Government of Malawi

MINISTRY OF HEALTH

REPORT ON THE ASSESSMENT ON THE CURRENT STATE OF DISTRICT HEALTH SYSTEM DECENTRALIZATION CARRIED OUT FROM 21ST TO 31ST MAY, 2018

June 2018

Department of Planning and Policy Development

Ministry of Health

P.O. Box 30377

Lilongwe 3.

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LIST OF ABBREVIATIONS AND ACRONYMS

CHAM	Christian Health Association of Malawi
CSO	Civil Society Organization
DC	District Council / District Commissioner
DEC	District Executive Committee
DHMT	District Health Management Committee
DHO	District Health Officer
DHRMD	Department of Human Resource Development
DH&SS	Director of Health and Social Services
DIPs	District Implementation Plans
DPD	Director of Planning and Development
EHP	Essential Health Package
HAC	Hospital Advisory Committee
HCAC	Health Centre Advisory Committee
HCMT	Health Center Management Committee
H&EC	Health and Environment Committee
HR	Human resource
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
LASCOM	Local Assembly Service Commission
MoH&P	Ministry of Health and Population
MoF	Ministry of Finance
MoLG&RD	Ministry of Local Government and Rural Development
MHSP-TA	Malawi Health Sector Programme Technical Assistance
M&E	Monitoring and Evaluation
NGO	Non Governmental Organization
OPC	Office of the President and Cabinet
SDG	Sustainable Development Goals
TWG	Technical Working Group
VDCs	Village Development Committees

1. INTRODUCTION

This report presents the findings of an assessment on the decentralized district health system which was carried out by the Ministry of Health and Population (MOHP) with financial assistance from the Malawi Health Sector Programme - Technical Assistance (MHSP-TA) between 21st and 31st May 2018.

In response to the National Decentralization Policy (1998) and the Local Government Act (1998), good progress has so far been made by the Ministry of Health and population in the decentralization of health services delivery to district, health centre and community levels in an effort to improve management, coverage and quality of services. In 2005 the MOHP published **"Guidelines for the Management of Devolved Health Service Delivery by District Councils"** in order to take hands off and simply keep eyes on the devolved functions. Subsequently, the guidelines gave District Councils the **managerial autonomy** over district health services delivery to improve outcomes. Immediately, District Councils assumed control of the devolved health functions.

So far, the Ministry has devolved secondary and primary level health functions, human resources, ORT budgets, planning and budgeting function and monitoring and evaluation function to the districts. In addition, the MOHP has defined and institutionalized Essential Health Packages (EHPs) for secondary, primary and community levels through Health Sector Strategic Plan 1 and 2 in order to enhance the operationalization of the decentralized health system at district level.

In 2015, as part of the Government-wide Public Sector Reform programme launched that same year by the State President, the Ministry of Health, with the assistance of the Malawi Health Sector Programme Technical Assistance (MHSP-TA) initiated the process of fully decentralizing the district health system so that the ministry should focus its attention on the policy formulation and policy implementation functions, standard setting and enforcement functions, and training, amongst other key functions. The process began with a series of consultations and the development of a draft concept note on full decentralization of the district health system which was presented to the Leadership and Governance Technical Working Group (TWG) in June 2017. The concept note was revised and finalized in February 2018 with a detailed system structure and implementation plan. The next step in this process is to develop District Health System Operational Guidelines to guide District Councils on the management of the decentralized district health system that would ensure improved management, coverage, efficiency and quality of health services in line with the HSSP and Sustainable Development Goals (SDGs). It is in view of the foregoing the Department of Planning and Policy

Development DPPD) saw it necessary to undertake a rapid assessment of the district health system whose results would inform the process of developing the Decentralized District Health System Operational Guidelines.

The assessment was designed to ascertain the current state of the district health system in order to identify current system's strengths and gaps which would help in mapping out the focus areas for the planned operational guidelines. This assessment was also designed against the background that in 2015 consultants were hired with financial assistance from MHSP-TA to carry out a feasibility study on full decentralization of the district health system in which they identified several system and operational related challenges which were seen as impeding full decentralization of health service delivery at district, health centre and at community levels. So, the 2018 assessment focused on the progress made by districts and concerned stakeholders in addressing the challenges and gaps identified by the consultants in 2015.

2. Objective of the assessment

The assessment was designed mainly to measure progress made by District Councils in addressing the health system related problems and gaps identified by the consultants in 2015 while paying attention to the principles of devolution advocated in the National Decentralization Policy (1998) and the Local Government Act (1998) which include the devolution of **powers, functions, responsibilities, HR and budgets** to the districts; and the **promotion of people participation and democratic governance** in health service delivery.

Specifically, the assessment was designed to measure the extent to which District Councils are able to manage the fully devolved health service delivery functions and also identify areas requiring further support.

3. Thematic areas of the assessment

The assessment focused on the following thematic areas:

a. Capacity, Management, decision-making and coordination of health services delivery at secondary, primary, community levels with a focus on Human Resource Management, Financial Management systems and capacities;
b. Leadership, governance and accountability
c. Planning, monitoring and evaluation of health services [including community participation];
d. Reinforcement of policies, regulations and guidelines;

e. Linkages, power relationships [autonomy levels] and information sharing within the district health system and with Central level ministries and agencies;
f. Relationship of District Councils with urban Councils, CHAM and Private hospitals and clinics;
g. Fulfilment of Central level commitment to full decentralization of the district health system;
h. Political will at national, district, health centre, and community level.

4. METHODOLOGY

The assessment was carried out by a team of officials from both the Ministry of Health and Population and the Ministry of Local Government and Rural Development (MOLGRD). It was a qualitative assessment and involved key informant interviews, focus group discussions and review of available documents. It targeted the different levels of the district health system which included District Council Management, Health and Environment Committee (HEC), District Executive Committee (DEC), Council Members, District Health Management Team (DHMT), Hospital Advisory Committee (HAC), Health Centre Management Teams (HCMTs), Health Centre Advisory Committees (HCACs), City Council Management, Town Council Management.

At the District Council Secretariat, the assessment focused on the extent to which the Council management was able to manage the district health system, and how they impacted on the lower levels of the system and the quality of health services. In the urban councils, the assessment focused on the capacity of the councils to manage health services within their jurisdiction and their preparedness to take over urban-bound health facilities and portfolios that are currently under district councils.

The assessment was carried out in six districts, one city council and one town council namely: Rumphi and Mzimba districts in the north; Mchinji and Salima districts in the Centre; and Mangochi and Blantyre districts in the South, Lilongwe City Council and Kasungu Town Council in the centre. Health centres covered in this assessment were Malembo in Mangochi, Bolero in Rumphi, Jenda in Mzimba, Chileka in Blantyre; Kochilira in Mchinji; Maganga in Salima.

5. FINDINGS

5.1 Capacity, Management, decision-making and coordination of health services delivery at secondary, primary, community levels with a focus on HRM, Financial Management systems and capacities

Bearing in mind that the Ministry of Health and Population had passed on the managerial autonomy to district councils manage these functions in 2005, twelve years down the line, questions in this thematic area centred around the role, capacity and autonomy of the district council to manage the devolved health functions i.e., secondary and primary health, human resources, ORT budgets, planning and budgeting, monitoring and evaluation, and the Essential Health Packages (EHPs) for secondary, primary and community levels. Two district councils (33%) referred to Decentralization Policy and Local Government Act as their guiding tools on their roles in the management of devolved health functions but no district or urban council made reference to the 2005 MOH Guidelines for the Management of Devolved Health Service Delivery by District Councils. However, all of them generally cited their roles in health as leadership, management, HR management, control of resources, coordination, and monitoring. No mention was made of planning and EHP delivery functions.

The councils' awareness of the devolved health functions and the scope of health services in the district was relatively low considering the managerial responsibility which has been devolved by the Ministry of Health to the councils. For example, only Rumphi was able to tell the exact number of health NGOs/CSOs in the district and those registered with the district council and those which were addressing the issues highlighted in the HSSP. It is important that district councils as recipients of the devolved functions be very clear on what was handed down to them for which they will also be held accountable by both the higher level as well the community they serve.

In all district councils (100%) the assessment teams noted a few hitches around the district council management team. All district councils did not have in place a full Director of Health and Social Services (DH&SS). The post of the Director of Health and Social Services has remained unfilled for over a decade. In the absence of the DH&SS, the assessment teams held discussions with the District Commissioners (DCs), Director of Planning and Development (DPD), Human Resource Officers, DPD and other council officials who could not articulate deeply enough on issues of health management.

The teams learnt that, in the interim, current District Health Officers (DHOs) in these districts had been appointed as acting DH&SS. To the contrary, DHOs did not avail themselves as at the Council Secretariat Management; rather, they only participated in DMHT discussions at the hospital. It was learnt that the appointment of DHOs as acting DH&SS has received mixed reactions from the DHOs themselves and hospital staff. It is like DHOs are wearing two hats, that of acting DH&SS and DHO. As a result, the DHOs are not giving the due attention to the new role of DH&SS at the Council Secretariat as they are also in full charge of hospital management. In the districts visited, DHOs confirmed having received the appointment which they said was not official or substantive and that this appointment did not mandate them to be at the council secretariat to discharge the roles of DH&SS full time. The source of this appointment was also not very clear which also calls for the Ministry of Health and Population HR to investigate and establish the truth of the matter. However, DHOs spent most their time at the hospital with hospital staff. It could therefore be deduced that in the absence of a full time DH&SS at the council secretariat there seems to be minimal commitment from the council secretariat management to manage district health services as evidenced by lack of documentation on clear roles on management of district health services and the absence of the DH&SS. The forgoing also poses a question for the coordination of health services in districts where it was found that 67% of the DHMTs indicated that their council management had substantial capacity for smooth coordination of district health services. These were Rumphi, Mzimba, Mangochi and Blantyre. However, this coordination role of the council secretariat was hardly visible at health centre level where only in a third of the districts visited health centres indicated having interacted with council officials. For example, Malembo Health Centre indicated having seen District Council's officials at their premises once in that year and that staff at the Health Centre knew very little about decentralization.

The management capacity of the council secretariat on health devolved functions has been worsened by inadequate resources for effective management of the functions. All district councils (100%) indicated that they did not have adequate resources to effectively manage health services. They did not have adequate funds, human resources, equipment, drugs and supplies, transport and infrastructure. These problems also came up during interviews held with Council members, DEC members, DHMT, HAC and HCMT.

On the part of HR, it was learnt that all district councils (100%) had just partial authority/autonomy to hire, discipline and award staff because Local Assembly Service Commission (LASCOM) had an upper hand on the control of senior staff, and, on the other hand, district councils lacked the funds for

hiring additional staff. The above observations echo observations made earlier during the Health Sector Wide Approach (SWAP) era (2004-2010) when health decentralization also dragged due to the fact that the components of decentralization (i.e., Functions, autonomy, HR, Finance) did not devolve at the same pace. Indeed, management of any venture is bound to be problematic in the absence of the necessary ingredients that are necessary for successful management which includes autonomy and resources. Therefore this means the devolved health functions need to go with corresponding autonomy and resources. The holes and gaps in the devolved health system need to be sealed for the councils to perform effectively.

Apart from the above problems, one serious problem that is in general impeding management of devolution in the districts is 'misalignment' of sectors and staff grades that does not translate into anything like a district council hierarchy or organogram or a coherent district council system. This is posing a challenge for decision making, passing of decisions and meaningful communication, reporting and feedback. In districts like Mangochi, this has bred long bureaucracy and procurement processes where it takes unnecessarily long times to get things done, especially those which require management or financial authorization from the council management. For example, in Mangochi district, the grades of heads of HR and Accounts at the DHO are higher than the grades of their bosses at the council secretariat. This has affected interpersonal relationships, decision-making, authorization processes, procurement processes and the understanding critical issues of the health sector by the council secretariat to the extent that the DHO would go for unnecessarily long periods without funds and critical supplies such a Lactogen for orphaned babies. Also mentioned in the misalignment of sector staff and grades was the misalignment of the DEHO at the hospital and the District Environmental Officer of Department of Environmental Affairs (DEO) at the DC's office. Who is supposed to report to who?

Also cited by the District Commissioners is the gap that existed between Hospital systems and council secretariat systems such as the DHIS of the hospital and the M&E system at the Council which makes it difficult for the council management to have timely data and information for decision making and direction.

Having shouldered the responsibility of managing the devolved health functions, district councils have indicated that they still need support from the Central level and particularly from the following ministries and departments:

a. **MOHP:** To make a deliberate drive to harmonize the district health system with the district council system, and minimize dual reporting and

health staff's allegiance to top MOHP officials than to the council management;

b. **MoLG&RD:** To demonstrate political will/drive for devolution so that decentralization moves at the required pace in districts. It should also take drastic steps to re-integrate all staff under the district council in a meaningful hierarchy that translates into a district council establishment. LASCOM should fill existing vacancies and should not by-pass DCs but liaise with them when transferring staff;
c. **DHRMD:** To harmonize sector staff (grades) at the council into what will look like a District Council organogram and should also devolve full HR autonomy to DCs.
d. **MoFEPD:** To permit District Commissioners to use all revenue for local development and also permit them to use the District Development Plan (DDP) to raise funds for local development. MoFEPD should make consultations with Councils and appreciate their real problems and needs instead of solely relying on the allocation formulas which are not doing justice to their districts and should also honour councils' budget ceilings;
e. **OPC:** To sustain high level political will by issuing directives that will drive and enhance coordination of the decentralization process. OPC should enhance follow-up on the reforms which they initiated up to the lower levels;
f. **SERVICE COMMISSIONS:** To make a deliberate move to harmonize themselves in favour of decentralization or else, other service commissions should align themselves to LASCOM in order for LASCOM to deliver effectively and efficiently on staff of all sectors in the district. Service commissions/LASCOM should carry out periodical assessment of HR gaps and fill existing HR gaps timely;
g. **REGULATORY BODIES:** To continue accreditation issues, regulating standards and professional ethics among health workers e.g., Nurses and Midwives Council

5.2 Leadership, governance and accountability

Overall, the leadership in health management was, to an extent, adversely affected by the absence of the Director of Health and Social Services (DH&SS) at the district council whose post remains unfilled over ten years since the post was established. Nevertheless, councils indicated that they were able to engage different players and stakeholders in health through development and submission of sector plans/DIPs, conducting trainings

where appropriate, periodic supervision and performance assessments, and reporting.

And all district councils (100%) confirmed having in place all required governance structures which were fully constituted, active and with defined roles which ranged from Full Council, Health and Environment Committees, Area Development Committees (ADCs) up to Village Development Committees (VDCs) at village level. All districts used HACs and HCACs to oversee and hold health facilities accountable. The low capacities of the HACs and HCACs is the major impediment to delivery of their services. Cases of no clear collaboration with hospital management teams are high, and over time the oversight function greatly diminishes. Operations of HACs/HCAC mostly depends on financial support from hospital management teams, so in the event of a soar relationship, financial support is limited. Nevertheless, the participation of the decentralized structures in periodic DIP implementation reviews/updates is sketchy. However, as cited above, in the absence of the Director of Health and Social Services at the councils the effectiveness of this leadership in the management of devolved health functions may have been compromised to some extent. Blantyre district, for example, indicated that all their committees from Full council to VDC were not trained on their roles.

One problem affecting leadership in health management cited by Mangochi District Council was that, it appeared that some NGOs working in the district were sanctioned to operate in their district by MOHP Headquarters. As such, the NGOs had their own interests and were difficult to manage and to hold them accountable for what they were doing in the district.

5.3 Planning, monitoring and evaluation of health services [including community participation]

Planning, monitoring and evaluation are crucial elements of management where the absence of these in management processes may result in the quality of health services being compromised. One of the roles of the council leadership and management in this respect is to initiate and coordinate these management functions. However, visits to Mchinji, Blantyre, Mangochi and Rumphi DHMTs (50%) revealed that the council secretariat did not participate in their health planning, monitoring and evaluation activities and did not give feedback to the DHMTs on their performance. It was worse at health centre level only in 1 of the 6 districts where council secretariat availed themselves in planning, monitoring and evaluation activities of the health

centre. The rest of the districts did not receive the intervention in this area nor had they received appraisals, feedback and mentorship from the district level. The same applied to stakeholder/community involvement where 80% of HAC and all HCACs (100 %) indicated not taking part in budget monitoring. This actually contravenes the decentralization policy which advocates for the promotion of people participation and democratic governance in health service delivery and all development matters.

5.4 Reinforcement of policies, regulations and guidelines

The assessment also looked at the district councils' leadership focusing on and commitment to delivery of quality health services. Indeed, policies and guidelines are crucial in management of healthcare delivery and help different players keep in focus and track of the necessary standards and targets. Questions in this thematic area centred around the district council leadership's awareness of relevant policies and their capability to enforce them down to grassroots. All district councils (100%) were aware of 'some' National level policies relating to healthcare delivery, local government, finance and human resources. All district councils (100%) had public health bye-laws which were being updated.

However, the district councils admitted that the adherence to the policies by the majority of staff and partners was just 'fair', a sign that there were some hitches down the district health system. For example, Mangochi District Council Secretariat indicated that they had a number of problem NGOs in the district which were not adhering to some of policy requirements because they had their own interests or strong allegiance to their donors. The Mangochi DHMT, however, attributed the low adherence to policies partly to laxity in the District council management perhaps due to the absence of the Director of Health and Social Services at the district council.

Mangochi also observed that national level policies were generally too broad to address some district specific issues.

5.5 Linkages, power relationships [autonomy levels] and information sharing within the district health system and with Central level ministries and agencies

Questions in this area were specifically intended to measure the coherence and efficiency of the district health through the district council's leadership styles, autonomy and coordination over the devolved health functions in the

entire district health system. This was also to check if there was reasonable transfer of powers, as well as flow of decisions and feedback from the district level down to the health centre and back. Findings revealed that levels of autonomy at district and hospital levels ranged from medium to high from district to district, while health centre management teams exercised low to medium autonomy.

The medium to high autonomy at district and hospital was an indication that (1) either the central ministries including Ministry of Health still had a hand on some of the devolved health functions or some district level functions had not been fully devolved and the example was HR; (2) district council management were also holding back some powers that deprived the DHMTs and HCMTs of the necessary autonomy. In 5 of the 6 districts visited (83%) Health centres had no power to formulate their facility's plans, budgets and procurement needs and received resources that were not in line with the demands of the facility. This defeats the purpose of devolution.

With regard to the flow of decisions and feedback, it was found out that levels of reporting/feedback from the community level to the council Secretariat varied from district to district from 'low' to 'high'. This revealed that there were also some hitches (1) between the different levels of the district health system as cited above and (2) amongst the sub-systems of the district health system. For example, Mangochi District Council Management indicated that some of the hospital/facilities systems were not linked to the council Secretariat systems e.g. DHIS2 was not linked to the Council M&E database system. As a result, the District Council did not have up-to-date healthcare services delivery data at the council. As already cited above one likely contributory factor to this problem is the absence of the Director of Health and Social Services at the council secretariat who could have facilitated such linkages and timely availability of the required health data and information.

5.6 Relationship of District Councils with urban Councils, CHAM and Private hospitals and clinics

The district councils visited admitted that, currently, they were involved in the coordination of almost all health activities in the district, that is health activities provided by MOH, CHAM, urban councils, NGOs and the private sector. The coordination was through direct participation in their activities, meetings, SLA arrangements, enforcing compliance to the district council requirements through MOUs and reporting. It was thus found out that in all

districts visited (100%) where there were town/municipal/city councils such as Mangochi, Kasungu and Blantyre all urban health centres were under the DHO and managed by the DHO. Health related disasters and outbreaks were managed jointly by the DHOs and the relevant departments in the urban councils.

Decentralization in Malawi has meant giving powers to local governments to take charge of local development. This has given prominence to district councils and urban councils respectively where either of the two need to redefine development in their areas of jurisdiction. Yet, for many years now, all public health facilities in a district, both urban and rural, have been run by District Health Offices under the Ministry of Health and Population. Decentralization entails that city/municipal/town councils ought to bear the responsibility of running and managing urban bound facilities. However, district councils also needed to rethink their relationship with other non-urban facilities operating under CHAM and Private ownership to ensure a well coordinated district healthcare for universal coverage and quality health.

Deliberate move was made to assess two urban councils on their views about the full decentralization of the district health system which the MOHP is undertaking jointly with the Ministry of Local Government and Rural Development. To this effect, Lilongwe City Council and Kasungu Municipal Council were selected for the purpose. Indeed, it was found out that almost all urban-bound health facilities were not under the urban council but under the district council and managed by the DHO. However, in the past, some of the urban health facilities were under the urban council especially in Lilongwe City and Blantyre City. Then a deliberate shift was made by the government to have them under DHOs. Hence, Kasungu Municipal Council did not have a clinic of its own and neither did it have a department of Health and Social Services.

Kasungu Municipal Council had just a small health section headed by one officer equivalent to HSA who was responsible for only waste management in the town. The Municipal Council further indicated that the rest of health matters in the municipality were under the DHO and that they too sat on the committee of the district HEC. The Municipal Council still made contributions to urban health beyond waste management in constructing facility infrastructure which were later handed over to DHO to equip and manage. Lilongwe City Council had just as staff clinic situated at Town Hall and a public clinic at Chinsapo which is solely managed by

the Lilongwe DHO, otherwise it is almost the same scenario as Kasungu where all facilities were under the DHO. Unlike Kasungu Municipal Council, the Lilongwe City Council had a Department of Health and Social Services headed by a Public Health expert who concentrated on solid and liquid waste management in the city. The department did not focus on curative aspects and did not have experts in this area.

Interestingly, there is good collaboration between district councils and urban councils on health related matters. In times of emergencies such as disease outbreaks, the district and urban councils work together through one committee, the district council Health and Environment committee (H&EC), with the DHO providing staff and supplies for interventions. However, this still poses a question for full decentralization of the district health system. In terms of the preparedness to take over urban-bound facilities and health portfolios, the two urban councils visited had varied views. Kasungu Municipal Council said that they were not prepared to take over urban facilities since they did not have staff and funds to manage such. They proposed that the government should decentralize this in a well planned and phased approach to allow for necessary restructuring and adjustment in their council. Doing this in a hurry will lead to total chaos. Lilongwe City council said they were prepared to take over urban facilities if the government transferred the budget and all resources for those facilities from the DHO to the City Department of Health and if Parliament provided for a special budget for this. Lilongwe City Council said this was a good move as city health issues and problems would receive the due attention from city authorities.

5.7 Central level commitment to full decentralization of the district health system

District council management and DHMTs were asked about the level of assistance and support they had received from the national level towards devolution and any difficulties, problems and challenges they faced with regard to support they got from the national/central level ministries, departments and regulatory bodies towards full decentralization of the district health system. Specifically the target ministries and departments include MoH&P, MoLG&RD, MoF, DHRMD, OPC, Service Commissions and Regulatory bodies. The districts rated the support from national level as just 'fair' which means not satisfactory, not good and not excellent. They said they did not get the all required support particularly from MoH&P, DHRMD,

MoLG&RD and Service commissions in terms of the necessary **'drive'** to harmonize health and council systems, to minimize dual reporting/allegiance to the top MOH officials; to move devolution forward; to fill existing vacancies; to harmonize sector staff and grades into an ideal district council establishment and hierarchy. DCs were not consulted when transferring their staff. DMHTs also noted that the drive from the central level towards full decentralization was slow and not visible enough.

The districts observed that it was evident from the way the Council Secretariat was conducting business relating to health that powers to manage district sectors had not been fully devolved to District Commissioners as DCs did not have full control on issues of HR.

5.8 Political will at national, district, health centre, and community level

Districts were asked if they received enough political will or any political interference towards decentralization at the different levels of the health system. As cited in the above sections, all districts lamented that they did not receive the expected political drive from MoLG&RD and OPC. It was not clear to them as to who of these two, OPC and MoLG&RD was on top of decentralization agenda. Rumphi and Mzimba indicated that they had experienced incidence of political interference or domination in the management of health service delivery.

6. SUMMARY

The Decentralization programme has been going on in Malawi for 20 years now. Indeed a lot has happened considering that the first phase in the late 1990s was for laying the ground works relating to addressing capacity gaps and this was followed by the second phase that put in place the necessary components, frameworks and systems for decentralization and ushered actual devolution of functions putting decentralization on the wheels to where we are now. The year 2005 saw the devolution of various health functions to district councils which raised the status and responsibilities of councils and their respective District Commissioners. Indeed decentralization started on a good note and with good momentum. This was mainly because the right structures, support and resources for moving the decentralization agenda were in place. A fully fledged Decentralization Secretariat provided the necessary drive. All areas of decentralization received due support such as IEC, Training/Capacity building, Planning and M&E, Administrative reforms,

Fiscal reforms and coordination of the relevant ministries, departments and agencies.

However, as evidenced by the findings in this report, the drive and momentum in decentralization has died down as if we have arrived at the goal set out in the Constitution of Malawi, the National Decentralization Policy and the Local Government Act as well as the Malawi Growth and Development Strategy. Over 10 years from when actual devolution of functions began there still appear problems and gaps impeding this move and specifically the decentralization of the district health system. Over 10 years the office of the Director of Health and Social services has remained vacant at the district council and yet we have expected them to perform. There is need to redefine the roadmap of devolution and to drum up necessary support so that councils can indeed stand on their feet and run the show of meaningful and productive local development that will contribute to national development goals and the SDGs.

As a contribution towards redefining the roadmap for devolution, the Ministry of Health intends to use the findings in this report to develop operational guidelines for the management of full decentralization of the district health system for use by councils and stakeholders. It is envisaged that these operational guidelines will put to shape the process of decentralizing the health system as well as attract the necessary attention and support from concerned stakeholder at all levels.

7. CONCLUSION

In conclusion, the assessment has revealed that most of the challenges and gaps identified by the consultants in 2015 have not been addressed by the councils and concerned stakeholders indicating that strategies need to be put in place to rectify the gaps and challenges alongside the process of fully decentralizing the district health system. The major challenges currently impeding full decentralization of the district health system are (1) the absence of the 'necessary drive', support and coordination from the central level ministries, departments and service commissions; (2) incomplete devolution; (3) misalignment of sectors and grades within the councils which is negatively impacting on decision-making processes and speed of development; (4) the unfilled post of Director of Health and Social Services; (5) the unpreparedness of urban councils to take over urban facilities and the entire urban health portfolio immediately; (6) the absence of a clear system

for tracking and reviewing issues of decentralization; and (7) inadequate sensitization/capacity building on devolution within the councils.

8. RECOMMENDATIONS

Based on the findings of this assessment there following recommendations are proposed for smooth implementation of a fully decentralized district health system.

a. MOHP should develop operational guidelines on management of devolved functions to guide council management, staff and all stakeholders and lobby for the required support from the central level
b. MoLG&RD and OPC should jointly set up a national level decentralization committee to fast-track decentralization issues preferably to chaired by OPC and its secretariat to be based at MOLGRD. The committee should be given the mandate to drive, coordinate and monitor and evaluate devolution as did the Decentralization Secretariat in the past.
c. MoLG&RD should come up with a well defined IEC/Communication strategy on devolution as there are people out there who do not know much about devolution. Perhaps this could be another mandate of the task force/committee in 2 above.
d. MoLG&RD and OPC should set up a decentralization specific M&E system to track devolution, provide timely information and organize periodic appraisals, reviews, and feedback to all ministries and concerned stakeholders otherwise many people are in the dark as what is happening on devolution. Perhaps this could be another mandate of the task force/committee in 2 above.
e. OPC under the Public Sector Reform Programme should provide the necessary and visible drive to guide and facilitate a well defined and phased approach to full decentralization taking into account prevailing problems and gaps in district and urban councils. This is also critical.
f. MoLG&RD with assistance of other ministries should resume training/building capacity of key council staff on management of devolved functions since some of the are not sure about this aspect.
g. MoLG&RD, LASCOM, DHRMD should jointly facilitate the filling of key posts on the Council's establishment e.g., the post of Director of Health and Social Services which has remained vacant over 10 years.
h. MoLG&RD, LASCOM, DHRMD and related bodies should make a deliberate move realign and harmonize all sector staff and their grades in

all district councils in order to create an enabling hierarchy and environment for making and passing of decisions, information flow, reporting, feedback and accountability as well as meaningful public service productivity.

i. MoLG&RD, LASCOM, DHRMD should fast track the appointment of Director of Health and Social Services in all district and city councils.

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