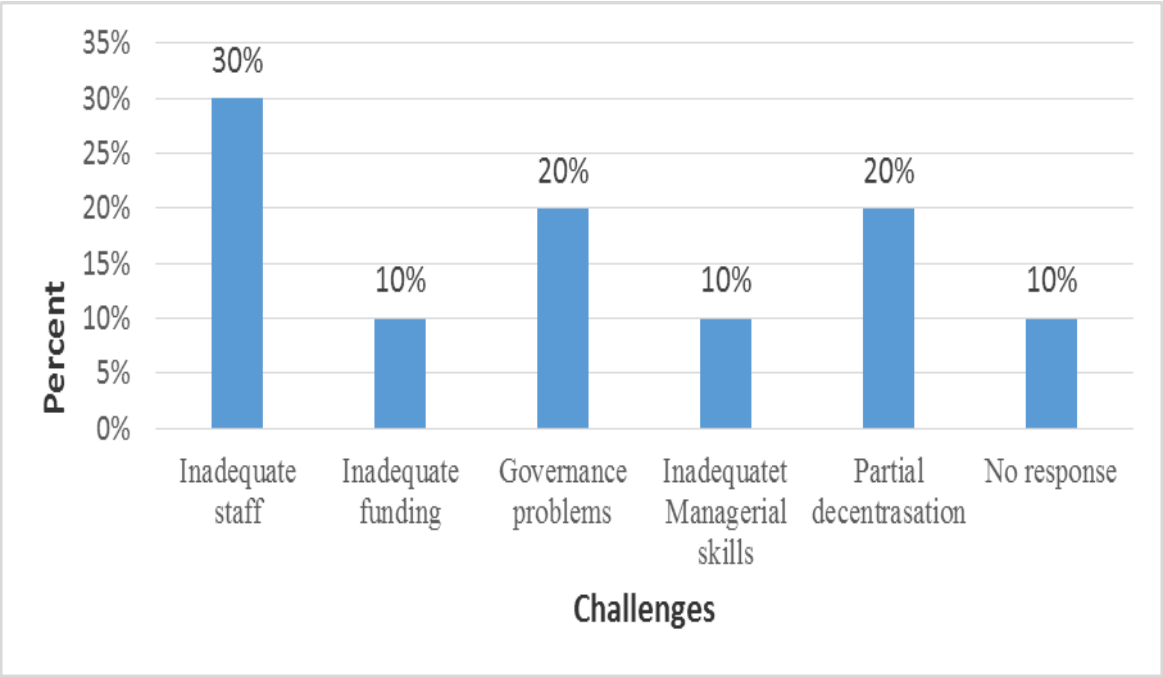


Figure 4.12: Challenges Associated with Decentralisation of Health Services in Blantyre

Participants interviewed indicate that some health facilities in the district have inadequate staff to support the provision of health services and this leaves the DHO with no option but to engage health workers on locum(where an extra payment is given for extra hours worked)and relief duties. Failure by the DHO to pay locum in most cases results in health workers refusing to work and this leaves many patients unattended to, hence affecting the provision of health services in the district. This is shown in Figure 4.12.

4.5.2 Partial decentralisation

The second challenge that came out prominently is that not all provisions of the Policy have been implemented in full as provided for in the National Decentralisation Policy (1998). Participants mentioned that there is a half-hearted tendency to translate the provision of the Policy into practice. For example, it was indicated that human resource is still centrally managed. Issues regarding discipline, recruitment and promotion of health workers are centrally managed. As a result, some indicators are not improving despite implementation of the policy.

4.5.3 Governance problems

Before the introduction of decentralisation, the delivery of social services in the district was done by line ministries. There was no integration of social services delivery in the district. Participants mentioned that after the introduction of the policy in 1998, health services were integrated to the District Council with the DC as Head of Secretariat and Council Chairperson as the Head of the elected arm of the Council.

The study further shows that the DHO has dual reporting relationships. On the one hand, he reports to the DC as controlling officer in the district and on the other hand, he also reports to the line MOH through the South West Health Zone Office. To that effect, one key informant remarked on the dual reporting relationships in the district and said that:

Extract 4.11

This is causing confusion as some DHOs tend not to follow advice from the DCs. They tend to follow instructions from the parent Ministry.

This implies that implementation of the policy in the district has resulted in some challenges that negatively impacts on the provision of health services.

4.5.4 Inadequate funding

The findings also indicate that limited resources for the implementation of programmes on decentralisation heavily contribute to partial decentralisation of the policy. The Participants singled out the manner in which the Malawi Kwacha was heavily devalued by 100% in 2012. This reduced the currency's purchasing power and led to failure to implement some of the important health activities, hence the dwindling in performance of some indicators.

In explicit terms, funding levels were far much better before decentralisation than after decentralisation as evidenced by the dwindling funding levels in US Dollars over the two periods before and after decentralisation. See Figure 4.13.

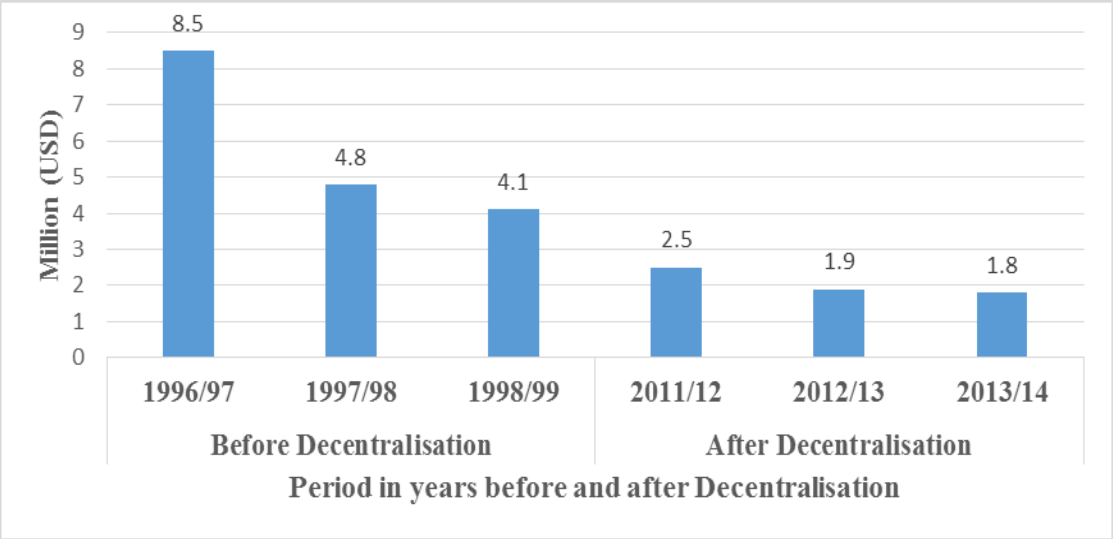


Figure 4.13:Bar graph showing funding levels in Blantyre before and after Decentralisation

4.5.5 Inadequate managerial skills

The study shows that most managers joining the health profession do not have managerial skills to implement health services delivery. Participants said that unlike before decentralisation where the Ministry of Health Headquarters used to organise an orientation of health workers on government procedures at Mpemba Staff Development Institute, current managers joining the Ministry in the district are not oriented due to inadequate funding as shown in Figure 4.13 and this poses a challenge on the implementation of the policy.

4.5.6 Misprocurement of drugs

The results of the study indicate that procurement procedures had been flouted by those responsible for drug procurement as they chose to by-pass and ignore an already existing system in order to satisfy their sinister motives. In this case, participants indicated that huge quantities of drugs were unprocedurally procured from private suppliers instead of the CMST. Participants further mention that private suppliers gave kick-backs to those responsible for procurement in the form of commission in order to win favours from those doing the procurement.

The study further established that the CMST does not give kick-backs to those responsible for procurement and this forced them to go for private drug suppliers. Hence, the whole process of drug procurement was marred by irregularities before the government centralised the function in 2012.

4.6 Level of Decentralisation in delivery of Health Services and perceptions on its effect

This section presents the level of decentralisation in the delivery of health services and perceptions on its effect. The section is divided into two sub-sections. Sub-section 4.4.1 presents perceptions on the positive effect of decentralisation and Sub-section 4.4.2 presents perceptions on the negative effect of decentralisation.

4.6.1 Positive effects of decentralisation

(i) Decrease in number of HIV related deaths

Findings of this study indicate that fewer people are now dying of HIV/AIDS than a period before decentralisation in the health facilities that this study took place. In this regard, participants revealed that before decentralisation, 0.9% of the people used to die of the disease in the sampled facilities every year. However, participants mentioned that after the introduction of decentralisation in 1998 and subsequent introduction of an Antiretroviral Therapy (ART) in 2004, there has been a substantial decrease in number of HIV related deaths in the district. In this context, 0.3% of the people died of the disease in the sampled facilities in 2014. From the above statistics, it should be observed that an increase in annual ART scale-up in the district may have been influenced by decentralisation. Consequently, this has significantly reduced the HIV related deaths in the district. This was corroborated by a HAC member who remarked that:

Extract 4.12

"We used to bury people dying of HIV/AIDS on a daily basis. Ever since decentralisation was introduced, we have seen the introduction of ART which has tremendously mitigated HIV related deaths. Cases of people dying of the disease have now gone down. Community awareness of the disease by health workers has also contributed positively to change in the mind-set of the people about the disease. People are now going for HIV testing and Counseling in large numbers".

From the findings, the study observes that the HIV prevalence rate for the district is 17.8% amidst the background of fewer people dying of the disease ever since ART was introduced in the district. This was corroborated by a clinician who vociferated that:

Extract 4.13

"You see, before decentralisation was introduced in 1998, the HIV prevalence rate in Blantyre was at 28%.In 2012 after the reform was introduced, the rate was at 17.8%. I therefore see a positive impact of decentralisation on health services delivery in the district".

These remarks were also corroborated by a mid-wife who commented that:

Extract 4.14

"I see a positive change with decentralisation of health services in the district. A reduction in HIV related deaths tells it all. As for the high HIV prevalence rate in the district, i think there are other factors associated with implementation of the reform".

To this end, a Health Surveillance Assistant also added his voice by saying that:

Extract 4.15

"There is a dismal positive effect of decentralisation in the district as evidenced by the current HIV prevalence rate of 17.8% against the current national rate of 10%. You see, a good number of crucial health indicators are not improving despite implementation of the reform. May be government should implement the policy in full".

In summary, there is a decrease in number of HIV related deaths in the district. This can be attributed to the introduction of ART in the district. ART was introduced through the decentralisation of management services in the district.

(ii) Establishment of governance structures at the District Council Level

Decentralisation has resulted in the establishment of governance structures at the district level. In this regard, participants mentioned that the District Council is made up of two arms: a political arm composed of councillors and MPs and an administrative arm called the Council Secretariat. While Councillors and MPs are elected and serve a five-year term, permanent council employees manage the council secretariat.

The findings further indicate that a number of governance structures have been established at the District Council as a result of decentralisation. The study observes that the basic governance structures at the local level that help in health services delivery are the Village Development Committee (VDC), Area Executive Committee (AEC), Area Development Committee (ADC) and Health Centre Advisory Committee (HCAC).There are also district level institutions like the District Executive Committee (DEC) and the Hospital Advisory Committee (HAC). This is shown in Figure 4.14.

Findings of the study further show that the District Commissioner is the controlling officer at the District Council Level with the DHO as the head of the District Health Office as shown in Figure 4.15. This was corroborated by both officials at the Health Zone Office and the District Council as payments at district level are authorised by the DHO and approved by the District Commissioner.

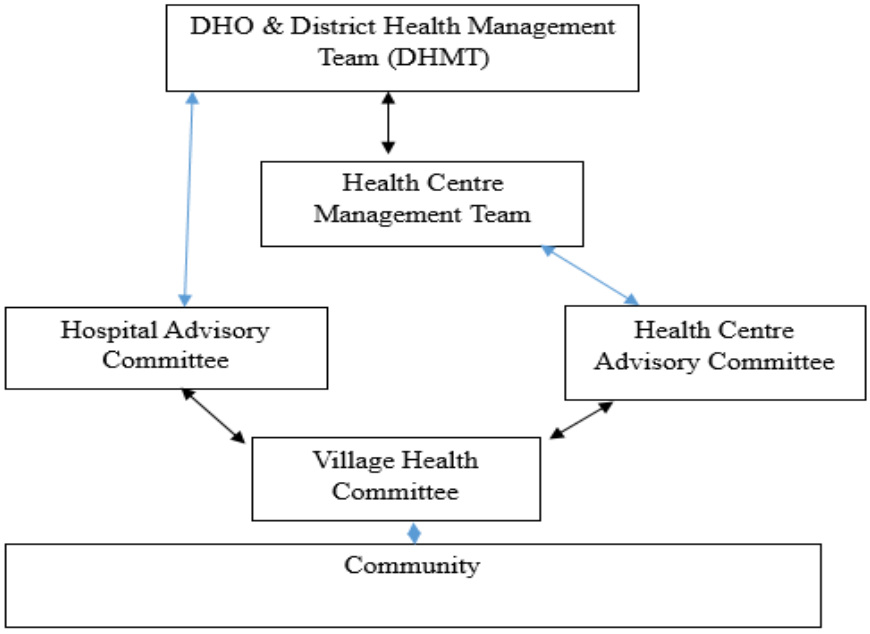


Figure 4.14: Health Governance Structures at District, Health Centre and Community Levels

In this regard, the study noted that the district has been empowered to make decisions on management of health services and this has ensured quick solutions to local problems than waiting for the central level. This has also helped the district health office to utilise existing resources in their sectors within the district through the District Commissioner's office.

(iii) Strengthened the processes of accountability

As one way of implementing decentralisation at the district level, participants mentioned that the community is represented by the Hospital Advisory Committee (HAC) while at health centre level, it is the Health Centre Advisory Committee (HCAC) and at the village level, it is the Village Health Committee (VHC). In this case, the DHMT is accountable to HAC and the Health and Environment Committee of the council at district level while the Health Centre Management Team is accountable to the HCAC at Health Centre Level. It was also mentioned that at village (community) level, HSAs are accountable to the VHC while at health centre level they are accountable to the HCAC.

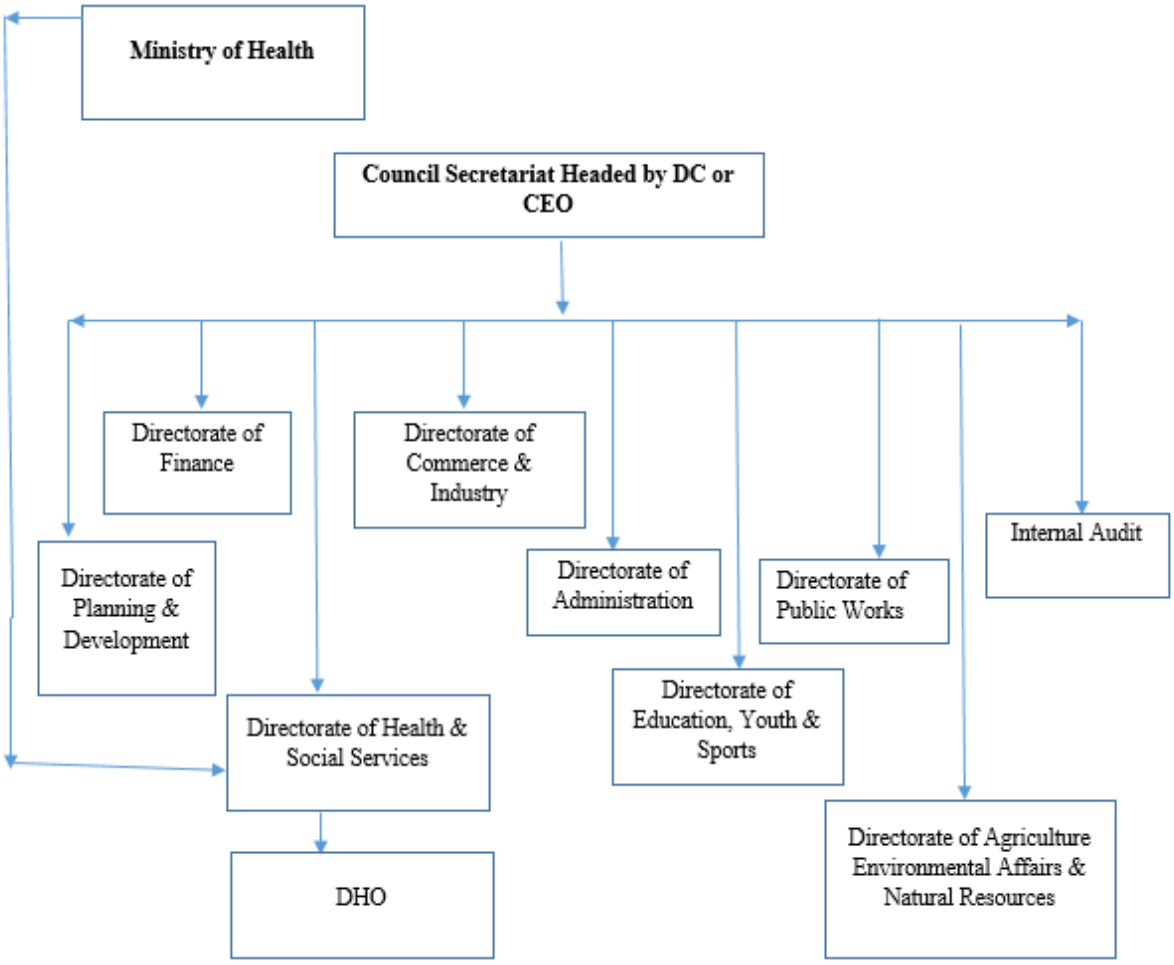


Figure 4.15: Organogram for the Council Secretariat showing a link with the Ministry of Health

Results of the study further show that the DHO and other members of the DHMT are part of the DEC at council level. This is the technical and advisory committee to the council. The policy

means that the DHO is responsible to the District Hospital Advisory Committee. However, both the DHO and DC are answerable to the Health and Environment Committee of the council.

From the findings, it should be noted that the Health and Environment Committee at the District Council where the DC and the DHMT are accountable to has just been instituted after the May, 2014 tripartite elections that ushered-in new councillors after an absence of close to ten years. The study also observes that HAC, HCAC and VHCs to which health services providers are accountable have been in existence long before the May 20, 2014 Tri-partite Elections only that they were not active.

The participants however mentioned that many health centre committees have not been trained or oriented in what is expected of them as one key informant cited the role of drug monitoring in rural areas

Extract 4.16

"They don't know the type of drugs and quantities in boxes but they are told to sign that they have witnessed drug deliveries as a requirement of the policy"

In summary, the study has shown that implementation of the decentralisation policy has a positive effect on health services delivery as it has positively enhanced accountability of the DC and DHO and his management team to the community in the provision of health services in the district.

4.6.2 Negative effects of decentralisation in the District

(i) Limited decision-making powers

With the decentralisation policy, one of the major areas for policy implementation is decision-making power. Some participants mentioned that the district is allowed to make very limited decisions with the majority of decisions being centrally controlled by the Ministry of Health.

The study reveals that the local council's power is very limited despite decentralisation as it has no control over many functions. For example, the annual budget ceiling for the district is determined by the Ministry of Health (MoH) without consultations with the district on the need and requirements. Furthermore, development of the district's annual plan is based on prescribed guidelines and templates by the MoH. This limitation is also extended to procurement of goods

and services. For example, participants mentioned of drugs where MoH procures drugs centrally. The DHO's office is only required to place an order at the Central Government Stores Trust (CMST) and payment is done by Treasury through the Line Ministry. The DHO only receives the delivery note after delivery of the drugs. This poses a challenge as the CMST often times runs short of drugs thereby under-supplying the district health office, hence shortage of drugs in the entire district.

Participants also pointed at issues of human resources where the DHMT has no control at all in most critical human resource issues such as recruitment, discipline and posting of members of staff. For example, promotions and disciplining of employees are done by the Appointment and Disciplinary Committee and through the Health Services Commission (HSC). The DHMT has no influence on promotions and long-term trainings despite being people who monitor performance of workers as it is not consulted by the appointing authority.

Limited decision-making power was also noted on the composition of the DHMT. Participants explained that MoH has power to decide who should be part of the DHMT. This was evidenced by circulars which directed DHOs to include certain cadres such as human resources and spokesperson into the DHMT. The circular, however, was silent on whether the DHMT members could co-opt some individuals into the management.

(ii) Decrease in rate of maternal deliveries by SBAs

The study participants said that despite the introduction of decentralisation policy in 1998, the rate of maternal deliveries by skilled birth attendants has been decreasing from 80% in 1998 to 43% in 2014. Some participants attributed this to such factors as ill-treatment of maternal mothers by midwives and the distance that they cover to reach a health facility to access health services. They explained that despite availability of midwives in health facilities, pregnant women shun these facilities in favour of TBAs, hence decreasing the rate of maternal deliveries by SBAs. They further added that many women cannot manage to walk long distances to access health services, hence opting for TBAs.

(iii) Decentralisation as a potential fertile breeding ground for conflict

Results of the study reveal that decentralisation is a potential fertile breeding ground for conflict in the district. In this regard, participants mentioned that the reform has brought about dual reporting relationships on the part of the DHO. The DHO reports to the District Commissioner

and at the same time the Ministry of Health through the Zone Office. One key informant highlighted that this is causing confusion as some DHOs tend not to follow instructions from the DC; they tend to follow advice and instructions from the mother Ministry.

This was accentuated by one DHMT member who stated that

Extract 4.17

"One cannot cut the arm that feeds him…The DHO leans towards the side that provides him with the daily bread and butter…"

(iv) Decentralisation as a breeding ground for corruption.

Some participants hinted that decentralised local governance structures in Blantyre have enhanced corruption in relation to awarding of contracts and other related acts. The participants attributed this to the structure of the district council. This has consequently led to, *inter alia*, financial mess in local councils, loss of citizen and donor trust as well as low quality infrastructures. One participant remarked that

Extract 4.18

"Some of these civil servants are very corrupt. They connive with contractors to swindle public money. You see, there are plenty of sub-standard and unfinished projects in the district where money was collected by unscrupulous contractors for work that was either partially or not done at all."

This implies that decentralisation has brought about corruption at the local level as people in the district are exposed to a lot of monetary resources that tempt them to behave corruptly.

4.7 Conclusion

This chapter has presented the research findings with reference to the available literature. The study indicates that decentralisation has taken place though partially. Some functions that were identified for decentralisation have been retained by the Ministry of Health.

The study also portrays that decentralisation has been implemented in isolation of other factors. Though decentralisation has taken place, the study indicates that it has been ineffective. The study also reveals that there are perceptions for both positive and negative effects of decentralisation. While the positive effects signify that decentralisation has taken place, the negative effects indicate that decentralisation has been ineffective owing to the fact that it has not

been implemented in full. The next chapter presents a discussion and interpretation of the findings.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter presents a discussion and interpretation of the results of the study based on the research questions and objectives as given in Chapter one and in relation to reviewed literature. Section 5.1 covers a discussion on people's views about decentralisation of health services. Section 5.2 discusses decentralisation and the implementation of health service delivery. This is followed by section 5.3 which provides the state of decentralisation of some health indicators in the district. A discussion on challenges associated with decentralisation of health services are presented in section 5.4.Section 5.5 outlines the level of decentralisation in the delivery of health services and indicator performance in the district. The chapter ends with a conclusion in section 5.6.

5.1 People's views about Decentralisation of Health Services

This section presents a discussion on people's views about the implementation of decentralisation of health services in the district. The first subsection starts with a discussion on views as to whether decentralisation has been implemented fully or not. This is followed by another subsection that discusses views about who is responsible for the implementation of decentralisation in the district.

5.1.1 Views on whether decentralisation has been implemented fully or not

Though there are traces of activities regarding the level of decentralisation in the district, 72% of the study participants mentioned that the reform has been implemented in part. This is envisaged by the fact that only four out of the six functions that were identified for devolution have been decentralised to the district level. The other functions are still retained by the Ministry of Health. This finding is in agreement with what Chiweza (2010) found with regards to implementation of decentralisation in the country. In her study, it was revealed that despite donors pumping more money into the country to implement the reform, some government ministries including the Ministry of Health seem not ready to devolve their powers and authority to the local level. This has a negative effect on improving service delivery in the country.

Considering the fact that decentralisation transfers power, authority and responsibilities from the centre to the peripheral (Tambulasi & Kayuni, 2006), the study observes that less power, authority and responsibility have been decentralised to the district due to the partial devolution of the functions. This defeats principles of decentralisation that propagate for the transfer of all functions to the lower levels of health service delivery in a bid to improve efficiency and effectiveness.

In line with the above argument, it should be stressed that those functions that have been decentralised have partially positively affected health service delivery in some instances as some people are able to access basic health services in their areas. This has improved the health status of the people in one way or the other. On the other hand, those functions that have not been decentralised in full have negatively contributed to the low performance of some indicators.

In summary, the study observes that decentralisation has been partially implemented in the district. Though touted as a panacea for improving service delivery, the results signify that the underperformance of some indicators and let alone the unsatisfactory service delivery in the district are due to the fact that the reform has not been implemented in full.

5.1.2 Views about who is responsible for the implementation of decentralisation in the District

Findings as presented in section 4.2 indicate that the DHO and his DHMT are responsible for the implementation of decentralisation of health services in the district. The study further reveals that the DHMT sees to it that all health services are provided at the right place and time and using the right equipment and materials.

Participants also mentioned that apart from the district health office, other health providers include CHAM institutions, private healthcare institutions and non-governmental organisations (NGOs). The DHO's Office ensures that these institutions are coordinated properly to make sure that equitable healthcare is provided to the people of the district.

This finding confirms what the Decentralisation Guidelines (2005) stipulate. The guidelines emphasise the fact that the DHMT, which receives direct technical support and supervision from the Zonal Health Support Office, is responsible for the implementation of decentralisation. This

is done by ensuring that the district offers the right services to the right people at the local level in conjunction with partners that operate in the district.

Furthermore, the findings reveal that the DHO is also responsible to the District Commissioner in running the day-to-day-affairs of the district and the DHMT is responsible to the Health and Environment Committee of the District Council as well as the Hospital Advisory Committee (HAC).

In summary, the DHO and his management team are responsible for the implementation of decentralisation in the district. However, their role is complemented by other health providers such as CHAM institutions, private health facilities and those institutions run by parastatals.

5.2 Functions that have been devolved and those that have been retained by the Ministry of Health

This section presents a discussion on functions that have been devolved and those that have been retained by the Ministry of Health in the implementation of health service delivery. The section has four subsections. The first sub-section 5.2.1 discusses decentralisation and the health service delivery. This is followed by subsection 5.2.2, which provides functions that have been devolved at the ministry level. Sub-section 5.2.3 gives a discussion on decentralisation at the district level. Finally, the section ends with sub-section 5.2.4 which presents a discussion on retention of functions that were meant for decentralisation from the MoH Level to the District Level.

5.2.1 Decentralisation and the health service delivery

As part of the reforms in the health care delivery system in Blantyre, the Decentralisation Policy (1998) and the Local Government Act (1998) promote the transfer of managerial and financial authority from the Central Government to the District Council to ensure efficient and effective delivery of health services. According to the Decentralisation Policy, the District Council "is charged with the overall development of the district". Specifically, the DHO and his management team are responsible for the provision of health services in the district. In addition, CHAM and private health facilities also complement government in the provision of health services.

Meanwhile, decentralisation is currently being implemented in the district as a means of improving performance and outcomes of national health care system. But for this to be effective,

it requires full implementation of the policy and not otherwise. In a situation where the policy has not been implemented in full, for example, where not all autonomy has been granted to the DHMT, this has an implication on the services being implemented at the district in relation to the expectation of the policy. This could be related to resistant to change or a situation where the Central Government does not want to relinquish power to the lower level.

For the policy to be effective at the implementation level, decentralisation of health services requires a strong political will and effective leadership that can overcome resistance to change for the Central Government. In this regard, Bossert (2000) contends that decentralisation in Africa is largely an ideal than reality. He argues that most of the times, the Central Government is seen to be on top of things and as a result centralisation is still in place despite efforts to decentralise.

5.2.2 Functions that have been devolved from the Ministry to the District Level

Findings of the study as presented in section 4.3 indicate that the MoH initially planned to retain ten functions and these are policy development, review and enforcement; regulation of the sector and donor coordination; resource mobilisation, budget review and analysis; human resource planning and development; quantification and national procurement of essential drugs, supplies and major equipment; epidemiological surveillance and compilation of national health statistics; development and enforcement of treatment protocols, standards and norms for service delivery; health legislation and its enforcement; provision of high level technical support to the operational level and fulfilling obligations to international health and liaising with international donors.

In the same vein, literature as provided in the Decentralisation Guidelines (2005) indicates that the Ministry of Health identified six functions for decentralisation to the lower levels of health service delivery in 2004. These functions are:

(i) Health Planning
(ii) Financial Management, budgeting and Resource Allocation
(iii) District Implementation Plan (DIP)
(iv) Monitoring and Evaluation
(v) Human Resource Management
(vi) Research

This study however has established that not all the six functions that were identified for decentralisation have been devolved to the district level. While some functions have been devolved, the study shows that others have been retained by the MoH. This affects the implementation of the policy as the retained functions contribute to the partial decentralisation of the policy.

5.2.2.1 Functions that have either been devolved fully or partially at Ministry Level

(i) Financial management, budgeting and resource allocation

The first function that has been devolved partially is financial management, budgeting and resource allocation. This study has found that before decentralisation, both annual and monthly resource allocations were done by the Ministry of Health. The district was only at the receiving end where it was mandated to implement activities using the already allocated resources. After decentralisation, the function has been devolved to the district level where both resource allocation and implementation of activities are done.

In this tune, the Ministry of Health devolved the function to the District level alongside the Medium Term Expenditure Framework (MTEF) as a tool to ensure that budgets are programme or "*activity –based*" and the ceiling is allocated to the sector based on the priority (Malawi Government, 2003a, p.3). In addition to that, the function is partially decentralised to the district as evidenced by the fact that the Ministry of Health is responsible for setting up the budget ceiling in conjunction with treasury. In other words, the DHMT does not have powers and authority to decide on the ceiling for the district. The district is only told what to do and how much to expend (The Malawi Decentralisation Guidelines, 2005).

Therefore, the study observes that the function has been devolved to the district though in part. This compromises the efficiency and effectiveness of the reform. It could have been better if the function were decentralised in full to the district.

(ii) Health planning

Planning is one of the core functions of management in any organisation (Longenecker & Pringle, 1994). As such, it must be undertaken within the boundaries of available resources. In view of this, the study as presented in section 4.2 observes that health planning at MoH level has

been decentralised to the district level though with some control. In this perspective, participants mentioned that the DHMT is allowed to make some annual plans for the district. The study further observes that systematic planning was introduced at the inception of decentralisation as compared to the haphazard way it was conducted before decentralisation. These plans are sent to the Ministry for approval before implementation.

It is also observed that even after the introduction of the policy in 1998, planning is still done within the budget ceilings as provided and approved by the MoH and Treasury. Thus, the annual budget ceiling for the district is determined by the Ministry without consultations with the district on the need and its requirements. By implication, this means that the function is not fully decentralised to the district level though it was identified for full devolution. This causes a lot of problems as the district is forced to re-work on an already made budget to prepare a new budget based on this ceiling. This is hectic and cumbersome as time is wasted in the process and this negatively affects the delivery of health services in the district.

(iii) District Implementation Plan (DIP)

The personal interviews reveal that the DHMT is mandated to see to it that the annual plan otherwise known as District Implementation Plan (DIP) is formulated on a yearly basis to take into account district specific needs. Participants mentioned that under the full devolution, the planning process is anticipated to be coordinated by the Health Services Directorate in conjunction with the Director of Planning and the Health and Environment Committee of the District Council based on planning guidelines issued by the Central MOH.

However, since decentralisation is not fully implemented, coordination of the DIP is made by the DIP Coordinator who also happens to be a member of the DHMT. In this context, the coordinator ensures that all partners in the district prepare their activities based on the district specific needs and not the needs of the partners themselves. This ensures that the district implements health services that are really demanded by the people. In addition, the South West Zonal Health Support Office and the DHMT provide technical support to the District Council during planning taking into account the review of the DIP implementation especially outstanding issues. These reviews are done on a quarterly basis to make sure that the district implements plans that are budgeted for and ensure that the planned activities are actually implemented.

The above discussion entails that despite the effort to decentralise, the Ministry of Health does not want to devolve its powers and authority in full and this defeats the essence of the reform. Literature reveals that those institutions that embrace decentralisation in full end up improving the lives of the people they serve tremendously. Therefore, the fact that the Ministry of Health does not want to embrace decentralisation in full entails a slow progress in reducing the burden of disease in the district.

(iv) Supervision, Monitoring and Evaluation of Health Service Delivery

This function is essential as it ensures that proposed activities are actually implemented and that they are on course to achieve the agreed goals and objectives. In this perspective, the findings as presented in 4.2.1 show that supervision, monitoring and evaluation of health service delivery have been decentralised to the district level. The DHMT receives technical support and supervision from Zonal Health Support Office based on the integrated supervision check list. The DHMT, in turn, is required to support and supervise health centres, CHAM and private sector institutions on a regular basis using the appropriate sections of the integrated check list. The DHMT further compiles supervision reports and provide feed-back to the sites they supervise and take the necessary action to improve service delivery.

In agreement to the findings, the Decentralisation Guideline (2005) point out that when supervision (use of the integrated check list), annual performance reviews, regular HMIS returns, special surveys and scheduled meetings are decentralised to the district level, they form the basis for monitoring and evaluating decentralised health services. In line with this, the DHMT is responsible for ensuring that data collected at the district, health centre and community levels are used at the point of collection for decision making, and that it is submitted in a timely manner and is of acceptable quality. The DHMT is further required to analyse the data, compile it, use it for decision making and provides feedback to the lower levels and submit the required information to the Zone and national level.

Considering that the relationship which exists between the Ministry of Health and the District Council is that of the principal and his agent, Bossert and Beauvais (2002), argue that the Ministry of Health monitors the performance of his agent (the DHMT) basing on the set goals and objectives. Thus, the principal/agent relationship that exists between the centre and the

periphery focuses us to see it as dynamic and evolving. It also allows us to focus on defining what the national level can do to encourage the local council to achieve the broad goals of health policy.

The study also shows that it is only small projects that are decentralised to the district level. This implies that the DHO and his management team are only left with the task of supervising minor projects in the district. This raises questions as to why these officials labour to go to the districts to do work which can be easily done by the DHO and his management team.

In summary, though supervision has been decentralised to the district level, the Ministry of Health still retains some power and authority to discharge it. The district is only left with the responsibility to supervise minor projects.

5.2.2.2 Functions that have not been devolved at the Ministry Level

Though decentralisation of health services implied the devolution of all the six functions to the district, results of the study reveal that only four functions were devolved either fully or partially and two of the six functions were retained by the Ministry of Health. These functions are human resource management and research.

(i) Human Resource Management

Studies in Human Resource Management (HRM) show that human resources are the most critical and delicate resource of all resources that an organisation can have (Armstrong, 2010). Therefore, they must be handled properly by those people in positions of authority.

Basing on the findings of the study, hiring and firing of human resources is still done by the Ministry of Health. The DHMT members have no control at all in most critical human resource issues. The DHMT only has a mandate to recommend to the Ministry of Health as to who should be disciplined but the final decision to hire and fire rests in the hands of the Ministry of Health in conjunction with the Health Services Commission (Decentralisation Guidelines in Malawi, 2005). Only discipline of junior staff is done by the DHO's office but again this requires the final approval of the Ministry of Health.

From the discussion, it can be argued that this arrangement is not in tandem with principles of decentralisation since the DHO and his management team, who are supervisors of the entire human resources at district level, are better placed to discipline the employees. This is so because they know the people very well (Decentralisation Guidelines, 2005).

Furthermore, the study also shows that promotions of staff are not decentralised to the district since they are done by MOH through the HSC. Despite being people who monitor performance of workers on the ground, DHMT members do not have an influence on promotions since they are controlled by the MoH. This arrangement is flawed as undeserved health workers end-up being promoted thereby leaving hard-workers stack in their various positions for ages. In other words, promotions are not based on performance management and this demotivates the hard-workers in their quest to improve health service delivery.

In this context, Herzberg (1959) argues that promotion can increase job satisfaction by giving employees such incentives as sense of recognition, responsibility and achievement. This in turn encourages employees to work hard, hence improving health service delivery.

The decision to determine the size of the DHMT under this function is not decentralised to the district as the DHO is just dictated on who should be a member of the DHMT(Interview with a DHMT Member, September, 2014). This was evidenced by circulars which directed DHOs to include certain cadres such as human resources and spokesperson in the DHMT. The circular, however, was silent on whether the DHMT members could co-opt some individuals into the management. This limits the DHO to take people who can be of help into the DHMT, hence it has a negative effect on the decentralisation of health services in the district.

(ii) Research

This is one of the functions that was identified for decentralisation at the on-set of the decentralisation policy in the district. Among other things, health systems research was meant to increase equity (access and coverage), increase efficiency in resource mobilisation, enhance accountability, improve health systems management and development, monitor and improve the quality of care and improve health outcomes (Decentralisation Guidelines, 2005). This initiative was arranged in line with guidelines from the National Health Sciences and Research Committee

on the conduct of health research. This function is therefore essential for the implementation of evidence based decisions that affect the health sector.

This study however indicates that despite the plan to decentralise the function, it still remains in the hands of the Ministry of Health. At the district level, health systems research has not been institutionalised and that the DHMT and other members of staff have not been given the necessary skills and resources to undertake such research. All research works conducted in the district after the introduction of the policy are initiated by the Ministry.

From the above discussion, one can be tempted to conclude that the Ministry of Health has over done it by centralising some of the functions that were identified for devolution. It should also be pointed out that centralisation of some functions is a means to correct some of the evils in the system like corruption. Therefore, with all the observations about the choice of DHMT members lying in the hands of the Ministry of Health, one can predict the mayhem that could follow if this responsibility were placed in the hands of the DHO. It could have been detrimental to do so as the standard requirements of WHO could not have been met. This is so because some DHOs could have abused the system by appointing their colleagues into the DHMT and this could have compromised the performance of the DHMT in health service delivery. In addition to that, it could be very difficult on the part of the Ministry to rate the performance of the DHMT considering the factors that the DHMTS for each district could have been made of different individuals with different professional backgrounds.

5.2.3 Decentralisation at District Level

5.2.3.1 Function(s) that have been devolved at the District Level

A closer look at the functions at the District Level shows that only one function has been decentralised to the lower level of health service delivery. In this perspective, participants mentioned that supervision, monitoring and evaluation of health service delivery are the only function that has been decentralised to the lower level.

(i) Supervision, monitoring and evaluation of health service delivery

This function is essential as it ensures that proposed activities are actually implemented and that they are on course to achieve the set goals and objectives. In this perspective, the findings show

that the function is decentralised to the health centre level as the DHMT receives technical support and supervision from Zonal Health Support Office based on the integrated supervision check list. Consequently, the DHMT is required to support and supervise health centres, CHAM and private sector institutions on a regular basis using the appropriate sections of the integrated check list. The DHMT is therefore required to analyse the data, compiles the supervision report, use it for decision making, provide feedback to the sites visited, take the necessary action to improve service delivery and submit the required information to the Health Support Zone and national level.

On the other hand, the health centre staff are required to use the integrated supervision checklist to supervise the HSAs, CBDAs, and other community health workers and provide the necessary feedback reports for action.

Therefore, it is appropriate to say that monitoring and evaluation have been partially devolved to the health centre since the district retains part of the activities associated with this function. For example, analysis of the data for decision-making still remains the duty of the district since the health centre does not have the capacity to do that.

5.2.3.2 Functions that have not been devolved at the District Level

Though supervision, monitoring and evaluation of health service delivery has been decentralised from the District Level to the Health Centre Level, the DHMT still retains some functions, power and authority. The study shows that the DHMT retains such functions as financial management, budgeting and resource allocation; District Implementation Plan (DIP) and Health Planning. This entails that decentralisation has been implemented in part in the district. This retention of functions contributes negatively to the delivery of health services in the district.

5.2.4 Retention of functions that were meant for devolution from the MoH Level to the lower levels of health service delivery

Despite implementation of the policy being under way in the district, findings of the study show that there is retention of functions from the MOH to the District Level. For example, after devolving four functions at the Ministry Level, two functions were retained namely human

resources and research. Similarly, three functions were retained at the district level with only one function devolved to the health centre level.

Hence, the central argument in this study is that decentralisation has not been implemented in full in the district. This is evidenced by the retention of functions at each level of health service delivery. This has resulted in an incomplete cycle of implementation of the policy and consequently compromised the quality of health service delivery. In turn, this has exacerbated inefficiency and in-effectiveness of health service delivery in the district.

If decentralisation were implemented in full, there could be a significant improvement is health service delivery. This owes to the fact that decentralisation improves health service delivery in all studies conducted in developing countries.

5.3 State of Decentralisation of some Health Indicators

This section presents a discussion on the state of decentralisation of some health indicators in the district. The section has five subsections that are presented in order of specific objectives of the study. Subsection 5.3.1 discusses the state of maternal health deliveries by SBAs. This is followed by subsection 5.3.2 which presents a discussion on factors for the decline in maternal health deliveries by SBAs in relation to decentralisation of health services. Subsection 5.3.3 gives the state of HIV/AIDS in the district. While subsection 5.3.4 covers factors behind the high HIV prevalence rate among the 15-49 age group, the section ends with a discussion on the state of HIV related deaths in subsection 5.3.5.

5.3.1 The State of maternal health deliveries by Skilled Birth Attendants

Maternal health deliveries by Skilled Birth Attendants (SBAs) are regarded as one of the prerequisite for achieving the fifth Millennium Development Goal (MDG 5) of reducing maternal mortality rate by 75% by 2015. Though this is the case, findings of the study indicate a rapid decrease in maternal deliveries by SBAs after the inception of the decentralisation policy in the district. The study observes that some women opt to be attended to by unskilled birth attendants otherwise known as Traditional Birth Attendants (TBAs) instead of SBAs.

Though Narayanan (2009) argues that improvement in maternal health deliveries in health facilities result in reduction in maternal mortality rate in many African countries, some women in

Blantyre personally choose to resent health facilities with SBAs and this is feared to be dangerous as it exacerbates maternal mortality rate in the district.

It is with this background that the Malawi Government banned the use of TBAs in the country in 2012 to contain some maternal challenges brought about by practices of TBAs that contribute to the high Mortality Rate in the country. Blantyre District immediately responded by banning all activities of TBAs in the district.

While literature indicates that decentralisation improves service delivery at the local level as contended by Chiweza (2010), the study shows that the rate of maternal deliveries by skilled birth attendants in Blantyre is not improving as it is at 43% and this is a decline from 63% in 2012. Considering that government banned all activities of TBAs in 2012 and encouraged safe delivery at health facilities by SBAs, the policy is not working as expected.

In this regard, it should be observed that though some TBAs went through formal training for two weeks at Mulambe Hospital in Lunzu before the ban on how to help pregnant women during delivery, their role was changed by government in 2012 from that of providing maternal health services to mothers during delivery to that of referring them to health facilities. This policy however does not work as many TBAs are still practicing their trade in the district illegally despite the ban.

In an ideal situation where decentralisation is implemented in full, it is expected that the rate of maternal deliveries by skilled birth attendants would increase due to an increase in trained SBAs and in turn this would reduce maternal mortality rate. The central idea is that decentralisation increases monetary resources channelled towards the training of midwives in different colleges. Consequently, this leads to an increase in number of SBAs graduating from colleges, hence an increase in maternal deliveries by SBAs. However, in a situation where the policy has not been implemented in full, the assumption is that service delivery would be affected. This explains why the rate of maternal health deliveries by skilled birth attendants in the district is declining.

With the above understanding, it is imperative to conclude that partial implementation of decentralisation in the district is a major factor for the decline in the rate of maternal deliveries by skilled personnel. This is so because management and the initiative to train mid wives lies in the hands of MOH and not the lower levels responsible for the implementation of the policy. This

signifies that the needs of the district cannot be resolved by MoH as it is not wholly in touch with activities on the ground. The DHO's office could have been better placed to implement the training function since the DHO and his management team know the needs of the district better than MOH. The DHO could have known better the number of midwives to be trained with the aim of increasing the rate of deliveries by skilled birth attendants.

5.3.2 Factors for the decline in maternal health deliveries by Skilled Birth Attendants

Findings of the study as indicated in subsection 4.3.2 show that ill-treatment of pregnant women is one of the factors responsible for the decline in rate of maternal deliveries by SBAs. In this regard, the study reveals that few pregnant women choose to go to health facilities for maternal deliveries by SBAs because of fear of some midwives who end up ill-treating them. This factor is however exacerbated by the fact that decentralisation has not been implemented in full in the district. Full implementation of decentralisation could have given the DHO and the DHMT authority to discipline mid-wives who misbehave accordingly as authority to discipline health workers is currently controlled by MOH.

In support of the above argument, findings of the study reveal that availability of TBAs is another factor for the decline in maternal deliveries by SBAs. In this context, pregnant women prefer to be assisted by TBAs than SBAs despite the ban. In the process, those that go to health facilities for assistance by SBAs are very few and this explains why the rate of maternal deliveries by SBAs is declining.

With reference to the number of skilled birth attendants, the results show that there is a shortage of qualified mid-wives since their training is centrally controlled by MoH in collaboration with training institutions in the country. The results further indicate that some health facilities do not even have a qualified midwife which forces pregnant women to seek for an alternative means of assistance from TBAs.

In summary, basing on the findings, the decline in rate of maternal deliveries by SBAs is due to partial decentralisation of health services in the district. Functions like training of health workers that could be better implemented by the DHO's Office are still controlled by the Ministry of Health. Similarly, discipline of health workers is still done by the Ministry of Health. Disciplinary issues often take time to complete and this promotes issues of indiscipline at work

stations. This leads to the decline in rate of maternal deliveries by skilled birth attendants in the district.

5.3.3 The state of HIV prevalence rate in the district

The state of HIV/AIDS in the district is a bit worrisome as results as presented in subsection 4.3.3 indicate that the HIV prevalence rate is 17.8% against the current national rate of 10%. As a district, implementation of decentralisation seems to have no positive effect as the rate is still increasing despite the policy being under implementation. This result is against the general expectation that decentralisation improves service delivery (Bossert, 2000) and this would in turn translate into low HIV prevalence rate in the district. Furthermore, the expectation was that the reform would bring about people's change in their attitude towards HIV/AIDS and that less people would contract the virus.

On the other hand, though the HIV Prevalence rate is still quite high in the district, the study has shown a positive effect as decentralisation has managed to bring down the HIV prevalence rate from 28% at the time the reform was introduced to 17.8%. This significant positive effect can be attributed to the HIV interventions like ART that have been implemented since 2004.

5.3.4 Factors behind the high HIV prevalence rate among the 15-49 age group

Since 1985 when the first AIDS case was diagnosed at Kamuzu Central Hospital in Lilongwe, Central Malawi, HIV prevalence rate increased significantly among persons aged 15-49: it rose to a peak of 16.4% in 1999 among persons aged 15-49, after which it started declining(Malawi Global AIDS Response Progress Report for 2010). Furthermore, the Malawi Demographic and Health Survey (MDHS, 2010) results show that in 2004, the HIV prevalence in Malawi was estimated at 12.0% among persons aged 15-49 and in 2010 this decreased to 10.6% and further to 10% in 2014 (Annual Health Sector Performance Report, 2014). This demonstrates that over the last decade or so the prevalence of HIV has been going down (MDHS, 2010). The results also indicate that there are many factors that contribute to the high HIV prevalence rate. One such factor is migration whereby people move from rural areas to the city in search of employment opportunities.

In principle, the assumption is that decentralisation is a powerful instrument to improve service delivery at community level (Bossert, 2000). Decentralisation of health services was therefore meant to improve peoples' awareness about the dangers of the HIV pandemic. However, despite the dangers being preached to them, people are still contracting the HIV Virus due to movement to urban areas for employment. With full implementation of the policy, there would be a boom in economic activities in rural areas and consequently people would get employment without necessarily going into the city. In the long run, this could lessen the transmission of HIV virus into the city, hence the number of people contracting the virus could decline. However, with partial implementation of the policy, there is no economic boom in rural areas and therefore people choose to migrate into the city to look for jobs thereby transmitting the Virus.

As presented in subsection 4.3.4, another factor responsible for the high HIV Prevalence rate is poverty. In the case of women and young girls, they trickle down into the city to look for money to fend for themselves. Failure to get employment forces them to sleep around with multiple partners in search of money, hence contracting the deadly HIV virus. The results therefore show that many people are HIV positive because they contracted the virus in an attempt to fend for themselves thereby increasing the HIV Prevalence rate.

From the above discussion, it can be argued that partial decentralisation has brought about poverty which in turn has increased the rate of HIV prevalence. The discussion also entails that decentralisation has not been effective in the district as people are not economically empowered to conduct economic generating activities at the local level in order to fend for themselves.

Furthermore, the results also indicate that use of unprotected sex has contributed to the high HIV prevalence rate in the district. In this regard, people do not fear to have sex without protecting themselves. This behaviour is attributed to several factors one of which is culture that propagates the belief that an individual cannot enjoy sex if he/she uses a condom. Another reason is religion whereby church doctrines stipulate that members of a particular faith should not use a condom as doing so is tantamount to promoting adultery. It is these reasons that have led to the use of unprotected sex among many people in Blantyre and this in turn has resulted in the high HIV prevalence rate. It is however important to note that all these things happen within the framework of the implementation of decentralisation.

As far as lack of civic education is concerned, the results show that the available civic education bodies are not doing their job right since they prioritise on the use of condoms rather than telling people to refrain from promiscuity. Instead of prioritising on telling people the dangers of contracting the HIV virus, the results show that they preach that having sex with multiple partners is not a problem as long as a condom is used. Thus, they encourage boys and girls to condomise implying that they are very safe to have multiple partners so long as a condom is used. This gives a very bad impression as people do not fear to sleep around with multiple partners, hence, increasing the rate of HIV prevalence in the district.

From the discussion, it can be stressed that even though there are civic education bodies in the district, their presence is not felt as their messages are misdirected and misleading to change the mind-set of the people. This further increases the HIV Prevalence rate in the district.

5.3.5 State of HIV related deaths in relation to decentralisation of health services in the district

Findings of the study as presented in section 4.3.4 show that there has been a decrease in HIV related deaths now as compared to the time decentralisation was introduced in the district. The results indicate that at the time of introduction of the policy in 1998, there was no ART initiative in place and that ARVs were hardly available for free for many infected people in the district. Compounded by lack of civic education and poverty, many people died in the process.

However, after the introduction of the policy and subsequent introduction of ART services in the district in 2004, the trend reversed and the number of people dying of the virus tremendously declined. This is also attributed to the Global Fund that provided funding to the Malawi Government for the procurement of ARVs.

It should however be stressed that both decentralisation and the Global fund are the initiative of the Bretton wood institutions (World bank and IMF) and without them, there could be no ARVs and let alone the introduction of ART. This is so because the Government of Malawi could not afford to procure ARVs and other associated essential drugs to support the ART program. Hence, many people could have died of HIV/AIDS by now.

5.4 Challenges associated with Decentralisation of Health Services in Blantyre

This section presents a discussion on challenges associated with decentralisation of health services in the district. The section has five subsections. Subsection 5.4.1 covers a discussion on inadequate staff while subsection 5.4.2 discusses partial decentralisation in the district. Subsection 5.4.3 provides governance problems while subsection 5.4.4 presents a discussion on inadequate funding. Inadequate managerial skills are discussed in subsection 5.4.5. Finally, the section ends with mis-procurement of drugs which is covered in subsection 5.4.6.

5.4.1 Inadequate staff

Basing on findings from participants, inadequate staff is one of the major challenges associated with implementation of decentralisation in the district. In this regard, participants mentioned that many facilities do not meet the minimum staffing norms of 2 clinicians, 2 nurses and 1 Assistant Environmental Health Officer per health centre (Interview conducted on 3rd November, 2014). The study further shows that some health facilities are only managed by nurses due to inadequate medical assistants in the district. This problem is however conspicuous in rural health facilities where many health workers refuse to work. The findings further reveal that urban health centres have more than the required number of health workers. This is so because the DHMT does not manage to deploy them to rural health facilities since many of these health workers are women whose husbands also work in the city of Blantyre.

From the above discussion, it can be stressed that health facilities that have inadequate staff to support the provision of health services compel the DHO to engage health workers on *locum* and *relief duties. Locum* is a term which means "monetary payment to health workers for working extra hours to cater for the shortage of staff" (Human Resource for Health Interventions, 2010). It can further be explained that inadequate funding on the part of the DHO leads to inadequate staff in health facilities as health workers do not want to work on locum for fear of not being paid.

5.4.2 Partial implementation of the reform

The study as presented in section 4.6 shows that there is a half-hearted tendency by authorities to translate the provision of the policy into practice (Interview conducted on 22 November, 2014). For instance, instead of decentralising the identified functions for efficient and effective health

service delivery, the Ministry of Health retains some functions like drug procurement and research. This has a negative effect on the delivery of health services.

The mere fact that MoH still clings onto some critical functions that could have been decentralised to the district implies that there is inefficiency and ineffectiveness in health service delivery in the district. Coupled by the fact that the CMST does not have a capacity to procure drugs for all health facilities in the country, this partial implementation of the policy has brought more harm than good. This is evidenced by unavailability of essential drugs in many facilities of Blantyre and this affects the delivery of health services and indicators in the district.

It is therefore imperative to explain that decentralisation has not been effective in the district because the reform has not been implemented in full. The Ministry of Health chose to retain some functions that were identified for devolution. Decentralisation could have been effective if it were implemented in full.

5.4.3 Governance problems

Blantyre District embraced the policy of decentralisation because it was felt that the reform would bring about good governance that could in turn improve health service delivery. However, in spite of the policy, the study shows that governance problems are some of the challenges facing the district. This is shown by the deep-rooted conflicts in the district as the DHO has dual reporting relationships (Interview conducted on 25th November, 2014). The study has established that the DHO reports to both the DC and the Central Line Ministry of Health.

Another problem is that the elected councillors and members of parliament in the district do not see each other eye-to-eye as the councillors are seen as potential threats to their positions especially if the MP does not perform during his/her five-year tenure of office. This has a potential negative effect to the delivery of health services in the district.

The problems are also expressed by the lack of knowledge on the part of HAC members on their roles and responsibilities. Some of them do not know what they are supposed to do in the implementation of the policy.

5.4.4 Inadequate funding

Findings of the study also indicate that funding levels have been a challenge as the ideal budget for the district has been trimmed to only a quarter of the required sum of money to run the district for the entire fiscal year. This has paralysed the district's health service delivery as daily operations are highly affected. The district experiences inadequate fuel for ambulances, inadequate cleaning materials, stationery and at one point, Blantyre Water Board resorted into disconnecting the water in an attempt to force management to settle down debt for the water bills (Interview conducted on 27th November, 2014).

This problem is feared to have contributed to the ineffectiveness of the reform in the district especially after the introduction of the policy. It should also be realised that some of the challenges faced by the district are a result of donor-pull out due to the famous massive plunder of public resources dubbed '*Cash-gate'* (Interview conducted on 29th November, 2014). Coupled with the shortage of drugs in health facilities , this finding is detrimental to health service delivery as the district scaled-down many of its operations due to low funding levels, hence the district's failure to provide proper health care to the people.

5.4.5 Inadequate managerial skills

In an attempt to know the requisite skills necessary for the provision of health services in the district, the study reveals that inadequate managerial skills has negatively contributed to the implementation of the policy in the district.

Unlike in the past whereby all officers joining the health sector used to be oriented on government procedures at Mpemba Staff Development Institute, the trend is not the same now as officers work for years without being oriented but only to learn few and some of the skills on the job (Interview conducted on 19th November, 2014). This tendency has deprived newly recruited officers of the required skills and knowledge, hence exacerbating issues of indiscipline in the district. This in turn has affected the performance of some indicators in the context of decentralisation in the district.

5.4.6 Misprocurement of drugs and other materials

Another challenge of decentralisation is that procurement procedures are flouted as the district chose to procure huge quantities of drugs from private suppliers instead of CMST. The study establishes that private suppliers give kick-backs to those responsible for procurement in the form of commission (Interview conducted on 17th November, 2014). It was further established that the CMST does not give kick-backs and this forced those responsible for drug procurement to go for private drug suppliers. Hence, the whole process of drug procurement was marred by irregularities before the government centralised the function in 2012.

In this regard, respondents for instance commented that "since the Council Managers are given the autonomy to do the purchasing process, shop owners give 'commissions' to the Procurement Officer (who purchases project materials) so that they can always purchase from them. Some officers even put it as a condition that they will make their tender fail if they will not give them 'commissions" (Interview conducted on 2oth March, 2014).

5.5 Level of Decentralisation in delivery of health services and perceptions on its effect

This section discusses the level of decentralisation in the delivery of health services and perceptions on its effect. The section has two subsections. Subsection 5.5.1 presents an interpretation on perceptions on the level of positive effect of decentralisation and subsection 5.5.2 covers a discussion on perceptions on the level of negative effect of decentralisation in the delivery of health services.

5.5.1 Positive effect of Decentralisation

(i) Decentralisation and the decrease in number of HIV related deaths

Findings of the study indicate that there has been a decrease in number of HIV related deaths in the district as fewer people are now dying of HIV/AIDS than a period before decentralisation. Participants mentioned that before decentralisation, 7806 people that represent 0.9% of the total population of the district used to die of the disease every year. However, after decentralisation and subsequent introduction of Art in 2004, only 2709 people used to die every year and this represents 0.3%. There is therefore no doubt that the decrease in number of HIV related deaths in the district is due to the decentralisation of EHP services in the district. It should also be noted

that the Global Fund made it possible for HIV/AIDS, which is one of the EHP services, to be fully implemented at the local level. This, too, necessitated the birth of ART which has reduced the number of deaths and improved the provision of health services in the district.

It should be noted that before decentralisation, there was no Global Fund in the country; neither was there anything to do with ART. ART only came into being in 2004 after the introduction of the Global Fund. Thus, the Global Fund has improved health service delivery and reduced the HIV related deaths in the district.

It is however surprising to note that though the number of HIV related deaths is decreasing, the HIV prevalence rate is still high. This is against the assumption that decentralisation improves health service delivery (Bossert & Beauvais, 2002). Therefore, it can be argued that the high HIV Prevalence rate cannot be explained due to decentralisation alone. There are other factors that should be implemented alongside decentralisation. In other words, decentralisation cannot be implemented in isolation.

In summary, even though decentralisation has reduced the number of those dying of HIV/AIDS, many people are still contracting the HIV Virus as evidenced by the high HIV prevalence rate in the district. This result contradicts findings of the MDHS (2010) which indicate that both HIV related deaths and HIV Prevalence rate for the country are declining. Therefore, there are other factors responsible for the increase in the HIV Prevalence rate in the district.

(ii) Decentralisation and accountability

Decentralisation entails good governance as principles of accountability and transparency are central and applied to the letter. It therefore follows that decentralisation brings accountability structures to the local level and these structures enable the elected public officials to be accountable to their actions. Literature indicates that accountability entails responsibility for the quality of services, efficiency, sustainability, etcetera, towards stakeholders (Tambulasi, 2005).

After the introduction of decentralisation in the district, there has been a proliferation in accountability structures at the district level. The district has seen the introduction of a functional health committee at the council level which plays a vital role of checks and balances to the council executive hence improving the delivery of health services. The district has also seen the

birth of Village Health Committees (VHCs) at the community level to ensure that public officers are accountable to their actions in the provision of health services.

From the above discussion, it should be noted that the DHMT is accountable to HAC as well as the Health and Environment Committee at the district level. On the other hand, the Health Centre Management Team is accountable to the Health Centre Advisory Committee (HCAC) at the Health Centre Level and HSAs are accountable to the VDC at the community Level.

While HAC and VHC are seen as structures that could be used during delivery of decentralised health services, Blantyre District has these structures in place but their effectiveness is questionable. The district experienced the high rate of drug pilferage that could have been dealt with by these structures. This may be due to lack of training and orientation on their roles to effectively support implementation of the reform in the district.

In line with the above argument, it can be pointed out that more often than not, decentralisation fails to meet its promises of increased accountability as personal interests, partisan politics, corruption and nepotism among others, are the main reasons for observed low accountability and transparency (UNDP, 2002) in decentralised governance. In this regard, selfish council officials exploit and take advantage of the new opportunities presented by the decentralised structures to pursue their personal gains. Since resources are spent and invested at the elected official's discretion in a decentralised system (Manhood, 1993), decentralised governance becomes a vehicle for bringing the once centralised and hidden resources closer to the local political elite for plunder.

Thus, despite the decentralisation policy being in place, the district has faced a number of challenges with regard to its implementation. This may be due to lack of political will on the part of the central government. The Health and Environment Committee at the District Council where the DC and the DHMT are accountable to, has just been instituted. The councillors were ushered-in after the tripartite elections in May, 2014. This was after the absence of close to ten years due to lack of political will to hold elections. It should be observed that in-availability of such a structure contributed negatively to the implementation of health services delivery in the district.

In this context, Brinkerhoff (2003) argues that the extent to which public agencies are accountable to citizens depends among other factors upon how other citizens are unlikely to be in

a position to push for accountability when systems decline to be responsive. While accountability structures play an increasingly important role in health sector accountability through participation in service delivery and policy networks, it is argued that meaningful checks and balances can be achieved if individual members of the structures have adequate education. Hence, despite the structures and different committees being in place, their effectiveness is at times questionable as they are compromised by the level of knowledge and lack of adequate education on their part.

5.5.2 Negative effects of decentralisation in the delivery of health services

(i) Decentralisation and the partial devolution of some decision-making powers

Despite decentralisation being under implementation, the study shows that the district has no control over some functions that are crucial to health service delivery. This has a negative impact on the provision of health services in the district. This is seen in that some indicators are not improving despite implementation of the policy. This puts the DHO and his DHMT at an awkward position on their accountability to HAC and the Health and Environment Committee of the District Council.

Considering that effective decentralisation of decision-making powers goes with authority and power to the local level, the authority and power given to the district is limited. For example, the district management is given an already predetermined ceiling during the planning phase without matching with the real district needs. The annual budget ceiling for the district is determined by the Ministry without consultation with the district on the need and requirement of the district. This renders the DHMT useless as the team acts as a figurehead and this explains why some health indicators are not improving in the district despite implementation of the policy. Even the planning and budgeting control is also limited because the central level determines the templates to be used during the planning phase by the district. This negatively affects flexibility on functionality of the district health system.

(ii) Decentralisation and the decrease in rate of maternal health deliveries by Skilled Birth Attendants

Another negative effect of decentralisation is the decrease in rate of maternal deliveries by skilled birth attendants. Though the policy is still under implementation, the rate of maternal deliveries

by skilled birth attendants is still declining. This phenomenon can be explained partly due to ill-treatment of expectant mothers by some midwives, inadequate number of mid-wives as well as distance that maternal mothers cover to reach a health facility to deliver. The argument here is that these factors force expectant mothers to seek the attention of TBAs rather than skilled birth attendants. In turn, this decreases the rate of maternal deliveries by skilled birth attendants in the district.

In the above discussion, the ideal situation could be that with implementation of decentralisation in the district, the number of skilled birth attendants would increase and that more health facilities would be constructed within the recommended radius of 8km. In turn, this could lessen the burden of travelling long distances to a health facility to seek medical attention. Furthermore, training institutions would train more midwives that could have been deployed to various health facilities after training, hence increasing the rate of maternal deliveries by skilled birth attendants. But this is not the case in the district

(iii) Decentralisation and the increase in the HIV prevalence rate among the 15-49 age group in the District

Findings of the study as presented in subsection 4.4.4 show an increase in HIV prevalence rate among the 15-49 age group in the district. In this regard, before introducing the reform in 1998, the HIV Prevalence rate was 28%.The rate significantly declined to 13.2% in 2012. This significant decrease can be explained by the implementation of the policy.

However, the rate soured to 17.8% against the national rate of 10% in 2014.This variance is explained by the social economic problems faced by people living in rural areas of the district and other surrounding districts that migrate to the city thereby either transmitting or contracting the HIV Virus. Many people trek into the city in search of employment and in the long run end up engaging in promiscuity, hence transmitting the HIV virus to others. In the same vein, poverty has also been mentioned as one of the leading factors that exacerbate the spread of HIV as women tend to sale their bodies in exchange for money, hence contracting the HIV virus.

Therefore, it can be argued that though decentralisation is meant to improve health service delivery and subsequently reduce the HIV/AIDS scourge, the situation is worrisome in the

district as the rate is still high. This is partly due to the fact that the reform has been implemented in isolation in the district.

(iv) Decentralisation as a potential fertile breeding ground for conflict

Though conflict cannot be avoided due to its tendency to enhance unity in organisations, it sometimes leads to underperformance if it is not managed properly. In this context, the study reveals that in spite of its positive contributions towards democratic governance in the district, decentralisation has been a catalyst and fertile breeding ground for conflict. This result is in agreement with Tambulasi (2006) who argued that decentralisation results in a potential breeding ground for conflicts in organisations. This phenomenon is a negative impact as some officers end-up having dual reporting relationships instead of the principle of unity of command propagated by Henry Fayol in Boone (2009). In this regard, the DHO has a dual reporting relationship as he reports to the DC at the council level and at the same time to the Line Ministry of Health through the South West Zone Health Office. This causes conflict and confusion as some DHOs tend to follow instructions from the Central Line Ministry rather than the DC in situations where the local government policy is in contradiction to that of the Ministry of Health. This situation has been like that because ever since decentralisation was introduced, postings, promotions, further training and salaries have been under the control of the Line Ministry of Health.

From the above discussion, it can be argued that decentralisation has ushered conflicts into the district as the DHO at times experiences an internal conflict to choose where to take instructions from between the DC and the Central Line Ministry of Health in the context of receiving conflicting instructions from the two. This negative effect retards the delivery of health services as the DHO lands into a state of confusion as to what to do in that context.

(v) Decentralisation as a breeding ground for corruption.

The personal interviews revealed that decentralisation itself has brought in unhealthy breeding ground for corruption. In this regard, the general feeling of the respondents was that decentralisation has brought down financial resources to the local elites that were once very distant from them thereby bringing avenues for corruption. In this regard, one respondent

commented that "decentralisation has created a lot of greed, expectations and aspirations" (interview conducted on 20thNovember, 2014).

Washington (1997, p.6) observes that "more direct contact with public money coupled with fewer controls over its use may increase the temptation and opportunities to indulge in corrupt or fraudulent practices and make conflicts of interests more likely". In fact, corruption in Malawi is widespread, deep and severe to the extent that Khembo (2005b) as cited in Tambulasi (2005, p. 54) referred to Malawi as a country "stuck in corruption". Chaziya (as cited in Tambulasi, 2005) noted that in Malawi "Corruption is too much to the extent that things are not done according to merit"(p. 54).

In the same manner, Meinhardit and Patel (2003), noted that corruption in Malawi is severe so that public office is "pursued not as a vocation but as an occupation to redeem oneself and one's family out of poverty". Even the Malawi Government itself once admitted that "corruption is still high" (Mzembe, Cited in Khembo, 2005a, p. 6). In addition, the former President of Malawi, Bakili Muluzi, also attested that "corruption in Malawi has been endemic and has slowed down economic growth" (Muluzi quoted in Mail & Guardian, 5 April, 2004).

The country's donors have also been alarmed at the level of corruption in Malawi. For instance, the American Government could not give aid to Malawi because Malawi's greed and graft are so widespread that putting money where there is corruption is a waste (Morrison, 2003). The Danish Government withdrew funds because "corruption became a markedly increasing issue" (Danish Charge to Malawi, Mr Pedersen, in BBC News Online, 31 January, 2002). The European Union did not only withdraw aid but also demanded refund from government of K650 million that they disbursed but was "diverted and mismanaged" (BBC online, 19 November, 2001).

Indeed in "Malawi corruption has, over the past few years, worked itself into the fabric of general living" (Mchombo, 2000). It is estimated that Malawi loses about MK22 million a year to corruption (Khembo, 2003) representing about 1/3 of its annual revenue (Khembo, 2005b). According to the 2002 Transparency International country studies conducted in more than 30 countries in Africa; and 102 worldwide, Malawi was ranked positions 11 and 35, respectively, on the corruption ladder (Transparency International, 2002). In 2004 Malawi stood among 60 most

corrupt countries in the world and was ranked number 87 scoring 2.8 points as compared to number 83 in 2003 (Khembo, 2005b).

In this study, corruption in Blantyre is evidenced by the number of uncompleted projects in the district where structures are left in ruins without being completed even though the contractors collected all the money meant for the projects. This result is corroborated by Tambulasi and Kayuni (2006) who argued that decentralised local governance structures in the country have promoted corruption among the local councils in relation to awarding of contracts and this has resulted in a financial mess in the districts due to non-completion of projects.

In summary, corruption is deep-rooted in Blantyre since the advent of decentralisation in 1998. Since there are many projects that have not been completed due to corrupt practices by some officers, it can be concluded that decentralisation is a breeding ground for corruption as it entices officers to behave corruptly due to too much exposure to money at the local level. This is a negative impact because the malpractice retards the delivery of health services in the district and some structures that could have been completed and used as health facilities are still in ruins and grounded.

(vi) Decentralisation and the coordination between the Ministry of Health (MoH) and the Ministry of Local Government (MoLGRD)

Malawi's decentralisation process has undergone three phases which are devolution during the colonial era, deconcentration during the single party era and currently devolution during the multiparty era (The Decentralisation Process, 2004). This devolution approach is enshrined in the Decentralisation Policy of 1998 which is backed by the Local Government Act of March 1998. The approach involves collapsing central government structures at the district and lower levels into one local government structure. This is expected to improve the delivery of public goods and services to people at all levels, especially in rural parts of the country.

However, even though decentralisation in the form of devolution has taken place in the district, the study has shown that the central oversight role is dual as MoH provides technical oversight through directorates plus Monitoring and Evaluation oversight through the Zone office. The MoLGRD mainly provides fiscal oversight through the National Local Government Finance Commission (NLGFC). Furthermore, the study shows that the Line Ministry of Health is

mandated to develop policies and even resource mobilisation, but policy implementation is supposed to be through local Government. This demands a lot of coordination between the two ministries to ensure that there is smooth implementation and delivery of health services

The study has further established that the two ministries do not consult before communicating to the district. For example, during the development of District Implementation Plan (DIP), the district uses guidelines that are developed by MOH with a special template given to them. Furthermore, when it comes to submission time, the district council demands the use of a different template. This causes confusion and waste of resources in terms of finance and time. It also puts pressure to the district on which direction to follow. Therefore, for effective health service delivery, there has to be coordination between all stakeholders involved.

In conclusion, the results show that there is weak coordination between the two ministries and this has hugely and negatively affected the smooth implementation of the policy. For decentralisation to be effective, it demands effective communication and consultation between the two ministries in order to improve health service delivery and health indicators.

5.6 Conclusion

This chapter has discussed the research findings by looking at the state of decentralisation of health services in the district. The study has found that decentralisation of health services and indicators have taken place and that its effects have been felt.

It has been established that though decentralisation has taken place, it has not been effective because it has been implemented in part. Some critical functions that were meant for decentralisation are still controlled by the Ministry of Health. This leaves few functions to be implemented at the lower levels of service delivery. Additionally, the study has established that decentralisation has not been effective because it has been implemented in isolation. Decentralisation does not act on health in isolation from other factors. Therefore, to be effective, it has to be implemented alongside other factors.

The decline in some of the health indicators in the district can therefore be attributed to partial implementation of the policy which has rendered the reform ineffective. The indicators could

have improved if decentralisation were implemented in full. Therefore, both health service delivery and health indicators can improve if decentralisation is implemented in full.

The study adopted the Public Administration Framework of decentralisation with devolution as the most preferred typology. Devolution is adopted because it allows citizenship participation in decision-making. Furthermore, the typology encourages bottom-up approach in decision-making and top-down accountability. This has allowed the local people to demand accountability from duty bearers. The next chapter presents conclusions and recommendations.

CHAPTER SIX

RECOMMENDATIONS AND CONCLUSION

6.0 Introduction

This chapter outlines the recommendations and concludes the study based on the results. The chapter is organised into five sections. The first section 6.1 presents a summary of the study findings. This is followed by section 6.2 which outlines lessons drawn from the study findings. Section 6.3 provides recommendations for the study. Suggested areas for further research are presented in section 6.4. The chapter ends with section 6.5 which is conclusion.

6.1 Summary of the Study Findings

6.1.1 People's views about decentralisation of health service delivery

Studies conducted the world over suggest that decentralisation is a key reform to the efficient and effective delivery of health services (Chiweza, 2010). This is in line with findings of the study on people's views about decentralisation which indicate that the reform has taken place though in part. The partial implementation of decentralisation has resulted in the partial improvement in health service delivery in the district.

The study also observes that lack of local councillors for ten years ever since the policy was introduced contributed to failure to implement the policy in full. This is due to the fact that there were no accountability structures at the local level to monitor activities of the council secretariat on behalf of the community.

Central to the improvement of health service delivery is the Public Administration Theory of Decentralisation developed and pioneered by Rondinelli in 1983. The study uses *devolution* as a form of decentralisation as enshrined in the Local Government Act (1998). Because of its immense success especially in developing countries, many countries in Africa including Malawi adopted the framework as a means to efficient and effective health service delivery. In the same vein, Blantyre District adopted decentralisation as a vehicle through which health service delivery can be improved.

Evidence from the study however suggests that not much service delivery could at present be attributed to decentralisation process itself (Chiweza, 2010). Some improvements in health service delivery may be attributed to other factors as well. The potential for decentralisation to contribute to improved service delivery very much depends on the implementation status of decentralisation itself and the functionality of the decentralised structures and systems that are meant to improve service delivery. The study also notes that the implementation of decentralisation is still on-going.

6.1.2 Decentralisation of health indicators and functions that have been devolved and retained by the Ministry of Health

The study has shown that the level of decentralisation in the delivery of health services has improved as seen by the decline in HIV prevalence rate among the 15-49 age group. In this perspective, the study has established that just before 1998, the rate declined from 28% in 1998 before decentralisation to 13.2% in 2013 after the reform was introduced. Following the introduction of decentralisation and subsequent ART scale-up in 2004, findings have also shown a significant decrease in number of HIV related deaths in the district. For example, 7806 people that represent 0.9% of the total population of the district used to die of the disease every year before decentralisation. However, soon after the ART scale-up in 2004, the number declined to 2709 people every year and this represents 0.3% of the Blantyre population.

As for the rate of maternal delivery by SBAs, decentralisation has shown no positive effect as the indicator declined from 80% just before decentralisation in 1998 to 63% in 2012 and he rate further declined to 43% in 2014.

Therefore, although decentralisation has taken place and service delivery improved, some indicators have performed poorly in line with decentralisation. This signifies that decentralisation has produced mixed results in the district. Hence, the mixed results suggest that there are some factors other than decentralisation that influence the delivery of health services and indicator performance.

The decline is also explained due to the fact that the reform has been implemented partially and in isolation. Thus, decentralisation does not act on health in isolation from other factors. For the reform to be effective, it has to be implemented alongside other factors.

6.1.3 Challenges associated with decentralisation of health services and indicator performance in the district

The process of decentralisation in Blantyre has been experiencing considerable setbacks, which have constrained the performance and influence of the District as an efficient, and accountable service provider (Chiweza, 2010). Some of them include the non-functional nature of key institutions meant to drive the decentralisation process; resistance to change among the officials of the Ministry of Health with the aim of safeguarding their positions; staffing problems at the district and sub-district levels; limited capacity of the district and sub-district structures to discharge their functions; weak M&E systems and practices; dwindling knowledge and awareness of decentralisation among implementing agents, district staff and political leaders; limited downward accountability, as well as limited coordination between MoH and MoLG; governance problems; inadequate funding; inadequate managerial skills and mis procurement of drugs and other materials.

These problems taken together have curtailed the potential of the decentralisation process to institute district councils as integrated units at the local level, with substantial capacity to deliver services effectively and contribute towards improved health service delivery.

6.1.4 The level of decentralisation in the delivery of health services and perceptions on its effect

The study has established that there are both positive and negative effects in the delivery of health services. In other words, the study has established some successes and many implementation failures. However, though there are mixed results, the study observes that there have been a substantial improvements in health service delivery as evidenced by the increased access to health services in the district. This is further vindicated by the devolution of some functions from the Ministry to the district level.

In addition, there has been an improvement in the HIV prevalence rate in the district now as compared to a period before decentralisation. In 1998, the HIV Prevalence rate was 28%. But now the rate is at 17.8%. This decrease is also corresponding to the decrease in number of HIV related deaths in the district.

The study also observes that decentralisation has brought about accountability structures such as HAC, VHC, HCAC and VDC just to mention but a few. These are necessary for the efficient and effective delivery of health services.

Though the study has established some positive effects to the delivery of health services and indicators, decentralisation has negatively affected the provision of health services in the district. The two sampled indicators have not improved satisfactorily over the period of implementation. Furthermore, the reform has exacerbated conflicts among players over resources as corruption is more deep-rooted in the district now than a period before decentralisation.

6.2 Lessons drawn from the Study Findings

(i) It has been shown in the study that decentralisation of health services and indicators have taken place in the district. This is evidenced by an improved people's access to health services now as compared to a period before decentralisation. However, it should be noted that not much service delivery could at present be attributed to decentralisation itself. There are other factors that may be responsible for the improvement of health service delivery in the district.

(ii) Decentralisation has not been implemented in full in the district. Some critical functions that were identified for devolution are still retained and controlled by the Central Line Ministry of Health. The remaining functions have been devolved to the district level. Therefore, the potential for decentralisation to contribute to improved service delivery very much depends on implementation status of decentralisation itself and the functionality of the decentralised structures and systems that are meant to improve service delivery (Chiweza, 2010). Therefore, the lesson learnt is that partial implementation of decentralisation leads to little positive effect in the delivery of health services and indicator performance.

(iii) Another lesson drawn from the study is that successful policy implementation is determined by the political will of the leadership. Considering that the district went through a period of ten years without elected councillors, lack of political will by the political leadership contributed to the partial implementation of the policy and this in turn contributed to the decline in health service delivery and indicator performance.

(iv) Decentralisation is not a fit- for-all affair. What works best in one district cannot work best in another. Districts that form part of the city are more prone to the HIV transmission than those that do not form part of the city. In other words, districts that are part of the city like Blantyre are more likely to have a high HIV Prevalence rate than those that do not belong to the city. This is so because of migration of the people from rural areas into the city. Realising that decentralisation is a vehicle through which economic development trickles down to the local level, implementation of the policy at that level creates jobs for the people right in their local communities and this reduces incidences of migration into the city. This arrangement acts as a deterrent for people to migrate into the city to seek for jobs and in the long run transmit or contract the HIV Virus.

6.3 Recommendations

In light of the study findings, the following recommendations are made in order of decentralised health service delivery and indicator performance.

6.3.1 Decentralisation must be implemented in full

The study reveals that despite having a policy on decentralisation of health services which is backed by the constitution and Local Government Act (1998), not all provisions of the policy have been implemented in full. Furthermore, some of the functions that were identified for devolution were retained by the Ministry of Health. Therefore, for an efficient and effective health care delivery and indicator performance, decentralisation must be implemented in full.

6.3.2 Decentralisation must be implemented alongside other factors for it to be effective

Decentralisation in the district has been implemented in isolation of other factors. As a result, the reform has not been effective. Decentralisation does not act on health in isolation of other factors. Therefore, to be effective, it has to be implemented alongside other factors.

6.3.3 Need for a strong leadership and political will

Lack of political will to implement the policy in full forced the district to run for ten years without councillors. As a result, there were no accountability structures such as Health and Advisory Committee (HAC) and the Health and Environment Committee to which the DC, DHO

and DHMT are accountable. Hence, there are accountability issues as some institutions of governance are not in place and this enables authorities not to be held accountable in whatever they do. Therefore, for the policy to be implemented in full, there must be a strong leadership and political will.

6.3.4 Need for an improved coordination and cooperation between the Ministry of Health (MOH) and the Ministry of Local Government and Rural Development (MoLGRD)

The study has established the lack of coordination between the Parent MoH and MoLGRD. This is shown by the circulars emanating from one Ministry that contradict policies of the other Ministry and go direct to the district without knowledge of the other Ministry. Therefore, there is need to improve on coordination between the central ministries to avoid confusion at district level.

6.3.5 Need for capacity building to strengthen governance structures

The advent of decentralisation in the district ushered-in governance structures that are meant to strengthen institutions of accountability and transparency. The study however observes that these structures are not equipped with the knowledge on how they ought to perform their roles and responsibilities. In the same vein, some HACs are either not available in some health facilities or they do not know what to do. Therefore, the existing governance structures must be strengthened by ensuring that each one undergoes capacity building on its roles and responsibilities.

6.3.6 Regular holding of Local Government Elections

The study notes that the district went through a period of ten years without conducting local elections. This implies that for ten years there were no councillors to make public officers accountable to their actions. In other words, there was no downward accountability as institutions and structures meant for that were unavailable. Therefore, the study recommends that holding of local elections should be treated as a matter of priority.

6.4 Suggested Areas for Further Research

6.4.1 Decentralisation of some indicators other than HIV prevalence rate and Rate of Maternal Health Deliveries by Skilled Birth Attendants

The study investigated the level of decentralisation in the delivery of health services and indicators and perceptions on its effect. Improvement in these indicators represents a crucial aspect in the implementation of decentralisation in the district. Considering that only two indicators were selected for the study, inclusion of the other indicators could give a more meaningful result for the study. Therefore, the study of decentralisation in relation to the remaining indicators could be a potential area for study.

6.4.2 Decentralisation of health services and indicator Performance in districts that do not form part of the city

This is another potential area for further study because it targets districts that do not form part of the city. The study of decentralisation of health services in any of these districts could provide the basis for a good comparison as to whether factors that affect decentralisation in Blantyre can do the same in these other districts.

6.4.3 Factors other than Migration, poverty and use of unprotected Sex that are responsible for the high HIV prevalence rate

The study has observed that there are other factors that may be responsible for the high HIV Prevalence Rate other than migration, poverty and use of unprotected sex. This could also be another potential area for further research.

6.5 Conclusion

Decentralisation entails the transfer of power and authority from the Central Government to the local councils. The importance of embracing the reform in the health sector therefore cannot be over-emphasised as it improves service delivery and indicator performance.

However, though this is the case, there have been mixed results in the study. While on one hand the study observes that decentralisation has taken place, it has on the other hand been established that health service delivery has not been implemented fully. Similarly, the study has also shown

that some indicators have not improved despite implementation of the policy. The mixed results signify that decentralisation has not been effective because it has been implemented in part. In addition, decentralisation has been implemented in isolation of other factors. On this note, decentralisation does not act on health in isolation from other factors. Therefore, to be effective, decentralisation must be implemented in full and alongside other factors.

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APPENDICES

APPENDIX 1: LETTER OF APPROVAL TO THE BLANTYRE DISTRICT COMMISSIONER

Dear Sir/Madam,

RE: SEEKING APPROVAL TO CONDUCT RESEARCH IN THE ORGANISATION

I am a Masters in Business (MBA) Student at the University of Malawi- the Polytechnic. We are required to undertake a research in any area of our choice in partial fulfilment of the requirements for the degree of Master of Business Administration. I chose the research topic: *"Level of Decentralisation in the delivery of Health Services in Blantyre District and perceptions on its effect".*

I therefore write to seek your approval to include your organisation on the list of participating organisations. This will involve administration of questionnaires to some directors including the Director of Administration, Director of Planning and Development, Director of Finance, and the Human Resource Management Officer. The questionnaire to the directors will require between 10 to 15 minutes to complete. I intend to administer the questionnaires the week beginning 17th November, 2014. The answers from the questionnaires will be used as the main data set for my research project.

The information provided will be treated with the strictest confidence. There will be no request for names or addresses anywhere on the questionnaire. I also attach a letter of introduction from the Polytechnic on the same.

Thanks in advance for your help in this matter.

APPENDIX 2: CONSENT FORM FOR PARTICIPANTS

Dear Respondent,

The researcher is an Executive Master of Business Administration (MBA) Student at the Malawi Polytechnic of the University of Malawi pursuing studies on "*The level of decentralisation in the delivery of health services in Blantyre District and perceptions on its effect."*I am required to conduct a research study in this area as part of the fulfilment for the Master of Business Administration.

Purpose of this study

The purpose of this research is to establish the level of decentralisation in the delivery of health services in the district.

Description of procedures to be followed

You are kindly asked to assist the researcher with information by participating in this research study which aims at collecting data for the purpose of formulating an analytical framework with which to evaluate the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect. Your participation in this study is on voluntary basis. If you volunteer to participate in the study, you are free to terminate the interview at any time of the interview, and you may choose not to answer any of the questions. You may accept, refuse, or withdraw at any time for whatever reasons without being harassed.

Expected duration of participation

The duration of this study will be no more than four months and as such you will be asked to voluntarily answer the questions regarding the topic under study as soon as possible. In depth interviews and focus group discussions will not be longer than 45 minutes to serve time as many participants will be interviewed and many focus group discussions will be conducted.

Benefits of this study

There are no direct monetary benefits for your participation in the study; however, the study will help to improve implementation of decentralisation of health services in Blantyre District. The study will further form a basis for future research studies on decentralisation of health services in Malawi.

Risks involved in this study

The main risk is that participants may feel uncomfortable answering some of the questions during the interviews. Participants may also feel embarrassed or afraid to disclose information about their work and the conduct of senior management team members towards the implementation of decentralisation in the district. With this risk, the participants will not be mentioning their names during the focus group discussions and the in-depth interviews. Participants will also not be allowed to write down their names in the questionnaires. This will generally enhance their openness during the administration of the instruments.

Privacy and confidentiality

Any information collected will be purely for academic purposes and therefore the responses you provide will be treated with utmost confidentiality. No participants' names will be attached to the study and mentioned in any report or publication of this study. The data will be kept confidential to protect participants' privacy. All of the information provided will be stored privately with identification codes if any. The data will only be used to evaluate and improve the delivery of health services in the district.

Who to contact for answers to your questions

If you have any questions or concerns regarding this study, please do not hesitate to contact the researcher whose contact details are outlined below.

Sandram D.E.M. Naluso

0888562914/0993121990/0111621595

snaluso@yahoo.com /Sandramnaluso70@gmail.com

You can also contact the following in case you want to know more about your participation in this study

The MBA Coordinator,

Malawi Polytechnic,

P/Bag 303,

Blantyre.

Participant Declaration

I have read (or someone has read to me) and understood the information above. I have been given an opportunity to ask questions and my questions were appropriately addressed. I therefore voluntarily consent/disagree to participate in the above described research project.

Identity & Signature of participant/thumb prints_____

Date_____

Identity & Signature of witness (for those who cannot write) _____

Date_____

Name & Signature of the person obtaining Consent _____

Date _____

Thank you for accepting to participate in this research study

APPENDIX 3: QUESTIONNAIRE FOR DISTRICT COUNCIL OFFICIALS, ZONAL HEALTH OFFICIALS AND DISTRICT HEALTH MANAGEMENT TEAM MEMBERS

IDENTITY SECTION

Profession/Designation…….……Identity code…….....

Workplace ……

Date … …….

Instruction (s)

- *Please tick or State as appropriate*
- *Be as objective as possible and do not write your name on any of the pages.*

SURVEY QUESTIONS

SECTION 1: PEOPLE'S VIEWS ABOUT DECENTRALISATION OF HEALTH SERVICES IN BLANTYRE

1. In your opinion, what is decentralisation about?

[A] Transfer of power and responsibilities from the centre to the peripheral

[B] Good governance and politics

[C] Transparency and Accountability

[D] Power to the people

[E] Other (s). Please Specify:

_____

_____

2. Are health services in Blantyre District decentralised?

[A]. Yes [B]. No

[C]. Partly [D]. Don't Know

SECTION 2: DECENTRALISED AND RETAINED FUNCTIONS BY THE MOH

3. Which functions have been decentralised and which ones retained by the Ministry of Health?

_____

_____

4. If yes, what features make the health sector decentralised?

[A] Availability of EHP to the community

[B] Improvement in the health status of the people

[C] Monopoly of Central Medical Stores Trust to supply drugs in all health facilities in Malawi.

[D] Other(s). Please, specify

_____

_____

5. What are the major benefits of Decentralisation of Health Care Delivery in Blantyre district?

[A] Brings health services closer to the people

[B] Improves the health status of the people

[C] Improves good governance as it increases citizenship participation in decision-making

[D] Enhances Accountability and transparency

[E]Other(s) Please, specify_____

_____

6. In what ways has decentralisation influenced health service delivery in respect of the following (provide examples and suggest improvements)

(i) Diagnosis

_____

_____

(ii) Drugs

_____

_____

(iii) Sundries

_____

_____

(iv) Medical Equipment

_____

_____

(v) Patient care

_____

_____

7. The health sector in Malawi has been implementing decentralisation in order to improve the performance of health indicators. Two such indicators have not been improving over the years and these are: Rate of maternal deliveries by skilled personnel and HIV prevalence rate among the 15-49 age group. Could you give reasons why they are not improving?

_____

_____

8. On the whole, what are your impressions about decentralisation of Health Care Delivery in Blantyre?

[A Below 50% [C] Between 70% and 80%

[B] Between 51-69%. [D] Over 81%.

Table below shows two isolated health indicators in Blantyre District as provided by the Health Management Information System (HMIS) Office.

Health Indicator	**Before Decentralisation**			**After Decentralisation**			
				The last 3 years			**Target by 2016**
	1996	**1997**	**1998**	**2011**	**2012**	**2013**	
Maternal Health Deliveries Rate of Maternal Deliveries by skilled personnel	78%	80%	80%	63%	46%	61%	80%
HIV/AIDS HIV prevalent rate among the 15-49 e age group	33%	28%	29%	13.2%	14%	17.8%	12%

Adapted from the 2013 Blantyre DHO HMIS Report

SECTION 3: FACTORS FOR THE DECLINE IN HEALTH INDICATORS IN BLANTYRE

9. Which factor(s) contributes to the decline in maternal health deliveries by skilled personnel in the district as presented in table above?

[A] Ill-treatment of antenatal mothers by midwives in government healthy facilities

[B] Lack of healthy facilities within a walkable distance of 10 Kilometres by expectant mothers

[C] The mushrooming of TBAs in the district despite government's attempts to discourage them.

[E] The friendly manner in which TBAs handle maternal deliveries

[F] Shortage in number of skilled personnel

[G]Other(s).Please specify_____

10. Recently, government banned all activities of Traditional Birth Attendants (TBAs) in the district as it was felt that they exacerbate maternal deaths in Malawi. Are you aware of activities of (TBAs) in the District?

[A] Yes [C] Not sure

[B] No [D] None of the above

11. If yes, could the decline in maternal deliveries by skilled personnel be explained due to maternal use of TBAs as an alternative to skilled birth attendants? Please explain your answer

_____

_____

12. Of late, there has been a general outcry about the shortage of health workers in the country. Could the decline in maternal health deliveries by skilled personnel in the district be explained as a result of the shortage of mid-wives in health facilities of the district?

_____

_____

13. Why are maternal mothers opting for TBAs rather than skilled birth attendants? Please explain._____

_____

14. (a) Has decentralisation of health services improved the availability of skilled personnel for maternal health deliveries in the district?

[A] Yes [C] Don't know

[B] No [D] Partly

(b). Justify your answer in (13) above.

_____

_____

15. Could the increase in maternal deaths in Blantyre be attributed to the decline in maternal health deliveries by skilled personnel? Explain your answer

_____

_____

16. Does decentralisation have any impact on the rate of maternal deliveries by skilled personnel in Blantyre? Please, justify.

_____

_____

17. What do you think are factors behind the high HIV prevalence rate among the 15-49 age group in Blantyre?

(A) Incorrect use of condoms (B) Lack of health promotion

(C) Partial decentralisation in Blantyre (D) Poverty

(E) Lack of abstinence (F) Others. Please specify

_____

_____

18. Does decentralisation of health service delivery have any effect on the HIV prevalence rate among the 15-49 age group? Please, justify

_____

_____

19. Could the high HIV prevalence rate be attributed to low funding levels to the Ministry of health as a result of donor pull-out and fatigue or migration of affected people to the city of Blantyre? Please explain your answer.

_____

_____

SECTION 4: CHALLENGES ASSOCIATED WITH DECENTRALISATION OF HEALTH SERVICES IN BLANTYRE

20 (a). Outline the major challenges associated with decentralisation of health services in the district?

_____

_____

(b). Suggest ways of overcoming the challenges in 19 (a) above.

[A] Political will to conduct regular elections for councillors

[B] Full decentralisation of health services in the district

[C] Good governance

[D] Other (s).Please specify

_____

SECTION 5: RECOMMENDATIONS FOR THE IMPROVEMENT OF DECENTRALISATION OF HEALTH SERVICES IN BLANTYRE

21. What recommendations can you give for decentralisation of health services to be effective in Blantyre?

_____

_____

Your views will contribute greatly to the process of understanding and improving the challenges faced in decentralised health care service delivery in Blantyre District.

THANK YOU VERY MUCH

APPENDIX 4: INTERVIEW GUIDE FOR HEALTH CENTRE ADVISORY COMMITTEE MEMBERS AND TRADITIONAL BIRTH ATTENDANTS (TBAs)

IDENTITY SECTION

1. Profession/Designation…….……Identity code…….....

2. Workplace ……

3. Date of Interview…

Instruction(s) /Information to be read to all respondents

This interview is seeking your views about access to, and the quality of health care services you receive in public health facilities. Your information will be treated with total confidentiality. You have a right to opt out of this interview/discussion at will and at any time. You can also have access to the transcript of this interview if you wish.

SECTION A: INTERVIEW GUIDE FOR HEALTH CENTRE ADVISORY COMMITTEE MEMBERS (HAC)

Interview guide questions

1. One of the functions of government is to provide health services to the people. Are people receiving the required health services when they visit health facilities in the district? Explain your answer_____

_____

2. Dou you think government is doing enough to reduce incidences of disease burden in the district? Justify your answer.

_____

_____

3. Malawi Government introduced the policy of decentralisation in 1998 to improve health service delivery at the local level. Are you aware of the existence of this policy in the district? Explain your answer.

_____

_____

4. Do you think there is any reduction in the levels of diseases burden or not in the community as a result of decentralisation of health services?

_____

_____

5. What factors do you think are responsible for the decline in the rate of maternal deliveries by skilled personnel in Blantyre?

_____

_____6.

Do you think these factors are a result of partial implementation of decentralisation or shortage of skilled personnel in aiding maternal deliveries in the district? Justify your answer.

_____

_____

7. Could you suggest some factors behind the high HIV prevalence rate among the 15-49 age group in Blantyre despite decentralisation of health services in the district?

[A] Abject poverty in the slums and suburbs of Blantyre city

[B] Under-utilisation of female condoms by women

[C] Decentralisation of EHP not being implemented in full in the district

[D] Others. Please specify.

_____

_____

8. Do you think decentralisation has any impact to health service delivery in Blantyre? Justify your answer.

_____

_____

9. What challenges are associated with decentralisation of health services in the district?

_____

_____

10. Could you suggest some practical ways on how decentralisation can improve health service delivery in the district?

_____

_____

SECTION B: INTERVIEW GUIDE FOR TRADITIONAL BIRTH ATTENDANTS (TBAs)

IDENTITY SECTION

1. Profession/Designation…….……
2. Identity code…….....
3. Location of the interview ……
4. Date of Interview.……

Instruction(s) /Information to be read to all TBAs

This interview is seeking your views about the quality of health care services you provide to maternal mothers in the district. Your information will be treated with total confidentiality. You have a right to opt out of this interview/discussion at will and at any time. You can also have access to the transcript of this interview if you wish.

Interview Questions

1. What do you like about your job as a TBA?

_____

_____

2. What type of facilities/equipment do you use to aid maternal deliveries?

_____

_____

3. Have you ever been given any formal training to improve upon your skills? If Yes, What external support do you get to improve your quality of service delivery as a TBA?

_____

_____

4. Of late, government banned activities of all TBAs in the country because it is alleged that your activities promote maternal deaths in the country. Why are you still engaging in providing the services illegally in the district?

_____

_____

5. Why do you think mothers patronise your places for maternal deliveries despite the ban?

_____

_____

6. How do you coordinate your activities with the District Council?

_____

_____

7. Would you like to work with the District Council in carrying out your duties? In what ways?

_____

_____

8. What challenges do you face in carrying out your duties as a TBA?

_____

_____

APPENDIX 5: FOCUS GROUP DISCUSSION QUESTIONS

IDENTITY SECTION

1. Profession/Designation…….……
2. Identity code…….....
3. Location of the interview ……
4. Date of Discussion……

SECTION A: FOCUS GROUP DISCUSSION QUESTIONS FOR CLINICIANS, MID-WIVES AND HSAs

Instruction(s) /Information to be read to all participants

This discussion is seeking your views about access to, and the quality of health care services you provide in public health facilities. Your information will be treated with total confidentiality. You have a right to opt out of this discussion at will and at any time. You can also have access to the transcript of this discussion if you wish.

1. Do you know anything about decentralisation/What does decentralisation mean to you?
2. Do you think decentralisation has taken place in Blantyre?
3. Since the introduction of decentralisation, how have things changed here?
4. What is it that have improved?
5. In case of maternal health deliveries by skilled personnel, is there anything that has improved? Justify your answer.
6. What about the rate of HIV prevalence in Blantyre
7. So, in general, what can you say about the level of decentralisation in the delivery of health services in Blantyre and perceptions on its effect?

SECTION B: FOCUS GROUP DISCUSSION QUESTIONS FOR PATIENTS /GUARDIANS

1. What health services have you received at this facility since your arrival?
2. Do you think you have received the right services at this facility?
3. What do you think can be done to improve health services delivery at this facility?
4. In terms of maternal deliveries by skilled personnel, why do you think some women go to a TBA for maternal deliveries instead of skilled personnel at a health facility?

5. What is your advice to such women who patronise TBAs' premises for help instead of a health facility

6. HIV/AIDS is said to be one of the single largest killer in Blantyre. Could you outline factors behind the high HIV prevalence rate in Blantyre?

7. What do you think should be done to improve the rate of maternal deliveries by skilled personnel and reduce the HIV prevalence rate in Blantyre?

APPENDIX 6: FREQUENCY TABLE FOR FACTORS BEHIND THE HIGH HIV PREVALENE RATE AMONG THE 15-49 AGE GROUP INBLANTYRE.

Factor	**Frequency**	**Percentage Frequency**	**Cumulative Frequency**
Poverty	1	30%	30%
Migration/Urbanisation	4	40%	70%
Unprotected sex	3	20%	90%
Lack of Civic education	1	10%	100%

APPENDIX 7: FREQUENCY TABLE ON THE STUDY RESPONSE RATE FOR PARTICIPANTS

Category	Frequency	Percentage Frequency
DHMT	5	83%
Zone	2	50%
DC Officials	7	75%
TBAs	9	100%
Midwives	7	77.8%
HSAs	9	100%
HAC Members	2	50%
Clinicians	8	88.9%
Patients/Guardians	12	100

THANK YOU VERY MUCH