

Country Profile Case Study

ASSESSING THE RATIONALE FOR, AND FORMS OF, DECENTRALISATION

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OBJECTIVES

- to review the differing experiences of selected countries with respect to their rationale for initiating decentralised health management and the types of decentralisation initiated;
- to compare and contrast experiences of the countries profiled with participants' own experiences;
- to provide analytical frameworks for understanding different types of, and approaches to, decentralisation.

PROCESS OF ANALYSIS

Participants are divided into small groups, each of which is then allocated 2-3 country profiles. It is suggested that each individual reads one of the profiles allocated to their group in advance of the session, and so comes prepared to discuss with group colleagues. Group work time will focus on comparing and contrasting different country experiences. The following questions provide a starting point for these discussions.

QUESTIONS TO CONSIDER IN ANALYSING COUNTRY PROFILES

Please consider these questions whilst reading and discussing the country experiences, drawing also your own knowledge of any of the countries under review into this discussion.

Type of decentralisation:

- What different streams or types of decentralisation have been introduced within each country?
- For each country, was there decentralisation of political or technical/managerial authority, or both?
- What, if any, structures or bodies were affected by decentralisation, or established in the process of decentralisation (e.g. local government, hospital boards, etc.)?
- In what ways are the experiences of the countries reviewed different or similar to other countries represented in the group? Have any other types of functions or bodies been the focus of decentralisation in these other countries?

Rationale:

- What are the explicit stated reasons or motivations for decentralisation and what, if any, implicit reasons are suggested to underlie decentralisation?
- Do the reasons or motivations differ by type or 'stream' of decentralisation? How and why? Is there any conflict between the different motivations?
- If you know any country under assessment, do you agree with the analysis of its experience? If not, what do you think the rationale(s) for decentralisation in the country was?
- Are these country experiences' different or similar to other countries represented in the group?

Drawing conclusions:

- Does the type of decentralisation have any influence over whether the objectives established for decentralisation are achieved? If so, which type appears more appropriate as a mechanism to achieve which goal?
- What other key factors influence the achievement of objectives?
- Do you see the transfer of authority of any function to bodies outside the public sector as a form of decentralisation? Why/why not?

DECENTRALISATION IN KENYA

Extracted from: Cohen S., Mwanzia J., Omeri I., Ong'ayo S. *Decentralization and health system change in Kenya* Case study prepared as part of the WHO multi-country study on decentralisation and health system change (1996)

Country experience reported until 1995

BACKGROUND

An outline of health sector reform in Kenya 1970-1995

After independence in Kenya in 1963, the health sector was managed by both the Ministry of Health, which ran the hospitals, and the elected Local Authorities which were responsible for the clinics and rural health facilities. By 1970 there was increasing concern over the variable quality of care provided by the local authorities and as a result the MOH took over the rural health facilities and most of the urban clinics.

The Ministry of Health management system was based on the District Health Management Team (DHMT). The British introduced DHMTs during the colonial days and after independence the practice was continued. However, it was not until the 1970s under the donor supported Rural Health Development Project (RHDP) that the District Health Management Team took on their central role in health service management. Their role was further enhanced when, in 1983 the government introduced its broad decentralisation policy, the District Focus for Rural Development and the DHMT was used as a vehicle to implement this policy in the health sector.

Since independence in addition to decentralisation, there have been three other important policy developments in the health sector. Firstly, in 1986 the Kenyan government adopted the Primary Health Care Approach and this has remained a major plank of their health care policy to date. Secondly, at the end of the 1980's, largely as a result of global economic conditions, the government came under pressure to reduce public spending. As a result government spending on health in real terms was cut and in 1989 fees for health care government facilities were introduced. Lastly, in 1992 District Health Management Boards were introduced primarily to oversee use of the revenue generated by fees charged at health facilities.

Overall government policy framework

Since independence in 1963 a key tenet of the government has been the promotion of community self-help or 'Harambee'. However, in the seventies and early eighties there was a tendency for politicians to use this Harambee spirit to initiate the construction of capital projects in their own constituencies. The result was that health facilities, schools, cattle dips, bridges etc were erected all over the country. This led to variable standards of building and the inequitable distribution of facilities countrywide. Moreover, although communities provided capital revenue, the government was expected to provide staff for facilities and meet any recurrent costs.

It was this situation in the early eighties that prompted the government to develop a strategy that could utilise the harambee spirit, but at the same time co-ordinate inputs and ensures the equitable distribution of limited resources. The strategy was to: first, ensure that all district development plans were co-ordinated, prioritised and dealt with in an equitable manner; and secondly, to establish an administrative system which encouraged grassroots participation. This was the basis for the decentralisation of administrative structures promoted in Kenya through the District Focus for Rural Development strategy.

The seventies were marked both by a change in leadership in Kenya and changing economic fortunes. Kenya's economy, like many countries in the region has been strongly influenced by the international economic climate. The oil crisis in 1972 marked a downturn in the economy. This was partially reversed due to the coffee boom in 1976/77. However, this improvement was short lived because of the sharp increase in crude oil prices that occurred in 1978. By 1984 the GDP growth rate had fallen to less than 1%. Internal budgetary controls led to some improvement in the situation in the mid-eighties, but this was not sustained and the economy dipped to a low point in 1992. This was partly as a result of poor performance in the domestic market and a result of a donor freeze on aid in 1991.

The decline in Kenya's economy led to the implementation of a Structural Adjustment Programme. This had a severe impact on financing for the health sector, as acknowledged in Kenya's 1994 Health Policy Framework.

The early nineties also witnessed some significant political changes. In 1992 Kenya held its first multiparty elections and President Moi was returned to power. In addition, Kenya experienced substantial pressure from major donor agencies to institute political and economic reform. It is debatable whether significant policy changes, for example in the public sector, have resulted from domestic adjustment to the new economic climate or conditionality of donor funds to government. The important point for this study is to acknowledge bilateral and international agencies as significant actors in the policy arena.

MAIN FEATURES OF DECENTRALISATION POLICY

Major streams of decentralisation

- Decentralisation to lower levels of the government across all sectors: The District Focus for Rural Development (1983)
- Decentralisation to lower levels of the Ministry of Health administration: The District Health Management Teams (1975/79)
- Decentralisation to lay management boards within the Ministry of Health: The District Health Management Boards (1992)

Minor streams of decentralisation

- Decentralisation to provider institutions: The Kenyatta National Hospital (1990s)
- Decentralisation to community -based groups: The Bamako Initiative (1989)
- Decentralisation to private sector institutions.

Decentralisation to lower levels of the government administration across all sectors.

The District Focus for Rural Development - 1983

The DFRD strategy was to shift the responsibility for planning and implementing rural development from the headquarters of ministries to the districts. The District Development Committee (DDC) became the focal structure for implementation of the DFRD and was a body made up predominantly of district civil servants, MPs and local councillors. It had a broad ranging role including rural development planning and co-ordination, project implementation, management of financial and other resources, overseeing local procurement of goods and services, management of personnel and provision of public information. It was also intended that the strategy would improve communication between local community and government officers through Development Committees at sub-locational, locational and divisional levels.

The primary objective of the DFRD was the desire to see a more equitable approach to rural development in Kenya. Thus, the explicit objectives of the District Focus for Rural Development were:

- equitable distribution of development, bearing in mind regional disparities;
- decentralisation of decision making;
- greater involvement of the beneficiaries in development activities;
- to ensure continuation of the Harambee spirit; which was already supplementing government of Kenya (GOK) financed capital projects.

The strategy represented a major policy shift taken by the relatively new administration of President Moi. Whilst the policy framework was developed by the Office of the President, each Ministry was expected to implement the policy in their respective sector.

Decentralisation to lower levels of the Ministry of Health administration.

The District Health Management Teams - 1975/79

The membership of the DHMT, its functions and responsibilities were only clearly laid out during the 1970's as part of the Rural Health Development Project and were identified as:

- formulation of relevant health objectives for the district in support of national health policies
- participation in the total development of the district through the DDC.
- identification of target populations and 'at risk' groups in order to meet their needs
- training deployment and development of staff
- preparation of budgets and authorisation of expenditure
- initiating and supporting community based health activities
- monitoring and supporting rural health facilities
- determining the staffing capacity and location of health facilities
- liaising with non-government organisations involved in health activities at the district
- developing and maintaining a management and health information system in the district.

It is hard to obtain a clear picture of the original objectives for the formation of the District Health Management Teams but it was probably organisational - a way of providing an integrated approach to the management of district health services. Whether the original 'DHMT' approach was actually viewed as 'decentralising' is unclear. The idea of making the DHMT the focal point of a decentralised health care system appears instead to have been associated with the introduction of the DFRD.

Decentralisation to lay management boards within the Ministry of Health

The District Health Management Boards - 1992

The District Health Management Boards were formed in 1992 to oversee the use of funds generated through the national cost-sharing policy. The DHMBs oversee the management of health services in the district in order to ensure proper use and accountability of public funds, and provide the link between the public and the district health care system. Their responsibilities include:

- reviewing and sanctioning planning proposals including those submitted to DDC for approval.
- setting performance targets and ensuring that services are being provided in accordance with Treasury instructions.
- monitoring the performance of DHMTs through review of progress reports.
- receiving reports on Exchequer allocations to the district and ensuring that “voted” (allocated) funds are used for their intended purpose
- visiting health institutions and handling matters raised by patients including complaints/dissatisfaction about quality of care.
- approving the use of the facility improvement fund in accordance with the accounting officer’s instructions.
- ensuring financial reports are submitted to the ministry of health in time.

Originally, it was intended that the DHMBs should only monitor the cost-sharing programme. However, the 1994 Health Policy Framework suggested that their role should be extended to permit them to oversee all health sector activities within their districts - and the 1995 DHMB operation guidelines gave them the responsibility of reviewing and approving overall recurrent and development budgets.

However, the main objective of DHMB establishment was not to increase decentralisation in the health sector. Instead it was to establish a mechanism to oversee the cost-sharing programme in three ways. First, it was hoped that the DHMBs would ensure that money raised through user fees would be properly accounted for and would not be misused. Secondly, it was hoped that the DHMBs would represent the public’s views on the most appropriate way to spend the cost-sharing funds. Thirdly, the DHMB was seen as a watchdog for the public over the standard of care offered in the Ministry’s health facilities. Although the creation of DHMBs led to a more decentralised system, this was not a prime objective of the initial policy.

Other forms of decentralisation

The Kenyatta National Hospital - 1990s

In Kenya, the Kenyatta National Hospital, the national referral hospital is given a block grant and is managed by a board of trustees. A similar arrangement exists for Kenya’s Medical Training Centres.

The Bamako Initiative - 1989

The Bamako Initiative was introduced in Kenya in 1989. It is seen as an important mechanism for strengthening Primary Health Care Services in Kenya. Decentralisation is seen as being central to the implementation of this programme - referring to the transfer of power from the district centre to the community level. Therefore, BI takes decentralisation a step beyond the district level.

Decentralisation to private sector institutions.

It is estimated that the private sector, both for profit and not for profit account for approximately 40% of hospital and **outpatient** provision in Kenya. Kenyan law has always permitted private practice as long as practitioners are registered and have obtained a private practice license. However, until recently, there has not been any specific policy directed towards the private sector.

Although there is legislation in place to regulate the private sector, there has been a growth in unregistered clinics and the quality of care in this sector is very variable. As a result the 1994 Health Policy Framework highlighted the need to improve regulation of the private sector even whilst seeking to encourage collaboration between the private and public sectors (through, for example, incentives for the private sector to move to under-served areas.)

FORM OF DECENTRALIZATION

New and restructured levels and institutions

The District Administration

The DFRD created a new administrative system, which focused on the DDC. Certain features of this system are worth noting. Firstly, the DDC has assumed a pivotal role in the District. The DDC reviews all district plans, decides on district development priorities and draws up annual budgets. All departmental heads have to seek approval by the DDC for their plans. The intention is that the DDC should co-ordinate district plans and maximises use of resources. However, the performance of DDCs varies a great deal between districts. Effectiveness depends on the calibre and enthusiasm of key members such as the DC and MPs. Work can also be slowed down if the Committee is unable to resolve conflicts between competing interest groups. Conflicts may occur not only between politicians from different political positions but also between political representatives and civil servant.

Secondly, it was intended that the sub-district development committees, in particular the locational and sub-locational DC should carry out need assessments of their population and act as a source of project ideas for their catchment areas. However, these Committees are often under-resourced, for example they may not have basic stationery, so that in many cases they are unable to fulfil their responsibilities.

Thirdly, although it was intended that some personnel management functions should be decentralised, under the District Focus, strategic planning for personnel remained with the Directorate of Personnel Management. This is a national body under the Office of the President. The DPM determines staffing complements for each ministry and salary scales for each job group. All appointments above a certain rank are decided on by the DPM. A second national body, the Public Service Commission deals with other personnel issues such as recruitment and staff discipline.

The Health Sector

The organisation of the health sector structures is perhaps less clear than the district administration. This is probably because they have been changed and adapted over a number of years rather than having undergone a single restructuring process. For this reason there may be some dispute about the exact relationship between certain structures.

There are two types of bodies in the health sector. Management Teams which are made up of technical MOH staff, and a variety of committees and boards made up of community representatives with limited technical input from MOH staff. The management team are the PHMT, DHMT, the Hospital Management Committee (HMC) and the Health Centre Management Team (HCMT).

The PHMT should be involved in monitoring and evaluation of district activities and although the team was strengthened with the return of the post of Provincial Hospital Secretary, it is still handicapped by limitations in funding and staffing. In particular the money allocated for transport and allowances (about 11% of each team's budget) is inadequate for them to travel around the Province and provide supervision.

Despite the shortage of staff the PHMT is in a strategic position to strengthen DHMT operations if adequately funded. Appropriate tasks could include co-ordinating all types of training for DHMTs and supervising district health service operations.

The District Medical Officer of Health (DMOH) leads the DHMTs. The DMOH may be relatively junior and have very little management experience, whereas an experienced Medical Superintendent may lead the Hospital Management Committee. In theory, the DMOH should oversee all expenditure in the district including the hospital. However because of the relative seniority of the Medical Superintendent, the latter may be unwilling to accept the authority of the DMOH. In some cases this situation has led to tension between these cadres.

Lastly, each health centre should have a Health Centre Management Team (HCMT), responsible for planning and managing health services not only within the health centre but the entire catchment area (the Rural Health Unit). However, these HCMT are not always constituted or active.

An important feature of the health system is the relationship between the technical DHMTs and the bodies which are made up of non-MOH staff, the DHMBs, the HCC, and the VHC. The DHMBs are formally constituted and their relationship to the DHMT is clearly spelt out, whereas the Health Centre Committees and the Village Health Committees membership may be either nominated or elected by the local community and their relationship to formal structures in the health sector is far more nebulous.

Most of the districts have operational DHMBs. Each team is made up of 9 members who represent a variety of community interests within the district. Members may be retired senior civil servants, local NGO members, women's groups representative, local businessmen. Board members are nominated by the DC and DMOH and appointed by the Minister of Health. At the time of this study, the selection procedure was overseen by the Kenyan Health Care Financing Secretariat (KHCFS). The DMOH and District Commissioner are also members of the Board. In order to work more effectively, the Boards operate through three sub-committees. The finance and general purposes committee, the quality of curative services committee, and the public health care committee.

In the same way as the DHMBs monitor and support the DHMT, some health facilities are supported by Health Centre Committees. These committees have arisen from community self-help groups which initiated the construction of local health centres and dispensaries. The community interest in these facilities still exists and some of these committees are now exploring ways of maintaining the services of the facility or supporting services like providing security and purchasing kerosene for sterilisation of equipment.

Village Health committees were formed in many communities in the late '80' s when Kenya started its PHC Programme. In 1991 some VHCs were retrained and took on additional responsibilities as part of the Bamako Initiative Programme.

Responsibility and Authority

DHMTs have responsibility in four principal areas: population needs assessment; personnel management and in-service training; district planning; and budgeting of district services. In practice authority is lacking in several key areas. The DHMT has no control over salary scales and only very limited control over the hiring, firing and posting of personnel. In addition, training is frequently organised through centrally controlled vertical programmes. Secondly the responsibility for preparing budgets is not matched by the authority to decide allocations within the district's recurrent and development budgets. This is still done centrally and may also affect the DHMT's authority in planning.

DHMBs have responsibilities in four main areas: representation of the views of the community in the planning of health services at district and national level; approving FIF, AIE requests, recurrent and development budgets; supervising service delivery; promoting health awareness in the general public. At present, the main area in which responsibility is not matched by authority is in the approval of recurrent and development budgets. Only the FIF budget can currently be approved by the DHMB, and although this decision can be altered by the KHCFS, this rarely happens.

DISCUSSION OF THE FORM DECENTRALISATION

One can pick out specific features of the form of decentralisation that have been influenced by both the policy formulation process and the means that were chosen to implement decentralisation in Kenya.

Firstly, the two policy streams of decentralisation in the health sector and the policy stream of decentralisation of the district administration has resulted in two parallel structures developing at the district level. There are both formal and informal links between these systems and although it may lead to rather a lot of committees at the district level, by and large the linkages between these systems seem to work well. However, the responsibilities and relationships of the sub-district structures both in the health sector and the district administration are less clearly defined. This may be because community structures were created to improve grassroots representation rather than for organisational reasons and during implementation inadequate time and resources were invested in making these structures work effectively.

Secondly, the implementation process did not adequately address issues of restructuring in the MOH HQ. The result is that linkages, communication, co-ordination and accountability between national and district levels are complex and at times confused. This situation may have been alleviated if the Provincial level had maintained its importance and acted as a co-ordinating body between the national and district levels.

DECENTRALISATION IN NICARAGUA

Extracted from: Sandiford P. *Decentralisation and health system change: Nicaragua case study* Case study prepared as part of the WHO multi-country study on decentralisation and health system change (1995)

Country experience reported until 1995

Background

This paper describes the most recent efforts to decentralise health services in Nicaragua, beginning about 1991 under the leadership of the then Minister of Health Dr Salmeron and continuing at an even faster pace under his successor, Ms Martha Palacios.

Nicaragua has had a turbulent political history over the last 20 years characterised by revolution, civil war, and change from the long-standing dictatorship of the Somoza family to the radical left-wing nationalist government of the Sandinistas and finally, in 1990, to a democratically elected government with a mix of neo-liberal and social democratic policies. Over the same period, the country's economy contracted severely as a consequence of the revolution, the war, the US economic embargo, hyperinflation and property confiscation, all of which were aggravated by the inevitable flight of capital and technical expertise. The first priorities for the Chamorro government were the negotiation of a definitive peace settlement and stabilising the economy. The former was achieved relatively swiftly although bands of discontented ex-combatants (from both sides) continued to cause problems until very recently.

Turning the economy around took a little longer. The Sandinistas left a legacy of very high inflation and a weak currency caused to a large extent by an enormous budget deficit. The peace dividend allowed reductions in the size of the armed forces but cuts in social sector spending were also necessary, particularly given that the economy was still contracting. With international assistance, inflation was gradually reduced and it became possible to achieve some exchange rate stability after initially introducing a new currency and then in January 1993 devaluing by 20% against the US dollar (although a policy of sliding devaluation, currently running at 12% per annum, has been in place for almost three years). Other economic liberalisation measures have included the removal of export and price controls, privatisation of certain state corporations (often in fact returning them to their previous owners), and allowing private banks and currency exchange houses to operate, all good examples of the generally favourable attitude to private enterprise that now prevails in the Nicaraguan government.

As was to be expected, the structural adjustment package produced recessive effects to begin with which were felt most acutely by the poor. However, there was at last some modest economic growth of 3.2% in 1994 and about 4% in 1995. Unfortunately, government projections for coming years do not envisage very high per capita growth rates.

Two major economic problems have yet to be fully addressed. One is the enormous external debt which, at 750% of GDP (in 1992), is the highest in the world. The other is the large number of outstanding disputes over property ownership caused by the Sandinista confiscations, and especially the so-called pinata in which thousands of titles were given to FSLN supporters after they lost the elections in 1990.

With an estimated 44% of households surviving under conditions of extreme poverty, no Nicaraguan government can ignore issues of equity, and indeed the government's social policy implores that the material and spiritual benefits of society be taken to the historically marginalised and exploited sectors of Nicaraguan society. However, having witnessed the effects of the previous government's attempts to create greater social justice, the Chamorro administration has been careful to avoid measures that might further undermine confidence in property rights or the government's commitment to fiscal prudence. Hence the general direction of the National programme for Social Development and Poverty Reduction were not redistributive per se but rather advocated administrative decentralisation and intersectoral action mainly it seems, to improve allocative efficiency. Decentralisation may have been viewed as a means to target vulnerable and impoverished populations by allowing decision-making at local level where there is greater knowledge of who and where these groups are. In other respects government policy has attempted to increase the role of the private sector and move the country towards a more free market model, whilst strengthening democratic institutions.

Decentralisation experience

To understand the recent decentralisation of health services in Nicaragua it is necessary to see how their organisation has evolved under the previous governments. In the time of Somoza, health services had been provided by the 19 Local Social Welfare Boards, administering the hospital and ambulatory care clinics in each of provinces, the National Social and Public Welfare Board which ran 25 'National' hospitals, and the Nicaraguan Social Security Institute which in 1976 covered less than 10% of the population but was well financed and provided services of good quality.

One of the first decrees of the Government of National Reconstruction established the National Unified Health System (Decree 35, 28 August 1979), which brought under the direct control of the Ministry of Health all the Local (actually provincial) Social Welfare Boards and the National Social Security and Welfare Board (which between them ran hospitals and health services throughout the country), as well as the services owned and operated by the Social Security Institute. After defence, health and education were high priorities for the Sandinista government which perceived these sectors as having been neglected under the Somoza government and also saw them as important sources of popular support. In the name of equity, the privileges enjoyed by the insured in access to health services originally owned and run by the Social Security Institute were abolished and hence these facilities became no different from any of the others run by the MoH. Moreover, 9% of the social insurance contributions collected from the insured was handed to the Ministry of Finance ostensibly to be passed over to the Ministry of Health but in practice the funds simply formed a part of the treasury's general revenues. Indeed the Sandinista government, like others in the region, used the pension fund as a sort of 'petty cash' supply, seriously jeopardising the actuarial stability of the INSS. The government of President Chamorro therefore inherited a highly centralised health system.

Beginning around the mid-1980s the government, following WHO/PAHO guidelines, attempted to reorganise health services into district health systems or 'Local Integral Health Care Systems' (SILOS) as they have been called. In theory, this meant decentralising the health system, but in practice the handing over of responsibilities was not matched by loosening central control over resources. Though some hospitals and regions did experiment with local budgeting at the end of the 1980s a number of problems were encountered and the previous system was soon re-established. The Health Master Plan for 1991-1996 proposed to extend the decentralisation process and stated:

“As part of the development of the SILOS, the process of decentralising budgeting, administration, planning delivery and evaluation of services, programmes and projects at municipal and regional levels will be reinforced and deepened.”

The decentralisation process really began in earnest during the Chamorro government. It must be seen however, as just one component, albeit the most important, of a much broader process of reform to the sector as a whole. A key element promoting the decentralisation of health services has been a desire to democratise management, which in practice meant providing an opportunity for inputs into health policy from community organisations, local government, the private sector, NGOs, unions and so on. It is difficult to see why such an emphasis was placed on this notion of democratisation but one reason could be that it was a strategy used to gain the support of stakeholders who might otherwise oppose the changes, by offering mechanisms that would allow their input into policy formulation (which in fact they did).

On the other hand, there does appear to have also been a genuine desire on the part of policy-makers to create a less politicised health system, one with greater accountability to the public and one which was more responsive to the needs and desires of service users. In this sense decentralisation served another key area of overall government policy, namely that of securing peace within the country. Following the elections of 1990, the new minister of health Dr Salmeron, gained some support from the Sandinista controlled health workers union by continuing the previous government's health policy and by not making large numbers of political appointments within this ministry. This created a favourable climate to allow the new minister, Ms Palacios who took office in January 1993, to implement more substantive changes within the organisation. In particular, she was keen to depoliticize the existing mechanisms for community participation in health, which consisted of one organisation under strict Sandinista control and another led by the liberals. It appears that her desire was not to gain control over these channels for volunteer health worker participation, but rather to take them out of the political arena. Indeed some of her proposals intended to encourage participation at local level were considered threatening by the Sandinista Community Movement and therefore were not adopted, but eventually this aim was achieved by decentralisation because it was no longer possible nor appropriate for such groups to negotiate with the central ministry of health as they had been accustomed to do.

A third rationale for decentralisation does appear to be purely technical and it was based on the recognition that the health system had become a set of vertical programmes operating independently of each other and of the hospitals (the latter absorbing a large proportion of the government's budget for health). A decentralised health system, it was felt, would integrate the vertical programmes and address the health needs of the entire population, with an emphasis on women's and children's health. Greater allocative efficiency would help the government to deal with the financial strains caused partly by the epidemiological transition in the population that is increasing demand for expensive curative and palliative health services.

Critics of the decentralisation policies argued that the government was 'passing the buck' by handing responsibility for the running of health services over to the Boards of Directors. To support this view they pointed to the cutback in government health spending in real terms. While the architects of the decentralisation deny this, the government had hoped that decentralisation would facilitate more action in health from some of the other sectors, and originally it was intended that means-tested user

charges would be introduced as one aspect of the change. Financial considerations were therefore important factors in the decision to undertake these changes.

Nicaragua initially opted to decentralise to the provincial level by setting up (legally) independent boards of directors. Since July 1995 however, there have been moves to further decentralise to the level of the municipality whilst retaining the provincial structures. However, the precise form of municipal authority in health remains undefined.

The policy formulation process for decentralisation began on 26 February 1991 with a ministerial resolution (No. 91) "initiate a process of reorganization of health services with the aim of organizing the Local Systems for Integrated Health Care". These SILAIS as they became known, were a Nicaraguan variation on the PAHO promoted concept of Local Health Systems or SILOS. The resolution was followed by a nationwide consultation process through Regional Health Fora in which the ministry's proposals were discussed by representatives of civil society and particularly the local government authorities. These were not just meetings for government to inform the different groups of the intended changes but real interchanges of opinion and ideas which formed important inputs into the final policy. For example, it was originally proposed to form Local Health Councils with an essentially advisory role but the representatives of local government made it clear that they wanted a more active involvement with real decision-making power. It was hence from these discussions that the idea of the Provincial Health Boards arose. The Regional Health Fora were followed by a National Health Forum in which the final decentralisation proposal was presented. This was ratified by central government at the National Health Conference in June 1991.

From the outset, external donors and lending agencies were supportive of these and other health sector reforms, and loans from the World Bank and Interamerican Development Bank were secured to assist in the process. However, the changes were being driven very much by the Minister of Health and in fact if anything, external agencies were recommending that they proceed at a slower pace than they did. The consultation process succeeded in winning the support of municipal governments, community organisations, churches and a number of NGOs but the Sandinista dominated unions (i.e. the Federation of Health Workers, the Women's Association Luisa Amanda Espinoza, the National Union of Farmers and Cattle Ranchers and the Community Movement) still opposed many of the proposals. For example, it was originally hoped that decentralisation would open up possibilities for alternative financing methods but the unions felt that this would simply be a first step towards privatisation and their opposition meant that these ideas were eventually dropped. Other criticisms were made of the cut in the health budget, the reduced access to medicines due to privatisation of pharmacies, the decrease in the number of employees brought about by the government's voluntary severance programme for the civil servants, the equity implications of reviving differential care for the insured, reduced opportunities for community and worker inputs to health policy, and poor management skills of SILAIS directors. Nevertheless, after an agreement was reached with the Federation of Health Workers to end a strike a period of labour stability followed.

The other stakeholders from whom resistance to the decentralisation was felt were staff in the central ministry of health and regional level staff, prior to the elimination of this level. In fact it was due to this resistance from the regional health authorities that this level in the system was later abolished.

Form of Decentralisation

Nicaragua eventually opted for a form of decentralisation that created semi-autonomous provincial (departamento level) health authorities (SILAIS) run by Boards of Directors made up of representatives of civil society including local government officials, churches, and 'distinguished members of the community'. Managua the capital was divided into three health authorities. Each provincial health authority had a network of primary care clinics and a hospital with the four basic specialities (general medicine, general surgery, paediatrics, and obstetrics and gynaecology).

The Board of Directors includes the members of the Hospital Executive Committee (one of whose members is the director of the SILAIS). This executive committee is in charge of the day to day running of the hospital. The Boards of Directors have the role of ensuring that resources are used appropriately and that quality of care is optimised. Their specific functions at provincial level require them to approve the strategic health plan, the service programme and the budget developed by the SILAIS staff, and to monitor their implementation. The Boards of Directors are also responsible for naming the local health authorities. The Boards remain answerable to the Ministry of Health for the use of central government funds by means of a contract signed between the ministry of health and the director of the SILAIS (after approval by the Board of Directors). In this contract the director agrees to meet service productivity, health and user satisfaction targets (for all health services including the hospital), in return for the funds and technical assistance provided by the Ministry. Moreover, each health unit within the jurisdiction of the SILAIS negotiates its own budget and contribution to meeting the contractual obligations. Executive power in the provincial health authority rests with a team composed of the director, a health administrator, an epidemiologist, a financial administrator and a nurse.

A minor variation from this structure occurs for the North and South Autonomous Atlantic Regions where the director of the SILAIS answers to the regional governor and where the Regional Council plays the same role as the Board of Directors.

A Board of Directors was also formed for each national reference hospital (in Managua) with equivalent functions to those of the Boards of Directors of the provincial health authorities. Thus the hospital director signs a contract with the ministry of health similar to the one signed by provincial health authorities. The hospital is assigned a budget based on satisfaction of demand and efficiency criteria.

Provincial health councils were set up as coordinating bodies with participation from other sectors and social groups. In March 1993 a National Health Council was formed, headed by the minister of health and made up of the National Assembly's health commission, representatives of civil society, the unions, private enterprise, community organisations, women's organisations and churches. The National Health Council developed a national health policy with a set of guiding principals.

With decentralisation, the SILAIS took over functions of health needs assessment and planning (local programming) within the framework of national priorities defined by the ministry of health, appointment and distribution of staff. The plan for the province, which must be approved by the Board of Directors, is set out in the annual contract negotiated with the ministry of health and includes performance targets, as well as a budget to cover the operating costs of the envisaged activities. In practice however, the actual level of funding depends upon the total ministry of health budget provided by the Ministry of Finance, which means that the final budget for each province has to be decided centrally.

DECENTRALISATION IN ZAMBIA

Extracted from: Choongo D and Milimo J. *Decentralisation and health system change: Zambia Case Study*. Case study prepared as part of the WHO multi-country study on decentralisation and health system change (1996)

Country experience reported until 1995

BACKGROUND

Political and Economic Context

At the time of independence in 1964, Zambia had a population of about 3.5 million and a per capita income of K450 (in constant 1977 kwacha), a level commensurate with many middle-income Countries. Today, the population has risen to nearly 9 million inhabitants and a per capita income has dropped to K250. According to a recent World Bank study, 68% of the population now lives in poverty. The assessment also indicated that 88% of rural households were poor, 76% (core poor) compared to 44% in urban areas at 29% (core poor). Even if one takes a more conservative definition of poverty, almost one third of households spend 70-85% of their income on food. The 1992. Demographic and Health Survey showed that economic decline has been associated with deteriorating rates of infant, child and under 5 mortality.

From 1964 to 1975, GDP grew faster than population. Copper production and prices were high and the income was used to finance a rapid expansion in social services. However, the situation changed dramatically in the mid 1970's. The combination of falling international copper prices, growing competition from more efficient producers, reduced demand resulting from the world-wide energy crisis and the growing cost of production from ageing mines, led to a massive decline in revenues. Failure to diversify the economy meant that, while copper continues to account for the majority of export earnings (90% in 1989), its contribution to government revenues has dropped from over 40% at independence to less than 1% today.

The situation was made worse by the fact that, rather than introduce necessary economic reforms, the UNIP Government reacted to the crisis by extensive borrowing from the domestic and international capital markets. The state-dominated economy of the 1970's and 1980's was characterised by an overvalued currency, price controls, export restrictions and consumer subsidies. The net result was that by 1993 external debt stood at more than US\$7 billion. In addition, food subsidies to urban areas and the failure to develop agricultural policy exacerbated out-migration from rural areas and led to a growing concentration of population and services in urban areas. Between 1974 and 1990, Zambia's GDP grew at an average rate of 1% per year, while population grew at over 3% per year during the same period.

Attempts to introduce reform began in 1985, but little progress was made until the Movement for Multi-Party Democracy (MMD) formed a new government in 1991. The first democratic elections following independence not only signalled the population's rejection of a one-party state and a concern for a more democratic system of government, but the MMD was elected on the basis of its pledge to address the Country's economic problems. The current Economic Reform Programme (ERP) aims to promote recovery from the prolonged recession and to mitigate the most serious problems caused by Zambia's massive debt. The ERP forms the basis of Rights Accumulation Programme with the IMF, through which Zambia has earned rights to future borrowing to finance its arrears. Key areas of

progress include liberalisation of foreign exchange systems and removal of price controls and licensing restrictions. The fiscal deficit has been reduced, but in early 1993 a loss of monetary control led to a very high inflation. Fortunately this was brought under control later in the year and inflation is currently running at about 35-40%. Cash-based budgeting has had the effect of controlling public expenditure but revenue collection remains weak. Recent liquidity problems have therefore, resulted in significant reductions in the funds available for recurrent spending. Areas in which the pace of reform has been slow included the planned privatisation programme and, most particularly, the Public Sector Reform Programme.

Zambia continues to receive the largest amount of aid of any recipient under SPA II, but much of it continues to flow out to International Financial Institutions without any impact on the local economy.

Zambia's debt and other economic problems are such that substantial programme aid will be needed at least for the rest of the decade to provide the imports essential for economic recovery. Whilst further structural and economic reform is undoubtedly required, it will take place in the face of accumulation evidence of the extent of rural poverty, and at a time when the new government is preparing for the next election scheduled for 1996.

Decentralisation Policy

A concern for decentralisation has been a long-standing feature of public policy in Zambia, as evidenced by the establishment of elected local government councils immediately after independence. However, the form and objectives of decentralisation have changed significantly over the last three decades.

Until the Local Administration Act was passed in 1980, much of the focus of early attempts at decentralisation had concentrated on the Provinces. The 1980 Act, however, shifted attention once again to the Districts. The elected local councils were abolished and, in their place, new political bodies were formed. The new district councils were composed of central government and UNIP officials, locally elected representatives of the party, traditional chiefs and representatives of community organisations. Although the council had greater administrative powers than their predecessors, it was generally agreed that the main objective of the policy was to strengthen the position of UNIP, through the appointment of its supporters to key positions throughout the Country.

The district councils established under the 1980 Act prepared their own budgets for national approval and were to have control over most government staff working in the area. However, strong links were maintained with technical ministries in Lusaka. Furthermore, the influence of district councils over the health sector was constrained by subsequent developments, which placed greater financial control in the hands of Provincial Permanent Secretaries and the Provincial Accounting and Control Units. Under these arrangements which existed until the implementation of the current reforms, the Province received an earmarked grant which was channelled to the office of the Provincial Medical Officer.

For the purpose of the current analysis it is useful to distinguish two main streams of decentralisation policy. The first concerns decentralisation to local government as part of the Public Sector Reform Programme. The second stream of decentralisation policy is specific to the health sector, and is set out in the MMD Government's Health Reforms.

Decentralisation to local government

While the political objectives have changed, the form of decentralisation to local government builds on some aspects of the previous system. The key difference being that local councils are now elected, and thus seen as a mechanism for increasing popular involvement in development initiatives and ensuring that local government officials are held accountable to community representatives.

Local councils will in future be funded according to a formula based on the population they serve. However, the Provincial Accounting Control Unit (PACU) under the Provincial Permanent Secretary will continue to play a significant role in controlling disbursements. Before the health reforms all matters concerning control of communicable diseases were under the control of the Local Government for urban district councils. For rural ones the Ministry of Health was responsible, in actual fact whenever there was an outbreak of a disease the Ministry of Health had to provide resources and logistics. The same applied for the other services such as, sanitation, water supplies, food inspection, and licensing of trading premises.

Under the National Health Services Act, No. 22 of 1995, there has been division of activities or responsibilities between the local authorities and the District Health Boards. In the National Health Services Act 1995, issues relating to the provision of clinical care have been affected by the repeal of item 40a, of the second schedule of the Local Government Act. All the other services such as environment health, sanitation, water engineering, building inspections and licensing will be performed by local authorities. However, whilst larger cities may be able to implement their responsibilities, smaller cities may have neither human resources nor logistics support facilities to do so.

Decentralisation and the health reforms

Health Boards

The document "National Health Policies and Strategies", which sets out policies underlying the reform process, received cabinet approval in October, 1992. The reforms are centred around three key themes:

- **Leadership:** The Ministry of Health provided political and right leadership at district, province, central and hospital levels in the implementation of health programmes hence the capacity building for the Health Management Teams.
- **Accountability:** The reforms should aim to make providers of health care more accountable to those that use the services and accountable to whatever they are doing. e.g. use of resources, having resources in place that promote accountability.
- **Partnership:** Is perceived in terms of users contributing towards the cost of care, and in terms of government working in partnership with donors and agencies in the private and voluntary sector in the implementation of the reform programme and sectoral Ministries in the government.

In terms of decentralisation policy, the health reforms aim to achieve their objectives through the establishment of Autonomous Health Boards. These will be constituted in each district and for all provincial, general and central hospitals. The Central Board of Health will be established to carry out a specified range of functions as outlined in the Act. The Central Board of Health is institutionally separate from a much reduced Ministry which, under the Minister and Permanent Secretary, is responsible for policy, and for negotiation with the Ministry of Finance and Cabinet Office for the health budget. The Central Board is, in turn, responsible for overseeing the implementation of policy, through its control of the contracts negotiated with district and hospital boards. The objectives of these arrangement is to reduce

political involvement in the management of services and specific allocation of resources, whilst maintaining proper accountability to Parliament for how public funds are spent.

Membership to the Boards will be drawn as specified in the National Health Services Act of 1995. Seven members will be appointed by the Minister and the others will be drawn from a wide range of organisations. As the criteria to be used by the Minister in appointing the seven is not specified, some concern has been expressed about the Minister's influence over the Boards.

Overall, therefore, the Boards oversee the work of health management teams at each level and the intention is that in addition to considerable financial autonomy, they will become independent employers of health services staff. The reforms therefore envisage that whilst most health care will remain publicly funded, it will be largely provided by an organisation that it is legally and institutionally separate from the civil service.

District and hospital management teams

As highlighted, the relationship between the centre and districts is governed by plans prepared by the district. Following the approval of plans by central authorities, the CBOH signs a contract which specifies the resources that the district will receive. If a district fails to account satisfactorily for funds received or if performance lags significantly behind agreed targets, subsequent transfers of funds can, and, have been withheld until the situation is remedied. When these sanctions are imposed, the pressure both from their own staff and local politicians on DHMTs that fail to perform are obviously significant. Moreover, there has been at least one instance in which misuse of funds was detected by the monitoring system, which has resulted in the offenders being imprisoned. The contractual relationship between DHMTs and the centre is clearly, therefore, one with real teeth. The District Health Management Team is the executive body of the Health Service Board and, as for itself, the relationship between the district and health centres is governed by plans prepared by the health centres. These plans make up the district health plans. The DHMT is responsible for overseeing health centre plan preparation and the monitoring of performance against specified activities.

District and Hospital Management Teams do, therefore, control a significant proportion of their recurrent budget. Since 1994 they have been responsible not only for donor funds but also for the recurrent departmental charges financed by GRZ. At present, salaries are paid directly and most drugs are supplied from the centre. Districts do, however, have the authority to purchase additional medicines from fee income and to use a small proportion (5%) of the government grant for this purpose. Facilities and other capital assets are still formally owned by Government and there is no intention as of now that ownership will be transferred to the Boards when they are fully established. The block grant provided to districts is not divided into capital and recurrent expenditure. Instead, the MOH guidelines specify that districts can spend up to 10% of the grant on capital items and is the same to hospitals. The idea behind this strategy is that it gives districts the autonomy to purchase necessary equipment without being subject to the controls over capital expenditure imposed by the MOF. Central and other hospital management teams also have the authority to contract out services to private providers through the Tender Board.

Mission Health Services

The government provides substantial financial support to missionary organisation throughout the country. Although no definitive figure is available, it is likely that government funding constitutes something in the order of 50% of their running costs.

Until 1993, funds were channelled as a single block grant to the Christian Medical Association of Zambia (CMAZ), who then divided the funds between member organisations. In line with the idea that all recurrent funds would be channelled through the districts, the MOH decided in 1994 that the CMAZ subvention would go directly to the districts, and that they in turn would disburse the money to mission hospitals and health centres in their area. Unfortunately, the districts were not provided with the necessary instructions as to how funds were to be allocated and as a result, several missionary organisations, particularly those operating health centres, did not receive their funds. After a series of negotiations which aimed to clarify the situation, the original decision was over-turned by the Minister, and in 1995 CMAZ once again received an overall block grant.

The 1995 annual meeting of CMAZ member organisations reaffirmed their support for the reform process and it is likely the a new funding mechanism, whereby a proportion of mission running costs will be controlled by the districts, will be agreed. However, it is clear that while CMAZ is able to insist that government funding for mission hospitals remains specifically earmarked and thus protected from reallocation -it will be difficult for districts, in which there is excess hospital capacity, to rationalise services and to prepare comprehensive facility plans.

Policy formulation process

It is possible to identify at least three sets of factors which have influenced decentralisation policy and the design of the health reforms. Firstly, frustration with the previous system of provincial administration. From 1990 until the introduction of the reforms, funds for health from the government budget were provided under separate votes for Ministry of Health headquarters, four national health institutions, and as sub-heads for each Provincial Medical Officer (PMO) under the general vote for each Province. Provincial funds for all sectors were passed to the Provincial Accounting Control Unit (PACU), and from PACU to the PMO's office. Resource allocation to districts followed no set procedures. As the PMO was the spending officer for district health care, district officials had to raise vouchers for any expenditure for approval by the PMO. Apart from the delay involved and the arbitrary nature of the approval process, this meant that districts had no clear idea of the resources available to them, and had no experience in the preparation of budgets or in accounting for expenditure. Not only were districts starved of resources, the process was perceived as unfair and thus further contributed to low morale. The situation was not improved by the fact that Provincial Medical Offices felt that they, in turn, were unjustly treated by the PACU.

The original authors of the health reform policy were keen to downgrade provincial involvement, with some going as far as to suggest that the PMO's office be abolished completely. Whilst this radical view did not prevail, it was clear that decentralisation would need to be designed in order to give districts far more control over human and financial resources than had previously been the case. Furthermore, given the limited credibility of local government, it was necessary for the architects of the reform process to design their own system for ensuring public accountability.

The Health Reforms were designed at a time when thinking about the role of the state was changing, particularly in relation to the provision of health care. The authors of the reforms were therefore able to draw on a broader range of international experience, notably from Europe and the Scandinavian Countries, than would have been the case had the reforms been introduced in the mid 1980s. The second major influence then, is the introduction of market-oriented or contractual mechanisms as a means of achieving equity and efficiency objectives, in place of traditional bureaucratic controls.

Thirdly, a great deal of thought about the need for and form of decentralisation had taken place prior to the 1991 election. The health sector was therefore, ready for change at a time when formulation of the overall Public Sector Reform Programme was only in its early stages. The political importance of making rapid and substantive improvements in the health sector smoothed the way for the Ministry of Health to move ahead with its own plans independently from the rest of government.

Opposition to the policy of decentralisation at it was originally designed was expected from two main sources: officials at central and provincial level, whose positions would be threatened by the changes; and politicians at the national level, who, because of the power invested in the Health Boards, would no longer have the same personal influence over the allocation of resources within the system. This explains also why the National Health Service Act No. 22 has still vested a lot of power in the Minister of Health in the appointment of board members and directors of boards. These factors have inevitably influenced the actual form that decentralisation will take. However, the key point to emphasis is the importance, and manifest success, of the public relations effort mounted by the promoters of the reform. Having set out the basic strategy, a great deal of energy has been, and continues to be, invested in explaining the reforms to the public, to health workers at all levels, to politicians (from the Government and opposition), to other concerned ministries and to donor agencies.

In contrast to many other countries, where donor agencies have been a major influence behind the introduction of decentralisation in the health sector, this is not the case in Zambia. Donors have provided financial and technical support to a policy, which is largely home-grown.

DECENTRALISATION IN UGANDA

Extracted from: Okuonzi S. and Lubanga F. *Decentralisation and Health System Change in Uganda*. Case study prepared as part of the WHO multi-country study on decentralisation and health system change (1995)

Country experience reported until 1995

BACKGROUND: RATIONALE AND POLICY FORMULATION

The Country

Uganda is located at the heart of Africa astride the equator. It covers a total area of 241,031 km with a population of about 19.3 million. Nearly 90% of this population is rural. Aggregate development indicators are poor. IMR is 122 per 1000 live births and MMR is estimated at 550 per 100,000 births. Life expectancy at birth is estimated variably at between 43 and 47 years. Only about 50% of the population is within 5km radius or one hour's walk from a health facility.

Per capita GDP is only about US dollars 180 although the economy has been improving since 1986. It has been growing at a rate of 6% per annum. Inflation has largely been controlled through economic recovery, stabilization and structural adjustment measures. The government has rebuilt a large part of the shattered infrastructure it inherited in 1986. But spending on health has remained low: public sector spending (including external aid) was US dollars 2.82 per capita while that of the private sector was US dollars 4.91 per capita in 1992/93. Total health spending of US dollars 7 per capita is significantly lower than the average for developing countries (of US dollars 12 per capita per year).

Administratively, the country is divided into 39 districts with populations ranging between 20,000 to 1, 000, 000. Each district is divided into 3 to 8 countries. Two **districts**, Kiboga and Kisoro, are however one-county districts although we were told that Kiboga would soon be divided into two counties. A county is subdivided into five subcounties on average. A subcounty has a population of between 15,000 to 30,000. A subcounty is made up of parishes, and a parish of villages. Each of these administrative units - from village to national level - is the political responsibility of an elected council, locally known as a Resistance Council (RC).

Overall Government Policy Framework

When the NRM came to power in 1986, it inherited a country that had been reduced to extreme poverty through destruction of infrastructure, corruption and mismanagement over the previous twenty years. Since 1987, the government has directed its efforts to four main areas: consolidation of peace and stability which are conditions necessary for development; rebuilding public infrastructure; promoting private sector growth, and political liberalisation (institutional political reform, democratisation and decentralisation).

There are four related but concurrent reform initiatives which have affected the organisational and institutional **development** in the health sector.

- a) liberalization and privatization;
- b) constitutional reform to democratise the national political system and provide a new legal framework for the country;

- c) decentralisation of power, functions and resources to local governments, leading to the empowerment of local communities;
- d) civil service reform to raise the efficiency and effectiveness of public administration.

Main Features of the Decentralisation Policy

Policy Content

The decentralisation policy in Uganda seeks to transfer certain functions, powers, responsibilities, resources and competence from central government to local governments, and from higher local government councils to lower councils in order that decisions are made as close as possible to where services are delivered. In particular, it seeks to transfer political, administrative, financial, personnel and planning authority from the centre to the District and Urban Resistance Councils.

Policy Objectives

The policy has five objectives, namely:

- to transfer real power to districts and thus reduce the load of work on remote and under resourced central officials;
- to bring political and administrative control over services to the point where they are actually delivered, thereby improving accountability and effectiveness, and promoting peoples feeling of ownership of programmes and projects executed in their districts;
- to free local managers from central constraints and, as a long term goal, allow them develop organisational structures tailored to local circumstances;
- to improve financial accountability and responsibility by establishing a clear link between the payment of taxes and the provision of services they finance;
- to improve the capacity of local councils to plan, finance and manage the delivery of services of their constituents.

Centre-local relationship

The centre retains responsibility for inter-alia arms, defence, banks, currency, taxation of income, citizenship, migration, copyrights, monuments, public records, justice, higher education, hospitals, making and enforcing national laws, and national planning. Other functions have been decentralized and the centre's role with regard to decentralized functions has been limited to issuing policies and regulations, setting standards, inspection and technical support. Local governments are responsible for primary education, primary health care, feeder roads and field services of decentralized departments/ministries. They also set levels of and charge fees for services and facilities provided, licenses and permits issued. They make bye-laws. The centre no longer has power to terminate the mandate of councillors or to dissolve local government councils. Accountability for transferred funds from the centre is made to local government councils. The councils are employers of all staff in devolved services.

Streams of Decentralisation

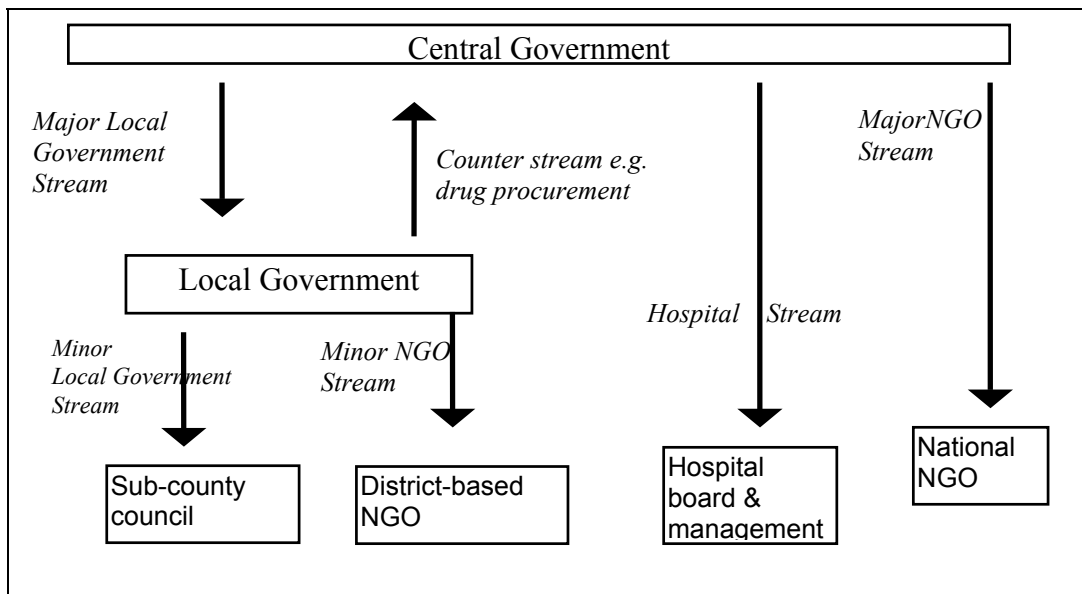
There are four streams/strands of decentralisation starting at different times, each with distinct features, namely:

- (i) The Local Government stream which transferred authority across sectors, to elected local governments. Implementation of new measures for devolution started in July 1993. Major features of the changes being the transfer of financial and personnel control to local governments and the increase in the latitude of autonomous decision making powers of local councils.

- (ii) The transfer of authority to District Health Teams. It was first initiated in 1987. This transferred managerial responsibilities to appointed health officials of local government hospitals and NGOs. It was meant to enhance horizontal coordination and optimisation of resource(s) utilisation. Although initiated by the Ministry of Health, the DHTs are seen as a Local Government reform features.
- (iii) The transfer of authority to Health Unit Management Committees. The initiatives in this area were launched in 1990. The HUMCs are composed of lay members. They are responsible for staff oversight, inspection and broad spending decisions at the health units. Although initiated by the MOH, HUMC's are now seen as LG bodies, accountable to the DRC through the District Council and Standing Committees on Health.
- (iv) The transfer of authority to non-governmental organisations, both by the centre and also by the district authorities. NGOs have taken on appreciable responsibility for service provision - both PHC and hospitals.

Figure 1 outlines the main streams of decentralisation, whilst the main functions of the key institutions involved in some way in public health care delivery are summarised in Table 1.

Figure 1: Streams of Decentralisation



| Table 1: Functions of key institutions | |
|---|--|
| Level/Institution | Key Functions |
| National Resistance Council | National legislation Approval of national budget |
| District Resistance Council | District policy District legislation Approval of budget and plan Coordination between sectors |
| District Development Committee | Elaboration of district development plan |
| District Health Team | Technical advisors to DHC Supervise health units and services, Implement health plans and policies |
| District Service Committee | Recruit, promote discipline and terminate Staff |
| District Tender Board | Tendering of goods and services |
| Hospital Board | Management of staff and other resources Budget and financial control Procurement of supplies Generation of income |
| Health Unit Management Committees (including district rural hospital management committees) | Staff discipline Responsible for equipment and supplies, Income generation, use and accountability of hospital finances, Link between staff and community |
| Subcounty Health Committees | Initiate, Co-ordinate and supervise community based health projects Supervise health units |
| Villages Health Committees | Identify health problems Initiate health action |

The main linkage between one council and another is through the representational hierarchy of the RC system. A higher council comprises of representatives (executive members) of a lower council. Hence, matters from a lower council are carried to a higher council and vice versa, by members who sit on both councils.

Policy Formulation Process

Reasons for Decentralisation

One reason for decentralizing has been historical: to restore, redefine and refine institutions and practices of local governance that existed in early 1960s when local governments were largely autonomous in decision making.

Another reason has been NRM's belief that people are able to govern themselves in peace and dignity, in pursuit of their collective well being once entrusted with their own destiny through popular democratic local institutions. The centre should only define laws, rules and regulations but vest power, resources and responsibilities to local councils.

Policy Conception and Initiation

Decentralisation was conceived by the NRA while waging a guerrilla war in the early 1980's. Initially, local councils (RCs) were set up to watch out for enemy reconnaissance. When vast areas had been liberated from the government control, these councils became responsible for law and order. When NRA took power in 1986's RCs were established countrywide. In 1987, the legal basis for RCs was provided for in a statute called The Resistance Councils and Committees Statute, 1987 hereafter referred to as the RC statute which empowered councils to exercise limited political control over public administration. In effect though, the councils could only act as watchdogs, and often toothless bulldogs.

By 1990, it had become evident that the application of the 1987 RC statute had only succeeded in raising political consciousness and promoting deconcentrated field administration, but had failed to effectively empower the people and to promote democratic local self-governance. The statute had two serious drawbacks: it did not sufficiently empower local councils to control funds disbursed in their districts nor control personnel working within their areas of jurisdiction.

Policy evolution

Fresh efforts were thus made to review the local government system to make it more democratic and effective. Policy proposals were discussed in seminars and workshops by policy-makers, politicians, experts, academics and other interest groups. In 1991, a memorandum proposing far-reaching reforms in the personnel and financial management systems, functions and new structures of local government was approved by Cabinet.

Following further debate and consideration in national fora, cabinet revised its earlier decisions and approved a number of changes, in 1993. The significant changes were as follows:

- each local government would have a separate personnel system with powers to hire and fire but, through an independent District Service Committees;
- financial transfers from the centre to local government for the recurrent budget would be by block and equalization grants based on objective criteria;
- the chairman of a DRC, the highest elected official in the district, would become the political head of a district instead of the CGR; and the DDC would consist of elected councillors, and would only be advised by technocrats.

Consequent upon the approval of those policy changes by Cabinet, the NRC (legislature) debated and passed the 1993 Local Governments (Resistance Councils) statute with amendments.

Stakeholder Analysis

With regard to decentralisation, six categories of stakeholders may be identified. The donors, central government civil servants, district administration staff, district professional personnel, district non -professional staff, national and district politicians. Table 2 presents the analysis.

| Table 2: Stakeholder analysis | |
|--------------------------------------|--|
| Stakeholders | Reactions to Decentralisation |
| Donors | Supported decentralisation because they were fed up with corruption and tardiness of the bureaucracy at the centre. Resources would not reach local governments. Donors supporting vertical programmes still want more control at the centre. Some do not approve of the block grants system. They prefer central government transfers earmarked programme by programme (vote system). |
| Central Civil Servants | Do not support decentralisation of loss of power and control over logistics and funds. |
| District Administration | Highly support decentralisation because they Staff have gained more control over professional staff, funds and logistics. And because of independence to decisions without frequent reference to the centre. |
| District Professional Staff | Mixed response: support decentralisation for increased access to resources and independence from the centre. But fear for promotional outlets and advancement. They do not trust local politicians. Also feared for possible whimsical management of the personnel function and victimisation. |
| District Non-professional Staff | Generally undecided about decentralisation. Did not see any immediate benefit. Many have been retrenched; those in service have insecure jobs. Retrenchment under the civil service reform was erroneously regarded as a decentralisation imperative. Others have gained through better payment from local financing initiatives. |
| National Politicians | Some support a federal system of government and heightened autonomy. Others support a certain degree of decentralisation preferring certain powers to remain at the centre. |
| District Politicians | Highly support decentralisation and prefer greater autonomy from the centre. |

DECENTRALISATION IN PAPUA NEW GUINEA

Extracted from: Axline W.A. 'Prologue to decentralisation: politics and administration. In Thomason J. A., Newbrander WC., and Kohlemainen-Aitken R-L (eds) *Decentralisation in a developing country: The experience of Papua New Guinea and its health service*. Pacific Research Monograph No. 25 Canberra: National Centre for Development Studies, Research School of Pacific Studies, The Australian National University

Country experience reported until the late 1980s

Introduction

Papua New Guinea is a country of almost 4 million people inhabiting an area of 462,840 square kilometres. It comprises a mainland territory, which occupies the eastern half of the Island of New Guinea, and a number of islands including the provinces of Manus, East New Britain, New Ireland and the North Solomons. Papua New Guinea is a 'young' country in the sense that it became independent from Australia only in 1975 and first contact between its indigenous peoples and outsiders was made more recently than nearly any other country in the world.

Only 1 per cent of the land in is of high agriculture potential with another 28 per cent being of moderate potential. Copra has been cultivated in plantations since the beginning of the European occupation. Coffee and cocoa plantations were developed after World War II. However, the main feature of the rural economy during the 1960s and 1970s was the development of smallholder plantations, so that now 75per cent of coffee production and more than 40 per cent of copra and cocoa come from smallholdings. This widespread cultivation of cash crops has resulted in the construction of a very good road network in the high-lands, with other roads on a more limited scale in various coastal areas. Larger plantations owned by communities or commercial bodies still exist, and these continue to be worked by migrant labourers, recruited from other parts of the country.

Since the mid-1970s, most of Papua New Guinea's foreign exchange earnings have come from gold and copper mining. Alluvial gold has been mined from different parts of the country since the beginning of the century, but the main source of income, until 1989, was the gold and copper mined at Panguna. The mine was forced to close in 1989 due to problems with landowners. Another large gold and copper mine at Ok Tedi and several other gold mines in the process of development should soon make Papua New Guinea one of the world's major producers of gold.

The educational system has greatly expanded since World War II. Adult literacy is estimated at 33 per cent, and more than 60 per cent of eligible children are enrolled at primary schools. However, less than 40 per cent complete primary school and only 16 per cent have the opportunity of going to secondary school. Papua New Guinea has a wide range of tertiary training institutions, and has largely succeeded in producing its own professional workforce.

The political institutions of Papua New Guinea take the form of the Westminster parliamentary system. The national parliament at Port Moresby has 109 members and the Queen of England, represented by the Governor-General, is Head of State.

Background to decentralization

Papua New Guinea embarked on a process of decentralization at a time when current development thinking emphasized self-reliance, more equitable distribution of wealth and greater political participation. It is not surprising then, that these aims are reflected in the existing decentralized system of government in Papua New Guinea and, being as ambitious as they were, that they would involve some conflicts and contradictions.

At independence in 1975, Papua New Guinea adopted a series of policies which, among other things, aimed to overcome two of the legacies of the colonial experience: the high degree of centralization of political and administrative power, and the great geographical inequality of wealth and distribution of government services within the country. These policies were embodied in the creation of a national planning system, with mechanisms for redressing spatial inequalities, and in the creation of a decentralized political system to provide a basis for wider participation in the political process.

The contradiction in these policies lay in the competition for control over the allocation of scarce resources necessary to effect any policy of spatial redistribution. If the national government retained this control, it could reallocate resources from the richer to the poorer areas. If resource allocation was transferred to provincial control as part of a process of decentralization, the means of redistribution would be denied to the central government.

The policy of decentralization that Papua New Guinea adopted was ambitious and led some analysts to argue that the government had denied itself the means to effect any significant redistribution, particularly as regards the delivery of government services.

The political context for decentralization

The conditions and impetus for decentralization came directly from the colonial heritage and post-colonial situation in Papua New Guinea. Australia's main concern during its United Nations trusteeship of the territories of Papua and New Guinea, was to maintain a buffer against potentially expansionist Asian nations, and there had been little attempt to settle the territory or to bring about economic development. Independence came very rapidly in 1975, with little planning or preparation. Out of this hasty transition to self-government and political independence emerged a new entity with all the formal trappings of a sovereign state, but lacking the underpinnings of a functioning political system. The new nation of Papua New Guinea faced the challenge of effecting major political and administrative changes over a relatively short period of time.

With independence came the formal transfer of power to the State of Papua New Guinea, but this act in itself did not result in the creation of a working political system under indigenous control. It did represent the breaking of the highly centralized control of Canberra, but the greater tasks of Papua New Guineans assuming control over a large and pervasive bureaucracy, bringing this administrative structure under effective political direction, and moving away from the highly centralized bureaucratic structure which characterized Australian rule, still remained.

During the period of self-government from 1972-1975, some changes occurred, although the pattern of administration which had developed during colonial rule survived almost intact. The combination of a highly centralized, externally directed administrative structure, with heavy reliance on external resources and little meaningful local participation, was not easily or quickly changed. In the transition

from a colonial state which had served as an authoritarian and passive instrument of social control, to a post-colonial state that assumed the role of promoter of social and economic change, the bureaucracy emerged as the dominant political actor. The concentration of resources and skills that came from a long period of administrative rule permitted bureaucracy to participate effectively in, and, in many cases, to dominate all stages of the political process, from policy formulation to implementation. In addition, there had been no tradition of political participation in policy making, which placed politicians at a distinct disadvantage compared with bureaucrats who had greater skills, and were less fragmented. This disadvantage was reinforced by the absence of coherent political parties or interest groups around which political interests could coalesce. When formal authority was passed from Australia to Papua New Guinea, bureaucrats had well-developed habits of participating in the political process, and were able to exercise their powers within an already existing administrative structure. Politicians found themselves in an unfamiliar position within the newly created political institutions which had been drawn from an alien tradition. They had neither the practice nor the skills necessary to hold their own in political competition with the bureaucrats.

The process of bringing bureaucratic power under political control continues in Papua New Guinea today. It is conditioned by the fact that politicians are also preoccupied with the establishment and consolidation of their own political base, and they have to do this within the new decentralized structures through which political conflict is now channelled. The slow institutionalization of the political system was reflected in the lingering domination of technocratic administrators in policy formulation, many of whom were foreigners, and in the attempts by frustrated politicians to participate actively in policy implementation, especially where distribution of funds was involved.

The extreme cultural fragmentation and great physical diversity of Papua New Guinea, together with its relatively recent history of contact with outsiders, posed challenges to the development of a homogeneous political culture appropriate to the Western political institutions that had been introduced. In this fragmented diversity can be found a number of different regional styles of politics, ranging from peaceful, pragmatic and conciliatory through a more confrontational ideological and polarized style, to a violent aggressive individualism. The relatively high degree of political participation found at the local level was in contrast to the centralized system of authority exercised by kiaps (government administrative officers under the Australian administration) at the district level. The formal mechanism for bringing together the various elements of institutional reform was an electoral system based on universal adult suffrage.

The decision to proceed with political decentralization was taken within the broader context of all the preceding political changes: the creation of new political institutions; attempts to bring a dominant bureaucracy under effective political control; and provision of broader participation in the political process within a fragmented political culture.

The decision to create a decentralized system

The Constitution of Papua New Guinea was adopted after widespread consultation throughout the country, and after extensive study by a Constitutional Planning Committee. This committee recommended a decentralized form of government as a more appropriate structure for governing the wide diversity of people and cultures in Papua New Guinea.

The formal decision to create a decentralized political system in Papua New Guinea emerged from a variety of political factors: (1) the need to restructure the highly centralized colonial system of government and the desire to implement a broad set of national development goals, (ii) the need to unify the country under effective political control through a system that took into account the wide diversity and fragmentation of the society; and most immediately, (iii) the need to respond to micro-nationalist movements and threats to territorial integrity in the form of a secessionist attempt by the people of Bougainville.

The idea of decentralization for Papua New Guinea was not new. Some inquiries into the administrative reform of the 'kiap' system in the 1950's and 1960's had been concerned with effective administration at the district level. The possibility of giving institutional recognition to the existing disparities in political development had been discussed at the District Commissioners' Conference in 1969, and the Australian Prime Minister John Gorton proposed in 1970 that more substantial powers be devolved to regional or district authorities (Ballard 1981:96-8).

In 1972, a UNDP-commissioned team produced a report on development goals for Papua New Guinea which placed emphasis on self-reliance, development of local control, and decentralization of economic and political power. The eventual adoption of the 'Eight Aims' by the government included the commitment to decentralization in principle, a commitment that was followed by formal steps toward implementation. As part of the overall preparations for self-government and independence, a Constitutional Planning Committee (CPC) was established in 1972 to make recommendations on the eventual adoption of a national Constitution, including central/regional/local government relations and district administration. The CPC made its final report in 1974, and the principle entrenchment of provincial government in the Constitution was among their proposals. In a number of more economically and politically advanced districts, for example Bougainville, moves toward provincial government had already progressed significantly, and this was seen by some as a means to reconcile the demands for greater autonomy with the need to preserve national unity.

Some reticence was shown by the national government, however, partly because of a worry that decentralization would create overly powerful political centres in the provinces and reduce the possibility of redressing regional inequalities, and partly because of resistance on the part of national departments over a perceived domination of their powers. Growing controversy and increasing doubts led the government to delete the provision for provincial government from the Constitution in August 1975, and act which was shortly followed by the declaration of independence of Bougainville as the Republic of the North Solomons.

The crisis was eventually resolved with the conclusion of an agreement between the national government and Bougainville in August 1976. It spelt out the conditions under which powers would be transferred to the North Solomons Provincial Government, including the embodiment of these powers in an organic law. The principle of provincial government was to become entrenched in the Constitution, with the Bougainville Agreement providing the basis for the Organic Law on Provincial Government (OLPG) which spelt out the details of decentralization to be applied to all provincial governments in Papua New Guinea.

The role and function of provincial governments

Papua New Guinea is not a federal state, even though there are constituent units called provinces with extensive legislative and executive institutions which are

embodied in an organic law. It is more accurately described as a politically decentralized unitary system with clearly marked federal features (Committee of Review of the Financial Provisions of the Organic Law on Provincial Government 1982:49). The system was designed to provide for a strong central government with a significant role for provincial governments through the devolution of power.

The Organic Law on Provincial Government, provides for the distribution of powers between the central government and provincial governments. It gives provincial legislatures the power to make laws in three different categories: fields determined to be primarily provincial, fields where the legislative power is exercised concurrently with the national Parliament, and any other areas without national legislation, with certain limitations (OLPG section 20). Generally, the primary provincial powers include matters of a limited and local nature such as licensing, liquor control and primary schools, while the central government has exclusive powers in foreign affairs, defence and matters of national concern. The concurrent subjects represent virtually all the major areas of activity in which governments legislate in carrying out their task of governing society. These include education, health, transport, natural resources, land and commerce.

Provincial governments have a legislature with between 24 and 30 members, of whom 15 must be elected, half by direct elections, and others may be nominated (Papua New Guinea, Department of Decentralization [1977]). In practice, provincial governments have chosen direct elections as the rule for selecting members of the provincial Legislative Assembly. The Premier of each province can be elected indirectly, by the Legislative Assembly, or directly by all eligible voters in the province. In some provinces, the Deputy Premier is elected separately, which has caused problems for unified government control and stability where they are members of opposing factions.

The method of choosing the Provincial Executive Council (PEC) as well as the number of members of the Council, is determined by the provincial Constitution. Originally, the PEC was supposed to comprise no more than one-third of the membership of the legislative assembly, but in a number of provinces this rule has been ignored, with nearly the entire membership of the legislature holding a cabinet position in some area. This has occurred as a result of the need to obtain the support of a working majority (often an absolute majority) in a situation where neither political parties nor programmatic policies have provided a basis for organizing a stable coalition in support of the government.

Although provincial governments had the choice of organizing the PEC on the basis of portfolios or committees, all chose the former system, where each minister is responsible for a line division, in spite of arguments that their limited size made the committee more appropriate to their needs.

The various sources of funding for provincial governments are set out in the OLPG (section 53) and include the following: receipts from taxation imposed by provincial laws; grants from the national government; transferred national taxes; the proceeds of fees and charges collected under provincial laws; returns on, and proceeds of, investments; income from provincial government commercial enterprises; proceeds from short-term borrowings and loans from the national government; and such other moneys that are lawfully available to it under an Act of Parliament or a provincial law.

The principal source of funding for provincial governments takes the form of grants from the national government. The most important of these grants is the Minimum Unconditional Grant (MUG). Of all the provisions for financing provincial

governments, the MUG most clearly underpins the decentralization of political power, since it was designed to provide the basis for provincial governments to carry out successfully the activities transferred to them from the national government.

The formula for the MUG is set out in Schedule 1 of the OLPG, which requires the national government each year to pay provincial governments as unconditional grant adequate to permit the provincial government to maintain government services transferred to them at the level of spending in fiscal year 1976/77 (the base year). The grant is a 'minimum' grant in that the national government is obliged to pay no less than the amount determined by the formula fixed by the Organic Law. It is 'unconditional' in that no formal conditions are imposed on the provincial government with regard to the expenditure of the funds. The MUG is calculated using the mechanism of annual adjustment according to a formula designed to take into account increases in the cost of providing services and changes in the overall government revenue in Papua New Guinea. The first period of the MUG was the half fiscal year July to December 1977 (the fiscal year was adjusted to coincide with the calendar year in 1978), which then became the adjusted base year on which the formula was applied to calculate the MUG for the following year, and so on.

Conclusion

The relatively hasty transition from colonial rule to self government and independence, the inheritance of a highly centralized government system heavily reliant on external resources and with limited local participation, and the pressure of a number of micro-nationalist movements, all combined to complicate the process of political and administrative change. The assessment of decentralization will ultimately lie in an evaluation of the extent to which it has achieved its original goals. This requires a detailed analysis of the way in which provincial governments have been able to deliver services in the areas of responsibility transferred to them.

DECENTRALISATION IN MALI

Extracted from: Folz A., Ballo M.B., Naomory Traore M., Cisse H., Traore N. and Diakitie S. *Decentralisation and reforms in the health sector: the case of Mali*. Case study prepared as part of the WHO multi-country study on decentralisation and health system change (1996)

Reports on experience until 1995

THE CONTEXT FOR DECENTRALISATION

Political and Economic Background

The French colonial system inherited by the newly independent Malian state in 1960 was highly centralized. This provided the foundations for the new government to develop central planning under a socialist model. In 1968, the military government of Moussa Traore came to power in a coup d'état. This regime further reinforced the pattern of centralization, even whilst it shifted the governing ideological orientation. Traore ruled his one-party state with an iron hand and a fair disregard for human rights until 1991. The country then held a national convention, adopted a new constitution, held free elections in 1992, and installed a new government under the presidency of Alpha Oumar Konare.

Administratively, Mali is divided into six regions, with sub-units of 42 "cercles", and 279 "arrondissements". The constitution of 1960 had seen these as autonomous units, but authority and resources were never transferred. In contrast, some major cities had been given a modicum of deconcentrated rule, if not autonomy, when they were designated as communes as early as 1918 (Kayes and Bamako, the capital city). After 1954, the list expanded to include the cities of Segou, Mopti, and Sikasso and in 1977 Bamako was subdivided into six communes. Thus selected urban areas experienced some self-administration over the years whilst rural areas remained centrally administered.

However, the triple legacies of colonial administration, followed by a socialist state, followed by an oppressive one-party state converged to produce a highly centralized administrative framework, ill-suited to the country's stated new concerns for democracy, multi-parties, and a liberal economy. The new administration faced three major problems: first, how to continue to promote the democratic process that had begun during the transition to the new government; second, how to build confidence in the rule of law among a young population that had never experienced it in their lifetime; third, how to promote economic development through more liberal policies.

It chose to continue the process of democratization and to build confidence in the rule of law by decentralisation of both political and administrative structures. Instituted in 1993, this policy will be discussed in greater detail below.

Economic liberalization and development also presented challenges to the new government. At the behest of donors, Mali had introduced a structural adjustment program in 1988, the major objectives of which were to decrease the budget deficit markedly and to control fraud, particularly custom services' fraud. In 1994, Mali met or exceeded all its adjustment targets including meeting budgetary and debt targets, as well as the institution of policies that removed monopolies, price controls on agricultural products and privatized, reorganized, or eliminated formerly public enterprises. Rice and cotton production, textile manufacturing and the mining industry all flourished. These activities earned Mali a place among the few "success stories" of the international monetary fund's roster of "adjusting" countries. But these

achievements had, by 1995, not yet translated into economic relief for impoverished, particularly urban Malians and for the nearly 10,000 workers whose jobs vanished in the restructuring (with more expected as a result of civil service downsizing).

Health background

Despite the periods of drought and economic difficulties the health status of the Malian population changed little over time. For example, infant mortality estimates stayed within the range of 102 to 130 deaths per 1000 live births and malnutrition. But immunization rates remained low (less than 50 percent), while access to health services remains limited, particularly in rural areas.

Government expenditures for health represented a declining share of general government expenditure, falling from 8 percent in the late 1960s to less than 4 percent in the 1990s. This translates to a reduction in the real per capita health allocation (which fell from US\$3.7 in 1987 to \$2.8 in 1992). Foreign aid accounts for an increasing proportion of the health budget.

The Ministry of Health has built, maintains, supplies, and staffs most health institutions. These include three national hospitals, seven regional hospitals (one for each region and a network of health centers for each of the 46 cercles and the six communes of Bamako), as well as a network of dispensaries or maternities in the arrondissements. Some of the latter facilities were expected to function as general health centers (Centres de Sante d'Arrondissement or CSA). But by 1990 many hospitals and health centers functioned poorly. By September 1995, about 10 percent of arrondissement health centers had been revitalized with new or improved structures and equipment.

DECENTRALISATION

Background

For Malians decentralisation is not an idea of the 1990s but one that traces its origins back to the establishment of the first communes of Kayes and Bamako in 1918. It is an idea that has frequently resurfaced since and the country's experience can be characterised as a long inexorable process, inevitably (but agonizingly slowly), leading away from centralized colonial rule toward decentralisation. Since 1993, decentralisation has been right at the foreground of government policy.

Mali has experienced multiple streams of decentralisation. The major governmental stream is the process of territorial decentralisation. While the health sector is and will be affected by this territorial decentralisation, the health sector began its own activities, with at least three different streams which may also lead to decentralisation of health sector planning and management. These streams are: regional and district health planning; cost recovery/community health centers; and autonomy for selected government institutes and hospitals.

Across these streams decentralisation takes many meanings, ranging from devolution of administrative authority to sub-national authorities, to devolution of political power to sub-national authorities, to devolution of assets and management to private control. In recent years, the quest for decentralisation is closely linked to the quest for a multi-party democratic political system. The model for political decentralisation frequently cited by Malians is the United States. But this may not always be a helpful comparison, since that country began as 13 independent states which merged, while Mali is a unitary state attempting to establish sub-national entities.

In the discussions below the term “decentralisation” is used to denote any proposal or program or activity that shifts or attempts to shift power, authority, finances, or responsibility to sub-national units or to the private sector.

Territorial decentralisation

Mali has experienced two periods of territorial reform. This first starting in 1977; the second, in the 1990s. The reforms of 1977 marked the first serious attempt since independence to institute some degree of decentralisation and also provide the platform for initiatives in specific sectors, such as health, in the 1980s.

Territorial reforms of the 1970s and 1980s

The territorial reform of 1977 were codified in law, and gave each level of the existing administrative divisions new sets of responsibilities. Specifically, they divided the country into seven regions which were, in turn divided into cercles and these were then divided into arrondissements, and, finally, villages. The regions, cercles and arrondissements were designated as deconcentrated administrative units of the state, whilst the communes were designated as both a sub-unit of the state and as an autonomous entity with legal status.

The reforms of 1977 were designed to improve the planning capacity of the designated administrative units, by establishing regional and local development committees and councils, and by training administrative and elected personnel. These activities were again codified in regulations in 1981-1982 and amended by a law which specified, among other things, the manner in which development committees were selected and operated.

However, the implementation of these reforms was made the responsibility of the central Ministry of Territorial Administration which was the central administrative unit most threatened by the reforms. As it, therefore, had little interest in devolving power, little transfer of resources or responsibility took place.

The major legacy of the 1977 reforms was the creation of regional and local development committees and councils. From 1983 to 1986, training seminars were held for committee and council members throughout the county to support regions and localities in making their own development plans. A large number of Malians gained experience in planning through these seminars but the planning process did not become a decentralized administrative process in reality. Not only did the laws of 1977 create structures which maintained central control over the local level, but there was also political opposition to decentralisation.

Territorial reforms of the 1990s

Only after Moussa Traore was ousted in 1991 was decentralisation placed back on the political agenda. A consensus formed around the idea (perhaps reinforced by the break-up and reforms of the centralized states of Eastern Europe) that centralist states were failing. Some say the new government was anyway forced into a decentralisation policy because localities were seizing power. In any event, the 1992 constitution included provisions for decentralized territorial units. In January 1993, the new government issued a decree which created the ‘Mission de Decentralisation’ and gave it responsibility for assisting the Ministry of Territorial Administration to implement a decentralisation policy. In the next month the government issued a new law which laid out the framework for establishing decentralized regional and local structures. The aims of the decentralisation presented in documents were: extension of democracy; promotion of local development; creation of a framework for governance. Other objectives included the installation of a system of “transparent representation” capable of supporting individual and group development. Many saw

the goal of 'extending democracy' to mean challenging the power of the old regime who were still active in some areas.

Originally planned with a one year existence, the mandate of the Mission de Decentralisation was extended for three years (until the end of 1996) to give it more time and responsibility for implementing the reforms. More importantly, the mission was detached from the Ministry of Territorial Administration which had in the past shown itself reluctant to decentralize, and attached instead to the prime minister's office. This gave it status, access to and support from the highest levels of government.

When the decentralisation process is complete Mali will have a new political and administrative organization, with autonomous communes grouped into cercles, grouped in turn into regions. These new structures are accorded legal status to function as recognized civil entities able to levy taxes, spend, and enter into contracts. Arrondissements are eliminated as a level of government. These reforms will significantly alter existing territorial boundaries and undermine existing political alliances within those boundaries. Mali is reinventing its political and administrative system from the bottom up. It is a bold, daring, and unusual enterprise.

By September 1995, the decentralisation process was moving steadily, if slowly. In all regions, regional and local "groupements" had been formed to provide fora for discussing guidelines provided by the Mission de Decentralisation, and criteria for the creation of new communes (including lists of villages with their population and growth rates). Demarcation decisions lie, finally, with local commissions. Once the communes are delineated, elections will be held to elect councils and a mayor through proportional balloting. To constrain the excessive fragmentation that might result from allowing regional and local parties, the government requires that all candidates for elections must represent national parties. There is a danger that national party control could undermine local autonomy.

The process that Mali has implemented can be described as political decentralisation, with the expectation that administrative decentralisation will follow in its wake. However, while political decentralisation was well underway by mid-1995, administrative decentralisation was not. The Ministry of Territorial Administration had not yet responded to the Mission de Decentralisation's request to begin discussion on, and to present proposals for, administrative reforms.

Donors provided encouragement for decentralisation in the form of technical advice and large aid and loan packages, setting aside US\$6.5 million by 1995.

Health sector decentralisation

Three major forms of decentralisation can be identified in the health sector: regional and district health planning and administration; cost-recovery through autonomous, community-managed health centers; establishing the autonomy of public institutions, such as hospitals and institutes.

Regional and district health planning reforms of the 1980s

Both the territorial reforms of 1977-79 and the 1978 Alma Ata declaration provided a platform for early health sector decentralisation initiatives rooted in the belief that primary care would be easier to promote and administer from the regions and localities than from the center. The formally stated objectives of these initiatives were:

- to improve planning for the implementation of health for all by the year 2000,
- to guarantee geographic and economic access to all for health care;

- to lay the legal basis to permit cost-recovery and thereby encourage public participation;
- to mobilize additional resources in health and improve health services.

They were codified in a series of laws and decrees in 1980-81 which restructured the central ministry, created regional and local councils and committees, and added, at all levels, coordinating committees for health and social services.

Between 1983 and 1985, regional and cercle health staff received training in health planning and regions and lower levels then developed annual plans. These activities could be viewed, in part, as an early attempt to institute the district health system later promoted by the WHO.

Regional coordinating committees operated under the national committee and became inactive when that body stopped functioning (it held no meetings between 1986 and 1992). Nevertheless, manager say that this attempt at decentralisation provided, for the first time, the opportunity for the different levels of the health system to communicate with one another and gave regional and district officials experience in developing plans.

The district management committees were composed of representatives from the political party and from women's and youth groups. They were the administrative unit which set policies for publicly-run health centers whilst the technical committees, chaired by the chief physician and composed of health center staff, were the implementing arm. These health centers were permitted to purchase and sell essential drugs to the population, gaining some financial independence through the collection of fees. However, despite the requirement that the management committee members represent the community, there was little community input in these centers. The objective of public participation in management, for the most part, was not achieved.

The major hospitals also became the targets of reform. They were permitted to retain fee revenue for their own expenditure and were given more flexibility in managing their budgets. Nonetheless, the Ministry of Health still made all decisions about personnel, investment and overall hospital budget levels.

Ministry officials were later to say that these reforms represented, at best, a form of deconcentrated administration. They were also worried that the policy was driven more by the need to have an essential drug policy (as promoted by the donors, particularly WHO) than by the need to meet other objectives, such as improving quality of care and access for the population. After 1984, central government and consequently Ministry of Health interest in deconcentration in the health sector waned. Some said they wanted to take stock of the experience, others said that too many central government officials were simply not interested in continuing the experiment. However, some of the experiences were picked up again under later reforms whilst, in some areas, the committees established continued to function.

Autonomous community health centers (CSCOM)

The community health center movement grew out of earlier experiences which had demonstrated that populations were willing to pay for their drugs and for health services, and from the experiences of the local management committees that demonstrated that local management was possible. The community health centers became known as CSCOM (centres de sante communautaire).

Theoretically the publicly-run health centers of the 1980s with their management committees and technical committees had some autonomy from the Ministry of Health (they could keep some of the revenues they collected from fees and from the sale of drugs). Nevertheless, their budgets and expenditures were closely reviewed and set by the Ministry. It also allocated their equipment, infrastructure, and personnel. Moreover, within their local areas, the management committees exerted no control over the activities of vertical programs, such as immunization, family planning disease control, and aids, even when these activities took place within their health centres.

Two activities in the late 1980s set in motion the further development of community health centers. The first was the creation of autonomous urban health centers, which were not under government ownership, management or financing. These health centers were managed by a community board, albeit with approval from the communal authorities (mayor and chief physician). The second development was the creation/ renewal of community health centers in the public sector. These became the focus of a major joint donor-funded project, led by the World Bank Project Sante Population et Hydraulique Rurale (PSPHR).

Both developments benefited from new policies announced by the Health Ministry policy in December 1990, with the objectives of: strengthening the administration of health care services; assuring the availability of drugs; reinforcing community participation in system management and guaranteeing access; and mobilizing all resources, including cost-recovery in health facilities. These objectives were also supported by the stipulation that financing of the PSPHR project would be available to communities only with the following conditions:

- establishment of health team with two physicians in every cercle;
- existence of a CSCOM functioning according to acceptable norms of technical and financial performance;
- commitment of communities to contribute financially or in-kind at least 50 percent of the financing for rehabilitating or constructing CSCOM;
- commitment of the local development committee to spend at least 7 percent of its receipts from local taxes on health;
- assistance of the regional directions to satisfy these conditions.

Government officials signed this policy declaration in December 1990, in Washington, D.C. and some appear to suggest that it may have been signed under donor duress.

The first autonomous urban health center in the Bamako district of Banconi, opened its doors in 1989. What distinguished it from previous "community health centers" was that it was not a government facility with a community board added, nor was it a pilot donor project, nor was it a privately managed center. Banconi's community health association, known as Asacoba, nevertheless, did receive initial financial and technical support from donors, particularly from French bilateral aid. This support was phased out by 1994, leaving the center operating comfortably on the basis of revenue from user fees and the sale of drugs.

A management committee ran the health center responsible to an administrative council whose authority had been conferred by a general assembly of the population in the catchment area. The center hired its own staff and owned its equipment. Serving a catchment area of about 70,000 persons, the health center was well equipped and provided preventive and curative services, as well or better than most public or private centers in Bamako. By 1994, its staff of three physicians, two midwives, four nurses and other was providing over 23, 000 consultations yearly.

The high utilization rates were due in part to its location in the center of its catchment area and in part to the good reputation it achieved among the population.

Asacoba became a model for other community health centers, and by the end of 1994, there were at least 25 such community health centers operating in Bamako. In most cases, these centers provided adequate health services to the population. Most after a few years, were able to maintain a positive balance sheet, though usually with continued subsidies.

Autonomy of health institutions: hospitals and institutions.

By 1992, the three national hospitals had been designated as public institutions with financial autonomy, capable of making contracts, contracting, debts, etc, under law no. 90-110. They received all their existing resources (structure and equipment) from the state and took on responsibility for the management and financing of their institutions. However, the transfer of autonomy was incomplete as the laws governing the status of the hospital personnel were never passed. Some suggested this was due to a fear of the labour unions which had sided with the medical staff who did not want to be detached from the civil service. As a result, the status of the staff, whether they remained civil servants, whether they were employed by their respective institutions, whether their salaries were to come from the state or from the institution, was not made clear at the time the autonomy of the hospitals was determined. In addition, the hospitals could not hire or fire their staff, undermining their overall level of autonomy.

CONCLUSIONS

As Mali is in the early stages of both territorial and a health sector decentralisation it remains unclear what effects these processes will have. Its experience does, however, raise some issues that need further consideration.

Issues/concerns/conflicts in the Mali decentralisation process

1. In implementing its political decentralisation before designing administrative decentralisation the Mali government left a large number of issues to be resolved along the way. Administrative reorganization was sidelined while the more immediate political issues were attended to.

For example, the decision to start decentralizing from the bottom up, with the creation of communes, made sense from the political point of view. However, it made it difficult to discuss the transfer of responsibilities to different administrative layers and generated concern that such a piecemeal process would not produce an appropriate reallocation of administrative responsibilities.

The relationship among the different levels (commune, cercle, and region) was also unclear. Some said there was no hierarchy among them but others were concerned that certain functions would not be coordinated if there were no hierarchy. The relationship of the central state to the communes, cercles, and regions also remained uncertain. Finally, whilst civil service personnel were only to be transferred from the centre to the newly decentralized units at a later stage, there was concern that, in the health sector at least, this transfer would be resisted by professionals and labor unions.

2. The relationship between territorial decentralisation and the health sector's three streams of decentralisation was also quite unclear. Two of the health streams, district health planning and hospital autonomy, could be adapted

quite easily to the structures of the new territorial decentralisation. Districts could become the new cercles although further clarification was needed about the extent of their responsibility for planning and supervisory functions. Hospitals, whether national or regional could also develop relationships with their respective governmental levels.

A more difficult issue was the future of CSCOMs. First, many existing CSCOM health areas straddle communes or may straddle future communes as their catchment areas were drawn to meet logical health planning criteria, rather than responding to political needs. What happens to existing CSCOM that straddle communes? Do they serve only one commune or do they serve two or three communes and what community, then, does the community association represent?

Second, the legal status of CSCOM will have to change. Under present law. CSCOM operate with the approval of local authorities, with a contract with the Ministry of Health. Once communes are created throughout the country, will communes be the legal entities required to approve the establishment, functioning, and closing of CSCOM? Will communes have the capacity to do so and assure that CSCOM are meeting standards of care as well as financial viability?

Third, if the communes take on the legal authority to approve CSCOM within their jurisdictions why will a community with elected leaders also need community health associations that hold general assemblies and elections? Should each sector hold its own elections to manage its own activities in a commune? And if the CSCOMs are recognized as non-governmental organizations, as some of those in Bamako are, do they still need to follow the criteria for CSCOM as stated in existing laws? If so, who will enforce the regulations? The communes or the national government?

The fourth concern arose before the current territorial decentralisation but remains important. Who becomes responsible for public health under the new dispensation? If the communes are made responsible for immunizations, the cold chain, tuberculosis, leprosy, sanitation, and water supplies, what is their capacity to finance, manage, and regulate these formerly vertical programs of the Ministry of Health. Where will communes find support for these activities: from the cercle, region, or the central ministry?

Finally, many have asked how communes will finance these activities. While seven percent of its funds are required by law to be set aside for health, more clarification is needed about how to use these funds: are they for public health? research? health services? salaries? drugs? investment? And whose responsibility is it, communes or cercles or regions to assure that health centers are financially viable and functioning appropriately?

3. Donors have played an important role in the decentralisation process. Whilst they are seen as having been very supportive to Malian needs for support to carry out the territorial decentralisation reforms, they are seen to have promoted their own agendas in relation to health sector reform. Despite the Ministry of Health's formal commitment to the policies of cost-recovery, community health centers, and many related reforms, there remains concern about how these will work in practice - particularly in the new environment of territorial decentralisation.

Hypotheses/observations about the decentralisation process

1. *Political and administrative control:* in one-party states political and administrative control are combined. When a country, such as Mali, seeks to move away from the one-party orientation then it may make sense to start with political decentralisation if any political power is to be devolved to sub-national levels. Mali's choice is bold, but Mali's leaders will need considerable help in dealing with the administrative fall-out from the political decentralisation.
2. *Competing objectives for decentralisation:* The diverse objectives established for decentralisation in Mali include, as a minimum: democracy; local autonomy at sub-national levels; local participation in health services (assuming that the local interest would be to promote health and health services which, in turn, would promote better management, more transparency, and more efficient services); promoting the financial viability of health centers through drug sales and fees; creating or extending the private or non-governmental sector to promote efficiency and equity and to improve access. The range of objectives may offer something for everyone and therefore garner good support for decentralisation; however, too many objectives may ultimately kill expectations and so the overall process.

Moreover, many of these objectives compete. For example, private and non-governmental health centers are much less concerned with equity than governmental ones (thus only one of the Bamako CSCOM had a policy of providing free care to indigents). This suggests that multiple demands and expectations were being laid on an implementation process that was uncertain and fragile.

3. *Many types of decentralisation:* The range and diversity of the decentralisation processes being undertaken simultaneously was itself confusing to those involved in them. They included: within central government; from central government to sub-national units; from the Ministry of Health to hospitals; from the Ministry of Health to community health centers; from the Ministry of Health to private centers. Each form type requires a legal framework and regulatory structure but planning this environment, let alone implementing it, is inevitably difficult given the number of different types of decentralisation.
4. *Order of implementing decentralisation:* As noted, Mali began by creating a new political framework with its own legal and regulatory basis. It is difficult to know the best order to implement the other activities required to develop decentralisation. These include: a legal and regulatory framework for administration; transfer of personnel; transfer of funds and control of funds; reallocation of functions among levels of government; redesign of information systems; training for new responsibilities at all level. It is important to see look at other countries' experience in this regard.
5. *Resistance to decentralisation:* Given the range of interests likely to be affected by the process, resistance to decentralisation can come from many sources. In Mali, unlike some other countries, not only did the party in power promote decentralisation strongly but the major opposition parties also supported it. In contrast, labour unions, and particularly professionals, voiced opposition. But the balance of support and opposition varied between decentralisation types. By 1995 territorial decentralisation had met fairly low

resistance and the national consensus around these activities was high. That consensus may decline as the outcomes of political struggles emerge. Resistance to health sector decentralisation appeared much higher because the rationale for rallying a community around health was not clear. The reforms were also perceived as donor-driven, rather than as a Malian response to a Malian problem.