Title: More Roles, Less Power? Decentralization and District Health Management Teams Performance in Health Service Delivery

Subtitle: A Synthesis of Evidence From Malawi, Ghana, and Uganda.

A thesis submitted in partial fulfillment of the requirement for the degree of Master of Science in Public Health and Health Equity by

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Declaration:

I have carefully acknowledged and referenced the use of other people's work in accordance with academic requirements.

The thesis titled "**More Roles, Less Power? Decentralization and District Health Management Teams Performance in Health Service Delivery. A Synthesis of Evidence from Malawi, Ghana, and Uganda**" is my own work.

Signature: 

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Abstract

Decentralization is widely regarded as a strategy to strengthen governance, accountability, and responsiveness in the health systems globally, including across sub-Saharan Africa. This thesis synthesizes evidence on how decentralization has influenced the performance of the District Health Management Teams (DHMTs) in Malawi, Ghana, and Uganda. The main aim is to draw key lessons from both successes and challenges encountered and to generate practical recommendations for improvement. Using a structured literature review guided by Regmi et al.'s (2010) analytical framework, the study analyzed the decentralization effects on management structures, processes, and service delivery outcomes.

The findings show that, despite decades of reforms, DHMTs in all three countries still lack genuine control over finances and staff, as central authorities retain most of the decision-making power. While some local successes, such as improved maternal health in Malawi, community outreach in Uganda, and immunization gains in Ghana, highlight potential benefits, these were usually supported by donors or strong individual leaders, rather than by a systemic change. The challenges outweigh the purported benefits of decentralization, as issues persist. Unpredictable and delayed funding, staff shortages, poor infrastructure, and weak or symbolic community participation limit the effectiveness of DHMTs. Rural and underserved areas are the most affected.

The evidence suggests decentralization has focused more on changing formal roles than on delivering real power and resources to district teams. To achieve meaningful improvements, the study recommends that real financial power and human resources authority be devolved to DHMTs, with adequate funding and clear accountability structures.

Key Mesh Terms: Decentralization; District Health Management Teams; Health Systems; Sub-Saharan Africa; Health Service Management.

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List of Abbreviations

ADC	Area Development Committee
CAO	Chief Administrative Officer
CHAM	Christian Health Association of Malawi
CHMC	Community Health Management Committee
CHPS	Community Health Planning and Services
CSO	Civil Society Organizations
DA	District Assembly
DAHWP	District Annual Health Work Plan
DC	District Commissioner
DC	District Councils
DCE	District Chief Executive
DEC	District Executive Committee
DHA	District Health Administration
DHIP	District Health Implementation Plan
DHMT	District Health Management Team
DHO	District Health Officer
DHIS2	District Health Information Systems 2
DHS	Director of Health Services
DDHS	District Director of Health Services
DSMT	District Supervision Management Team
FBO	Faith-Based Organization
HBP	Health Benefit Package
HCMC	Health Centre Management Committee
HEC	Health and Environment Committee
HR	Human Resources
HSJF	Health Sector Joint Fund
HSDP	Health Sector Development Plan
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
LGA	Local Government Act
MCH	Maternal Child Health

MMDA	Metropolitan Municipal and District Assemblies
MoH	Ministry of Health
MoLG	Ministry of Local Government
MTDP	Mid-Term Development Plan
NDP	National Decentralization Policy
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHP	National Health Policy
ORT	Operational Recurrent Transactions
RHA	Regional Health Administration
SBA	Skilled Birth Attendants
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SSA	Sub-Saharan Africa
SWAp	Sector Wider Approach
UNMHCP	Uganda National Minimum Health Care Package
UHC	Universal Health Coverage goals
VHT	Village Health Team

Glossary of Key Terms

Decentralization: While there is no universally accepted definition of decentralization among scholars, the majority agree that it involves shifting specific managerial, technical, or fiscal duties from central government to peripheral units, most commonly at the district level (Cobos Muñoz *et al.*, 2017).

Devolution: This is a form of decentralization where authority for decision-making is granted to local governments by the central level (Wei *et al.*, 2023).

Health System: It encompasses all organizations, individuals, and activities primarily aimed at promoting, restoring, and maintaining health. It also covers both interventions that address broader determinants of health and those directly contributing to improved health outcomes(World Health Organization, 2007).

District Health Management Team (DHMT) comprises professionals from various technical backgrounds who jointly provide leadership, supervision, and coordination of health services at the district level (Rufaro Chatora, Prosper Tumusiime, 2003).

District Health System: Typically, this comprises a network of hospitals and primary healthcare facilities that serve a defined population within a specific catchment area, overseen by the district health management teams (Doherty *et al.*, 2018).

DHMT Performance: It is the ability of the DHMTs to oversee, coordinate, and implement health policies and activities aligned with local health priorities, thereby improving health service delivery and contributing to better health outcomes within the decentralized health systems (Bonenberger *et al.*, 2015).

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The unmerited favor of God, for which I am grateful every day, has sustained my MPH-HE journey here in Amsterdam. I am reminded that … “My grace is sufficient for you, for my power is made perfect in weakness.” 2 Corinthians 12:9. God's grace has brought not only a dream but also a lifelong hope to fruition.

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To my thesis advisor, words fail me. My idea began as a mere whim. Now here I am with a 50 plus page document. Thank you.

Introduction

I serve as a Director of Health Services in Zomba District, one of Malawi's 29 districts. In this role, I lead the District Health Management Team (DHMT), which is responsible for coordination, management, and delivery of health services. Malawi's decentralized health system mandates DHMTs to oversee service delivery under the Ministry of Health (MoH) and Local Government (MoLG). The firsthand experience sparked my interest in understanding how decentralization influences DHMT functioning and performance. This study is both professionally and personally relevant, as it allows me to deepen my understanding of the rationale behind decentralization, reflect on my leadership role, and identify areas for improvement and policy advocacy to enhance DHMT performance.

Health system decentralization has become a prominent reform strategy in many sub-Saharan African (SSA) countries, including Malawi, Ghana, and Uganda. It involves transferring decision-making authority from the central government to local entities. The aim of decentralization is to enhance responsiveness, efficiency, accountability, and equity in health service delivery (Bernard F. Couttolenc, 2012; Rodríguez *et al.*, 2023). Within the decentralized health systems, DHMTs play a critical role in planning, budgeting, resource allocation, and service implementation (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021; Bulthuis *et al.*, 2021).

However, the performance of the DHMTs under decentralized health systems varies widely across contexts. Whether the expected benefits of decentralization are realized depends heavily on the context in which it is being implemented (Sapkota *et al.*, 2023). In Malawi, for example, decentralization has empowered local councils by devolving some of the resource baskets, such as operational budgets. Yet, persistent resource constraints and tension between central and local actors have often undermined the performance of the DHMTs (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021; Bulthuis *et al.*, 2021; World Bank, 2021). This limits the progress towards Universal Health Coverage (UHC) goals (Jagero, Nelson; Kwandayi, Hardson H.; Longwe, Annie, 2014; Masefield, Msosa and Grugel, 2020; Erixy Naluso and Isaac Kanyangale, 2024).

Similarly, in Ghana and Uganda, decentralization has contributed to improved local planning, greater responsiveness to community needs, and increased stakeholder participation in health service delivery. However, these gains have been tempered by political interference, limited physical autonomy, overlapping mandates, and bureaucratic structures (Sarah Byakika, Freddie Ssengooba, 2019; Rodríguez *et al.*, 2023).

The study synthesizes evidence on how decentralization has influenced the performance of the DHMTs in Malawi, Ghana, and Uganda. These countries were purposively selected as early adopters of decentralization with a substantial body of policy analysis and research available (Bernard F. Couttolenc, 2012; Chen *et al.*, 2021; KIT Royal Tropical Institute, 2024). The study examines how decentralization has shaped DHMT roles in planning, resource management, supervision, and service management at the district level. It also explores how these roles influence outcomes in health service delivery. Finally, the study aims to generate evidence-informed and actionable recommendations to strengthen DHMT functioning and support ongoing and future reforms in similarly decentralized health systems.

This thesis is organized as follows: Chapter One presents the background information, and Chapter Two the problem statement and justification and objectives. Chapter Three covers the methodology and conceptual framework guiding the study. Chapter Four details the results. Chapter Five discusses the results in relation to policy and practice. Chapter Six concludes with recommendations for strengthening the performance of DHMTs in decentralized health systems.

Chapter One

1. Background

1.1. Health System Decentralization—Global Context

Health system decentralization involves devolving powers, roles, and functions from the central government to lower levels, aiming to improve performance, efficiency, accountability, and responsiveness in the health services provision (Abimbola, Baatiema and Bigdeli, 2019; Sapkota *et al.*, 2023). Decentralization typically takes four forms: deconcentration (transferring tasks to regional offices), delegation (assigning functions to semi-autonomous groups), devolution (granting decision-making powers to local governments), and privatization (shifting responsibility to private entities) (Bossert and Mitchell, 2011); **see Figure 1**.

Figure 1: Four Main Forms of Decentralization in the Health Sector

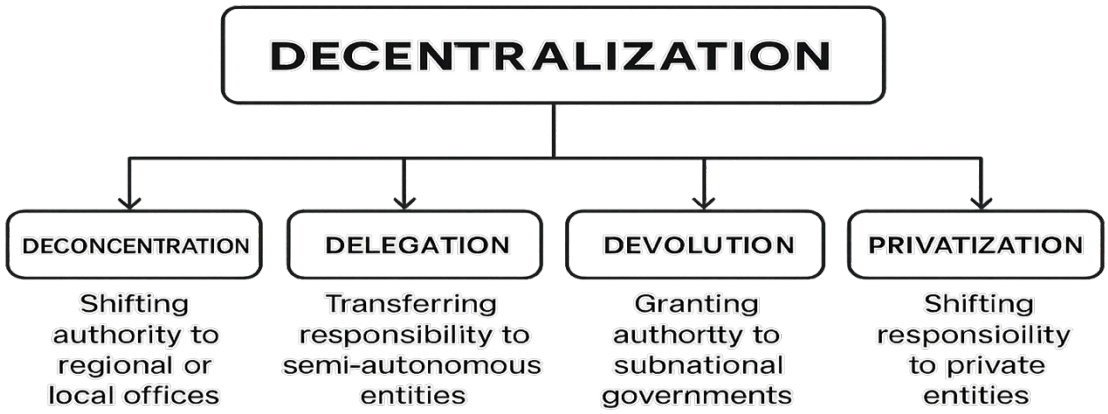


Figure 1: Source, As described by Saltman et. al (2008) (Saltman, Richard B. (Editor), Bankauskaite, Vaida (Editor), and Vrangbæk, Karsten (Editor), 2008).

People widely view the global movement towards decentralization, which started over five decades ago, as a strategy for achieving effective governance and sustainable development. Both developed and developing nations have implemented decentralization reforms to improve health outcomes and service delivery(Bossert, Thomas, 2010). The Sustainable Development Goals (SDGs), particularly Goal 3, on "ensuring healthy lives and promoting well-being for all," and the drive for Universal Health Coverage (UHC) are closely linked to these reforms (Abimbola, Baatiema and Bigdeli, 2019; Mahmood *et al.*, 2024). Evidence shows that decentralization enhances responsiveness and accountability by bringing decision-making closer to communities, thereby strengthening the systems' resilience and efficiency (Abimbola, Baatiema and Bigdeli, 2019).

Decentralization has produced a range of positive outcomes for governance and health systems, especially when local authorities are given genuine decision-making power and adequate resources. Systematic reviews and comparative studies show that decentralization can increase community participation and enhance responsiveness to local health needs. It also empowers local governments to make decisions that are better aligned to their specific contexts (The World Bank, 2013; Bulthuis *et al.*, 2021; Mahmood *et al.*, 2024). In SSA, including Malawi, Ghana, and Uganda, decentralization reforms have enabled the devolution of authority and resources for service delivery and the development of local infrastructures. This has led to greater responsiveness to the community needs and improved access to health services in previously underserved areas (Dickovick, J. Tyler; Riedl, Rachel Beatty, 2015; Bulthuis *et al.*, 2023; Rodríguez *et al.*, 2023). Furthermore, decentralization has allowed for greater flexibility in policy implementation and encouraged local innovations. It has also strengthened supervision of healthcare workers and, in some cases, resulted in improved health outcomes (Faguet, 2015; Abimbola, Baatiema and Bigdeli, 2019).

On the other hand, despite the purported benefits, decentralization continues to face significant challenges that undermine its effectiveness. Ambiguous roles between the central government and local authorities result in continued central control over key appointments and budgetary decisions at the local level. Such ambiguities can limit local autonomy and hinder intended improvements in governance and service delivery (Faguet, 2015; Abimbola, Baatiema and Bigdeli, 2019; Sapkota *et al.*, 2023). Also, inadequate and unpredictable funding, as well as limited technical and managerial capacity among local authorities, results in further limitations of the decentralized units to effectively deliver the devolved functions (World Health Organization, 2022; Mahmood *et al.*, 2024). Another persistent challenge is that weak accountability mechanisms and resistance to reform by political and local officials also derail progress. This has frequently resulted in increased bureaucracy, clientelism, and, in the worst cases, corruption (Dickovick, J. Tyler; Riedl, Rachel Beatty, 2015; Paul Smoke, 2015; Sapkota *et al.*, 2023).

1.2. Evolution and Rationale of Decentralization in Sub-Saharan Africa

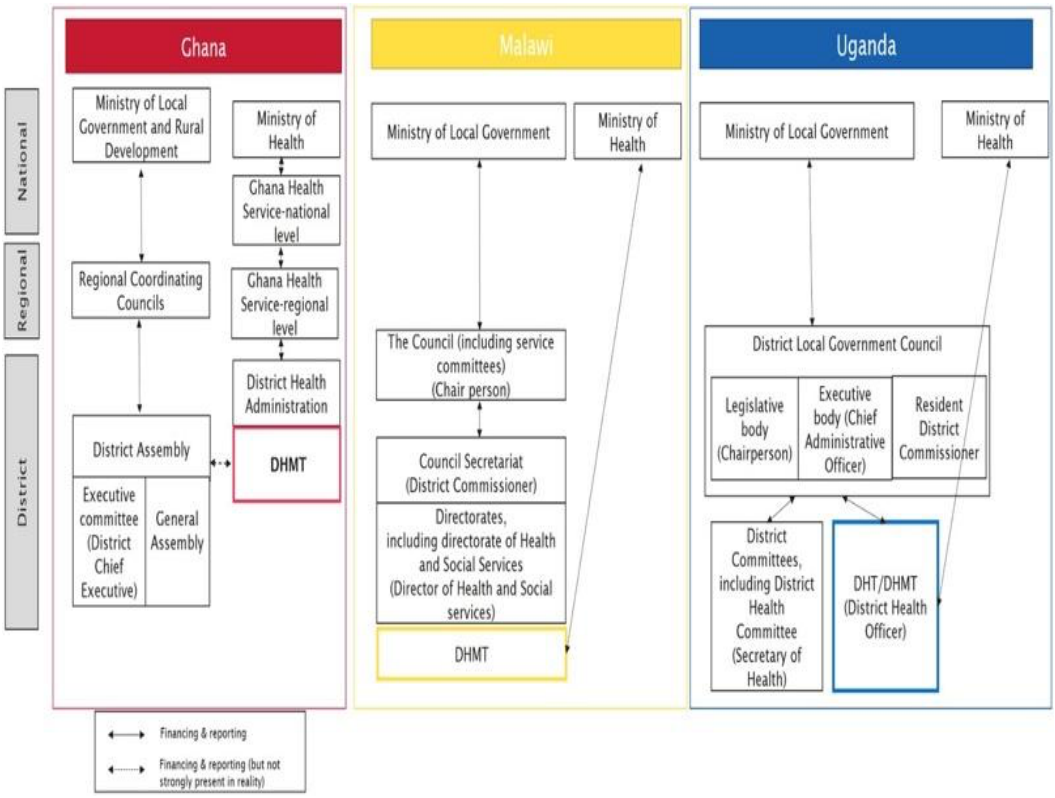
The momentum for decentralizing health systems in the SSA increased after the Alma Ata Declaration in 1978, which underscored the importance of primary health care, community participation, and equity (Abimbola, Baatiema and Bigdeli, 2019). Over the past several decades, most SSA countries adopted decentralization as a central strategy for improving health sector governance service delivery (Zon *et al.*, 2017; Hobdari, Nguyen, *et al.*, 2018). Devolution and deconcentration have emerged as predominant forms in the region, involving the transfer of responsibilities and authority for planning, budgeting, resource allocation, and service delivery from central governments to local governments or districts (Bossert, 2003; Zon *et al.*, 2017; Abimbola, Baatiema and Bigdeli, 2019). This trend has been observed in most SSA countries, including Malawi, Ghana, and Uganda, each adapting decentralization to unique political, economic, and organizational contexts (Bossert, 2003; Azevedo, 2017; Hobdari, Nguyen, *et al.*, 2018).

The rationale for decentralization is grounded in the belief that local authorities, by virtue of their proximity and understanding of the community health needs, are better positioned to allocate resources efficiently and tailor services to local priorities. Theoretically, this approach is expected to enhance efficiency, accountability, and responsiveness in health service delivery (Zon *et al.*, 2017; Hobdari, Nguyen, *et al.*, 2018; Abimbola, Baatiema and Bigdeli, 2019). Empirical evidence in this region suggests that decentralization may also contribute to economic growth

and social cohesion when supported by strong institutions and robust local capacity (Hobdari, Dell'Erba, *et al.*, 2018).However, the outcomes have been mixed, with persistent challenges related to financing, human resources management, and ambiguity in decision-making authority and roles between central and local governements (Zon *et al.*, 2017; Zon, 2021; Noory, Hassanain and Kassak, 2024). Implementation processes are often influenced by political dynamics, stakeholder engagement, and the broader socio-economic environment, which can affect the realization of intended benefits (Inkoom and Gyapong, 2016; Noory, Hassanain and Kassak, 2024).

In response to these policy shifts, Malawi, Ghana, and Uganda have implemented various forms of decentralization as core health sector reforms, aiming to improve governance, performance, and accountability at the district level (Bossert and Mitchell, 2011; Inkoom and Gyapong, 2016). These experiences, alongside those of other SSA countries, highlight both the promise and the complexity of decentralization as a pathway towards more equitable and effective health systems.

Figure 2: Decentralization Context and Structures in Malawi, Ghana, and Uganda



Source: Health system decentralization Structure for Malawi, Ghana, and Uganda (Bulthuis *et al.*, 2021).

Figure 2 illustrates the organizational arrangements established in the three different countries to drive the health system decentralization agenda. In all these countries, district councils or assemblies are responsible for the delivery of decentralized health systems through the DHMTs. The ministries of Health (MoH) and Local Government (MoLG) sit high in the hierarchy. The DHMTs have dual reporting lines; they report to both the MoLG through the District Commissioner (DC) in Malawi, the District Chief Executive (DCE) in Ghana, and the Chief

Administrative Officer (CAO) in Uganda while also reporting directly to the MoH. However, Ghana's structure is distinct in that it features regional coordinating councils, creating an additional reporting layer between the national and district level (Bernard F. Couttolenc, 2012; Bulthuis *et al.*, 2021; Chen *et al.*, 2021).

1.3. Specific Country Contexts: Malawi, Ghana, and Uganda

Malawi

The journey of Malawi's health system decentralization began in 1998 with the enactment of the Local Government Act (LGA) and the National Decentralization Policy (NDP) (Ministry of Health and Population, Government of Malawi, 2018; Erixy Naluso and Isaac Kanyangale, 2024). These reforms were designed to devolve authority and responsibilities from the central government to district councils, aiming to strengthen local governance, accountability, and responsiveness (UNDP, 2022; 'Malawi National Decentralization Policy (Second Edition, 2024)', 2024).

In practice, this meant councils were not only tasked with managing service delivery, human resources, and planning but were also given a greater role in budgeting. Financial autonomy, in this context, extended beyond simply preparing budgets: district councils gained authority to generate local revenue, allocate resources according to local priorities, and manage expenditures with less direct oversight from central-level authorities (Hobdari, Nguyen, *et al.*, 2018; UNICEF Malawi, 2022). However, despite these policy provisions, genuine financial independence has often been limited by ongoing reliance on central government transfers and continued central control over major financial decisions (Borghi *et al.*, 2018; World Bank, 2021).

Building on this policy framework, councils were further empowered to oversee primary and secondary health services delivery, with the DHMTs playing a central role in coordination and implementation at the district level. They are responsible for translating policy into practice, managing health resources, and ensuring accountability ('Malawi Decentralization Policy 1998', 1998; Ministry of Health and Population, Government of Malawi, 2018; Bulthuis *et al.*, 2021). As shown in figure 2, the DHMTs formally report to the DC under the MoLG and to the MoH for technical guidance. However, in practice, this dual reporting structure often leads to ambiguity and tension, as DHMT must navigate overlapping demands from both central and local authorities (Ministry of Health and Population, Government of Malawi, 2018; Bulthuis *et al.*, 2021).

In addition to these administrative reforms, Malawi established structures such as the Health and Environment Committee (HEC) and Hospital Advisory Committees (now Health Center Management and Committees, HCMC) to promote local accountability and community participation (Ministry of Health, Government of the Republic of Malawi, 2023). Community engagement is further strengthened through continuous collaboration with local leaders, especially traditional authorities and councilors (Ministry of Health and Population, Government of Malawi, 2018; Evelyn Udedi, 2021; Erixy Naluso and Isaac Kanyangale, 2024).

However, despite these efforts, Malawi's health system decentralization process continues to face challenges such as ambiguous roles and responsibilities, resource constraints, political interference, and limited capacity among DHMTs (Ministry of Health and Population, Government of Malawi, 2018; Bulthuis *et al.*, 2021; Erixy Naluso and Isaac Kanyangale, 2024).

Ghana

The decentralization of health systems in Ghana began in the 1980s. Similar to Malawi's ambitions, the aim was to improve service delivery effectiveness, promote local accountability, and ultimately address the health needs of local communities (Kojo Sakyi, 2008; Bernard F. Couttolenc, 2012; Bulthuis *et al.*, 2021). The Ghana Health Services (GHS) was established as a semi-autonomous agency responsible for health service delivery at national, regional, and district levels. This development resulted from a rigorous legal framework anchored in the LGA 2016 and the Ghana Health Services and Teaching Hospitals Act (1996) (Bernard F. Couttolenc, 2012; Sumah and Baatiema, 2018; Exemplars in Global Health, 2024).

As shown in figure 2, Ghana's decentralization of health systems takes two forms: deconcentration and devolution. The current practice is that MoH has delegated operational responsibility of health service provision to GHS. The GHS, in turn, has established Regional and District Health Administrations (RHAs and DHAs) to oversee and coordinate health services at regional and district levels (Bernard F. Couttolenc, 2012). In this arrangement, the DHMTs, led by the District Director of Health Services (DDHS), have the responsibility of managing the public health facilities and implementing national health policies in the district. However, they are vertically accountable to RHAs and GHS and only report to the district assembly on a horizontal basis (Bernard F. Couttolenc, 2012; Sumah and Baatiema, 2018; Bulthuis *et al.*, 2021; Exemplars in Global Health, 2024).

According to the LGA 2016, several functions previously managed by the MoH have been devolved to district assemblies in Ghana. These include oversight of health infrastructure, human resources management, planning, budgeting, resource allocation, disbursement of health funds, health service delivery, and monitoring and evaluation, as well as policy input (Bernard F. Couttolenc, 2012; Government of Ghana, 2016; Ayim, Agyepong and Enyimayew, 2023).

Notwithstanding the aforementioned implementation arrangements, Ghana's decentralization process faces numerous challenges. The main challenge is blurred lines of authority and accountability due to overlapping roles among the MoH, GHS, RHAs, DHAs, and district assemblies. Consequently, there is fragmented management and weak local capacity and ownership (Bernard F. Couttolenc, 2012; Sumah and Baatiema, 2018; Bulthuis *et al.*, 2021).

Uganda

Uganda began reform of health sector decentralization in the 1990s. The reform aimed to improve efficiency and accountability. It also sought to enhance community participation and make health services more responsive to local needs. This decentralization reform is anchored in the legal provision in the LGA of 1993 and subsequent legislation. Through these laws, significant authority and responsibilities were devolved from the central MoH to district authorities (Sarah Byakika, Freddie Ssengooba, 2019; Chen *et al.*, 2021)(16,17).

A wide range of functions have been devolved. This includes planning, budgeting, procurement of drugs, human resources management, and overall oversight of health services delivery. DHMTs led by the DHOs are central to the management and delivery of district health services. They are responsible for the implementation of national health policies through the execution of the devolved functions (Martineau *et al.*, 2018; Sarah Byakika, Freddie Ssengooba, 2019). As shown in Figure 2, the DHMT has a dual reporting line: it administratively reports to the Chief Administrative Officer (CAO) under local government at the district level and also reports directly to the MoH. The DHMT also works closely with the District Health Committee, which is

responsible for prioritization of resource allocation for district health services (Martineau *et al.*, 2018; Sarah Byakika, Freddie Ssengooba, 2019).

Despite the above organizational arrangements, the health sector decentralization process in Uganda has faced persistent challenges. Limited decision space for the DHMTs is a major issue, as the central level still retains some responsibilities and powers, with some of the roles being unclear. Also, limited resources and local capacity hinder effective DHMT management of district health services (Anders Jeppsson, 2004; Alonso-Garbayo *et al.*, 2017; Martineau *et al.*, 2018; Bulthuis *et al.*, 2021).

Chapter **Two**

2. Problem Statement and Justification, and Study Objectives

2.1. Problem Statement and Justification

The central problem is that decentralization reforms have failed to deliver on their promise of improved district health service performance due to systemic constraints, leaving DHMTs unable to achieve intended outcomes (Bossert and Mitchell, 2011; Masefield, Msosa and Grugel, 2020; Bulthuis *et al.*, 2021). Decentralization has been widely adopted globally, including in SSA countries, with Malawi, Ghana, and Uganda among the early adopters of this health sector reform. The intended aim was to improve the responsiveness of health service delivery and outcomes in the districts. However, results remain inconsistent and suboptimal (Heerdegen, Aikins, *et al.*, 2020; Bulthuis *et al.*, 2021).

The concept of decentralization argues that delegating authority and decision-making power to local levels would improve accountability, responsiveness, and local ownership (Bossert and Mitchell, 2011; Jiménez-Rubio, 2022). In practice, however, there are persistent challenges such as central control, political interference, weak DHMT capacity, limited autonomy, and decision-making power. These challenges undermine the presumed benefits of decentralization (Bulthuis *et al.*, 2021; Rodríguez *et al.*, 2023; KIT Royal Tropical Institute, 2024).

For instance in Malawi, conflicting reporting structures and central control over key resources constrain DHMT's ability to plan and implement locally responsive health interventions(Masefield, Msosa and Grugel, 2020; KIT Royal Tropical Institute, 2024). Similarly in Ghana and Uganda, narrow decision-making space, hierarchical influence, and role confusion have affected DHMT's authority and performance (Heerdegen, Gerold, *et al.*, 2020; Bulthuis *et al.*, 2021).

These challenges not only compromise DHMT's performance in district health service delivery but also derail progress towards Universal Health Coverage (UHC) and equitable health outcomes (Masefield, Msosa and Grugel, 2020; Jiménez-Rubio, 2022). Studies across SSA show that these challenges are not unique to one country but reflect broader systemic weaknesses in decentralized governance (Bonenberger *et al.*, 2015; Silva, 2016; Bosongo *et al.*, 2023).

DHMTs play a key role in translating national policy into local implementation at the district level. However, many DHMTs continue to experience systemic challenges as highlighted above, with serious implications for overall health system performance and population health outcomes (Bossert and Mitchell, 2011; Sapkota *et al.*, 2023).

Although these challenges are widely documented these in peer-reviewed and grey literature, there is little consolidated evidence on how decentralization has influenced performance of the DHMTs in managing and delivering health services (Bulthuis *et al.*, 2021; Sapkota *et al.*, 2023). This gap makes it dificult for policymakers, implementers, and partners to draw lessons and design targeted solutions.

This study aims to fill this gap by answering the question, **"How has decentralization influenced the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda?"** To organize the analysis, I will use the analytical framework of "Decentralization and Its Effect on District Health Services" developed by Regmi et al. (2010). The framework focuses on decentralization structure, processes, and effects on service delivery. By examining these dynamics, the study seeks to inform both policy and practice, ultimately strengthening DHMT functionality and improving health outcomes in decentralized health systems.

2.2. Study Objectives

2.2.1. Broad Objective

To synthesize evidence on how decentralization has influenced the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda, and to generate actionable recommendations for strengthening decentralized health systems.

2.2.2. Specific Objectives

1. To identify and critically analyze the key successes and persistent challenges affecting DHMT performance under decentralized health systems in Malawi, Ghana, and Uganda.

2. To examine how decentralization has shaped DHMT roles and performance in planning, resource management, supervision, and service management at the district level in Malawi, Ghana, and Uganda.

3. To explore how DHMT performance influences district health service delivery outcomes within decentralized governance frameworks in Malawi, Ghana, and Uganda.

4. To provide evidence-informed policy recommendations for improving DHMT functioning and enhancing service delivery outcomes under decentralized governance.

Chapter Three

3. Methodology and Analytical Framework

3.1. Study Type

This study adopts a structured literature review approach. It is guided by the analytical framework of "Decentralization and Its Effect on District Health Services" developed by Regmi et al. (2010) (Regmi *et al.*, 2010). The aim is to synthesize how decentralization has influenced the performance of the DHMTs in Malawi, Ghana, and Uganda. It draws on both peer-reviewed and grey literature.

3.2. Study Area

The three countries, Malawi, Ghana, and Uganda, were purposively selected because they are early adopters of decentralization reform in the health sector. Located in SSA, these countries share broadly similar contexts in terms of socio-political, economic, organizational, and governance arrangements. This renders them appropriate for a multi-country synthesis regarding the influence of decentralization on DHMTs performance in the decentralized health system (Bulthuis *et al.*, 2021, 2023). In addition, each country possesses comprehensive and higher-caliber policy evaluation and research about health sector decentralization. This provides strong evidence base. This enables an in-depth synthesis of structural, institutional, and contextual arrangements underpinning decentralization and how these influence the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda (Sumah and Baatiema, 2018; Chen *et al.*, 2021; Erixy Naluso and Isaac Kanyangale, 2024).

3.3. Search Strategy

I performed searches across various academic databases and search engines to discover key studies for this review. These included PubMed, Scopus, Web of Science, and Google Scholar. In addition, I explored relevant websites, such as those of the World Health Organization (WHO) and the World Bank. I also reviewed country-specific MoH portals for Malawi, Ghana, and Uganda to uncover grey literature and policy documents. Boolean operators (e.g., "AND," "OR") were used where supported, and the searches were adapted to each platform. Key concepts were grouped into thematic blocks aligned with the analytical framework: decentralization structure, DHMT processes, and effect on service delivery performance **(see Annex 1).**

Key Words: Decentralization, Authority, Responsibilities, Accountability, Resource allocation Service Management, Policy Development, Service Delivery, Service Performance, responsiveness.

3.4. Inclusion and Exclusion Criteria

In this study I have included both peer-reviewed and grey literature published in English between 2010 and 2024. The focus was on studies that investigated how decentralization influences DHMT performance in decentralized health settings. Priority was given to studies from Malawi,

Ghana, and Uganda. To provide broader context, I also considered literature from other African regions and international sources.

The search was guided by the analytical framework, which focuses on the three domains, namely, Decentralization structure, Processes, and Effect on Service Delivery. Note that a few earlier studies were also included solely to provide historical or contextual background.

I excluded studies that did not examine the influence of decentralization on DHMT performance. I also excluded those that did not address the three main domains of the analytical framework. Also, research not focused on Malawi, Ghana, and Uganda; publications released outside the 2010-2024 period; and studies not published in English were excluded.

3.5. Analytical Framework

In this study I have used the analytical framework of *Decentralization and Its Effect on District Health Services* developed by Regmi et al. (2010) (Regmi *et al.*, 2010). I did select this framework because of its comprehensive approach to understanding the decentralization and district health service delivery. The frame has three domains, namely, Decentralization, Processes, and Effects.

1. **Decentralization**, which involves the transfer of authority, roles, responsibilities, and resources from the central to district level.

2. **Processes** refer to the core health functions of the DHMT, such as policy development, service management, and service delivery.

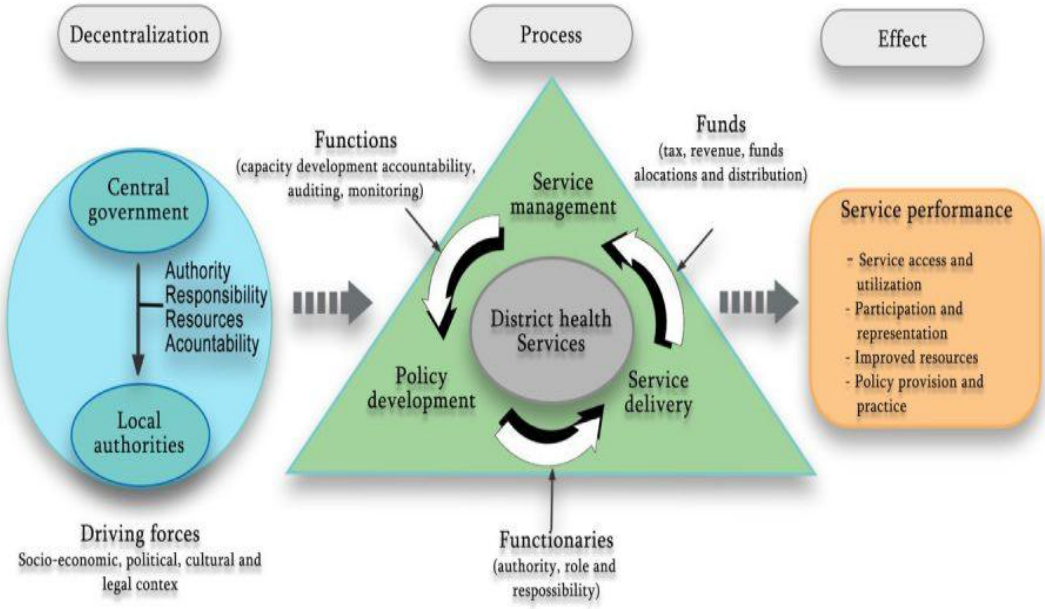
3. **Effects on Service Delivery Performance**, capturing outcomes of structural and process changes on health services.

These three domains are unidirectional and sequentially linked. Decentralization structures create an enabling environment and decision space for DHMTs. This, in turn, shapes how district-level processes are carried out, influencing DHMT performance. Ultimately, this influences service delivery outcomes.

This framework has guided the literature search and structuring of the results section across these domains. It is particularly suitable for exploring how decentralization has influenced the performance of the DHMTs in decentralized health systems.

By using this framework, the study synthesizes evidence on how decentralization has influenced the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda. It also draws on experience and lessons learned to generate evidence-informed and actionable recommendations for strengthening decentralized health systems.

Figure 3: Conceptual Framework of Decentralization and Its Effect on District Health Services



Source: Regmi et al. 2010(Regmi *et al.*, 2010).

3.6. Methodology Limitations

This literature review methodology has got some limitations. First, selection and language biases may have excluded other equally relevant studies. Second, focusing on only three countries limits the generalizability of the study findings. This is because each country's unique context may not reflect broader SSA realities. Third, by relying solely on published literature, I may have missed recent developments and policy changes. To address these methodological limitations, I used a transparent search strategy with clear inclusion and exclusion criteria. I also supplemented database searches with manual searching, including snowballing the reference lists. The English language restriction is acknowledged, and future scholars are encouraged to include local languages.

Chapter Four

4. Study Results

The results of this study are organized according to the three domains of the conceptual framework; **Decentralization**, **Processes**, and **Effects on Service Delivery Performance.** Within each domain, findings are synthesized thematically to address research objectives, drawing evidence from Malawi, Ghana, and Uganda. The analysis integrates insights across these countries to highlight how decentralization has shaped the performance of DHMTs in health service delivery. Where available, country-specific examples and relevant data are used to illustrate broader patterns and contextual experiences.

4.1. Decentralization (Structure)

4.1.1. Devolved Functions (Authority, Responsibilities, Resources, and Accountability)

Malawi

Malawi's decentralization policy was first approved in 1998 and became operational in 2004 following the devolution of several functions to District Councils (DCs). The goal was to enhance democratic local governance and improve public service delivery ('Malawi Decentralization Policy 1998', 1998; 'Malawi National Decentralization Policy (Second Edition, 2024)', 2024). In the health sector, the MoH devolved planning, budgeting, and monitoring responsibilities, particularly around Operational Recurrent Transactions (ORT), to the DCs and DHMTs to enhance service delivery (Ministry of Health and Population, Government of Malawi, 2018). DHMTs are mandated to lead district health planning and coordinate service delivery, supported by structures like Health Centre management committees (HCMCs) and Health and Environment Committees (HECs), which enhance accountability and community engagement (Lodenstein *et al.*, 2019; Erixy Naluso and Isaac Kanyangale, 2024).

Despite these reforms, there are still constraints on actual decision-making. Key aspects such as recruitment, salary payments, and approval of major expenditures remain under the central control (UNICEF Malawi, 2022). A significant share of the funding received at the district is tied to centrally defined priorities, restricting DHMT's ability to respond to local needs (Rodríguez *et al.*, 2023). Efforts to revise the resource allocation formula (RAF) in 2019 aimed to improve equity in resource distribution, but implementation remains incomplete (McGuire *et al.*, 2020; Government of Malawi, Ministry of Health, 2023).

Ghana

Ghana's decentralization process began in the late 1980s and was formalized through the LGA of 1993 (repealed and replaced by the LGA of 2016) and the 1992 Constitution (Government of Ghana, 2016). These reforms aimed to improve service delivery, local accountability, and participatory development planning (Agyepong, 1999; Government of Ghana, 2016). In the health sector, decentralization was operationalized through the Ghana Health Services and Teaching Hospital Act of 1996, which created the GHS as a semi-independent agency tasked with overseeing health services provision (Government of Ghana, 1996). Under this arrangement, the

DHMTs are mandated to plan, coordinate, and monitor health services at the district level (Abimbola, Baatiema and Bigdeli, 2019).

However, the operationalization of health system decentralization has been uneven due to overlapping mandates between Metropolitan, Municipal, and District Assemblies (MMADs) and GHS regional directorates, leading to fragmented decision-making (Kwamie *et al.*, 2016). Although districts undertake planning and budgeting, their financial autonomy is restricted by centrally imposed budget limits and delays in fund releases (Ayim, Agyepong and Enyimayew, 2023). Control over HR functions such as recruitment and staff deployment remains centralized with the Public Service Commission and GHS headquarters. This limits the ability of DHMTs to address local staffing needs. Although structural reforms were initiated in the 1990s, full decentralization of financial and human resources control has not been fully realized (Government of Ghana, 2016; Sumah and Baatiema, 2018; Ayim, Agyepong and Enyimayew, 2023; Exemplars in Global Health, 2024).

Uganda

Uganda introduced decentralization reforms through the 1995 Constitution and the LGA of 1997. These frameworks granted local governments responsibility for managing service delivery, including health planning, budgeting, and implementation (Government of Uganda, 1995, 1997). Decentralization in the sector was operationalized primarily in the early 2000s through the Sector-Wide Approach (SWAp). Through this mechanism, donor funding was consolidated to support district-led execution of national health priorities and service delivery mandates (Cruz, Valeria Oliveira *et al.*, 2006).

DHMTs, led by the DHOs, are responsible for overseeing and coordinating all health-related activities at the district level (Tetui *et al.*, 2016). Despite having formal authority, DHMTs operate under structural constraints, including top-down budget ceilings and regular funding delays. Key HR functions, such as hiring, payroll, and deployment, remain centralized, limiting DHMT ability to manage their workforce in line with districts needs. Moreover, donor-driven vertical programs often dominate the planning processes, making it difficult for DHMTs to align plans with locally defined health priorities (Bulthuis *et al.*, 2021; Mansour *et al.*, 2022).

While formal legal provisions through frameworks exist in all three countries, the actual autonomy of the DHMTs remains constrained in practice due to persistent central control over key resources and decision-making processes (Government of Uganda, 1997; Bulthuis *et al.*, 2021; Mansour *et al.*, 2022).

Summary Table 1: Successes and Challenges with Devolution of Functions in Malawi, Ghana, and Uganda

Country	Successes	Challenges
Malawi	DHMTs formally assigned roles in planning, budgeting, and coordination. ORT devolved to the district level. Community structures support local accountability.	Central control is retained over recruitment, salaries, and key expenditures. Most funding is tied to central priorities. RAF revision not completed
Ghana	Legal framework mandates decentralization of planning, coordination, and service management. Traditional leaders contribute to community engagement and local service accountability.	Centrally imposed budget ceilings limit accountability. Delays in funding disbursements. Limited financial autonomy by DHMTs
Uganda	Local governments legally assigned health services responsibilities, including coordination. SWAp supported district-level planning.	Limited fiscal space for local authorities. Top-down budget ceilings and funding delays. Donor vertical programming dominates district planning.

4.1.2. Driving Forces Behind Decentralization

Socio-economic Drivers

Across the three countries, decentralization was adopted as a strategy to address service delivery gaps, enhance local accountability, and improve efficiency of public sector spending. In both Malawi and Uganda, decentralization was driven in part by the goal of improving access to essential services. The approach particularly targets delivery of health care services to underserved and remote populations. The rationale behind these reforms was that local governments, due to their proximity to the communities, would be better placed to identify local needs and respond through more tailored service delivery (Government of Uganda, 1997; UNICEF Malawi, 2022).

In Ghana, decentralization advanced alongside wider fiscal and administrative reforms introduced during the Structural Adjustment Program (SAP) era. Rising fiscal pressure and efforts to improve the efficiency of public spending contributed to the transfers of planning and budgeting functions to the districts. However, despite these changes, local governments still faced significant limitations in financial autonomy (Bossert, 2002; Ayim, Agyepong and Enyimayew, 2023). Similarly, Uganda's SWAp was a donor-backed strategy aimed at enhancing the efficiency of resource allocation. It sought to empower districts to take a leading role in planning and coordinating service delivery using pooled funds (Cruz, Valeria Oliveira *et al.*, 2006).

Development partners also played a critical role in advancing decentralization. International donors and development agencies supported decentralization reform as one way of promoting good governance and health systems strengthening (Cruz, Valeria Oliveira *et al.*, 2006; Sharma *et al.*, 2024).

Political Drivers

Political transitions and democratization movements were equally influential in shaping decentralization trajectories. In Ghana, the return to multiparty democracy in 1992 and the subsequent 1993 LGA marked a deliberate shift toward devolving power and enhancing local participation (Government of Ghana, 2016). Similarly, Malawi's transition from one-party rule in 1994 laid the foundation for decentralization reforms formalized through the 1998 National Decentralization Policy and LGA ('Malawi Decentralization Policy 1998', 1998). In Uganda, the 1995 Constitution and the 1997 LGA institutionalized decentralization as a key mechanism for participatory governance and post-conflict state-building (Government of Uganda, 1995, 1997).

In all three countries, decentralization also served as a political function by helping central governments legitimize their authority and manage public expectations. In Uganda, for instance, it was used strategically to rebuild trust in state institutions, especially in post-conflict northern districts (Mansour *et al.*, 2022). In Malawi, decentralization helped to reconfigure accountability relationships by transferring certain service delivery responsibilities to local authorities, though central control remained dominant (Ministry of Health and Population, Government of Malawi, 2018; Lodenstein *et al.*, 2019; UNICEF Malawi, 2022).

Cultural Drivers

In Malawi, the establishment of local governance structures such as Health Centre Management Committees (HCMCs), Health and Environment Committees (HECs), and Area Development Committees (ADCs) was established to foster grassroots participation and accountability in health planning and service delivery (Evelyn Udedi, 2021; Ministry of Health, Government of the Republic of Malawi, 2023). However, the effectiveness of these committees varies across the districts. While some actively visit health facilities and mediate between providers and users, others are inactive due to limited training, unclear mandates, and insufficient institutional support (Butler *et al.*, 2020).

In Ghana, traditional authorities like chiefs have an important effect on community engagement with DHMTs. They act as gatekeepers who mobilize communities and lend legitimacy to health initiatives (Annobil, Dakyaga and Sillim, 2021). Formal community structures such as Community Health Management Committees (CHMCs), Health Committees (HCs), and Unit Committees (UC) serve as links between DHMTs and the local population. They contribute to resource mobilization and accountability. These structures, however, face challenges related to limited capacity, vague mandates, and a lack of logistical or financial support to carry out their mandates (Kweku *et al.*, 2020; Agalga, Alatinga and Abiiro, 2022).

Similarly in Uganda, local councils and Village Health Teams (VHTs) have historically enabled community participation. The VHTs play an important role in health promotion, disease surveillance, and community mobilization. Their effectiveness, though, is inconsistent due to lack of training, inadequate supervision, and poor logistical support (Mays *et al.*, 2017).

Legal Drivers

In Malawi, the 1998 LGA provided the legal foundation for devolution of key sectors, including health, to District Councils ('Malawi Decentralization Policy 1998', 1998). However, in practice, the health sector remains governed by sector-specific policies and MoH guidelines that maintain dual reporting lines. Consequently, many DHMTs continue to report directly to MoH. Moreover, despite the legal reforms, full fiscal autonomy and decision-making authority in the districts are

yet to be fully realized (Jagero, Nelson; Kwandayi, Hardson H.; Longwe, Annie, 2014; World Bank, 2025).

In Ghana, the decentralization mandate is rooted in the 1992 Constitution and the LGA of 1993 and 2016. These legal frameworks establish the authority of District Assemblies (DAs) over development planning and service delivery (Government of Ghana, 2016). The GHS and the Teaching Hospital Act of 1996 further create a semi-autonomous structure to oversee health service delivery (Government of Ghana, 1996). Nevertheless, DHMTs operate within a complex network of reporting relationships involving GHS, MMDAs, and regional coordinating bodies. These overlapping mandates contribute to fragmented accountability and affect local decision-making (Ayim, Agyepong and Enyimayew, 2023).

Uganda has one of the most legally recognized decentralization frameworks. The 1995 Constitution and the 1997 LGA comprehensively assign powers and responsibilities to local governments. This includes control over health service delivery (Government of Uganda, 1995, 1997). Nevertheless, recent policy reversals, such as the recentralization of health worker recruitment and payroll management, have diluted the decentralization efforts (Mansour *et al.*, 2022).

Summary Table 2: Successes and Challenges of Decentralization Drivers in Malawi, Ghana, and Uganda

Driver	Successes	Challenges
Socio-economic	Increased responsiveness of health services to local needs (e.g., Malawi and Uganda). Enhanced planning coordination through donor-supported pooled funds (e.g., Uganda's SWAp).	Limited fiscal autonomy at the district level. Inadequate technical capacity for effective budgeting and planning. Heavy reliance on external funding affecting sustainability.
Political	Improved state citizenry trust in post-conflict areas through localized governance (Uganda). Reconfiguration of accountability relationships by transferring certain service delivery responsibilities to local authorities (Malawi).	Central control over key functions such as HR and funds. Fragmented authority due to dual reporting. Policy reversals undermine decentralization efforts and gains.
Cultural	Community mobilization strengthened by traditional leaders (Ghana). Grassroot structures (VHTs, HCMCs) have facilitated health promotion and community dialogues.	Inactive committees due to unclear mandates and poor support (training, logistics, and financial). Uneven participation across districts.
Legal	Strong statutory backing in Uganda, with clear local authority for health service delivery.	Legal decentralization is not fully operationalized as central ministries retains influence over key decisions (Malawi and Ghana). Overlapping institutional mandates lead to weak accountability and confusion. Erosion of local powers through recent policy shifts (recentralization).

4.2. Decentralization Processes

4.2.1. Policy Development

DHMTs in Malawi, Ghana, and Uganda are formally mandated to translate national health policies into operational district plans. However, their capacity to set priorities and engage in evidence-based planning is influenced by how decentralization has been structured and implemented in each country (Kwamie *et al.*, 2016; Ministry of Health and Population, Government of Malawi, 2018; Bulthuis *et al.*, 2021).

In all three countries, MoH retains the primary responsibility for policy formulation. They develop overarching frameworks such as Malawi's Health Sector Strategic Plan III (HSSP III), Ghana's Health Sector Medium Term Development Plans (MTDPs), and Uganda's Health Sector Development Plans (HSDPs). These align with broader development agendas, such as Ghana's Agenda 111, Malawi's Vision 2063, and Uganda's Vision 2040. They also guide district-level implementation towards UHC through district-level plans, namely, District Health Implementation Plans (DHIPs) in Malawi, District Annual Health Work Plans (DAHWPs) in Uganda, and Annual Action Plans (AAPs) in Ghana (Ministry of Health, Uganda, 2021; Government of the Republic of Malawi, Ministry of Health, 2022; Ministry of Health, Republic of Ghana, 2022). Policy dissemination generally follows structured mechanisms, including circulars, technical guidelines, and national or regional planning meetings, which aids in communication (Ministry of Health, Uganda, 2021; Ghana Health Service, 2023).

However, policy formulation remains largely top-down across the three nations, presenting a significant challenge. Limited DHMT involvement in defining priorities, meaning they receive national targets only during annual planning meetings, which severely restricts their ability to adapt plans to local contexts (Kwamie *et al.*, 2016; Bulthuis *et al.*, 2021). This top-down approach also manifests as planning exercises are constrained by short timelines (sometimes less than two weeks). Equally, district targets and budget ceilings are centrally determined, which offer little room to incorporate community-specific needs (Henriksson *et al.*, 2019; Ayim, Agyepong and Enyimayew, 2023). In Ghana, for instance, DHMTs have reported that budget ceilings and planning instructions are often given after priorities have been centrally predetermined, leaving little or no room for local stakeholder consultations (Ayim, Agyepong and Enyimayew, 2023). Furthermore, despite decentralization's intent to increase local planning autonomy, DHMTs still have limited influence over national targets and minimal discretion to modify plans in response to district-specific realities (Henriksson *et al.*, 2019; Ayim, Agyepong and Enyimayew, 2023; Rodríguez *et al.*, 2023). In Uganda, the central government sets annual targets for antenatal care coverage, even in districts where there is a shortage of health care workers. Delays in policy dissemination, inadequate staffing, and weak technical capacity in planning further restrict the DHMTs' ability to adapt policies effectively at the district level (Chen *et al.*, 2021).

Despite these prevalent problems, some districts have engaged meaningfully, demonstrating areas of success. In Malawi, some DHMTs reported greater ownership of planning processes following the introduction of integrated supportive supervision (ISS), which encourages data-driven target setting and local performance reviews (Rogers *et al.*, 2024). In Uganda, DHMTs that have participated in the "One Plan" initiative harmonizing reproductive, maternal, newborn, child, and adolescent health (RMNCAH) planning reported improved coordination across stakeholders and clear alignment with district priorities (Ministry of Health, Uganda, 2024). Donor and partner engagement also plays a supportive role in some districts. In Malawi and Uganda, development partners provide technical assistance for data analysis and integration of disease-specific priorities into district plans, helping DHMTs meet deadlines and improve the quality of the plans (Henriksson *et al.*, 2019; Rogers *et al.*, 2024). However, the level of support

varies across the districts. In Ghana, DHMTs and MMDAs coordinate to align health plans with broader local development frameworks. Yet overlapping mandates between GHS and local governments often lead to fragmentation and weak intersectoral collaboration (Kwamie *et al.*, 2016). Highlighting an area that is simultaneously designed for success but faces persistent challenges.

Summary Table 3: Successes and Challenges in Policy Development in Malawi, Ghana, and Uganda

Theme	Successes (+)	Challenges (-)	Example
National Policy Frameworks	Comprehensive strategic plans guide district health priorities and planning.	National MoHs retain strong control limiting .	Malawi (HSSP III) Ghana (MTDPs) Uganda (HSDPs)
Policy Dissemination	Structured communication via circulars, guidelines, and planning meetings.	Late, top-down policy communication limits DHMTs ability to adapt plans locally.	All three countries
Planning Timelines and Flexibility	Some local ownership is encouraged through initiatives like ISS One Plan.	Short planning timelines, centrally set targets, and budget ceilings restrict flexibility.	Malawi(+ISS), Uganda (+One Plan), Ghana (Budget ceilings imposed late)
Partner Support	Donor/partner technical assistance improves planning quality and data use	Support varies per district, reliance on doners create inconsistency.	Malawi Uganda (+), Ghana (fragmented support)
Coordination and Collaboration	Efforts made to align DHMTs with local governments planning structures.	Overlapping mandates cause fragmentation and weak intersectoral coordination.	Ghana (GHS vs MMDAs)
Local Decision Space & Adaptation	Increased ownership reported where supervision and coordination improve.	Limited discretion to modify centrally set targets; staffing and capacity shortages.	Uganda (fixed ANC targets)

4.2.2. Service Management

DHMTs in Malawi, Ghana, and Uganda are formally mandated to coordinate and manage the delivery of health services at the district level (Ministry of Health, Republic of Uganda, 2015; Government of the Republic of Malawi, Ministry of Health, 2022; Ghana Health Service, 2023). Their core responsibilities include the development and implementation of annual district health plans, supervising health facilities, and ensuring service delivery is aligned with national guidelines and priorities (Heerdegen, Gerold, *et al.*, 2020; Ministry of Health, Republic of Uganda, 2020). Consistent with decentralization policy, DHMTs are also expected to collaborate with a broad set of stakeholders, including faith-based organizations (FBOs) such as the Christian Health Association of Malawi (CHAM) and the Uganda Catholic Medical Bureau (UCMB), as well as Non-Governmental Organizations (NGOs) and local government structures. This collaboration helps extend service access and coverage to rural and underserved areas (Ministry of Health and Population, Government of Malawi, 2018; Ministry of Health, Uganda, 2024).

Despite their mandate, coordination between DHMTs and local government institutions such as District Councils in Malawi, District Assemblies in Ghana, and District Local Governments in Uganda remains inconsistent. In Malawi, although DHMTs operate under the District Council, they are often excluded from key budgeting and decision-making platforms, resulting in parallel planning processes and weak alignment between health and broader development priorities (Kasambara *et al.*, 2017; Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). A similar challenge is observed in Ghana, where DHMT plans are frequently under-integrated into composite district plans led by MMDAs, weakening cohesion and resource allocation (Kwamie, Dijk and Agyepong, 2014; Kwamie *et al.*, 2016). Uganda faces additional complexity with misaligned planning cycles and funding streams between DHMT and the District Technical Planning Committees (Henriksson *et al.*, 2017).

Nonetheless, some districts demonstrate positive examples of effective collaboration. For example, integrated planning meetings in Uganda's Arua District have reportedly improved alignment between health priorities and district development plans (Ministry of Health, Uganda, 2024). In Malawi, stakeholder engagement platforms such as the District Executive Committee (DEC) have, in certain districts, enabled joint review and co-financing of health interventions, particularly with CHAM and local NGOs (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021).

Supportive supervision remains a core DHMT function and includes facility visits and mentorship aimed at ensuring adherence to service delivery standards. However, supervision activities are irregular due to insufficient operational funding and logistical challenges (Henriksson *et al.*, 2017; Avortri, Nabukalu and Nabyonga-Orem, 2019; Ministry of Health, Republic of Uganda, 2020)(86,91). In Malawi, delayed ORT disbursements in some districts resulted in cancellation of supervision visits and left some facilities unmonitored (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). In Ghana, donor reliance to finance supervision raises questions about the sustainability and local ownership (Aikins *et al.*, 2013).

DHMTs in all three nations also confront major challenges when it comes to human resource management. Although responsible for staff coordination, DHMTs have limited authority regarding recruitment, deployment, and retention, as these powers reside with central or regional authorities (Kwamie *et al.*, 2016; Henriksson *et al.*, 2019; Heerdegen, Gerold, *et al.*, 2020). For example, in Ghana, DHMTs rely on GHS for staff movement approvals, causing delays that disrupt service continuity and complicate local planning (Heerdegen, Aikins, *et al.*, 2020). Similar issues prevail in Uganda, where DHMTs lack autonomy to hire and reassign staff even to urgent service delivery gaps (Henriksson *et al.*, 2017). In Malawi, despite LGA

responsibility for staffing, key decisions such as deployment and promotion remain under the central MoH, resulting in confusion and weakened district responsiveness (Kasambara *et al.*, 2017; Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021).

To strengthen performance management, Malawi, Ghana, and Uganda have adopted systems like the District Health Information Systems 2 (DHIS2), performance review meetings, and results-based management frameworks (Adaletey *et al.*, 2015; Henriksson *et al.*, 2017; Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). In Malawi, DHMTs use DHIS2 data to monitor health indicators and guide decision-making (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). Ghana has introduced performance league tables and peer review mechanisms to motivate improvements in service delivery (Adaletey *et al.*, 2015; Ghana Health Service, 2023), while in Uganda, DHMTs use DHIS2 and "One Plan" scorecards for tracking progress and informing plans (Henriksson *et al.*, 2017). These tools help DHMTs to identify service delivery gaps and inform corrective action.

However, the effectiveness of these systems is compromised by poor data quality, irregular reporting, and limited analytical capacity at the district level (Odei-Lartey *et al.*, 2020). In Ghana, peer reviews and league tables are used; however, they often lack timely feedback and follow-up support (National Development Planning Commission (NDPC) & UNICEF, Ghana, 2023). In Uganda, although performance data is generated, DHMTs lack both authority and resources to act on the findings, reducing the impact of routine monitoring (Henriksson *et al.*, 2017).

Summary Table 4: Successes and Challenges with Service Management

Themes	Successes (+)	Challenges	Country Examples
Coordination with Local Government	Integrated planning meetings improving alignment with broader development plans.	Parallel planning, exclusion from key decision-making platforms.	Uganda (+ Arua district); Malawi, Ghana (under integration of plans
Stakeholder Collaboration	DEC platforms enable joint reviews and co-financing with NGOs and FBOs.	Coordination complicated by misaligned planning cycles and fragmented funding streams.	Malawi (+CHAM & NGOs) Uganda (UCMB)
Supportive supervision	Institutionalized as a core DHMT function, involving facility visits, mentorships, and quality assurance.	Irregular supervision due to insufficient operational funding, delayed disbursements, and logistical challenges	All countries Malawi (-delayed ORT) Ghana (Donor dependency)
Human Resources Management	DHMTs are responsible for staff coordination in the districts.	Limited authority over recruitment, deployment, and retention. Centralization delays staff movements and service continuity.	All countries (-centralized decisions)
Performance and Data Usage	Adoption of DHIS2, performance reviews, scorecards, and performance-based management frameworks supports monitoring.	Poor data quality, inconsistent reporting, limited analytical capacity, and weak follow reduce effectiveness.	All countries (+ DHIS2 usage); Ghana: delayed feedback, Uganda: Limited authority to act on the gaps

4.2.3. Service Delivery

DHMTs across Malawi, Ghana, and Uganda are responsible for ensuring effective delivery of essential health services at the district level, in alignment with national priorities and health strategies (Ministry of Health, Republic of Uganda, 2015; Government of the Republic of Malawi, Ministry of Health, 2022; Ghana Health Service, 2023). Service delivery is organized across three tiers: from community and primary levels up to district and referral care. These are guided by defined national health benefit packages or minimum service standards (Ministry of Health and Population, Government of Malawi, 2018; Ministry of Health, Uganda, 2021; Connolly *et al.*, 2024). Within these frameworks, DHMTs are mandated to coordinate facility operations, monitor quality of care, and ensure availability of essential services such as antenatal care, immunizations, and obstetric care (Heerdegen, Gerold, *et al.*, 2020; Ministry of Health, Uganda, 2024).

However, the functional effectiveness of DHMTs is constrained by limited authority and control over critical inputs. These include staffing, infrastructure, and supply chains, which mostly are managed centrally or through vertical programs. Thereby reducing DHMT's discretion in local service challenges (Henriksson *et al.*, 2017; Awoonor-Williams and Phillips, 2022). For instance, in Ghana, DHMTs coordinate health services but rarely control deployment of HR and supply chain management, limiting their responsiveness to district-specific needs (Kwamie *et al.*, 2016). Equally in Uganda, DHMTs support district service delivery; resource constraints and managerial challenges impact workforce motivation and operational effectiveness (Henriksson *et al.*, 2017).Nevertheless, district-level innovations such as engagements with VHTs in Uganda's Arua district have improved outreach in remote areas by mobilizing community resources for locally adapted outreach services (UNICEF Uganda, 2020).

In Ghana, CPHS is designed to enhance community-level service delivery, yet DHMT reported a significant number of supervisory visits were cancelled in Northern Ghana in 2021 due to budget and vehicle constraints (Aikins *et al.*, 2013). However, peer monitoring mechanisms in selected municipalities tracked staff attendance. As a result, improved supervision and strengthened accountability processes (Martineau *et al.*, 2018). This scenario illustrates how localized management strategies can partially mitigate structural challenges.

Malawi's HBPs mandate comprehensive service entitlements. However, fragmented financing and resource flows across multiple channels significantly impact health service delivery. This complicates coordination and affects operational efficiency (Mchenga *et al.*, 2022; Connolly *et al.*, 2024).For example, while ORT funds are channelled through the DCs, drug budgets are centrally controlled, except for the smaller, devolved portion (10%). This impairs coherent resource management (Mchenga *et al.*, 2022; UNICEF Malawi, 2023). A 2023 MoH reported significant infrastructure deficits, with nearly 50% of facilities lacking reliable water or electricity. While over 60% of the health centres experienced drug stockouts for consecutive quarters (Ministry of Health, 2024). Despite these challenges, districts like Salima have demonstrated progress through donor-supported initiatives. The initiative emphasized data quality improvements and integrated quality reviews into annual planning, a positive step towards sustained oversight of drug and supply shortages (Kassim Kwalamasa, 2017).

Referral systems exemplify the ongoing gap between DHMT mandates and limited resource control. Although DHMTs coordinate referral networks and integrated service delivery, their lack of authority over key resources severely affects continuity of care (Henriksson *et al.*, 2017; Heerdegen, Gerold, *et al.*, 2020; Bulthuis *et al.*, 2021). In Ghana, referral care funding is mediated through the National Health Insurance Scheme (NHIS), which suffers from rigid reimbursement processes and delays. About 46% of clinical claims in the southern zone went unpaid, with

delays between one and four months. This resulted in facility operations being disrupted(83,104). Malawi similarly faces erratic ORT disbursements, limiting district capacity to sustain facility operations and outreach services (Kasambara *et al.*, 2017; Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). Inadequate transport logistics, poor road networks, and substandard facility infrastructure further burden Uganda's referral system. Approximately 30% of the health facilities lack essential medical equipment, and 40% are operating under poor conditions, complicating patient referral and care (Ministry of Health, Uganda, 2021, 2024; Rodríguez *et al.*, 2023).

These systemic constraints underscore a paradox within the decentralization reforms. Despite empowering DHMTs as critical actors for local service delivery, their restricted autonomy over human, financial, and logistical resources reflects recentralization tendencies that limit responsiveness to district health needs (Kwamie *et al.*, 2016; Bulthuis *et al.*, 2021). Despite these systemic challenges, some DHMTs have demonstrated innovative practices and collaborative efforts to ensure service continuity. These innovations include peer monitoring, data-driven planning, and use of community structures (Martineau *et al.*, 2018; Raven *et al.*, 2024).

Summary Table 5: Successes and Challenges under Service Delivery

Themes	Successes	Challenges	Country Examples
Service Delivery Organization	DHMTs coordinate essential services based on national guidelines and defined benefit packages.	Limited control over staff, infrastructure, and supplies.	All countries
Human Resources Management	DHMTs manage staff coordination and support workforce motivation where possible.	Lack of authority over recruitment and deployment delays workforce actions.	Ghana: DHMTs do not control HR deployment. Uganda: Staff motivation affected by limits.
Supply Chain and Infrastructure	Some districts improve supply oversight through data and quality initiatives.	Centralized budgets, frequent stockouts, and poor infrastructure hinder service delivery.	Malawi: Over 60% of facilities had drug stockouts, while 50% lacked water or electricity.
Supportive Supervision and Quality	Peer monitoring and local innovations improve staff attendance and supervision quality.	Budget and logistical challenges lead to frequent cancellation of supervisory visits.	Ghana: supervision visit cancellation. Uganda: VHTs improved outreach services.
Referral System Coordination	DHMTs coordinate referrals across care levels.	Poor transport, infrastructure, equipment shortages, and funding delays disrupt referrals.	Ghana: NHIS 46% claims unpaid. Uganda: Poor roads and equipment shortages
Innovations in Service Delivery	Using community health teams, peer monitoring, and data-driven planning enhances services.	Resource limits restrict scaling up and sustainability of innovations	Uganda: VHTs in Arua mobilized outreach. Ghana: peer monitoring improved accountability

4.3. Effect on Service Delivery

4.3.1. Service Access and Utilization

DHMTs in Malawi, Ghana, and Uganda are key in expanding health service access and utilization under decentralized health systems. They are tasked with outreach services coordination, health facility-level supportive supervision, and fostering partnerships ((Kwamie *et al.*, 2016; Henriksson *et al.*, 2017; Ministry of Health, Republic of Ghana, 2022).

DHMTs have leveraged multisectoral partnerships involving FBOs and private providers to expand maternal and child health (MCH) and general service coverage. For instance, in Malawi, coordination with facilities via Service Level Agreements (SLAs) supports outreach in underserved areas, enhancing free access to essential services (Ministry of Health and Population, Government of Malawi, 2018; Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). Similarly, in Uganda, DHMTs do collaborate with UCMB and other Civil Society Organizations (CSOs) to extend services. They do also mobilize Village Health Teams (VHTs) for health education and community referrals (Henriksson *et al.*, 2017; Musinguzi *et al.*, 2017; Institute for Reproductive Health (IRH), 2020), while Ghana's Community-based Health Planning and Services (CPHS) integrates private and FBO providers in district planning (Heerdegen, Gerold, *et al.*, 2020; Adusei *et al.*, 2024).

Following the aforementioned efforts, between 2019 and 2023, Malawi saw skilled birth attendants rise from 90% to 94%, with districts conducting intensive outreaches performing above average (Ministry of Health, 2024; National Statistical Office [Malawi] and ICF, 2024). Ghana improved full immunization coverage for under ones from 85.6% in 2019 to 91.4% in 2022 (Ghana Health Service, 2023). Uganda had facility-based deliveries increase from 70% in 2016 to 80% in 2022 (Ministry of Health, Uganda, 2024).

These trends coincide with increased deployment of community health workers. In Malawi and Uganda, DHMTs use Health Surveillance Assistants (HSAs) and VHTs, respectively, for health education and referrals (Musinguzi *et al.*, 2017; Institute for Reproductive Health (IRH), 2020). Ghana's CPHS initiative also enabled expanded community outreach, particularly in rural areas, by deploying Community Health Officers (CHOs) to deliver essential MCH services closer to households (Ghana Health Service, 2023; Koyaara *et al.*, 2024). These outreach services integrate services such as antenatal care, immunizations, and Malaria screening to maximize use of limited human resources (World Health Organization. Malawi Country Office, 2022; Alban *et al.*, 2023).

However, the extent of service improvements varies significantly across districts. Gains are linked to leadership strength, resource availability, and health worker distribution. These contextual differences influence both frequency and quality of outreach services and contribute to uneven uptake of services across regions (Heerdegen, Gerold, *et al.*, 2020; Adusei *et al.*, 2024). For instance, rural hard-to-reach areas experience more drug stockouts, infrastructural limitations, and health workforce shortages. These factors constrain DHMT's efforts in ensuring improved service access and coverage in underserved areas (Kasambara *et al.*, 2017; World Health Organization (WHO), 2024).

4.3.2. Participation and Representation

Participation and representation are core principles of decentralized health governance, and DHMTs are expected to promote inclusive engagements in the health planning, delivery, and monitoring. Across the three countries, Malawi, Ghana, and Uganda, various community structures such as Health Unit Management Committees (HUMCs), Village Health Teams (VHTs), Health Centre Management Committees (HCMCs), Community Health Management Committees (CHMCs), and local councils facilitate two-way dialogue between communities and DHMTs (Musinguzi *et al.*, 2017; Lodenstein *et al.*, 2019; Ministry of Health, Government of the Republic of Malawi, 2023).

These committees amplify community voices and drive grassroots participation in shaping health service delivery. They also enhance accountability by routinely relaying community health needs, concerns, and feedback to DHMTs. Importantly, they contribute to health planning by integrating locally identified priorities into district strategies (Lodenstein *et al.*, 2019; Ministry of Health, Government of the Republic of Malawi, 2023; Erixy Naluso and Isaac Kanyangale, 2024). These committees receive formal trainings and meet on a monthly or quarterly basis to discharge their duties, with members serving on a voluntary basis (Musinguzi *et al.*, 2017; Lodenstein *et al.*, 2019; Ministry of Health, Government of the Republic of Malawi, 2023). In Uganda, DHMTs engage VHTs, HUMCs, and local councils to gather feedback and strengthen community participation (Tetui *et al.*, 2016; Uganda Ministry of Health, 2024).

In Uganda, VHTs are particularly active in health education, home visits, and referrals. HUMCs also participate in facility oversight, although their roles vary depending on orientation and local support. In practice, participation is constrained by inconsistent committee functionality, unclear role definitions, and lack of operational support, challenges that limit responsiveness to local needs (Kimbugwe *et al.*, 2014; Mays *et al.*, 2017).

The CPHS strategy in Ghana emphasizes community involvement through CHMCs and traditional leaders. In high-performing districts, these structures support planning and service delivery, helping to raise community ownership (Awoonor-Williams, Phillips and Bawah, 2016; Ankomah, Fusheini and Derrett, 2024). However, several barriers hinder participation and involvement, such as inadequate training, unclear mandates, resource gaps, and limited coordination with DHMTs (Agalga, Alatinga and Abiiro, 2022; Bawontuo *et al.*, 2022). In some instances, political interference has also weakened local accountability mechanisms and diluted community representation (Debrah, 2016).

In Malawi, there is also emphasis through the policy frameworks that DHMTs work with various community structures such as CHMCs, HEC, and ADCs to incorporate community feedback into annual plans (L. Van Niekerk *et al.*, 2023). The platforms have helped in improved collaboration with traditional leaders and civil society, helping align district service priorities with community needs (Government of the Republic of Malawi, Ministry of Health, 2022; Ministry of Health, Government of the Republic of Malawi, 2023). However, effectiveness varies widely: some committees remain inactive due to weak capacity, lack of resources, and poor information flow, undermining community voices and local accountability (Lodenstein *et al.*, 2019). Also, issues of tokenistic involvement limit DHMTs engagements with local structures (Masefield *et al.*, 2021).

Nevertheless, despite these limitations, there is evidence that robust community participation contributes to improved service acceptability and responsiveness (Stephen Jones, Andrew Kardan, Maja Jakobsen, Serufusa Sekidde, 2013; L. Van Niekerk *et al.*, 2023). For example, districts with functional community structures have reported improved feedback mechanisms. This has helped in strengthening trust between communities and health providers and the provision of more tailored health interventions that respond to local priorities (George *et al.*, 2015; Lindi Van Niekerk *et al.*, 2023).

4.3.3. Improved Resources for Service Delivery

DHMTs are mandated to mobilize and manage resources for delivering health services in the district. These include HR, operational funds, infrastructure, medical equipment, and medicines and supplies (Ministry of Health and Population, Government of Malawi, 2018; Ghana Health Service, 2023; Ministry of Health, Uganda, 2024). However, in a decentralized health setting, their effectiveness in managing these resources depends on the authority, timely transfers, and the availability of complementary resources from partners and other stakeholders (Bulthuis *et al.*, 2021).

In Malawi, DHMTs rely on government allocations and donor-supported mechanisms such as the Health Services Joint Fund (HSJF) to finance operational and service delivery activities (Government of Malawi, Ministry of Health, 2023). In recent years, districts have benefited from increased resource flows through the decentralization of development budgets, including targeted funding for hospital rehabilitation and a dedicated 10% of drug budget allocation to improve local availability of essential medicines (Malawi Health Equity Network (MHEN); ActionAid Malawi, 2023; UNICEF Malawi, 2023). Additionally, some districts have implemented local accountability tools such as quarterly reviews and commodity tracking systems, which have helped reduce supply chain disruptions (Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L., 2021). While decentralization in Malawi has aimed to improve resource availability and system responsiveness, widespread systemic challenges remain. Many facilities still lack reliable water, electricity, and medicines (Gondwe *et al.*, 2022; Government of the Republic of Malawi, Ministry of Health, 2022).

In Ghana, while national recruitment drives and incentive programs have improved human resources deployment in underserved areas, DHMTs lack full control over staff decisions, hindering effective workforce planning and management (Martineau *et al.*, 2023). Equally, government and development partners have increased the availability of CHPS compounds and equipment in several districts. However, challenges persist in maintaining infrastructure and equipment due to resource limitations, both financial and HR (Ayim, Agyepong and Enyimayew, 2023). Additionally, delays in NHIS reimbursements, sometimes exceeding six months, affect procurement and timely delivery of services (Dalinjong and Laar, 2012; Laar, Asare and Dalinjong, 2021).

Uganda has made similar gains in district-level resource availability. DHMTs have leveraged partnerships with faith-based and civil society organizations to extend service delivery in remote areas(Shumba *et al.*, 2017; Bäck *et al.*, 2025). The upgrade of 190 health facilities between 2020 and 2024 has realized significant infrastructure investments. This has been achieved through collaboration with development partners (World Bank, 2023). However, the effective use of these investments is affected by weak capacity for maintenance systems in the districts due to high staff turnover and limited discretion over HR management. Only 50% of DHMTs report having the autonomy to influence staff deployment (Alonso-Garbayo *et al.*, 2017; Mansour *et al.*, 2022).

Overall, while decentralization has brought modest increases in resource availability, DHMTs remain constrained by delayed financial flows, centralized decision-making on HR issues, and weak autonomy over budgetary allocations. These limitations hinder their ability to respond to local needs and weaken service delivery performance, particularly in rural and underserved areas (Bulthuis *et al.*, 2021, 2022, 2023).

4.3.4. Policy Provision and Practice

Under decentralized healthcare systems, DHMTs are mandated to translate national health policies into local plans. Across Malawi, Ghana, and Uganda, this role involves aligning district-level implementation with national goals like UHC using instruments such as DAHWPs, DHIPs, and AAPs combined with service delivery guidelines and supervision tools (Ministry of Health, Uganda, 2021; Government of the Republic of Malawi, Ministry of Health, 2022; Ministry of Health, Republic of Ghana, 2022).

In practice, DHMTs' ability to domesticate policies depends heavily on their autonomy, resource control, and coordination with partners (Alonso-Garbayo *et al.*, 2017; Bulthuis *et al.*, 2021). In Malawi, DHMTs use the HSSP III's HBP and accompanying standard operating procedures (SOPs) to structure service provision around quality domains such as client safety, leadership, and people-centered care (Government of the Republic of Malawi, Ministry of Health, 2022). Ghana's CHPS serves as the operational community health strategy, while MTDPs guide district planning, while Uganda's "One Plan" approach and use of District Supervision, Monitoring, and Accountability Tools (DSMTs) are intended to enhance standards in service delivery (Ministry of Health, Republic of Ghana, 2016; Ministry of Health, Uganda, 2021).

Despite the availability of these frameworks, DHMTs across the three countries face common implementation challenges. These include limited flexibility to adapt policy priorities to local contexts, delayed or insufficient funding, and human resource shortages, particularly in technical cadres needed for monitoring, supervision, and service integration (Alonso-Garbayo *et al.*, 2017; Makwero, 2018). In Uganda and Ghana, fiscal ceilings and weak inter-sectoral coordination contribute to fragmented or partial policy implementation (Abimbola, Baatiema and Bigdeli, 2019; Rodríguez *et al.*, 2023). In Malawi, partner-driven vertical programming and inflexible funding streams have constrained the push toward integrated, people-centered models of care (Sakala *et al.*, 2022).

Ultimately, structural constraints in decision space and resource autonomy undermine the effectiveness of DHMTs in translating policy into practice. While some districts have demonstrated innovation in aligning plans with local health priorities, the limited operational flexibility undermines responsiveness and sustainability (Martineau *et al.*, 2018; Bulthuis *et al.*, 2023; Rodríguez *et al.*, 2023).

Summary Table 6: District Service Performance under Decentralized Health Systems

Themes	Successes	Challenges	Country Examples
Service Access and Utilization	DHMTs coordinate outreach and partnerships. Community health workers improve service reach. Increased MCH services uptake.	Rural areas face stockouts. Districts experience uneven service coverage.	Malawi: CHAM SLAs increase service access. Ghana: CHPS boosts immunization coverage.
Participation and Representation	Community committees engage in planning and feedback. Regular meetings and training strengthen roles.	Inconsistent committee activity. Limited resources and political interference. Tokenistic participation	Malawi: HCMCs and HECs. Ghana: CHMCs Uganda: VHTs
Improved Resources for Service Delivery	Increased funding and infrastructure investments. Partnerships extend services. Recruitment incentives improve staffing.	DHMT's control over budgets and HR is limited. Delays in funding. Poor maintenance and supply gaps	Malawi: HSJFs Ghana: NHIS reimbursement delays. Uganda: Facility upgrades amid HR shortages.
Policy Provision and Practice	District plans align with national policies. Utilization of monitoring and supervision tools. Some local adaptation of priorities.	Lack of flexibility in adapting policies. Staff shortages. Funding ceilings and weak coordination. Vertical programs limit integration.	All have localized plans and face autonomy limitations.

Chapter Five: Discussion

5.1. Introduction

The main objective of this study was to synthesize evidence on how decentralization has influenced the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda and to generate actionable recommendations for strengthening decentralized health systems. Rooted in Regmi et al.'s (2010) analytical framework, this review focused on how decentralization structures, district-level processes, and service delivery outcomes interconnect and influence each other.

5.2. Key findings

A central recurring theme throughout this study is the persistent gap between policy intent and practical reality. While decentralization reforms in Malawi, Ghana, and Uganda were designed to strengthen local governance, accountability, and responsiveness, the true decision-making power over finances and human resources remains centralized. DHMTs can develop plans and identify local priorities, but they have limited power over funding flows and staff management. This disconnect between what reforms promise and what is delivered on the ground is considerable and a big elephant in the room.

There have been notable and often isolated successes. For example, Malawi's improved maternal health outcomes through FBO partnerships, Uganda's VHT-driven outreach to remote communities, and increased immunization coverage in Ghana with strong community-based engagements. However, these examples are exceptions and often rely on donor support or strong local leadership and cannot be easily scaled up or sustained under current decentralized health systems. In the majority of the districts, persistent delays in operational funding, staff shortages, and weak infrastructure, especially in hard-to-reach areas, are commonplace.

What is perhaps most striking and surprising is how these systemic gaps and obstacles have repeated for decades even after several reform efforts. Many facilities still lack reliable water, electricity, and medicines. Community-level committees such as HCMCs or VHTs are inconsistently functional, often handicapped by underresourcing or unclear roles. This demonstrates that giving formal mandates alone to DHMTs without resources is not enough for transformation and achievement of the expected benefits of decentralization.

Furthermore, even though decentralization patterns appear similar across these three countries, their practical implementation varies due to a unique combination of structural arrangements and contextual challenges. In Malawi and Uganda, for instance, unclear reporting lines and retained central powers over resources persistently constrain DHMTs. In Ghana, overlapping responsibilities between GHS and district assemblies result in fragmented oversight and planning. In all cases, this fragmentation and ambiguity breed slow progress, duplication, and frustration among district health managers. In essence, reforms have often focused more on redefining roles and responsibilities than on transferring meaningful decision space and control.

5.3. Interlinkages Between Various Factors

Clear interconnectedness emerged between central resource retention, process bottlenecks, and service delivery challenges. When DHMTs lack autonomy over staff hiring and resource allocation, their ability to plan, supervise, and respond flexibly to local needs is severely limited. These process bottlenecks, in turn, impact service delivery outcomes, especially in underserved populations and hard-to-reach areas.

For example, while current interventions in Malawi and Uganda focus on expanding outreach through community structures, these often fail to address deeper underlying structural problems. These problems include fiscal dependency and top-down management. Ghana's expansion of community-based immunization has improved some indicators, but broader health outcomes remain constrained by persistently fragmented authority. This demonstrates how isolated service interventions only go so far without systemic changes in DHMTs management and resource environments.

5.4. The Known and Unknown: Data Strength, Gaps, Contradictions, and Bias

While the review uncovered moderate gains like Ghana's rising immunization rates and the increase in births attended by skilled staff in Malawi, there are significant unknowns. Most of the evidence remains at national or district averages, with little disaggregation by region and urban vs. rural setting, gender, or marginalized groups. This means that underlying inequities such as persistent gaps in access or outcomes for remote and disadvantaged populations are often hidden.

Critically, data inconsistencies and potential biases are pronounced. For specific challenges such as drug stockouts or staff absenteeism, the literature sometimes reflects underreporting. This could possibly be the case due to reputation concerns or sensitivity about exposing failures. In some cases purported improvements are attributed to decentralization when, upon closer inspection, these are results of broader health system investments or donor projects running parallel to official reforms.

Contradictions between policy and documents and district realities were evident. For example, in Malawi, while decentralization frameworks mandate the timely transfer of operational funds to local authorities, several reports indicated persistent delays in fund disbursements. This in turn leads to interruption of services and cancellation of supervision visits. This reinforces the need for more granular and context-sensitive data collection in future studies.

5.5. Linking Factors, Interventions, and Feasibility

The major barriers to DHMT performance, which include lack of financial autonomy, limited human resources control, and operational funding unpredictability, are well documented in the literature and my findings. Interventions like supportive supervision, data-driven decision-making, and community health structure involvement have encouraging results in some districts. However, these interventions are most effective only when strong leadership, reliable funding, and external support are present. In settings without these favorable conditions, transferring such success is less feasible.

For example, peer monitoring and partner-supported planning in Salima, Malawi, helped reduce stockouts, but similar innovations flounder in less limited-resource and non-partner-supported districts. This case underscores that while scalable impact from small pilot innovations is possible, it demands more than copying surface features. It is essential to address core

resources and autonomy constraints. Where donor-funded models have worked, sustainability is questionable: once external support is withdrawn, benefits often erode.

5.6. Relevance and Usefulness of Analytical Framework

The Regmi et al. (2010) framework was, on balance, a valuable guide for organizing my review and connecting decentralization structures, management processes, and service delivery outcomes. Its clarity supported a systematic synthesis of evidence from Malawi, Ghana, and Uganda, allowing me to draw recurring patterns as well as context-specific differences.

However, its limitations became clear along the synthesis. The framework does not adequately account for the political economy dynamics, such as the influence of donor priorities or elite capture, that shape how decentralization unfolds. Its linear, unidirectional structure does not easily accommodate the feedback loops and adaptation I found in real settings, where frontline challenges sometimes reshape district planning or spur local innovation. Also what was missing is the equity dimensions, how reforms play out across regions, and different population groups.

For future studies, I recommend adapting the framework in this area to more directly integrate political, donor, and equity aspects and to reflect iterative and adaptive realities of district management.

5.7. Strengths and Limitations of the Study

A key strength of this work is its integrative synthesis; by bringing together evidence from Malawi, Ghana, and Uganda through a structured analytical framework, I was able to identify both recurring patterns and context-specific differences. This approach provides a richer understanding of where and why decentralization efforts have, on occasion, succeeded but more often fallen short.

However, the study is marked by limitations. First, there is a systematic bias of literature towards national policies and donor-led initiatives, with insufficient depth on the district-level experiences or failures. Attribution is also problematic. Many sources credit decentralization for improvements that may have come from other system-wide reforms or partner interventions. Reporting bias was also evident, as negative experiences were limitedly captured in the literature in part due to political or institutional sensitivity.

As previously indicated in the methodology limitations, my reliance on secondary sources and English-language materials may have led to the underrepresentation of direct district-level perspectives. This limitation might have led to missing valuable local innovations and challenges, potentially affecting the completeness and fairness of the synthesis. Future research should therefore prioritize primary data collection and include sources in the local language to capture these critical perspectives holistically.

Chapter Six

6. Conclusions and Recommendations

6.1. Conclusion

This study set out to synthesize evidence on how decentralization has influenced the performance of DHMTs in managing and delivering health services in Malawi, Ghana, and Uganda. The goal was to offer evidence-informed and actionable recommendations for strengthening decentralized health systems. Through the lens of the analytical framework by Regmi et al. (2010), and drawing on both peer-reviewed and grey literature, several core conclusions emerge.

The promise of decentralization remains largely unfulfilled. Despite the widespread reform aimed at improving responsiveness of health service delivery and outcomes by empowering DHMTs, real authority over finances and human resources remains centralized. This fundamental constraint has created a persistent gap between decentralized policy intentions and live realities at the district level. Fragmentation and ambiguity continue to undermine effective local health management. Unclear roles, reporting lines, overlapping mandates, and the retention of core powers at central levels have led to confusion, duplication, and slow progress. Notably, in Ghana, the division of responsibilities between GHS and district assemblies has hampered cohesive planning and oversight.

There are instances of isolated successes, but these are not yet systemic. Gains such as improved maternal health in Malawi through FBO partnerships and effective outreach in Uganda using VHTs, and enhanced immunization coverage in Ghana through communities all show potential. However, these successes are highly context dependent, often donor-driven or reliant on strong local leadership, and not yet scalable or sustainable with the prevailing system. While community outreach and supportive supervision deliver localized improvements, these do not substitute the need to reform authority structures and resource flows at the systemic level. External interventions are rarely sustainable unless underlying bottlenecks are addressed.

Resource and capacity gaps persist across all three countries. Delays in operational funding, staff shortages, and infrastructure deficits remain common, particularly in hard-to-reach areas. This is compounded by inconsistent functionality in community structure engagement structures and weak data for performance monitoring. In addition, data and accountability gaps further limit learning and adaptation. Most available evidence remains aggregate and national. Hence, underlying inequities whereby urban vs. rural locations, regions, or vulnerable groups are hidden. Underreporting and contradictions between policy and practice further obscure where and why reforms succeed or fail. Current and ongoing interventions often fail to address root causes.

Throughout the review several questions remain unanswered. Among the most pressing are: What specific configurations of decentralization unlock transformative gains? What mechanisms best safeguard equity as authority and resources are devolved? Future research should consider attending to these critical gaps.

6.2. Recommendations

Based on the findings and conclusion of this study, the following recommendations are proposed to address the main challenges facing DHMTs in decentralized health systems in Malawi, Ghana, and Uganda. These recommendations are grounded in the evidence presented and are prioritized by urgency and feasibility; some should be implemented immediately (within three months), others in the short term (within 6 months), and some in the medium term (beyond 6 months) or as ongoing actions. They are also grouped and tailored by the main actors responsible for putting them into action. The aim is to help close the gap between policy and practice and to support more effective and equitable district health management.

For Policymakers and National MoH:

To strengthen district health management under decentralization, an immediate priority should be the devolution of real financial and HR authority to the district level. This process should begin with pilot projects in selected districts, where control over budgets and staffing decisions is transferred directly to DHMTs. Progress in these pilots should be jointly monitored with key partners. If results are positive, the approach can be incrementally scaled up nationwide. Delivering this foundational shift is essential, as it underpins the feasibility and successes of all subsequent reforms.

Equally urgent is the clarification of DHMT roles and reporting lines across the health system. Policymakers should organize joint workshops with MoH and local government authorities to comprehensively revise job descriptions and reporting structures, addressing the confusion and duplication that currently delays progress. Once updated, these protocols and organizational charts must be distributed widely to ensure consistency and shared understanding throughout the districts.

Ensuring predictable and timely operational funding for DHMTs is another immediate need. Transparent electronic fund transfers should be institutionalized to provide districts with direct access to operational budgets. Additionally, quick feedback mechanisms must be established to promptly resolve disbursement delays, thereby enabling DHMTs to reliably implement plans and supervise service delivery.

Finally, policymakers must invest in rural districts and address critical infrastructure needs to close persistent equity gaps. A thorough needs assessment should be conducted to identify priority districts and hard-to-reach areas. These areas should be explicitly included in central investment plans, with a dedicated share of the health budget earmarked for upgrading facilities, strengthening supply chains, improving utilities, and providing staff housing. Collaboration with donors and development partners is essential for aligning these priorities. These actions should begin as a medium-term priority and continue as part of ongoing system strengthening.

For DHMTs and Local Leaders

To enhance district health governance, a short- to medium-term priority should be strengthening community participation mechanisms. This can be achieved by providing annual training sessions and clear terms of reference for all community health committees. Each committee should receive a ring-fenced operational budget, and their ongoing recognition should be contingent on documented activity and demonstrated responsiveness to community feedback. Importantly, this strategy should be implemented after DHMTs secure stable funding and clarified reporting lines, ensuring committees have real opportunities and enablers to engage meaningfully.

Institutionalizing data-driven management and accountability should follow closely. Each bDHMT should designate a specific staff member as a DHIS2 or data focal person, responsible for assembling and analyzing routine data. Quarterly data review meetings should be mandated, with results used for both internal planning and public feedback sessions through local health scorecards. Implementing these practices in the short term will quickly improve planning, transparency, and community trust.

As a core system stabilizes, DHMTs and local leaders should focus on building and leveraging partnerships. This includes formalizing Memoranda of Understanding with FBOs, NGOs, and CSOs to collaborate on service delivery and outreach. Establishing annual cross-district learning forums will enable teams to share best practices and lessons learned, thereby accelerating gains. These efforts should be prioritized as supportive, medium-term activities once district management and funding systems are firmly in place.

For Development Partners and Donors

Development partners and donors should ensure that all support aligns with nationally and locally defined priorities. This alignment should include a requirement that every donor-funded project demonstrate consistency with district health plans. The MoH and DHMTs should jointly lead annual donor coordination meetings to harmonize reporting and reduce fragmentation. These practices should be adopted immediately and maintained on an ongoing basis to maximize the effectiveness and sustainability of external aid.

It is also vital that partners invest in operational research and capacity building as ongoing priorities. Funding should be directed to mixed-methods and operational research projects that treat DHMTs and communities as research partners, not just subjects. Every study should disaggregate results by region, urban vs. rural, and by gender for more precise targeted interventions. In addition, ongoing training for DHMTs should be incorporated into all capacity-building initiatives, providing a foundation for sustained improvement and equity.

Future Research

Building on the successes highlighted in different districts, future research should prioritize longitudinal and participatory studies that track how local health management and service delivery innovations are sustained, adapted, and sustained over time. This work should draw on mixed methods designs, combining routine data with qualitative insights from DHMTs and community stakeholders. Multi-year research partnerships will allow for in-depth understanding of which contextual factors support or hinder the decentralization reforms. Integrating research within existing district planning cycles and sharing lessons across the districts and policy forums could ensure that effective approaches aren’t only documented but also inform ongoing reforms.

7. References

Abimbola, S., Baatiema, L. and Bigdeli, M. (2019) 'The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence', *Health Policy and Planning*, 34(8), pp. 605–617. Available at: https://doi.org/10.1093/heapol/czz055.

Adaletey, D.L. *et al.* (2015) 'Peer-Performance Review as a Strategy for Strengthening Health In-formation Systems: A Case Study from Ghana', *Journal of Health Informatics in Africa*, 2(2). Available at: https://doi.org/10.12856/JHIA-2014-v2-i2-103.

Adusei, A.B. *et al.* (2024) 'Community-based Health Planning and Services programme in Ghana: a systematic review', *Frontiers in Public Health*, 12, p. 1337803. Available at: https://doi.org/10.3389/fpubh.2024.1337803.

Agalga, S., Alatinga, K.A. and Abiiro, G.A. (2022) 'Enablers and inhibitors of community participation in Ghana's Community-based Health Planning and Services programme: a qualitative study in the Builsa North Municipality', *BMC Health Services Research*, 22(1), p. 1468. Available at: https://doi.org/10.1186/s12913-022-08869-4.

Agyepong, I.A. (1999) 'Reforming Health Service Delivery at District Level in Ghana: The Perspective of a District Medical Officer', *Health Policy and Planning*, 14(1), pp. 59–69. Available at: https://doi.org/10.1093/heapol/14.1.59.

Aikins, M. *et al.* (2013) 'Evaluation of facilitative supervision visits in primary health care service delivery in Northern Ghana', *BMC Health Services Research*, 13(1), p. 358. Available at: https://doi.org/10.1186/1472-6963-13-358.

Alban, R. *et al.* (2023) 'Leveraging community health workers as vaccinators: a case study exploring the role of Malawi's Health Surveillance Assistants in delivering routine immunization services', *Human Resources for Health*, 21(1). Available at: https://doi.org/10.1186/s12960-023-00827-3.

Alonso-Garbayo, A. *et al.* (2017) 'Decision space for health workforce management in decentralized settings: a case study in Uganda', *Health Policy and Planning*, 32(suppl_3), pp. iii59–iii66. Available at: https://doi.org/10.1093/heapol/czx116.

Anders Jeppsson (2004) *Decentralization and National Health Policy Implementation in Uganda – a Problematic Process*. Doctoral thesis. Lund University. Available at: https://portal.research.lu.se/files/5879421/1693121.pdf (Accessed: 13 June 2025).

Ankomah, S.E., Fusheini, A. and Derrett, S. (2024) 'Unsung heroes in Ghana's healthcare system: the case of community health volunteers and community health management committee', *Health Research Policy and Systems*, 22(1), p. 10. Available at: https://doi.org/10.1186/s12961-023-01099-y.

Annobil, I., Dakyaga, F. and Sillim, M.L. (2021) "'From experts to locals hands" healthcare service planning in sub-Saharan Africa: an insight from the integrated community case management of Ghana', *BMC Health Services Research*, 21(1), p. 403. Available at: https://doi.org/10.1186/s12913-021-06407-2.

Avortri, G.S., Nabukalu, J.B. and Nabyonga-Orem, J. (2019) 'Supportive supervision to improve service delivery in low-income countries: is there a conceptual problem or a strategy problem?', *BMJ Global Health*, 4(Suppl 9), p. e001151. Available at: https://doi.org/10.1136/bmjgh-2018-001151.

Awoonor-Williams, J.K. and Phillips, J.F. (2022) 'Developing organizational learning for scaling-up community-based primary health care in Ghana', *Learning Health Systems*, 6(1), p. e10282. Available at: https://doi.org/10.1002/lrh2.10282.

Awoonor-Williams, J.K., Phillips, J.F. and Bawah, A.A. (2016) 'Catalyzing the scale-up of community-based primary healthcare in a rural impoverished region of northern Ghana', *The International Journal of Health Planning and Management*, 31(4). Available at: https://doi.org/10.1002/hpm.2304.

Ayim, A., Agyepong, I.A. and Enyimayew, N. (2023) 'Why district assemblies disburse resources to district health systems for service delivery at district level in the context of decentralization: a comparative study of two districts in the Volta Region of Ghana', *Frontiers in Public Health*, 11, p. 1136210. Available at: https://doi.org/10.3389/fpubh.2023.1136210.

Azevedo, M.J. (2017) 'The State of Health System(s) in Africa: Challenges and Opportunities', in Azevedo, M. J., *Historical Perspectives on the State of Health and Health Systems in Africa, Volume II*. Cham: Springer International Publishing (African Histories and Modernities), pp. 1–73. Available at: https://doi.org/10.1007/978-3-319-32564-4_1.

Bäck, A. *et al.* (2025) 'Collaboration between local authorities and civil society organisations for improving health: a scoping review', *BMJ Open*, 15(3), p. e092525. Available at: https://doi.org/10.1136/bmjopen-2024-092525.

Banda, H.; Chikaphupha, K.; Kwalamasa, K.; Sanudi, L. (2021) *PERFORM2Scale Malawi Country Report, 2021*. Lilongwe, Malawi: PERFORM2Scale Consortium. Available at: https://www.perform2scale.org/sites/perform/files/content/attachments/2021-12-07/Malawi%20Country%20Report%20Nov_30_2021%20Final.pdf (Accessed: 7 June 2025).

Bawontuo, V. *et al.* (2022) 'Power sources among district health managers in Ghana: a qualitative study', *BMC Primary Care*, 23(1), p. 68. Available at: https://doi.org/10.1186/s12875-022-01678-y.

Bernard F. Couttolenc (2012) *Decentralization and Governance in the Ghana Health Sector*. Washington, DC: World Bank. Available at: https://openknowledge.worldbank.org/server/api/core/bitstreams/a529821b-6fe0-597a-b9a3-66d29b1f4bce/content (Accessed: 7 June 2025).

Bonenberger, M. *et al.* (2015) 'Factors influencing the work efficiency of district health managers in low-resource settings: a qualitative study in Ghana', *BMC Health Services Research*, 16(1), p. 12. Available at: https://doi.org/10.1186/s12913-016-1271-3.

Borghi, J. *et al.* (2018) 'Health financing at district level in Malawi: an analysis of the distribution of funds at two points in time', *Health Policy and Planning*, 33(1), pp. 59–69. Available at: https://doi.org/10.1093/heapol/czx130.

Bosongo, S. *et al.* (2023) 'Capacity building of district health management teams in the era of provincial health administration reform in the Democratic Republic of Congo: a realist evaluation protocol', *BMJ Open*, 13(7), p. e073508. Available at: https://doi.org/10.1136/bmjopen-2023-073508.

Bossert, T. (2003) 'Decentralization in Zambia: resource allocation and district performance', *Health Policy and Planning*, 18(4), pp. 357–369. Available at: https://doi.org/10.1093/heapol/czg044.

Bossert, Thomas (2010) *Decentralization of Health Systems: Decision Space, Innovation, and Performance*. Washington, DC: Pan American Health Organization. Available at: https://www3.paho.org/hq/dmdocuments/2010/17-Decentralization_Health_Systems-Decision_Space_Innovation_Performance.pdf (Accessed: 10 June 2025).

Bossert, T.J. (2002) 'Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space', *Health Policy and Planning*, 17(1), pp. 14–31. Available at: https://doi.org/10.1093/heapol/17.1.14.

Bossert, T.J. and Mitchell, A.D. (2011) 'Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan', *Social Science & Medicine*, 72(1), pp. 39–48. Available at: https://doi.org/10.1016/j.socscimed.2010.10.019.

Bulthuis, S. *et al.* (2022) 'Assessing the scalability of a health management-strengthening intervention at the district level: a qualitative study in Ghana, Malawi and Uganda', *Health Research Policy and Systems*, 20(1), p. 85. Available at: https://doi.org/10.1186/s12961-022-00887-2.

Bulthuis, S. *et al.* (2023) 'How to scale-up: a comparative case study of scaling up a district health management strengthening intervention in Ghana, Malawi and Uganda', *BMC Health Services Research*, 23(1), p. 35. Available at: https://doi.org/10.1186/s12913-023-09034-1.

Bulthuis, S.E. *et al.* (2021) 'How district health decision-making is shaped within decentralised contexts: A qualitative research in Malawi, Uganda and Ghana', *Global Public Health*, 16(1), pp. 120–135. Available at: https://doi.org/10.1080/17441692.2020.1791213.

Butler, N. *et al.* (2020) 'A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi', *BMC Health Services Research*, 20(1). Available at: https://doi.org/10.1186/s12913-020-05394-0.

Chen, J. *et al.* (2021) 'Does decentralization of health systems translate into decentralization of authority? A decision space analysis of Ugandan healthcare facilities', *Health Policy and Planning*, 36(9), pp. 1408–1417. Available at: https://doi.org/10.1093/heapol/czab074.

Cobos Muñoz, D. *et al.* (2017) 'Decentralization of health systems in low and middle income countries: a systematic review', *International Journal of Public Health*, 62(2), pp. 219–229. Available at: https://doi.org/10.1007/s00038-016-0872-2.

Connolly, E. *et al.* (2024) 'Revision of Malawi's Health Benefits Package: A Critical Analysis of Policy Formulation and Implementation', *Value in Health Regional Issues*, 39, pp. 84–94. Available at: https://doi.org/10.1016/j.vhri.2023.10.007.

Cruz, Valeria Oliveira *et al.* (2006) 'Is the sector-wide approach (SWAp) improving health sector performance in Uganda?', in *Health Systems Reforms in Uganda: Processes and Outputs*. London: London School of Hygiene and Tropical Medicine; University of Melbourne; London School of Economics and Political Science. Available at: https://www.researchgate.net/publication/291540641_Is_the_sector-wide_approach_SWAp_improving_health_sector_performance_in_Uganda (Accessed: 23 July 2025).

Dalinjong, P.A. and Laar, A.S. (2012) 'The national health insurance scheme: perceptions and experiences of health care providers and clients in two districts of Ghana', *Health Economics Review*, 2(1). Available at: https://doi.org/10.1186/2191-1991-2-13.

Debrah, E. (2016) 'Decentralization, District Chief Executives, and District Assemblies in G hana's Fourth Republic', *Politics & Policy*, 44(1), pp. 135–164. Available at: https://doi.org/10.1111/polp.12146.

Dickovick, J. Tyler; Riedl, Rachel Beatty (2015) *Comparative Assessment of Decentralization in Africa: Final Report and Summary of Findings*. Report. ARD, Inc. for USAID. Available at: https://decentralization.net/2015/12/comparative-assessment-of-decentralization-in-africa/ (Accessed: 20 June 2025).

Doherty, T. *et al.* (2018) 'Role of district health management teams in child health strategies', *BMJ*, p. k2823. Available at: https://doi.org/10.1136/bmj.k2823.

Erixy Naluso, S. and Isaac Kanyangale, M. (2024) 'Decentralisation of the Health System Derailed by Organisational Inertia in Machinga, Malawi', *International Journal of Health Policy and Management*, 13, p. 7956. Available at: https://doi.org/10.34172/ijhpm.7956.

Evelyn Udedi (2021) *Assessing the Capacity of District Hospitals in Mobilizing and Allocating Resources*. Master's thesis (MScGHI - Master of Science in Global Health Implementation). Available at: https://nkhokwe.kuhes.ac.mw/bitstream/20.500.12845/635/1/Evelyn%20Udedi_MScGHI%20thesis_Approved%20copy_24032022.pdf (Accessed: 18 January 2025).

Exemplars in Global Health (2024) *How did Ghana change its approach to health system administration?* Available at: https://www.exemplars.health/topics/primary-health-care/ghana/pathway-1-how-did-ghana-change-its-approach-to-health-system-administration (Accessed: 12 June 2025).

Faguet, J.P. (2015) *Is Decentralization Good for Development? Perspectives from Academics and Policy Makers*. Oxford: Oxford University Press, Incorporated. Available at: https://eprints.lse.ac.uk/63178/1/Faguet_is%20decentralization%20good.pdf.

George, A.S. *et al.* (2015) 'Community Participation in Health Systems Research: A Systematic Review Assessing the State of Research, the Nature of Interventions Involved and the Features of Engagement with Communities', *PLOS ONE*. Edited by X. Li, 10(10), p. e0141091. Available at: https://doi.org/10.1371/journal.pone.0141091.

Ghana Health Service (2023) *Holistic Assessment Tool (4th Edition)*. Ghana Health Service – Performance Monitoring and Evaluation Division&Research and Development Division. Ghana Health Service. Available at: https://www.moh.gov.gh/wp-content/uploads/2025/01/Holistic-Assessment-Tool_4thEdition_FINAL-3.pdf (Accessed: 29 June 2025).

Gondwe, M.J. *et al.* (2022) 'Resource availability and barriers to delivering quality care for newborns in hospitals in the southern region of Malawi: A multisite observational study', *PLOS Global Public Health*. Edited by J. Robinson, 2(12), p. e0001333. Available at: https://doi.org/10.1371/journal.pgph.0001333.

Government of Ghana (1996) *Ghana Health Service and Teaching Hospitals Act*. Available at: https://www.moh.gov.gh/wp-content/uploads/2016/02/GHS-ACT525.pdf (Accessed: 27 June 2025).

Government of Ghana (2016) *Local Government Act, 2016 (Act 936)*, *Local Government Service*. Available at: https://lgs.gov.gh/local-governance-act-of-2016-act-936/ (Accessed: 12 June 2025).

Government of Malawi, Ministry of Health (2023) *National Health Financing Strategy for Malawi 2023–2030*. Government of Malawi. Available at: https://p4h.world/app/uploads/2024/04/Health-Financing-Strategy_Final_-9-January-2023_For-Launch_Signed1.x23411.pdf (Accessed: 13 May 2025).

Government of the Republic of Malawi, Ministry of Health (2022) *Health Sector Strategic Plan III 2023-2030: Reforming for Universal Health Coverage*. Available at: https://nkhokwe.kuhes.ac.mw/items/9e80e747-f125-433f-b6fe-16d85da38ea9 Access Date: January 21, 2025 (Accessed: 21 January 2025).

Government of Uganda (1995) 'The Constitution of the Republic of Uganda'. Government Printer. Available at: https://www.ec.or.ug/docs/Constitution_1995.pdf (Accessed: 3 July 2025).

Government of Uganda (1997) *The Local Governments Act*. Available at: https://media.ulii.org/media/legislation/18245/source_file/24ba3bdae3b83536/1997-5.pdf (Accessed: 3 July 2025).

Heerdegen, A.C.S., Gerold, J., *et al.* (2020) 'How Does District Health Management Emerge Within a Complex Health System? Insights for Capacity Strengthening in Ghana', *Frontiers in Public Health*, 8, p. 270. Available at: https://doi.org/10.3389/fpubh.2020.00270.

Heerdegen, A.C.S., Aikins, M., *et al.* (2020) 'Managerial capacity among district health managers and its association with district performance: A comparative descriptive study of six districts in the Eastern Region of Ghana', *PLOS ONE*. Edited by K. Gholipour, 15(1), p. e0227974. Available at: https://doi.org/10.1371/journal.pone.0227974.

Henriksson, D.K. *et al.* (2017) 'Enablers and barriers to evidence based planning in the district health system in Uganda; perceptions of district health managers', *BMC Health Services Research*, 17(1), p. 103. Available at: https://doi.org/10.1186/s12913-017-2059-9.

Henriksson, D.K. *et al.* (2019) 'Decision-making in district health planning in Uganda: does use of district-specific evidence matter?', *Health Research Policy and Systems*, 17(1), p. 57. Available at: https://doi.org/10.1186/s12961-019-0458-6.

Hobdari, N., Nguyen, V., *et al.* (2018) 'Lessons for Effective Fiscal Decentralization in Sub-Saharan Africa', *Departmental Papers / Policy Papers*, 18(10), p. 1. Available at: https://doi.org/10.5089/9781484358269.087.

Hobdari, N., Dell'Erba, S., *et al.* (2018) *Lessons for Effective Fiscal Decentralization in Sub-Saharan Africa*. Washington, D.C: International Monetary Fund (Departmental Papers). Available at: https://doi.org/10.5089/9781484358269.087.

Inkoom, D.K.B. and Gyapong, A.Y. (2016) 'Decentralization in Africa: Local Government and Health Care in Ghana, Malawi and Tanzania', in C.N. Silva (ed.) *Governing Urban Africa*. London: Palgrave Macmillan UK, pp. 99–124. Available at: https://doi.org/10.1057/978-1-349-95109-3_4.

Institute for Reproductive Health (IRH) (2020) *Strengthening Family Planning with Faith-Based Organizations in Uganda*. Georgetown University, Institute for Reproductive Health. Available at: https://www.irh.org/resource-library/brief-strengthening-fp-with-fbos-in-uganda/ (Accessed: 5 July 2025).

Jagero, Nelson; Kwandayi, Hardson H.; Longwe, Annie (2014) 'Challenges of Decentralization in Malawi', *International Journal of Management Sciences*, 2(7), pp. 315–322.

Jiménez-Rubio, D. (2022) 'Health System Decentralization: Creating as Many Problems Than It Solves? Comment on "The Effects of Health Sector Fiscal Decentralisation on Availability, Accessibility, and Utilisation of Healthcare Services: A Panel Data Analysis"', *International Journal of Health Policy and Management*, p. 1. Available at: https://doi.org/10.34172/ijhpm.2022.7432.

Kasambara, A. *et al.* (2017) 'Assessment of implementation of the health management information system at the district level in southern Malawi', *Malawi Medical Journal: The Journal of Medical Association of Malawi*, 29(3), pp. 240–246. Available at: https://doi.org/10.4314/mmj.v29i3.3.

Kassim Kwalamasa (2017) *Reflections on the Salima Quality Improvement team experience Author*. Available at: https://www.reachoutconsortium.org/news/reflections-on-the-salima-quality-improvement-team-experience-a-locally-led-data-quality-improvement-initiative/.

Kimbugwe, G. *et al.* (2014) 'Challenges Faced by Village Health Teams (VHTs) in Amuru, Gulu and Pader Districts in Northern Uganda', *Open Journal of Preventive Medicine*, 04(09), pp. 740–750. Available at: https://doi.org/10.4236/ojpm.2014.49084.

KIT Royal Tropical Institute (2024) *Perform2Scale: Contributing to Universal Health Coverage in Ghana, Malawi, and Uganda*. KIT Royal Tropical Institute. Available at: https://www.kit.nl/institute/project/perform2scale-contributing-to-universal-health-coverage-in-ghana-malawi-and-uganda/ (Accessed: 8 January 2025).

Kojo Sakyi, E. (2008) 'Implementing decentralised management in Ghana', *Leadership in Health Services*. Edited by J. Bowerman, 21(4), pp. 307–319. Available at: https://doi.org/10.1108/17511870810910100.

Koyaara, A.D. *et al.* (2024) 'Community-Based Health Planning and Services (CHPS) concept and access to healthcare delivery in Sefwi Wiawso Municipal, Ghana', *BMC*

Health Services Research, 24(1). Available at: https://doi.org/10.1186/s12913-024-11179-6.

Kwamie, A. *et al.* (2016) 'The path dependence of district manager decision-space in Ghana', *Health Policy and Planning*, 31(3), pp. 356–366. Available at: https://doi.org/10.1093/heapol/czv069.

Kwamie, A., Dijk, H.V. and Agyepong, I.A. (2014) 'Advancing the application of systems thinking in health: realist evaluation of the Leadership Development Programme for district manager decision-making in Ghana', *Health Research Policy and Systems*, 12(1), p. 29. Available at: https://doi.org/10.1186/1478-4505-12-29.

Kweku, M. *et al.* (2020) 'Volunteer responsibilities, motivations and challenges in implementation of the community-based health planning and services (CHPS) initiative in Ghana: qualitative evidence from two systems learning districts of the CHPS+ project', *BMC Health Services Research*, 20(1), p. 482. Available at: https://doi.org/10.1186/s12913-020-05348-6.

Laar, A.S., Asare, M. and Dalinjong, P.A. (2021) 'What alternative and innovative domestic methods of healthcare financing can be explored to fix the current claims reimbursement challenges by the National Health Insurance Scheme of Ghana? Perspectives of health managers', *Cost Effectiveness and Resource Allocation*, 19(1). Available at: https://doi.org/10.1186/s12962-021-00323-2.

Lodenstein, E. *et al.* (2019) '"We come as friends": approaches to social accountability by health committees in Northern Malawi', *BMC Health Services Research*, 19(1), p. 279. Available at: https://doi.org/10.1186/s12913-019-4069-2.

Mahmood, S. *et al.* (2024) 'Decentralization of the health system – experiences from Pakistan, Portugal and Brazil', *Health Research Policy and Systems*, 22(1), p. 61. Available at: https://doi.org/10.1186/s12961-024-01145-3.

Makwero, M.T. (2018) 'Delivery of primary health care in Malawi', *African Journal of Primary Health Care & Family Medicine*, 10(1). Available at: https://doi.org/10.4102/phcfm.v10i1.1799.

'Malawi Decentralization Policy 1998' (1998). Government of Malawi. Available at: https://npc.mw/wp-content/uploads/2020/07/Decentralization-policy.pdf (Accessed: 15 June 2025).

Malawi Health Equity Network (MHEN); ActionAid Malawi (2023) *The 2023/24 Health Sector Budget Analysis*. Malawi Health Equity Network & ActionAid Malawi. Available at: https://malawi.actionaid.org/sites/malawi/files/publications/THE%202023-24%20HEALTH%20SECTOR%20BUDGET%20ANALYSIS.pdf (Accessed: 14 June 2025).

‘Malawi National Decentralization Policy (Second Edition, 2024)’ (2024). Government of Malawi, Ministry of Local Government. Available at: https://www.localgov.gov.mw (Accessed: 18 June 2025).

Mansour, W. *et al.* (2022) ‘Management of human resources for health in health districts in Uganda: A decision space analysis’, *The International Journal of Health Planning and Management*, 37(2), pp. 770–789. Available at: https://doi.org/10.1002/hpm.3359.

Martineau, T. *et al.* (2018) ‘Strengthening health district management competencies in Ghana, Tanzania and Uganda: lessons from using action research to improve health workforce performance’, *BMJ Global Health*, 3(2), p. e000619. Available at: https://doi.org/10.1136/bmjgh-2017-000619.

Masefield, S.C. *et al.* (2021) ‘Stakeholder engagement in the health policy process in a low income country: a qualitative study of stakeholder perceptions of the challenges to effective inclusion in Malawi’, *BMC Health Services Research*, 21(1), p. 984. Available at: https://doi.org/10.1186/s12913-021-07016-9.

Masefield, S.C., Msosa, A. and Grugel, J. (2020) ‘Challenges to effective governance in a low income healthcare system: a qualitative study of stakeholder perceptions in Malawi’, *BMC Health Services Research*, 20(1), p. 1142. Available at: https://doi.org/10.1186/s12913-020-06002-x.

Mays, D.C. *et al.* (2017) ‘Supporting and retaining Village Health Teams: an assessment of a community health worker program in two Ugandan districts’, *International Journal for Equity in Health*, 16(1), p. 129. Available at: https://doi.org/10.1186/s12939-017-0619-6.

McGuire, F. *et al.* (2020) ‘Allocating resources to support universal health coverage: development of a geographical funding formula in Malawi’, *BMJ Global Health*, 5(9), p. e002763. Available at: https://doi.org/10.1136/bmjgh-2020-002763.

Mchenga, M. *et al.* (2022) ‘Developing Malawi’s Universal Health Coverage Index’, *Frontiers in Health Services*, 1, p. 786186. Available at: https://doi.org/10.3389/frhs.2021.786186.

Ministry of Health (2024) *Health Sector Annual Progress Report for the 2023-24 Fiscal Year*. Lilongwe, Malawi: Government of Malawi. Available at: https://health.gov.mw/storage/resources/Annual%20Report%202023-24%20FY_FINAL_06122024docx%201.pdf (Accessed: 24 June 2025).

Ministry of Health and Population, Government of Malawi (2018) *Report on the Assessment on the Current State of District Health System Decentralization Carried Out from 21st to 31st May, 2018*. Available at: https://p4h.world/app/uploads/2023/02/Report20on20assessment20of20the20district20health20system20June202018.x23411.pdf (Accessed: 4 March 2025).

Ministry of Health, Government of the Republic of Malawi (2023) *Malawi National-Community Health Framework*. Lilongwe, Malawi: Ministry of Health, Malawi. Available at: https://www.hcwpolicylab.org/wp-content/uploads/2024/07/Malawi-National-Community-Health-Framework-2023-2030.pdf (Accessed: 18 May 2025).

Ministry of Health, Republic of Ghana (2016) *National Community Health Planning and Services (CHPS) Policy*. Ministry of Health, Republic of Ghana. Available at: https://www.moh.gov.gh/wp-content/uploads/2016/02/CHPS-policy-final-working-draft-for-validation.pdf (Accessed: 1 July 2015).

Ministry of Health, Republic of Ghana (2022) *Health Sector Medium-Term Development Plan 2022–2025*. Policy document/strategy. Government of Ghana. Available at: https://extranet.who.int/countryplanningcycles/planning-cycle-files/health-sector-medium-term-development-plan-2022-2025 (Accessed: 29 June 2025).

Ministry of Health, Republic of Uganda (2015) *Health Sector Development Plan 2015/16–2019/20*. Strategic Plan. Kampala, Uganda: Ministry of Health. Available at: https://www.health.go.ug/sites/default/files/Health%20Sector%20Development%20Plan%202015-16_2019-20.pdf (Accessed: 3 July 2025).

Ministry of Health, Republic of Uganda (2020) *Annual Health Sector Performance Report: Financial Year 2019/2020*. Kampala, Uganda. Available at: https://library.health.go.ug/sites/default/files/resources/Annual%20Health%20Sector%20Performance%20Report%202019-2020%20FY-1_0.pdf (Accessed: 4 July 2025).

Ministry of Health, Uganda (2021) *Ministry of Health Strategic Plan 2020/21–2024/25*. Kampala. Available at: https://library.health.go.ug/sites/default/files/resources/MoH%20Strategic%20Plan%202020_25_0.pdf (Accessed: 3 July 2025).

Ministry of Health, Uganda (2024) *Annual Health Sector Performance Report 2023/24*. Ministry of Health, Uganda. Available at: https://library.health.go.ug/sites/default/files/resources/Annual%20Health%20Sector%20Performance%20Report%20%20FY%202023_24.pdf (Accessed: 9 July 2025).

Musinguzi, L.K. *et al.* (2017) 'Linking communities to formal health care providers through village health teams in rural Uganda: lessons from linking social capital', *Human Resources for Health*, 15(1), p. 4. Available at: https://doi.org/10.1186/s12960-016-0177-9.

National Development Planning Commission (NDPC) & UNICEF, Ghana (2023) *2022 District League Table Report*. NDPC & UNICEF Ghana. Available at: https://www.unicef.org/ghana/reports/2022-district-league-table-report (Accessed: 30 June 2025).

National Statistical Office [Malawi] and ICF (2024) *2024 Malawi Demographic and Health Survey: Key Indicators Report*. Report. Zomba, Malawi, and Rockville, Maryland, USA: National Statistical Office and ICF. Available at: https://www.jointdatacenter.org/2024-malawi-demographic-and-health-survey-mdhs-key-indicators-report/ (Accessed: 16 February 2024).

Noory, B., Hassanain, S. and Kassak, K. (2024) 'The implementation process of decentralization of health services: a qualitative perspective from Sudan', *Frontiers in Public Health*, 12, p. 1439219. Available at: https://doi.org/10.3389/fpubh.2024.1439219.

Odei-Lartey, E.O. *et al.* (2020) 'Utilization of the national cluster of district health information system for health service decision-making at the district, sub-district and community levels in selected districts of the Brong Ahafo region in Ghana', *BMC Health Services Research*, 20(1), p. 514. Available at: https://doi.org/10.1186/s12913-020-05349-5.

Paul Smoke (2015) 'Accountability and Service Delivery in Decentralising Environments: Understanding Context and Strategically Advancing Reform', in *A Governance Practitioner's Notebook: Alternative Ideas and Approaches*. Paris, pp. 219–232. Available at: https://www.oecd.org/dac/accountable-effective-institutions/Governance%20Notebook%202.6%20Smoke.pdf (Accessed: 20 June 2025).

Raven, J. *et al.* (2024) 'From PERFORM to PERFORM2Scale: lessons from scaling-up a health management strengthening intervention to support Universal Health Coverage in three African countries', *Health Policy and Planning*, 39(8), pp. 841–853. Available at: https://doi.org/10.1093/heapol/czae063.

Regmi, K. *et al.* (2010) 'Understanding the effect of decentralisation on health services: The Nepalese experience', *Journal of Health Organization and Management*, 24(4), pp. 361–382. Available at: https://doi.org/10.1108/14777261011064986.

Rodríguez, D.C. *et al.* (2023) 'Political economy analysis of subnational health management in Kenya, Malawi and Uganda', *Health Policy and Planning*, 38(5), pp. 631–647. Available at: https://doi.org/10.1093/heapol/czad021.

Rogers, B.M. *et al.* (2024) 'Strengthening district health management and planning: an evaluation of a multi-country initiative in Eastern and Southern Africa', *Gates Open Research*, 8, p. 38. Available at: https://doi.org/10.12688/gatesopenres.15007.1.

Rufaro Chatora, Prosper Tumusiime (2003) *Management, Leadership and Partnership for District Health*. Training Module AFR/DHS/03.02. Brazaaville: World Health Organization, Regional Office for Africa. Available at:

https://iris.who.int/bitstream/handle/10665/358067/AFR-DHS-03.02-eng.pdf (Accessed: 15 June 2025).

Sakala, J.J. *et al.* (2022) 'The Integration of vertical and horizontal programmes for health systems strengthening in Malawi: a case study', *Malawi Medical Journal*, 34(3), pp. 206–212. Available at: https://doi.org/10.4314/mmj.v34i3.11.

Saltman, Richard B. (Editor), Bankauskaite, Vaida (Editor), and Vrangbæk, Karsten (Editor) (2008) *Decentralization in health care: Strategies and outcomes*. Maidenhead, UK (European Observatory on Health Systems and Policies Series, World Health Organization). Available at: https://eurohealthobservatory.who.int/docs/librariesprovider3/studies---external/decentralization-in-health-care.pdf?sfvrsn=1f1d5377_3&download=true (Accessed: 8 June 2025).

Sapkota, S. *et al.* (2023) 'The impact of decentralisation on health systems: a systematic review of reviews', *BMJ Global Health*, 8(12), p. e013317. Available at: https://doi.org/10.1136/bmjgh-2023-013317.

Sarah Byakika, Freddie Ssengooba (2019) *Decentralisation and the Uganda Health System: What can we Learn from Past Experiences to Facilitate the Achievement of Universal Health Coverage?* Kampala, Uganda: Makerere University. Available at: https://speed.musph.ac.ug/wp-content/uploads/2019/03/Chapter-6.pdf (Accessed: 13 June 2025).

Sharma, L. *et al.* (2024) 'Donor coordination to support universal health coverage in Malawi', *Health Policy and Planning*, 39(Supplement_1), pp. i118–i124. Available at: https://doi.org/10.1093/heapol/czad102.

Shumba, C.S. *et al.* (2017) 'Client satisfaction in a faith-based health network: findings from a survey in Uganda', *African Health Sciences*, 17(3), p. 942. Available at: https://doi.org/10.4314/ahs.v17i3.38.

Silva, C.N. (ed.) (2016) *Governing Urban Africa*. London: Palgrave Macmillan UK. Available at: https://doi.org/10.1057/978-1-349-95109-3.

Stephen Jones, Andrew Kardan, Maja Jakobsen, Serufusa Sekidde (2013) *Local Perceptions, Participation and Accountability in Malawi's Health Sector*. 2/2013. Oslo, Norway: Norad Evaluation Department. Available at: https://www.norad.no/contentassets/fafce062a5014a9b94e775d8c818e6e3/local-perceptions-participation-and-accountability-in-malawis-health-sector.pdf (Accessed: 26 June 2025).

Sumah, A.M. and Baatiema, L. (2018) 'Decentralisation and Management of Human Resource for Health in the Health System of Ghana: A Decision Space Analysis',

International Journal of Health Policy and Management, 8(1), pp. 28–39. Available at: https://doi.org/10.15171/ijhpm.2018.88.

Tetui, M. *et al.* (2016) 'Building a competent health manager at district level: a grounded theory study from Eastern Uganda', *BMC Health Services Research*, 16(1), p. 665. Available at: https://doi.org/10.1186/s12913-016-1918-0.

The World Bank (2013) *Decentralization*. Available at: https://www.worldbank.org/en/topic/communitydrivendevelopment/brief/Decentralization (Accessed: 20 June 2025).

Uganda Ministry of Health (2024) *National Community Health Strategy Implementation Guidelines*. Kampala, Uganda: Uganda Ministry of Health. Available at: https://library.health.go.ug/sites/default/files/resources/241113_NCHS%20Implementation%20Guidelines.pdf (Accessed: 3 July 2025).

UNDP (2022) *Malawi National Human Development Report 2021: Delivering Sustainable Human Development and Accountability at the Local Leve*. 7th Edition. United Nations Development Programme (UNDP), p. Lilongwe, Malawi. Available at: https://www.undp.org/sites/g/files/zskgke326/files/migration/mw/Malawi-National-Human-Development-Report-2021---SUMMARY-REPORT.pdf (Accessed: 22 June 2025).

UNICEF Malawi (2022) *Fiscal Decentralisation in Malawi Situational Analysis Final Report*. UNICEF. Available at: https://www.unicef.org/esa/media/11161/file/UNICEF-Malawi-NLGFC-IGF-%20Fiscal-Decentralisation-Situational-Analysis-2022.pdf (Accessed: 2 December 2024).

UNICEF Malawi (2023) *Health Budget Brief 2023/24: Building a Resilient and Sustainably Financed Health System in Malawi*. Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/reports/health-budget-brief-202324 (Accessed: 4 March 2025).

UNICEF Uganda (2020) *VHTs lead to increase in demand of health services in Northern Uganda*. Available at: https://www.unicef.org/uganda/stories/vhts-lead-increase-demand-health-services-northern-uganda (Accessed: 12 June 2025).

Van Niekerk, L. *et al.* (2023) 'From idea to systems solution: enhancing access to primary care in Malawi', *BMC Health Services Research*, 23(1), p. 547. Available at: https://doi.org/10.1186/s12913-023-09349-z.

Van Niekerk, Lindi *et al.* (2023) 'Social innovation in health: strengthening Community Systems for Universal Health Coverage in rural areas', *BMC Public Health*, 23(1). Available at: https://doi.org/10.1186/s12889-022-14451-8.

Wei, Y. *et al.* (2023) 'The impact of devolution on experienced health and well-being', *Social Science & Medicine*, 333, p. 116139. Available at: https://doi.org/10.1016/j.socscimed.2023.116139.

World Bank (2021) *Public Financial Management in the Health Sector in Malawi: Opportunities to Strengthen Service Delivery at the Local Level*. Washington, DC: World Bank. Available at: https://documents1.worldbank.org/curated/en/241411624431388240/pdf/Public-Financial-Management-in-the-Health-Sector-An-Assessment-at-the-Local-Government-Level-in-Malawi.pdf (Accessed: 19 June 2025).

World Bank (2023) *Uganda Intergovernmental Fiscal Transfers Program (UgIFT) – Implementation Status and Results Report (ISR).* World Bank. Available at: : https://projects.worldbank.org/en/projects-operations/project-detail/P160250 (Accessed: 15 July 2025).

World Bank (2025) *Malawi Governance to Enable Service Delivery Project: Project Appraisal Document*. PAD2819. Washington, D.C: World Bank. Available at: https://documents1.worldbank.org/curated/en/298021587052632997/pdf/Malawi-Governance-to-Enable-Service-Delivery-Project.pdf.

World Health Organization (2007) *Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action*. Policy Document. Geneva: World Health Organization. Available at: https://apps.who.int/iris/handle/10665/43918 (Accessed: 15 June 2025).

World Health Organization (2022) *Health financing and public financial management in decentralized health systems*. Report. World Health Organization. Available at: https://www.who.int/news/item/12-07-2022-health-financing-pfm-decentralization (Accessed: 20 June 2025).

World Health Organization. Malawi Country Office (2022) *WHO Malawi Country Office – Comprehensive Annual Report Year 2022*. Lilongwe, Malawi: World Health Organization, Regional Office for Africa. Available at: https://www.afro.who.int/sites/default/files/2023-11/WHO%20Malawi%202022%20Annual%20Report.pdf (Accessed: 26 June 2025).

World Health Organization (WHO) (2024) *WHO Malawi 2023 Annual Report*. Available at: https://www.afro.who.int/sites/default/files/2024-08/WHO%20Malawi%202023%20Annual%20Report.pdf (Accessed: 18 January 2025).

Zon, H. *et al.* (2017) 'Municipal health services provision by local governments: a systematic review of experiences in decentralized Sub-Saharan African countries', *Health Policy and Planning*, 32(9), pp. 1327–1336. Available at: https://doi.org/10.1093/heapol/czx082.

Zon, H. (2021) *Decentralization of health resources to local governments in Burkino Faso*. maastricht university. Available at: https://doi.org/10.26481/dis.20212206hz.

Annex 1: Search table

Problem/Issue term			**Elements** (From the framework)		**Geographical scope**
OR	Decentralization Devolution (District Health Management Teams) DHMT (District Health Services) (District Health Systems) (Service Performance)	**AND**	Authority Responsibility Resources Accountability (Socioeconomic context) (Political context) (Cultural context) (Legal context) (Policy development) (Service management) (Service delivery) (Capacity development) (Funds allocation) Monitoring Supervision (Service access) (Service utilization) Participation Representation (Improved resources) (Policy provision) (Policy practice) Effectiveness Equity Quality	**AND**	Malawi OR Ghana OR Uganda OR (Sub-Saharan Africa)

Annex 2
KIT Institute (Masters or Short Course) Participants
Declaration for Use of Generative AI (GenAI)

Check the box that applies to your completion of this assignment:

☐ I confirm that **I have not used** any generative AI tools to complete this assignment.

☒ I confirm that **I have used** generative AI tool(s) in accordance with the ***"Guidelines for the Use of Generative AI for KIT Institute Master's and Short Course Participants."*** Below, I have listed the GenAI tools used and for what specific purpose:

Generative AI tool used	**Purpose of use**
1. Perplexity	Used for brainstorming and broadening of ideas and structuring of the write-up. Also helped with clarity and smooth flow and polishing of the text. I did use it to make the write-up concise to stay within the word count.
2. QuillBot	Supported paraphrasing and grammar check
Zotero	Reference management