

**AN EVALUATION OF THE IMPACT OF THE IMPLEMENTATION OF CAPACITY
BUILDING STRATEGIES IN THE PROVISION OF HEALTH SERVICES IN THE
CENTRAL REGION OF MALAWI**

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CENTRAL REGION OF MALAWI**

by

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DATE SUBMITTED: DECEMBER 2012

DECLARATION

I, Rosemary Shanice Chowawa, declare hereby that the mini-dissertation entitled *An evaluation of the impact of the implementation of capacity building strategies in the provision of health services in the central region of Malawi*, is my own work and has not been submitted for a degree at another university

SIGNATURE

DATE

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SUPPLEMENT C : INTERVIEW GUIDE.

SUPPLEMENT D : CERTIFICATION STATEMENT

SUMMARY

TITLE: AN EVALUATION OF THE IMPACT OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES IN THE PROVISION OF HEALTH SERVICES IN THE CENTRAL REGION OF MALAWI

The purpose of the study was to evaluate the impact of implementing capacity building strategies on the provision of health services in the central region of Malawi. The study intended to determine why a lack of quality services is still prevailing in the health services in the central region despite implementing capacity building strategies aimed at improving the delivery of health services. In addition to this, to come up with recommendations to improve the implementation of the existing capacity building strategies so that the implementation results in the intended impact, that is efficient and effective provision of health services in the central region of Malawi.

The studies reviewed what various scholars have written on capacity building in order to ground capacity building in Public Administration and provide the study with a conceptual, theoretical and legislative framework. This enabled the researcher to describe the nature and place of capacity building in Public Administration. It was evident from the review that the implementation of capacity building strategies is a systematic process which requires that chief officials follow all the steps in order to effectively and efficiently implement the capacity building strategies so that the intended impact is achieved. In this regard, capacity building is a management function which requires that chief officials play an enabling role by providing the necessary resources (both human and financial) and policies that support the implementation of capacity building strategies.

The study used both quantitative and qualitative research methods whereby thirty-five respondents composed of political office-bearers and chief officials from Lilongwe, Dedza, Mchinji and Dowa districts and Ministry of Health Headquarters in the central region of Malawi were given self-administered questionnaires to complete. Face-to-face interviews and document analysis were also used as research methods. The intention

was to determine the problems that are being experienced in the implementation of the existing capacity building strategies and find out if the strategies are resulting in the intended impact. The study findings confirmed that there are indeed problems being experienced in the implementation of the existing capacity building strategies, namely: inadequate human and financial resources, corruption, political interference, lack of consultation with stakeholders and lack of political will to make sure that the implementation of the capacity building strategies is effectively and efficiently done. It was also revealed that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region of Malawi, hence indicating a need to change in approach.

The study concludes that in order for the capacity building strategies to achieve the intended impact there is a need to broaden the scope of the legal framework on health capacity building strategies in Malawi, enforce the use of performance standards and improve the operational framework to gain efficiencies and effectiveness from current investments in capacity building.

KEY WORDS

Administration

Capacity

Capacity building

Efficiency

Effectiveness

Management

Organising

Planning

Policy making

Public administration

CHAPTER ONE

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Providing the capability to satisfy current and future government health care demands is a fundamental responsibility of operations management. An appropriate balance between capacity and demand can ensure effective service delivery and satisfied patients, health professionals and health workers, whereas getting the balance incorrect can be potentially ineffective. The purpose of this chapter is therefore to provide a framework for the study, articulate the study procedure, describe and explain what the study intends to investigate and the importance thereof.

The following standardised aims have been set for the chapter. Firstly, the chapter provides background to the study and the problem. Secondly, the chapter elucidates the identified problem and explains the background circumstances which led to the origin of the problem. Thirdly, following the problem statement the chapter presents the objectives and hypothesis for the study. Fourthly, the chapter justifies the significance of the study, provides an outline of the chapters and a theoretical framework for the study. Fifthly, the chapter explains the delimitations of the study and lastly, the chapter provides definitions of specific terms and words used in the study, to eliminate possible confusion because words often have different meanings. The background to the study can be explained as follows.

1.2 BACKGROUND TO THE STUDY

The Republic of Malawi (Constitution) Act, 1966, provides for a right of its citizens to access health services. These health services are delivered to the citizens through public and private health institutions. All public health services are provided by the National Government in the three regions, namely the Southern, Northern and Central region in Malawi. The Minister of Health is the political head in the Ministry and for purposes of recruitment and discipline is assisted by a Government Health Service Commission appointed by the President for a period

not exceeding three years and consisting of a Chairperson and not less than six and not more than ten other members (*Act 14 of 2002, section 4, 5 and 6*). The Commission is 'responsible to determine service conditions of officials appointed in the Government Health Service; to recruit and appoint such personnel' (*Act 14 of 2002, section 8*).

Health systems and services are largely affected by the size, quality, skills and commitment of health workers. Health indicators for Malawi have generally remained poor over the years due to shortages of human resources among other factors. As a result the efficient and effective delivery of quality health services is greatly affected. The Ministry of Health has described its human resources situation as near collapse since for example the health worker to patient ratio is too high. Health workers are overwhelmed by the demand for services resulting from population growth and high levels of the HIV and AIDS pandemic along with the high rate of brain drain stripping the Ministry of Health of its critical personnel such as nurses and doctors (*Human Resources for Health Country Report, 2009*). Further to this, the Ministry of Health is also faced with a high vacancy rate, with 49799 as a total number of health workers in Malawi for a population of 14,185,482. Currently the Ministry is operating with a vacancy rate of 52%. In order to address this problem it was decided to implement an Emergency Human Resource Programme (*EHRP*), a capacity building strategy that aimed at addressing the staffing crisis in the Malawi Health Sector. The EHRP had the following five elements:

- Improving incentives for attracting health professionals and workers by introducing a 52% salary top up and re-engagement of qualified Malawian health professionals who had retired from service
- Expanding domestic training capacity by 50% overall including doubling number of nurses and tripling the number of doctors and clinical officers in training.
- Using international volunteer doctors and nurse tutors to fill critical posts while Malawians are being trained.
- Provision of technical assistance to bolster capacity and build skills within the Department of Health's human resources planning and development functions
- Establishing more robust monitoring and evaluation capacity for human resources in the health sector within the existing health management information systems. (Mangham L.J. and K. Hanson, 2008: 1433 - 1441)

As per the mandate for the Ministry of Health in facilitating the constitutional mandate of the Republic of Malawi, the health sector has been prioritized with a particular focus on capacity building (Malawi Government, 2005: 10). However, this focus has been at policy and programme level, and it has been observed that there is an intermittent and inconsistent focus on the actual strategies that comprehensively build capacity in human resources and the environment, tools and processes through which these personnel in health services are expected to perform their functions. The EHRP as a capacity building strategy has failed to comprehensively address the human resources problems in the Ministry of Health and Population. Health professionals still face many challenges such as work overload leading to fatigue and low productivity; no opportunities for career development; lack of incentives; non-availability of resources and lack of supervision and appraisal among others. (Manafa *et al.*, 2009)

1.3 PROBLEM STATEMENT

The efficient and effective provision of health services in the central region of Malawi is essential for the promotion of the general health and welfare of the citizens. Lack of quality services prevails in the health services in the central region due to the irrelevant and often insufficient implementation of capacity building strategies, which causes unnecessary mistakes, complaints from patients and unnecessary wastage of financial and human resources. Despite the Ministry of Health's implementing three main capacity building strategies aimed at enhancing the capacity of health professionals and hospitals in Malawi, health sector basic indicators such as maternal mortality, infant mortality, malaria incidence, under five malnutrition and general deprivation continue to make Malawi one of the poorest countries on the African Continent as regards health services (*Malawi Government, 2002: 3-6*).

1.4 HYPOTHESIS

Polit and Hungler (1993:89) assert that the problem and hypothesis statements are seen as broad purpose statements and give rise to the setting of specific objectives, which indicate the intent of the study to prove or disprove something. Hence a hypothesis is an empirically testable version of a proposition. It is a tentative statement in a testable form and predicts a

particular relationship between two or more variables (Bailey, 1982:41; Neuman, 2006:58). The current research hypothesis is postulated as below:

- In this study, it will be proved that the implementation of the existing capacity building strategy impacts negatively on the provision of health services in the central region in Malawi

1.5 OBJECTIVES OF THE STUDY

The objectives of the study are to:

- Review the present implementation of the capacity building strategies in the delivery of health services in the central region of Malawi.
- Investigate and evaluate the reasons and causes for capacity building problems in the delivery of health services;
- determine and evaluate the impact of capacity building strategies on the delivery of health services; and
- where possible, make recommendations to improve the implementation of the existing capacity building strategies so that efficient and effective health services are delivered.

1.6 SIGNIFICANCE OF THE STUDY

A public service is judged by one main criterion above all, namely its effectiveness in delivering services which meet the needs of the citizens. The development of health services in Malawi is intended to have a major impact on the daily lives of the citizens (*Malawi Government, 2005: 11-12*). The study is important in that it will evaluate the implementation of the current capacity building strategies for the delivery of health services. The study will expose and analyse the problems faced by the Ministry of Health because the policy and practice of capacity building should be informed by research evidence. It is therefore essential to firstly investigate the effectiveness and the impact of the current capacity building strategies. Secondly, to provide recommendations to enable policy-makers to make changes and thus more effective departmental policy and programmes. The study should thus be important to political office-bearers and chief officials of the Ministry of Health to effectively and efficiently deliver its health services. The study could make a scientific contribution to the existing body of knowledge of

capacity building strategies and could also be used as a frame of reference by students and researchers with similar interests in the area of Public Administration. Any study is time and place bound and the delimitation of the study can be described and explained as follows.

1.7 DELIMITATION OF THE STUDY

The delimitation of the study also referred to as the scope or delineation of the study (Hofstee, 2006:87), explains the extent of the matters to be dealt with within a specific geographical area. The study delimited the following three areas for investigation.

1.7.1 PERIOD OF STUDY

The study was undertaken in January 2011 and completed in December 2012

1.7.2 SURVEY AREA OF THE STUDY

The Ministry of Health was established in 1964 to provide the traditional curative, preventive and rehabilitation health care services. The political head of the National Department of Health is a Cabinet Minister assisted by a Deputy Minister and a Government Health Service Commission. (*Act 14 of 2002, section 4, 5 and 6*). The Minister and Deputy Minister are accountable to Parliament (*Republic of Malawi (Constitution) Act, 1966, section 92 and 93*).

The survey area was delimited to the Central region of Malawi, which is one of three regions. Each region is further divided into Districts with District Health Offices and hospitals in each district as well as other small health units. The central region has been divided into the following eight districts:

- Dedza
- Dowa
- Kasungu
- Lilongwe
- Mchinji
- Ntcheu
- Ntchisi
- Salima

The Ministry of Health and Population has its head office situated in Lilongwe, the capital city of Malawi with an estimated number of 49799 appointed personnel. The overall goal of the health sector is to raise the level of health status of all Malawians by reducing the incidence of illness and occurrence of death in the population. The vision, mission and core values of the Department of Health are as follows:

Vision: A state of health for all people of Malawi that would enable them to lead a quality and productive life.

Mission: Provision of strategic leadership for the delivery of a comprehensive range of quality, equitable and efficient health services to all people in Malawi by creating an enabling environment for health promoting activities.

Core Values: Transparency, networking, creativity, accountability and professionalism.

The health services are rendered by the public officials of the Government Health Service. These officials are classified into:

- Health professionals, namely persons registered under law such as medical doctors, dental surgeon, pharmacists, nurses and midwives.
- Health workers, namely the administrative, scientific and support personnel employed in the health service and designated by the above Health Service Commission in consultation with the Civil Service Commission or an assembly. (*Act 14 of 2002, section 2*).

It is, however, the administrative personnel, especially the chief officials who are responsible for making health services possible by implementing the applicable executive policy and capacity building strategies (Thornhill, and Hanekom, 1986:7). The study thus dealt with administrative functions which make health services continuously possible. Against this background the concepts of capacity building and policy implementation were investigated within a public administrative framework

1.7.3 THEORETICAL SCOPE

Robbins (1980: 170) writes that a “(t)heory describes a set of systematically interrelated concepts or hypotheses that purports to predict phenomena.” A theory is also seen as “an

acceptable explanation of an observed phenomenon or a set of interrelationships” (Correia, 2003:15). Theory can be defined as a supposition or a system of ideas explaining something. It is based on general principles. The principles on which a subject of study is based. (*Oxford Advanced Learner’s Dictionary, 1995:1237*). Using a theory as a basis for the study can be of great assistance in understanding a problem and exploring alternative courses of action. However, William James in (Whisenand *et al.*, 1996:22) asserted that “theories are instruments, not answers to enigmas in which we can rest.” Against this background the concept of capacity building within policy implementation can be based on theory and be described and explained within a Public Administration framework. In this study the classical theory and the systems theory was used as a base and framework for the study, as explained in section 2.1 of Chapter Two.

1.8 OUTLINE OF CHAPTERS

To ensure that the research project is manageable it is necessary to develop a study plan which directs the researcher and the reader. A study plan has a dual purpose: Firstly, to organise the theoretical and empirical information into specific chapters, sections and subsections to ensure sense. Secondly, the outline seeks to direct the reader by indicating what can be expected in each chapter (Bailey, 1982:53). The study plan consists of the following chapters:

Chapter One gives an introduction and general orientation to the study. The chapter describes and explains the problem statement and hypothesis, objectives of the study, necessity of the study and delimitations of the study, as well as terminology and definition of terms and concepts used in this study. Essentially Chapter One indicates what the whole study entails.

Chapter Two deals with the literature review based on the distinguished opinions and views of secondary sources and different researchers and authors whose work is significant in this particular research field. Henning (2004:27) writes that a literature review is often a separate chapter in a research report in which the researcher synthesises the literature on his/her topic and engages critically with it. Chapter Two provides three frameworks for the study, namely a theoretical framework which is based on the classical theory and systems theory, a conceptual framework which deals with the nature and place of capacity building in Public Administration

and Management and a legislative framework for the implementation of capacity building strategies.

Chapter Three deals with the research design and methodology of the study. The purpose of the chapter is to describe the instruments to be used in the research, and outline the research techniques used to evaluate the cooperative role of political office-bearers and chief officials in the rendering of health services. Firstly, the requirement to obtain permission to conduct research is explained. Secondly, the research design, approaches and strategy used in the study are described and explained. Thirdly, the research methodology, consisting of the population, samples used, data collecting instruments and procedures used are described and explained. Lastly, the adherence to specific considerations in the study is described and explained.

Chapter Four deals with the analysis, interpretation and presentation of the data collected during the empirical testing. The purpose is to analyse, interpret and evaluate the collected data and available public documentation and applicable literature to organise the research findings around the research objectives to be able to test or verify, confirm or refute with evidence the problem and hypothesis. Appropriate analysis techniques were used to analyse the data scientifically.

Chapter Five is the concluding chapter and summarises the critical findings and deductions made in the preceding chapters. Specific shortcomings and problem areas in the implementation of capacity building strategies are explained and recommendations to prevent problems are provided. It also presents areas requiring further research

1.9 DEFINITION OF TERMS AND WORDS

A language such as English is dynamic and constantly changing and words and terms often have a variety of interpretations. This essentially means that various assumptions regarding the English lexicon open the language to various expressions and misunderstandings. Thus, in order to avoid such misunderstanding and subsequent misrepresentation of terms and words in this study, it is important to clearly explain the meaning attached to such terms and words used in this study. For the purpose of this study, the following terms and words are explained.

1.9.1 ADMINISTRATION

Administration is the joint action taken by two or more persons to make goal realisation possible. Administration is part of the executive functions performed by public officials. All work can be classified into specific functions and processes. Cloete (1986: 2 and 1989: 2) states that administration is described as part of the executive functions performed by public officials. The administrative functions can be classified into the following functions:

- Policy making
- Organising
- Financing
- Staffing
- Procedure determination and
- Controlling (Cloete, 1986:2)

1.9.2 EFFECTIVENESS AND EFFICIENCY

Effectiveness is the ratio measure relating observed output to be planned output over some time period. Because both outputs are measured in the same units, the ratio expresses the percentage of effectiveness for the assessment period (Brewer and Deleon: 1983:328). Meiring (2001:84) writes that “(t)he impact of policy can be

evaluated by looking at the effectiveness and efficiency of the services rendered. Effectiveness and efficiency are the prime difference between policy input and policy output. Services are rendered effectively if the amalgam of resources and interaction with the environment is measured against costs and indeed is achieved”. Thus effectiveness and efficiency in the provision of health services is about producing the desired outcomes as outlined by policy

1.9.5 PRODUCTIVITY

Productivity is simply defined as a measure of the amount of output generated per unit of input (Boyle, 2006:4).

1.9.6 CAPACITY

Capacity is normally understood as the ability to perform and deliver what is expected of an individual, organisation and informal set-up institutions (Vincent-Lancrin, 2006: 8; Conrad and

Kamanga, 2010:13), Grindle and Hilderbrand (1994:2) define capacity as the ability of organisations to perform appropriate tasks efficiently and effectively. The Institute for Education Planning (IIEP) (2006:43) concurs with Grindle and Hilderbrand (1996:443) by writing that capacity is the ability of individuals, organisations and systems to perform appropriate functions efficiently and effectively.

1.9.7 CAPACITY BUILDING

Hussein (2006: 374) views capacity building as the overall ability of individuals or groups to actually perform organisational responsibilities effectively and efficiently with emphasis on human resources (*United Nations Development Programme* (2005:3). Conrad and Kamanga (2010:18) extend the area of focus in capacity building to include systems within which the individuals work and interact, and defined the domains within which capacity building as a concept is expected to play a role; the domains included human resources, strategic alignment, management and administration as critical areas that are mutually inclusive.

1.10 CONCLUSION

It is the mandate of the Government of Malawi to provide primary health care to the citizens as this is presented as a basic right that each and every citizen of Malawi is expected to enjoy. Effective and efficient provision of health services to the citizens largely depends on the cadre of human resources the health sector has. Cognizant of the foregoing, the Government of Malawi has over the 2005/2006 and 2009/2010 fiscal years invested resources to build the human capacity of health workers so that they provide better health services to the improve the welfare of the citizens. Nonetheless, over the same period, performance of basic health indicators has not affirmatively responded to the levels of investments made. Therefore this study will assess the impact of capacity building strategies on human resources in the health sector and how the implementation of these studies have impacted on the overall performance of the Malawi Health sector within the study period .

CHAPTER TWO

2.0 LITERATURE REVIEW ON THE NATURE AND PLACE OF CAPACITY BUILDING IN PUBLIC ADMINISTRATION

2.1 INTRODUCTION

The literature review for this study requires that capacity building be grounded in Public Administration and be provided with a conceptual, theoretical and legislative framework to ascertain whether there is evidence available in the field of study and that similar research has been done. The purpose of this chapter is to review the applicable secondary literature to provide the above framework on the nature and place of capacity building in Public Administration. For this purpose two theories will be used to base the framework in Public Administration, namely the classical theory and the systems theory.

The chapter consists of three main sections in addition to the introduction and conclusion. The following aims have been set for the sections. Firstly, a theoretical framework and base for capacity building within Public Administration will be described and explained. Secondly, a conceptual framework for capacity building within Public Administration will be provided. Capacity building will be described and explained as a management function to ensure effective and efficient work performance in a public sector environment. Lastly, the legislative requirements and framework for rendering health services in Malawi will be described and explained.

2.2 THEORETICAL FRAMEWORK AND BASE FOR CAPACITY BUILDING IN PUBLIC ADMINISTRATION

A theoretical framework is the basis on which a study could be grounded. A theory in this context means a set of ideas to explain something or an opinion about something (Ngantweni, 2010:5). A theoretical framework thus orientates the study, provides shape and support. Usually the research will remain within the boundaries of the frame (Henning *et al.*, 2004:25). The need for a theory base is confirmed by Hofstee (2006:30) who writes that “If you can’t come up with a theory base that relates to whatever it is that you want to do, then the chances that it will work at all are slim”. Nigro and Nigro (1984:1) also explain a theory as a set of

interrelated concepts, definitions and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena. Correia *et al.* (2003:16) write that “(u)sing a theory as a basis can be of great assistance in understanding a problem and exploring alternative courses of action”. Henning (2004:25) writes that a theoretical framework “... reflects the stance the researcher adopts in her research and that is why you can say that it frames the work”. It can thus be deduced that a theory provides a set of ideas that are used for explaining a phenomenon. In this study theory forms the basis for an attempt to investigate the impact of implementing capacity building strategies on health services in Malawi.

As explained in section 1.7.3 of Chapter One, this research intended to base capacity building for health services on the classical theory and the systems theory. Both these theories can be described and explained as follows.

2.2.1 Classical Theory

The classical theory can be seen as a stage in the development of scientific management (O'Donnell, 1966:37). This theory designated classical theory by Maerch and Simon is closely associated with essays by Gulick, Urwick, Fayol, Mooney and others (O'Donnell, 1966:37).

People have worked for thousands of years; however few people had ever looked at human work systematically. In the 1830s, Charles Babbage (1856-1915) wrote about the need for a systematic study and standardization of work operations to improve productivity (Robbins, 1980:35). Babbage believed that efficiency in the British factories could be improved through scientific management. This objective could be attained by dividing up work and assigning work to individuals on the basis of skill and by replacing manual operations with automatic machinery (Robbins, 1980:35). Fredric W. Taylor introduced the scientific management approach in 1885, aimed at increasing workers' productivity by breaking down work into simple but repetitive tasks, providing thorough training, isolating individuals from distractions and each other and paying good wages with bonuses for productivity over predetermined levels (Drucker, 1982:337; Young, 1986:168). Davis and Heineke (1991:19) write that “Taylor's philosophy was not greeted with approval by all his contemporaries. On the contrary, some unions resented or feared scientific management”. However, Smit and De Cronje (1992:17) confirm that Taylor and his adherents showed that it was possible to improve the productivity

of workers. Managers and academics became aware for the first time that management can apply scientific approaches and methods to attain objectives effectively.

Different approaches were developed in response to the needs and issues confronting managers over the years. These needs and issues were caused by a rapidly changing environment such as caused by the industrial revolution and more specifically ignorance on the part of managers of their responsibility to organize and standardize the work to be done and "...workers were often viewed as just another interchangeable asset, like plant and equipment" (Davis and Heineke, 1991:19). Van der Westhuizen (1991:65) writes that the ideas that workers could be programmed like machines could be seen as the basic shortcoming of Taylor's work. It can be deduced from the above exposition that the classical theory takes efficiency and effectiveness as the objective with the division work and specialization of function. At this point, it is important to discuss the general characteristics of the classical theory.

2.2.1.1 General Characteristics of the Classical Theory

The classical theory takes efficiency as the objective by concentrating on the functions and processes required to be carried out to achieve predetermined objectives. It views administration and management basically with the division of work and specialization of functions. The aim is to continuously ensure that the operational workers are used as effectively and efficiently as possible in the rendering of services (Terry, 1977:4). Various classifications of these functions have been determined over time (O'Donnell, 1966:37; Berkley, 1984:57). Gulick for example designates the work of chief officials/executives as planning, organizing, staffing, directing, coordination, reporting and budgeting, an acronym known as POSDCORB (Learned and Sproat, 1966:49; Cutchin, 1981:76). Capacity building is thus seen as a management function because all personnel should not only be capable of providing services but should also have the ability to provide services effectively and efficiently.

Various scholars have written that in any complex organisation whether private or public, one finds the same basic processes of administration: defining purposes, planning, organizing, recruiting, selecting, rewarding, communicating, budgeting, decision making, managing, motivating, controlling and measuring results. This mixture of functions is not a clear exposition of the administrative and management functions but it indicates that work can be classified in

various functions. Cloete (1985:1-2) contends that administration consists of specific enabling functions, that is functions to make provision of services continuously possible, namely policy making, organizing, staffing, financing, determining of work procedures and controlling. It can thus be deduced that capacity building as a management function ensures that both the organization and the human resources in it are equipped to efficiently and effectively render services hence increasing productivity. It involves identifying an individual's specific roles in the organization and building his or her capacity to specialize in his/her work.

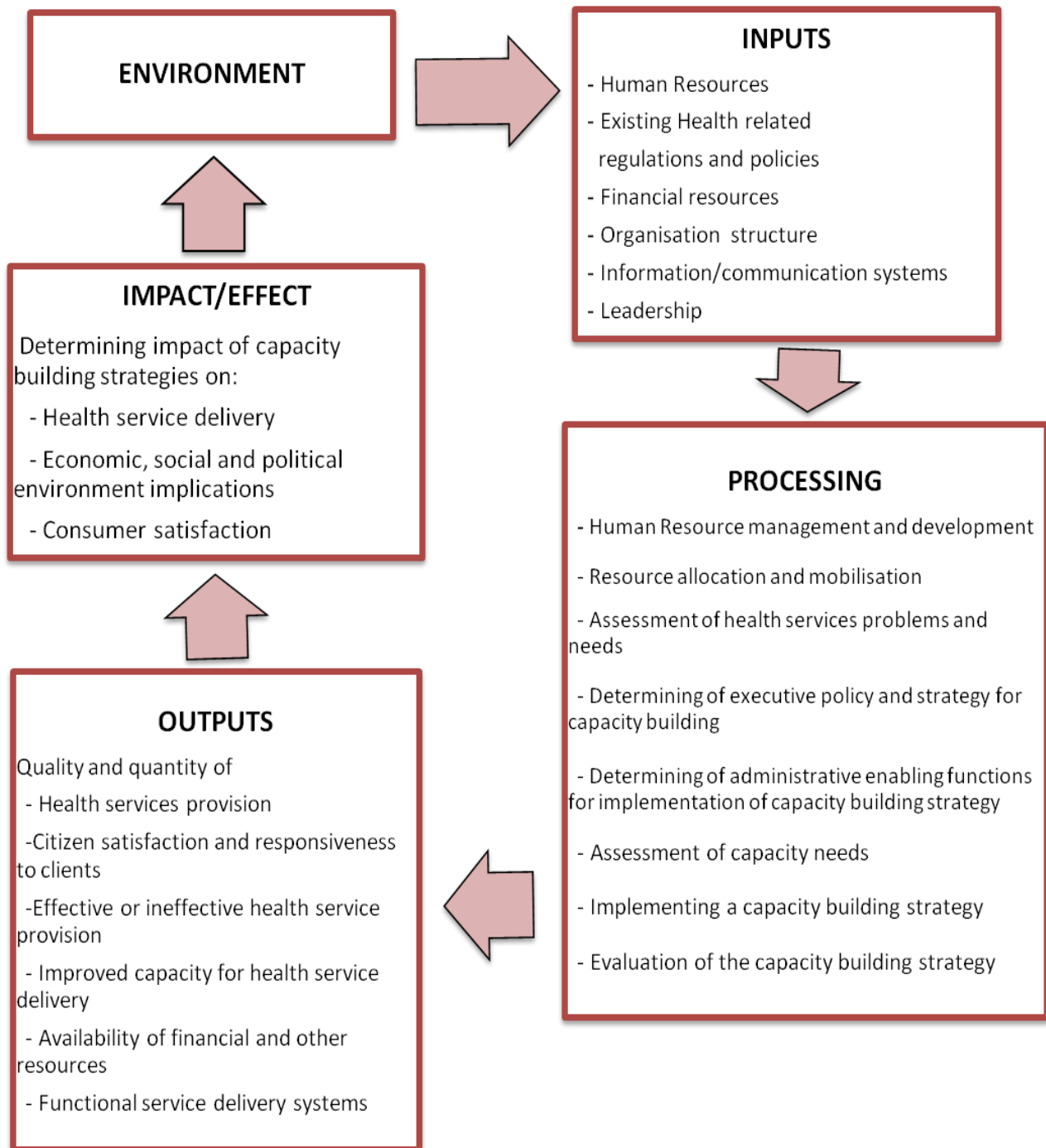
In addition to the classical theory, the systems theory was used to evaluate the impact on the implementation of human resource capacity building strategies in the provision of health services in Malawi.

2.2.2 Systems Theory

A system is seen as an organised whole consisting of specific identifiable parts which are connected and directed for some purpose (Terry, 1977:27). The systems theory consists of a set of interrelated elements or phases functioning as a whole (Smit and De Cronje, 1997:62). Luthans (1997:477) writes that a system cannot survive without continuous input, the transformation process and output. Hellriegel et al. (1999:61) assert that the systems viewpoint "represents an approach to solving problems by diagnosing them within a framework of inputs, transformation processes, outputs and feedback". However, the systems theory cannot only have specific output as manifested in for example health services but also a specific impact, which is seen as the consequences, effects and side effects (Spadaro, 1975:6; Meiring, 2001:84). A specific relationship exists between the reason for solving the problem for example for rendering a specific service, the services that are rendered and the impact on the environment.

Thus, it can be deduced that the systems theory has essential phases or components and takes place in a specific environment and time. To illustrate the phases to evaluate the implementation of human resource capacity building strategies in the Ministry of Health, the following model was used.

FIGURE 2.1: SYSTEMS THEORY FOR EVALUATION OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES FOR HEALTH SERVICES



(Based on Meiring, 1978:308, Hellregel *et al.*, 1999:713.)

The above model can be described and explained as follows.

2.2.2.1 The Environment Factors

The environment is seen as the total reality within which human beings live and can be divided for study purposes into various categories, for example the physical, economic, social, religious and political environments. In addition, the environment is time and place bound and in a constant state of change. It also gives rise to various needs, problems and demands from the people living within such environment. The provision of health services involves people who interact with other people to accomplish goals. The environment is also influenced by various environmental factors such as floods, inflation, and outbreak of diseases or violence which give rise to human needs and subsequent action to solve problems and satisfy needs. The executive policy, that is the policy made by politicians in a legislature, is always a starting point for the provision of health services (De Villiers and Meiring, 1995:74 and 79).

2.2.2.2. The input phase to the provision of health services

The input phase is important because it provides the means required to deliver health services in a specific environment. In addition to an executive policy such as *the Republic of Malawi, Government Health Service Act, 2002 (Act 14 of 2002)*, Health services also require personnel such as chief officials, managers and subordinates, equipment, facilities, materials, money and information. A multitude of decisions ought to be taken to make it possible to render health services. Stevenson (1993:244) writes in this regard that these decisions have an impact on capacity. The quantitative relationship between the means (including all financial, human and time resources) refers to the ratio in which the means/ resources are combined to obtain the optimal provision of health services and to utilize the capacity available. (Marx *et al.*, 1998:216).

2.2.2.3 The Processing Phase to Provide Health Services

The processing also known as the transformation phase (Hellriegel *et al.*, 1999:713) refers to the conversion of the inputs into outputs and consists of various processes. These processes are seen as the executive functions and are classified into three main groups, namely the

administrative enabling functions, the operational functions also known as the functional activities and the management functions (Meiring, 2001:48; Cloete, 1986:2). Capacity building is explained as an operational function. Hellriegel *et al.* (1999:713) explain operational management as “the systematic direction, control and evaluation of an entire range of processes that transform inputs into finished goods and services”. The term capacity refers to an upper limit or ceiling on the load that an operating unit can handle (Stevenson, 1993:240). The essence of the processing is to add value to the service.

2.2.2.4 The Output Phase

The output is the original input as changed by the transformation process and is influenced by the quality and standard of work performance and the efficient and effective provision of services (Hellriegel and Slocum, 1996:55). The output system refers to the qualitative and quantitative services that are provided. Capacity will thus have the maximum output that can possibly be attained. The actual output achieved will however depend on the available inputs.

2.2.2.5 The Impact Phase

A distinction should be made between the output and the impact of a system because a service provided as output will always have a specific usefulness or utility for the consumer. Consumers will always evaluate a service in accordance with specific criteria, such as costs and quality. The impact of a service will thus be to the advantage or disadvantage of the consumer, will be optional or compulsory and can in the end have economic, social and political implications (Meiring, 2001:91; Laver, 1986:53 and 69). The impact of a system is also described as the effect and side-effects. Bozeman (1979:263) writes that “(t)he best administered program is of no value if nothing significant is accomplished”. Portney (1986: 10) also claims that “in most evaluation studies, the important question is whether governmental programs or policies ‘caused’ the impact that they were supposed to do”. Thus the impact of implementing capacity building strategies will be known by looking at the quality of health services being delivered to the citizenry and high level of satisfaction with health services.

2.2.2.6 The Feedback Phase

Feedback is information about a system's status and performance. Feedback is an important requirement for any of the governing, administrative, and operational processes. Feedback can be positive or negative. Feedback makes it possible that the work can be assessed and, if necessary, corrected (Stoner, 1982:53; Stacey, 1996: 254 and 277). Political office-bearers, chief officials and managers need to know how well the subordinates are performing and how effective and efficient are the services provided. To ascertain performance and improve on the achievements, feedback is required, which is processed for future utilisation (Marx et.al., 1998: 704). In a hospital, feedback may take for example the form of surveys, financial reports, production records, inspection reports and performance appraisals. Stevenson (1993: 6) asserts that "(t)o ensure that the desired outputs are obtained measurements are taken at various points in the transformation process (feedback) and then compared to previously established standards to determine if corrective action is needed". All employees ought to receive direct and clear information about their work performance from the task itself or from others (Hellriegel et al., 1999:474). Thus in the Ministry of Health, upon implementing the capacity building strategy, where there is a need for improved performance, health professionals need to be appraised for their performance and management also needs to find out from the stakeholders such as the citizens about their satisfaction with health services so that efficiency and effectiveness are maintained.

It can be deduced that capacity building is a systematic process which consists of the input, output, processing, impact and feedback phases hence systems and classical theories have been used to explain capacity building as an activity that emphasizes efficiency and effectiveness in the utilisation of organisational resources, thereby improving the performance of the organisation as a whole.

2.2.2.7 The Relationship between the Classical Theory and Systems Theory

Classical theory as espoused by Fredric W. Taylor and other various scholars on scientific management concentrates on how best management can increase productivity so that the objectives of the organization are achieved effectively and efficiently (Robbins, 1980:35). In this way classical theory emphasizes on the functions and processes that are required to be carried out. Similarly systems theory recognizes the fact that an organisation is a system with interrelated phases functioning as a whole (Smit and De Cronje, 1997:62). This means that in

order for productivity to be increased all the phases in the system need to work together. Everyone in the organisation has a role to play. Systems theory gives ensures that resources in the organisation are available and are being used efficiently and effectively to maximise productivity.

In this regard, capacity building is a systematic management function which is carried out to ensure that the personnel in the health institutions have the right skills and adequate resources to achieve the predetermined objectives. It can thus be deduced that both classical theory and systems theory explain capacity building as an activity that emphasizes efficiency and effectiveness in the utilisation of organisational resources, thereby improving the performance of the organisation as a whole. And by implementing capacity building strategies, an organisation, in this case the Ministry of Health in Malawi aims at improving its service rendering to the citizens and if this is not achieved, it means that something is wrong in the system and hence needs to be changed. Thus, classical theory and systems theory explain why the capacity building strategies that are being implemented are not achieving the predetermined objectives in the Ministry of Health by outlining the necessary activities and functions that need to be carried for a system to be successful and functional.

2.3 NATURE AND PLACE OF CAPACITY BUILDING IN PUBLIC ADMINISTRATION (A CONCEPTUAL FRAMEWORK)

A concept is an idea, usually of a kind of object or state of affairs expressed in a word or phrase (Solomon, 1994:350). Conceptualisation, according to Neuman (2006: 182), "... is the process of taking a construct and refining it by giving it a conceptual or theoretical definition". A conceptual framework is thus described as a system of concepts within which objects are classified and recognised in a specific way and in which specific interpretations and ideas are given priority (Solomon, 1994:350). Capacity building is thus a concept within Public Administration both as a science and a field of action.

Capacity building is work performed by chief officials and is implemented to improve the skills and knowledge of public officials and the work performance of departments , to improve the ability of role-players to effect change and influence it, to make informed decisions, to access, use and manage resources as effectively and efficiently as possible (Paul, 1987:18; Van der Walt *et al.*, 1998:146). Capacity building takes place on the operational level and is thus closely linked to the rendering of services because capacity building focuses on the provision

of service capacity of a particular operations process. The systems approach to capacity building can thus also be used to convert capacity inputs to capacity output and thus to improve the rendering of health services. The nature of capacity building can be described and explained as follows

2.3.1 Nature of Capacity Building

Capacity building is a management function which needs to be determined, implemented and evaluated to ensure effective and efficient work performance and thus service rendering at the operational level. Lipsey (1989:184) explains capacity as the output that corresponds to the minimum average total cost. The basic objective is to utilise the available capacity optimally (Hugo *et al.*, 2000: 226). Capacity refers, according to Stoner (1982:222), to "... the maximum theoretical rate of productive or conversion capabilities for an existing product [and service] mix of an organizations operation". Cronje *et al.* (2002:382) point out that a suitable balance is required between the available capacity and the expected demand for a service. If the balance is wrong, for example if too much capacity and too little demand or too little capacity and too much demand are present, then the organisation is faced with a potentially disastrous situation. Capacity decisions will thus have an impact on service rendering. Capacity on the operations level of a department can be defined as the maximum usable operations capacity of a particular operations process over a specific period of time under normal operating circumstances (Cronje *et al.*, 2002:383). However, Stevenson (1993: 242) writes that "when a multitude of services are involved, as is the case with [health services], using a simple measure of capacity based on units of output can be misleading". The problem is compounded if the department renders a variety of services. In such cases a measure of capacity that refers to the availability of inputs could be used, for example a hospital has only a certain number of beds available. Koonts *et al.* (1964: 140) assert that "one could vary inputs against outputs until the additional input equals the additional output. ... This would then be the point of maximum efficiency".

It can thus be deduced that an organisation such as the Ministry of Health should have sufficient capacity to render services as effectively and efficiently as possible. It should thus have the ability to perform what is expected by the citizens. The capacity to develop

sustainable skills rests primarily on the organisational structures and resources available to the organisation (Hawe et al., 1999: 29). Conrad and Kamanga (2010:13) assert that capacity building includes systems within which the officials work and interact, and define the domains within which capacity building as a concept is expected to play a role. The domains include for example human resources, strategic management and performance appraisal (Conrad and Kamanga, 2010:13). It is clear from the above discussion that capacity is conceptually explained in various ways and that it is difficult to provide a single explanation for it. Capacity building as a function however is part of public administration and its place can be described and explained as follows.

2.3.2 Place of Capacity Building in Public Administration

The ultimate aim of capacity building is to be capable, that is to have the ability or quality to render public services as effectively and efficiently as possible, under prevailing circumstances. Capacity building is for this reason directly linked to the utilisation of available resources (such as financial and human resources) and other means such as policy, structures, procedures and control measures and standards, required to render public services. De Villiers and Meiring (1995:171) write that “(i)t is a prerequisite in any work situation that the means to do the work should not only be provided, but that steps should be taken to ensure that such means be used as effectively and efficiently as possible”. Three main groups of functions should be performed. Firstly, the subordinate personnel should be provided with the means to do the work. These functions are known as the enabling functions and can, according to Cloete (1984:2), be classified into policy making, financing, organising, staffing, determining of procedures, and controlling. It then follows that from a Public Administrative perspective

- policy, i.e. objectives and guidelines for capacity building;
- financial resources for capacity building;
- organisational structures for capacity building;
- personnel for capacity building;
- procedures and methods for capacity building; and
- control measures and standards for capacity building

should be determined (Meiring, 2001:48). Secondly, that the subordinate personnel use the above means to render public services. These functions are known as the functional activities (Cloete, 1983:6), or the operational functions (Meiring, 2001:41), or just described as operations (Pearce, 1994:314). The following functions can be seen as examples of operations functions in a hospital: Bathing of babies; giving of an injection; changing the dressing on a wound; and health education for mothers (Meiring, 2001:42). Lastly, chief officials and supervisors should ensure the best possible results in the provision of services, which means to obtain maximum output with minimum input or the best possible service at the lowest cost. These functions are described as the management functions. Taylor (1971:9) writes that “(t)he art of management... [is] knowing exactly what you want men to do, and then seeing that they do it in the best possible way”. It can be deduced that to achieve results and to perform according to expectations the supervisor must induce his/her subordinates to use the above resources and other means, even the equipment, facilities, materials and information that are provided, as effectively and efficiently as possible. It can also be deduced that the supervisors and subordinates should have sufficient capacity to operate.

2.3.2.1 Capacity Building in Operations Management

Public services are rendered on the operations level and should be managed as best as possible. Various operations are carried out to render services. Operations management is “(t)he systematic direction, control, and evaluation of the entire range of processes that transform inputs to finished goods and services” (Hellriegel and Slocum, 1996: 249 and 767). Stevenson (1993:4) writes that operations management is “(t)he management of systems or processes that create goods and/or provide services”. Various different classifications of the management functions are provided by authors. Schwartz (1980:5) writes for example that “(n)early all writers treat the functions of planning, organising and controlling as management functions. Other functions that have been proposed are staffing, directing, leading, measuring, motivating and communicating. In this text five functions – planning, organizing, staffing, directing and controlling – are treated.” However, Hellriegel and Slocum 1996:8) refer only to planning, organising, leading and controlling.

It is essential to note that the supervisor or manager does not manage materials, money, time or machines, but people, who in turn achieve some degree of tangible output through the use

of resources/means (Poppleton, 1976: 31). However, various references to different types of management are found in the literature, for example strategic management, personnel management, financial management, project management and operational management. Operations management is explained as those management activities that take place to create products and services and this definition is thus important for this study (Greasley, 2007: 3). Operations management is purposeful action and the objectives deal for example with the

- characteristics of the service to be provided;
- quality of the service;
- efficiency through effective personnel relations; and
- control over labour costs, material, and machines (Shim, *et al.*, 1999:3).

It can thus be deduced that operations management as a group of functions is the core process of any public department/ institution. It is the only group of functions to ensure that services are rendered effectively and efficiently. As work towards goal attainment proceeds, it is important to supervise and monitor progress on a regular basis. It thus goes together with the operations functions which are being managed.

The management functions for capacity building can be described and explained as follows.

2.3.2.1.1 Planning For Capacity Building

Starling (1977:126) writes that “(p)lanning is reasoning about how an organisation will get where it want to go. Its essence is to see opportunities and threats in the future and exploit or combat them by decisions taken in the present”. Planning always follows policy making. Policy is described as an authoritative exposition of objectives which indicate what the policy makers wish to do, what they want to achieve and where they want to go with the development of a community or state (Meiring, 2001:51). Planning, according to Cloete (1975:27), must be carried out to find the best course of action to achieve policy objectives which have been identified and described in the policy statement.

Planning can be undertaken for various periods of time, for example long-term planning, which is of a strategic nature and short-term planning which is of a tactical nature. Strategic planning

is defined as a set of decisions and actions resulting in the formulation, approval and implementation of strategies designed to achieve specific predetermined objectives (Code, 1990: 110). Such a set of decisions and actions will for example determine the long-term performance of capacity planning in a health department. Davis and Heineke (2005; 4) write that “(w)ithin the operations function, management decisions can be divided into three broad areas:

- Strategic (long-range) decisions.
- Tactical (medium-range) decisions.
- Operational planning and control (short-range) decisions.”

A strategy is

- comprehensive in that it covers all major aspects and functional areas of a department (Robbins, 1980:158);
- used to create focus, consistency and purpose for a department by producing plans, patterns and perspectives that guide action (Nutt and Backoff, 1922:20);
- a statement of direction that serves as a central theme guiding and co-ordinating functional action (Robbins, 1980:158);
- both an explanation of past action and a guide for future initiatives and programmes (Day, 1990:21); and
- integrative, which mean all its parts are compatible with each other and fit smoothly together.

It can be deduced that capacity building as a function involves management of the organisation’s resources including financial, material and human resources. It also entails planning for the future capacity of the organisation by implementing strategies that would ensure that the health department has the right quantity and quality of capacities to enable it to render its services efficiently and effectively.

2.3.2.1.2 Organising of Capacity Building Structures

Organising as a managing function entails the creation of structures for the implementation of predetermined policy for the rendering of services. Organising is described as a structural and a human phenomenon. As a process it consists of the following consecutive enabling steps to create structures:

- Creation of work units in the form of posts, sections, divisions, and departments which are the result of work division (Smit and Cronje, 2002 : 191)
- Allocation of functions to these work units (Kroon, 1990: 8)
- Delegation of authority to work units (Kroon, 1990: 8)
- Creation of internal and external communication channels; and the
- Creation of behavioral relationships in the work units (Terry, 1977: 264; Davis and Heineke, 2005:35)

Once the organisational work has become operational the managers/supervisors must continuously ensure and improve effectiveness. Organisational effectiveness may be obtained as follows:

- Monitoring of the span of control according to the mental and physical abilities of the individual supervisors and his/her subordinates (Cloete, 1995:71)
- Promoting unity of action and command (obtain teamwork) (Cloete, 1995:79)
- Continuous adaption to a changing environment (Meiring, 2001:111; Koontz and O'Donnell, 1964:208)
- Elimination of conflict situations in the work environment (Meiring, 2001:112)
- Promoting co-ordination (Smit and De Cronje, 2002: 192)

In this regard, capacity building is critical to operations management as it enables the organisations to put in place required systems and structures that ensure that there are sufficient capacities to render health services. However, having structures and systems in place is not enough, as effective implementation of capacity building strategies requires that there is also good leadership to motivate human resources to achieve the set capacity goals. The management function of leading capacity building personnel is explained below.

2.3.2.1.3 Leading Capacity Building Personnel

Leadership is described as the process of leading which involves influencing subordinates to act towards the attainment of the objectives set in the policy. Leadership is thus based on interpersonal relationships. Leading is the ability to get subordinates to do their best in the execution of their functions (Hellriegel, Jackson and Slocum, 1999:500; Marx et al., 1998: 354). Leadership is concerned with personal qualities and attributes as well as acquired skills, and involves both the behaviour of the leader, the situation and the group involved (Craythorne, 1980:305).

Mitchell and Larson (1987:434) write that several aspects of leadership should be noted, inter alia, that it

- is a process and not a person;
- requires a formal leader who exhibits leadership, who does have to be a formal leader;
- implies a degree of legitimacy;
- requires the subordinates must either explicitly or implicitly consent to the leader's influence;
- requires subordinates to allow themselves to be influenced;
- implies that the leader's power is ultimately rooted in the group itself; and
- if the leader is unable to move the group towards the desired objectives, he/she is not exerting leadership.

It can thus be emphasized that leadership capacity is the engine that inspires and gives direction in the delivery of service. Hence the leadership capacity of chief officials should be enhanced to integrative, entrepreneurial and administrative leadership which is necessary for forecasting and planning to meet future challenges. In this regard it can be deduced that in order for capacity building strategies to be well implemented, it is important that there is committed and dedicated leadership that would ensure that the capacity building personnel are motivated to ensure that capacity plans are carried out and goals are achieved.

Part of leading in any organisation entails control of activities, thus leading the capacity building personnel also includes controlling all capacity building activities to ensure that they are carried out according to the right procedures and standards. This is explained below.

2.3.2.1.4 Controlling of Capacity Building Activities

To ensure effective capacity implementation it is required not only that each official knows exactly what is expected, according to what standards the work performance will be judged and what criteria will be applied, but that each supervisor should know what control measures and standards are to be applied and how to exercise control. Control is exercised to ensure that the work is properly done and carried out in accordance with the policy and procedures laid down (Stoner, 1982: 17). Control can only be exercised if reliable control measures are in place, such as inspections, auditing, reporting and statistical returns, and control standards, such as hospital standards have been determined and approved (Hellriegel, Jackson and Slocum, 1999:659; Meiring, 2001:164). Marx *et al.* (1998:355) asserts that control is essential to ensure that quality standards are maintained and that the necessary adjustments are made in time. The measures used to exercise control have two main characteristics or components, namely to check the work of subordinates and to demand accountability for an irregularity or deviation from the existing policy or procedures (Meiring, 2001: 165).

Capacity building activities are carried out to ensure that the organisation has the right quantity and quality of capacities to render services effectively and efficiently. It is thus important that these activities be controlled so that they are implemented according to laid down policy and procedures. In this regard it can be deduced that controlling of capacity building activities cannot be avoided as it helps in ensuring that the correct and required standards are maintained and where possible corrective measures are put in place so that resources are not wasted but are used in improving performance and service delivery.

2.3.3 CAPACITY BUILDING AS A PROCESS

A process can be described as a course of action which consists of various consecutive related steps or a series of events, which form a recognisable pattern and which appear so often that the same pattern repeats itself (Crowther, 1995:922; Van Dyk, 1960:96; Meiring, 1987: 15). Capacity building can thus be seen as a process because it consists of consecutive steps to be carried out. Cronje *et al.* (2002:383) write that quantitative data on the expected demand, and the required capacity to satisfy it, must be obtained by applying the following five steps:

- **Engaging stakeholders and building consensus among management**

This involves discussing and reaching an agreement on what are the key service delivery challenges and how those can be addressed through capacity building. This step allows both the stakeholders and management to define the scope, focus and boundaries of capacity building which ensures that capacity building activities are carried out within the set boundaries, hence avoiding wastage of resources and time.

- **Capacity needs assessment**

In order to implement effective capacity building strategies that would result in the improvement of the organisation's performance there is a need to determine the exact total demand and capacity required. This also involves identifying areas which require additional training (in terms of human capacity) and which areas should be prioritised. It should however be pointed out that it is sometimes necessary to conduct performance assessments before capacity needs assessment as sometimes the organisation may fail to deliver services due to other factors such as unfavourable working environments and lack of incentives (Ogiogio, 2005:4). The capacity needs assessment step leads to capacity planning whereby capacity building strategies are formulated and the means of implementing them are also put in place. This step also includes building the commitment of stakeholders towards achieving the capacity goals set and also putting in place controlling measures to ensure that capacity building activities are carried out according to agreed policy and procedures (UNDP, 1998: 5).

- **Formulating capacity building response/strategies**

A response to the capacity need assessment conducted in step two would be based on four core issues, namely the institutional arrangements, leadership, knowledge (knowledge is the foundation of capacity) and accountability. It is at this stage that capacity building strategies are defined and methodologies to be used and the cost requirements are identified before the implementation stage (Ogiogio, 2005: 6).

- **Implementing capacity building strategies**

Involves creating intentional structures to manage and monitor progress over time because capacity building is an ongoing commitment to continuous improvement. The implementation stage also includes putting in place evaluative indicators to measure the effectiveness of the initiated programmes.

- **Monitoring and evaluation**

This is the last step of the capacity building process. Monitoring and evaluation promotes accountability and should be based on the four core issues of the organisation, namely; the institutional arrangements (for example, policies and procedures for recruitment, incentive systems, performance evaluations), leadership, knowledge and accountability. This step involves monitoring progress of capacity building programmes and activities, conducting impact evaluations and obtaining feedback on capacity building activities. There must always be a framework for measuring outcomes and impact of interventions so as to encourage more productive and efficient use of resources in an organisation (Ogiogio, 2005:8).

It can be deduced that capacity building is a systematic process which includes five main steps, namely engagement of stakeholders, capacity needs assessment, formulating capacity building strategies, implementing capacity building strategies and most importantly evaluation and monitoring of the capacity building activities to ensure that they are being implemented according to plan.

2.3.4 FACTORS INFLUENCING CAPACITY BUILDING

There are various factors that influence effective and efficient implementation of capacity building activities. Stevenson (1993:244) writes that various factors will have an impact on capacity building, for example

- The design of facilities, including size and provision for expansion is important,
- Location factors such as transport costs, labour supply, and energy sources are also important.
- Layout of work area often determines how smoothly the work can be performed.
- Environmental factors such as heating, lighting and ventilation play an important role.
- Product or service design can have an important influence on capacity.
- The quantity capability of a process is an obvious determinant of capacity. A more subtle determinant is the influence of output quality,
- The training, skills and experience required to perform a job all have an impact on potential and actual output.
- Employee motivation has a basic relationship to capacity, as do absenteeism and labour turnover.
- Product or service standards, especially minimum quality and performance standards can restrict options in increasing and using capacity.

Capacity building is influenced by various factors from both the internal and external environments of the organisation that range from poor incentives, performance standards, availability of skills, knowledge and expertise to carry out a job to weak leadership and ineffective management style. It is thus important to take these various factors into consideration when coming up with capacity building plans.

In summary it can be deduced that capacity building is the process or an activity that aims at improving people or entities to carry out stated objectives. It is the work of chief officials that is implemented to improve the overall performance of the organisation as a whole. In this regard, capacity building is a management function which involves utilisation of the material, financial and human resources in the organisation in order to render services effectively and efficiently.

Further to this, capacity building ensures that the organisation has the right quality and quantity of capacities to render services and it is for this reason that it is closely linked to operations management which ensures that the goals of the organisation are achieved as effectively and efficiently as possible. Thus, as a management function, capacity building involves planning, organising, leading and control of capacity building initiatives so that the required demand for capacity is known, the right systems and structures are put in place, there is commitment and motivation on the part of capacity building personnel, and finally so that capacity building activities are implemented according to laid down procedures and standards, thereby preventing wastage of scarce resources.

It can also be deduced that capacity building is a systematic process which consists of five main steps which have to be followed. These are engagement of stake holders, capacity needs assessment, formulation of capacity building strategies, implementation of capacity building strategies and finally monitoring and evaluation of capacity building programmes to ensure that agreed procedures are followed and standards are being adhered to. Since capacity building is critical to any organisation, it is important to take into consideration various factors that may impact on capacity building activities such as poor incentives, weak leadership and poor management style, availability of skills, training and expertise to do the job and employee motivation. This would ensure that mitigating measures are put in place.

2.4 LEGISLATIVE FRAMEWORK FOR CAPACITY BUILDING IN THE RENDERING OF HEALTH SERVICES

The legal framework capacity building in Malawi is not as extensive as it is in other countries like South Africa. In Malawi there are mainly only three, namely the Republic of Malawi (Constitution) Act, 1966, as amended, an Act of Parliament and official policy documents. The three legal framework instruments may be discussed as follows:-

2.4.1 CONSTITUTIONAL REQUIREMENTS FOR CAPACITY BUILDING

The Republic of Malawi (Constitution) Act, 1966, as amended, in sections 13, 25 and 30 presents the need for capacity building. The implications of the provisions emphasize the need for and the creation of an enabling environment for the delivery of quality health services.

Section 13 provides as follows: - The state shall directly promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals:-

Subsection (c) To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care; and

Subsection (f)(iii) To provide access to the education sector and to devise programmes in order to offer greater access to higher learning and continuing education. The spirit behind this section is that all efforts must be made to ensure that the appropriate health services are provided to the citizens of Malawi. In addition to the existing knowledge levels, the section implies that there should be a deliberate policy to equip those concerned with relevant skills and attitudes even if it means training further to acquire higher qualifications.

Section 25 (3) provides that private schools and other private institutions of higher learning shall be permissible, provided that –

- (a) Such schools or institutions are registered with the State department in accordance with the law
- (b) The standards maintained by such schools or institutions are not inferior to official standards in State Schools.

This section aims at ensuring the provision or existence of numerous avenues of increasing capacity. The government under the circumstances is mandated to create favourable conditions for other role-players like the private sector and other institutions to establish health training institutions in order to ensure the availability of qualified health personnel.

Section 30 provides for the right to development. Subsection 1 provides that all persons or peoples have the right to development and therefore to enjoy economic, social, cultural, and political development and women, children, and the disabled in particular, shall be given

special consideration in the application of this right. Subsection 2 provides that the State shall take all necessary measures for the realization of the right to development. Such measures shall include amongst other things equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure. Subsection 3 provides that the State shall take measures to introduce reforms aimed at eradicating social injustices and inequalities.

Subsection 4 provides that the State has a responsibility to respect the right to development and to justify its policies in accordance with this responsibility.

Subsections 2 and 4 are pillars of this study. Under subsection 2 the access to resources and health services calls for the state to empower the health sector in all aspects which should include human resource capacity and skills and the corresponding working or business environment. This resource capacity also includes the infrastructure and equipment or any other tools that would facilitate the efficient and effective delivery of health services to the citizens of Malawi. Government action should always follow some laid down policy, thus subsection 4 targets political office bearers to formulate policies and programmes that would ensure, foster or regulate the provision of quality health services. It can be deduced that the legal framework in Malawi does not specifically narrow down to capacity building since most capacity building initiatives or activities are just implied in the legal framework.

2.4.2 PARLIAMENTARY MEASURES FOR CAPACITY BUILDING

In addition to the *Constitution of the Republic of Malawi*, 1994, there is also an Act of Parliament, the *Public Service Act*, 1994 (Act 19 of 1994), as amended, which gives effect to the provisions of the Constitution. The *Public Service Act*, 1994, was enacted to make provision for the human resource management of the Malawi public service and for matters ancillary thereto or connected therewith. A major contribution of the *Public Service Act*, 1994, is the creation of a substantive Department for Human Resource Management and Development to specifically focus on management and capacity building in the public service to which the Ministry of Health is party. This is provided under section 19 of the Act. For purposes of this study it is the human resource development which is a matter of relevance.

2.4.2.1 FUNDAMENTAL PRINCIPLES OF CAPACITY BUILDING AS SET OUT IN THE *PUBLIC SERVICE ACT, 1994*

Parliament created the Department of Human Resource Management and Development in order to ensure that matters of human resources are given special attention. The department was later renamed as the Department of Public Service Management to reflect the overall role it plays in the delivery of its functions.

Section 3 of the Act provides principles of the administration of the public service to the effect that:-

The public service shall –

- (a) aim to deliver services to the public in an efficient and effective manner;
- (b) be the instrument for generating and maintaining public confidence in the Government;
- (c) be impartial, independent and permanent so as to enable the public continue to receive Government services and in order that the executive functions of government continue uninterrupted irrespective of which political party is in power;
- (d) be guided only by concerns of the public interest and of the welfare of the public in the delivery of services and the formulation and implementation of development projects;
and
- (e) aim to achieve and maintain the highest degree of integrity and proper conduct amongst the personnel at all grades.

As noted, the principles call for efficient delivery of the public service. It is only qualified and well trained personnel that would achieve this feat. In addition, the qualified personnel deliver with confidence and professionalism and the public has high regard for the officials concerned, leading to a satisfied citizenry. In the Ministry of Health, it has been observed that capacity building strategies have a correlation to the performance of the health facilities. It can then be deduced that the *Public Service Act, 1994* (Act 19 of 1994), as amended, concentrates on one aspect of capacity building which is human resource development. In this regard it falls short of extensive capacity building as capacity building is more than training but also includes organisational development to ensure sustainability. However, the *Public Service Act, 1994* (Act 19 of 1994), is cognizant of the role human resources play in service delivery and hence establishes the Department of Public Service

Management to specifically coordinate and manage all the human resource capacity building activities so that the public service (including the Ministry of Health) has the requisite skills, knowledge, competencies and attitudes to deliver services to the citizenry efficiently, economically and effectively.

2.4.3 POLICY DOCUMENTS

In Malawi there are three main policy documents and guidelines that further support the implementation of capacity building activities, namely the *Malawi Government: National Training Policy*, 1996, *Training Guidelines and Procedures*, 2009, and Terms of reference. However, it should be pointed out here that the policy documents on capacity building only concentrate on one component of capacity building which is human resource development so that capacity building for health services still lacks guidance. In this regard only the role of the *National Training Policy*, 1996, will be discussed since the remaining two documents derive from it and thus both the training guidelines and procedures are applied in line with the *National Training Policy*, 1996, and other government policies.

The *National Training Policy*, 1996, recognises the strategic role of human resources in every facet of development and thus emphasizes that the process of human resources planning, training and utilisation is indispensable to effective mobilisation and development of all national resources. The objective of the national training policy is to ensure the timely training of adequate and appropriate human resources in the public and private sectors to survive in the ever-changing social and economic environment as consistent with government development strategies. In this regard the national training policy sets out the guidelines for human resource capacity building to ensure that an opportunity is available for organisational and individual growth and public officials need to invest in the capacity building of their employees in order to ably tackle the challenges that come with the changing in the environment. The goal for the national training policy is to optimise the performance of both the public and private sectors at all levels. In this regard, training is considered to be essential and critical in achieving sustainable human resources in quantitative and qualitative terms. On this basis, the national training policy sets out the objectives for training, training priorities, strategies and the role of government in training.

It can be deduced that the legal framework for capacity building is not comprehensive as there are mainly only three namely the *Constitution of the Republic of Malawi, 1994*, and the others mentioned above. The Constitution of Malawi does not really discuss capacity building for health services and even the *Public Service Act, 1994 (Act 19 Of 1994)*, and the policy documents concentrate only on human resource development which is only one component of capacity building. In this regard, there is a need to extend the legal framework to ensure that capacity building activities are carried out within the legal context.

2.5 CONCLUSION

The purposes of this chapter were to ground capacity building in Public Administration and provide a theoretical, conceptual and legislative framework for capacity building. It can be deduced that capacity building is a systematic process which consists of input, output, processing, impact and feedback phases, hence systems and classical theories have been used to explain capacity building as an activity that emphasizes efficiency and effectiveness in the utilisation of organisational resources, thereby improving the performance of the organisation as a whole. It was found that capacity building is the work that is performed by the chief officials and is implemented with the aim of improving skills, knowledge and competencies of public officials and work performance of departments. In this regard, capacity building involves improvements in the utilisation and management of resources to ensure effective and efficient service delivery. Since capacity building focuses on the provision of service capacities, it is closely linked to rendering of services. Thus, capacity building is a systematic process that aims at converting capacity inputs into capacity outputs thereby improving the rendering of health services.

Furthermore, it can be deduced that capacity building is a management function whose basic objective is to utilise the available capacity optimally. Hence organisations like the Ministry of Health in Malawi should have sufficient capacity to render services as effectively and efficiently as possible. Consequently, as a management function, capacity building involves planning for capacity building, organizing of capacity building structures, leading of capacity building personnel and controlling of capacity building activities. All these management functions ensure that capacity building plans are achieved according to the laid down procedures and standards, capacity building personnel are motivated and committed to implement the planned

activities, thereby leading to efficient, effective and improved service delivery in the Ministry of Health. It has further been found that it is important that the implementation of capacity building activities or strategies follows the required steps of capacity building, meaning that firstly, stakeholders should be engaged. Secondly, capacity needs assessment should be conducted to identify the required capacity gaps and demand. This should be followed by formulating capacity building strategies and implementation of the capacity building strategies. It is essential to monitor and evaluate progress of implementing the planned capacity building strategies so that appropriate changes are made to the capacity building plans if they are not meeting the set objectives. It was also observed that the legal framework for capacity building is not comprehensive as there are mainly only three policy documents, namely the *Constitution of the Republic of Malawi, 1994*, *The Public Service Act, 1994*, and other policy documents. The Constitution does not really discuss capacity building for health services and even the *Public Service Act, 1994* (Act 19 of 1994) and the policy documents only concentrate on human resource development which is only one component of capacity building. In this regard, there is a need to extend the legal framework to ensure that capacity building activities are carried within the legal context.

It is therefore evident from the above discussion that capacity building is a solution to problems being faced in the public service in terms of effective and efficient service delivery as it enables chief officials to attain set objectives and do the work that relates to each service. Hence the requisite need for capacity building in Public Administration as no institution will be able to achieve its goals and objectives if it does not have human, technical, financial, material and leadership capacities that would enable it to efficiently and effectively deliver its services to the community.

CHAPTER THREE

3.0 RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter gives an overview of and the plan that this study will follow. The chapter will describe and explain the methods for collecting data in relation to the impact of implementing human resource capacity building strategies on health services. This is important because every scientific study involves a practical testing component which is necessary for confirming or invalidating the research hypothesis and attaining the research objectives set out in the study.

The following aims have been set for this chapter. Firstly, the chapter describes and explains the method that was followed to obtain permission from the Ministry of Health to conduct the research within its demarcated boundaries. Secondly, the chapter explains the research design of the study. Special attention is given to the research approaches and strategy. Thirdly, the research methodology is explained. Special reference is made to the target population, respondent selection and sample details. Fourthly, the chapter describes and explains the data collection methods used in the study. Special attention is given to the questionnaire and interview details, and the official document analysis. Fifthly, the data analysis methods are explained. Sixthly, the limitations of the study are discussed. Lastly, an undertaking to uphold strict ethical behaviour and conduct is provided (Hofstee, 2006: 113).

3.2 PERMISSION TO CONDUCT RESEARCH

Bell in Cohen *et al.* (2000:53) writes that "... it is advisable to make a formal, written approach to the individuals and organisations concerned, outlining your objectives and plans honestly". In this regard, prior permission was sought from the Head of the Ministry of Health to conduct the research within the institution and administer research instruments to the politicians and chiefs of administration in the Ministry. The permission was granted on 8 July 2011.

The purpose of the request was to obtain informed consent from the respondents to participate in the investigation. The letter indicated the main purpose of the research. It also included the significance of the research to health service delivery in terms of ensuring the implementation of relevant human resource capacity building strategies that would lead to motivated and skilled health personnel.

Seeking permission to conduct the research helped in maximizing the response rate during data collection. Therefore, having obtained the permission to conduct research, the next step was to identify an appropriate design and methodology for the research as stated below.

3.3 RESEARCH DESIGN

When research is conducted to investigate a research hypothesis, data are collected from the objects of inquiry with the aim of solving the problem concerned. This means that the data and results that are obtained from the research assist in accepting or rejecting the hypothesis. In this regard research design is seen as (the process of designing) the overall plan for collecting and analyzing data, including specifications for enhancing the internal and external validity of the study (Polit and Hungler, 1993:445). Kerlinger (1986:10) further adds that scientific research is a systematic, controlled, empirical and critical investigation of natural phenomena, guided by theory and hypotheses about the presumed relations among such phenomena. In every research project it is important to determine exactly what methods are to be used to collect data and what factors will influence the collection.

This section therefore explains the research approach and strategy, methodology, data collection tools and data analysis techniques.

3.4 RESEARCH APPROACH AND STRATEGY

The research involved both quantitative and qualitative analysis; therefore mixed methods were adopted as an overall research approach. Quantitative methods were used to understand the effectiveness of the capacity building strategies as they relate to selected health service

indicators that determine and define health service delivery. Qualitative methods were used in assessing the impact of capacity building strategies on health service delivery as well as in the triangulation of what else could be done to improve health service delivery through capacity building (Tesch, 1990:55).

The strategy used in the study, especially through the qualitative approach was descriptive. In this regard, data were collected through a survey that used structured questionnaires and guided interviews in soliciting information from the politicians and chief officials on the implementation processes on capacity building strategies and the resultant impact on the delivery of health services (Mouton, 2008:107).

3.4 RESEARCH METHODOLOGY

The research followed a concurrent research design with mixed methods, where quantitative secondary data were collected and analyzed, in addition to the parallel collection and analysis of related primary and secondary qualitative data. Thereafter, the data results were compared to arrive at deductions from the study questions.

In addition to the concurrent triangulation of the data, qualitative data on policies that guide capacity building strategies during the study period were collected and analyzed in an attempt to establish the consistency in the policies as a guiding principle in the implementation of health capacity building strategies, administration of the health workers and systems upon building the capacity and the related impact on the quality of health service delivery. Since this exploration was based on emerging issues, the research used a concurrent nested design within the broader context of mixed methods with qualitative data being the dominant feature at this stage. This allows for a deeper understanding of emerging issues and agrees with experiences and practice in research as espoused by Creswell (2003:12).

3.4.1 Respondent Selection

Research design requires the identification of specific respondents selected from the population that is targeted. For a clear understanding of the respondents to be used in the study, a distinction should be made between two concepts, namely population and sample. Both concepts may be discussed as follows.

3.4.1.1 Population Explained

By population is meant a complete collection of all the individuals, objects or measurements sharing a specific characteristic of interest of which the properties are to be analysed (Willemse, 1990:3) The characteristics of a population can be expressed numerically in a quantitative population or non-numerically in a qualitative population. If the population contains a countable number of items, it is said to be finite, and when the number of items is unlimited, it is said to be infinite (Willemse, 1990: 3). In this study the population was non-numerical and finite.

A total population is the entire collection of cases that meets a designated set of criteria and data. However, populations vary in size (Wisniewski, 1994:76; Lipsey, 1989:294). In this study the total population was the total number of politicians, political office-bearers, chief officials, subordinates and other role-players such as medical doctors, dental surgeons, pharmacists, nurses and scientific and support personnel employed in the health services in the three regions in Malawi. It is clear that the total population was too big to undertake a meaningful and objective study for the purpose of a mini-dissertation. Neuman (2006: 224) claims that a target population is thus required and that such a target population is a significant pool of elements from a larger population. The target population is smaller than the total population and includes only those sampling units with characteristics that are relevant to the stated problem (Wegner, 1993:4) The target population was thus limited to the central region of Malawi and included only the politicians and chief officials who are directly involved in decision making for and implementation of capacity building. A sample was selected as follows from the target population.

3.4.1.2 Sampling Details

By sampling is meant the selection of a portion of the target population as representative of that population. A sample always implies the simultaneous existence of a larger population of which the sample is a smaller section or portion (De Vos et al., 2005:193). A sample was required because it is not possible to study everybody in the population due to constraints of time and costs. Such a sample however ought to make social scientific analysis possible (Harvey and MacDonald, 1993:116). Sampling should address three specific questions, namely:

(a) The sampling unit

The sampling unit is made up of the respondents to the survey. Deciding who to survey requires that the boundaries of the sampling area, from which data are sought, be clearly described and explained (Schiffman and Kanuk, 1997:36).

In this study the sampling unit was the Ministry of Health, specifically in the central region of Malawi and comprised of the politicians and chief officials in the Ministry of Health central office and related political and administrative units at the Kamuzu Central Hospital, Mchinji District Council, Dedza District Council and Dowa District Council as a case study for the relevant health service delivery. Therefore respondents in the study were selected from the population comprising of these institutions and political and administrative officials therein.

(b) The sample size

The correct and adequate sample size is dependent upon the nature of the population and the purpose of the study (Bailey, 1982:100). The larger the sample, the more likely the responses will reflect the total population under study although a small sample can often provide highly reliable findings, depending on the sampling procedure adopted (Schiffman and Kanuk, 1997:36). In this study a sample of thirty-five (35) respondents was selected depending on the roles performed. For instance, in order to get information on the operation and implementation of the capacity building strategies in the health units of the scoped responding institutions and respondents there were two groups from which the samples were made. The groups included politicians and chief officials of the Ministry of Health Central Office, District Offices and Kamuzu Central Hospital. The respondents are described in detail below:

Chief officials

- Eight chief officials from the Ministry of Health Central administrative
- Three administrative personnel from Dedza District Hospital
- Three administrative personnel from Mchinji District Hospital
- Three administrative personnel from Dowa District Hospital
- Three administrative personnel from Kamuzu Central Hospital

Total: 20 respondents

Political office-bearers

- Two Ministers for Health
- One Deputy Minister responsible for capacity building in the Office of the President and Cabinet.
- Three Members of Parliament for Dedza District
- Three Members of Parliament for Lilongwe District
- Three Members of Parliament for Mchinji District
- Three Members of Parliament for Dowa District.

Total: 15 respondents.

(c) The sampling methods

There are various sampling methods, for example non-probability sampling such as quota sampling, cluster sampling, snowball sampling, random sampling, stratified sampling, systematic sampling and purposive sampling (Salkind, 1997:379; Neuman, 2006:220). Non-probability sampling is the selection of sampling units from a population using non-random procedures (Schiffman and Kanuk, 1997:38; Neuman, 2006:220). Non-probability sampling was seen as appropriate for this study and hence the sample of 35 respondents was selected from the target population purposively. Purposive sampling is a non-random sample in which the researcher uses a wide range of methods with a specific purpose in mind. This essentially means that the sample was based on the judgment of the researcher and did not follow the theory of probability in the choice of elements, such as political office-bearers and chief officials from the sampling population (Kumar, 2005:117; Neuman, 2006:223; Babbie and Mouton, 2002:207). The sample size and sampling method having been explained, the instruments that were used for collecting data will be explained below.

3.4.2 Data Collection Instruments and Procedure

Scientific research consists of two supplementary phases, namely a theory construction phase, based on a literature study and a theory testing phase based on an empirical study. The literature study consists of primary and secondary sources. Primary sources for the purpose of this study consisted of the applicable legislative measures, Ministry of Health's annual strategic plans, reports and minutes. Secondary sources consisted of relevant published books on the topic.

Data need to be collected and analysed to test the viability of the hypotheses. Various instruments can be used for the collection of data, for example a literature study, interviews and questionnaires (Hofstee, 2006: 116). In this study, data were collected by using the following three instruments: questionnaires, interviews and documentation analysis. The questionnaire details may be discussed as follows:

3.4.2.1 Questionnaire Details

In this research one structured questionnaire was used and combined questions that were scaled and used on a Likert scale; coded questions and open ended questions that sought agreement or disagreement with facts researched in the literature review and other documentation from the Ministry of Health. Questions generally posed in the questionnaire focused on the research questions but were targeted at two categories of office bearers as detailed in the sample. These included the politicians and the chief officials. The orientation of the questions to the politicians was policy related whilst for the chief officials the questions were oriented towards development of the capacity building strategies, processes involved and implementation of the strategy, more especially to the administrators at hospital and district level. Specifically, the questionnaire dealt with:

- The processes used in the development of the capacity building strategies
- Nature of capacity building
- Problems with the implementation of capacity building strategies (input phase)
- Evaluation of executive policy/legislation for capacity building (input phase continued).
- Evaluation of administrative enabling function for capacity building (processing phase).

- Evaluation of capacity building strategies for the provision of health services (output phase).
- Impact of capacity building policy/strategies on public health services and the citizens (impact phase).

The questionnaire was administered by the researcher for purposes of enhancing respondent understanding and improving the response rate. This was done by personally handling the questionnaires to the respondents with explanations and calling back later for collection.

3.4.2.2 Interview Details

Interviews are the predominant mode of data collection of information in qualitative research. Regarding an interview, Kvale (1996:14) remarks that an interchange of views between two or more people on a topic of mutual interest, sees the centrality of human interaction in knowledge production, and emphasises the social situations of research data (Seidman, 1998:2). Semi-structured interviews were used in the study.

After preliminary transcription of the questionnaires, emerging issues were triangulated further by following up with interview guides from a sub-set of the chief officials and politicians in the sample. This was purposively aimed at getting more information on the thoughts of those in authority and making decisions for the implementation of the capacity building strategies in the Ministry of Health in Malawi. This sub-set targeted the heads of institutions in the sample and the general orientation of the interviews was to gather information on the direction the institutions would take if they had to implement the capacity building strategies differently. These were very short and generic interviews focusing on this forward looking question and recommendations drawn from the emerging themes collected from the process oriented questions dealt with in the questionnaire.

3.4.2.3 Official Document Analysis

Further to the questionnaire and the interviews, the researcher used document analysis as a tool to understand the context within which the strategies for capacity development are formulated and implemented. Secondly, the study sought to understand the impact of implementing the capacity building strategies on service delivery in the health sector of the Ministry of Health; therefore in addition to other sources of information, it became imperative

for the researcher to use official secondary data from the Ministry of Health for an insight into the performance of the health sector within the study period.

Other than studying the performance of the health sector using secondary data as motivated above, the study also used the secondary data sources to analyze documents and evaluation reports that had guided the human resource capacity building strategies and set the stage for implementation and how these concepts were applied in shaping up future strategies.

Therefore through document analysis, the researcher was able to determine the extent to which the implementation of the capacity building strategies in the Malawi Ministry of Health had contributed to the delivery of health services to the citizens and what plans were adopted for systemic improvements to the modalities of formulating and implementing capacity building strategies in the health sector for an effective and efficient service delivery.

3.4.3 Response Rate

Sufficient response rates are important for surveys because a survey that collects very few data may not contain substantial information (Welman and Kruger, 2000:183). In this regard a response rate is the percentage of people who respond to a survey. The questionnaire statistical details were as follows:

Table 3.1: QUESTIONNAIRES USED AND RECEIVED

QUESTIONNAIRE	USED	RECEIVED BACK	PERCENTAGE
One: Political office-bearers and chief officials	35	25	71.0%
Totals	35	25	71.0%

It can be deduced that a response rate of 71.0% is acceptable and valid as it is supported by Barbie (1973:165) who writes that a response figure of at least 50.0% should be sufficient for data analysis of a questionnaire, a figure of 60.0% can be seen as “good” and a figure of 70.0% as “very good”.

3.4.4 Data Analysis

Data analysis is the process of selecting, sorting, focusing on and discarding data. These activities are performed to ensure the accuracy of the data and the conversion from data form to a reduced form which is more appropriate for data analysis. Essentially data analysis enables the researcher to interpret data and make sense of them (Welman and Kruger, 2000:67).

In this context there are two types of data, namely quantitative and qualitative. Quantitative data are analysed deductively through statistical procedures while qualitative data analysis involves the integration and synthesis of narrative non-numeric data and these data are analysed inductively (Polit and Hungler, 1993:41; Henning, 2004:104 and 127).

3.4.4.1 Criteria for Analysis

In order for data to be turned into meaningful information, there is a need to analyse it as also agreed by Vithal and Jansen (1997:27) who write that researchers can only make sense of the data they collect through organising and arranging data into a manageable form. As earlier indicated, the study had both quantitative and qualitative elements. The study used preliminary analysis during data collection to allow for immediate follow up within the data collection period. Transcriptions of interviews and notes collected during the research were also used. Before analysis data were classified and coded. The data from the questionnaires were coded by categorizing and breaking them into broad sections in order to make sense of the accumulated information for graphical and quantitative analysis of the perceptions of respondents in the research. In this regard, quantitative data were analysed deductively through statistical procedures whereby the Statistical Package for Social Sciences was used for analysing the data and the results were interpreted by means of figures and charts followed by textual explanation. The qualitative data, on the other hand, were analysed inductively, this involving the integration and synthesis of the narrative non-numeric data. Tables were used to reflect responses, while responses to open questions were also processed for interpretation. Further to this, in analyzing all the data, deductions were made based on the responses from the respondents, in this way giving broader perspective on the impact of implementing the human resource capacity building strategies on health services.

The content of the documentation that set a base for the strategies in the health sector and related directions was also analysed qualitatively and thematically in relation to the objectives of the research. Data were collected, recorded and arranged for systematic interpretation and also packaged into manageable themes and variables for easy interpretation.

3.5 LIMITATION OF THE STUDY

Capacity building is a broad subject area with relatively new concepts and theorisation. This being the core area under study, the orientation of capacity issues in the study was limited to systems theory. There was an attempt to link the implementation of the capacity building strategies by the politicians and chief officials in the Ministry of Health, but it must be noted that positive results are the outcome of other factors that supplement the implementation of capacity building strategies. Therefore results from the study will be closely aligned to what is achievable practically within the strategies employed and where necessary within the confines of systems theory.

3.6 ETHICAL CONSIDERATIONS

Strydom (2005:56) writes that the fact that human beings are sometimes the objects of the study in the social sciences raises unique ethical problems. In this regard, Marlow (1998:151) emphasizes that it is important that the researcher obtains the informed consent of the potential participants, that the participants be told what the purpose and the objectives of the research are, to enable them to give their voluntary consent or otherwise reject participation before commencement of the exercise. Since all the respondents in this survey were Government officials who are also custodians of confidential information, the following guidelines and practices were strictly adhered to. Firstly, anonymity; the name and personal details of the respondents were not disclosed. Secondly, all sources of information used were acknowledged to avoid plagiarism. Thirdly, respondents were not coerced to divulge any confidential information and respondents were given freedom of choice about participating in the research through informed consent. The respondents were also advised that they could pull out of the research at any time. Lastly an introductory letter from the University of Fort

Hare and the Ministry of Health describing the purpose and objectives of the study was presented to the respondents to address potential resistance.

3.7 CONCLUSION

The research design and methodology for this study were determined by the research problem, objectives and research questions. Firstly, the important stage in the study was seeking written permission to conduct research and approval from the Ministry of Health. The purpose of the request was to obtain the informed consent of the participants to participate in the investigation, thereby maximizing the response rate during data collection. Secondly, the research design and methodology determined the data collection methods to be used and the population details which provided the information about the subjects on which conclusions for the study could be applied. In this regard the research involved quantitative and qualitative analysis, therefore a mixed methods approach was adopted. The research strategy used in the study was descriptive hence data were collected through a survey that used structured questionnaires and guided interviews.

Thirdly, in this study the total population included a number of politicians, political office-bearers, chief officials, subordinates and other role-players such as medical doctors, dental surgeons, pharmacists, nurses and scientific and support personnel employed in the health services in the three regions in Malawi. However, the target population was limited to the central region of Malawi and included only political office-bearers and chief officials who are directly involved in decision making for and implementation of capacity building. Furthermore, in the study a sample of 35 respondents was selected purposively; these were selected from the politicians and chief officials in the Ministry of Health. Fourthly, questionnaires, interview guides and document analysis were used as data collection instruments for the study. The questionnaires had both open ended and closed questions in order to get in-depth information pertaining to human resources capacity and its challenges in the Ministry of Health. In addition to this, 35 questionnaires were personally distributed and collected by the researcher and the response rate was 71.0% which was considered good for the study.

Fifthly, the data analysis process enabled the researcher to systematically arrange data for interpretation. Quantitative data were analysed deductively through statistical procedures in which the Statistical Package for Social Sciences was used for analysing the data and the results were interpreted by means of figures and charts followed by textual explanation. The qualitative data, on the other hand, were analysed deductively and involved integration and synthesis of the narrative non-numeric data. Tables were used for responses and responses to open questions were also processed for interpretation. In analyzing all the data, deductions were made based on the responses from the respondents, in this way giving a broader perspective on the impact of implementing the human resource capacity building strategies on health services. In addition to this, transcriptions of interviews and notes collected during the research were also used and the content of the documentation set a base for the strategies in the health sector and related directions was analysed qualitatively and thematically in relation to the objectives of the research. Finally, ethical considerations were strictly adhered to by ensuring anonymity of the respondents. It can thus be deduced that the design and methodology used limited the research to be within the planned framework and structure of the study. Chapter Four will describe and explain the analysis and interpretation of the data collected.

CHAPTER FOUR

4.0 DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter presents and analyses the data collected through distribution of questionnaires and administration of interviews among selected respondents. The study involved both quantitative and qualitative analysis to understand the opinions of various health service stakeholders as regards the effectiveness of the capacity building strategies in relation to health service delivery and assessing the impact of capacity building strategies on health service delivery in the Central Region of Malawi .

The role that a government plays in promoting the general welfare of its citizens is clearly seen in the nature and scope of the public services that are provided. It is expected that such services should satisfy the needs, interests and expectations of the citizens. However, the fact that the citizens as consumers attach a specific use to a service, such as health services, does not mean that such a service will be to their advantage. The provision of services, which ought to take into account the realities of an ever-changing environment, will always have a specific influence and impact on the environment and the citizens. The services are thus not the output of the system, but will also have a specific impact. A specific relationship thus also exists between the need for a service, the processes to provide the service and the result, that is the output and impact.

An evaluation of the impact of health services in the central region of Malawi is fundamental to the promotion of the citizens' wellbeing. Rodee *et al.* (1976:196) write that "... the promotion of the general welfare is the greatest happiness of the greatest number" of citizens or as Bentham (1823: 23) and other liberal thinkers (Rodee *et al.*, 1976:105) assert, the aim is to maximize pleasure and to minimize pain. For this reason the emphasis of the study is placed on an evaluation of the impact of the implementation of capacity building strategies in the central region of Malawi. As indicated in section 1.3 of the Introductory chapter this research intended to investigate and prove as true the following study problem: A lack of quality services is prevailing in the Ministry of Health due to the irrelevant and often insufficient implementation

of capacity building strategies, which causes unnecessary mistakes, complaints from patients and unnecessary wastage of financial and human resources. In addition the hypothesis for this study stated that ‘the implementation of the existing capacity building strategy impacts negatively on the provision of health services in the central region in Malawi’.

To achieve these aims the data received from the respondents were analysed, interpreted and evaluated as follows. Firstly, the chapter was divided into specific sections and sub-sections as posed by questions in the questionnaires. Secondly, the demographical details of the respondents were explained. Thirdly, the nature and place of capacity building for the provision of health services were evaluated, described and explained. Fourthly, the chapter analyses and evaluates the problems experienced with the implementation of capacity building strategies for health services. Fifthly, the chapter evaluates the executive policy/legislation for capacity building in the health environment. Sixthly, the chapter evaluates the enabling administrative functions for capacity building for health services. Seventhly, the chapter describes and explains the outputs of capacity building strategies. Lastly, the chapter evaluates the impact of capacity building strategies on the environment and the citizens. But firstly, it is important to interpret the personal details of the respondents as set out below.

4.2 DEMOGRAPHICAL/PERSONAL DETAILS OF RESPONDENTS

The respondents of the study came from diverse posts and offices relevant to the provision of public health services in the central region of Malawi. A demographical analysis was used in the study for two reasons, namely firstly, to identify population characteristics to determine basic information about the respondents and secondly, to provide identification information about the respondents, such as the gender, education, language proficiency, age, post/office held and years of service of the respondents. (Okubena, 2010:146). The demographical details are based on a quantitative analysis, which is described as the manipulation of numerical data through statistical procedures (Polit and Hunger. 1993:444). The demographical details of the respondents are discussed as follows:

4.2.1 Office/Posts of the Respondents

The office of a political office-bearer or the post a chief official holds refers to the responsibility and designation of the incumbent in relation to this study. Respondents were required to indicate the office or post they occupy at work. The table below depicts the various positions and posts occupied by the respondents who completed and returned the questionnaire.

Table 4.1. RESPONDENTS' OFFICE/POST

Post	Frequency	Percent	Valid Percent	Cumulative Per cent
Head of Department	3	12.0	12.0	12.0
Head of Department at District Level	3	12.0	12.0	12.0
Administrative Personnel	13	52.0	52.0	52.0
Members of Parliament	6	24.0	24.0	24.0
Total	25	100.0	100.0	100.0

Table 4.1 above shows that the majority (76.0%) of respondents in the Ministry came from the administration section. This leverages the study findings as these are the implementers of the capacity building strategies in the Ministry of Health, hence the information provided is closely aligned with the reality on the ground. Whereas 24.0% of the respondents were heads of department both at the headquarters and district levels, this may be seen as thereby enhancing the credibility of the responses provided in the survey.

As for the political office-bearers, six questionnaires were distributed to members of Parliament in the central region and six questionnaires were completed and returned, representing a 100.0% response rate. This was good for the study as political office-bearers deal with the complaints from the citizens and challenges in the constituencies in regard to health service delivery.

4.2.2 GENDER DISTRIBUTION OF RESPONDENTS

Gender equality in the contemporary work environment is a legislative requirement in various democratic states.

Table 4.2: GENDER DISTRIBUTION OF RESPONDENTS

Sex	Frequency	Percent
Male	19	76.0
Female	6	24.0
Total	25	100.0

From the Table above, male respondents formed 76.0% in the study. This is the case due to the gender distribution where there are more men than women working in the administration cadres of the public sector. As highlighted in Table 4.2 above, the majority (52.0%) of the respondents were from the administrative sections where there is male dominance; as such this has affected the gender combination of the respondents. Nonetheless, the gender distribution effects are mitigated through the nature of the questions posed, which are gender neutral.

4.2.3 YEARS OF SERVICE OF RESPONDENTS

In this survey it was important that the years of service of the respondents to be interpreted as well to ensure the richness and quality of the data, because the years of experience of the respondents helped in bringing out the challenges that are being faced in the implementation of the existing capacity building strategies in the health sector.

Table 4.3: RESPONDENTS' YEARS OF SERVICE

Years of Service	Frequency	Percent
<5	8	32.00
5-10	4	16.00
10-15	3	12.00
15-20	2	8.00
>20	8	32.00
Total	25	100.00

From Table 4.3 above, 32.0% of the respondents have less than five years' experience, and this balances up with the fact that the other 32.0% of the respondents have more than 20 years of experience in the health sector. This validates the findings to a higher extent due to the fact that those with less than five years of experience have just joined the Ministry of Health as there is a high rate of labour turnover. As for those who have served for less than twenty years, the majority of them is nevertheless the heads of department and hence has vast knowledge of the capacity problems that the health sector is experiencing, thereby enriching the results of the study. Approximately 16.0% of the respondents have served for five to 10 years, 12.0% have 10 to 15 years of work experience and 8.0% have served the Ministry for 15 to 20 years. It can be deduced that the respondents' wide range of work experience enabled the researcher to acquire divergent responses on the implementation of the capacity building strategies, thereby enriching the data collected.

4.2.4 RESPONDENTS' ACADEMIC QUALIFICATIONS

The academic qualifications of the respondents were also analysed as they impact on the relevance and the quality of the data in the study.

Table 4.4: RESPONDENTS' ACADEMIC QUALIFICATIONS

Qualification	Frequency	Percent
Certificate	4	16.0
Graduate Degree	11	44.0
Postgraduate degree	8	32.0
Other	2	8.0
Total	25	100.0

From the above results it can be seen that the majority of the respondents (44.0%) have a degree, with 32.0% of the respondents having postgraduate qualifications. This clearly indicates their competencies in the field of administration as they possess the requisite skills and knowledge to carry out their duties competently. The academic qualifications also

influenced the quality of data provided by the respondents in the study. Some 16.0% of the respondents have a certificate, whilst 8.0% possess other qualifications such as diplomas and advanced diplomas.

Based on the above exposition, the following deductions can be made. Firstly, the majority of the respondents came from the administration which leverages the study findings as these are the actual implementers of the capacity building strategies in the Ministry of Health, thereby providing the reality on the ground. Secondly, the respondents do not meet the requirement of female representativity and males are in the majority. Thirdly, the years of service and thus experience are evenly spread with the majority of the respondents falling in the 20 plus years' bracket. The respondents were sufficiently experienced to be able to complete the questionnaire and to provide reliable data for analysis and evaluation. Lastly, the research shows that the respondents are academically, especially at graduate and postgraduate levels, well qualified to act as respondents in the survey. The qualitative data analysis and evaluation, dealing with the findings of the study, are discussed in the ensuing sections.

4.3 THE FINDINGS OF THE SURVEY RESEARCH. THE EVALUATION OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES FOR THE RENDERING OF HEALTH SERVICES

The discussion in this section starts with an explanation of the nature and place of capacity building.

4.3.1 NATURE AND PLACE OF CAPACITY BUILDING

Within public administration, capacity building is a management function which needs to be determined, implemented and evaluated to ensure effective and efficient work performance. Capacity building means different things to different people; as such it was imperative that respondents be asked to give their own understanding and meaning of capacity building as below.

4.3.1.1 MEANING OF CAPACITY BUILDING

Capacity building is an important function in any public institution as without capacity, institutional objectives cannot be achieved. However, capacity building means different things to different people. To some it solely means training and development of human resources implying that the emphasis is on human capacity, while to others it means more than human resource development. It includes institutional development and financial management. However, according to Hussein (2006: 374), capacity building is the overall ability of an individual or group to actually perform organisational responsibilities effectively and efficiently with emphasis on human resources. *UNDP* (2005:3), Conrad and Kamanga (2010:18) extend the area of focus in capacity building to include systems within which the individuals work and interact, and defined the domains within which capacity building as a concept is expected to play a role; the domains included human resources, strategic alignment, management and administration as critical areas that are mutually inclusive. It was therefore important to test the perceptions of the respondents. This was done as follows.

Question (a): Please explain the meaning of capacity building, according to your experience in your own words below

Answer: The majority (80.0%) of the respondents describe capacity building as provisioning of training aimed at developing workers in an organisation in a specific field to build the skill base deemed critical for the overall performance of an organisation. It is apparent in this view point that respondents looked at capacity building from the human resources perspective, this corroborating the inclination of the strategic framework of Malawi's health sector, which focuses on eight major health sector policies: The Essential Health Care Package, Human Resource Development, Pharmaceutical Support Service, Health Facilities Development, Hospital Autonomy, Health Care Financing, SWAP and Decentralisation of health care management (*Government of Malawi and the German Technical Cooperation, 2007: 6*). These frameworks are largely people centred, and focused on the abilities of the human resources to perform identified functions.

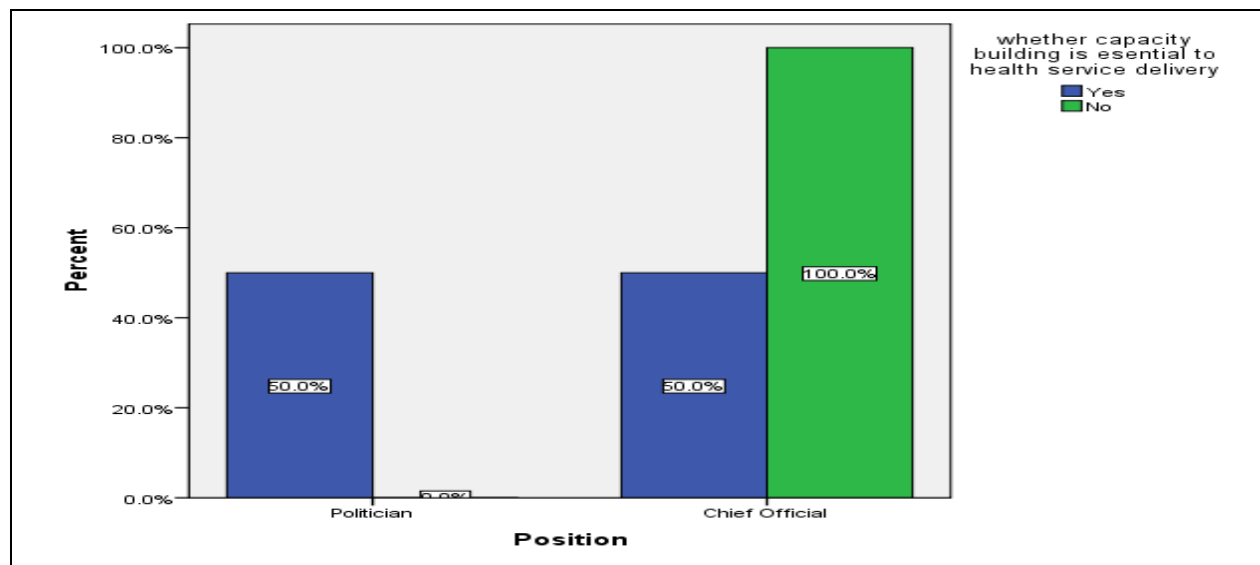
Nonetheless, a minority (20.0%) of the respondents expanded the meaning to include the working environment, financial resources and materials that facilitate good performance of human resources in organisations and help the organisation meet clientele expectations. These respondents' view on the nature and place of capacity building concurs with the view of

UNDP (2005:3) and Conrad and Kamanga (2010:18) that also extended the area of focus in capacity building to include systems within which the individuals work and interact. Conrad and Kamanga go on to define capacity building in four domains, where human resources, strategic alignment, management and administration are looked at as critical areas that are mutually inclusive. This implies that strategizing on capacity building implies in-depth analysis of these domains.

Question (b): Do you consider capacity building an essential function in rendering of health services?

Answer: Answer: The responses provided by the respondents on the capacity building as an essential function are expressed in the following figure.

Figure 4.1: RESPONSES ON THE CAPACITY BUILDING AS AN ESSENTIAL FUNCTION



Fifty percent of the political office-bearers and all the chief officials (100.0%) agreed that capacity building should be considered as an essential function in the rendering of health services. The positive response was motivated as follows by the respondents.

- Capacity building in the health sector will help in the development of the country; since healthy people with productive means are able to contribute to the development of economies which brings about development.
- Capacity building improves service delivery as there will be enough skilled personnel to deliver the services

- With a number of specialised training courses that are offered under capacity building programmes, health professionals are able to deal with many health issues, such as Prevention of Mother to Child Treatments.

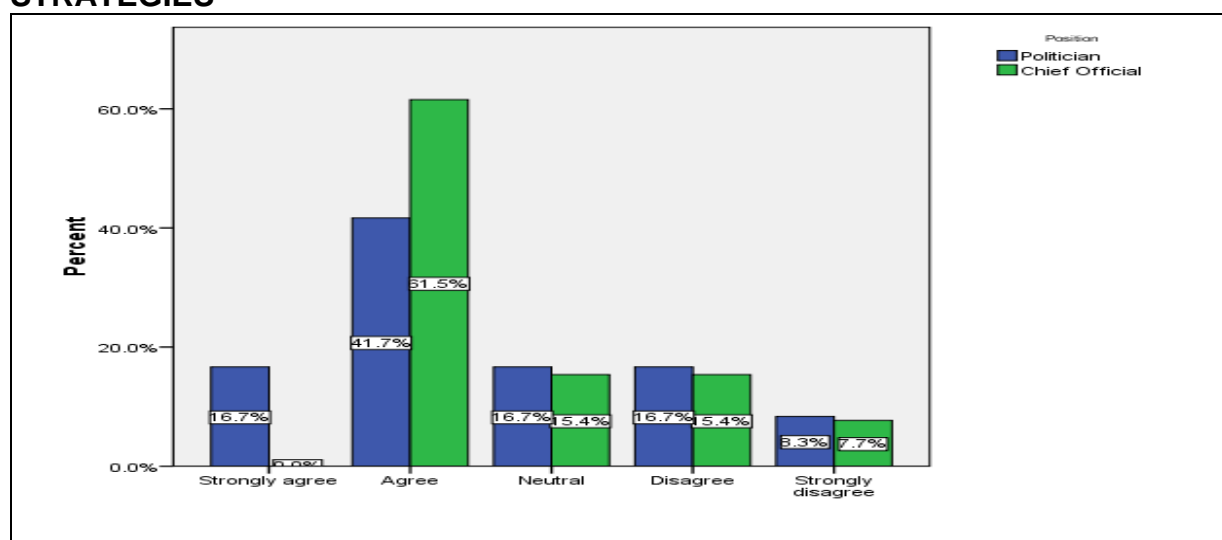
Nonetheless, 50 % of the chief officials who were sceptical in their responses on the importance of capacity building cited problems that they have experienced with the implementation of capacity building strategies as informing their responses and position on the matter. It can thus be deduced that capacity building is an essential function in providing public health services effectively and efficiently as without capacity no organisational goals and objectives can be achieved. These responses in fact corroborated assertions by Hussein (2006: 374), *the Africa Capacity Building Fund* (2004:7) and the *World Bank Report*, (2004:6), which view capacity building as the overall ability of individual or group to actually perform organisational responsibilities effectively and efficiently. In analyzing capacity building issues, the emphasis is on human resources. This raises the significance of human resources in developing strategies for capacity building, among other facets of capacity building. These analyses hold capacity building as a critical and requisite element in implementing plans and delivering services to organisations clientele. However, training human resources alone is not enough as there is also a need to ensure that material and financial resources are available in the hospitals for efficient and effective health services.

4.3.2 PROBLEMS WITH THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES

(a) Statement: The implementation of the existing capacity building strategy impacts negatively on the provision of health services in the central region...”

Answer: Figure 4.2 below demonstrates the type of responses as provided by the respondents

Figure 4.2: RESPONSES ON THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES



In response to the question on whether the implementation of the existing strategies has any negative impact on the provision of health services in the central region, a small minority (16.7%) of the political office-bearers strongly agreed, 41.7% of the political office-bearers and 61.5% of the chief officials agreed and gave the following reasons for their answers:

- Centralised control of resources and decisions in the implementation of the capacity building strategies in Malawi's central region health sector is a major problem, since there is a tendency to focus on central needs without an appropriate view of needs at decentralised levels within the region.
- There are not enough financial resources to sustain the capacity building programmes hence leading to failure to meet the targets in terms of human resources trained.
- There is still an increased demand for health services and a lack of drugs and equipment is still prevailing in the district hospitals.
- There is increasing dissatisfaction with the health services being provided amongst the citizens in the central region.

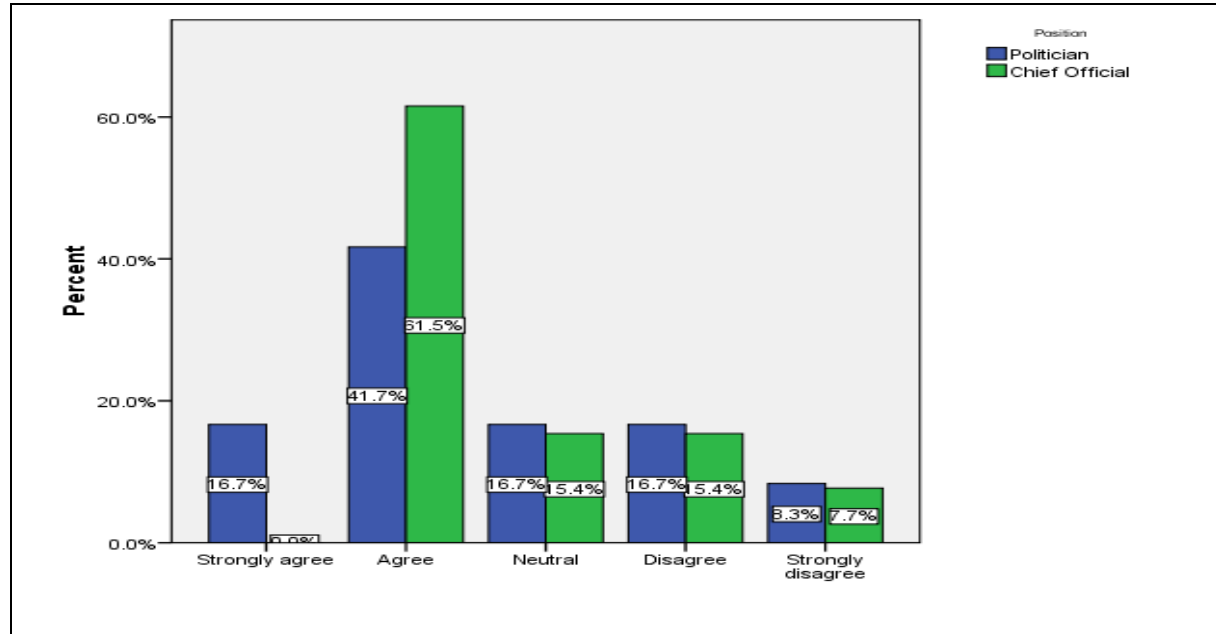
On the other hand, the minority 16.7% of political office-bearers and 5.4% of chief officials disagreed, 3.3% of the political office-bearers and 7.7% of the chief officials strongly agreed with the assertion saying that effective and efficient health services provision is still possible with the implementation of the existing capacity building strategies although quality of the health services being provided is still unacceptable to the citizens. A minority (16.7%) of the political office-bearers and 5.4% of the chief officials who were non-committal (neutral)

operate at legislative level and in the districts hence they have little information on the capacity building strategies the health sector is implementing as these are seen as executive strategies and mainly done at the headquarters. It can thus be deduced that the implementation of the existing capacity building strategies is indeed impacting negatively on the provision of health services in the central region as there is high dissatisfaction with the services being provided mainly due to absolute control of decisions on capacity building by the chief officials at the central headquarters and a situation requiring redress if capacity and related provisioning of health services are to be standardised for the equitable benefit of all citizens in the central region.

Statement (b): A lack of quality is prevailing in the provision of health services in the central region of Malawi

Answer: Figure 4.3 below provides the percentages of the responses obtained during the survey.

Figure 4.3: RESPONSES INDICATING WHETHER LACK OF QUALITY IS PREVAILING IN THE PROVISION OF HEALTH SERVICES IN THE CENTRAL REGION



Looking at Figure 4.3 above supports the view that problems with the implementation of capacity building strategy affect the quality of health services being provided in the central region of Malawi and are caused by irrelevant and often insufficient implementation of capacity building strategies, as 25.0% of the political office-bearers and 7.7% of the chief officials strongly agreed, 33.3% of political office-bearers and 38.5% of the chief officials agreed that

lack of quality is indeed affecting the services being rendered to the citizenry in the health facilities within the central region of Malawi and motivated their responses as follows:

- Shortage of skilled medical personnel
- Lack of working materials such as drugs and equipment
- High patient to doctor ratios
- Inadequate human and material resources compromise quality

And thus proposed a re-examination of quality assurance in the recruitment and motivation of health professionals among other issues that require focusing in order to improve the situation and bring in extra efficiency and effectiveness in the delivery of health services within the region. A minority (8.3%) of political office-bearers and 30.8% of chief officials disagreed with the statement, whilst 25.0% of political office-bearers and 15.4% of chief officials strongly disagreed with the statement and gave the following reasons for their answers:

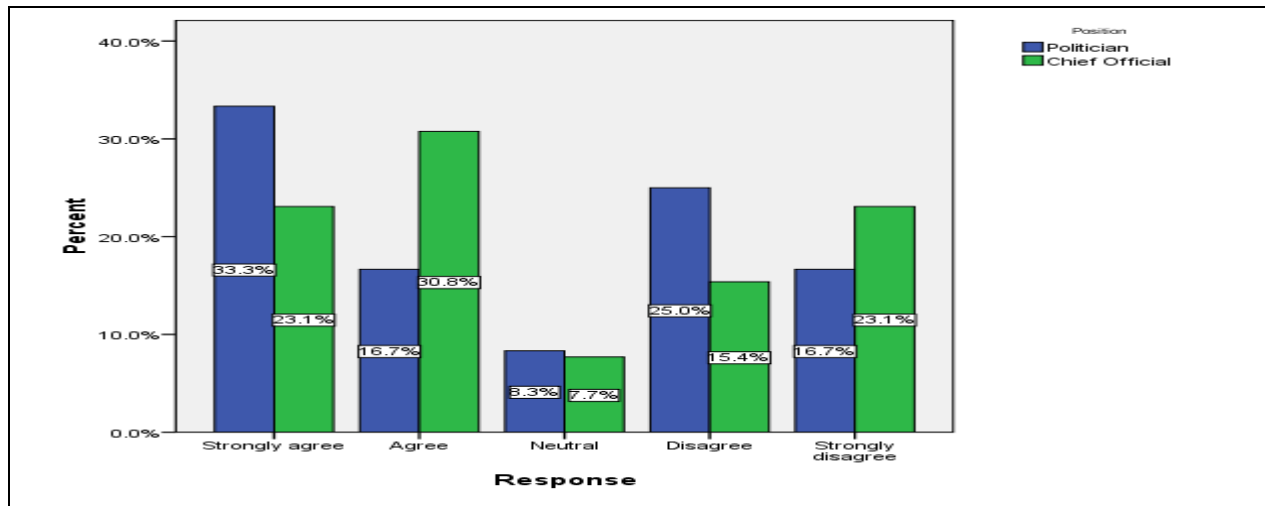
- Chief officials reported that there was more to the provision of quality services than the implementation of capacity building strategies. For example, motivation of the health professionals and political will to ensure that financial resources are adequate for delivering the health services.
- Effective implementation of capacity building strategies cannot really guarantee provision of quality health services.
- The HIV/AIDS pandemic is also a major challenge in the provision of quality health services.

It can thus be deduced that a lack of quality is prevailing in the provision of health services in the central region due to shortage of skilled medical personnel, lack of working materials such as drugs and equipment and also high patient to doctor ratios. However, it was also asserted that there was more to the provision of quality services than the effective implementation of capacity building strategies.

Statement (c) The lack of quality health services is caused by irrelevant and often insufficient implementation of capacity building strategies.

Answer: Figure 4.5 below illustrates the responses from the chief officials and political office-bearers.

Figure 4.1: LACK OF QUALITY HEALTH SERVICES IS CAUSED BY IRRELEVANT AND OFTEN INSUFFICIENT IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES



A majority of political office-bearers (33.3%) and 23.1% of chief officials strongly agreed with the assertion, whereas 16.7% of political office-bearers and 30.8% of chief officials agreed that irrelevant and insufficient implementation of capacity building strategies is causing the delivery of poor quality health services and indicated the following motivations for their responses:

- Lack of monitoring and evaluation
- Poor recruitment process that also affects the type of personnel that are recruited to deliver health services to the citizens.
- Usually the implementation of capacity building strategies is done without consultation with other relevant stakeholders, such as District Health officers, and inadequate resources.
- Capacity building strategies are usually implemented without proper planning and adequate resources.

On the other hand, 25.0% of political office-bearers and 15.4% of chief officials disagreed, whereas 16.7% of the political office-bearers and 23.1% of chief officials strongly disagreed and gave the following reasons for their answers, namely a lack of quality health services results from various factors other than poor implementation of capacity building strategies, such as

- Lack of motivation due to poor remuneration packages
- Lack of political will to adequately fund the health sector

- Lack of patriotism – health professionals are not committed to offering their services.

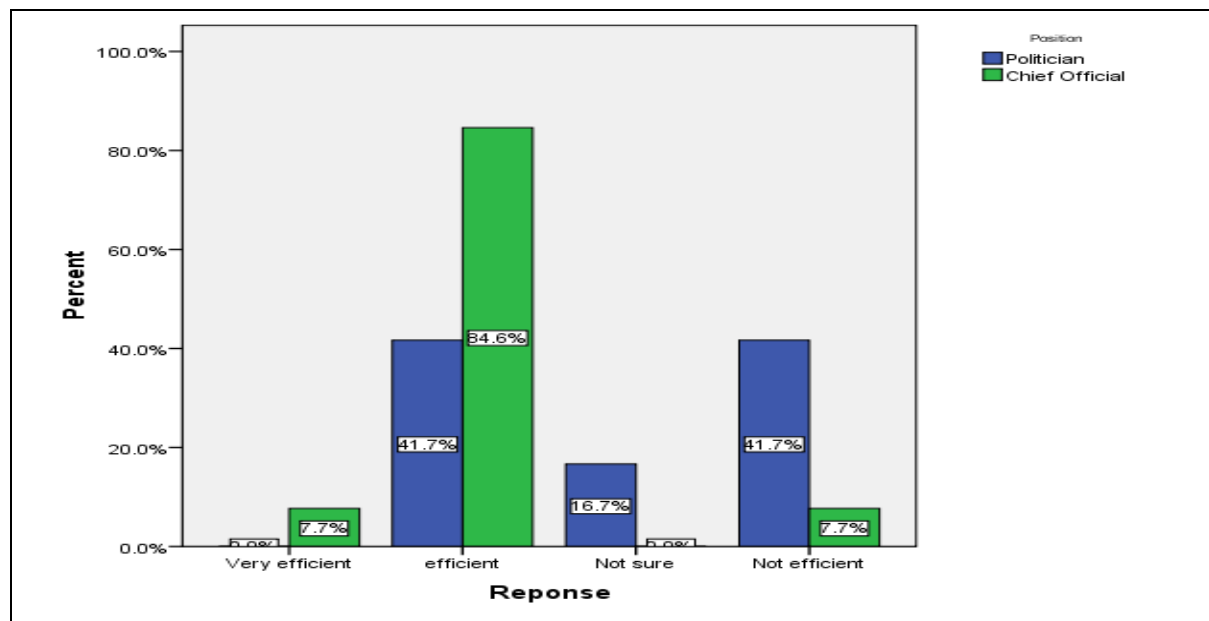
Altogether 8,3 percent of political office-bearers and 8,3 percent of chief officials were neutral, saying that they did not know anything about the implementation of capacity building strategies in the Ministry of Health.

It can thus be deduced that insufficient and irrelevant implementation of capacity building strategies is indeed causing a lack of quality services due to poor planning, inadequate resources and lack of monitoring of the capacity building strategies being implemented. This has compromised the quality of health services being delivered as there are not enough human and material capacities to deliver services and meet the ever-increasing demand for health services.

Statement (d): In your opinion please rate the efficiency of the health sector

Answer: The responses are illustrated in Figure 4.6 below.

Figure 4.5: EFFICIENCY OF THE MINISTRY OF HEALTH



Looking at Figure 4.5 above, 7.7% of chief officials reported that the health sector is very efficient, whilst the majority of 84.6% of chief officials and 41.7% of political office-bearers found the health sector efficient in the sense that despite problems the sector is facing in terms of inadequacy of resources and skills, some service is still rendered to clients and citizens within the central region. On the other hand, the minority of 41.7% political office-bearers and 7.7% chief officials found it not efficient as the services being rendered by the Ministry of

Health are not improving as evidenced by delays in receiving services. Some 16.7% of the political-bearers were not sure of the efficiency of the Ministry of Health and gave the following main reasons for their answer:

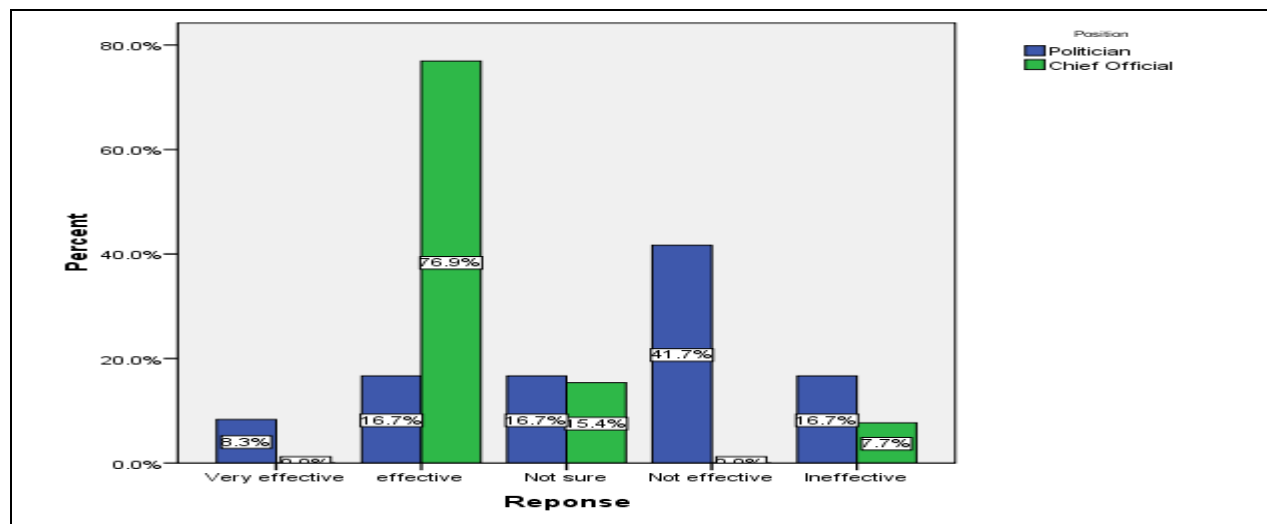
- There is no objective assessment of the health services being rendered
- There is usually no evaluation in place to seek for public opinions on the provision of health services as efficiency of the health services means satisfaction with the services being provided.

It can thus be deduced that despite facing several challenges, the Ministry of Health is still considered to be efficient.

Question (e): In your opinion, rate the effectiveness of the health sector?

Answer: Figure 4.6 below demonstrates the types of responses as provided by the respondents.

Figure 4.6: EFFECTIVENESS OF THE MINISTRY OF HEALTH



From Figure 4.6 above, 8.3% of political office-bearers found the Ministry of Health very effective, 16.7% of political office-bearers and a majority of 76.9% of the chief officials found the health sector effective within the region largely because of the ability of the sector to refer other health-related cases to centralised and specialised health facilities for support with ease. On the other hand, the majority of 41.7% of political office-bearers found it not effective, while

16.7% of political office-bearers and 7.7% of chief officials reported it ineffective for the following reasons:

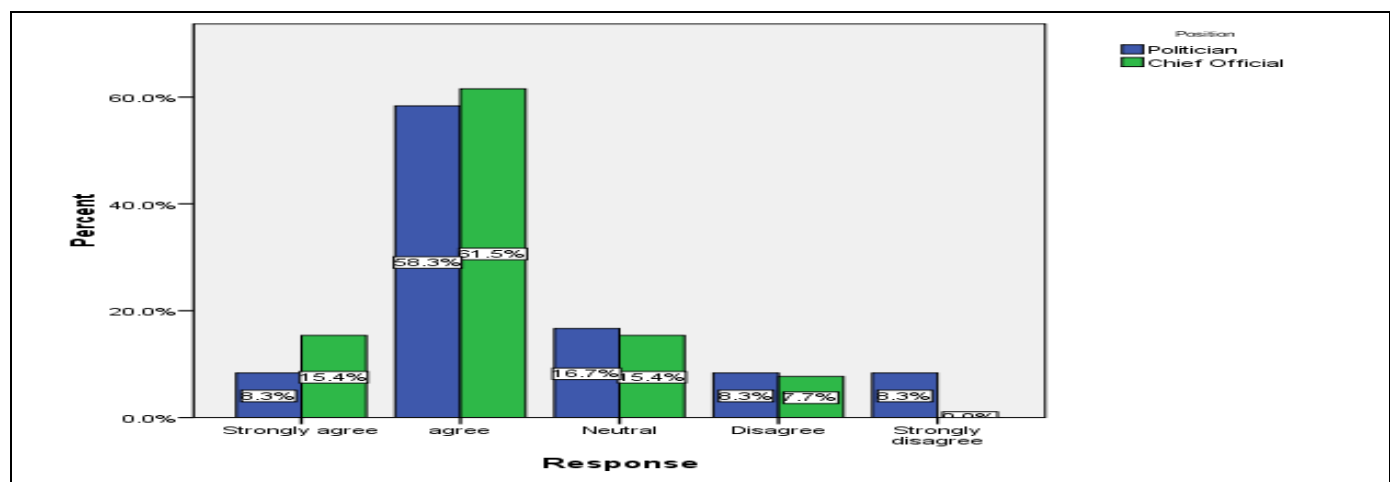
- Increased rate of corruption in the Ministry especially in the hospitals where resources are never enough as a result of theft of drugs and operating materials by the health workers.
- Non-commitment of the health professionals to ensure that resources are used effectively mainly due to lack of interest and motivation.

As noted from Figure 4.6 above, 16.6% of the political office-bearers and 15.4% of the chief officials were not sure whether the Ministry of Health is effective or not and the majority of these respondents had less than five years' experience in their posts. It can thus be deduced that the Ministry of Health is effective although sometimes referrals from health centres to district hospitals are at a larger cost as clients have to be provided with public transport and support medical personnel to accompany the referrals and this renders the process inefficient and a waste of financial and human resources (as corroborated by respondents to the following question and in Figure 4.8 below:

Statement (f): Ineffective implementation of capacity building strategies causes unnecessary mistakes, complaints and unnecessary wastage of financial and human resources.

Answer: Figure 4.7 below demonstrates the types of responses that were provided by the respondents.

Figure 4.7: RESPONSES INDICATING WHETHER INEFFECTIVE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES CAUSES UNNECESSARY MISTAKES, COMPLAINTS AND WASTAGE OF HUMAN AND FINANCIAL RESOURCES



Notably, the analysis above showed inconsistent results. Whilst respondents agree that the health services provisioning in the central region of Malawi is both effective and efficient, respondents noted implementation of capacity building as one of the areas that are problematic. Some 8.3% of the political office-bearers and 15.4% of the chief officials strongly agreed, a majority of 58.3% of political office-bearers and 61.5% of chief officials agreed that ineffective implementation of the capacity building is leading to wastage of both human and financial resources mainly due to:

- Poor understanding of organisational objectives and poor implementation which in turn lead to discontent among the key stakeholders
- The Malawi Health sector faced an acute shortage of human resources prior to 2004 for the following reasons:
 - There have been low institutional capacities to produce qualified health professionals through local training institutions, retaining those in service and accessing technical assistance to fill the human resources gaps in the sector. Reasons behind these factors have varied from personal emoluments, working environment and related other challenges that the public health service faces. For example, poor infrastructure and access to drugs and equipment makes it difficult for health workers to perform their jobs properly, thus contributing to a low motivation of the health workforce (Malawi Health Equity Network and Volunteer Services Organisation, 2004:10).
 - In addition to the above, health professionals that the system has retained are merely status holders. Aukerman (2006: 17) note that the higher qualified workers that remain in the health sector are surviving on a strategy that sees them supplementing their poor incomes through reliance on daily allowances from workshops and seminars, savings on stipends from long-term training programmes, business activities, preference for working stations with perceived lower costs of living, pilfering of drugs meant for patients, “French leave” (dual practising or working in both private and public health service facilities), consultancies and getting paid for work not done e.g. being on a public-financed pay roll while working for private institutions (dual salaries).

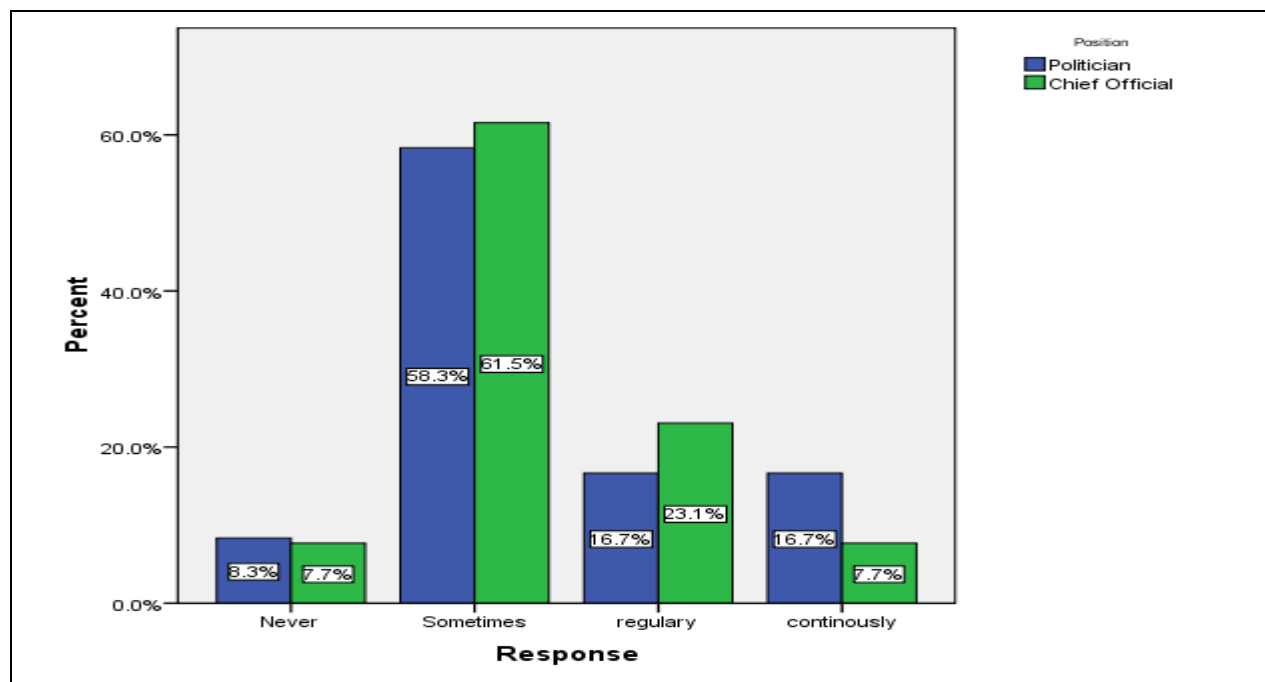
Having noted the impact of such a demotivated personnel and the poor quality of services clientele are experiencing from the health service delivery, the health sector hatched the emergency human resource plan to mitigate some of the problems noted above and in a bid to foster the improvement of health service delivery in Malawi. On the other hand, a minority of 8.3% of political office-bearers and 7.7% of the chief officials disagreed and 8.3% of political office-bearers strongly disagreed. Furthermore, 16.7% of the political office-bearers and 5.4% of the chief officials were neutral.

It is thus deduced that in spite of some progress the health sector has posted over the years, performance has not been optimal leading to wastages in terms of resources (both human and financial). This has negated the impact of capacity building strategies on the quality of health services the citizens are otherwise obtaining.

Question (g): Does your Ministry /Department experience other serious problems in the implementation of capacity building strategies for the provision of health services?

Answer: The findings on the existence of serious problems in the implementation of capacity building strategies are expressed as follows:

Figure 4.8: WHETHER THE MINISTRY OF HEALTH EXPERIENCES PROBLEMS IN IMPLEMENTING THE CAPACITY BUILDING STRATEGIES



The responses provided to the above question in Figure 4.9 of the survey reflected that a minority of 8.3% of the political office-bearers and 7.7% chief officials stated that they have never identified problems with the implementation of the capacity building strategies in the health sector of the central region in Malawi. A majority of 58.3% of political office-bearers and 61.5% chief officials noted problems with the implementation of capacity building strategies and plans in some instances (sometimes), whereas 16.7% of political office-bearers and 23.1% of chief officials noted regular problems with the implementation of capacity building strategies and plans, whilst a minority of 16.7% of the political office-bearers and 7.7% of chief officials noted continued problems with the implementation of capacity building strategies in the health sector of the central region of Malawi and gave the following reasons for this answer:

- Inadequate financial resources
- Political interference
- Poor staffing levels.
- Corruption
- Demotivation and non-commitment of human resources who implement the capacity building strategies.

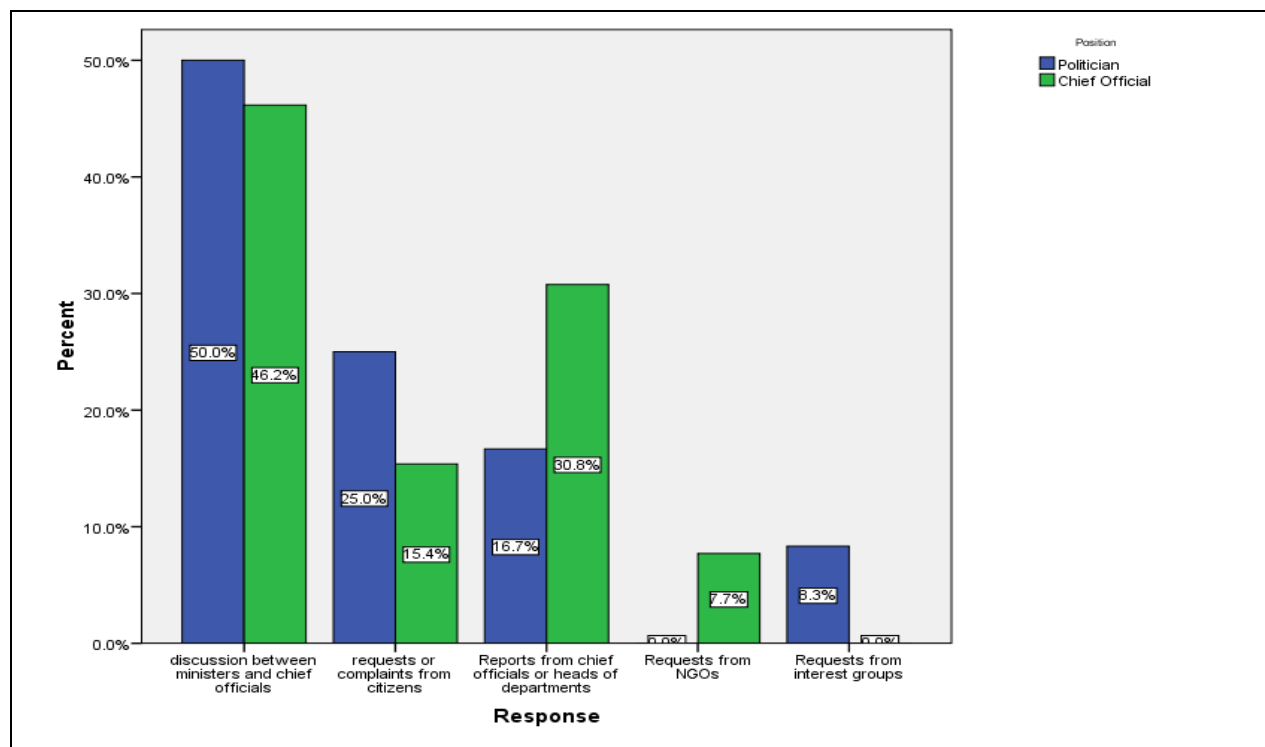
Firstly, on financial resources, respondents noted central financing mechanisms done at national level as skewing towards the immediate needs at the central level, thereby disregarding critical and pressing capacity needs identified in district and local assembly capacity building plans; hence incrementing the challenges being faced at these levels. Secondly, political influence is reported at national level and minor traces identified at district level and in referral hospitals. It was reported that political office-bearers have undue influence on chief officials, in particular at national level on identification of benefactors in the implementation of the capacity building strategies and plans, resourcing of district health facilities, e.g. provision of inputs required for health service delivery; and formulation of related policies on the implementation of capacity building strategies. These problems have resulted in inequitable access to interventions in capacity building strategies and plans and related impacts in the central region of Malawi.

This being the case, respondents suggested decentralising the formulation, control mechanisms, monitoring and resourcing of capacity building strategies to local assemblies and referral hospitals. The suggestion is made on the premise that implementation of capacity building strategies and service delivery happens at these levels with the exception of policy related capacity building at national level. This is so because the *Health Act, 2002* (Act 14 of 2002, section 4, 5 and 6), places policy custodianship at national level. In addition to this, respondents suggested the strengthening of political systems at decentralized level to guide and empower chief officials and administrators with systemic mechanisms that will aid decision making on input-related factors in the implementation of capacity building strategies. It is expected that such systems will help avert political influence on administrative decisions and inform the roles political office-bearers and chief officials play in the implementation of capacity building strategies in the health sector as well as health-related service delivery.

Question (h): How do the ministers as political office-bearers become aware of community problems?

Answer: Responses are indicated in Figure 4.9 below.

Figure 4.9: WAYS THROUGH WHICH POLITICAL LEADERS BECOME AWARE OF COMMUNITY HEALTH PROBLEMS

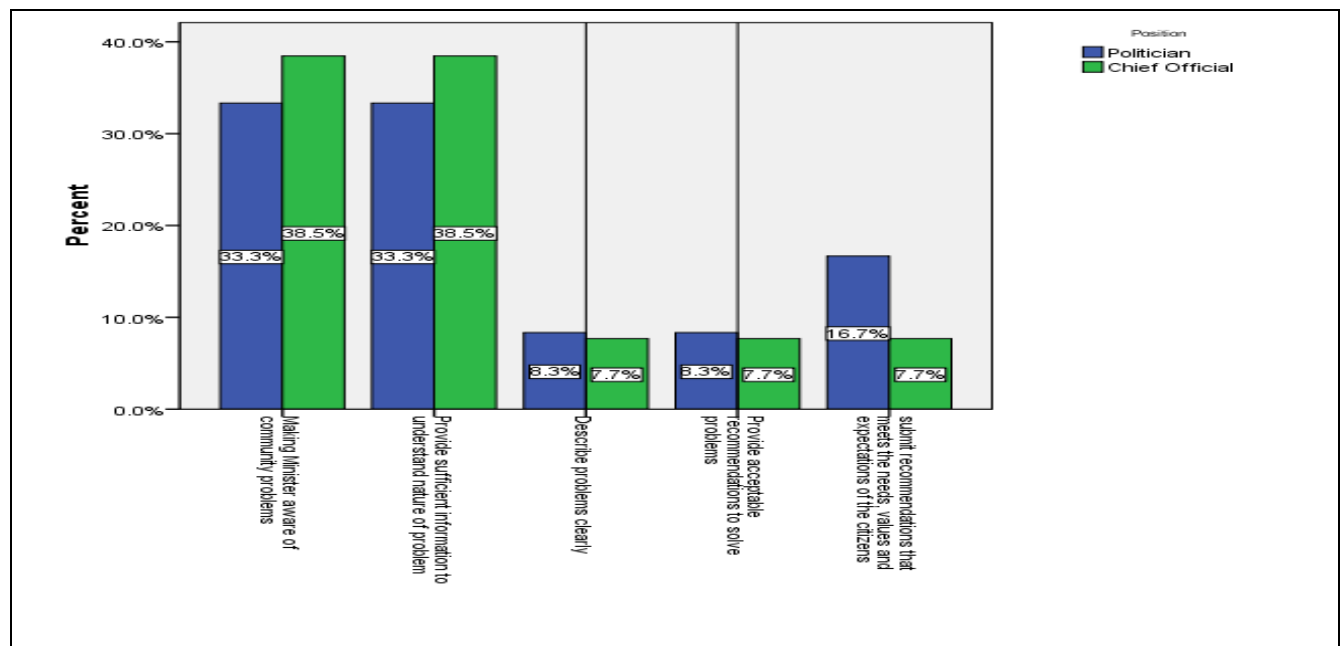


From the above Figure, a majority of 50.0% of political office-bearers and 46.2% indicated that information is obtained from the discussions between ministers and chief officials, while 25.0% of political office-bearers and 15.4% of chief officials indicated that information is from the complaints from the citizenry, 16.7% of political office-bearers and 30.8% of chief officials said it is from the reports from chief officials and heads of departments, whilst a minority of 7.7% of political office-bearers indicated that information is obtained from the requests from non-governmental organisations and 8.3% of chief officials observed that information is also gained from other interest groups. It can be deduced that much of the information about community problems is obtained from the discussions between ministers and chief officials. This is because ministers play a leading role in legislation, regularisation and policy direction on capacity building in the health sector, which information is of critical significance. This being the case, chief officials have an important role in providing factual information to the political office-bearers

Question (i): Do the chief officials play a meaningful role in making legislation for capacity building?

Answer: Figure 4.10 illustrates the roles that the chief officials play in legislation for capacity building.

Figure 4.10: WHETHER THE CHIEF OFFICIALS PLAY A MEANINGFUL ROLE IN LEGISLATION FOR CAPACITY BUILDING



From the above Figure, 33.3% of political office-bearers and 38.5% of chief officials observed that chief officials and administrators spend much of their time in making ministers aware of health-related community problems, again 33.3% of political office-bearers and 38.5% of chief officials observed that chief officials spend time providing sufficient information to political office-bearers to understand the nature of the health related problems in their constituencies. A minority of 8.3% of political office-bearers and 7.7% of chief officials said chief officials provide acceptable recommendations to solve the community problems and again 8.3% of political office-bearers and 7.7% of chief officials said chief officials describe problems clearly and provide acceptable recommendations to solve the problems, whereas 16.7% of the political office-bearers and 7.7% of the chief officials observed that chief officials submit recommendations that meet the needs, values and expectations of the citizens.

The above results challenge chief officials in terms of the meaningful roles they are expected to play in administering capacity building as well as managing health service facilities in the central region of Malawi. It is clear that chief officials spend much of their time in this respect providing information to the political office-bearers in addition to making departmental and operational policy (Meiring 2001:63-65) which is supposedly core to their roles in public administration. This therefore asks for re-examination of the roles and chartered time management on the part of the chief officials managing the public health sector in the central region of Malawi. The situation above showed that chief officials have limited meaningful inputs in decisions made at executive level, which leaves decision making to the political office-bearers whose interests as presented earlier are bound by constituencies' interests and not necessarily global interests, therefore allowing for perpetuation of inequitable access to health services by the citizens in the central region of Malawi. This situation raises the question of sufficiency in legislation on capacity building for the provision of health services.

It can thus be deduced that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region as this is evidenced by a prevalent lack of quality in the health services that are delivered to the citizens. Furthermore even though the health sector is rated as fairly efficient and effective, it is faced with an acute shortage of human resources which is made even worse with the problems that are being experienced in the implementation of capacity building strategies. Such problems

include the following: inadequate financial resources, political interference, poor understanding of organisational objectives, poor planning of the capacity building strategies and lack of monitoring and evaluation. It is also worth mentioning that the current legislation is insufficient for carrying out capacity building interventions for effective and efficient health service delivery. This is due to the fact that chief officials have limited meaningful inputs in decisions that are made in regard to capacity building thereby leaving decision making to political office-bearers whose interests are bound by constituencies' interests.

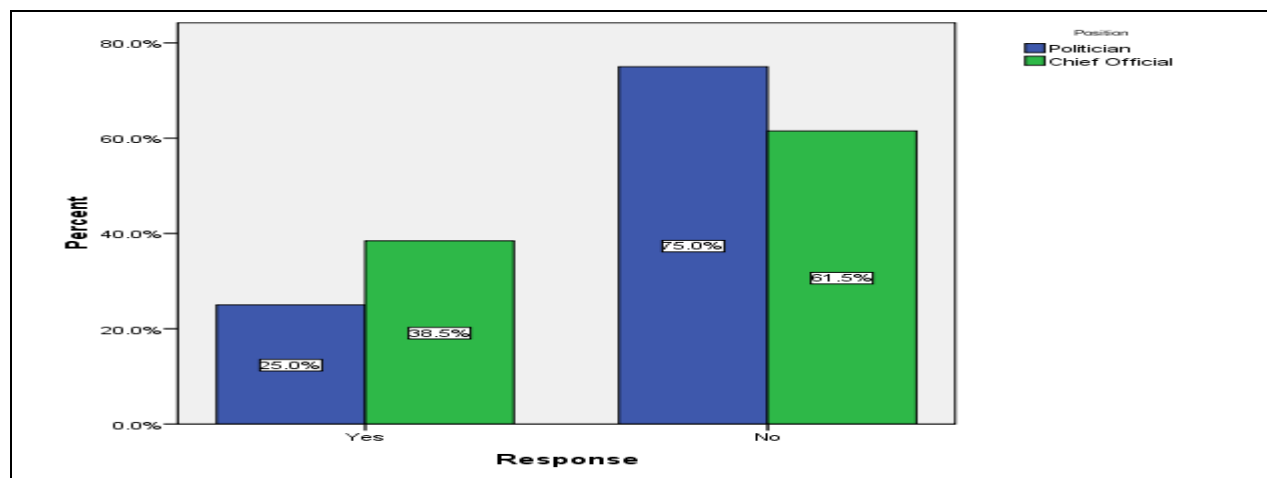
4.3.3. EVALUATION OF EXECUTIVE POLICY/LEGISLATION FOR CAPACITY BUILDING (INPUT PHASE)

In order for capacity building initiatives to be appreciated and comprehensively implemented, there is a need for legislation to bind the chief officials and politicians to this role. Currently, the legislation that is in place is not comprehensive enough to support the capacity building activities that are implemented in the Ministry of Health.

Question (a): Does the existing legislation provide sufficiently for capacity building for the provision of health services?

Answer: Figure 4.11 illustrates the responses from the respondents.

Figure 4.11: WHETHER THE EXISTING LEGISLATION PROVIDES SUFFICIENTLY FOR CAPACITY BUILDING FOR THE PROVISION OF HEALTH SERVICES

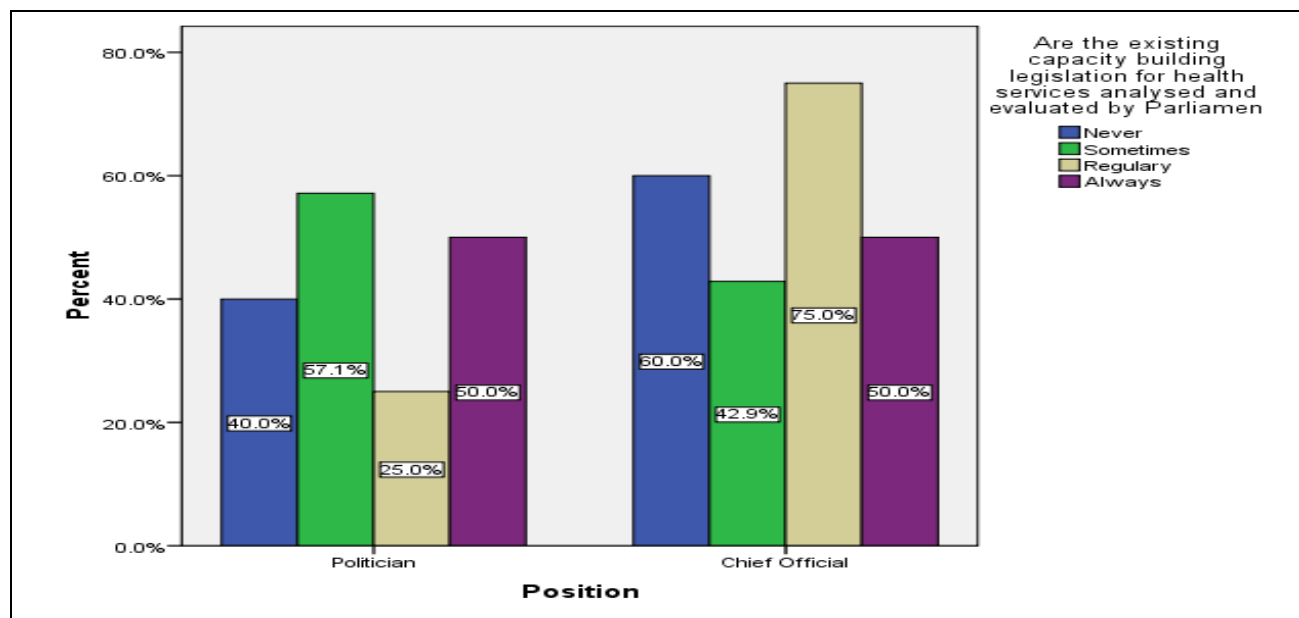


From Figure 4.12 it can be seen that the majority (75.0%) of political office-bearers and 61.5% of chief officials answered negatively that the legislation is insufficient. When asked to motivate their responses, the respondents indicated that the current legislation does not really bind the Ministry to capacity building. For example, it does not make it mandatory for the Health Service Commission to fill all the vacant positions, thereby leading to a high vacancy rate and acute human resources shortage. On the other hand, the minority of 25.0% of political office-bearers and 38.5% of chief officials answered positively that the legislation is sufficient as the Ministry of Health is still able to implement capacity building programmes within the scope of the current legislation.

Question (b): Is the existing capacity building legislation for health services analysed and evaluated by Parliament?

Answer: The responses are illustrated in Figure 4.12 below.

Figure 4.12: WHETHER THE EXISTING CAPACITY BUILDING LEGISLATION FOR HEALTH SERVICES IS ANALYSED AND EVALUATED BY PARLIAMENT



From the above Figure the majority of 57.1% of the political office-bearers and 46.9% of chief officials indicated that the existing capacity building legislation for health services is sometimes analysed and evaluated by Parliament, 40% of the political office-bearers and 60% of chief officials stated that the capacity building legislation for health services is never analysed and evaluated by Parliament, whereas 25% of the political office-bearers and 75% of the chief officials indicated that the legislation is regularly analysed and evaluated by Parliament before chief officials and administrators in the public health sector implement the capacity building strategies. On the other hand, asked if the analysis is done by Parliament, 50% of the chief officials indicated that the existing capacity building legislation for health services is always analysed and evaluated by Parliament.

It can therefore be deduced from the foregoing that whilst chief officials do not play a meaningful role in analysing, evaluating and advising the political office-bearers on policy for capacity building, the political office-bearers also do not comprehensively scrutinize the legislation before presentations in and enactment by Parliament, and implementation of capacity building policy in the central region of Malawi. These findings therefore suggest that capacity building legislation and strategies that were implemented do not undergo the requisite evaluation and may not be reflective of expectations and interests of the public health sector clientele.

4.3.4 EVALUATION OF ADMINISTRATIVE ENABLING FUNCTION FOR CAPACITY BUILDING (PROCESSING PHASE)

Chief officials have a role to provide the required means for capacity building activities to be done efficiently and effectively in the Ministry of Health. This is achieved by performing the administrative enabling functions which consist of policy making, organising, financing, staffing, determining of procedures and controlling of capacity building initiatives. The implementation of the administrative enabling functions to make capacity building possible was evaluated as follows.

Question (a): Did your departmental head and deputies lay down specific capacity building departmental policies to adapt existing legislative measures to departmental circumstances?

Answer: Figure 4.13 below shows the responses as provided by the respondents.

Figure 4.13: WHETHER THE DEPARTMENTAL HEAD AND DEPUTIES LAID DOWN A SPECIFIC CAPACITY BUILDING POLICY, TO ADAPT EXISTING LEGISLATIVE MEASURES TO DEPARTMENTAL CIRCUMSTANCES

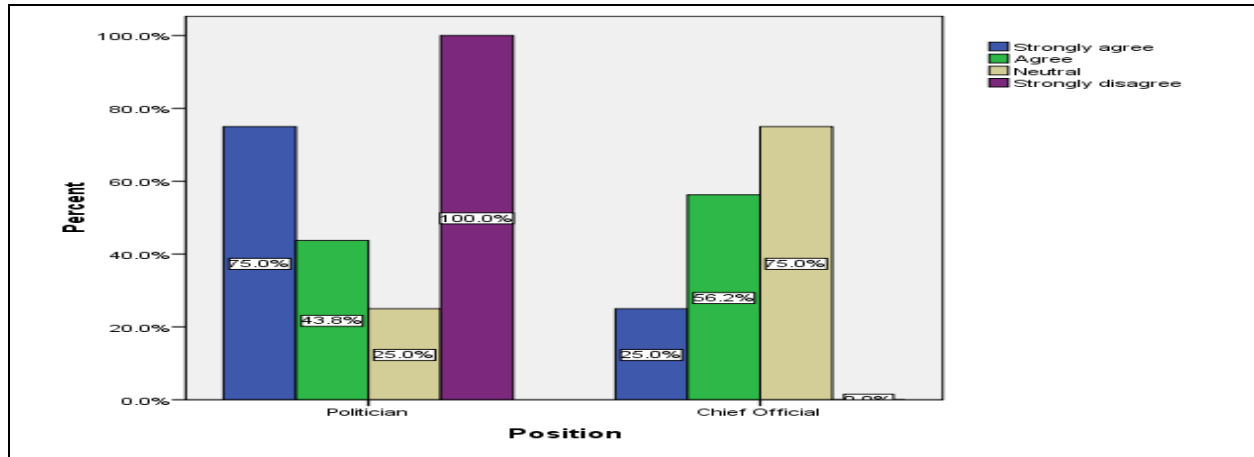
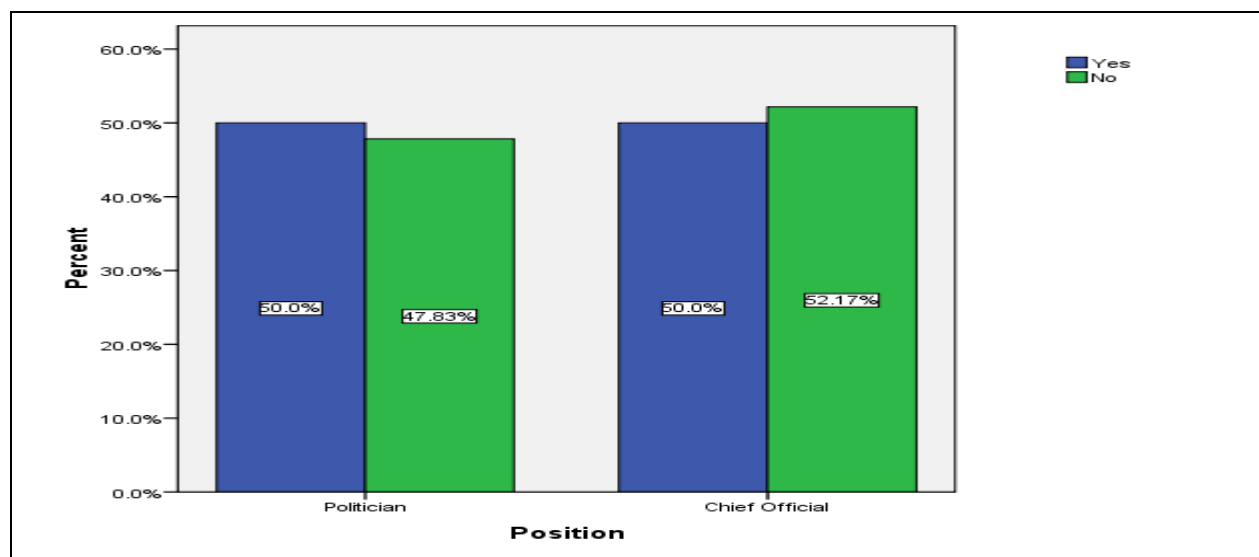


Figure 4.13 shows that the majority of 43.8% of political office-bearers and 56.2% of chief officials agreed, while 75.0% of political office-bearers and 25.0% of the chief officials strongly agreed. On the other hand, 25% of political office-bearers and 75% of the chief officials were neutral whereas no chief official in the respondents' sample disagreed. The respondents further stated that the adaptation is conducted annually during the development of the annual programme of work, work plans and the fiscal budget. Probed on the sufficiency and effectiveness of the departmental policy, respondents indicated that these are not sufficient or effective. It can thus be deduced that the Ministry of Health has a specific capacity building policy that adapts to the existing legislative measures although they are archaic and thus need to be reviewed to meet the current capacity needs.

Question (b): Does your ministry/ department have sufficient financial resources to implement capacity building strategies?

Answer: Figure 4.14 below illustrates the responses from the respondents.

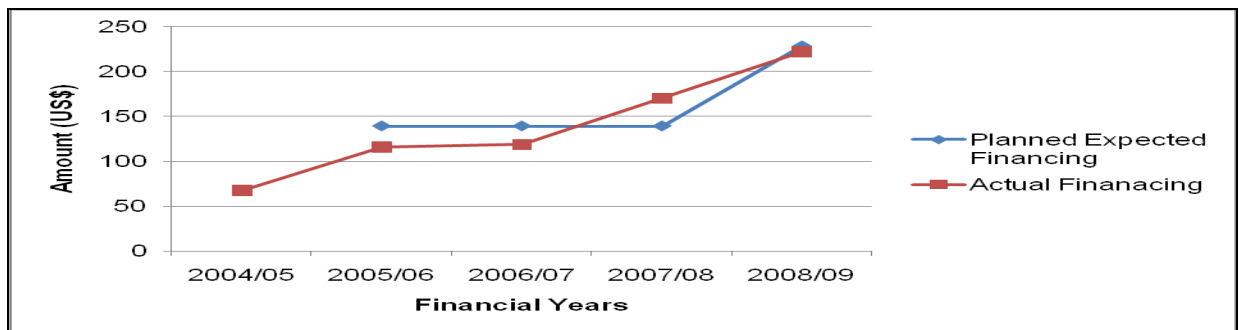
Figure 4.14: WHETHER THE MINISTRY OF HEALTH HAS SUFFICIENT FINANCIAL RESOURCES TO IMPLEMENT CAPACITY BUILDING PROGRAMMES



In the above Figure, 47.8 of the political office-bearers and 52.8% of the chief officials indicated that the financial resources are insufficient and gave the following reasons for their answers.

- Budgetary allocation to their departments, sections and district assemblies is inadequate to implement the adapted capacity building strategies. Therefore the capacity building strategies and plans are developed and available, but not implemented due to financial constraints. This has led to inadequate skilled human resources in health facilities.
- Donor over dependency – more donor financial resources are earmarked money hence difficult to access to support capacity building programmes
- Increased demand for capacity building hence financial resources would never be enough.

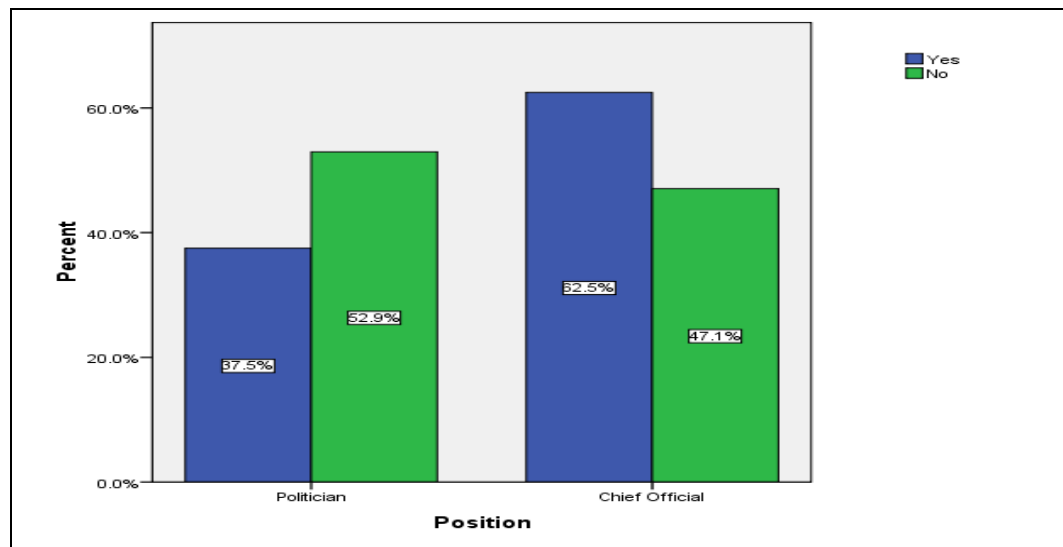
On the other hand, 50% of the political office-bearers and 50% of the chief officials reported that the financial resources are enough for implementing capacity building programmes. However, trends in the health sector show that over the past years the sector has been allocated more money than originally planned.

Figure 4.15: TREND ANALYSIS OF PUBLIC HEALTH EXPENDITURE (2004 – 2009)

From the responses it can be deduced that the financial resources are not enough for implementing the capacity building activities.

Question (c): Does your ministry /department have sufficient trained and skilled personnel to implement capacity building strategies effectively?

Answer: Figure 4.16 below reflects the responses as provided by the respondents.

Figure 4.16: WHETHER THE MINISTRY OF HEALTH HAS ADEQUATE TRAINED AND SKILLED HUMAN RESOURCES

In the above Figure, 52.9% of the political office-bearers and 47.1% of the chief officials indicated deficiencies in trained and skilled personnel to implement capacity building strategies. This provided an interesting line of questioning as to how the service centres in the health sector are able to provide for some services. On the other hand, 37.5% of the political office-bearers and 62.5% of the chief officials indicated that the human resources are enough to implement the capacity building programmes. However a document search has provided for strategies that the health sector has implemented at the national level as elaborated by Mangham, (2007:4). Efforts to address these capacity deficiencies included allowing for 52%

taxable salary increment to health workers in eleven groups focusing mainly on the mid-level, such as nurse/midwives, clinical officers and medical assistants; enhancing training and utilizing additional external technical assistance in the delivery of health services. Specifically the following actions were undertaken:

(i) Gap Filling

Through this approach the health sector was able to partner with organisations such as United Nations Volunteers and Medecins Sans Frontieres in an attempt to address the critical shortfall in health worker numbers by strategically filling gaps with international volunteers. Undoubtedly this has had an enormous impact on service delivery and is a meaningful step towards the more sustainable capacity development of Malawian counterparts, who receive in-service training and mentoring from these volunteers. (Martin-Staple, 2004:25).

(ii) Locums

This was another model whereby the health sector introduced pay incentives for health professionals working extra hours well above the hours prescribed in the conditions of service. This has been questioned in terms of effectiveness. Some quarters have raised concerns about the focus and time spent on regular duties and the silent motivation this provides to some health workers to barely conduct a locum in order to meet their living costs, apart from the physical strain this causes on them in terms of functional levels of energies required to efficiently and effectively perform their duties and offer health services to expected levels. (Malawi Government, 2007:15)

(iii) In – service training of health professional workers

Through the devolved bodies like the Medical Council of Malawi; Nurses and Midwives Council of Malawi; Pharmacy and Poisons Board of Malawi the health sector devised a means of developing programmes for the Continuous Professional Development of health professionals as a motivating bid for retaining mid-level and junior level health career professionals. However the mandate of these professional bodies leaves out critical health service complementary professionals such as Environmental Health professionals and Health Surveillance professionals who are very critical in preventive health service delivery apart from the curative health service delivery. (Malawi Government, 2007:20)

(iv) Part-Time Recruitment of Retired Staff

This is a relatively new initiative within the 2010 Human Resources Development and Deployment policies. The purpose of re-recruiting retired health workers on a part-time basis is to increase the numbers of health workers as well as providing mentorship to junior personnel.

It can thus be deduced from the above analysis, that although the Ministry of Health has put in mechanisms to ensure that there are enough human resources to carry out its capacity building activities, the human resources are still not adequate, more especially that those who are implementing the capacity building initiatives lack the requisite skills.

Question (d): Does your ministry/department have sufficient organisational structures such as divisions, sections and posts to implement capacity building strategies effectively?

Answer: The answers are illustrated in the Figure below.

Figure 4.17: WHETHER THE MINISTRY OF HEALTH HAS SUFFICIENT ORGANISATIONAL STRUCTURES TO IMPLEMENT CAPACITY BUILDING STRATEGIES EFFECTIVELY

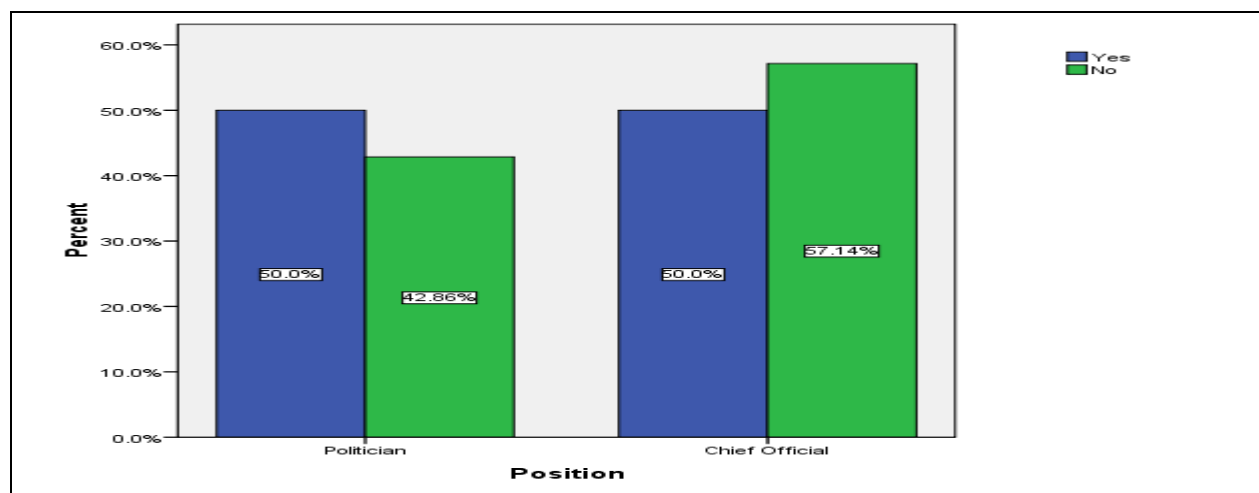


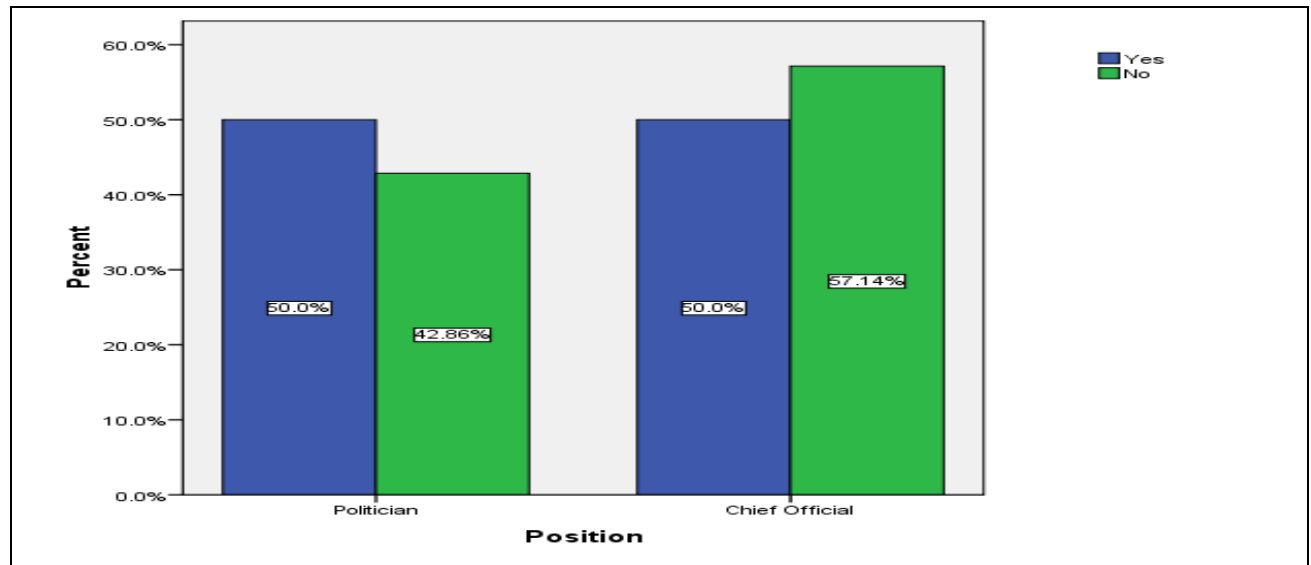
Figure 4.17 above reflects how the respondents answered during the survey. Under this question, the majority of 50.0% of the political office-bearers and 50% of the chief officials answered in the affirmative, indicating the presence of well-established organisational structures aimed at supporting the implementation of the capacity building strategies. Some 42.6% of the political office-bearers and 57.4% of the chief officials answered in the negative

because of the Ministry's operation of a high vacancy rate. However, based on the above figure, it can be deduced that the Ministry of Health has well-established organisational structures in place for effective implementation of capacity building activities although other respondents pointed out the issue of vacant posts as a challenge.

Question (e): Does your ministry/department have sufficient work procedures and methods in place to ensure effective service provision?

Answer: Figure 4.17 below illustrates the responses from the respondents.

Figure 4.18: WHETHER THE MINISTRY OF HEALTH HAS SUFFICIENT WORK PROCEDURES AND METHODS TO ENSURE EFFECTIVE SERVICE PROVISION

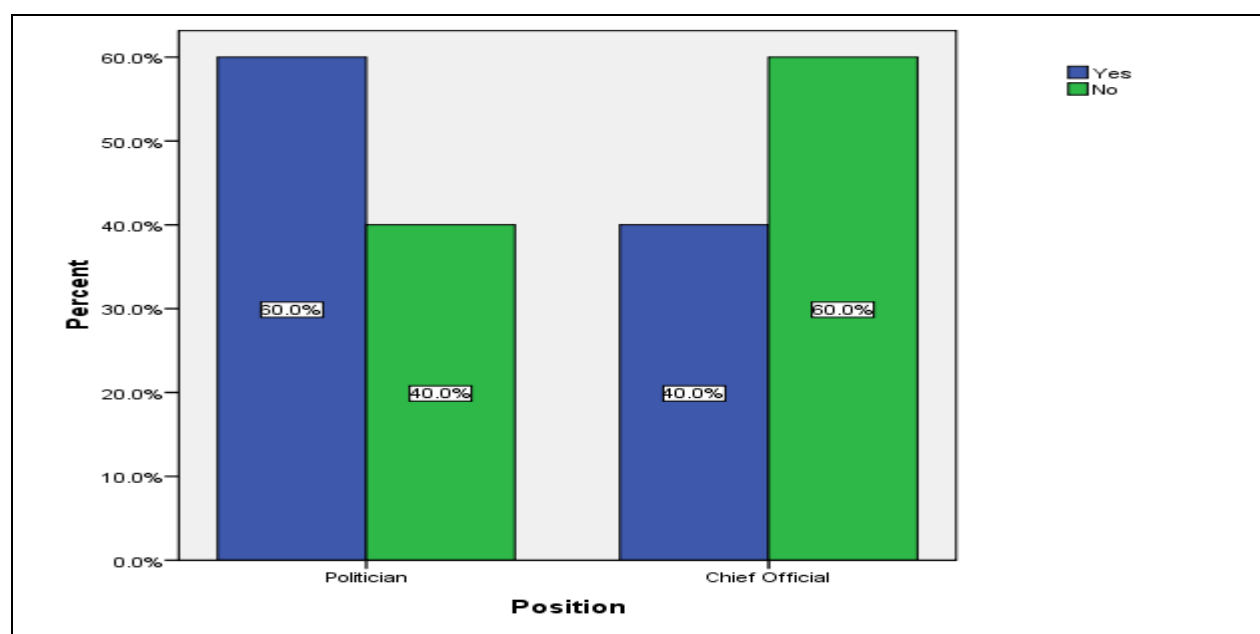


From the above Figure, it can be seen that 50.0% of the political office-bearers and 50.0% of the chief officials indicated that the departments have supportive and well-defined work procedures and methods to ensure effective service provision whilst 42.8% of the political office-bearers and 57.2% of the chief officials indicated that the Ministry did not have any. However, health practice in Malawi is regulated through the *Health Act, 2002* (Act 14 of 2002), the Malawi Public Service Regulations (1994) and programmatically through the Essential Health package which clearly stipulates work procedures and methods to ensure effective service provision (Africa Development Bank, 2006:12). It can therefore be deduced that the Ministry of Health has sufficient work procedures and methods in place to ensure the effective implementation of capacity building strategies.

Question (f): Does your ministry/department have sufficient control measures and standards in place to ensure the effective implementation of capacity building strategies?

Answer: The answers to this question are shown in Figure 4.18 below.

Figure 4. 19: WHETHER THE MINISTRY HAS SUFFICIENT CONTROL MEASURES AND STANDARDS IN PLACE TO ENSURE EFFECTIVE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES



In response to the above question, 60.0% of the political office-bearers and 40.0% of the chief officials answered in the affirmative. On the other hand, 60.0% of the chief officials and 40.0% of the political office-bearers stated that the departments and sections that they are working in do not have sufficient control measures and standards in place to complement the organisational structures to ensure the effective implementation of capacity building policy strategies and delivery of quality health services to the citizens. This is mostly due to poor planning of the capacity building activities which results in compromising the standards.

Therefore, the foregoing indicates that health facilities in the districts, referral hospitals and national level offices have structures that support the implementation of the capacity building strategies and health service delivery in general. However, the control mechanisms that assure enforcement of capacity building policies, plans and strategies in these institutions require strengthening so that processes that are undertaken to build capacity in human and material

resources benefit the organisational structures and work procedures in this regard and that delivery of health services' outputs are up to the expectations of the citizens.

Based on the above analysis it can be deduced that the policies for capacity building are archaic and not sufficient to meet the current capacity needs in the health sector. Further to this, financial and human resources are inadequate to implement the available developed capacity building strategies despite having in place well-defined work procedures and organisational structures aimed at supporting the implementation of capacity building strategies. However, the control measures and standards that are in place are not enough for the enforcement of effective implementation of capacity building policies, plans and strategies and therefore require strengthening.

4.3.5 OUTPUT FROM THE IMPLEMENTATION OF THE CAPACITY BUILDING STRATEGIES IN THE PROVISION OF HEALTH SERVICES

Any capacity building strategy implemented is supposed to lead to proved capacity in the Ministry of Health and therefore improved health service delivery.

Question (a): Capacity building is an important function of the Ministry/ Department.

Answer: Figure 4.19 demonstrates the answers as provided by the respondents.

Figure 4.20: CAPACITY BUILDING AS AN IMPORTANT FUNCTION OF THE MINISTRY

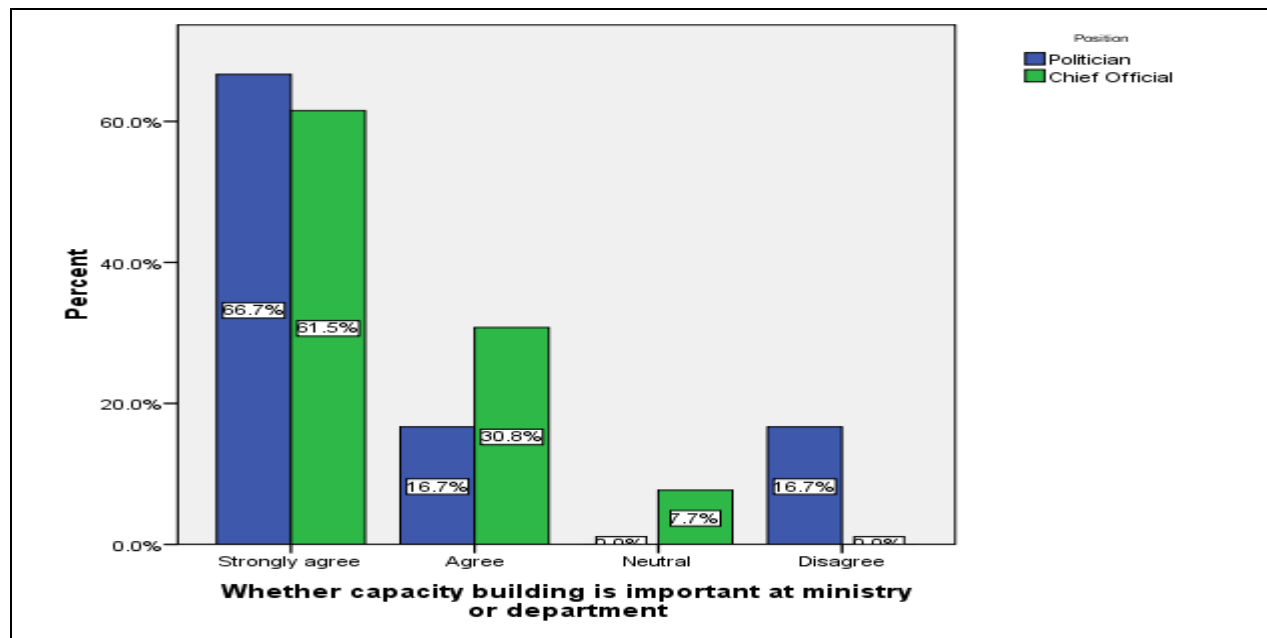


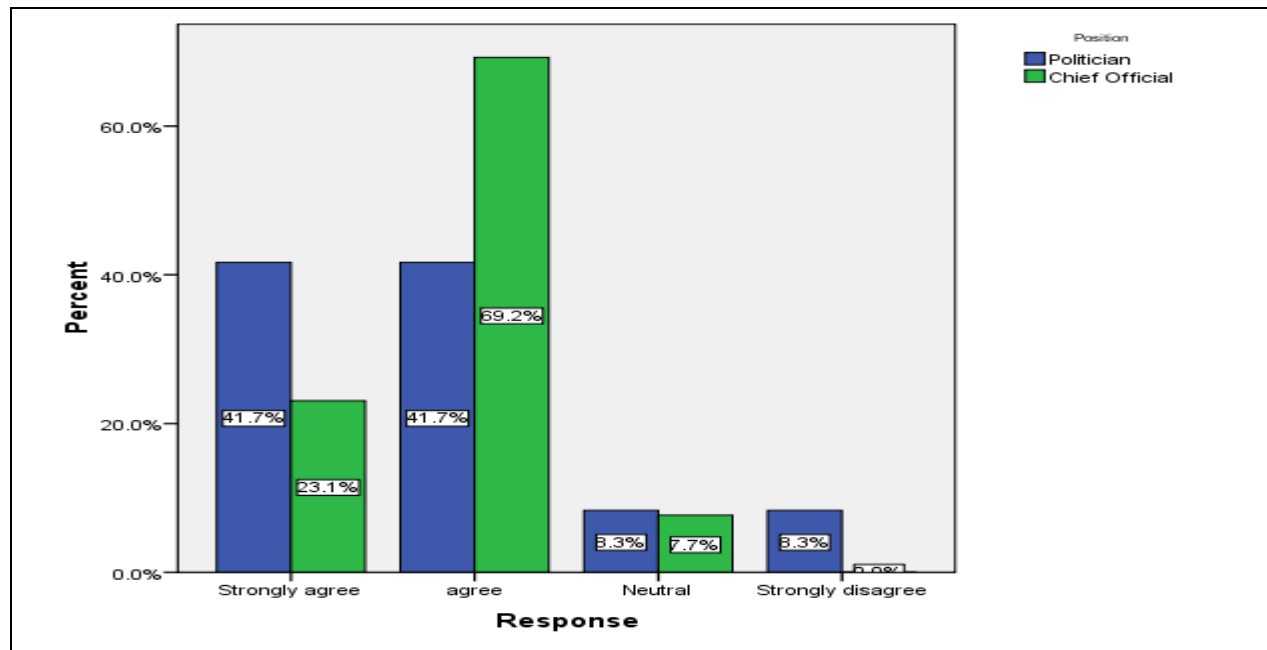
Figure 4.20 above shows that the majority of the political office-bearers and 66.7% of the chief officials strongly agreed, Some 16.7% of the political office-bearers and 30.8% of the chief officials agreed that capacity building is an important function of the Ministry of Health,

departments and sections in all health units and facilities in the central region of Malawi. On the other hand, a minority of 7.7% of the chief officials were neutral and 16.7% of the political office-bearers strongly disagreed that capacity building is an important function of the Ministry, saying that there is more to the provision of health services than capacity building, such as adequacy of financial resources and operating materials like drugs. Based on the above responses, it can be deduced that capacity building is indeed an important function of the Ministry as no services would be provided without capacity.

Statement (b): Health services cannot be provided effectively without suitable and sufficient human and financial resources.

Answer: Figure 4.21 below shows the responses as provided by the respondents.

Figure 4.21: HEALTH SERVICES CANNOT BE PROVIDED EFFECTIVELY WITHOUT SUITABLE AND SUFFICIENT HUMAN AND FINANCIAL RESOURCES

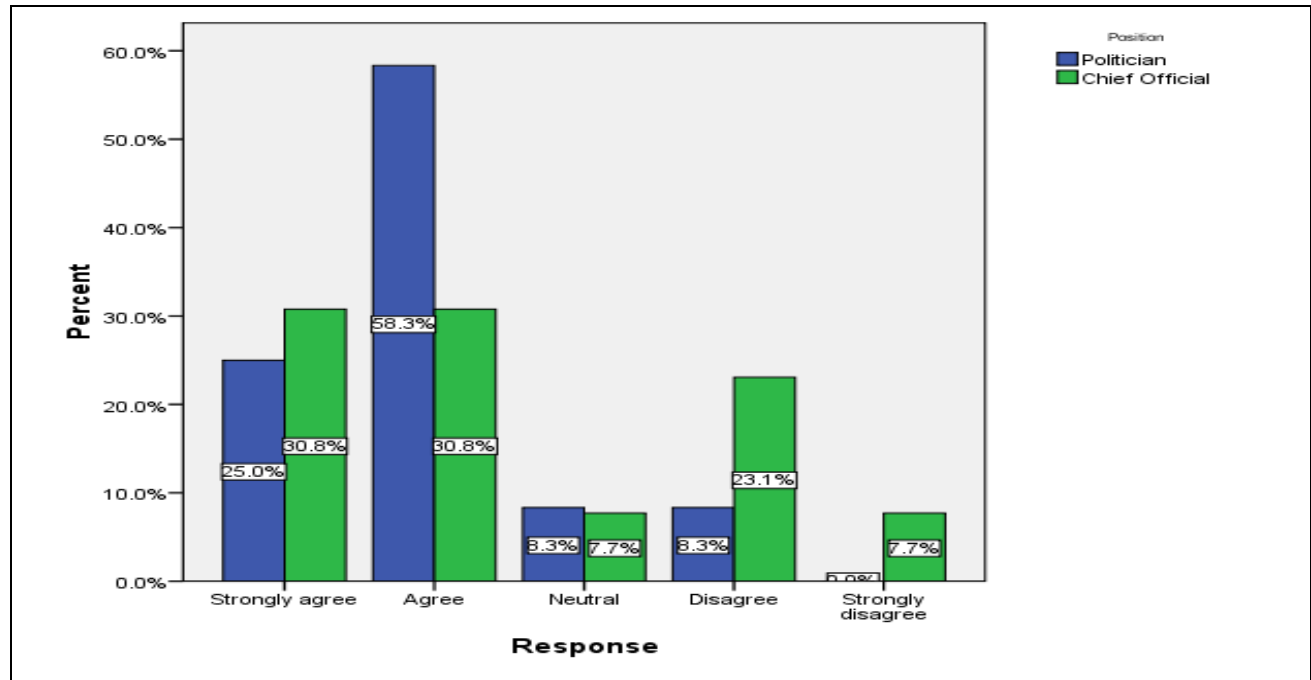


From the above Figure it can be seen that the majority or 69.2% of the political office-bearers and 41.7% of the chief officials agreed, and 41.7% of the political office-bearers and 23.1% of the chief officials strongly agreed that health services cannot be provided effectively without suitable and sufficient human and financial resources whilst a minority of 3.3% of the political office-bearers strongly disagreed, and 3.3% of the political office-bearers and 7.7% of the chief officials were neutral. It can thus be deduced that it is true that health services cannot be provided effectively without suitable and sufficient human and financial resources as indicated by the majority of the respondents.

Statement (c): The provision of health services by the Ministry/Department does not satisfy community needs effectively.

Answer: Figure 4.22 reflects the responses as provided by the respondents in the study.

Figure 4.22: COMMUNITY ASSESSMENT ON THEIR SATISFACTION WITH THE PROVISION OF HEALTH SERVICES



Note must be taken of the aforementioned and of the state of health provisioning especially regarding the inadequacy in human and financial resources as well as inadequate attention to detail in the implementation of the capacity building strategy and plans. From the above Figure, the majority of 41.7 % of the political office-bearers and 23.1% of the chief officials strongly agreed, 41.7% of the political office-bearers and 69.2% of the chief officials agreed that the health services being provided by the Ministry of Health in the Central Region of Malawi do not exclusively satisfy the needs of the communities. On the other hand, a minority of 8.3% of the political-office bearers and 7.7% of the chief officials were neutral, whilst 8.3 % of the political office-bearers disagreed and gave the following reasons for their answer:

- Availability of Health Surveillance Assistants who live within the communities and provide basic health education information such that in an event of illness, within the communities there are clinics/dispensaries where outpatients are treated.
- There is a health centre serving a population of 50,000 which has admission facilities and health professionals.

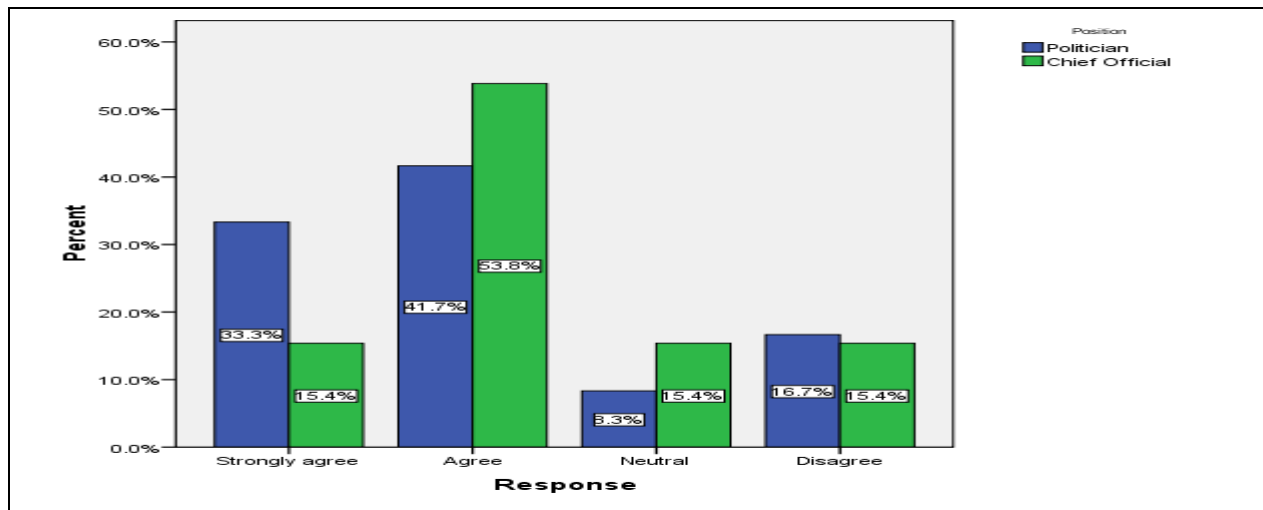
- Political office-bearers indicated that when they are addressing meetings with the people, there are no complaints from the communities in regard to health services except a few cases where drugs are in short supply.

It can be deduced that health services being provided by the Ministry of Health in the central region of Malawi do not exclusively satisfy the needs of the communities.

Question (d): The output of the health services being rendered will change the economic, social and physical environment to such an extent that development takes place.

Answer: The responses to this question are illustrated in Figure 4.23 below.

Figure 4.23: THE OUTPUT OF THE HEALTH SERVICES BEING RENDERED WILL CHANGE THE ECONOMIC, SOCIAL AND PHYSICAL ENVIRONMENT TO SUCH AN EXTENT THAT DEVELOPMENT TAKES PLACE



Whereas respondents rated the health service provision as efficient and effective, limited resources such as drugs and equipment, qualified clinical personnel, in particular in the districts and health centres, undermine the external efficiency and effectiveness of the health sector and challenge the chief officials and administrators to re-examine the inputs, processes and outputs that the implementation of the capacity building strategies and plans is yielding. Going with “business as usual” implies developmental losses in terms of changes due to the economic, social and physical environment as corroborated in the responses from the respondents where a majority of 33.3% of the political office-bearers and 15.4% of the chief officials strongly agreed, 41.7% of the political office-bearers and 53.8% of the chief officials agreed with the fact that quality health services as an output have a positive effect on the

development in terms of the social, economic and physical environment and gave the following reasons for their answers:

- Quality of health personnel and health services will be improved
- Only healthy people can contribute to the development of the country and Government spending on health services will be reduced if people are in good health
- In order for development projects to be successful, they need healthy people and people have a right to quality services.

On the other hand, a minority of 16.7% of the political office-bearers and 15.4% of the chief officials disagreed saying that it is only good health that can lead to development. A minority of 8.3% of the political office-bearers and 15.4% of the chief officials were neutral. It can thus be deduced that improved health services will lead to changes in the economic, social and physical environment which will in turn lead to development of the country.

It can generally be deduced that capacity building is an important function of the ministry as health services cannot be provided effectively without suitable and sufficient human and financial resources. However, at the moment the provision of services by the health sector does not satisfy community needs effectively though quality health services as an output have a positive effect on the development in terms of the social, economic, and physical environment since a healthy nation is a vibrant and prosperous nation.

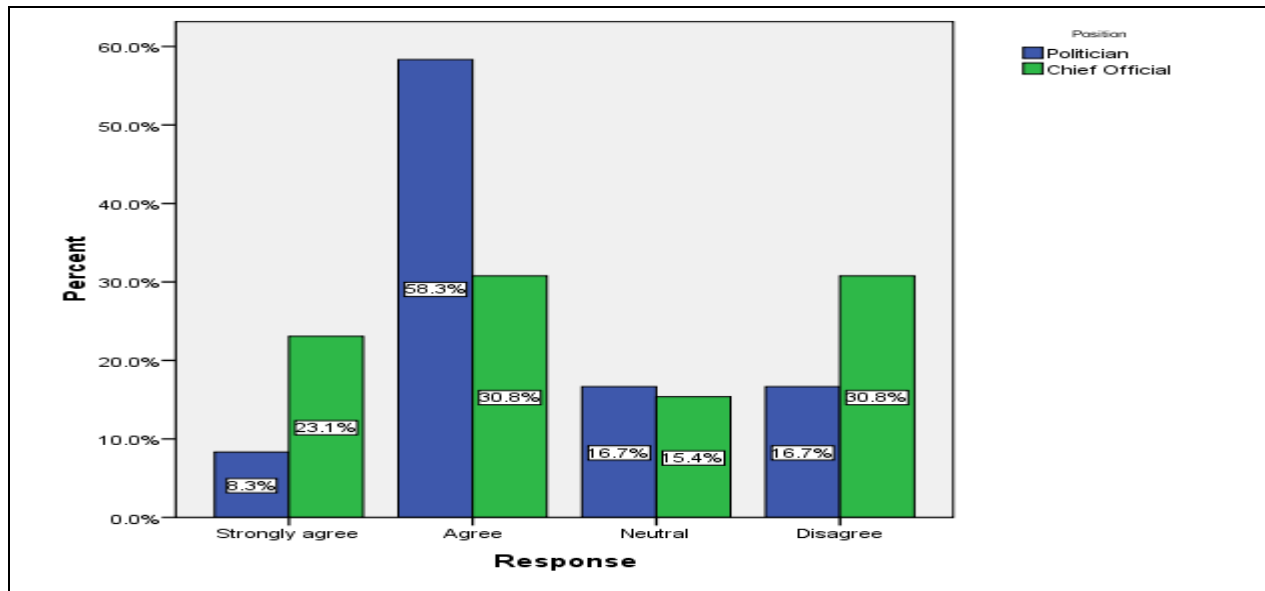
4.3.6 IMPACT OF CAPACITY BUILDING POLICY/ STRATEGIES ON PUBLIC HEALTH SERVICES, THE ENVIRONMENT AND CITIZENS

The impact of implementing capacity building strategies is established by looking at the quality of health services being delivered to the citizens and the high level of satisfaction with the health services in Malawi. Thus, it was important that the impact of the capacity building strategies on health services be revealed in the survey.

Question (a): Does the Ministry of Health consider seriously the impact of health services on the environment and citizens?

Answer: Figure 4.24 below illustrates the responses as provided by the respondents.

Figure 4.24: WHETHER THE MINISTRY OF HEALTH CONSIDERS SERIOUSLY THE IMPACT OF HEALTH SERVICES ON THE ENVIRONMENT AND CITIZENS



The above Figure shows that 8.3% of the political office-bearers and 23.1% of the chief officials strongly agreed, 58.3% of the political office-bearers and 30.8% of the chief officials agreed that there is always a serious consideration of the impact of health services on the environment and citizens; this was largely attributed to:

- The average increase in mortality rates and other illnesses that require specialised equipment and human personnel such as cancer cases, diabetes and sugar ailments among others.
- There is always monitoring and evaluation of the impact of health services on the environment and citizens.
- Environmental Impact assessment is always mandatory under donor funding.

On the other hand, 16.7% of the political office-bearers and 30.8% of the chief officials disagreed that the Ministry of Health seriously considers the impact of its services on the environment and the citizens. Some 16.7% of the political office-bearers and 15.4% of the chief officials were neutral. In this regard, it can be deduced that the Ministry of Health always considers the impact of its services on the environment and citizens through environmental impact assessments and regular monitoring and evaluation of health services.

Question (b): Do the citizens easily access health services in the rural areas?

Answer: Figure 4.25 below reflects the responses as provided by the respondents in the study.

Figure 4.25: WHETHER CITIZENS EASILY ACCESS HEALTH SERVICES DELIVERY

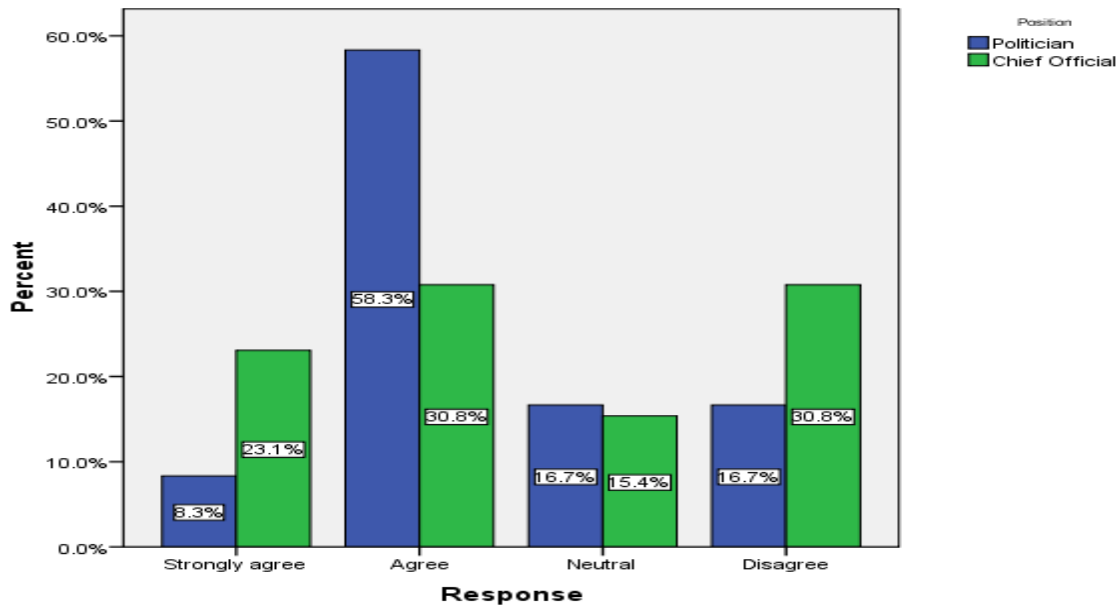


Figure 4.26 above shows that a minority of 8.3% of the political office-bearers indicated that citizens in the rural areas have no access to health services. On the other hand, a majority of 60.0% of the political office-bearers and 53.8% of the chief officials indicated that citizens are sometimes accessing health services in general; 25.0% of the political office-bearers and 30.8% of the chief officials stated that the citizens are regularly accessing the quality health services they would want to access from the public health facilities in the central region of Malawi, whereas 16.7% of the political office-bearers and 15.4% of the chief officials indicated that citizens always have access to health services in the central region. Reasons behind the failure to have access health services in the rural areas included the following:

- Household: hospital distances whereby health centres are far apart from the communities
- High doctor: population ratios whereby there are only a few qualified health professionals in the rural areas.
- Shortages of drugs in public health facilities

- Inadequate and outdated policies guiding implementation of capacity building strategies.

It can be deduced that the citizens generally have access to the health services in the rural areas although the quality of such services is sometimes challenged by long distances to the health centres and a shortage of qualified health professionals and drugs in the rural areas.

Question (c) Do the existing policies/strategies and actions result in the impact they were supposed to bring about?

Answer: The majority of the respondents both the chief officials (65.0%) and the political office-bearers (100.0%) indicated that the existing policies or strategies on capacity building did not result in the intended impact for the following reasons:

- Expected results were not achieved due to inadequate human and financial resources
- Poor implementation of the capacity building strategies since only the needs of the central office were prioritized, thereby failing to build capacity at the district level.
- No consultations between chief officials implementing the strategies and the stakeholders.
- Nepotism and political interference.
- Low capacity of the local training institutions

On the other hand, a minority of the chief officials (35.0%) reported that the existing strategies, policies and actions on capacity building have resulted in the intended impact and motivated their answers by the following:

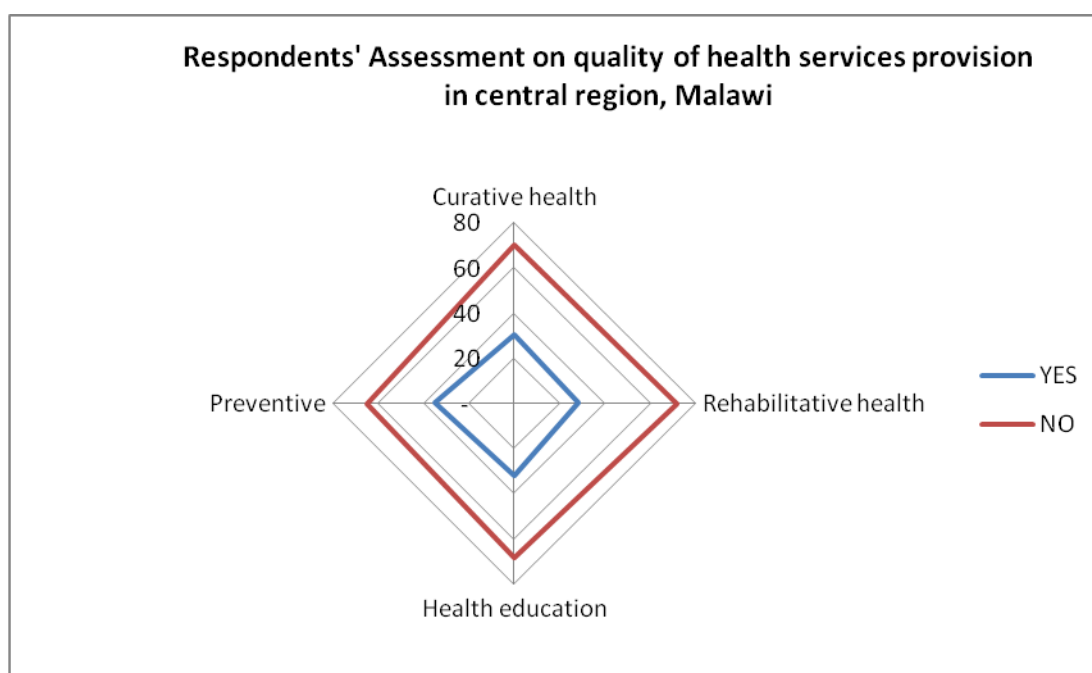
- Increased number of trained health professionals in the hospitals and health centres.
- The doctor to patient ratio has been slightly decreased.
- Improved performance of health professionals in the central region.

It can thus be deduced that the implementation of the existing capacity building policies/strategies and actions did not result in the intended impact hence indicating a need to improve the approach.

Statement (d): Assessment on quality of health services provision as regards curative health, rehabilitated health and educational health services.

Answer: Figure 4.26 below presents a radar view of the assessment of the respondents on the quality of services the citizens are receiving in terms of preventive health services, curative health services, rehabilitated health services and educational health services.

Figure 4.26: RADAR ASSESSMENT ON QUALITY OF HEALTH SERVICE PROVISION IN CENTRAL REGION, MALAWI



The radar view shows that respondents gave an average 70.0% rejection that there is a positive impact of capacity building strategy implementation on the quality of health services being provided in terms of curative health, preventive health, health education and rehabilitative health. This is agreed to by Pearson (2010:24), DFID (2010: 52 – 56) and Bowie (2009: 10 - 16) who argued that despite improvements in the health sector being above 50.0% of expected outputs, the framework developed by the Ministry of Health to track progress in the implementation of the Malawi Health sector programme of works (Ministry of Health, 2005: 13 – 14) indicated areas that required more focus and commitment if related closely to capacity building. This provided reason for more exploration on whether the strategies and interventions the sector has implemented over the past five years have a bearing on the overall health service delivery or not. This review is indicated in column (e) of Table 4.5 below:

TABLE 4.5: REVIEW OF OUTPUT PERFORMANCE OF THE MALAWI HEALTH SECTOR (2004/05 - 2008/09)

Measure (a)	Baseline (b)	Latest 2008/09 (c)	2011Target11 (d)	Review of Progress (e)
OPD service utilization	800/1000 population	1290/1000 population	>1000/ 1000 population	Met
Proportion of year-old children immunized against measles	82.0%	89.0%	90.0%	Met
CPR (modern methods)	28.1%	41.0%	40.0%	Met
Proportion of births attended by skilled health personnel	38.0%	52.0%	75.0%	Met, target unlikely to be met at this rate
pregnant women receiving at least two doses of intermittent preventive therapy	46.8%	46.7%	90.0%	Little progress. Target unlikely to be met at this rate

From the review in Table 4.5 above, it is apparent that there is a need for a closer look at the resource development strategies in a holistic manner, assessing the way the sector is being administered whilst being mindful of levels of administration, management of the health structure as well as strategic positioning of the health sector in totality. This is evident in the table above in that most of the targets are met and where positive progress is posted relate to the curative aspects of health service delivery. Indicators closely tied to systemic issues such as doctor/ patient coverage, vitamin supplementation and preventive indicators are posting low and unoptimistic results when the targets are factored into consideration. Therefore, whereas the health system may have done better in the provision of the health service delivery as above highlighted, a refocus on capacity building aspects mentioned may add value to the progress being made in the sector on the indicators.

4.3.6.1 FACTORS INFLUENCING CAPACITY BUILDING AND ITS IMPACT ON THE PROVISION OF HEALTH SERVICES

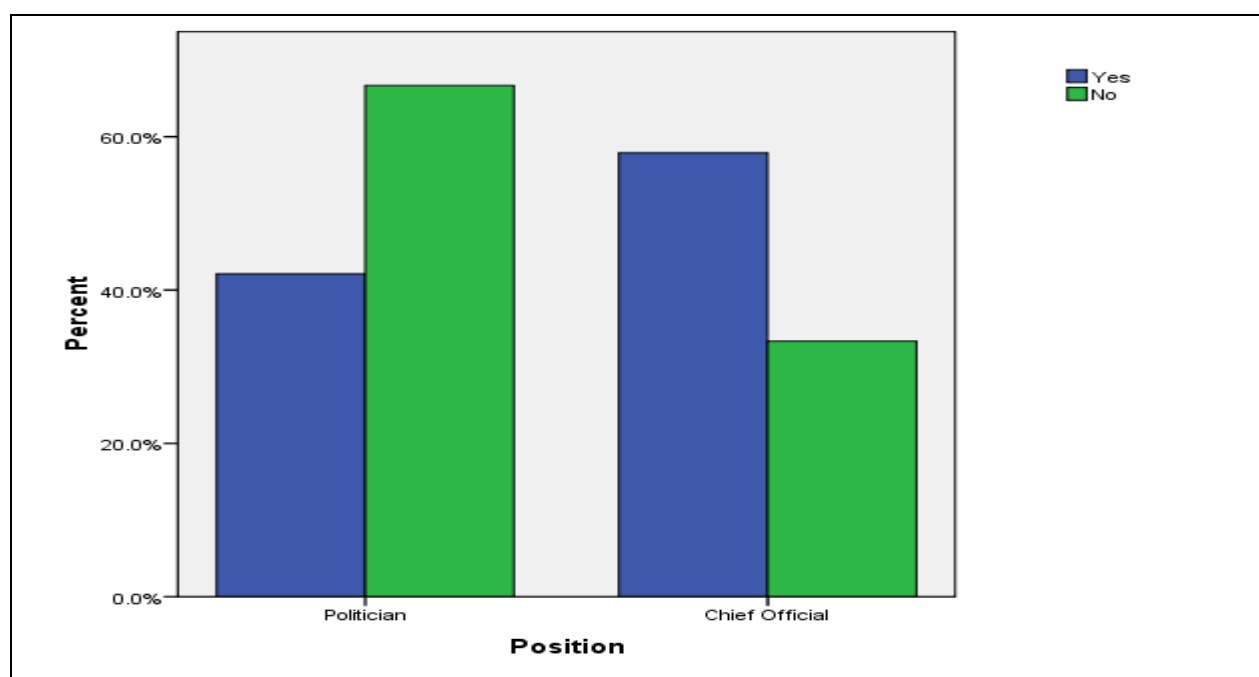
There are various factors from both the internal and external environments of the organisation that influence effective and efficient implementation of capacity building activities. Stevenson (1993:244) writes that such factors will have an impact on capacity building negatively or positively. These factors include poor incentives, performance standards, availability of skills,

knowledge and expertise to carry out a job to weak leadership and ineffective management style. It is thus important to take these various factors into consideration when coming up with capacity building plans.

Question (a): A specific relationship exists between capacity and impact of service rendered.

Answer: Figure 4.27 below shows the responses as provided by the respondents.

Figure 4.27: WHETHER A SPECIFIC RELATIONSHIP EXISTS BETWEEN CAPACITY AND THE IMPACT OF SERVICE RENDERED



In this Figure, the majority of 56.7 % of the political office-bearers and 84.6% of the chief officials answered in the affirmative, whilst a minority of 33.3% of the political office-bearers and 15.4% of the chief officials answered negatively. The majority of both political office-bearers and chief officials also agreed that the following factors always influence capacity building and impact it negatively: lack of operating equipment, affordability of health services, increasing demand for health services. Other factors include nepotism, corruption and theft of working materials by human resources in the health sector. Based on the above analysis, it is clear that there is a positive relationship between capacity of the Ministry of Health and the services it renders.

It can be deduced that much as the provision of health services here are a mandate to the right to health of the Malawi population which the health sector serves, the intervention is being

implemented without a gliding scale to which the citizens' willingness and ability to pay will be cultured in relation to the socio-economic development of Malawi. This puts the intervention into question on aspects of administration such as organisational design, decentralisation, re-engineering role clarification and value chain and in particular, on the sustainability of the intervention. This is greatly supported from overseas development assistance resources that development partners are putting into the health sector. With no indications of the time span under which such an intervention will be implemented, it is recognized that the public sector must often play a strong role in enlarging and upgrading the delivery services even if it does not conduct all activities itself.

However, regardless of their size and complexity, public sectors worldwide tend to be weak in health policy/strategy formulation, oversight, planning, budgeting, management, monitoring and evaluation, and in accountability to the public. They also typically suffer from insufficient access to recurrent finance, inadequate human capital, poor incentives for performance, and poor governance. Information systems, including surveillance, and epidemiological research tend to be inadequate, and even where they exist they are inadequately deployed for problem solving (World Bank, 2004: 45).

This therefore calls for a review of the strategic positioning of the health sector regarding the implementation of the essential health package as regards other elements of capacity building that progressively moves the health sector into a position so that it is able to sustain its overall objective. Some of these aspects that may require further analysis include but are not limited to elements such as a re-examination of the institutional traditions and myths, laws and regulations and organisational architectural capacities in a bid to strategically position the health sector so that it meets its objectives.

It can therefore, be deduced that implementation of capacity building strategies in the central region of Malawi is impacting negatively on the provision of health services largely due to non-availability of financial and human resources. This goes back to the enabling functions of the chief officials and challenges the chief officials to ensure that the means are provided for effective and efficient implementation of capacity building strategies in the central region of Malawi.

4.4 CONCLUSION

The chapter dealt with an analysis and interpretation of the data collected by questionnaires that were distributed to chief officials and political office-bearers in the four districts of the central region in Malawi. The questions in the questionnaire were based on the theoretical framework that was provided in Chapter Two of this study. The purpose was to prove or refute the study hypothesis that "the implementation of the existing capacity building strategies impacts negatively on the provision of health services in the central region in Malawi". Based on the data collected, the following information was established. Firstly, it was interesting to note that male respondents formed 76.0% and females formed only 24.0% of respondents to the study. However, this did not have any impact on the findings of the study as the questions were gender neutral. It was also found that 32% of the respondents had more than 20 years of work experience and another 32.0% of the respondents had less than five years of work experience which enabled the researcher to have divergent responses on the implementation of capacity building strategies thereby enriching the data collected. It was also worth noting to find that 44.0% of the respondents had a degree and 32.0% had a postgraduate qualification which clearly indicated their competencies in the field of administration as they possess the requisite skills and knowledge to carry out their duties competently. The academic qualifications also influenced the quality of data provided by the respondents in the study. Thus, personal details of the respondents were necessary for clearly understanding the responses from the respondents in the study and making the study credible and logical. Secondly, on the nature and place of capacity building, it was found that capacity building is mainly looked at from the human resources perspective ignoring other equally important aspects of capacity building such as organisational development, financial management and leadership development. However, capacity building should include the working environment, financial resources and materials that facilitate good performance of human resources in an organisation. It was also further found that capacity building is an essential function of the chief officials in providing public health services and that it helps in development since healthy people with productive means are able to contribute to the development economies of the country.

Thirdly, concerning the problems being experienced with the implementation of the capacity building strategies, it was found that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region in

Malawi due to centralised control of resources and decisions in the implementation of the capacity building strategies. This is because there is always a tendency to focus on central needs without necessarily considering the needs at decentralised levels within the region. Related to the same is the prevailing lack of quality services that is also prevalent in the health facilities in the central region. This is due to the fact that effective and efficient implementation of capacity building strategies is challenged due to inadequate financial resources and political interference. However, it was also found that despite facing various problems in terms of inadequacy of resources and skills, some service is still being rendered to the clients and citizenry within the region hence to some extent the health sector is still considered efficient and effective in the region.

Fourthly, on enabling administration functions, it was found that chief officials have an important role to provide information to the political office-bearers who in return play a critical role in legislation, regularisation and policy direction on capacity building in the health sector. However, it was revealed in the study that chief officials, on the contrary, spend much more time on making the political office-bearers aware of health related community problems than on describing the problems clearly and providing acceptable recommendations to solve the problems. It was also interesting to find that chief officials have limited inputs in decisions made at executive level, thereby leaving decision making to political office-bearers whose interests are bound by constituencies' interests hence perpetuating inequitable access to health services by the citizens in the central region.

Fifthly, on evaluating the existing executive policy and legislation for capacity building, it was found that the existing legislation on capacity building is insufficient, indicating that the chief officials are not playing a meaningful role in recommending and advising the political office-bearers on policies and legislation in capacity building for health services. As such the capacity building strategies that are implemented within the health sector do not really undergo the requisite scrutiny by Parliament and may therefore not be reflective of the expectations and interests of the public sector clientele.

Sixthly, it was also interesting to find out that capacity building strategies and plans that are developed and available in the health department are usually not implemented mainly due to financial constraints thereby leading to inadequate skilled human resources in health facilities. Thus, there is little progress being made in the effective and efficient implementation of capacity building strategies in spite of having in place well-defined work procedures and organisational structures aimed at supporting the implementation of such initiatives. Related to the same is the absence of sufficient control measures and standards that assure that activities undertaken to build capacity benefit the organisation in improving health service delivery. As a result of the afore-mentioned, the capacity building strategies are not leading to the desired outputs.

Seventhly, it was agreed that health services cannot be provided efficiently and effectively without suitable and sufficient human and financial resources. The problem of shortages in human resources is further complicated by inadequate attention to detail in implementing the capacity building strategies and plans. In this regard, it was found that the citizens / communities are not really satisfied with the provision of health services in the central region in Malawi due to limited resources such as drugs and equipment, qualified medical personnel in particular in the districts and health centres. It was further revealed that there are various factors that are influencing the implementation of capacity building strategies and are thus impacting negatively on the provision of health services. These factors range from shortages of human and financial resources to more specifically a lack of operating equipment, shortage of drugs, affordability of health services, increasing demand for health services and nepotism, just to mention a few. This clearly demonstrates that the implementation of the existing capacity building policies/strategies and actions did not result in the intended impact, hence indicating a inadequacy of approach.

In summary, it is worth mentioning that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region of Malawi. This is mainly due to the fact that capacity building is a systematic process whereby all the steps must be followed and the chief officials have a duty to carry out their enabling functions so that the means are provided for efficient and effective implementation of the capacity building strategies and plans. Chapter Five will focus on the findings of the study, and provide concluding remarks and recommendations.

CHAPTER FIVE

5.0 FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

Health systems are largely affected by the size, quality, skills and commitment of health workers. Efficient and effective provision of health services in the Central Region in Malawi is essential for the promotion of the general health and welfare of the citizens. This means that in order for the health sector to deliver its services, it needs to have the right quantity and quality of capacity in place. In this regard, the health sector has been implementing capacity building strategies aimed at enhancing the capacity of health professionals and hospitals in Malawi. However, despite these efforts, a lack of quality services prevails in the health services rendered in the central region in Malawi. This necessitated the conducting of a study evaluating the impact of implementing the capacity building strategies on health service delivery with the aim of proving or refuting the contention that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region in Malawi.

The purpose of this chapter is to consolidate and conclude the findings of the study. The study dealt with the impact of the implementation of capacity building strategies on health services and is thus evaluative in nature. The following aims have been set for the chapter. Firstly, summarising all the findings of the study. Secondly, the chapter evaluates the validity, truth and reality of the stated problem and hypothesis and makes concluding remarks on observations that have serious implications in the study. Lastly, specific recommendations on the implementation of effective capacity building strategies that impact positively on the provision of health services in the central region, which are based on the findings of the study, are provided as possible solutions to the identified shortcomings in the provision of health services. The findings and conclusions of the four chapters are discussed accordingly below.

5.2 FINDINGS OF THE STUDY

The mini-dissertation consists of five chapters and the findings of the study provide important results that reflect the purpose and objectives of the study. The findings of the study also present a true reflection of the researched problem and define the credibility of the study. The

findings of each chapter are explained as follows. Chapter One provided an introduction and general orientation to the study. It described and explained the problem statement, hypothesis, objectives and necessity of the study, delimitations in the study, terminology and definition of terms and concepts in the study. Thus, Chapter One generally indicated what the study entailed. Chapter Two was a literature review on the nature and place of capacity building. The purpose was to ground capacity building in Public Administration and provide a conceptual, theoretical and legislative framework. This was to ascertain whether there is sufficient evidence in the field of study and similar research conducted.

It was found that a theoretical framework is essential in Public Administration as it provides a base for a set of ideas that are used for explaining phenomena. In this study the classical theory and the systems theory formed a basis for evaluating the impact of implementing capacity building strategies on health services. It was also further found that:

- Capacity building is work performed by chief officials and is implemented to improve the skills and knowledge of public officials and the work performance of departments and/or organisations.
- Capacity building is a management function that ensures that services are rendered efficiently and effectively, thus an organisation should have sufficient capacity to perform what is expected by citizens and this involves planning and organising for capacity building, leading capacity building personnel and controlling capacity building activities.
- Capacity building is directly linked to utilisation of available resources and means such as policy, structures, procedures, control measures and standards to render public services. In this regard, capacity building implementation is a systematic process that has five main steps, namely engagement of stakeholders, capacity needs assessment, formulating capacity building strategies, implementing capacity building strategies and most importantly evaluation and monitoring of the capacity building activities to ensure that they are being implemented according to plan.
- Capacity building is influenced by various factors from both the internal and external environments of the organisation that range from poor incentives, performance standards, availability of skills, knowledge and expertise to carry out a job to weak leadership and ineffective management style. It is thus important to take these various factors into consideration when coming up with capacity building plans.

- The legal framework for capacity building is not comprehensive as there are only three main sources, namely the *Constitution of the Republic of Malawi*, 1992, the *Public Service Act*, 1994 (Act 19 of 1994), as amended, and departmental policy documents. These sources concentrate on only one aspect of capacity building, namely human resource development.

In Chapter Three the research design and the methods for collecting data in relation to the impact of implementing capacity building strategies on health services are described and explained. The chapter was divided into the following subsections: permission to conduct research, research design which also covered the research approach and strategy of the study, research methodology with specific reference to respondent selection, target population, sampling unit, sample size and sampling methods. The chapter also discussed the data collection instruments and procedures with special attention to the questionnaire used, interview details and official document analysis. Limitations of the study, ethical considerations and data analysis were also explained in this chapter. In this study, the target population was the chief officials in the Ministry of Health and political office-bearers in the central region in Malawi and 35 respondents were selected depending on their roles. Thus, 35 questionnaires were distributed to the targeted respondents with a response rate of 71.0% which was considered to be very good. Further to this, face-to-face interviews with selected respondents were conducted and official documents were also analysed and this involved an analysis of documents and evaluation reports that have guided the capacity building strategies and set the stage for implementation and how these concepts are shaping up future strategies.

The permission to conduct research was obtained from the Ministry of Health. The questionnaires were distributed to and collected from the political office-bearers, chief officials and stakeholders/citizens of the central region of Malawi and both the qualitative and quantitative research methods were adopted and used in the study. The qualitative research method was used because it is based on reality using verbal terms and not numbers or measurements to understand the social environment, whereas quantitative research was used because it measured the data of the social reality and was concerned with the numbers in order to describe the characteristics of the unity of analysis. The case study was used as a research strategy because it typically observed the characteristics of an individual unity rather than manipulating variables to determine the usual significance concerned with instances of representative samples. The study was limited to and conducted in the four districts of the central region, namely Mchinji, Lilongwe, Dowa and Dedza. The empirical study was

conducted during the period from July to December 2011 and the target population was the total number of political office-bearers, health officials and citizens of the central region in Malawi. The data collection procedure was clearly analysed and interpreted and the response rates were explained in Chapter Four.

Chapter Four deals with the analysis and interpretation of data collected through the distribution of questionnaires and administration of interviews among selected respondents. It presents the results of the research that underpinned the objectives and hypothesis of the study with the aim of proving or disproving the research hypothesis.

Chapter Four was divided into two main sections for the purpose of analysis, interpretation and contextualisation of the collected data, namely the

- Demographic details of the respondents which utilised a quantitative data analysis and which dealt with the age, gender, years of service, home language, and education qualifications of the respondents.
- Evaluation of the implementation of capacity building strategies for the rendering of health services which involved a qualitative data analysis and which dealt with the classical theory and the systems theory to analyse and interpret the problems in the provision of health services and evaluate the impact of the implementation of capacity buildings strategies on health services.

The findings in regard to demographic /personal details were discussed as follows.

(a) Demographic/Personal Details

When analysing and evaluating the research data for the demographic details of the respondents it was found that

- A small majority of respondents came from the administration section (52.0%) which leverages the study findings.
- The majority (76.0%) of the respondents were male whilst females made up only 24.0% clearly showing a gender imbalance.
- A minority (32.0%) of the respondents have less than five years of experience and this balances up with the fact that the other 32.0% of the respondents have more than 20 years of experience in the health sector, meaning that the respondents had sufficient experience to provide reliable data in the study.

- The majority of the respondents (44.0%) have a degree, with 32.0% of the respondents having postgraduate qualifications thereby influencing the quality of data provided by the respondents since the respondents had the requisite knowledge and skills in capacity building implementation

It can thus be deduced that the personal details of the respondents were relevant as they impacted on the trustworthiness of the data in the study due to the respondents' position, maturity in work experience and academic qualifications.

(b) Meaning of capacity building

On the meaning and nature of capacity building, the study found that capacity building is looked at narrowly from the human resource perspective and mostly includes provision of training to human resources in order for them to acquire the requisite skills. However, capacity building is more than training. It was revealed that capacity building should also include the working environment, financial resources and materials that facilitate good performance of human resources in organisations and help the organisation meet clientele expectations. The study further found that capacity building is an essential function in providing public health services effectively and efficiently as without capacity no organisational objectives can be achieved. Various reasons were given for considering capacity building an essential function in the organisation, for example:

- Capacity building improves service delivery as there will be enough skilled personnel to deliver the services
- Capacity building in the health sector will help in the development of the country since healthy people with productive means are able to contribute to the development of economies which brings about development
- With a number of specialised training courses that are offered under capacity building programmes, health professionals are able to deal with many health issues, such as Prevention of Mother to Child Treatments.

(c) Problems with the implementation of capacity building strategies

Capacity building strategies are implemented with the aim of improving service delivery and the following were the findings regarding the problems with the implementation of the capacity building strategies. Firstly, the study found that the implementation of the existing capacity

building strategies in the Ministry of Health is impacting negatively on the provision of health services in the central region for the following reasons:

- Centralised control of resources and decisions in the implementation of the capacity building strategies in Malawi's central region health sector is a major problem, since there is a tendency to focus on central needs without consideration of needs at decentralised levels within the region.
- There are not enough financial resources to sustain the capacity building programmes leading to failure to meet the targets in terms of human resources trained.
- There is still an increased demand for health services and a lack of drugs and equipment is still prevailing in the district hospitals.
- There is increasing dissatisfaction with the health services being provided amongst the citizens in the central region.

Secondly, the study also found that a lack of quality is prevailing in the provision of health services in the central region due to a shortage of skilled medical personnel, lack of working materials such as drugs and equipment and also high patient to doctor ratios. It was further revealed by the study that irrelevant and insufficient implementation of capacity building strategies is causing the delivery of poor quality health services for the following reasons:

- Lack of monitoring and evaluation
- Poor recruitment process that also affects the type of personnel that are recruited to deliver health services to the citizens.
- Usually the implementation of capacity building strategies is done without consultations with other relevant stakeholders such as District Health officers and without adequate resources.
- Capacity building strategies are usually implemented without proper planning and adequate resources.

Thirdly, it was revealed that despite facing various challenges, the Ministry of Health is still considered both efficient and effective. Fourthly, the study found that there are continued problems with the implementation of capacity building strategies in the health sector of the central region of Malawi and gave the following reasons for this answer:

- Inadequate financial resources

- Political interference
- Poor staffing levels.
- Corruption

(d) Demotivation and non-commitment of human resources who implement the capacity building strategies

The study revealed that the human resources who implement the capacity building strategies are not motivated due to poor working conditions such as low remuneration packages and lack of requisite skills in capacity building. As a result capacity building implementation comes second to the other responsibilities and duties.

(e) Evaluation of executive policy/legislation for capacity building

It has been found that the existing policy /legislation for capacity building is insufficient and that chief officials do not play a meaningful role in analysing, evaluating and advising the political office-bearers on policy for capacity building. This also entailed that the political office-bearers do not comprehensively scrutinize the legislation before presentations in and enactment by Parliament, and implementation of capacity building policy in the central region of Malawi. These findings therefore suggested that capacity building legislation and strategies that were implemented do not undergo the requisite evaluation and may not be reflective of the expectations and interests of the public health sector clientele.

(f) Evaluation of administrative enabling function for capacity building

Chief officials have a role to play in providing the required means for capacity building activities to be done efficiently and effectively in the Ministry of Health. The study has found, firstly, that the Ministry of Health has a specific capacity building policy that adapts to the existing legislative measures although they are archaic and thus need to be reviewed to meet the current capacity needs. Secondly, that the Ministry of Health does not have sufficient financial and skilled human resources to implement the capacity building strategies effectively and efficiently mostly at health facilities because there is a high rate of labour turnover and vacancies and the Ministry is always underfunded making capacity building implementation largely dependent on donor funding. And It has been further revealed in the study that although the Ministry of Health has put in mechanisms such as locums, essential health packages and centralized training plans to ensure that there are sufficient human resources to

implement its capacity building strategies, the existing human resources capacity is still not adequate more especially since those who are implementing the capacity building initiatives lack the requisite skills such as monitoring and evaluation, report writing, human resource development and project management skills. Thirdly, that the Ministry of Health has well-established organisational structures in place for effective implementation of capacity building strategies although other respondents pointed out the issue of low staffing levels as a major challenge. Fourthly, that the Ministry of Health has sufficient work procedures and methods in place to ensure the effective implementation of capacity building strategies but also that there are insufficient control measures and standards in place to complement the organisational structures to ensure the effective implementation of capacity building strategies and delivery of quality health services to the citizens. This is mostly due to poor planning of the capacity building activities which results in compromising the standards. It was thus suggested that the control mechanisms that assure enforcement of capacity building policies, plans and strategies in the Ministry of Health require strengthening so that processes that are undertaken to build capacity in human and material resources benefit the organisational structures and work procedures in this regard; and that the delivery of health services' outputs is up to the expectations of the citizens.

(g) Output from the implementation of the capacity building strategies on the provision of health services

Any implementation of capacity building strategies is supposed to lead to improved capacity and provision of health services. The study confirmed that capacity building is an important function of the Ministry of Health, departments and sections in all health units and facilities in the central region of Malawi as no services would be provided without capacity, and that health services cannot be provided effectively without suitable and sufficient human and financial resources. The study also found that at the moment the provision of services by the health sector does not exclusively satisfy community needs effectively though quality health services as an output have a positive effect on the development in terms of the social, economic and physical environments since a healthy nation is a vibrant and prosperous nation.

(h) Impact of implementing capacity building strategies on public health services' delivery and citizens' access to health services

The study revealed that the Ministry of Health considers the impact of its services on the environment and citizens through environmental impact assessments and regular monitoring and evaluation of health services. It was also found that the citizens generally have access to the health services in the rural areas although the quality of such services is sometimes challenged by the following:

- Household: hospital distances – whereby health centres are far apart from the communities
- High doctor: population ratios whereby there are only a few qualified health professionals in the rural areas.
- Shortages of drugs in public health facilities
- Inadequate and outdated policies guiding implementation of capacity building strategies.

The findings further revealed that the existing policies and strategies on capacity building did not have the intended impact, thus indicating a need for a change in approach. This was mainly for the following reasons:

- Expected results were not achieved due to inadequate human and financial resources.
- Poor implementation of the capacity building strategies since only the needs of the central office were prioritized thereby failing to build capacity at the district level.
- No consultations between chief officials implementing the strategies and the citizens.
- Nepotism and political interference.
- Low capacity of the local training institutions

It has also been found that there is no positive impact of capacity building strategy implementation on the quality of health services being provided in terms of curative health, preventive health, health education and rehabilitative health and this suggested a need for a closer look at the resource development strategies in a holistic manner, assessing the way the sector is being administered whilst being mindful of levels of administration and management of the health system as well as strategic positioning of the health sector in totality by making sure that key stakeholders especially those from the district levels are involved in formulating and implementing the capacity building strategies. It can be inferred that consultation with

stakeholders as regards capacity building strategies would ensure a more successful implementation since it instils the spirit of ownership in the stakeholders.

(i) Factors influencing capacity building and its impact on health services

The study found that there are several factors that influence capacity building and its impact on service delivery. Such factors include poor incentives, performance standards, availability of skills, knowledge and expertise to carry out a job, to weak leadership and ineffective management style, lack of operating equipment, affordability of health services, and the increasing demand for health services. Other factors include nepotism, corruption and theft of working materials by human resources in the health sector. Based on the above analysis, it is clear that there is a positive relationship between the capacity of the Ministry of Health and the services it renders. It is thus important to take these various factors into consideration when coming up with capacity building plans.

It can therefore be inferred that the study found that the implementation of the existing capacity building strategies is impacting negatively on the provision of health services in the central region in Malawi as confirmed by the evidence forthcoming from the study and thus indicating a need for a change in approach.

5.3 CONCLUDING REMARKS

In this study, it has been found that the stated problem of a lack of quality services prevailing in the health services in the central region due to the irrelevant and often insufficient implementation of capacity building strategies, which causes unnecessary mistakes, complaints from patients and unnecessary wastage of financial and human resources, is true and real and remains unresolved. The main reason for the continuous existence of the problem has been found to be inadequate financial and human resources to support the successful implementation of capacity building strategies. Evidence has confirmed also that the health services rendered are inadequate and not effective. It was also found that the hypothesis which stated that the implementation of the existing capacity building strategy impacts negatively on the provision of health services in the central region in Malawi is also true and valid. The hypothesis is true and valid because the evidence confirmed that the implementation of the existing capacity building strategy impacts negatively on the provision of health services in the central region in Malawi.

The study has revealed the following as the main problems with the implementation of the existing capacity building strategies.

- Centralised control of resources and decisions in the implementation of the capacity building strategies in the Malawi's central region health sector is a major problem, since there is a tendency to focus on central needs without consideration of needs at decentralised levels within the region.
- There are not enough financial resources to sustain the capacity building programmes leading to failure to meet the targets in terms of human resources trained.
- There is still an increased demand for health services while a lack of drugs and equipment is still prevailing in the district hospitals.
- There is Increasing dissatisfaction with the health services being provided amongst the citizens in the central region.
- There is a lack of consultation with key stakeholders in the processes of developing the capacity building strategies and the actual implementation of the capacity building strategies which has led to a lack of ownership among the stakeholders, resulting in non-commitment and wastages of the scarce human and financial resources.

In addition to this, the study has revealed that the ineffective implementation of the capacity building strategies is leading to wastage of both human and financial resources mainly for the following reasons:

- Poor understanding of organisational objectives and poor implementation which in turn lead to discontent among the key stakeholders
- The Malawi Health sector has also faced an acute shortage of human resources due to the fact that ineffective implementation of the capacity building strategies is leading to wastage of both human and financial resources mainly due to low institutional capacities to produce qualified health professionals through local training institutions, retaining those in service and accessing technical assistance to fill the human resources gaps in the sector.

In this regard, in order to effectively and efficiently implement the capacity building strategies, there is a need to change the approach in the implementation so that wastages in both human and financial resources are avoided and the intended objectives and impact of the capacity building strategies are achieved. The study recommendations arising from these findings are discussed below.

5.4 RECOMMENDATIONS

Recommendations to improve the implementation of the capacity building strategies in Ministry of Health so that the strategies have a positive impact on the provision of health services in the central region of Malawi are suggested as follows:

- **Broaden the scope of the legal framework on Health Capacity Building Strategies in Malawi**

The current scope of the legal framework as stipulated in the laws and policies governing health service delivery in Malawi is limited to skilled human resources and geared towards sustaining the brain gain by retaining the human resources in the sector. However, capacity building goes beyond human resources. The assessment indicates that shortfalls in effective implementation of the capacity building strategies in the health sector are caused by other capacity building factors such as poor leadership and mentoring, inadequate physical resources such as working equipment and steady supply of essential drugs, inadequacies in administrative and managerial capacities and health education and behavioural changes that sustain demand for quality health services in the citizenry. Therefore this calls for the revision of these legal and policy frameworks to provide for a legal and policy environment that allows for resourcing investments in these areas aimed at improving the delivery of health services.

- **Improve operational framework to gain efficiencies and effectiveness from current investments in capacity building in the health sector**

The study has revealed a centralised implementation of the capacity building strategies in the health sector. Whilst not bad in itself, this has led to focusing the implementation of the health services at the central offices, and chief officials. This has resulted in building a lot of capacities in planning and policy-related elements of the health sector but little focus on the operating units that deliver health services to the citizens. It is therefore recommended that the health sector should deconcentrate or delegate control of resources and identification of capacity needs to decentralized structures such as regional and district hospitals to gain in efficiency and effectiveness as indicated by respondents during the study that, given this autonomy, they will build capacities in areas that directly affect their operations and negate delivery of services to their clients.

- **Strengthen the executive policy legislation of the Capacity Building in Health Services delivery**

In order to further improve dialogue and create space for legislating the health sector, there is need for deliberate efforts to build the capacity of the chief officials in health systems legislation so that they are able to play a meaningful role in providing advisory services with regard to the provision of good information to political office-bearers in this respect. Most of the political office-bearers that are expected to deliberate on and define governing law and policies for the health sector come from diverse backgrounds with limited knowledge in this area, and this applies to most of the chief officials too. However, the expectation is that the chief officials will advise the political office-bearers on the technical content to frame the laws and policies in the health sector. Therefore, in order to allow the chief officials to perform this function it is imperative that they should be capacitated to provide good information that will be used by the political office-bearers to shape the health practice landscape in Malawi through well-defined legal instruments that at minimum meet the expectations of the citizens and other stakeholding clients.

- **Enforce use of performance standards**

To ensure that the administration and management of the health sector provides services that the citizenry look up to and expect, there is a need for deliberate efforts to define and enforce performance standards that will evaluate individual performances of the health personnel as well as agents in delivery of services to the citizens. This could also be utilized in meriting career progression of personnel in the health services, motivating the health service providers and helping in the “brain gain” situation, as well as ensuring intrinsic efforts with the individuals to demand and pay for their own capacity building in order to progress career wise.

- Speed up the recruitment process in the Ministry of Health so that there are adequate human resources to implement the capacity building strategies as the study has revealed that the Ministry is operating at a high vacancy rate.

1.5 IMPLICATIONS OF IMPLEMENTATION OF THE RECOMMENDATIONS

The anticipated implications may be discussed as follows.

- **Policy Implications:** Implementing the recommendations effectively requires a policy shift in the training function of the Department of Health. The training function and related resources will have to be decentralized to health units such as district hospitals and health centres. This is a resource neutral implication that will allow for close matching of training needs and the training that health personnel undertake. Implementation of this will however require strengthening of controls at the decentralized levels so that abuse of training personnel identification is meritorious and performance based.

In addition to the above, there will be a need for a strengthened outreach and development function that should create an information feedback loop between the chief officials and the political office-bearers aimed at creating synergies between the executive health policies and legislative health framework.

- **Financial Implications:** There will be a need to set up minimum budgeting and financial resource allocation standards. Factors that should be permuted in the formulae for these should include leadership and mentoring of health personnel, training needs, and supply chain of medical supplies on a per capita basis and contingent on historical disease incidence per geographical location and emergency responses.
- **Organizational Implications:** The Department of Health organizational systems will have to respond to performance assessments set by the Government of Malawi. These performance systems should be aligned to the career management, development and growth of health personnel. This will make it possible to reward good performers' and set precedents and encourage improvement in non-performers and enable the meeting of clientele expectations of health services regarding services obtainable from the health personnel.
- **Personnel retention:** A significant number of medical personnel working in the health facilities sampled in this study are underqualified. There will be a need for a deliberate upgrading programme that will provide an opportunity for the health personnel to upgrade to a bachelor's level. Since the compensation plan of the Department of Health

is tied to qualifications in addition to experience, this will motivate personnel to move to a relatively higher compensation scale, thereby retaining them in the hospitals.

Cost Implications: The recommendations presented herein are low cost. Critical to their implementation is both executive and political will as these will involve management changes and reallocation of executive functions between units at central and decentralized levels. The cost that will be borne in implementing most of these recommendations will include managing change coming out of the reallocation of functions, responsibilities and resources within the units, managing work attitude after the changes, and financing and managing related training to units that will have added on functions and responsibilities in the wake of the management reforms, especially regarding controls and procedures in doing business in the health sector.

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SUPPLEMENT A

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The Principal Secretary,
 Ministry of Health,
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Dear Sir,

PERMISSION TO CONDUCT RESEARCH

I write to seek permission to conduct research in the Ministry of Health from 1st to 30th September 2011. My name is Rose Shanice Chowawa and I am currently pursuing a Master's Degree in Public Administration at the University of Fort Hare in South Africa.

As part of the requirements for the degree, I am supposed to conduct research and submit a mini dissertation or assessment. The research will be solely for academic purpose and nothing else. My research topic is **"Evaluation of the impact of**

implementing human resources capacity building strategies in public health services in the central region in Malawi. I assure you that I shall observe professionalism and ethical on considerations maintaining anonymity of the participants concerned.

My research will target officials from Ministry of Health Headquarters and health p[professional at Kamuzu Central Hospital, Dedza, Salima, and Mchinji Hospitals. I also intend to conduct structured interviews with the District Health Officers from this hospital. Please be informed that once the research is completed, the report will be made available on request to your Ministry for your attention.

I hope my request shall meet your favourable attention.

Yours faithfully,

Rose Shanice Chowawa

SUPPLEMENT B

: + 265 789 400
Facsimile: + 265 789 431

All Communications should be addressed to:
The Secretary for Health



In reply please quote No.

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

Ref. No. ADM 1/1

24th August 2011

Ms R Chowawa
c/o Deapartment of Public
Service Management
P O Box 30227, Lilongwe 3

Dear Madam,

RE: REQUEST TO CONDUCT RESEARCH IN MINISTRY OF HEALTH

I refer to letter from the University of Fort Hare, South Africa, in which it was stated that you would wish to conduct research in the Ministry of Health in partial fulfilment of the requirements of your Masters Degree in Public Administration. In this regard, I hereby convey authority to enable conduct the said research on condition that you shall observe professionalism and research ethics during your research. In addition, you are required to submit a report of your research findings to the Ministry of Health to enable it make evidence based changes.

A handwritten signature in black ink, appearing to be 'H R Chimota'.

H R Chimota
For: **SECRETARY FOR HEALTH**

SUPPLEMENT C**UNIVERSITY OF FORT HARE****DEPARTMENT OF PUBLIC ADMINISTRATION****QUESTIONNAIRE 1: QUESTIONNAIRE TO POLITICAL OFFICE-BEARERS AND CHIEF OFFICIALS ON THE EVALUATION OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES IN THE PROVISION OF HEALTH SERVICES IN THE CENTRAL REGION OF MALAWI****QUESTIONNAIRE ONE: EVALUATION OF THE IMPACT OF IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES ON PUBLIC HEALTH SERVICES IN THE CENTRAL REGION OF MALAWI****1. EXPLANATION OF TERMS USED IN THE QUESTIONNAIRE**

Executive Policy	Policy made by a legislative institution, such as a Malawi Nurses Council, District Assembly, Ministry of Health such as regulations to guide practice and standards in the Malawi health sector
Policy Implementation	Implementation of executive policy in delivering health services.
Efficiency	Quality outputs from minimal inputs
Effectiveness	Efficient production of outputs meeting quality standards
Organizational	Department with its divisions, sections and various posts

structure	rendering housing services
Health standards	Prescribed minimum requirements
Political office-bearers	Elected members of Parliament, who are sometimes also appointed Ministers responsible for specific Ministries.
Control measures and standards	Inspection, auditing, reporting and cost analysis measures to ensure effective work performance
Chief Officials	Principal Secretary, Heads of sections in the Ministry of Health and District Health Officers and Commissioners
Capacity	The ability of individuals, organisations and systems to perform appropriate functions effectively and efficiently
Capacity building	The overall ability of individuals or groups to actually perform organizational responsibilities effectively and efficiently with emphasis on human resources

2. INSTRUCTIONS ON HOW TO COMPLETE THE QUESTIONNAIRE

2.1 Please read the questions carefully before filling in the details on the questionnaire.

Where applicable, place 'X' in the necessary box

Example 1

Question: Who decides on an Executive policy in the health sector in Malawi?

Answer

Politicians	1	X
Chief Officials	2	

Statement: Here the respondent has indicated that politicians decide on a development policy.

2.2 In some questions you will be required to indicate, on a five point scale (marked 1-5), the extent to which you agree or disagree with the given statement.

Example 2

Question: The citizenry are required to be provided with health service delivery

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5
	X			

Statement: The respondent agrees with the statement in this example.

2.3 Some questions will require a 'Yes' or 'No' answer

Example 3

Question: Is implementation of capacity building strategies essential to delivery of quality health services ?

Answer	Tick Box	Code
Yes		1
No	X	2

Statement: The respondent indicated that implementation of capacity building strategies is not essential to the delivery of quality health services.

2.4 In some questions, you will be requested to provide your view/ opinion in a written statement based on your experiences with an issue.

Example 3: Please explain in your own words the impact the health sector in Malawi's central region has had from the implementation of a capacity building strategy

Statement: You will be expected to provide your answer in the space provided above.

3. DEMOGRAPHICAL (PERSONAL DETAILS OF RESPONDENTS (Quantitative data))

3.1 What office/post do you hold? Please tick as appropriate in the area provided

Position/Post	Tick Area	Code
Cabinet Minister		1
Head of Department at Ministry of Health and Population Services Headquarters		2
Head of Health Department at District Level		3
Administrative Personnel at District Level/ Headquarters of the Ministry of Health and Population Services		4
Member of Parliament		5

3.2 Indicate your sex, please tick as appropriate.

Sex	Tick Area	Code
Male		1
Female		2

3.3 Please print your department/office name in the space provided.

--

3.4 Indicate years of service as political office-bearer or chief official. Please tick as appropriate

Range of Years of Service	Tick Area	Code
< 5		1
5- 10		2
10- 15		3
15 – 20		4
> 20		5

3.5 Indicate your highest academic qualification, please tick as appropriate

Qualification	Tick Area	Code

Certificate		1
Graduate Degree		2
Postgraduate Degree		3
Other, <i>Please specify</i>		4

4. SPECIFIC QUESTIONS REGARDING THE EVALUATION OF THE IMPACT OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES ON PUBLIC HEALTH SERVICE DELIVERY

4.1 NATURE OF CAPACITY BUILDING

4.1.1 Meaning of capacity building

(a) Please explain the meaning of capacity building, according to your experience, in your own words below

(b) Do you consider capacity building an essential function in the rendering of health services?

Answer	Tick Box	Code
Yes		1
No		2

Please motivate your answer

4.2 PROBLEMS WITH THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES (INPUT PHASE)

(a) “The implementation of the existing capacity building strategy impacts negatively on the provision of health services in the Central Region of Malawi”.

1	2	3	4	5
---	---	---	---	---

Please motivate your answer

(b) A lack of quality is prevailing in the provision of health services in the central region of Malawi.

1	2	3	4	5
---	---	---	---	---

Please motivate your answer

(c) The lack of quality health services is caused by irrelevant and often insufficient implementation of capacity building strategies.

1	2	3	4	5
---	---	---	---	---

Please motivate your answer

(d) In your opinion, please rate the efficiency of the health sector

Very efficient	Efficient	Not Sure	Not Efficient	Very Inefficient
1	2	3	4	5

Please motivate your answer

(e) In your opinion, rate the effectiveness of the health sector

Very effective	Effective	Not Sure	Not Effective	Very Ineffective
1	2	3	4	5

Please motivate your answer

(f) Ineffective implementation of capacity building strategies causes unnecessary mistakes, complaints and unnecessary wastage of financial and human resources.

1	2	3	4	5
----------	----------	----------	----------	----------

Please motivate your answer

(g) Does your Ministry/Department experience other serious problems in the implementation of capacity building strategies for the provision of health services?

Never	Sometimes	Regularly	Continuously
1	2	3	4

Please motivate your answer

(g1) Please list three (3) problems being experienced with the capacity in your Ministry/Department

(j) _____

(ii) _____

(iii) _____

(g2) Please provide three (3) causes for such problems

(i) _____

(ii) _____

(iii) _____

(g3) Provide three (3) possible solutions to such problems

(i) _____

(ii) _____

(iii) _____

(h) How do the political office-bearers, e.g. Minister become aware of community health problems?

(Please number the following means in order of preference from 1 to 7)

Through the following means	Order of Preference
Discussions between Minister and chief officials	
Requests/complaints received from citizens	
Reports from Chief Official/Heads of departments	
Requests from Non-governmental organisations	
Requests from other Interest groups.	
Reports in newspapers, opinion polls, etc	
Other: _____	

(i) Do the chief officials play a meaningful role in the following steps to make legislation for capacity building?

Making Minister aware of community problems	Yes	No	1
---	-----	----	---

Providing sufficient information to understand the nature of the problem	Yes	No	2
Describing the problem clearly	Yes	No	3
Providing acceptable recommendations to solve the problem	Yes	No	4
Submitting recommendations that meet the needs, values and expectations of the citizens	Yes	No	5

4.3 EVALUATION OF EXECUTIVE POLICY/LEGISLATION FOR CAPACITY BUILDING (INPUT PHASE CONTINUED)

(a) Does the existing legislation provide sufficiently for capacity building for the provision of health services?

Yes	No	Do not know
1	2	3

Please motivate your answer

.....

(b) Is the existing capacity building legislation for health services analysed and evaluated by Parliament?

Never	Sometimes	Regularly	Always
1	2	3	4

Please motivate your answer

.....

4.4 EVALUATION OF ADMINISTRATIVE ENABLING FUNCTION FOR CAPACITY BUILDING (PROCESSING PHASE)

(a) Did your Departmental head and deputies lay down a specific capacity building policy, to adapt the existing legislative measures to departmental circumstances?

1	2	3	4	5
---	---	---	---	---

Please motivate your answer

If you agree, do you consider such departmental policy sufficient and effective?

1	2
Yes	No

If you do not agree, please motivate your answer

(b) Does your Ministry/Department have sufficient financial resources to implement capacity building policy/strategies?

1	2
Yes	No

- If no, please give reason why the existing financial resources are not sufficient.

(c) Does your Ministry/Department have sufficient human resources to implement capacity building effectively?

1	2
Yes	No

(d) Does your Ministry/Department have sufficient trained and skilled personnel to implement capacity building policy/strategies effectively?

1	2
Yes	No

If 'No', please give two reasons for your answer

(e) Does your Ministry/Department have sufficient organisational structures such as divisions, sections and posts to implement capacity building policy/strategies effectively?

Yes	No
1	2

If 'No', please motivate your answer

(f) Does your Ministry/Department have sufficient work procedures and methods in place, to ensure effective service provision?

Yes	No
1	2

If 'No', please provide reasons why not.

(g) Does your Ministry/Department have sufficient control measures and standards in place to ensure the effective implementation of capacity building policy/strategies?.

Yes	No
1	2

If 'No', please provide reasons why not.

4.5 EVALUATION OF CAPACITY BUILDING STRATEGIES FOR THE PROVISION OF HEALTH SERVICES (OUTPUT PHASE)

(a) Capacity building is an important function of the Ministry/Department.

1	2	3	4	5
---	---	---	---	---

If you disagree, please give reasons why it is not.

(b) Health services cannot be provided effectively without suitable and sufficient human and financial resources.

1	2	3	4	5
---	---	---	---	---

If you disagree, please comment.

(c) The provision of health services by the Ministry/Department does not satisfy community needs effectively.

1	2	3	4	5
---	---	---	---	---

If you disagree, please give reasons why it does

(d) The output, being the health services being rendered will change the economic, social and physical environment to such an extent that development takes place.

1	2	3	4	5
---	---	---	---	---

If you agree, please motivate briefly.

4.6 IMPACT OF CAPACITY BUILDING POLICY/STRATEGIES ON PUBLIC HEALTH SERVICES AND THE CITIZENS (IMPACT PHASE)

(a) Does your Ministry/Department consider seriously the impact of health services on the environment and citizens?

Never	Sometimes	Regularly	Always
1	2	3	4

Please motivate your answer

(b) Do the citizens easily access health services in the rural areas?

Never	Sometimes	Regularly	Always
1	2	3	4

Please motivate your answer

(c) Does your Ministry/Department have sufficient capacity to provide health services effectively?

Yes	No
1	2

Please motivate your answer

(d) All hospitals operate effectively due to sufficient and adequate capacity.

1	2	3	4	5
---	---	---	---	---

If you disagree, please give reasons why it is not so.

(e) A lack of sufficient and/or adequate sustainable capacity to provide health services will hamper the economic, social, physical, and even political environments to the disadvantage of the citizens.

1	2	3	4	5
---	---	---	---	---

If you disagree, please motivate briefly.

(f) Do the existing policy/strategies and actions result in the impact they were supposed to bring about?

Yes	No
1	2

If 'No' please motivate your answer

(g) Do the citizens receive the health services they expect to receive?

1	2	3	4	5
---	---	---	---	---

If you disagree, please provide reasons why the service is not meeting citizens' expectations.

(h) Are the citizens satisfied with the manner in which

- Preventive health services are provided?

Yes	No
1	2

- Curative health services are provided?

Yes	No
1	2

- Rehabilitative health services are provided?

Yes	No
1	2

- Educational health services are provided (e.g. to young mothers with babies)?

Yes	No
1	2

4.6.1 Factors influencing capacity building and its impact on the provision of health services.

(a) A specific relationship exists between capacity and the impact of a service

yes	No
1	2

(b) The following factors influence capacity and the impact negatively

Influencing factors	Never	Sometimes	Regularly	Always
	1	2	3	4
Lack of operating equipment				
Affordability of health services				
Increasing demand for health services				
Other factors: (Please complete)				
.....				
.....				
.....				
.....				

From your own experience, please comment on the above

- END OF QUESTIONNAIRE -

THANK YOU FOR YOUR VALUABLE INPUTS

SUPPLEMENT D

Interview Guide

List of Stakeholders for Interviews

Category	Sub-Category	Location
Chief officials of the Ministry of Health and Population	Controller for Human Resources Management and Development	Lilongwe, Capital Hill Offices
	Chief of Human Resources Management and Development	Lilongwe, Capital Hill
	District Health Officer	Mchinji District
	District Health Officer	Lilongwe District
	Kamuzu Central Hospital Administrator	Lilongwe
Politicians	District Commissioner	Lilongwe
	Member of Parliament for Lilongwe North Constituency	Mchinji
	District Commissioner	Lilongwe
	Member of Parliament, Mchinji Central	Lilongwe

This interview guide has been prepared for the participation of the individuals responsible for delivering health services in the central region of Malawi.

Guidelines

Research ethics will guide handling of the data from this interview.

Process

The researcher and/or field assistants will administer the interview guide based on the direct engagement with respondents.

Communication

The researcher and/or field assistants will engage the respondents in both Chichewa and English.

In all attempts, please elaborate on the questions posed.

Disclaimer

This interview guide has been prepared for a research project undertaken to fulfil the requirements of a Master's Degree in Public Administration at the University of Fort Hare.

Your participation will be greatly appreciated

INTERVIEW QUESTIONS

1. In your own understanding, what is capacity building?
2. Do you consider capacity building as an important function of the Ministry that would help in efficient and effective health service delivery?
3. In your own view, what are the major problems being faced in the implementation of the capacity building strategies in the Ministry of Health?
4. And how can these problems be solved?
5. Can you please outline and explain the control measures and standards that are in place to ensure effective and efficient implementation of the capacity building strategies?

6. Do you think that the implementation of the current capacity building strategies is leading to the intended impact on health service delivery?

Thank you for your time

SUPPLEMENT E



Language Quality Assurance Practitioners

Mrs KA Goldstone

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2 April 2013

TO WHOM IT MAY CONCERN

We hereby certify that we have language edited the mini dissertation prepared by Rosemary Shanice Chowawa entitled AN EVALUATION OF THE IMPACT OF THE IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES IN THE PROVISION OF HEALTH SERVICES IN THE CENTRAL REGION OF MALAWI and that we are satisfied that, provided the changes we have made are effected to the text, the language is of an acceptable standard, fit for publication.

Kate Goldstone

BA (Rhodes)

SATI No: 1000168

UPE Language Practitioner (1975-2004)

NMMU Language Practitioner (2005)

Patrick Goldstone

BSc (Stell)

DEd (UPE)