COLLEGE OF MEDICINE

Assessing the Capacity of District Hospitals in Mobilizing and Allocating Resources after Health Care Decentralization at Kasungu and Nkhotakota District Hospitals

By

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DECLARATION

I, Evelyn Zione Lifa-Udedi, hereby declare that this dissertation is my original work and has not been presented for any other awards at the University of Malawi or any other University.

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Date: 4th January 2021

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ABSTRACT

Delivery of efficient health services requires adequate and consistent availability of the right resources, be it human, financial, equipment or material resources. Decentralization has been considered a strategy to aid in resource mobilization for the health sector. The study aimed to assess the capacity of district hospitals in mobilizing and allocating resources after health care decentralization in Kasungu and Nkhotakota District. This was a cross sectional qualitative study which focused on DHMT members. A purposively selected sample of 14 participants from DHO and DC. Data was collected through in-depth interviews. Data analysis was done by on excel and Atlas Ti. All content with similarities were then grouped in different code groups that reflected the theme to which they presented and analysis was done based on the themes. A majority of participants were male at 79%, while 64% of the participants were within the young and productive age. 57%, had more than 10 years of experience working in government at senior level management while 71% of the participants had graduate level training. The results indicate that: there is lack of power and authority vested on DHMT as decision makers; inadequate and at times unclear decision-making powers (for recruitment, approvals); expectation that public institutions cannot be innovative (ability to think beyond the government funding), and lack of political will (inability of those in power to be ethical and just in making decisions affecting the health system). DHMT capacity in resource mobilization is limited. It is recommended that DHMT should receive skills and competency strengthening training particularly in regards to resources mobilization.

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ABBREVIATIONS AND ACRONYMS

ADC	Appointment and Disciplinary Committee
ART	Anti Retro Viral
CBOH	Central Board of Health
COMREC	College of Medicine Research and Ethics Committee
DC	District Commissioner/ District Council
DEC	District Executive Committee
DEHO	District Environmental Health Officer
DFID	Department of International Development
DHMT	District Health Management Team
DHO	District Health Office
DHSS	Director of Health and Social Services
DHRMT	Department of Human Resources Management
DMO	District Medical Officer
DNMO	District Nursing and Midwifery Officer
DIP	District Implementation Plan
GDP	Gross Domestic Product
GOM	Government of Malawi
HAC	Health Advisory Committee
HIV	Human Immuno-Deficiency Virus
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IFMIS	Integrated Financial Management Information System
INPATH	Integrated Pathways for improving maternal newborn health

LGSC	Local Government Services Commission
MOH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MPSR	Malawi Public Service Regulations
MSPA	Malawi Service Provision Assessment
NLGFC	National Local Government Finance Committee
NORAD	Norwegian Agency for Development Cooperation
ORT	Other Recurrent Transactions
PEPFAR	President’s Emergency Plan for AIDS relief
PHC	Primary Health Care
SWAP	Sector Wide Approach
UNICEF	United Nations International Children’s Education Fund
WHO	World Health Organization

CHAPTER 1 INTRODUCTION AND OBJECTIVES OF THE STUDY

There is global recognition of the importance of health sector financing for strengthening health systems to improve health outcomes [1–3]. Decentralization has been implemented in a number of countries with health care services occupying the central position [4]. As one of the earliest sectors to implement decentralization, the health sector through Ministry of Health in 2005 developed guidelines for management of devolved health service delivery, which envisioned that the managerial autonomy given to district assemblies, would help to achieve improved health outcomes [5].

It is the view of scholars that decentralized health systems ensure responsiveness and flexibility in management systems to meet local needs and better align with the key principles of primary health care service provision [6]. Under the Decentralization Act, secondary and primary level health services are delivered under the leadership of the District Health Management Team (DHMT) at the District Health Office (DHO) [5]but have dual responsibilities of managing both the district hospitals and wider district health services [7]. The DHMTs are under their respective District Commissioners (DC) as the controlling officer, and oversight of financial management comes from the National Local Government Finance Committee (NLGFC) [5].

As with other developing countries, Malawi faces challenges in having inadequate resources within the health sector, ranging from human resource, material, financial as well as infrastructure. With the heavy reliance on donor funding for the health sector, which threatens the survival of long term interventions [8], it seems imperative that the country should have identified other means of domestic resource mobilization. The design of the decentralized health

system in Malawi offers an opportunity for such however, there are some key challenges affecting the system that require urgent attention. One of the key challenges to decentralization is weak coordination of decentralization at the national level; the Ministry of Local Government Rural Development (MoLGRD) lacks the capacity to follow up closely on local activities [5]. A further challenge is the underfunding of District Implementation Plans (DIPs) and, finally [5], staff turnover, which is high, tends to affect health services delivery at the district level as it limits institutional memory and continuity [7]. This is compounded by the absence of clear functional roles and responsibilities, lack of terms of reference and job descriptions of DHMT members [7], is a drawback that affects the ability of the district leadership to exercise their decision making capacity.

Figure 1 illustrates the structure of health sector governance with clear lines of communication showing central level management units, being MoH and MoLGRD at the top and decentralization to district councils.

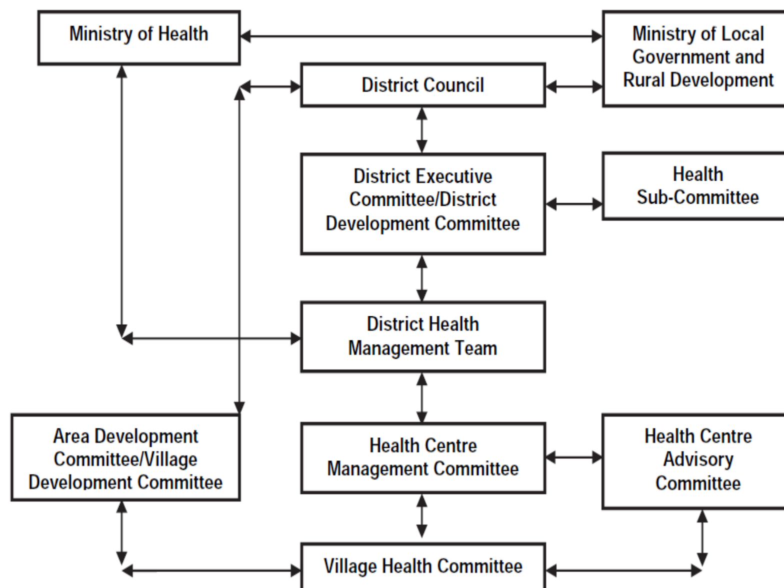


Figure 1: District Level Health Sector Governance Structure

Source MSPA2013 -2014 (SPA20)

This paper explored what, if any, has been the influence of decentralization on resource mobilization and allocation within districts and if there have been improvements in generating revenue, recruitment and retention of human workforce as well as availability of medical supplies and equipment.

Chapter 1 of this paper presents a look at Malawi's health care system and health financing which will open the discussion into what is known about decentralization and how it is applied to health service delivery.

1.1.1 Malawi's Health Care System

The government of Malawi, through the Ministry of Health, provides leadership for the entire process of health policy development; coordinating the development of plans, policy, investment plans, and monitoring implementation of the plans [5]. Health services in Malawi are provided by the public, private for profit and private not for profit sectors [9].The public health system is comprised of three levels namely primary, secondary and tertiary level which are linked through a referral system. The primary level consist of community initiatives with services mostly conducted by community based cadres [5]. The secondary level consists of district hospitals that are referral facilities for services offered at primary level of care and tertiary level consist of central hospitals, also mandated to offer professional training, research and support to the districts [5].

Given the well-defined structure of the health care system, it would be fair to say that the system is by design a decentralized system. The nature of service delivery typically associated with

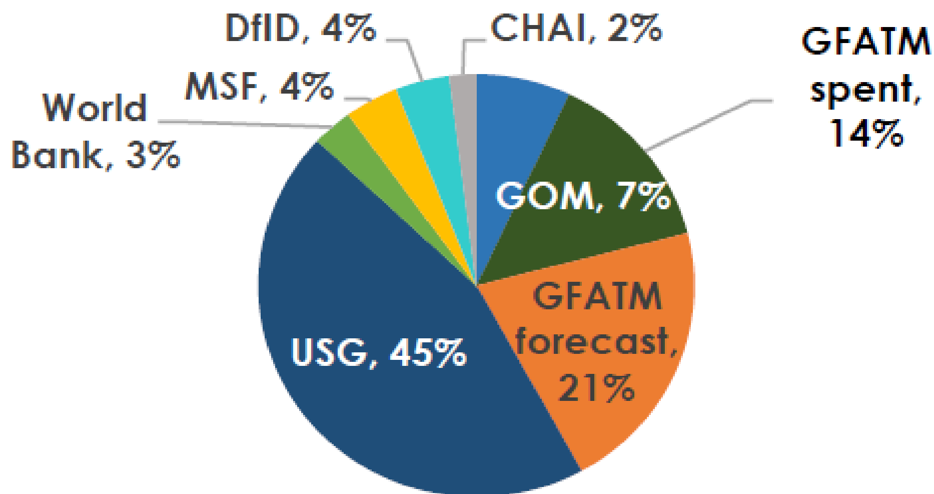
health care provision at secondary level would indicate that through the Ministry of Health, some administrative authority has been transferred to districts. The government of Malawi has established district level management teams with clearly defined administrative duties and has a degree of discretion allowing them to work independently without frequent reference to headquarters.

It is through these DHMTs that district annual plans and budgets are developed in collaboration with other stakeholders at local government. The transfer of authority to DHMT members supports the idea behind strengthening health systems from community level. It is for this reason, that health systems should be equally provided with adequate financing to support local level health needs, the following discussion looked into health care financing in Malawi.

1.1.2 Health Care Financing

According to the UNICEF Malawi 2018/19 National budget brief, the health sector was the country's fourth priority budget area that accounted for only 10% of the total budget falling 5% below the agreed target of 15% from the Abuja declaration [8]. The health sector budget was largely financed by donors and in most public facilities health services were free. From 2005 to 2018, 16 years' post joining the decentralization bandwagon, Malawi's health budget allocations have fluctuated between 9 %- 13%. This could be understood as emanating from the governments' reliance on international funding for most programs and having very minimal government funds to sustain them. Figure 2 below is an example of health resource financing from international support specifically for HIV. The figure is a schematic representation of government's heavy reliance on donor funding. Furthermore, on-budget support from

development partners was in a state of historic decline—due mostly to the impact of the 2013 “cashgate” government spending scandal, which saw a number of high level government officials caught up in looting of public funds—and with limited potential for GOM to grow its revenue, Malawi faced a fiscal crisis in the health sector [10]. The matter of health care financing remains of importance as at the heart of it all lays the availability of resources (human, revenue, as well as material) to ensure the operation of a functioning unit. With the existence of these clearly decentralized units, the question arose on whether or not with the budget challenges identified, could these units independently have the capacity to mobilize resources within their boundaries adequate for the provision of standard health care services in support of national efforts?



Source: PEPFAR, 2015.

Figure 2: International resources support- HIV resource support (2014-2017)

1.2 Background

Decentralization has been viewed by many scholars through a variety of diverse, often inconsistent, sometimes overtly contradictory, analytic lenses that are compounded by differences between those writing about decentralization as it applies in the field of public administration generally, in contrast to those seeking to apply decentralization specifically to the health sector.

Tsofa, defined decentralization as the practice of shifting power and authority over the management of public resources from national to sub-national levels of government [11]. While Mills et al 1990, described decentralization as 'the transfer of authority or dispersal of power in public planning, management and decision making from national level to subnational levels or generally from higher to lower levels of government'[12]. Mills' description was supported by that of Mumvuma, who stated that decentralization was "the transfer of responsibility for planning, management, and the mobilization and allocation of resources from central government and its agencies to field units of government agencies, subordinate units or lower levels of government, semi-autonomous public authorities or corporations and regional area-wide or functional authorities" [13,14]. This definition pointed out the different typologies that are *deconcentration*; transferring some administrative authority to lower levels[12,15], *delegation*; transfer of responsibility to lower organizational level [15], *devolution*; creation or strengthening of subnational levels of government that are substantially independent of the national level with respect to defined set of functions and have statutory authority to raise revenue and make expenditures [12] or, transferring authority to a lower political level [15] and *privatization* when tasks are transferred from public to private ownership [15]. The definitions

provided that decentralization entailed transference of capacity or ability from an institution or authority that was highly ranked to lower levels much closer to the communities. Furthermore, the definitions carried the logic behind decentralization by theoretically supporting the notion that smaller units' functioned more efficiently, more focused and accountable than larger units. Chinsanga pointed to the fact that Malawi's history with decentralization was varied, having its most recent linkages to the transition from one party autocratic regime to multiparty democracy in 1994 [14]. The 1994 reforms aimed at consolidating the country's developmental goal of poverty reduction, led to the formulation of the decentralization policy of 1998 which was enforced by the Local Government Act of 1999 [14]. With such a long history with decentralization, it was assumed that Malawi was best placed to produce great evidence from the effects of decentralization. However, this was marred by the lack of evidence to support this assumption.

1.3 Statement of the problem

It is common knowledge that the delivery of efficient health services requires adequate and consistent availability of the right resources, be it human, financial, equipment or material resources. This is the more reason Malawi is a signatory to the Abuja declaration where it pledged to allocate 15% of the national budget towards the health sector. Over the years the Ministry of Health, has put in place various strategies to aid in resource mobilization for the health sector as a means to the Abuja declaration and one of such strategies is decentralization of the health care system. However, despite the positive gains that have been attributed to decentralization and health delivery systems, there still remains a gap in addressing the limits of decentralization vis a vie authority accorded district health management teams in health

financing. In realizing this gap, this paper was developed to look at how decentralization has capacitated District hospitals in mobilizing and allocating resources. From the results it was anticipated that the Ministry of Health through the Local Governments would be assisted in addressing gaps in resources usually associated with less than adequate service delivery in district health facilities.

1.4 Literature Review

1.4.1 Decentralization

Globally the idea behind decentralization was realized due to political reforms that developing governments instituted post colonialism mostly around the 1900's. Historically central governments have been the key players in the provision of public goods and services [14], however, around the 1980s measures began to be devised to decentralize the economy by privatizing public sector enterprises, de-concentrating the over-centralized government administration, and strengthening local governments through devolution of various functions previously entrusted to central government units [16].

To date, there is no one definition of decentralization. It is a broad concept that can be classified as political, administrative or fiscal [14,16,17], while others choose to describe it as deconcentration, devolution and delegation. Though the concept is broad, a number of papers describe decentralization, or decentralizing governance, as the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity [16]. This reorganization increases the overall quality and effectiveness of the system of governance, while

increasing the authority and capacities of sub-national levels [16]. Decentralization is sometimes advocated on the grounds that it empowers sub-national communities and is therefore good on principle, and that the political disciplines on governments work more effectively at the local level [17]. Khan, observed that the vast majority of African countries have either started or deepened their local governance and decentralization reforms in the name of participatory governance [14]. Participatory governance in this case being likened to the authority and responsibility given to community/ local level structures, so as to stimulate active engagement of stakeholders in decision making. By allowing local communities and regional entities to manage their own affairs, and through facilitating closer contact between central and local authorities, effective systems of local governance enable responses to people's needs and priorities to be heard, thereby ensuring that government interventions meet a variety of social needs [17].

During his time, the then Secretary General of the United Nations, Kofi Anan, is quoted having said "*Good governance is perhaps the single most important factor in eradicating poverty and promoting development*" [18] . This statement supports the idea behind decentralization in that the decision making process is brought down much closer to the people it directly impacts. Perhaps then it would also be safe to assume that local governments, within their specific boundaries, are implementing a form of participatory governance in that they work with different stakeholders, both private and public in managing their communities. The Health department or health care system, particularly the district health offices, would be rightly deemed as such stakeholders. Some authors observe that health care decentralization is usually carried out through varying combinations of political, administrative and fiscal initiatives but with similar objectives of empowering local level actors to bring health care delivery closer to people.

Therefore, this classification of decentralization, political, administrative and fiscal, suits the purpose of this paper well since the writer aims to assess resource mobilization and allocation at district health facilities since decentralization.

1.4.2 Health Care Decentralization

As previously described, decentralization is a form of power transfer from a much higher authority to a lower level authority. In the case of health systems, this would translate into transfer of powers from the government through ministry of health to local government, districts or municipalities. In most countries health decentralization has been emphasized with the overall aim to improve health systems performance[18,19]. The arguments in favor of more decentralization in the health sector include: empowerment of local authorities to make decisions on their own; reducing levels of bureaucracy to achieve efficiency; better matching of health services with local priorities; promoting innovations in service delivery that address local needs; and enhancing stakeholder participation in decision-making [19]. Having learnt that decentralization is a complex idea and that a number of authors have used classifications such as, de concentration, devolution, delegation and privatization, in most countries health systems decentralization takes the form of devolution [14,19]. Okech, observed that there has been a worldwide trend in the devolution of authority in healthcare whereby the authority that was often sitting with one central Ministry or Department of Health devolved over time [20]. Malawi, Tanzania, Sudan and Kenya, are some of the countries with devolved health systems.

However this cannot be said of all health systems as some have instituted decentralization in the form of one or two classifications, for example Zambia's experience is a combination of

deconcentration to district health officials within the structures of the public health system and delegation of authority from the Ministry of Health to an autonomous Central Board of Health (CBoH), and to a lesser degree to the somewhat autonomous District Health Boards and District Hospital Boards [21]. Another country with a similar experience as of Zambia would be Ghana. However, Inkooma quotes Coutelenc's opinion that though de concentration and delegation are more pronounced the Ghanaian government has a different legal framework of devolution that appears to contradict the Ministry of Health/ Ghanaian Health Services model of delegation cum de concentration [14],though the ultimate aim remains improving health service provision.

In the case of Fiji, the least imposing form of decentralization (deconcentration) was applied, entailing shifting workload from the tertiary hospital to the peripheral health centers, without a commensurate transfer of authority [22]. There are arguments that deconcentration without a transfer of authority should not be considered decentralization as the organization continues to behave like a centralized system [22].

Although decentralization in different states may take one form or the other, a number of scholars have provided the view that indeed having transfer of responsibility to smaller units' results in increased accountability and allows community level decision making on matters closest to their interests. However, there are differing opinions regarding the extent to which the said benefits can be totally attributed to decentralization. In a study conducted in Fiji, the authors argue that attempts at shifting decision making to more decentralized health units are limited by partial autonomy from central level and constrained relationships at local level, which limits the benefits of decentralization for both users and providers, [23]. Rao, as discussed by Seshadri,

shares the same opinion of the Indian experience with health care decentralization, stating that one of the reasons for India's slow progress towards decentralized governance is due to political and bureaucratic resistance at the state level to sharing powers and resources with lower levels of government [24].

To try and answer the question of whether or not decentralization could improve resource mobilization and allocation at district level, this literature review will discuss the following: Perceptions of Health personnel on their autonomy in light of decentralization, Decentralization and Health service delivery, Decentralization and Human resources for Health, Health financing and decentralization.

1.4.2.1 Decentralization, Health Service Delivery, and Health Financing

As previously highlighted, many developing countries have adopted decentralization as an institutional response for more effective service delivery [18,24]. Delegation to local authorities is expected to improve services through a combination of better knowledge of local needs, preferences and providers' characteristics, higher accountability of policy-makers and efficiency enhancing competition among jurisdictions [25]. However there is limited empirical evidence examining the effects of decentralization on health system performance, particularly on efficiency and quality of health care services [6,26]. According to Panda and Thakur, the key objectives of a health system are to (i) address the health needs of local population and increase access to medicines and treatments for all; and (ii) to expand the reach of health services beyond large cities to the diverse rural areas[26]. The principle question in the discourse of decentralization in health hinges on whether or not decentralized governance accomplishes stated

goals of efficiency and quality health services [26] and allows for the provision of better and equitable health services to all citizens at an acceptable cost [26].

Efficiency in health system is defined as the best use of resources in production; avoiding waste, including waste of equipment, supplies, ideas [26,27]. Whereas quality in health services would be the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge[26]. Panda, asserts that efficiency affects and is affected by good governance, overall functioning of health units, and satisfaction of health workforce with existing provisions [27]. It is safe to imply that the two concepts work together, either through the former complimenting or supporting the other or vice versa. It is thought that whether the two work in conflict or agreement is dependent on incentives [28]. In other words, for example, good investments in skilled well compensated labor, medicines, equipment and a conducive environment would most certainly produce quality care efficiently.

In his systematic review Zon explains that publications that explore the outcomes in terms of access to services, equity and quality of care, indicates that there is no clear evidence showing the impact of decentralization on health services [28]. In a study in Zambia, conducted by Bossert, Chitah and Bowser, it is reported that despite declining health budgets, there was no clear evidence that decentralization has had on the country's health system [21]. Furthermore, allowing health officials a moderate degree of choice for many key functions has not led to radical increases in inequalities among districts and has not reduced utilization of health services [21]. However a number of scholars agree there are some reported increase in health services

attendance and use associated with decentralization and the key contributing factors are the availability of resources, particularly from international donors, community responsibility and ownership, community participation [28]. In another systematic review Dwicaksono and Fox share that the majority of studies in the health system inputs domain found harmful effects of decentralization on resource allocation for the health sector through budget allocation [6]. The findings contradict allocative efficiency arguments advanced in the decentralization literature, which suggest that, in decentralized systems, local governments are better able to match the provision of local public goods with local preferences [6].

Given the limited literature on the subject matter, there is need to have more investigation into the influence of decentralization on service delivery or performance particularly looking at issues of efficiency, equity and quality of health services. It could be said that one key component in ensuring efficiency, equity and quality of care is the availability of adequate and skilled workforce. Despite the autonomy given to health managers or local councils, lack of, or inadequate staffing renders the system inefficient and affects quality.

In another discussion, it was pointed out that globally, the importance of health sector financing to strengthen health systems has gained momentum and is viewed as an important element for growth and development. The economic rationales for decentralization, apart from the cost savings from reduced bureaucracy and faster decision-making, generally focus on the extent to which decentralization can lead to an increase in the welfare of local populations by allowing the supply of health services to be more in line with the services that local populations value more highly [29]. Local governments are heavily reliant upon central transfers as Hutchinson observes,

however they can raise funds from taxes, licenses and fees, user charges, rental income from council properties, government grants and government donations [29]; pre-payment for health care among the informal sector through tax or insurance contributions [1] just to mention a few. Figure 3 below shows distribution of transfers to District councils in Malawi which are mainly for personnel emoluments and other recurrent transactions; the majority of development expenditures are centrally located. Funds for health care activities originate from domestic sources (tax revenue) and from external sources, through general budget support, basket funding from donors,as well as pooled funds for the health sector as part of the Sector Wide Approach (SWAP), since 2004 [1].

The flow of funds within the Malawian health care systems is illustrated in figure 4.

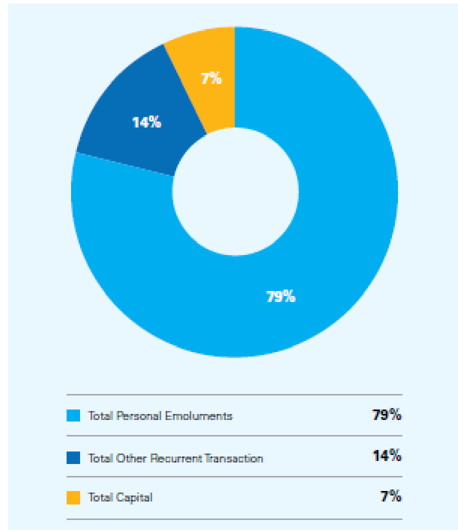


Figure 3: Composition of total transfers to district councils
Source: UNICEF Malawi 2018 Budget Brief

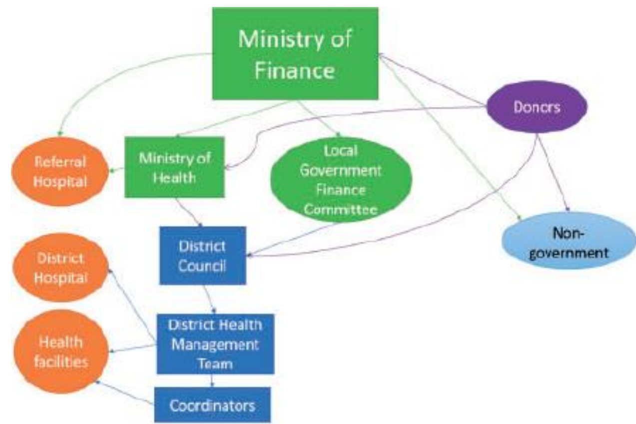


Figure 4: Transfers to district councils: Malawian health sector
Source: Borghi et al 2017

Though the need to generate more domestic resources for health as highlighted in the third international conference on financing and development in Addis Ababa [1] was highlighted, Hutchinson observed that even in countries with a good deal of local control over resources, local health sectors generally remain reliant on outside sources of funding, the central government, or donors [29]. He further states that fiscal decentralization, which generally involves granting control over allocation of resources for some proportion of health programs to local government or local health authorities, is less common in developing countries[29]. The assumption is that with developing countries, there is heavy reliance on donor funding and domestic resource base is fairly limited. In Malawi for example, the economy is less diversified, relying heavily on rain fed agriculture which accounts for 30% of the GDP with an export base that is very narrow [8]. Economic growth is also affected by slow development infrastructure

creation, less developed financial markets and weak but also less diversified investments [8] not to mention corruption which continues to pose a significant risk to national development [8]. In Zambia, decentralization introduced new responsibilities for control of expenditures at the district level [21]. As with the case in Malawi, DHMTs are also responsible for developing annual plans and budgets for district level activities. Budget transfers were made directly to the district level, contingent upon satisfactory quarterly performance audits and financial reports by the provincial offices and headquarters staff, and a review by a 'district basket steering committee' which managed the combined national and donor funds [21]. In Uganda Central government transfers accounted for the largest part of local governments' resources, 81 percent of total revenue in the mid-1990s, and are transferred through the Ministry of Local Government, with 18.7 percent being unconditional grants and 62.6 percent coming from several conditional grants e.g., for primary care [30,31].

The cases mentioned above support Hutchinson's observation that most health sectors generally rely on external funding sources. Further exploring the use of existing strategies of domestic revenue generation at district level appears plausible as it would seem the necessary structures required are already in existence through the decentralized institutions.

1.4.2.2 Decentralization and Retention of Human Resources for Health

It has been argued that human resource for health is one of the critical building blocks for health systems [11]. Health workers constitute the most critical and dynamic facet of the health system for effective service delivery [27]. In decentralized settings, performance management of the workforce depends on the extent of power allotted to the local authorities [32]. The previously

alluded statement that giving power/ authority to local governments provides an opportunity for proper governance and discretion for DHMTs to exercise this authority is somewhat challenged here, as it would appear there is an extent of the authority given. Indeed as observed by Kolehmainen-Aitken, most Low Middle Income Countries, DHMTs are assigned a range of responsibilities for managing workforce performance [33]. Garbayo, adds that forecasting HRH needs is perceived to be an important function of the DHMTs, they identify staffing requirements against the national approved positions (e.g. establishment) and pass that information to the district authorities [33]. However, often that information doesn't translated into new positions as financial constraints limit the capacity of the district or the central service commissions to authorize them [33]. Whether or not financial constraints exist, the matter still remains that despite authority vested in them, DHMTs have limited authority over HRH matters.

Local governments are given responsibility for delivering basic health services at the district hospital level and are, at least on paper, the employers of health workers; although all health workers must be selected and approved centrally [29]. However, local governments have little say in who is hired, disciplined and rewarded, which according to Gilson creates a poor incentive system, since workers face little likelihood of punishment for poor performance nor reward for outstanding performance as promotions are usually based on length of service [29]. Most authors have noted that matters of human resources remain the function of the central government very rarely is this function delegated to lower levels of government. As Zon points out, the decision-making of financial resource allocation and transfer remains under the control of the central or regional state and the same applies to the key functions in human resources management [28]. This also contradicts the fact that it is assumed being much closer to the communities allows

managers at local level to prioritize needs for their communities as they cannot hire according to their needs, and have to wait for decisions to me made by higher authority. This however, does not mean managers at local level are incapable of responding to the needs of their communities; despite the many constraints they meet, as discussed earlier regarding their authority, they are often creative about making the system work to their advantage. Often innovations in treatment provision, if conducted accordingly and taking into consideration all contexts, lead to an increase in utilization of services however staff numbers are rarely increased. For example in an ART and PHC integration program in South Africa, it was found that the provision of treatment at the clinic level inevitably resulted in a significant increase in the number of service users within a system that was already chronically understaffed and poorly equipped; however despite the 2-fold increase in utilization since the start of the program the number of professional nurses did not increase [31]. So despite improved service delivery, this very critical component of the health system is not adequately addressed.

Having human resource matters managed at central level can have its advantages and disadvantages. In a study of health sector decentralization in Pakistan, Bossert and Mitchell, reported that the de facto decision space over decentralized health sector management functions was always different from the de jure decision space; and that the difference was often due to the capacity of the individuals and institutions tasked to undertake the decentralized [11,18]. Tsofa, supports this statement, adding that it is important to ensure that appropriate peripheral level capacity to undertake decentralized functions, is in place in decentralized units if the benefits of health sector decentralization are to be realized [11]. These studies argue that it is for institutional and management capacity at district level and in order to allow for better

management of human resource matters at this level. In Kenya the rapid transfer of functions before counties had established their HRH management structures meant that they could not undertake key HRH management roles, including payroll management and payment of salaries [11]. When the counties eventually took up this role, payment of staff salaries was often delayed, with numerous pay-roll inconsistencies and discrepancies and some staff totally missing from the payroll [11]. For a number of authors this appears to be a recurring observation. Abimbola, studied the influence of decentralization on retention of primary health workers in rural areas in Nigeria and concluded that decentralization delayed the salary payment of health workers and that the health workers were not keen to work for primary care but opted for secondary tier of care [26]. Tsofa also observed that, in Tanzania after undertaking decentralization for all HRH management functions to the district level, rural districts were unable to attract and retain highly skilled staff such as medical specialists, leading the country to re-centralize some of the HRH management functions.

The decision to keep HRH matters at central level appears to be based on the matter of capacity of the institutions and management in fulfilling such responsibilities. Indeed, human resource matters are important and should be delegated to those managers who are actively present at local level but from the discussions it is safe to assume there is still some work to be done. It was earlier discussed that decentralization is not a one size fits all concept, issues of context really matter. What is also evident is that financial constraints stand out as the greatest challenges to management of human resource at local level. Perhaps then a look into health financing may assist into understanding what other opportunities exist to fully transfer authority to local level managers.

1.4.2.3 Perceptions of Health Personnel on their Autonomy in light of decentralization

The call for bureaucratic decentralization has partly been in response to the health for all agenda as articulated by the Alma Ata Declaration of 1978; as well as growing recognition that citizens need to be given voice to make governments more responsive, cost effective and accountable [24]. Governance as a key pillar of health system building blocks framework was explicitly recognized by WHO, supporting the idea of empowering governments to be transparent and have ownership in their undertakings. The significance of decentralized governance of health systems as to improve decision making at local levels in different tiers of health service delivery is constantly growing [26]. According to Michalski and Lynn, governance refers to 'the general exercise of authority' where authority—public, private or both—refers to institutions for maintaining control and enforcing accountability [34] and power being "the degree of control over material, human, intellectual and financial resources exercised by different sections of society" [32]. This supports the delegation of duties from central to local authorities as would be the case of Ministry of Health delegating to District Councils and DHMTs. As such, it is the expectation that DHMTs have power/ authority, as obligated by law, to exercise their duties and responsibilities for the benefit, growth and development of their communities.

Meanwhile it is important to also note that practices of power [and authority] lie at the heart of policy processes [32]. Giving authority/ power to district health management teams would allow for proper governance at district level, allowing the DHMTs to have discretion over the running of affairs in the district. In other discussions this discretion is known as decision space, a term coined by Bossert, referring to a range of choices allowed by central authorities to be utilized by local authorities [18,24,33]. The choices define the working of the decentralized bodies [21]. It is

argued that the robustness of a health system in achieving desirable outcomes , is contingent upon the width and depth of "decision space" at local level [26].

Bonenberger, Exworthy, Frosini and Seshadri, agree that although local managers in decentralized health systems may see their decision space expanded, in practice there are constraints to effectively using this space [33]. Hutchinson, having assessed the situation in Tanzania, notes that there has been very little scrutiny of decentralization in Tanzania as well as elsewhere [29]. He finds that district health managers faced many of the same problems: lack of coordination, poor managerial capacity and shortages of fiscal resources [29]. Kigume and Maluka share the same thought, stating that, while district health managers had authority in many health systems function areas, limited capacity of the local government in financial resources highly affected their capacity to make use of the available decision-making space [35]. In Zambia and Ethiopia, DHMTs had limited choice over sources of additional revenue, and were not accountable to local government as were devolved systems [21,36]. Furthermore, Chiweza, observes that some of the challenges faced by decentralization in Malawi have been resistance to transfer functions from the center within the agreed time frame as the center still acts as executives instead of supervising and advising [13]. This is a similar experience in India, as Seshadri noted there is political and bureaucratic resistance at state level to sharing powers and resources with lower levels, compounded by lack of clarity on responsibilities of local bodies, hindering progress [23].

Based on the definition of decision space and the limited data available from DHMTs experiences, it is likely that there is a limit to the authority/ power vested on local government.

Despite this, district health facilities continue to function and serving the communities, however it would be interesting to look at health service delivery with regards to the challenges faced by DHMTs in exercising their authority.

1.5 Justification of the Study

Whilst many theoretical foundations provide a basis for decentralization and improved service delivery, empirical evidence to determine the extent to which this actually happens is rather scares [13]. Though the roll out of decentralization has been well received, with improvements in community outreach clinics, referral systems from community to district hospitals, Malawi has also experienced a few challenges in its implementation, staff recruitment, high turnover rates of staff, knowledge deficiencies, and inadequate resources just to mention a few. Even though the decentralization of health systems is seen as a key strategy for improving resource mobilization, service delivery and ultimately health outcomes, there is limited evidence on the influence of this strategy on resource mobilization at district hospitals. The study attempted to assess whether district hospitals have the capacity to mobilize and allocate resources in light of decentralization.

1.6 Objectives

1.6.1 Broad Objectives of the Study

To assess the capacity of district hospitals in mobilizing and allocating resources after health care decentralization.

1.6.2 Specific Objectives

i. To explore the capacity of the hospitals in revenue generation and availability of essential medicines and supplies.

ii. To explore perceptions on hospital human resources management regarding recruitment and retention measures.

iii. To explore perceptions of health personnel on their autonomy in light of decentralization at district hospital.

CHAPTER 2 METHODS

Methodologies provide both the strategies and grounding for the conduct of a study[37]. In the literature reviewed, there was minimal evidence on the influence of decentralization on DHMT's capacity to mobilize resources. This study aimed at exploring this thought through the perceptions of the practitioners themselves. This section therefore presents the process that was used to carry out the research. It begins by discussing the research design, followed by the methods of data collection and the choice of data analysis method. Finally, it appreciates the possible constraints of the research.

2.1 Type of Research Study

Basing on different worldviews, there are three approaches to research which overlap and cannot be identified as independent [38]. These include quantitative, qualitative and mixed methods research.

For this study, a cross sectional qualitative method was used and followed the phenomenological approach. This approach was chosen with the aim of having study results help to provide more in depth understanding of the research question, particularly the question of perception of health management team on their capacity to be autonomous, across 2 different geographical areas.

2.2 Study Place

This study was conducted at 2 district hospitals; Kasungu and Nkhotakota district hospitals. Kasungu and Nkhotakota district hospitals serve both generational "village" and immigrant populations (due to their prominence as centers for Malawi's tobacco and fishing industries,

respectively). The assumption was that, being districts that are the hubs for the country's lucrative industries, there lay opportunities for domestic resource mobilization. However according to Borghi 2017, domestic health expenditure data from these 2 district and several others appeared to have very little use of domestic funding, 16.3% in Nkhotakota and 9.3% in Kasungu for the year 2011, however this was an improvement from the 6.7% and 5.3% respectively from the year 2006[1] despite the previously alluded to assumption. The investigator sought to explore what other opportunities existed for domestic resource mobilization in these 2 districts despite the already existing industries.

2.3 Study Population

A population is the entire aggregation of cases in which the researcher is interested [39]. The population under study is known as the target population. However, the accessible population, which is actually contingent to the target population, is the population from which the study will be conducted.

Health care workers, particularly hospital administrators, nurses, clinicians, medical doctors as well as district assembly staff particularly director(s) of finance, planning and administration and 3-4 policy makers at Ministry of Local government, Min of Health and Min of Finance/Treasury.

Inclusion Criteria:

1. Members of district health management team/district assembly personnel with management responsibilities/ senior representative from Ministry of Local Government, Health and, Finance and Treasury

2. Minimum of 2 years' work experience;
3. Working at either Kasungu or Nkhotakota district hospital
4. Those willing to participate and having provided an informed consent

Exclusion Criteria

1. Non- Members of district health management team/district assembly personnel with management responsibilities/ senior representative from Ministry of Local Government, Health and, Finance and Treasury
2. Less than 2 years' work experience
3. Not working at either Kasungu or Nkhotakota district hospital
4. Those not willing to participate and having not provided an informed consent

2.4 Study Period

Data collection was conducted between the months of August 2020 to September 2020. In depth interviews were conducted among consenting participants and interviews would last an average 50 minutes per participant. However, all interviews were conducted within 10 working days. Data analysis was conducted from November 2020 and report writing immediately after.

2.5 Sample Size

Sample is defined as a subject of the population meant to represent the full population [40]. The researcher had planned on identifying 16 participants using purposive sampling from the group of Senior Health management, policy makers and district assembly officials for their expected expertise on the subject matter. The number 16 was selected in response to the fact that DHMTs

are usually made up of a quorum of 10 managers, while departments of finance, planning and administration would have 1 director and their deputy per department at local government level, bringing total to 6 per district and a representative from Ministry of Local Government, Health and Finance and Treasury would bring the total population to 29. However, the researcher discovered that both DHOs had maximum 8 members of DHMT which brought total population to 22. Thus 16 participants would have represented about 73% of the total population being reached.

Unfortunately, only 14 participants consented to take part in the study which still represented about 64% of the total population under study.

2.6 Data Collection

A semi structured interview guide was used on key informants, [Appendix II]. The purpose of the key informant interview was to have a deep understanding of the perceptions of healthcare providers about the process of decentralization and how this provided an enabling environment to increase their capacity to mobilize domestic resources. Participants were given unique identification numbers to keep their identities private but also to keep recordings separate. In addition, the investigator requested the participants to share with her if they have any documents for analysis.

Trustworthiness was established by adhering to strict standards of credibility, transferability, conformability and dependability of data. Credibility was achieved through triangulation of the data as it was collected from multiple sources such as senior health managers, policy makers and

city assembly officials to draw conclusion about what constituted the truth. Furthermore, in-depth interviews were used for data collection thus necessitating analysis from a couple of qualitative research experts to minimize potential bias in thematic coding. An inquiry audit was conducted to achieve objectivity and neutrality of the information gathered thus providing evidence for dependability of data. An independent qualitative researcher was engaged to review the set of transcribed interviews and field notes, interview guides, and any other documents to validate the findings. Feedback from participants was obtained through debriefing meetings to allow them to provide inputs and clarifications into the findings. The standards of transferability and conformability were achieved through the conducting of the study in 2 sites, both being district hospitals. Inclusion of adequate information related to methodology enabled applicability of the data to other contexts.

2.7 Data Management

Data was managed by following good practices which required that storage, retrieval, re-use, and access should follow ethical considerations and quality standards. The collected data, in the form of interviews was transferred into a password protected laptop and the interviews were then transcribed by the researcher. Individual files were coded, and no names used. This strategy facilitated those participants remained anonymous. However, a log of codes and original interviews were kept, so that a recording could be identified in an event that a participant withdrew from the study. Lever arch files were used for storage of informed consent forms and kept in lockable storage cabinet. The electronic files (transcripts) were kept in password protected computers and external drives with access limited to the investigator and supervisors. Furthermore, hard copy files were stored in lockable file cabinets, which were also, only

accessed by the researcher and supervisors. The data will only be used, stored and destroyed following recommended research data management policies of University of Malawi. Specifically, the data shall be stored for 5 years from the end date of the project. This will allow the researcher and the supervisory team to access the data and when need arises.

2.8 Data Analysis

Interview recordings were transcribed, and then coded according to emerging themes, based on the responses from participants. The codes were developed on an excel document then exported to Atlas Ti, along with all transcripts. The researcher then went through all transcripts on the software application checking against each code to ensure there is no redundancy and that responses link accordingly to the questions asked.

All codes with similarities were then grouped in different code groups that reflected the theme to which they presented. This would eventually help the researcher to employ thematic analysis that would help illustrate the story as told by the participants. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon, it is a form of pattern recognition within the data, where emerging themes become the categories for analysis [40]. It is a useful method for examining the perspectives of different research participants, highlighting similarities and differences, and generating unanticipated insights; useful for summarizing key features of a large data set, as it forces the researcher to take a well-structured approach to handling data, helping to produce a clear and organized final report [41].

2.9 Ethical Considerations

The study proposed was non-clinical in nature and sought to engage adult human participants, particularly senior members forming the district health management team and other heads of department involved in hospital decision making. A few participants from the local district council and Ministries of Local Government and Ministry of Health were also be approached for participation. They were sampled on full knowledge that they met the inclusion criteria set for the study. Sampling was purposive as the investigator sought to engage participants who were likely to be well versed on the subject matter. There were two main ethical matters that the researcher faced with: a) the discussion around decentralization is often a sensitive matter, usually perceived through a political lens, it was possible that participants would feel intimidated by the study and perceive it as a fault-finding mission and b), the cost of participants' time, as these are senior members of staff who are often called into numerous strategic as well as technical meetings. Having explored the possible benefits of gathering evidence against risk to participants the investigator was of the opinion that the risk was minimal and the advantages of the evidence to be generated greater, for example, developing sound strategies that would strengthen existing systems.

Therefore, in mitigating ethical issues considered, the investigator sought written permission to conduct the study from College of Medicine Research Ethics Committee (COMREC), institutions responsible for facilities, that is, the MOH through specific DHOs as well as MoLGD through the DCs. The investigator provided study information to the participants, through the informed consent process [Appendix I], and explained that the participants were free to skip

questions and/or withdraw from the interviews at any point in time without explaining the reasons. After this process, the investigator obtained written consents from the participants.

CHAPTER 3 RESULTS

3.1 Introduction

This chapter presents and discusses the main findings that were captured during the study. In order to answer the research question raised and to meet the objectives of the study, relevant data was obtained and analyzed to bring forward the underlying points for this research.

The chapter begins with a brief description of demographic characteristics of the respondents. This is followed by a presentation of the results as per the emerging theme(s). The major theme that stood out was: lack of power and authority vested on DHMT as decision makers; within this theme other issues that arose were, inadequate and at times unclear decision-making powers (for recruitment, approvals); expectation that public institutions cannot be innovative (ability to think beyond the government funding), and lack of political will (inability of those in power to be ethical and just in making decisions affecting the health system).

Recommendations on how best to assist DHMTs in capacitating them with the ability to generate revenue, ensure adequate staffing and build and sustain their authority as provided by the study participants are also included in this section. Direct quotes from the recorded interviews are used to illustrate respondents' views.

3.2 Demographic Characteristics of Study Participants

3.2.1 Gender and Age of Participants

Study participants were selected from a population of senior managers from the 2 districts. In particular, the population comprised of senior managers at the DHO and senior managers at

district council. From the data presented a majority of participants 11, were male and about 8 of the participants are within the young and productive age.

Table 1 and figure 5 below are a representation of the gender and age distribution of the participants respectively.

Table 1: Age of participants

Characteristic	**Frequency (n=14)**
Age	
26 - 30	2
31-35	1
36- 40	5
41- 45	3
46 or more	3

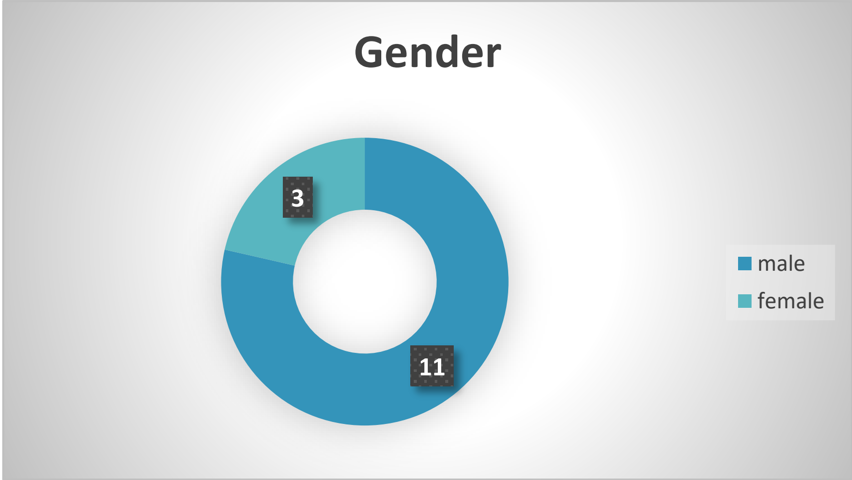


Figure 5: Gender distribution

3.2.2 Work Experience, in years, of study participants

Regarding the number of years that most participants have worked, the majority of participants, 8, have had more than 10 years of experience working in government at senior level management, while 3 have not less than 5 years and 10 years respectively. Figure 6 below illustrates these findings.

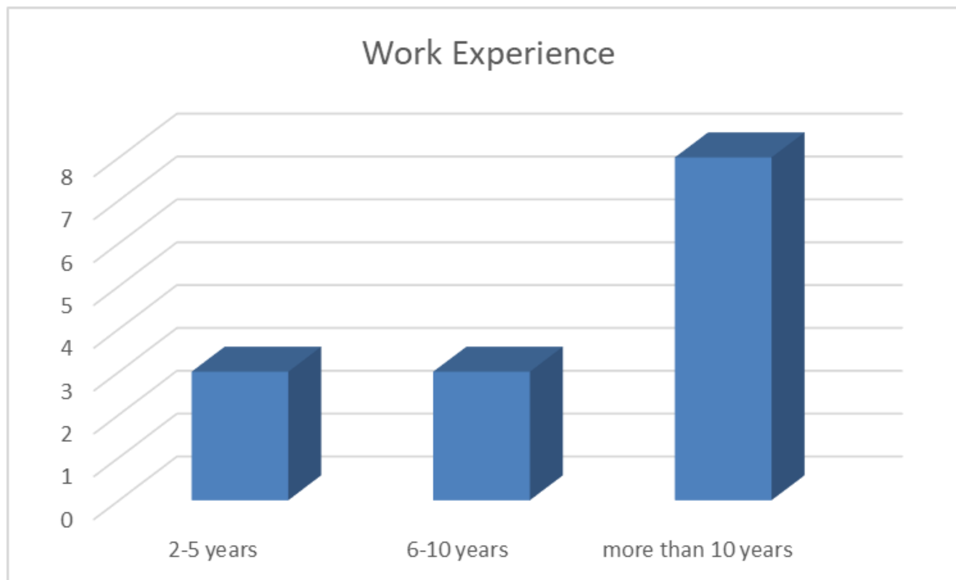


Figure 6: Work experience of study participants

3.2.3 Academic Qualification(s) of study participants

In terms of education 9 of the participants have graduate level training with only 1 out of the 14 participants having attained post graduate level training. 3 participants have Diploma level academic qualifications.

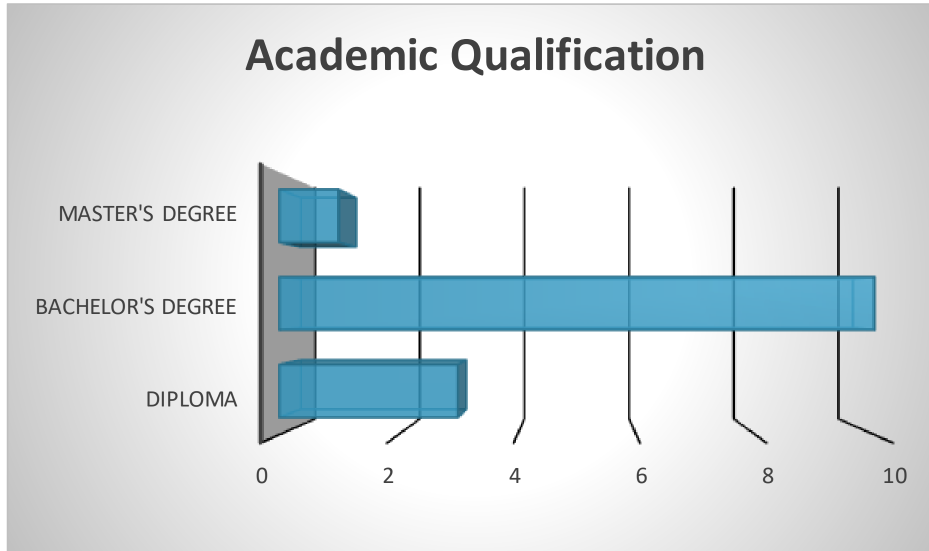


Figure 7: Academic qualification(s) of study participants

3.3 Emerging themes

The following are the theme(s) that emerged on perceptions of DHOs regarding their capacity to mobilize and allocate resources after health care decentralization.

3.3.1 Lack of Power and Authority

Most of the respondents expressed concern that they lack the powers and authority to make important decisions that concern the health sector at district level, though it is the expectation that after decentralization they would have such powers. Some respondents had this to say:

> *"Unfortunately, we say we are decentralized but we are not decentralized because funding for recruitment comes from central government and get authority from them"*
>
> ***Participant005 Nkhotakota,***

"DHMT autonomy can improve if more mandate can be given to the DHMT. For example, issues of spending, the monthly funding that we are given. It brings a lot of problems sometimes in terms of delays to spend the money just because the authority to have that money spent is not totally in the hands of the DHMT so sometimes you face problems because some of the mandate is not in the hands of DHMT. For example, if you are given that money, it comes to the DC, when it's there the DHMT will be communicated to and they make budget and send it DC now it will be authority of the council to process that payment. It's like you budget here that's all, the rest of the processes will be done at council and even there their processes are too long. This one is really affecting us. So if DHMT had that authority to do everything by themselves better like at central hospital they don't go to the district council so for them I understand it's a bit faster".

Participant006, Nkhotakota

"I think if the facilities can have power, that decentralization can really go down to the districts because I think it's just a way which is there but we are not using it, in reality we are not decentralized so if we can really be decentralized so that we can have plans for example on what staffing levels we really need so that we can be able to match the workload that is down here"

Participant011, Kasungu

3.3.2 Inadequate and unclear decision-making powers on recruitments and approvals

Some respondents were of the opinion that one of the challenges affecting their capacity, particularly in regards to addressing staffing allocations and providing approvals on important decisions has to do with having limited powers. Others further expressed that it is unclear what their functions ought to be as they are unable to have final say. The table below shows how respondents viewed their autonomy.

Table 2: Participants' perception of autonomy

Characteristics	**Frequency (n=14)**
Have full autonomy	3
Have No autonomys	4
Have limited autonomy	7

Others had the following to say:

> *"The challenges mostly are around decision making, as I mentioned we cannot go beyond our mandate so we have no mandate to recruit, to fire, all that so we can get frustrated because with the little workforce, funds we get so stretched. We get frustrated with the disciplinary processes when people are misbehaving because we do not have that mandate".*
>
> ***Participant010, Kasungu.***

> *"We need to be decentralized fully and we need to have adequate financial resources to recruit additional staff, unless we are fully decentralized with*

resources. Unless there is political will for district councils to be decentralized fully, is when we can strive to achieve the recommended number of required workforce, because at the moment it's as if we are relying on some else's pocket".

***Participant005, Nkhotakota*.**

"Of course as management team we are independent, we can make decisions on our own but what challenges us most is the issues of resources to implement those decisions. And sometimes we are not the last decision maker on some other issues, so even if we make decisions we still need to refer to a higher authority so that they can make a decision to accept or reject".

Participant011, Kasungu

3.3.3 Expectation that public institutions cannot be innovative (inability to think beyond the government funding)

Some respondents expressed that by virtue of being a public institution, DHOs cannot generate revenue, that they are limited to only government funding and some form of support from existing partners (donor funding agencies within the districts). Some had this to say on the matter:

"We don't generate any revenue, it's a public facility that offers free services so we don't generate any revenue. We receive monthly funding from the central government which is tax payer's money and we use that money to buy resources

and other necessities and for operations of the facility. Our partners sometimes they also help us with some funding"

Participant010, Kasungu

"Eeeeh on that one, may be it has been established as a culture that government should fund us. It requires maybe new ideas, for us managers to think widely on how we can be generating revenues from within. As of now as I said earlier we don't have any income generating activities that is carried out here. And right from where I am coming from we have shops for rent, whatever at least many revenue sources were there but with health I have seen it's a bit different in terms of revenue generation".

Participant007, Kasungu

"Well, I have to say on the part of revenue we don't do any revenue generation here. it's a public hospital".

Participant003, Nkhotakota

"We receive most of our funding from central level through our Ministry that where most of the funding comes from because we receive on a monthly basis, but apart from that we have other partners who support us in the district. Of course they don't provide the monetary resources but they ask us for activities which they would like to conduct so they directly support those activities which we are

conducting so that's how we are assisted apart from the funding from central level".

Participant011, Kasungu

3.3.4 Lack of Political Will (inability of those in power to be ethical and just in making decisions affecting the health system)

Further to the matters regarding power, authority and decision making, others were of the opinion that there seems to be some reluctance from central powers to fully delegate, devolve or decentralize powers to district level more over DHOs. It is perceived that not much attention is given to health sector priorities. The following are opinions of some:

"To me I feel here and there are still misunderstanding on issues to do with decentralization .The main issue is health is a big sector when they are told that they are part of decentralization to certain extent they do feel like they are called to be part of this just because they are seen to have a lot of money so in the process they will be contributing so many activities, at the end of the day reducing their capabilities of doing all activities because most of their moneys will be consumed by maybe the secretariat. In most Districts including here, what they feel is council eats a lot of their money but all in all they cannot operate without council so I feel like there is conflict though it's not like you can see it but through looking into it there is".

Participant002, Nkhotakota

"Sometimes at district council our funding is cut without the consent of the DHSS, so in that case it means we don't have full autonomy. Sometimes we dance to the tune of the DC, secretariat, especially when the DC is stubborn".

Participant005, Nkhotakota

"I think what I can add is that with decentralization we need to have the will from the central level authorities and politicians to really decentralize most of the things that need to be decentralized in order for districts to really make progress in development yah sure there is really much more that needs to be done from central level, even issues of financing at district level like in the health sector we need commitment to finance more the plans that we make at district level and build capacity at district level and to have a really willing heart by the central level team to really understand and appreciate that decentralization has to happen and has to continue happening".

Participant009, Kasungu

Summary of Findings

The findings indicate that a larger male representation in management roles from the 2 districts, however most participants have the academic and work experience to support their specific management roles, which would support the assumption that they understand the decentralization processes and could have the potential of mobilizing resources within their regions. The results also indicate than more than half of the respondents lack the power and authority to make important decisions while a considerable number also felt they are not provided enough

flexibility by virtue of being public institutions. Furthermore, a number of respondents felt there is an absence of political support towards full delegation of responsibilities.

3.4 Recommendations from Participants on how best to build capacity of DHO in resource mobilization and allocation

As part of the process of understanding the perceptions of the participants, the researcher further enquired on what recommendations members would make to build and sustain their capacity. Table 3 below presents suggested recommendations that were mentioned several times by the majority of participants.

Table 3: Recommendations from participants on how best to build capacity of DHMT in resources mobilization and allocation

Objective	**Recommendation**	**Quote**
To explore the capacity of the hospitals in revenue generation and availability of essential medicines and supplies	**Some control over health sector funding**	"If it was possible for the government to initiate a system whereby hospital will be given a 20 percent or something percent for the hospital to at least procure some items using private suppliers like the case with the central hospitals because in district hospitals we always depend on Central Medical stores but the central hospitals they are privileged to have a percentage on their drug budget whereby they can procure the items using the private suppliers, that can help to meet the demands on the items or the particular items are out of stock". **Participant001, Nkhotakota**
	Introduction of user fees	"By introducing at least, a small fee, people have to pay at least a small fee yeah. It doesn't mean that people cannot afford to pay, people can afford to pay at least

		a small fee, at the end of the day it will be a relief to the hospital if people can start paying a small fee for the drugs at least it can bring a bit of relief yeah the hospital can generate some revenue". **Participant008, Kasungu**
	Introduction of User fees	"I may suggest to say already government is piloting a project in central hospitals were they have paying and non-paying so for those patients who cannot afford anything they can still access the services through the non-paying but for those who feel they can afford to contribute something then they can access through the paying department others call it cost sharing. If we can have cost sharing that can help us to have another source of income". **Participant006, Nkhotakota**
	Increase in health sector funding	"I think it starts with government, central government, if I have to put it plainly there has to be an increase in the ORT and drug budget since most districts are not able to do most of their planned activities".**Participant013, Kasungu**
To explore perceptions on hospital human resources management regarding recruitment and retention	**Increase recruitment numbers**	"If the government can just recruit them and maintain them at this same hospital by doing that it means even our ORT will no longer be directed to relief allowances because these people will be accommodated on the government payroll. Yeah I can be happy. Even relief nurses can leave once they acquire jobs

measures		at private hospitals, they go there and reduce staff here. So if these relief nurses can be accommodated on government payroll that one can also work". **Participant007, Kasungu**
	Increase salaries	"Central government need to do something about salaries because in most cases when the turnover is happening it's because you have seen somewhere where which is quite different from where you are working". **Participant004, Nkhotakota**
	Delegation of recruitment responsibilities to address vacancy rates	"So I think lessening the restrictions and allowing us those rights would do us some good. Also the issue of employment of staff we are still depending on central level as well because we can't employ people on our own we are just given once they have employed at central level even when we know first-hand our vacancy rate or our gaps we cannot employ, we can't even generate resources". **Participant008, Kasungu**
	Providing incentives to employees	"The issue of motivation because staff retention depends on how the people feel about their employment and the institution and then they can stay with us for a long time. Yeah so the best way is to ensure that we keep our staff motivated

		ahhh the issues of like housing for the staff, yah, giving due praise whenever they do well, yah, continuous capacity building of staff and all that you know can lead to staff retention in our institutions in the district". **Participant009, Kasungu**
To explore perceptions of health personnel on their autonomy in light of decentralization at district hospital	**Capacity building or training of DHMT**	"Resources, capacity building, so to make sure that the councils are independent they have to make sure that there are people who are able to mobilize resources. There may be these simple things like proposal writing, they look simple but they are very important because if you are going to be independent, yes you need resources but also very important for you to be able to mobilize resources so if there is that capacity building for members of DHMT then yes". **Participant013, Kasungu**
	Availability of resources linked to decision making powers	"Management teams can have the power to make decisions and the power to implement then that would help. Most of the times the power to implement is in the resources that the management has so if we can have adequate resources, thought resources are never adequate it would be easy for management to make decisions and implement them, yeh". **Participant011, Kasungu**

		"I think we need to build the capacity of managers at district level, the DHMT, their capacities need to be built on quite a number of areas, yah". **Participant009, Kasungu**

CHAPTER 4 DISCUSSION

4.1 Introduction

This chapter aims to expound on the findings that have been presented in the previous chapter and draw conclusions that could contribute to the discourse around decentralization and capacity of DHMT towards health systems strengthening.

More than 2 decades post decentralization and the development of implementation guidelines for a devolved health system, Malawi still has not made much significant gains in the health sector particularly in regards to domestic resource mobilization and allocation. The HSSP II has referred to the country's focus on strengthening governance of the health sector in order to improve efficiency and get the maximum out of existing resources i.e. human, financial and material [7] as a priority. It is for this reason that the researcher sought to assess the perceptions of DHMT on their capacity to contribute to the country's ambition as stated in the HSSP II.

4.1.1 Objective 1: To explore the capacity of the hospitals in revenue generation and availability of essential medicines and supplies

As presented in the previous chapter almost all the respondents stated that there is no revenue generation in the DHOs and the main reason for this is that these are public institutions that run using government funding, hereby known as ORT. With the exception of some support from donor funded agencies within the districts, there exists no other source of income for the facilities. Total health expenditure in Malawi over the period 2006–11 grew almost 3-fold from 47 to 129 billion Kwacha, though the share of the domestic budget allocated to health has been consistently below the 15% recommended in the Abuja declaration [1]. Health sector allocations have continued to grow through the years however have remained short of meeting

the recommendation [42]. The share of the total government budget allocated to the health sector has averaged 9.6% between FY2012/13 and FY2019/20 [42]. Despite the development of the HSSP II in 2017, government has still fallen short of its estimates as Figure 8 on the next page depicts the trends in allocations over this period. Resource constraints often hamper the efforts of the DHO to provide services to all equitably. Despite this realization, DHOs remain the main actors in the delivery of primary health care in most developing countries, including Malawi. The question that comes to mind, then, is how is such a huge expectation levelled upon an institution that is ill equipped, could this not be cause for a disaster?

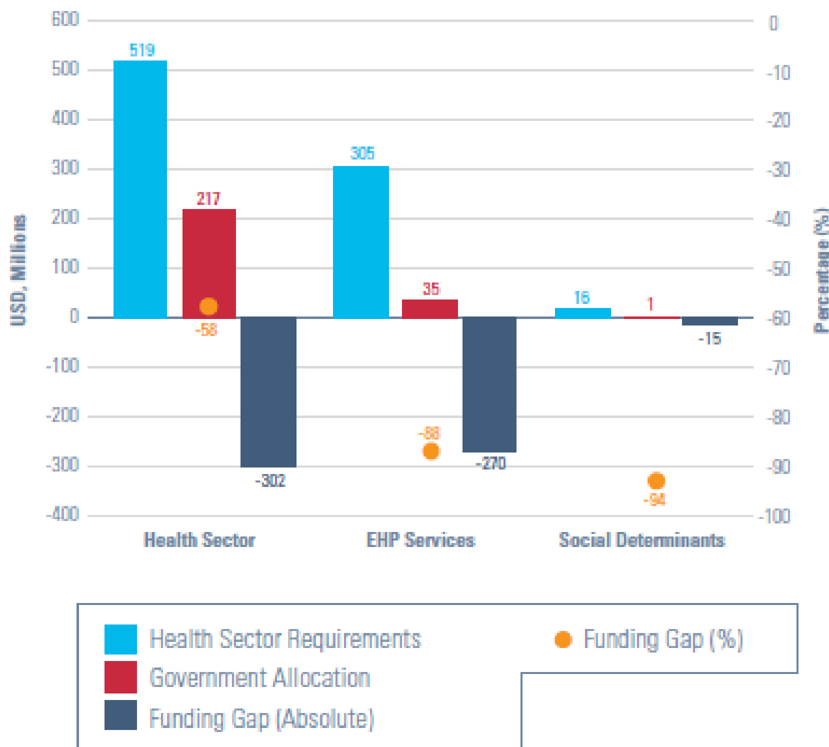


Figure 8: Health sector allocations compared to HSSP cost estimates

Source. Malawi UNICEF BUDGET BRIEF 2019/2020 p. 7

The figure above presents a rather uncomfortable picture for a country whose district hospitals appear to be less motivated in exploring domestic resource mobilization and always relying on insufficient government funds. This opinion is supported by statements made by some respondents.

In contrast, a related study comparing decentralized and non-decentralized districts in Tanzania, it was the view of DHMTs that decentralized districts reported better outcomes – or at least no significantly worse outcomes - related to resource availability than districts that were not decentralized [29]. Interestingly this is the opinion is shared by other respondents from this study. This suggests that indeed, though not having this resource mobilization capacity, the efforts being made are helpful.

In another study assessing health financing at district level in Malawi, it was reported that respondents highlighted a number of challenges in relation to the receipt of government funds[1]. First, government funds were universally perceived to be insufficient relative to needs, with the budget reportedly remaining constant despite inflation[1]. It is safe to assume this is related to the perception of respondents that the 2 districts are not decentralized, and that had they been decentralized the experience would mimic the Tanzania experience.

4.1.2 Objective 2: To explore perceptions on hospital human resources management regarding recruitment and retention measures

The World Health Organisation ranks Malawi as one of the countries with acute shortage of health workers with a current shortage of at least 7,000 Health Surveillance Assistants (HSAs)

[42]. Human resources for health remain an integral part of a successfully functioning health system, in fact some may argue that without the human machinery then there would be no hospital, as echoed by some respondents in this study.

None the less, it is one the HSSP II's objectives to improve availability, retention, performance and motivation of human resources for health for effective, efficient and equitable health service delivery [7]. The aim of the objective is to focus on improving the absorption and retention rate of health workers in the public health sector while also achieving an equitable distribution [7]. This is an interesting observation that one of the country's guiding instruments provides such a clear and arguably concise aim, that according to the majority of the respondents, is failing to achieve even at 50 %. It begs the question of whether or not with all the efforts and achievements gained in other areas, can they be sustained on a workforce that is hanging by the threads?

The matter of adequate staffing and its effect of quality of care or patient outcomes has previously been discussed in other studies looking at human resources for health. A study in Queensland Australia, looked at nurse patient ratios across the region. It was observed that nurse-to- patient ratios varied considerably across Queensland Health hospitals and worse nurse-to-patient ratios were linked with patient mortality, worse quality of care and patient safety and nurse emotional exhaustion and job dissatisfaction[43]. In a similar study conducted by Timothy, and systematic review of studies on nurse patient rations it was reported that higher levels of nurse staffing was associated with a decrease in the risk of in hospital mortality and nurse-sensitive outcomes [44,45]. However, Timothy, further cautions that addressing the problem of poor patient outcomes, requires a comprehensive approach that optimizes the effects of the

elements of the structure and process of care [44]. Patient-to-staff ratio, therefore, can be modelled with other elements of the structure and the process of care for optimal patient outcomes, and the project seeks to develop such a model [44]. This idea is supported by Aiken, that while hospital nurse staffing levels have been demonstrated in many studies to be important in producing good patient outcomes, the international hospital outcomes study provides compelling evidence that poorly organized practice environments can negate the benefits of excellent staffing [46].

Others would argue that issues of human resources for health are not given much thought but are quite important for all other developmental sectors rely on a robust and healthy population; and at the core of that service provision is the workforce within the health system. Issues of job dissatisfaction and low motivation often have an impact on retention of staff within public institutions. However, others were of a differing opinion, that even though resources maybe an issue of contention, staff retention in public institutions is not a problem, because there is job security, and there are several opportunities to be seized particularly in regards to institutional memory, learning and growth.

4.1.3 Objective 3: To explore perceptions of health personnel on their autonomy in light of decentralization at district hospital

According to the findings presented in chapter 3, much of the debate fell on the matter of power and authority boiling down to decision making and the overall opinion that districts were not fully decentralized. Incidentally, this feeling of inadequacy gives the impression that DHMT are not autonomous and this affects the functioning and/or operations of the health sector at district level.

These findings are supported by reports from a related qualitative study conducted in Ghana, Malawi and Uganda, where respondents reported that decentralisation has affected the DHMTs' decision-making power as through devolution the District Councils (should) have more decision-making power; that delegation of authority from national level to the districts, and by moving authority across from DHMTs to District Councils, the DHMTs' decision-making power within the district is affected [47]. Another study conducted in Kenya, assessing power priority setting after decentralization also reported that Health workers, particularly at sub county, health facility and community levels often described feeling excluded from both county and community decision-making structures [32]. Seshadri reported similar findings stating that there were some areas where perceived decision space was uniformly low, regardless of designation or location; Human Resource Management was an area where all designations, including Senior Health Management, perceived themselves to have low autonomy in decision-making [24].

The country's HSSP II 7th objective is to improve leadership and governance across the health sector and at all levels of the health care system [7]. Furthermore it is stated that this HSSP II's focus is on governance [7]. It would be safe to assume that with delegation of powers from central government to districts, DHMT should be capacitated with decision making responsibilities to lead in the implementation of this strategy. This is supported by Nyikuri who argued that district managers typically have planning and coordination roles, including guiding, mentoring and overseeing staff operating at sub-district and facility levels; they may also be responsible for strategic planning and oversight of the health system in their districts for translating policies from higher levels of health system hierarchies to district level, and are

answerable in turn to actors back up the system[48]. Unfortunately, DHMT appear to be still lacking in that capacity.

Summary of the Discussion

The discussion has unearthed several issues regarding capacity of the hospitals in revenue generation and availability of essential medicines and supplies, perceptions on hospital human resources management regarding recruitment and retention measure and perceptions of health personnel on their autonomy in light of decentralization at district hospital. Thus, it is apparent from the discussion that district health offices have not yet attained the right capacity to generate resources to manage operations of the hospitals independent of the central government as it was evident from the respondents that the funds still come from the central government. Similarly, it is also evident that despite decentralization, the district hospitals do not have much autonomy in decision making. However, on issue of human resource recruitment and retention, it appears decentralization does not have much influence because of the sense of job security that the staff have working with the government.

CHAPTER 5 CONCLUSION AND RECOMMENDATIONS

Following presentation of the results collected from the study and subsequent discussion around these in chapters 3 and 4, this chapter provides the conclusion(s) drawn from the discourse and recommendations made that have health systems strengthening implications.

5.1 Conclusions

This paper sought to explore how decentralization has capacitated DHOs through DHMT, in mobilizing and allocating resources within their districts. Supported by the aims from the HSSP II which realized that finances, human and material resources remain a challenge, the researcher's aim was to contribute to the discourse around the gaps addressing the limits of decentralization vis a vie authority accorded to district health management teams in health financing.

Based on the findings, the following conclusion came out clearly;

5.1.1 Capacity of DHMT is Limited

The study has shown that 50% of DHMT are of the opinion that they have limited capacity, while 29% feel they have no capacity at all, particularly in regards to resource mobilization and allocation. This is attributed to the fact that as public institutions they function at the behest of government and despite decentralization, it is still evident that much influential power and authority remains at central government. It has also been observed that DHMT capacity is further compromised by the devolution of other state functions to District Councils. However, despite these observations, it should also be noted that the study results have also shown that

decentralization is a process that is not straightforward particularly in the discussion around delegation of powers or authority. For example, authority in human resources requires amendments of recruitment policies, hierarchical structures in offices, changes in reporting lines, guidelines on appraisals, dismissals and promotions just to mention a few. None the less, whether its decision making related to human resource or decision making related to revenue generation, availability of resources remains a constant factor that can help to promote the capacity of DHMT in order to exercise their delegated authority.

5.2 Recommendations

Health is an important area of investment due to its impact on a number of sectors, in particular the development and economic sectors. DHMT is instrumental in the leadership and governance of this sector in order to achieve both national, international and global development goals. Unfortunately, they are met with difficult challenges in their pursuit of providing health for all as it has been observed in the previous discussions.

Based on the observations made and other suggestions from the participants, the researcher would make the following recommendations;

5.2.1 Strengthen DHMT Competencies through training

The researcher observed that DHMT are senior managers who by virtue of being heads of departments automatically meet the criteria of being a member of DHMT. From the results shared it is evident that from the 2 districts members have a number of years of service in government coupled with at least graduate level academic qualifications. However, these 2

factors do not make up the necessary skills in leadership, governance nor resource mobilization. Evidence from other studies suggests that empowering DHMT and developing some skills in entrepreneurship increases motivation to search for more funding and creative thinking in engaging with the private sector [49].

5.2.2 Provide opportunities for management of some health sector funding

As understood by members surveyed in this study, decentralization meant that there would be powers delegated to them at district level, however as observed this power over managing health sector funds is still controlled only this time by the local district council. It is the recommendation of the researcher that there should be some funding from the health sector that should be approved by the DHSS. This could be an agreed percentage of the total health funding budget that could be used for services such as overtime, cleaning services as well as catering for patients; areas which appear to be overlooked and force DHMT to make last minute accommodations on budgets that have already been approved.

5.2.3 Flexibility in resourcing medicines and medical supplies

It is also the researcher's recommendation that government should consider de-monopolizing the country's source of drugs and medical supplies. Unfortunately, as lamented by the survey participants in this study, CMST remains the sole source of drugs and medical supplies and, has proven to be at times unreliable. There exist other pharmaceutical companies in the country which government could engage and reach an understanding to as to ease the drug supply challenges often faced by district hospitals.

5.2.4 Revision of staff establishment for the various health facilities

The study has shown that there is high attrition rate in the 2 district hospitals, it is the researcher's opinion that aside from resignation, death and/or retirement, one of the other reasons that could not have been considered is that the country's population has grown immensely now at over 17 million people. There is need to make deliberate efforts to reduce the attrition rates revising staff recruitment numbers and allowing DHMT to slowly start addressing these vacancies and not waiting on central government.

5.2.5 Improvement of Infrastructure at district Health hospitals

One key factor that may influence clients seeking care at district health hospitals to pay for such services in the situation where paying services have been introduced, is the quality and condition of the infrastructure such services will be offered. Therefore, district hospitals must consider including funds for infrastructure improvement with the goal of introducing paying services in the improved facilities as strategy for resource mobilization.

5.2.6 Engagement of companies offering medical schemes

Most Malawians are now able to afford medical schemes that pay for their health services at private facilities whenever they are sick. Therefore, district hospitals can take advantage of that buy providing similar paying services where by medical scheme companies will be paying for their clients which has the potential of improving revenue streams for district hospitals.

5.2.7 Sensitization and Awareness

In the situation where, the district hospitals have introduced paying services, there is need for more awareness and civic education to clients and stakeholders that access health services at such services for them to appreciate some of the reasons why such a decision has been made. This will ensure that clients take the decision positively

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APPENDICES

Appendix 1: COMREC approval certificate

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.02/20/2936 - Assessing the capacity of district hospitals in mobilizing and allocating resources after health care decentralization by Evelyn Udedi

On 16-Sep-20

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study

16-Sep-20

Prof. E. Umar -Chairperson (COMREC)

Date

Approved by College of Medicine

16-Sep-2020

(COMREC) Research and Ethics Committee

Appendix 2: Permission to conduct study from Kasungu DHO

Telephone: + 265 253 400
Fax: + 265 253 630

All Communications should be addressed to:

The District Health Officer

In reply please quote No.
Ref. No. KDH/PF/435
MINISTRY OF HEALTH
KASUNGU DISTRICT HOSPITAL
P. O. BOX 19,
KASUNGU

30TH September, 2019

To : College of Medicine
Private Bag 360
Blantyre 3
Malawi
Tell : 01 871 911
01 874 107
Fax : 01 874 700

Dear Sir,

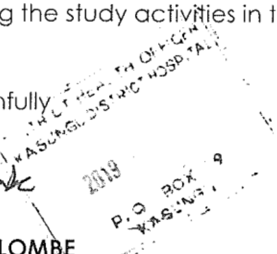
RE: LETTER OF SUPPORT FOR EVELYN UDEDI TO CONDUCT A STUDY

Refer to the subject mentioned above,

I am pleased to inform you that permission has been granted. You are welcome to conduct a study here at Kasungu District Hospital.

However, it should be noted that permission has been granted that on the condition that Director of Health and Social Services will be supervising the study activities in the district.

Yours faithfully



DR. E. GOLOMBE
THE DIRECTOR OF HEALTH AND SOCIAL SERVICES (Ag)

Appendix 3: Permission to conduct study from Nkhotakota DHO

Telephone: 01292277/258
Fax 01292363
All: Communications should be addressed to
: The District Health officer

NKHOTAKOTADISTRICT HOSPITAL
P.O. BOX 50
NKHOTAKOTA
MALAWI

10TH September, 2019

College of Medicine Research Ethics Committee
Private Bag 360
Chichiri
BLANTYRE 3

Dear Sir/Madam,

PERMISSION TO CONDUCT A STUDY AT OUR INSTITUTION

Approval has been granted to the bearer of this letter ***Miss. Evelyn Udedi*** from College of Medicine to conduct a Research Study in Nkhotakota District.

The study title is;

"Assessment of health care decentralization: health resource mobilization and allocation in central Malawian districts"

Any assistance rendered would be highly appreciated.

District Health Officer
Nkhotakota District Hospital
10 SEP 2019
P.O. Box 50
Nkhotakota

Dr. Pilirani Wezi Mumba
DIRECTOR OF HEALTH AND SOCIAL SERVICES

Appendix 4: Informed Consent Form

Assessing the capacity of district hospitals in mobilizing and allocating resources after health care decentralization, at Kasungu and Nkhotakota District Hospital

Investigators:

1. Evelyn Udedi, a Master in Global Health Implementation student at College of Medicine in Blantyre

Introduction

Hello. Thank you for taking the time to talk to me today. My name is ________________ and I am a student at the College of Medicine in Blantyre. I would like to invite you to take part in a research study assessing the capacity of district hospitals in mobilizing and allocating resources after health care decentralization. This document provides you with information about the study.

You are asked to participate in a research study because you are a senior manager at Kasungu/Nkhotakota District Hospital and have decision making authority or senior manager at the district assembly or senior representative at Ministry. Your participation in this study is entirely voluntary and you are free to withdraw at any point of the study. I will read the information below, and you are free to ask questions about anything you do not understand, before deciding whether or not to participate. After going through the document, one copy of this document will be given to you (if you wish to have it) and one will be kept at the College of Medicine in a safe and secure place.

Do you prefer to read the document on your own? Yes____ No_____ , If No allow me to take you through the document.

Why is this study being done?

The aim of this study is to assess the capacity of district health managers for domestic resource mobilization and allocation as a means of strengthening health service delivery within their districts.

The results of the study will be of significance because they will assist Ministry of health to come up with different strategies that will promote the districts abilities in resource mobilization and also help to ease the pressure on central government on the matter. During the interview, confidentiality and privacy will be observed. You will not give us your names instead we will identify you with a specific Identification number. As mentioned participation in this interview is voluntary and you may withdraw at any stage of the study if you wish to do so. The discussion will take approximately 30 minutes.

Who is being asked to take part in this study?

The people that are going to take part in this study are senior managers and members of the district health management team.

What is involved with participation in this study?

This study will involve asking you questions using an interview guide in an individual interview discussion. Please be informed that the interview will be recorded using a digital tape recorder and the recording transcribed from verbatim to a transcript that the principle investigator will use for analysis and final data presentation in the form of a dissertation.

What are the possible risks of this study?

There is no risk associated with your involvement in this study. As stated above, your names will not be used and you will be identified with specific identification numbers. We will try to protect your privacy and confidentiality. A summary of your information will only be shared to COMREC and the final dissertation will be shared with College of Medicine library. However, be assured that your names will not be mentioned in this information.

Will I benefit from taking part in this study?

Taking part in this study is voluntary and you will not receive anything for participating in this study.

Are there any costs to me if I participate in this study?

The cost involved in this study is your time only.

Is my participation in this study voluntary?

Your participation in this study is voluntary. You have the right to refuse taking part in it, or withdrawing from the study at any time. Your withdrawal from the study will not affect your relationship with the researchers nor other members of staff at the facility.

How can I get more information about this study?

Any more questions that you have, you are free to contact the following investigator on:

Name: Evelyn Udedi

Cell: +265 999 342 818

E-mail: evelynudedi@gmail.com

If you have any concerns about your rights and welfare regarding participation in this study, and want to ask someone independent anything about this research please contact:

The College of Medicine Research and Ethics Committee (COMREC) at:

COMREC Secretariat

ICT/Postgraduate Building (College of Medicine - Mahatma Gandhi Campus)

Mahatma Gandhi Road

Blantyre

Malawi.

Telephone +265 (0) 1 871 911

PARTICIPANTS CERTIFICATION

- I have read the information regarding this study and the researcher has explained well. He/she has answered all the questions that I had regarding the study and that I will be given a copy of the informed consent.
- I understand that the research will involve a one-to-one interview and will take 30 to 45 minutes of my time.
- I understand that participation in this study is voluntary. I can refuse or withdraw at any time and my withdraw will not affect my relationship with the researcher nor my colleagues
- I understand that I am encouraged to ask questions about any aspect of this research study during the course of this study, and that those questions will be answered by the researcher and data collectors listed on the first page of this form.
- I understand that the information that I will render in this study will be treated with confidential and no name will be used. I understand that the information will only be shared with COMREC and COM library.
- I therefore freely give consent to participate in this study.

____ ____/____/____

Participant's Signature/Thumbprint and Date

CERTIFICATION OF INFORMED CONSENT

With the information given to the research participant above, I certify that I have given adequate and right information. In case there are any questions that may arise during the study, the participant will be assisted accordingly. I have explained to him/her the nature and purpose of this research study, and I have discussed the potential benefits and possible risks of participating in this study. ____________________________________

____

Printed Name of Person Obtaining Consent Role in Research Study

_____________________________________ _____________

Signature of Person Obtaining Consent Date

Appendix 5: In-depth Interview Guide

QUALITATIVE INTERVIEW INSTRUCTIONS: This guide has been produced to assist the interviewer to steer the direction of the conversation with the interviewee. **It should feel like normal chatting.**

Good probes are questions that involve: “How?”, “Why?”, “Can you tell me more about…?”, “Can you give me an example?”, “I just want to clarify that I understood [rephrase information]”

Avoid probes such as: “Is there anything more?”, “What else?”, “You said that before”, or “That is different from what you said before….” – These may lead to yes/no responses or make someone feel defensive.

PLEASE SAY THE FOLLOWING SENTENCE INTO THE RECORDER:

Today is *[TODAYS DATE, DAY/MONTH/YEAR]_*. I am __[YOUR NAME] in *[FACILITY NAME]_* with respondent *[NUMBER OF IDI's THAT DAY (2 digits)]* [GENDER 1=Male,2=Female *(1 digit*)]

Section 1: Demographics

SHORT ANSWER QUESTIONS: ALL QUESTIONS IN SECTION 1 SHOULD BE ASKED EXACTLY AS WRITTEN. These should be recorded – no need to write down.

1. Sex
   a. Male
   b. Female

2. Age
   a. 20 – 25 years
   b. 26 – 30 years
   c. 31- 35 years
   d. 36 – 40 years
   e. 41 – 45years
   f. 46 or more years

3. Work experience

a. 1 year
b. 2 – 5 years
c. 6 – 10 years
d. More than 10 years

4. Your position/job
   a. Nurse
   b. Clinician
   c. DHO
   d. DMO
   e. DNO
   f. Other (Specify)______________________

5. Highest qualification
   a. Diploma
   b. Bachelor's Degree
   c. Master Degree
   d. Other (specify)_______________________

Section 2: IN-DETPH INTERVIEW GUIDE QUESTIONS

The following questions are aimed at understanding your perceptions about decentralization and whether this District Health Facility has the capacity to mobilize and allocate resources within its boundaries.

I would like to understand your perceptions on how the facility has been performing in regards to revenue generation and availability of supplies.

1. In your understanding where does most of this district's health funding come from and could you describe to me how that funding is sourced?

   Probes :
   a. Please explain to me what conditions are attached to these funds in order to get them?
   b. Describe the funding schedules and procedures that are ascribed to this facility?
   c. In your view is the funding adequate? If YES please explain? If NO please explain
   d. Explain the role of the district health management in budget preparations and work plan development?

e. Could you explain to me what other income generating activities does the facility usually undertake in order to generate more funds?
f. How would you describe the facilities ability to meet the demand of services?
   - Availability of drugs
   - Availability of utilities
   - Availability of transport and communications
g. Could you provide any recommendations on how best to assist the facility in ensuring adequate revenue generation and availability of resources?

I would now like your perception on human resources management at this district health facility.

2. In your opinion, would you say this district health facility is adequately staffed? Is YES explain? If NO explain?

Probes:

a. Describe to me the distribution of the different cadres of clinical staff and their responsibilities
b. To what extent is the district health management involved in the recruitment of staff at this facility? Please explain?
c. Are there particular recruitment schedules that the facility follows? If YES explain?
d. How does the facility manage staff turn overs?
e. Could you explain the processes of appraisal, reprimand, dismissal and/or promotion at this health facility
f. How does the district health management ensure staff motivation and commitment? Please describe
g. Could you provide any recommendations on how best to assist the facility in ensuring adequate staffing and human resource retention

Now I want to understand how you perceive the autonomy of the management team at this health facility

3. How would you describe the roles and responsibilities of the district management team at this health facility?

Probes:

a. Please describe the involvement of the district health management team on decisions made against health sector priorities in the district?
b. Please explain how approval processes are conducted at this facility?
c. Have there ever been cases of interference on the running of the facility from central government, if YES please explain?
d. On what merit are members of district health management team appointed?
e. Does the district health officer take the lead in such? If YES please explain his role?
f. Could you describe what challenges or draw backs that are encountered by the District health management team in exercising their autonomy?
g. In your opinion how has decentralization of health services influenced the roles and responsibilities of district health management teams?
h. Could you provide any recommendations on how best to ensure autonomy of district health management teams?

I would like to thank you for taking part in this interview. Please be assured that everything that has been discussed is confidential and only to be used for the purposes of this study. Your identity shall remain anonymous and will not be disclosed to anyone. Thank you for your time and participation.

Appendix 6: Manuscript

Perceived barriers to District Health Management Teams capacity to mobilize resources; a case of Kasungu and Nkhotakota District Hospital(s)

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Running/Short Title of Paper: Perceived barriers to District Health Management Teams capacity to mobilize resources

Key Words

- Decentralization
- Management Capacity
- Domestic resource mobilization
- Decision Making
- Health Policy

Platforms for Sharing Your Work Professionally and Socially

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Facebook: Eve Udedi

ResearchGate: Evelyn Zione Udedi

ABSTRACT

Introduction: The delivery of efficient health services requires adequate and consistent availability of the right resources, be it human, financial, equipment or material resources.

Objectives: To assess the capacity of district hospitals in mobilizing and allocating resources after health care decentralization; explore the perceptions of District Health Management teams'(DHMT) autonomy, decision making and influence on the administration of the health facilities.

Methods: This was a cross sectional qualitative study which focused on DHMT members. A purposively selected sample of 14 participants from District Health Office and District Council. Data was collected through in-depth interviews conducted on these key informants. Data analysis was done by on excel and Atlas Ti. All codes with similarities were then grouped in different code groups that reflected the theme to which they presented and analysis was done based on the themes.

Results: The study showed lack of power and authority vested on DHMT as decision makers was of the major theme; inadequate and at times unclear decision-making powers (for recruitment, approvals); expectation that public institutions cannot be innovative (ability to think beyond the government funding), and lack of political will (inability of those in power to be ethical and just in making decisions affecting the health system) also emerged.

Conclusions and recommendations: DHMT capacity in resource mobilization is limited. It is recommended that DHMT should receive skills and competency strengthening training particularly in regards to resources mobilization.

Background

There is global recognition of the importance of health sector financing for strengthening health systems to improve health outcomes [26-28]. One of the strategies that is seen as a viable option for strengthening the health system in resource mobilization is decentralization. Thus, with decentralization it is anticipated that decision makers at lower levels will have more capacity and authority to mobilize resources. The concept of decentralization has provided the view that health systems become more responsive and flexible in their management and administration so as to meet local needs and better align with the key principles of primary health care service provision[1–4]. Numerous studies have been conducted to assess the impact of decentralization on the efficiency of health systems and health outcomes and capacity of district health management teams (DHMT). Panda and Thakur, in a focused review of dimensions, difficulties, and derivatives in India argues that the robustness of a health system in achieving desirable outcomes, is contingent upon the width and depth of "decision space" at local level [23]. However, in a study on Decision space for health workforce management in decentralized settings: a case study in Uganda, Alonso, Raven, Theobald, Ssengooba, Nattimba and Martineau argued that that although local managers in decentralized health systems may see their decision space expanded, however in practice there are constraints to effectively using this space [24]. Similarly, Kigume and Maluka share the same thought, by stating that, while district health managers had authority in many health systems function areas, limited capacity of the local government in financial resources highly affected their capacity to make use of the available decision-making space [25]. Therefore, from the available literature, it is apparent that though tasked with such a great responsibility, DHMT often meet challenges in the pursuit of providing health for all whilst ensuring well-functioning systems for the delivery of quality primary health

care services. It should be noted that the district health management team is diverse and comprised of professions from different backgrounds such as Medical doctors, Nurses, Accountants, Administrators as well as managers [5] and, one may argue that the diversity of backgrounds is supposed to bring effectiveness in the whole process. Thus, capacity of health managers within such environments is often overlooked, yet the expectation of the system to successfully deliver is presumed highly possible through the same DHMT. A study by Heerdegen, Aikins, Agyemang, and Wyss found a positive association between the DHMTs' overall management capacity and district health performance [26]

Shortcomings within district health systems in Low Middle Income Countries (LMICs), such as an unequally distributed health workforce, high levels of absenteeism, medicine stock-outs and poor health outcomes, are often attributed to weak management capacity[6,7]. This is also compounded by the absence of clear functional roles and responsibilities, lack of terms of reference and job descriptions of DHMT members [8]. Therefore, there is need to strengthen the capacity of health managers among other interventions for the system to improve the delivery of services[7]; to improve performance and individual capacity among local health managers[3] as well as ensuring functional support systems and enabling work environments are in place, including an appropriate level of autonomy for the managers[3].

The significance of decentralized governance of health systems as to improve decision making at local levels in different tiers of health service delivery is constantly growing[9]. According to Michalski and Lynn, governance refers to use of authority where authority—public, private or both—refers to institutions for maintaining control and enforcing accountability[10] and power being the extent to which management of material, human, intellectual and financial resources is demonstrated by different people in society[4,11]. This supports the delegation of duties from

central to local authorities as would be the case of Ministry of Health delegating to District Councils and DHMTs. As such, it is the expectation that DHMTs have power/ authority, as obligated by law, to exercise their duties and responsibilities for the benefit, growth and development of their communities.

Meanwhile it is important to also note that practices of power [and authority] lie at the heart of policy processes[11]. Giving authority/ power to district health management teams would allow for proper governance at district level, allowing the DHMTs to have discretion over the running of affairs in the district. In other discussions this discretion is known as decision space, a term coined by Bossert, referring to a range of choices allowed by central authorities to be utilized by local authorities[12–14]. The choices define the working of the decentralized bodies [15]. It is argued that the robustness of a health system in achieving desirable outcomes , is contingent upon the width and depth of "decision space" at local level[9]. Bonenberger, Exworthy, Frosini and Seshadri, agree that although local managers in decentralized health systems may see their decision space expanded, in practice there are constraints to effectively using this space[14]. Hutchinson, notes that there has been very little scrutiny of decentralization across the globe; observing that district health managers faced many of the same problems: lack of coordination, poor managerial capacity and shortages of fiscal resources[16]. Kigume and Maluka share the same thought, stating that, while district health managers had authority in many health systems function areas, limited capacity of the local government in financial resources highly affected their capacity to make use of the available decision-making space[17].

Based on the arguments advanced for and against decentralization as a strategy for strengthening the health system in resource mobilization one may argue that there is more to be done in terms of generating the evidence on its effectiveness. Additionally, it will be also be necessary to look

at health service delivery with regards to the challenges faced by DHMTs in exercising their authority in the context of decentralization. This study therefore aimed at contributing to the evidence on Perceived barriers to District Health Management Teams capacity to mobilize resources in the context of decentralization.

Methods

This was a cross sectional qualitative study done in the districts of Kasungu and Nkhotakota to gain in depth understanding of the research question, particularly the question of perception of health management team on their capacity to be autonomous.

Study Setting

This study was conducted at 2 district hospitals; Kasungu and Nkhotakota district hospitals. Kasungu and Nkhotakota district hospitals serve both generational "village" and immigrant populations (due to their prominence as centers for Malawi's tobacco and fishing industries, respectively). The assumption was that, being districts that are the hubs for the country's lucrative industries, there lay opportunities for domestic resource mobilization. We sought to explore what other opportunities existed for domestic resource mobilization in these 2 districts despite the already existing industries.

Sample Size & Sampling

Sixteen participants using purposive sampling from the group of Senior Health management, policy makers and district assembly officials had been intended for participation due to their expected expertise on the subject matter. The number 16 was selected in response to the fact that DHMTs are usually made up of a quorum of 10 managers, while departments of finance, planning and administration would have 1 director and their deputy per department at local government level, bringing total to 6 per district and a representative from Ministry of Local

Government, Health and Finance and Treasury would bring the total population to 29. However, the researcher discovered that both DHOs had maximum 8 members of DHMT which brought total population to 22. Fourteen participants consented to take part in the study representing 64% of the total population of the study which was still adequate sample as they covered every position that is in the DHMT. Those that refused to take part indicated that they had previous commitments to which they could not get away from, and so finding time to participate was difficult.

Data Collection

Data was collected by the researcher for 10 days in the month of August 2020 to September 2020 and English was used as the medium of communication. A semi structured interview guide was developed as the main data collection tool. This was piloted amongst senior management personnel, who have similar roles and responsibilities as DHMT, at the investigators' workplace to ensure that any gaps in quality are identified and rectified before actual data collection was done. Interviews were scheduled according to times that were convenient for the participants and, conducted by the investigator in English. The purpose of the key informant interview was to have a deep understanding of the perceptions of healthcare providers about the process of decentralization and how this provided an enabling environment to increase their capacity to mobilize domestic resources. Participants were given unique identification numbers to keep their identities private but also to keep recordings separate. In addition, the investigator requested the participants to share with her if they have any documents for analysis. Data quality was maintained by ensuring that the right participants were recruited for the study, thus those only those who were part of the District Health management team and were willing to share their experiences. Additionally, the data collection tool was piloted amongst senior management team

at partners in hope and this provided the researcher an opportunity to refine any questions that were not clear. Further to this, participants were asked all questions in the data collection tool and in the same manner which ensured completeness and consistency of the data thereby increasing dependability and credibility.

Data Analysis

Interview recordings were transcribed, and then coded according to emerging themes, based on the responses from participants. Coding was done using deductive approach. And the codes were developed on an excel document then exported to Atlas Ti, along with all transcripts. The researcher then went through all transcripts on the software application checking against each code to ensure there is no redundancy and that responses link accordingly to the questions asked. All codes with similarities were then grouped in different code groups that reflected the theme to which they presented. This would eventually help the researcher to employ thematic analysis that would help illustrate the story as told by the participants. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon, it is a form of pattern recognition within the data, where emerging themes become the categories for analysis[18]. It is a useful method for examining the perspectives of different research participants, highlighting similarities and differences, and generating unanticipated insights; useful for summarizing key features of a large data set, as it forces the researcher to take a well-structured approach to handling data, helping to produce a clear and organized final report[19].

In order for the author to understand better the impact of health system decentralization on capacity of district health management to mobilise resources, data analysis was guided by Logic model for pathways of decentralised governance of health services on health outcomes. The model stipulates that decentralised health systems will have an impact on the following main

functional areas of the health system: Financing, service delivery and organization, Health workforce, access rules and governance rules. Thus, based on this Logic model, the analysis looked at how decentralization influenced financing/resource mobilisation. **Figure 1** below, is the Logic model for pathways of decentralised governance of health services.

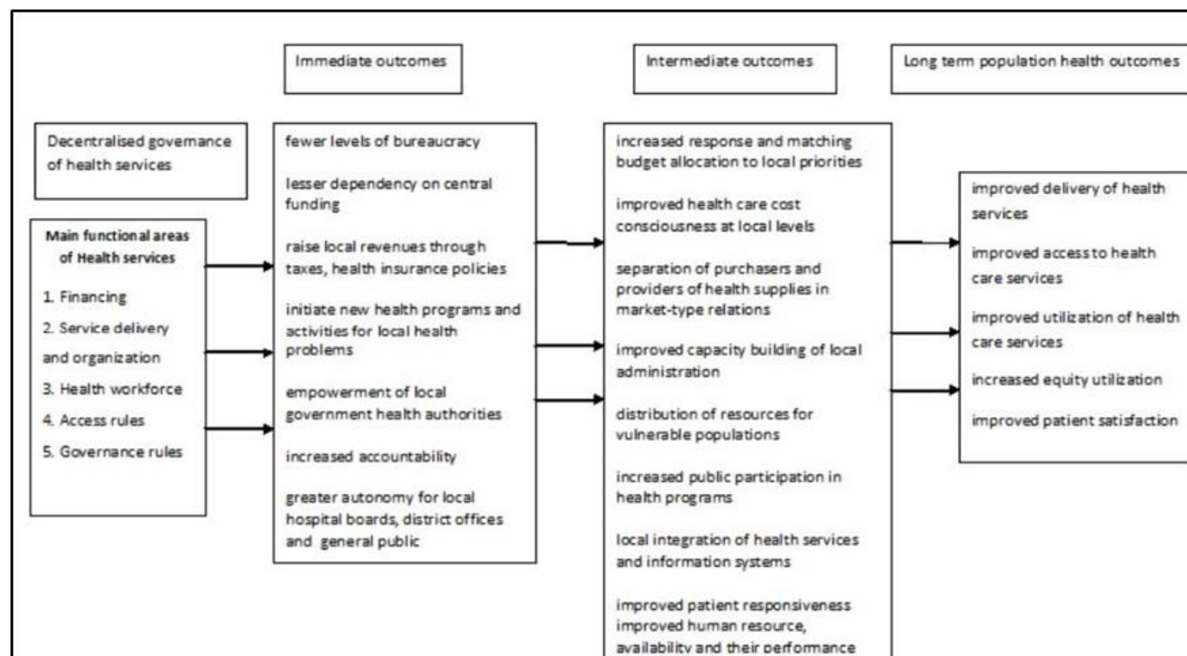

Figure 1. Logic Pathways of Decentralized Governance of Health Services

Source: Sreeramareddy_CT, Sathyanarayana_TN. Decentralised versus centralised governance of health services. Cochrane Database of Systematic Reviews 2013, Issue 11. Art. No.: CD010830.DOI: 10.1002/14651858.CD010830.

Ethics

The study was approved by the College of Medicine Research Ethics Committee of the University of Malawi. (Reference: P.02/20/2936)

Results

Participant Characteristics

We interviewed 14 participants from the 2 districts. The majority (11) were males; 8 had worked for more than 10years in government at senior management level; while 9 had graduate level training in their respective field of study.

Table 1.0 Sample of Characteristics

Characteristic	**n=14**
Gender	
Male	11
Female	3
Age	
26 – 30	2
31-35	1
36- 40	5
41- 45	3
46 or more	3
Work Experience (Years)	
2- 5	3
6- 10	3
< 10	8
Academic Qualification	
Master's Degree	1
Bachelor's Degree	10
Diploma	3

Barriers to DHMT's capacity to mobilize resources at district hospital management level

The barriers to DHMTs capacity which have been discussed below, were mainly expressed in four areas: 1) Lack of Power and Authority; 2) Inadequate and unclear decision-making powers on recruitments and approvals; 3) Expectation that public institutions cannot be innovative (inability to think beyond the government funding); 4) Lack of Political Will (inability of those in power to be ethical and just in making decisions affecting the health system).

Lack of Power and Authority

Most of the respondents expressed concern that they lack the powers and authority to make important decisions that concern the health sector at district level, though it is the expectation that after decentralization they would have such powers. Some respondents had this to say:

"DHMT autonomy can improve if more mandate can be given to the DHMT. For example, issues of spending, the monthly funding that we are given. It brings a lot of problems sometimes in terms of delays to spend the money just because the authority to have that money spent is not totally in the hands of the DHMT so sometimes you face problems because some of the mandate is not in the hands of DHMT. For example, if you are given that money, it comes to the DC, when it's there the DHMT will be communicated to and they make budget and send it DC now it will be authority of the council to process that payment. It's like you budget here that's all, the rest of the processes will be done at council and even there their processes are too long. This one is really affecting us. So, if DHMT had that authority to do everything by themselves better like at central hospital they don't go to the district council so for them I understand it's a bit faster".

Participant006, Nkhotakota

"I think if the facilities can have power, that decentralization can really go down to the districts because I think it's just a way which is there but we are not using it, in reality we are not

decentralized so if we can really be decentralized so that we can have plans for example on what staffing levels we really need so that we can be able to match the workload that is down here.” ***Participant011, Kasungu***

Inadequate and unclear decision-making powers on recruitments and approvals

Some respondents were of the opinion that one of the challenges affecting their capacity, particularly in regards to addressing staffing allocations and providing approvals on important decisions has to do with having limited powers. Others further expressed that it is unclear what their functions ought to be as they are unable to have final say. The table below shows how respondents viewed their autonomy.

Table 2. Participants perceptions on autonomy.

Characteristics	**Frequency (n=14)**
Have full autonomy	**3**
Have No autonomy	**4**
Have limited autonomy	**7**

Others had the following to say:

“The challenges mostly are around decision making, as I mentioned we cannot go beyond our mandate so we have no mandate to recruit, to fire, all that so we can get frustrated because with the little workforce, funds we get so stretched. We get frustrated with the disciplinary processes when people are misbehaving because we do not have that mandate”. ***Participant010, Kasungu.***

“Of course, as management team we are independent, we can make decisions on our own but what challenges us most is the issues of resources to implement those decisions. And sometimes we are not the last decision maker on some other issues, so even if we make decisions, we still

need to refer to a higher authority so that they can make a decision to accept or reject". ***Participant011, Kasungu***

Expectation that public institutions cannot be innovative (inability to think beyond the government funding)

It has been stated that funding for the health sector is dictated by central government and often times when this funding trickles down to local government it may be diluted further based on the needs at local level. This poses a challenge to DHMTs where they are often short of funds for other activities. Most respondents felt that there was a need to be empowered to source funding from elsewhere and make the most of opportunities that are present within their communities. Empowerment, in this regard would mean 'the ability of people with organisations to use their own initiative to further organisational interests[20], thus creating room for creativity, innovation and entrepreneurship:

"Eeeeh on that one, maybe it has been established as a culture that government should fund us. It requires maybe new ideas, for us managers to think widely on how we can be generating revenues from within. As of now as I said earlier, we don't have any income generating activities that is carried out here. And right from where I am coming from, we had shops for rent, whatever at least many revenue sources were there but with health I have seen it's a bit different in terms of revenue generation". ***Participant007, Kasungu***

Lack of Political Will (inability of those in power to be ethical and just in making decisions affecting the health system).

Further to the matters regarding power, authority and decision making, others were of the opinion that there seems to be some reluctance from central powers to fully delegate, devolve or decentralize powers to district level more over DHOs. It is perceived that not much attention is

given to health sector priorities. District governments deal with all public sectors and health may not always be a priority for them; moreover, the political nature of decentralization has its reflection at the local level as decisions often rely on elected district authorities who are under the influence of political patronage[14].

The following are opinions of some;

"Sometimes at district council our funding is cut without the consent of the DHSS, so in that case it means we don't have full autonomy. Sometimes we dance to the tune of the DC, secretariat, especially when the DC is stubborn". ***Participant005, Nkhotakota***

"I think what I can add is that with decentralization we need to have the will from the central level authorities and politicians to really decentralize most of the things that need to be decentralized in order for districts to really make progress in development yah sure there is really much more that needs to be done from central level, even issues of financing at district level like in the health sector we need commitment to finance more the plans that we make at district level and build capacity at district level and to have a really willing heart by the central level team to really understand and appreciate that decentralization has to happen and has to continue happening". ***Participant009, Kasungu***

Discussion

This qualitative study aimed to explore perceptions of DHMT's capacity to contribute to the country's ambition on strengthening governance of the health sector in order to improve efficiency and get the maximum out of existing resources i.e. human, financial and material[8] as a priority.

In theory, devolving authority to local health managers is meant to improve allocative and technical efficiency, equity, responsiveness to local needs and quality of services[14]. It is from this description that our research found that there were gaps regarding the matter of power and authority boiling down to decision making and the overall opinion that districts were not fully decentralized. Incidentally, this feeling of inadequacy gives the impression that DHMT are not autonomous and this affects the functioning and/or operations of the health sector at district level.

These findings are supported by reports from a related qualitative study conducted in Ghana, Malawi and Uganda, where respondents reported that decentralisation has affected the DHMTs' decision-making power as through devolution the District Councils (should) have more decision-making power; that delegation of authority from national level to the districts, and by moving authority across from DHMTs to District Councils, the DHMTs' decision-making power within the district is affected[4]. Another study conducted in Kenya, assessing power priority setting after decentralization also reported that Health workers, particularly at sub county, health facility and community levels often described feeling excluded from both county and community decision-making structures[11]. Seshadri reported similar findings stating that there were some areas where perceived decision space was uniformly low, regardless of designation or location;

Human Resource Management was an area where all designations, including Senior Health Management, perceived themselves to have low autonomy in decision-making[21].

Staffing in District Hospitals remains one of the major barriers affecting health care delivery[20,22] Decentralisation aims at equipping institutions such as DHMTs with the power to access their needs and make independent decisions regarding which needs to prioritise. Lack of autonomy and direction by DHMTs in Kasungu and Nkhotakota as revealed by this study could be one of the main reasons for poor service delivery in government institutions. With lack of power to hire, DHMTs carry the burden of having to demand better service delivery from an over-burdened workforce which can barely keep-up with the demand. Heerdegen et.al referring to the WHO Leadership and Management Strengthening frame concluded that inadequate staffing was the main cause of poor performance of health institutions.

How deep should decentralisation go beyond the usual central government to district level? Thus, how decentralized can district structures such as DHMTs be from DCs (the central authority at district level)? Findings of the study show that challenges that DHMTs face in resource mobilization are a function of lack of autonomy (decentralisation) from the DCs. Therefore, while decentralisation devolves power from central government, the same cannot be said for structures within the DC. Studies by McCollum, Henriksson and Bulthius, show similar trends in Uganda and Kenya[11,23,24]. Consequently, the failure to devolve powers beyond the DC level seem to simply transfer the problems observed from centralizing powers at the central government to these district structures.

The country's HSSP II 7th objective is to improve leadership and governance across the health sector and at all levels of the health care system[8]. Furthermore it is stated that this HSSP II's focus is on governance[8]. It would be safe to assume that with delegation of powers from

central government to districts, DHMT should be capacitated with decision making responsibilities to lead in the implementation of this strategy. This is supported by Nyikuri who argued that district managers typically have planning and coordination roles, including guiding, mentoring and overseeing staff operating at sub-district and facility levels; they may also be responsible for strategic planning and oversight of the health system in their districts for translating policies from higher levels of health system hierarchies to district level, and are answerable in turn to actors back up the system[25].

Limitations

Most of the participants of this study were male. With non-probabilistic sampling methods used and a large sample drawn from the DHMTs, these findings largely represent barriers that males experience. Females are marginalized in decision making processes, understanding gender dynamics in barriers to resource mobilization under decentralization policy is an area requiring further study.

Conclusion

Supported by the aims from the HSSP II which realized that finances, human and material resources remain a challenge, sought to contribute to the discourse around the gaps addressing the limits of decentralization vis a vie authority accorded to district health management teams in health financing. The study has shown that half of the DHMT are of the opinion that they have limited capacity, while almost a third feel they have no capacity at all. This is attributed to the fact that as public institutions they function at the behest of government and despite decentralization, it is still evident that much influential power and authority remains at central government. It has also been observed that DHMT capacity is further compromised by the devolution of other state functions to District Councils. However, despite these observations, it

should also be noted that the study results have also shown that decentralization is a process that is not straightforward particularly in the discussion around delegation of powers or authority. For example, authority in human resources requires amendments of recruitment policies, hierarchical structures in offices, changes in reporting lines, guidelines on appraisals, dismissals and promotions just to mention a few. None the less, whether its decision making related to human resource or decision making related to revenue generation, availability of resources remains a constant factor that can help to promote the capacity of DHMT in order to exercise their delegated authority.

COMPLIANCE WITH ETHICAL STANDARDS

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