Thesis Title

Decentralisation and Health Service Governance in Zambia

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For my daughters:

Lukundo, Winzile and Chiiluba.

Declaration

I certify that this thesis submitted for the degree of Doctor of Philosophy is the result of my own research, except where otherwise acknowledged. No portion of the work presented in this thesis has been submitted for another degree or qualification to this, or any other, university or institution.

Chishimba Nakamba Mulambia

Abstract

Decentralisation is a tool that's advocated for to govern health services by academic literature and development agencies. Its popularity stems from the notion that decentralisation increases local capacity by delivering efficient administrative and decision-making systems. Advocates of decentralisation further postulate that decentralisation allows for government to be closer to the people and is, therefore, a more responsive tool in improving delivery of social services and addressing poverty at local levels. Despite its popularity, critics of decentralisation often suggest that its success is dependent on the type of decentralisation that is implemented in specific contexts and how the implementation strategies relate to in-country institutional arrangements and capacities. In spite of its critics, decentralisation has over the years continued to dominate the development agenda in both developing and developed countries, especially in the health sector. In Zambia, since 1992 governments have implemented health sector decentralisation with varying degrees of success.

Therefore, this thesis seeks to examine why and how health sector decentralisation has been implemented in Zambia since 1992. Drawing on conceptual literature and historical understandings of decentralisation processes, the research uses the health policy triangle framework (HPTF) developed by Walt and Gilson (1994); to understand the content, context, processes and actors involved in Zambian national decentralisation processes between 1992 and 2018. The thesis uses two specific examples of decentralisation processes – the health reforms of 1992 to 2006; and the devolution agenda that started in 2002 to date.

Based on textual analysis of policy documents and on qualitative field research conducted in Zambia between February 2018 and August 2018 – forty-three (43) interviews conducted in total - the thesis makes contributions through a number of original insights and conclusions related to the practice of decentralisation for health service governance in Zambia. First, it shows how policy ideas come to the forefront of policy agenda and how and why these ideas come to be widely accepted in local policy practice in Zambia. Second, it locates the ensemble of actors and how they come to interpret policy ideas. Third, it demonstrates how actors' interactions shape policy interpretation and implementation. Lastly, it shows how international policy agenda engulfs local policy practice in Zambia and how the conglomerate of international ideas, ideologies and actors plays out within the Zambian context.

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I would like to start with thanking my supervisors Simon Rushton and Muhammad Saddiq for the relentless encouragement that this was doable. To Simon, thank you so much for the encouragement even when the days were at the darkest, when I felt it was impossible to carry on, you still believed and encouraged me that I could do it. I will forever remember the support rendered and I shall go out to do to others as you have done unto me. To Garrett Brown, thank you so much for your leadership in getting the original thoughts together and for having left me in the hands of intelligent and talented leadership to carry on with the supervision. Thank you to all the staff at the University of Sheffield, Department of Politics and International Relations.

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And most sincerely I would like to thank the Commonwealth Scholarships Commission, the Government of the Republic of Zambia and the University of Zambia for having provided financial support to conduct the study. I do hope that the study will provide useful policy guidance to developing health systems in Zambia especially amid the unprecedented Covid-19 outbreak. I lost loved ones, family and friends to Covid-19 and for me, it continues to be a frightening moment and an awakening call that a strengthened Zambian health system is required to effectively respond to global pandemics.

And lastly, I would like to say that "*Uwingila mumushitu ala tomfwa inswanswa".* Bemba Proverb - "*One who embarks on accomplishing a difficult task should not be discouraged by minor setbacks*".

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CATF	Community AIDS Task Force
CBoH	Central Board of Health
CPs	Co-operating Partners
CRAIDS	Community Response to HIV/AIDS
DACA	District AIDS Coordinating Advisor
DATF	District AIDS Task Force
DDCC	District Development Coordinating Committee
DFID	United Kingdom Department for International Development
DHO	District Health Office
DIP	Decentralisation Implementation Plan
D4D	Decentralisation for Development
FAMS	Financial Administrative Management System
GIZ	German Gesellschaft für Internationale Zusammenarbeit
HCCS	Health Care Costs Schemes
HMIS	Health Management Information System
HPTF	Health Policy Triangle Framework
HSDP	Health Sector Devolution Plan
INESOR	University of Zambia – Institute of Economic &Social Research
LGC	Local Government Commission
MAP	Multi-Country AIDS Strategic Framework
MCDMCH	Ministry of Community Development Mother and Child Health
MCDSS	Ministry of Community Development and Social Services
MLGH	Ministry of Local Government and Housing
MMD	Movement for Multi-Party Democracy
MoH	Ministry of Health
MSL	Medical Stores Limited
NAC	National AIDS Council
NASF	National AIDS Strategic Framework
NDP	National Decentralisation Plan
NHC	Neighbourhood Health Committee
NHSP	National Health Strategic Plan
PATF	Provincial AIDS Task Force
PDCC	Provincial Development Coordinating Committees
PF	Patriotic Front
PHC	Primary Health Care
PHO	Provincial Health Office
PMRC	Policy Monitoring and Research Centre
RAF	Resource Allocation Formula
SDAP	Sector Devolution Action Plan
SWAp	Sector-Wide Approach
UNDP	United Nations Development Programme
UNIP	United National independence Party
UNZA	University of Zambia
WB	World Bank
WDC	Ward Development Committee

WHO	World Health Organisation
ZANARA	Zambia National Response to HIV/AIDS
ZNAN	Zambian National AIDS Network

Chapter One

Why decentralisation and health governance in Zambia

Overview

Introduces the Research topic - Decentralisation and Health Service Governance

Establishes the importance of conducting the study

States the research question and explains the methods used to address the research question

Discusses the issues raised in addressing the research questions

Provides justifications of the importance of the study to the Zambian health sector and health sectors in developing countries

Explains the theoretical and practical benefits of the study – the importance of the study to academic inquiry and policy implementation in Zambia

Introduction

Decentralisation is a concept that has come to be widely linked with democratisation and development in developing countries (Olowu, 2003; Smoke, 2003). Although ideas of decentralisation have a long history rooted in attempts to push back the dominance of central government in administrative, political and fiscal control (See Fesler, 1965, Treisman, 2006), in recent years it has been promoted as a public sector reform policy that can promote good governance, improve the delivery of public services, and enhance public management and accountability (See Mills, 1990; Conyers, 2003; Smoke 2003, Brinkerhoff, 2004). Decentralisation is believed to deliver a number of benefits - and thus its adoption by developing countries has been widely supported by bilateral and multilateral agencies (Crook 2003, Ribot, 2003). Yet, in practice, decentralisation has often failed to yield the expected results (see Mills, 1990; Prud'homme, 1995). This has led to debates among academics and practitioners on the value of implementing decentralisation, and the recognition that, even though it may offer substantial benefits in theory, in practice the success of decentralisation can be challenged by domestic politics, structural constraints, and bureaucratic (under)performance (Smoke, 2015).

For most sub-Saharan African (SSA) countries, decentralisation has been pushed by reformers (politicians, academics, practitioners, multilateral and bilateral development agencies) with the belief that it has the potential to transform public institutions and build systems that are more responsive to people's needs and foster public accountability, which is often seen as lacking - and which in turn is seen as an impediment to economic growth (cf. Brinkerhoff and Goldsmith, 2002). These beliefs were popularised as a result of the political-economic environment in the late 1980s, when most sub-Saharan African countries were deemed to have poor governance structures that were blamed for economic underperformance and poor service delivery (Van de Walle, 2001a). Admittedly, most sub-Saharan African countries were characterised by poor health indicators, low investments in the health sector, and generally weak institutional capacities to manage health services (see, Baylies and Szefel, 1992; Kalumba, 1997; Van de Walle, 1999; Burnell, 2001). In addition, most of the developing countries in SSA in the late 1980's were governed by authoritarian regimes that had tight control on resources with poor accountability and widespread corruption (see, Van de Walle, 1999). Therefore, reforms in which decentralisation policies were embedded were employed as part of structural reforms in an attempt to create better organised regulatory frameworks, rules and procedures and strengthened institutional capacities (Van de Walle, 1999). The intention of the reforms was to reduce the role of the state (central governments) in economic and social activities (cf. Baylies and Szeftel, 1992).

Nonetheless, the implementation of reforms did very little to achieve good governance, let alone improve service delivery. By 2000, policy discussions emerged focussing on attempting to understand the failure of decentralisation policies in SSA contexts (see Brinkerhoff and Goldsmith, 2002). Most stated that the failures of decentralisation policies in SSA were due to failures of implementation (Burnell, 2001; Brinkerhoff and Goldsmith, 2002) rather than any deficiency in the idea of decentralisation itself. In the health sector (the focus of this thesis), it was widely noted that the stated benefits of health sector decentralisation were not automatic and guaranteed, with most literature advocating for the generation of thorough theoretical and practical evidence that could improve the chances of health sector decentralisation achieving the desired outcomes (Conyers, 2007).

Despite the doubts expressed in the literature with regards to whether decentralisation (in general, and in the health sector specifically) is beneficial in practice or not, decentralisation policies continue to be implemented across the world. Most African nations, and many international development partners, continue to see it as a key development policy tool (see, Hartmann and Crawford, 2008). Zambia – the focus of this thesis – is no exception. As this thesis goes on to explore, over recent decades, successive Zambian governments have promised to implement health sector decentralisation – and have done so with varying degrees of success. But in the case of Zambia – as in many other African countries who have pursued such a path – there has been little detailed empirical research on the factors that

have affected the success (or otherwise) of decentralisation efforts. Instead, the debates in the literature have often operated at a high level of generalisation, with the concept problematised and idealised in general without documenting what actually makes it work (or not) in practice.

This thesis seeks to contribute towards filling this knowledge gap by delineating how, in the Zambian case, decentralisation policies have been pursued in practice over time. But rather than attempting to evaluate the effectiveness or otherwise of decentralisation policies (for example, by attempting to quantify their impact on health outcomes over time), this thesis concerns itself with the policymaking and policy implementation processes and how these have affected (and been affected by) health governance at different levels within Zambia. The thesis concerns itself with the 'pluralistic' nature of policymaking, and considers what health sector decentralisation policies in Zambia were claimed to deliver on one hand, and on the other hand what happened when they were implemented – both idealistic and realistic ideologies (see Walt, 1994, p.49)

The substantive research question the thesis addresses is:

> Why has decentralisation persistently featured in policy discussions over health service delivery in Zambia, and how have decentralisation efforts affected, and been affected by, the governance of health service delivery in practice?

In order to answer this overarching question, the thesis addresses the following sub-questions:

a. What has driven the adoption of decentralisation policies in Zambia's health sector?

b. What factors have enabled/inhibited Zambia's health sector decentralisation processes?

c. How has political and bureaucratic action at different governance levels influenced health decentralisation policymaking?

d. How has political and bureaucratic action at different governance levels influenced health decentralisation policy implementation?

e. What implications do the answers to a, b, c and d have for arguments about decentralisation as a health sector reform tool (in Zambia, and elsewhere)?

To address these research questions, a qualitative methods approach was used. This included: i) a comprehensive review of international and national level secondary and raw data on decentralisation and health service delivery; ii) an analysis of policy documents on decentralisation in Zambia from government, donors, and non-governmental organisations which informed the research on factors that have helped to drive/inhibit decentralisation processes in Zambia; iii) semi-structured interviews with key stakeholders to capture their views and experiences of health reforms and decentralisation processes over time; iv)

informal follow-up conversations were conducted with participants who had given interesting views during the interview processes on their roles as policy actors and how they interpreted the controversies surrounding government dominance and donor influence in the Zambian decentralisation agenda. This allowed for the capturing of views that some participants were only willing to share off record), also a key strength of the methods utilised. The participants for these discussions were drawn from the donor community, government Ministries and agencies. A total of forth-three (43) key informant interviews were conducted. In whole, participant's perspectives helped in understanding the power relations and negotiation processes involved in the decentralisation agenda.

This combination of literature reviewing, documentary analysis and key informant interviews allowed for the research to; i) trace the history of Zambia's attempts to decentralise its health system (sub-questions a, b); ii) understand how political and bureaucratic actions have affected policymaking and implementation (sub-questions c, d). In the conclusion, the research draws on this material to consider the implications of the findings for decentralisation more widely (sub-question e).

What is decentralisation and how did it become linked to development?

In the development literature, decentralisation is understood to mean the distribution/sharing of functions, resources and power by central government to lower levels of government (see Schneider, 2003; Rees and Hossain, 2010). Thus, for much of the literature, decentralisation is measured according to how far central governments go in giving autonomy to lower government levels for decision making; ceding tighter controls of fiscal operations; and how much political space is given to lower levels to enable participation (Schneider, 2003; Manor, 2006).

Although decentralisation policies date back as far as the 1950s, it was not until the 1980s that development agencies popularised them as a way of addressing development problems in underdeveloped economies (Smith, 1985, p23). The poor economic performance in SSA was often blamed on autocratic government regimes that exercised tight controls over economic resources, and in which government spending on services did not benefit the populous but instead was seen to have bred corruption and political patronage (cf. Gilson and Mills, 1995). Decentralisation was thought to offer the opportunity to create pathways to initiating supportive contexts governed by legal frameworks and the creation of governance structures within local areas that would be responsible for decision making and accountability (see Gilson and Mills, 1995, Romeo, 2003).

As a result of these ideas, in the 1980s, many developing countries began to implement some form of decentralisation policies (see Hartmann and Crawford, 2008). Scholars, for example Smith (1985, p41) and Conyers (1984a; 1984b), tried to understand why governments were adopting decentralisation policies, and to trace the influence of development agencies' agendas on such policies.

On the question of why development agencies were so keen to promote these policies, their answers rested on the desire to improve accountability and responsiveness, taking government closer to the people and empowering communities, in the process fostering citizen participation (Crook, 2003) and making public officials accountable to the populous. Other arguments that emerged about the positive effects of decentralisation included reducing abuse of power by central governments (because by transferring some functions to lower levels of government, central government's powers are limited) and allowing for opposing groups and other minorities to have a degree of control of local jurisdictions (see Faguet, 2013). The belief was that decentralisation's ability to foster local decision making on one hand gives central governments the opportunity to better understand local problems and develop appropriate responses, while on the other hand it fosters efficient development of local plans and appropriate mechanisms in the use of resources because of existing local accountability (Mawhood, 1983; Ribot, 2003). Overall, then, development agencies saw decentralisation as a means to address political instability, to drive democratisation, and most importantly to improve the delivery of social services (Conyers, 1986b; Mills, 1990).

Internally, decentralisation policies were widely accepted by governments in SSA because they coincided with domestic political reforms pursued by new governments who were tied up with international demands and agenda around institutional reforms and debt restructuring (see, Gilson and Mills, 1995).

However, the more decentralisation policies were implemented in developing countries, the more difficult it became to rely on evidence that decentralisation actually delivers what it purports to (see Olowu, 1989; Manor, 2006).

Critics of decentralisation policies claimed not only that such policies do not deliver the purported benefits, but that they also create other problems such as increased corruption, marginalisation of smaller groups (for example ethnic minorities), bloated budgets, and disparities in regional development and functioning. Most of these arguments were substantiated by evidence from a plethora of African countries that had implemented decentralisation policies with limited results during the 1980s through to the 1990s - notably the works of Rondinelli et.al (1983), Conyers (1986a, 1986b), Smith (1985, p55), Olowu (1989), and Mills (1990). Moreover, within SSA some of the opposition to decentralisation related to the postcolonial power dynamics of the ways into which it was introduced by development agencies.

Second, critics also contend that it is difficult to determine the extent to which decentralisation has happened in countries, as many governance systems exist in a 'grey area' (Fesler, 1965) where some power or discretion is transferred to lower levels, but at the same time central governments will always have the obligation of performing certain functions such as policy making, setting standards and guidelines, resource mobilisation, and distribution.

Third, some localities tend to have better resources than others and therefore decentralisation becomes difficult to measure in such circumstances as it can be uneven across a country (Fesler, 1965, Conyers, 1986a), creating regional economic disparities in terms of wealth and benefits and distorting some aspects of policymaking processes (Hadiz, 2004).

For the purposes of this thesis, and as it will be discussed in Chapter Two, the focus is on how decentralisation affects service delivery - to be specific, health service delivery, as the health sector has been an area in which decentralisation has been commonly implemented as a policy designed to achieve health systems goals. The thesis does not take a principled position on whether decentralisation is or is not in theory a good policy approach. Rather, it regards decentralisation as a policy tool that can in principle contribute to the achievement of certain development goals (including health system goals), while taking into consideration that, like any other policy making and implementation process, decentralisation is affected by existing socio-economic conditions, political and bureaucratic factors. Thus, rather than debate whether or not Zambia has been right to pursue decentralisation of its health sector, the thesis attempts to provide a more contextually grounded discussion of *why* Zambian governments have chosen to do so, and what factors have (positively or negatively) affected the success of decentralisation. In the next section, the thesis briefly outlines the rise of health organisation reforms in Zambia, which are covered in more detail in Chapter Three.

The rise of Organisational reforms in Zambia's health system

While decentralisation has been the main feature of the health sector reform process in Zambia over recent decades, the agenda has largely been implemented in isolation of the broader national decentralisation process. For example, in 1995, the government of Zambia introduced legislation through Cabinet Circular No 1 of 1995 to strengthen the operations of provincial and district levels of government, including legislation that mandated local councils to operate a wide range of services (GRZ, 2002). These actions were considered part of the national agenda to decentralise a broad range of services through empowering lower levels of government. However, at the same time, the government separately passed the National Health Service Act of 1995 to specifically implement health sector decentralisation (revised DIP, 2009 – 2013). Neither of these government actions delivered significant change with regards to empowering and strengthening local councils which to date remain underfunded (cf. GIZ, 2016).

In 2004, when a new National Decentralisation Policy was launched, government set an ambition that health sector decentralisation was to operate under the umbrella of the National Decentralisation Plan. But again, this policy remained unimplemented and was retargeted for implementation in January 2016 (to date, the policy remains unimplemented). During this period, the health sector tried to implement various reforms which were not part of the wider National Decentralisation Plan. In 2006, for example, the 1995 Health Services

Act was repealed, and the Health Management Boards, and the Central Board of Health, were abolished (MoH SDP, unpublished). Furthermore, between 2011 and 2014, there were other organisational reforms in the public health service which affected the delivery of health services. This included the creation of additional districts (from 72 in 2011 to 103 in 2014 and 117 in 2018), and the realignment of the primary health care function at the Ministry of Health. In addition, HIV/AIDS services were decentralised through the creation of a separate set of structures and mechanisms. In addition, the management of the health sector has also involved some key events that have had an impact on health sector decentralisation as Table 1 details.

Table 1: Key Components of Zambia Health Sytems Reorganisation and Governance: 1992-2016

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
1992	Establishment of autonomous Hospital Management Boards at general and central level hospitals on basis of Medical Services Act of 1985		• Funding for provincial health services through provincial offices (1990-1993) • Health Care Financing TWG established	Cabinet approves the National Health Policies and Strategies
1993	• Creation of District Health Boards (legitimized in 1995 through the National Health Services Act) • Neighbourhood Health Committees established	• Sector Wide Approach programming (SWAp) mechanism introduced	• User Fees introduced in GRZ health facilities • Creation of the District Basket	

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
1994		Initial development and implementation of Financial and Administrative Management System (FAMS) at district level and below	• Prepayment in selected districts/third level hospitals commenced • Introduction of population based district resource allocation formula (RAF), and bed-day for hospitals	First National Health Strategic Plan (NHSP) 1995-1998 developed
1995		Definition of Basic Health Care Package of services for the first level referral services (1995/96)	• User Fees exemptions introduced • Revision of district RAF • Piloting of Health Care Costs Schemes (HCCS)	National Health Services Act legitimized, and establishes the legal basis for the creation of the Central Board of Health (CBoH), and District Health Boards
1996	• Creation of CBoH, which includes four regional offices • Medical Stores Limited (MSL) re-organised[1]		MoH takes over the function of procuring drugs and medical supplies from MSL	

1 When MSL was established in 1976, is was manufacturing, procuring, storing, and distributing essential drugs and medical supplies. In 1996, the process of restructuring MSL commenced. The key decision was to commercialise operations at MSL by contracting it out and restricting its functions to storage and distribution. Manufacturing of drugs and medical supplies was discontinued while the procurement function was transferred to MoH (MoH, 1991).

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
1997			Move to population-based funding for hospitals	• Initiation of process to develop Comprehensive Health Financing Policy • NHSP 1998-2000 developed
1998	• Re-establishment of National Malaria Control Program • MSL contracted-out to GMR under a lease agreement	Development and implementation of Health Management Information System (HMIS) at district level		Cabinet approval of National Drug Policy Cabinet approval of National Laboratory Policy
1999	Restructuring of CBoH and MoH • Scrapping of regional offices and re-establishment of provincial structures			• Cabinet approval of Reproductive Health Policy • Signing of SWAp MoU between MoH and CPs
2000				NHSP 2001-2005 developed

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
2003		Medium Term Expenditure Framework introduced by Government	• Basket funding expanded to secondary and tertiary hospitals, CBoH and MoH headquarters • Medical Levy[2] introduced	Draft Code of Conduct (CoC) as an instrument for conflict resolution in the SWAp
2004	MSL contracted-out to Crown Agents under a management contract	• Re-organisation of SWAp coordination mechanisms • Institutional and organisational appraisal of the health sector	Basket funding expanded to Statutory Boards, Training Institutions in form of capital expenditure and human resource development	
2005				• Repeal of the National Health Services Act of 1995 to pave way for the dissolution of the CBoH • Development of the NHSP 2006-2010 • Signing of new SWAp MoU between MoH and CPs

[2] The medical levy was a 1% tax on interest earned on savings and deposit accounts, treasury bills, government bonds and other similar financial instruments. The revenue generated was earmarked to the health sector (MoH, 1996)

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
2006	• CBoH dissolved • Institutional and organisational restructuring of the health sector commences (MoH & Stautory Boards)		• Some CPs (DfID and EU) shift from basket funding at MoH to Direct Budget Support at the Ministry of Finance • User Fees removed in all rural areas	
2007			User Fees removed in all peri-urban areas	
2009			Misapplication of funds leads to withdrawal of donor support, and casts doubts on future use of basket funding mechanism	
2010				Development of the NHSP 2011-2016
2011	Transfer of the primary health care (PHC) function to the Ministry of Community Devpt			

Date	Institutional	Systems Development	Health Financing Reform	Legislative/Policy/National Health Plans
2012			• User Fees removed at the entire Primary Health Care level • Results-Based Financing implemented in 11 districts countrywide	Comprehensive National Health Policy developed
2013			Medical Levy abolished	Signing of new SWAp MoU between MoH and CPs
2015	Re-merger of the PHC function to the MoH		Commencement of direct disbursement of operational grants from Ministry of Finance to distrcts	
2016	Structural re-organisation of the MoH			

Data sources with modification by author: Chansa 2009; Lake et al. 2000

The ideals that lay behind decentralisation in Zambia reflect the general international consensus on the theoretical merits of decentralising health care: the proposed improvement in the quality and coverage of health care that would result. This was closely linked with the WHO's 1978 Alma-Ata declaration[3] which pledged to reduce health inequalities within

[3]The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. Among other things that were discussed and affirmed were the definition of health, the roles that governments, health workers and communities should play in promoting health. It essentially laid out the plan for attaining health system goals.

countries, and between developed and underdeveloped countries, by the year 2000[4] (WHO, 1986). The declaration emphasised community participation in planning and organisation of Primary Health Care, in the belief that community involvement yields better health outcomes leading to reduced health inequalities (WHO, Alma Ata declaration 1978). The Alma Ata ethos is constantly cited in almost all the Health Strategic Plans in Zambia and formed the core basis of the health reforms. Furthermore, these health sector decentralisation efforts in Zambia have received support from both bilateral and multilateral organisations, such as the World Bank, World Health Organisation (WHO) and International Monetary Fund (IMF) (cf. Kalumba, 1994).

At the current time, Zambia's health system remains relatively centralised in terms of operations, although with delegated responsibilities from the centre to the lower levels of the health care delivery system. This warrants in-depth investigation to interpret and understand what has happened to the implementation of decentralisation in practice. The Ministry of Health (MOH) plays a dual role of policy formulation and strategic planning and delivery of health services, with provincial and District Health Offices (DHOs) being upwardly accountable to the MOH headquarters (cf. World Bank, 2018). Provincial Health Offices (PHOs) oversee a number of Districts and are responsible for providing guidance in planning and budgeting, service delivery, financial management, procurement, and monitoring and evaluation. Delivery of primary health services is undertaken at district hospitals, health centres, and health posts, while DHOs are responsible for district-level planning and budgeting, fiduciary management, and monitoring and evaluation (World Bank, 2018).

Zambia provides a useful case study in which to study health sector decentralisation because decentralisation has been the main feature of health sector reforms since 1992. This allows for investigation of why decentralisation was chosen as a policy option by several successive (sub-question a). The thesis examines the context and historical perspective of the health sector reforms between 1992 and 2018. To do so, a review of the policy objectives, and key political, managerial, technical and structural issues that have characterized the health sector reforms and decentralisation processes in Zambia was conducted, and they form the key aspect of the historical analysis as set out in Chapter Three. This provides some general understandings of the factors that have influenced decentralisation (sub-questions b, c and d), but such a historical review can only go so far. Therefore, the gaps were filled by conducting fieldwork focused on studying decentralisation in practice: its local rationales, drivers, and contextual factors that either aided or limited its ability to act as an effective or useful reform tool, allowing for a better determination of decentralisation embedded in the lived experiences of those who are affecting and effected the policy.

[4] In international policy theoretical explanations, the declaration implies how global set standards influence countries/states and the role of global organisations in exerting power to initiate new norms and models to change social understandings (see, Finnemore and Sikkink, 2001).

It is widely suggested that inefficient organisational arrangements lead to poor accountability and transparency and have a negative impact on health service delivery (not least in countries in SSA). Some of the frequently cited weaknesses include: (i) poor management of health services; (ii) health services not linked to the needs of the clients; (iii) clients having no say in the provision of health services; and (iv) no linkages between the communities and formal referral systems (See Andrews, 2011). It's for these reasons that several developing countries have implemented health reforms with a view to better organise their health system for increased efficiency, improved accountability, and better health outcomes (Mills et.al. 2002). These reforms have taken many forms but can be grouped into four (4) categories: (a) organisational reforms; (b) financing reforms; (c) provider payment mechanisms and incentives; and (d) changes in the regulatory environment and legal framework (see Gilson and Mills, 1995; cf. Chitah et.al, 2018).

Since 1992, the Zambian health sector has been reformed several times with a view to strengthening the health system and improving service delivery, generally with a focus on organisational and financing reforms (cf. Chitah et.al, 2018). Decentralisation (organisational and financial) has been the main feature of these reform process in Zambia and the ambition is to decentralise health service delivery based on the primary health care approach (MoH, 1992). For example, the 1992 health reforms later led to the creation of community and district management structures, health management boards, the Central Board of Health, and the Sector Wide Approach (SWAp) - which in turn facilitated fiscal decentralisation (Chansa, 2009, p18).

As this PhD research project seeks to provide a wider evidence base on decentralisation as a health system reform tool as it has been practiced, it seeks to contribute to understanding Zambia's historical successes and failures in implementing decentralisation policies to govern health services; the factors that have shaped decentralisation; local actions that have shaped and constrained decentralisation; and decentralisation's effects on local political action, donor actions and policymaking. In doing so, the thesis utilises the health policy triangle framework, which will be briefly introduced in the following section (with more details of how it is used to answer the research questions provided in Chapter Four).

The Health Policy Triangle Framework

The section begins introduces the health policy triangle framework. For the purposes of this thesis, the policy triangle provides a pathway to analyse policymaking and implementation in Zambia through: (i) how it emerges and develops (*process* and *context*) (ii) how it's influenced and shaped by internal and external *actors* (e.g., by political actors, bureaucrats and donor agencies); and iii) its nature and *content* (cf. Gilson et. al, 2018).

The health policy triangle has been widely utilised to understand how health systems are managed in their entirety. The framework explores the roles, interactions and influence of 'actors' on each other, and how their relationships and interactions ultimately affect health policy (Buse et. al, 2012). The framework also helps to create an understanding of how policy is formed, i.e. (i) what informs policy? (ii) how do health policies get on the national agenda and who tables them and why (Walt et.al, 2008) - hence the framework is used to understand policy processes in context. Furthermore, the health policy triangle exemplifies content, context, process and actors to represent the complex set of interrelationships to which health policies are subjected to (Buse et.al, 2012). And in addition, the framework takes into account the fact that health policy is highly influenced by politics, from formulation to implementation.

The health policy triangle was selected as the analytical framework to reflect the philosophical underpinnings of critical realism from which the research design has been approached. Based on critical realist approaches developed by Pawson and Tilly (1997), the research intends to interrogate the validity of assumptions and ideas about policy implementation, and to understand not only the outcomes that are produced from interventions, but also how *and why* they are produced - and the significance of the varying conditions in which interventions take place (Pawson and Tilly, 1997). In a nutshell, the research design aimed to interrogate policy programmes and how they are explained within social systems, with the assumption that "programs work (have successful outcomes) only in so far as they introduce the appropriate ideas and opportunities (mechanisms) to groups in the appropriate social and cultural conditions (contexts); therefore mechanism + context = outcomes" (Pawson and Tilley 1997; p56). Within critical realism, actors are regarded as being at the centre of interventions, because actors make (or don't make) decisions in response to what programmes are supposed to be implemented. The reasoning behind this is that actors respond to resources and opportunities available to them, and their response produces the outcomes (Pawson and Tilly, 1997: p.85). Therefore, the policy triangle fits appropriately due to its normative orientation towards providing analyses on how contextual factors alter and moderate the predicted outcomes and presuppositions of decentralisation policy in achieving health system goals. Furthermore it provides a framework to interrogate: 1) the roles played by various actors (the state, policymakers, providers, and citizens), based on decentralisation's assumption that it creates effective interlinking mechanisms amongst actors (Bossert, 1998); 2) the context within which decentralisation policies are operating, that is the social, political and economic context in Zambia (which includes a historical perspective);and 3) the underlying assumptions that decentralisation could lead to health system strengthening and improved delivery of primary health care services.

In line with these commitments, the policy triangle framework positioned the researcher to interrogate decentralisation policy documents, the environments in which decentralisation

policies have been introduced and why, how actors have engaged with the processes, and how the processes have produced the outcomes that they have in Zambia. In essence the interrogations were about *what do we know about decentralisation in Zambia*; and *why has it yielded the results that it has*. This enabled the researcher to understand decentralisation from experience and understanding the underlying institutions in the Zambian context which formed an important part of contributing to addressing the research question and generating the conclusions that are presented in Chapter Seven. Specifically, these conclusions are crucially important to the policy arena in Zambia because they make contributions to thinking about how the imminent devolution plan can contribute to better health outcomes.

Ontological and epistemological commitments of the research framework

The Zambian case study provides a unique context for studying health sector decentralisation because of the longstanding attempts at decentralisation that have been attempted over the past four decades. Given the ontological commitments of the research, the research had the task of unpacking how different actors' roles tend to affect the way decentralisation operates in Zambia. This is in line with social constructionism which facilitates understanding the actions of social actors so as to place many different interpretations on the situations in which actors find themselves (Saunders et.al, 2009 p.111). In this regard, the interviews allowed for the analysis of how actors involved in decentralisation in Zambia perceive different situations in a variety of ways as a consequence of their interactions with the policymaking process (Saunders et.al, 2009). These different interpretations are likely to affect their actions and the nature of their interactions with others. In this sense, studying actors is not only about how they interact with their environment, but also how they make sense of it through their interpretation of events and the meanings that they draw from these events. In turn, their own actions may be seen by others as being meaningful in the context of these socially constructed interpretations and meanings (Saunders et.al, 2009 p111). To state it in a more specific way as well as justifying the use of the health policy triangle framework; the framework allowed for understanding that the influence of politics on policy practice is a complex phenomenon, and that actors in policy process (at both the policymaking and implementation stages) exercise agency according to situations (Gilson et.al, 2018). Therefore, in the case of studying decentralisation in Zambia, the role of the researcher was to seek to understand the subjective reality of the actors in order to be able to make sense of and understand their motives, actions and intentions in a way that is meaningful.

With regards to the epistemological commitments of the research, various methods were used to not only to understand the situational factors that have affected the implementation of decentralisation but also attach meanings and interpretations to actors' behaviour and to understand why they make the decisions that they do in policy practice. Specifically, the use of in-depth interviews provided the researcher with the opportunity to 'probe' answers,

where interviewees were required to explain, or build on, their responses with regards to their involvement and perceptions of decentralisation processes in Zambia. This formed an important aspect of the project's interpretivist epistemology, helping the researcher to understanding the meanings that participants ascribe to various distinctive characteristics of policy processes in Zambia (cf. Saunders et.al, 2009 p.324). The value of in-depth interviews to the research was that interviewees identified unique characteristics that have driven decentralisation policies in Zambia, or rather how decentralisation agendas were brought to the fore on the national agenda. For example, two interviewees who were influential in driving the health reform agenda in the 1990s stated that they were able to command influence both at home and abroad regarding health sector reform because of their work experience and educational background (both had undertaken their studies in developed countries - one in the United States and the other in the United Kingdom), and in addition they both had political connections to the government through work relations. Such insights generated more meanings to add to the research: for example, in the stated case, it created an understanding that policy reformers are respected if they are regarded to have the necessary education and understanding of what policy reform is all about and that they need to be politically connected to initiate ideas (cf. Silverman, 2007). And in fact, one of the interviewees put it clearly that this PhD study was highly relevant to policy development in Zambia especially for the health sector, but without any political connections the thesis would develop ideas that will be archived in the library, regardless of whether they were useful (Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms).

A mapping process was undertaken to review three key decentralisation plans: the health reform process, the HIV/AIDS decentralisation process, and the national devolution plans. The mapping process enabled the research to identify the potential impact and risks of decentralisation plans to the overall policymaking process in Zambia. The backbone of mapping these processes was based on realistic evaluation where outcomes are explained by the action of particular mechanisms in particular contexts (Pawson & Tilley, 1997). Through the use of the policy triangle, further investigations were conducted on how Zambian governments make assumptions on the operations of decentralisation as a reform tool. That said, the value of the policy triangle to this research in this regard is that it positioned the researcher to interrogate the decentralisation policy documents, the environments in which decentralisation policies have been introduced and why, how actors have engaged with the processes, and how the processes have produced the outcomes that they have in Zambia. Similar to what has already been stated above; the interrogations were about; what should we know about decentralisation in Zambia, why is it popularised to govern health services; why does it yield the results that it does in the health sector and what does health sector decentralisation tell us about policymaking and socio-political processes in Zambia? This allowed for the research to understand decentralisation from past experiences and consider

the underlying factors that called for decentralisation to be implemented. The understandings led to the conclusions as established in the last chapter.

Importance of conducting the research

The substantive research question arose as a result of my interest in health systems development in Zambia on a professional level – first, having worked for the Ministry of Health for a period of two years from 2008 – 2010 as a research officer on a national advisory committee that was mandated to set up a regulatory research body to strengthen Zambia's health research agenda, so as to contribute to the strengthening of the national health research system and the health system itself (cf. CCGHR, 2010). Second, being a seasoned researcher in health promotion and having conducted studies that questioned the legitimacy of policymaking in developing economies, compelled further interests in studying why Zambia's health system remains challenged in so many ways despite various efforts implemented by governments and donors to improve health policy and governance. At the time the idea for the thesis was conceived, between 2012 - 2015, Zambia was going through various political and administrative reorganisations (see, Chapters One and Three). Of particular importance politically, the Patriotic Front (PF) government had won the election in 2011 having defeated the Movement for Multi-Party Democracy (MMD) which had been in power for 20 years, from 1991 to 2011. The PF campaign had identified itself with unmet political and socio-economic demands for most Zambians, with health being one of the target sectors of their popularised campaign slogan "*good health is an essential prerequisite for national development"* - a slogan that probably won the sentiments of the electorate (see, Fraser and Larmer, 2007; PF Manifesto, 2011 -2016).

The campaigns were widely premised on the promises of implementing decentralisation policies to take government closer to the people. And so, upon forming government in 2011, the PF embarked on acting on its promises, which did not necessarily fall within the existing national decentralisation plan policy that the previous government had (insufficiently) implemented. Among the key decisions was an executive order passed by the President, Mr Michael Sata, in 2012 to realign maternal and child health services from the Ministry of Health to the Ministry of Community Development and Social Services (MCDSS) (see, Chapter Three) while also having reaffirmed the commitment of his PF government towards implementing decentralisation to improve the delivery of health services through the National Decentralisation Plan policy (cf. revised DIP, 2009). Having been an ardent reformer of health services when he served as Minister of Health in the MMD government in 1995, at the peak of health reforms implementation, he was often praised for his good leadership in enhancing health service delivery (see, Chapter Five). However, the demise of President Sata in 2014 left the PF divided over succession; and in addition, when the party eventually won the by-election in 2014 following the death of Sata, it was a new PF that rescinded the decision to align maternal and child health services to the MCDSS, and returned it back to the MoH (PMRC, 2014). Decentralisation also became a distant topic. Thus, it was from these events

that I started to question how decentralisation of health services should be implemented on the premise of delivering better health governance frameworks that can propel improved health services delivery in Zambia, considering that, previously, a number of decentralisation policies had been implemented with limited results (see Chapter Three). Crucially for the health sector, that is no existing legal operational framework: decentralisation, if implemented, was going to fill that gap (see, revised DIP, 2009). Zambia presents a unique case into which to study decentralisation because of three specific decentralisation processes with varied outcomes, the HIV/AIDS having been deemed as successful, the health reforms having been repealed and the stalled current devolution plan.

Therefore, I considered that studying the case of Zambia would be a worthwhile intellectual journey that could provide useful insights for academics, development partners (multilateral and bilateral organisations) and policymakers in Zambia on approaches to decentralisation and health policy, explaining the contextualised interactions between institutions, interests and ideas in policy processes in Zambia (and, by extension, other low-and-middle income countries in sub-Saharan Africa (see, Walt et.al, 2008). Some may question why investigate Zambia and not another country with similar traits. Zambia was the focus of the study for the following reasons:

- Failure to find effective means of managing health services.
- Failure of decentralisation to attain health systems goals.
- Despite the limitations, decentralisation continues to be pursued.
- A large country with diverse cultures, economic pursuits etc.
- Presents dynamism within context, for example rural areas versus urban areas.
- Different donors involved in delivering health services – who bring along their own dynamics from their settings, including ideologies and political practises.
- Health sector is underdeveloped with poor primary health care indicators.
- Due to the nature of health services vis-à-vis institutional arrangements, decentralisation in Zambia is inevitable to deliver health services.
- My own professional experience that could contribute to the research.

Thesis contributions

The thesis makes four key contributions, based on theoretical and empirical evidence. The first contribution relates to why Zambia has continued to attempt health sector decentralisation and why the attempts have yielded limited success due to the changing socio-political contexts. The second contribution the thesis makes is about context and actors. The discussions relate to the power possessed by Zambian policy actors in driving policy agenda. Whereas there has been a push from international agencies with regards to legitimising the policy agenda through establishing legislative frameworks in developing countries like Zambia, where governance systems are relatively weak (see Reiss, 1985), the Zambian decentralisation cases demonstrate that local political practise continues to play a vital role in shaping policy and thus, contrary to what some literature asserts about African

actors in policy practice (see Barnes, et, al, 2014. P.65), they are not silent but salient players regardless of policy agenda being funded by external resources. This is important in understanding the role of the Zambian state in relation to international donors.

The third contribution is about the usefulness of the HPTF in locating how both local and international actors have emerged to shape policy agenda and how some actors have been left behind in policy processes but come to exert influence at the point they possess power to implement policy. The thesis shows that within the policy tier in the Zambian context, there is resistance to policy by bureaucrats throughout the health system as long as they feel that the policy does not serve their interests. The last contribution the thesis makes is on documenting the role of actors at all levels of the domestic health system, from the national down to the global, and the vital role that 'non-political elites' such as street-level bureaucrats and local health service administrators can play in shaping (and resisting) policy implementation.

Policy Relevance

This study is highly relevant to Zambia's development ambitions because: i) it comes at a time when the National Decentralisation Policy plan, initiated in 2002 and launched in 2004, is about to be implemented; ii) it takes cognizance of several other organisational reforms in the public health service, such as the creation of additional districts (from 72 in 2011 to 105 in 2014) and the realignment of the primary health care function at the Ministry of Health; iii) Zambia is currently transitioning from being a donor dependent to a self-sustaining country, and hence the need to strengthen governance systems.

The study will therefore provide policy makers with: i) a historical perspective on how successive health sector decentralisation processed have impacted on health service delivery; ii) locate contextual factors which will; iii) inform current thinking on the planned decentralisation rollout, the three outlined areas are in line with Kuruvilla, et.al (2006) research impact framework which highlights that research should have impact on policy, service and society. Other impact to the research relates to the researcher's positionality and dispositions to the research as will be discussed in the next section.

Chapter Structure

Having already provided an understanding of the overall focus and contribution of the thesis and the research question to be answered, it will be useful to map out the forthcoming chapters so as to demonstrate how the research questions are addressed by the thesis.

The next chapter (Chapter Two) explores in more depth the nature of decentralisation as a concept and the rationales for the adoption of health sector decentralisation policies in Zambia. The chapter lays the foundations for the thesis, expanding on the brief discussions in

this introductory chapter by characterising decentralisation; by discussing what decentralisation entails; by highlighting why it is favoured by some and not by others; and why some development advocates believe that decentralisation can trigger improved service delivery while others dismiss the idea. The Chapter also discusses the historical roots of decentralisation and its widespread implementation in African countries. The Chapter specifically asks why decentralisation has been promoted (not least by development agencies) to pursue health systems goals in African contexts, especially sub-Saharan African countries.

Chapter Three provides a historical overview of decentralisation and health sector decentralisation processes in Zambia from 1990-2019. The chapter situates how and why decentralisation policies were adopted by successive Zambian governments. A number of critical points are raised here to highlight how decisions to manage health services at local levels were arrived at (i.e., sub-question a): What has driven the adoption of decentralisation policies in Zambia's health sector?). The discussion also touches on how successive governments have utilised their political power to engage with decentralisation within and outside Zambia. The discussions in the Chapter also take note of the international pressure that Zambia is/was faced with in terms of implementing reforms, starting with the United National Independence Party that formed the government after independence from British Colonial rule in 1964 to the time that Zambia introduced political reforms that led to multiparty democracy.

Chapter Four discusses the methodological and conceptual approach and the usefulness of the Zambian case to studying how decentralisation works in practice, considering the international normative consensus on decentralisation and how it applies to the Zambian context. Having already provided the historical contexts to the evolution of decentralisation processes in Zambia, this chapter incorporates the health policy triangle framework to provide explanations of why health decentralisation policies in Zambia are/were shaped and have produced the results that they have. In addition, the Chapter justifies the choice of a qualitative research strategy as appropriate for exploring health sector management using decentralisation policies because it reinforces the ontological and epistemological positioning of the research. To conclude, the chapter highlights the relevance of the study to health sector development and policymaking processes in Zambia.

Chapter Five is the first of the two empirically grounded Chapters about the politics that have dominated the evolution of decentralisation processes in Zambia. Tracing the historical development of decentralisation through the health reform process, it considers how international influence shapes policy practise and the implications for policy outcomes and why the results did not match what was originally envisaged. The chapter argues that this is because the context into which these international ideas were introduced includes concealed power with the ability to shape the outcomes of the ideas introduced. The usefulness of health policy triangle framework in this regard comes into effect because it allows the chapter

to explain why decentralisation policies were produced, promoted, and transferred, and the impact on policy relations and interactions within Zambia. Using the health reform process – which happened to be the first decentralisation policy idea that was transferred along with socio-economic reforms - the chapter discusses the roles of *actors* at international, national and local level in decentralisation – a key element of the health policy triangle framework. The Chapter focuses on understanding how the transferring of decentralisation policies shaped the understanding of actors with regards to the impact of the policy and how their roles shaped the evolution of policy practise with regards to decentralisation. In other words, the chapter examines how international ideas merged with local policy entrepreneurship. How do actors respond to decentralisation decisions, and how does their interaction with situational factors and with each other affect policy production? In doing so, the Chapter provides understandings of how actors exercise agency in policymaking and for the purposes of this study, it's the agency exercised by actors that forms the focal point of how decentralisation policies affect the operation of health services delivery in Zambia (i.e., sub-questions c) and d).

Chapter Six is the second of the two empirically grounded Chapters. While Chapter Five focused on the health reforms, Chapter Six focuses on the devolution agenda in Zambia that began in 2002 but is yet to be fully implemented. The chapter has several overlapping ideas with Chapter Five but moves beyond that chapter to explain how and why the current decentralisation reform process has failed to be implemented. In particular this Chapter focuses on discussing how political actors in Zambia have repeatedly put this agenda at the fore of their campaign elections yet, when elected, have not followed through their campaign promises. Again, while the previously implemented decentralisation policies in Zambia (the health reform process and HIV/AIDS, as discussed in Chapter Three and Five) demonstrated how policy works in the Zambian context when produced and implemented through international/external influence and the impact on local practise and response, this Chapter is uniquely placed to explain the quest by sub-Saharan African Countries like Zambia to wean themselves off donor support. Thus, by using the devolution agenda, which is largely deemed to be domestically driven, this Chapter demonstrates how political practise has failed to sustain the reform amidst resource constraints, government transitions and suppressed actor participation. The chapter brings to the fore the complexities of implementing decentralisation embodied within the development lexicon and historical contexts explained by the academic literature (cf. Conyers, 1986a, Rondinelli, 1983, Brinkerhoff, 2004); that is the effects on decentralisation's results when it is subjected to a variety of political decisions, specifically the impacts of the devolution agenda on health sector governance. In sum, while Chapter Five focuses on understanding the life of decentralisation processes rooted in international policies, this Chapter focuses on understanding why a decentralisation policy that has been anchored on principles of *domestically driven policy agenda* has faced implementation challenges, including creating a legal framework into which to embed its practice.

Chapter Seven forms the conclusion Chapter, which provides a robust discussion of the conclusions of the research and explicitly outlines the main contributions that the thesis makes to the existing literature on how decentralisation has been practised in Zambia. The recognised limitations of the research are also discussed, along with the implications of the work for the future of decentralisation policies in the developing world (sub-question e). In a nutshell, this concluding chapter revisits the arguments that have been made in the thesis around decentralisation as a policy tool that can improve delivery of social services (more especially health in this case – the supposed claims for decentralisation to achieve health system goals) and more importantly achieve development goals in countries like Zambia. The chapter brings out a number of key learning points from the research to contribute to the gaps in the literature and identifies areas where improvements could be made when the Zambia National Decentralisation Policy is implemented.

Chapter Two

Conceptual Literature Review

Overview
Introduces the concept of decentralisation
Explains the history of decentralisation
Describes the rise of decentralisation in development policy
States the reasons why decentralisation was popularised
Examines the arguments in the literature
Establishes the use of merits and critiques of decentralisation as a development tool
Explains the dominance of health sector decentralisation

Introduction

Having introduced the research topic and the research questions in the previous chapter (One), the aim of this chapter is to examine existing debates and understandings related to the concept of decentralisation, as well as to investigate how decentralisation has been employed in public policy, within the development lexicon more broadly, and within the academic literature more specifically. As indicated in Chapter One, although decentralisation has been idealised by development agencies as a tool that can deliver development goals especially for the health sector, some literature suggests that there is little concrete evidence to track the specific impacts of decentralisation on health care systems, despite its widespread use (see Berman, 1995; Mohammed et.al, 2016). Others posit arguments on what really constitutes decentralisation (see, Smoke, 2003). Moreover, there is a growing criticism suggesting that the decentralisation of health services requires proper planning for it to be implemented successfully, and in many settings, health reform systems are not clearly understood well, and the perceived benefits of decentralisation not well laid out (Berman, 1995; Pollack, 2002). Bossert and Beauvais (2002) also note that understanding the effects of decentralisation requires new research efforts in order to better evaluate equity, efficiency and quality of a health system prior to implementation. In sum, it is often doubted whether

decentralisation can effectively lead to the attainment of health systems goals without considering the environment in which it's implemented, the capacity of the government to implement it, and the strength of lower levels of government where power and responsibilities intend to be shared (see Litvack, 1992).

Given the existing debates and lack of existing literature on how the contextual factors that affect how decentralisation impacts upon health systems development, this chapter seeks to examine the debates and review the different understandings found in the literature of what decentralisation is, and how it shapes and is shaped by health policy practice. In doing so, the Chapter debates the fundamentals of decentralisation's ethos and how they link to wider public policy making. The Chapter seeks to build on the discussion in Chapter One and further contribute to conceptual puzzles that emerge from the thesis' substantive research question, which is:

> Why has decentralisation persistently featured in policy discussions over health service delivery in Zambia, and how have decentralisation efforts affected, and been affected by, the governance of health service delivery in practice?

The Chapter explores, probes and problematises the concept of decentralisation in the development literature; explaining its emergence, what it is, what it purports to achieve, and why it came to be popularised as a development tool. As indicated in Chapter One, the thesis approaches decentralisation from a critical realist perspective, recognising that its ability to produce the desired outcomes is dependent on whether appropriate ideas and opportunities are introduced to a country/locality within appropriate socio-economic conditions. It's within the socio-economic conditions (context) that the research framework – the health policy triangle - is embedded to offer a lens for the critical assessment of, first, why decentralisation ideas are introduced and, second, why they produce the results that they have in the Zambian health sector.

The chapter begins by reviewing how decentralisation has been conceptualised in the existing literature. It then moves on to look at the history of decentralisation policies and the positive outcomes decentralisation has been claimed to produce (such as democratisation and accountability). Third, the chapter examines the critiques of decentralisation as a policy approach that are found in the literature. Finally, it examines why it has been particularly popularised as a reform tool in the health sector. In doing so, it lays the foundations for discussing the progression of decentralisation policies in sub-Saharan African (SSA) countries like Zambia (as outlined in Chapter Three) and demonstrates how a concept like decentralisation works in the health sector when subjected to four key elements – content, context, process and the influence of actors (the conceptual framework that is laid out in Chapter Four).

A review of the literature on decentralisation as a concept

Decentralisation has been a prominent public policy concept since its original appearance as a policy management tool more than four decades ago (Smoke, 2010). However, despite its widespread use, decentralisation as a concept remains ambiguous. This section starts with analysing decentralisation by defining the term, how it has been divided into a number of types and classifications, and how it came to occupy a prominent place on the development agenda.

Defining decentralisation

Decentralisation is a "*concept that is used to denote the reallocation of power, authority, resources and responsibility from the centre to the periphery for political, economic, fiscal, and administrative systems*" (Brinkerhoff & Leighton, 2002). Other general definitions of decentralisation suggest that it refers to *"the transfer of responsibility for planning, management and resource raising and allocation from the central government and its agencies to: (a) field units of central government (b) subordinate units or levels of government (c) semi-autonomous public authorities or corporations (d) area-wide regional or functional authorities or non-governmental private voluntary organisations"* (Rondinelli, 1981 p9; Mills 1990). There is, then, general agreement in the literature that decentralisation refers to the moving of resources and power from the centre to lower structures, primarily in three main areas: fiscal, political and administrative (Schneider, 2003).

Despite this apparent clarity, several conceptual debates have arisen in the literature. Within these debates, there are three main areas of contestation: the meaning of decentralisation (in that the term 'decentralisation' may imply different things within different contexts) (Conyers, 1986a); the difficulty of measuring decentralisation (how do we judge how far a country has decentralised? How do we know when decentralisation is complete?); and whether decentralisation is one thing, or whether different types exist.

Despite this shared general understanding of decentralisation described above, the exact meaning of the concept has been a subject of widespread debate, particularly the application of the concept within public policy. These debates date as far back as the 1960s when the concept of 'decentralisation' was popularised in the policy development lexicon by the World Bank (see, Fesler, 1965). The lack of conceptual clarity could be explained by the fact that implementing agencies are more interested in the application of decentralisation and achieving its purported benefits, and less interested in debating its precise definitions. Academics, meanwhile, have insisted on establishing clearer definitions and more solid conceptual foundations for the term, with a view of coming up with a widely accepted implementation framework (cf. Smith, 1985, p.227; Schneider, 2003). In practice, however, this has resulted in a variety of different academic approaches and debates over conceptualisation, and it is debatable whether these debates have added anything new to the world of policy implementation.

This thesis seeks to avoid becoming entangled in these conceptual debates given that it is more interested in how decentralisation operates within a particular national context. Thus, it defines decentralisation simply as a process (suffix - isation), where the central government makes a decision to cede control of some of the functions and responsibilities it holds, and to transfer those functions (administrative, political, fiscal) from national public offices/ministries to a lower level of government, or to any legally established entity within the public offices/ministries operating at the subnational level (provincial or district level). This working definition recognises the fact that there is no state in the world that has all its powers entirely concentrated at the centre, and further acknowledges that almost all states have a political structure that distributes functions through multilevel governance. As Smith (1985, p 67) argued, the choice of how subnational levels are structured is always political because the choice reflects the interest of central government and the outcomes that they plan to achieve from a chosen form of governance. Thus, the working definition adopted here recognises the political nature of decentralisation, without assigning a positive or negative political or normative judgement on it. Finally, the working definition adopted here deliberately ignores privatisation as a form of decentralisation, because privatisation goes beyond the transfer of functions and responsibilities and is more profit oriented (as explained in the next section).

Four types of Decentralisation

While there are several approaches to try to understand variation in decentralisation, one of the frameworks that has been at the centre of forming and shaping discussions on decentralisation is the public administration typology of decentralisation, which outlines four distinct types: *deconcentrating, devolution, delegation* and *privatisation* (Rondinelli, 1981). Essentially, these four types of decentralisations describe the responsibilities that the central government assigns to other structures within and outside government (Collins, P; 1974).

Deconcentration refers *to* the handing of some administrative power to the lower levels of central government structures. For example, within the structure of government ministries or agencies at provincial or district levels, depending on a country's political organisation. *Devolution* refers to the creation or strengthening of subnational units of government, where the activities of these subnational units are supposed to be outside the direct control of central government. *Delegation* refers to the transfer of power and responsibilities to entities that are indirectly controlled by the central government, usually satellite companies or organisations that are set up and assigned responsibilities to perform particular tasks on behalf of central government, with clear oversight mechanisms. *Privatisation* normally denotes when a government allows responsibilities and functions to be performed by private entities or voluntary organisations with minimal oversight. Privatisation is often seen as emerging independently on its own through the private sector naturally taking over responsibilities that cannot otherwise be performed by the government. However, it can also be argued that government can decide to privatise public goods according to market forces

(see Rondinelli,1983; Mills, 1990 and Mills et.al, 2002; Schneider; 2003). This framework also provides a way of understanding the distributions of power and resources 'horizontally' and 'vertically': deconcentration and devolution are usually deemed to work more in a vertical manner, while delegation encompasses both and privatisation is more horizontal (cf. Hartmann and Crawford, 2008; Cameron, 2014).

Here, two distinct issues arise pertaining to why different governments choose to pursue different forms of decentralisation The first is that decentralisation reflects the pre-existing powers and interests of government (for example, some central governments may structure decentralisation in a such a way that at lower levels power is held by unelected political party officials, which is very common in developing countries) (Smith, 1985, p61)). The second is that the process adopted will vary according to domestic decentralisation goals (Dale, 1987).

In practice, approaches to decentralisation often include a mix of choices, with central governments sometimes choosing to decentralise some functions through different mechanisms, whilst holding on to others. Mills (1990) argues that the four types of decentralisation are not clearly distinct from each other: some countries may pursue more than one of these types of decentralisation, for example deconcentration and devolution, which she says may overlap mainly because of central government retaining influence over policy direction and mobilisation of resources. Another example was highlighted by Conyers, (1986b) who showed that autonomy by local governments may not be entirely achieved within particular forms of decentralisation. Yet, one by-product of disjointed or multivariate decentralisation is that this is often deemed to hinder the progression of local government's ability to make independent decisions - and in the end can help to derail decentralisation (Schneider, 2003). Thus, many proponents of decentralisation fiercely oppose piecemeal decentralisation (for example where administrative functions are given to the periphery whilst fiscal control is retained by the centre), while those that argue against decentralisation see a more mixed approach as sensible, since policy directions are highly complex and, in their view, need to be directed at the national rather than local level (See Vries, 2000).

Regardless of such ongoing debates, the public administration framework has been useful in demonstrating the different theoretical and practical elements of decentralisation. As will be expanded upon in Chapters Five and Six of this thesis, aspects of public administrative modelling provide helpful baseline analytical tools for case study analysis and for helping to determine the various ways that contextual factors create unique forms and delivery of decentralisation.

A brief history of decentralisation policies

Most literature on decentralisation makes reference to the decision of countries to decentralise being based on a commonly held view of decentralisation promoting localised planning, which leads to more efficient and targeted allocation and management of resources

(cf. Mills, 1990). In more recent times, there has been a strong association made between decentralisation and good governance, especially in the context of public policy in developing countries (Rondinelli, 1981). Though these purported values are key to understanding why decentralisation is often pursued, it is also important to examine the historical emergence and development of modern understandings of decentralisation. This is because historical analysis helps to point out a variety of (f)actors that lead countries to decentralise and explains many of the essential elements behind decentralisation decisions. For example, historical analysis can help us better understand the role of donors in driving decentralisation policies, or whether these decisions were the product of domestic grassroots movements to regain political autonomy and control (Smith, 1985, p82). Within this thesis, historical analysis forms part of the analytical framework to be used to observe and analyse decentralisation trends over time, and to better understand why contemporary issues and debates around decentralisation are the way they are (cf. Bernstein, 2017). This could be understood in two ways: factors that *push* countries to decentralise, and factors that *pull* countries to decentralise. These issues are contextualised in Chapter Three, which traces the history of decentralisation policies in Zambia.

As history has it, decentralisation policies emanate from the deemed failures/limitations of centralisation (Conyers, 1984a). The Post World War II period, specifically the 1950s and 1960s, were a period when public administration theories and policies which hinged on transforming and modernising political processes and administration were dominant - particularly with a view to creating economic growth (Rondinelli, 2017). They were accompanied by reforms that were aimed at maximising efficiency in delivering public goods and services (Rondinelli, 1983, 1990). In many cases in the 1950s, policies advocated for strengthened central governments to control and drive a development agenda that was aimed at rebuilding national economies post-World War II (Rondinelli, 2017). However, these theories and policies proved to be unsatisfactory in promoting economic growth and, by the 1970s, most developed countries had started to decentralise their economies, with neoliberal policies being the driver behind the decentralisation agenda (Smoke 2003). Neoliberal policies had become popular in answering development problems because of their attractiveness in advocating for free markets and its corresponding feature of minimal central government control to drive the development agenda (see, Wunsch and Olowu, 1989). Furthermore, the global economic recession in the late 1970s and early 1980s led developed countries to decentralise planning and fiscal control in the belief that the top-down approach to development and policy implementation was the reason behind the economic recession and other development failures (Olowu, 1989).

As such, decentralisation emerged as a tool that was used in developed countries for economic reconstruction and was promoted by the World Bank and other lending institutions (Rondinelli, 1983). That said, decentralisation did come at a price, because it was sold along

with (neoliberal) economic reforms that countries were encouraged to adopt, many of which had detrimental impacts on the delivery of services (including health services) (see, Gill and Benatar, 2016). Even though there was a lack of evidence as to whether decentralisation had actually helped to reconstruct the economies of developed countries in the 1950s (Rondinelli, 1983), it was nevertheless perceived to be the answer to some of the problems of recession and sluggish development in the developing world. The result was, decentralisation ideas were transferred to the developing world, along with the structures and institutional architectures of the western world (Smoke and Lewis, 1996).

Although these policy trends in the 1970s and 1980s may have been the immediate cause of the widespread adoption of decentralisation in SSA, literature that discusses the beginning of decentralisation in African countries often traces it further back to its colonial routes (Conyers, 1984b; Mills, 1990). These literatures point out that decentralisation in most African states in the postcolonial period mirrored the models of decentralisation of their colonisers. For example, countries that had been colonised by the British tended to mirror Britain's approach to decentralisation, and the same was true of those colonised by the French (cf. Mills, 1990). As a consequence of colonial political arrangements, in most African countries the centralised forms of governance were similar to those of developed countries in the 1950s, and thus the transitions from centralisation to decentralisation were again highly influenced and reflective of western styles of governance (Conyers, 2007), only that in the latter decentralisation became synonymous to development and fixing inadequacies within systems.

The early post-colonial period saw most African governments lean towards centralised forms of governance, which was rational, because the principal aim was to consolidate power and national unity and stimulate economic growth (Mills, 1990, Smoke, 1993). Central governments emerged as the strongest providers of social services, including health, education and water and sanitation in developing economies (Conyers, 1984a). Most of the economies in the region were dominated by state owned industries and parastatals, leading to even greater centralisation of power (Rondinelli, 1983). There was often suspicion of local jurisdictions, which were seen to be a threat to central governments because local authorities represented small sects of ethnic and religious representation (Leonard & Marshall, 1996). Thus, for fear of reprisal and social upheaval, developing country governments opted for centralisation as a means of consolidating governance by controlling funds, administration and political authority from the centre (Smoke, 2003). Not only was central control seen by most governments in SSA as ideal at that time, but it was also necessary to have central political commitment to initiate development projects, although widespread support and participation (though in some ways feared) was also needed to implement and sustain economic development work (Rondinelli, 1983).

In recognition of this need for community support to promote development, some traits of decentralisation started to emerge in African countries in the late 1970s. This was seen, for example, in Tanzania and Zambia, where Ujamaa (a political concept of socialism) and Humanism respectively were the mantra (Olowu, 1989). Though these philosophies were centred on promoting community welfare and social cohesion to attain development, they were also seen to have been used to promote what were seen to be dictatorial governments with highly centralised political and economic control (see Smoke and Lewis, 1996). In addition, though these philosophies aimed to garner local support for central government in implementing development work, they were not in line with theories of democratic governance that were promoted by the West as a means of attaining economic growth and reinforcing democratic governance (Olowu, 1989). As a result, demands for more localised voices to be heard became increasing prevalent, which normatively undermined the claims for strong centralised governance.

Whilst it's true that most African economies shrunk in the post-colonial period, and therefore were looking to multilateral and bilateral organisations for help, these institutions in return demanded political and organisational reforms within countries in order for them to qualify for assistance (Wunsch and Olowu, 1989). As part of this, governments were encouraged by donors to loosen their control over the provision of public services and generally to loosen the shackles of central government dominance - with decentralisation at the core of the reforms to attain the purported benefits of efficiency and democratisation. As a result, decentralisation models emerged in developing countries in the post-colonial era and have now firmly rooted themselves within many African states (cf. Hartmann and Crawford, 2008).

However, an interesting debate has arisen over the pros and cons of this policy transfer to the developing world: Olowu and Wunsh (2004, p. 310) labelled this kind of policy entrepreneurship '*notorious*', while Hartmann and Crawford (2008) by contrast put an emphasis on its ability to foster participatory governance. Either way, as the 'piper calls the tune', it is doubted whether the decentralisation reforms that were introduced recognised some of the already existing decentralisation programmes that African countries had earlier embarked upon (Rondinelli, 1983a). In short, African countries were pushed to adopt a replica of decentralisation reforms that had been implemented in developed countries, with several limitations, and with limited acknowledgement of the contextual factors that moderate how supposedly universalistic decentralisation models apply in practice (Olowu, 1989). Lately these doubts have extended to criticise how donor reforms and programmes.

It is undeniable that decentralisation had a huge impact on African countries, being implemented widely in the public sector and in the delivery of services (Conyers, 2007). But there were a number of challenges in implementing decentralisation policies in Africa. From the outset, failures of development programmes in the developing world have largely been blamed on the lack of contextualisation of policy templates. As Rondinelli (1983) discusses, many of the models applied in Africa were typified by Western ideals. They were usually

transferred to developing countries attached to structural reform processes and promises of change (Helmsing, 2003), and the African institutional environment was often not taken into account when policies were transferred. Later in the thesis, in discussing whether decentralisation works or not, we will return to examine these critiques in detail[5].

As alluded to earlier, though the principal aim of many governments in both developed and developing countries in the 1950's - through to the early 1970's - was to consolidate power, the inefficiencies of central fiscal control and administrative decision-making were gradually admitted, and governments sought to find answers to emerging problems of stagnation and poor economic performance (Conyers, 2007). In this period, the World Bank and its underwriters often suggested decentralisation as the best means for addressing these problems and boosting development (Conyers, 1984b). In many ways, governments were being pushed to relinquish fiscal and administrative controls as a way of managing economic growth effectively and efficiently (Rondinelli, 1983, Smoke, 2003, Olowu, 2003). As the World Bank was pushing the decentralisation agenda forward, embedded in major economic reforms such as the structural adjustment, developing nations were heavily indebted and incapable of providing local social services, and thus the shifting of such responsibilities to local authorities became the rational (and often only) response (Conyers, 1984b). Though such developments seemed rational, local authorities in most developing countries at the time had significantly weakened, with the population questioning the legitimacy of locally elected officials. Thus, it was increasingly difficult to democratise service delivery (cf. Hartmann and Crawford, 2008, McConnell, 2010). This observation is of key relevance to this thesis as it establishes in later chapters the importance local authorities' perceived legitimacy in fostering local participation).

Moreover, in developed countries, decentralisation policies were widely supported and advanced by both right and left-wing politics. The right justified it as a means of increasing efficiency in government operations, with conservatives in countries like Britain and the USA opposing the dominance of growing power and dominance of fiscal control by central governments (Conyers 1984b). Meanwhile, the left justified decentralisation as an appropriate means of providing better services to the people (Mills, 1990). Developed countries were offering substantial bilateral support to African countries, thus also having huge stakes in driving the decentralisation agenda in African countries (Hartmann and Crawford, 2008).

By the 1980s and 1990s countries in SSA that had not adopted the decentralisation agenda were widely criticised and were often deemed ineligible for multilateral and bilateral support (Osei-Kufuor et.al, 2013). The situation was compounded by centrally run governments and state-owned enterprises' inability to offer quality local services to the people in most

[5] The discussions will be revisited in Chapters Five and Six where the thesis uses empirical evidence to show how decentralisation models have worked in the Zambian health sector.

developing nations, thus failing to fulfil government mandates. State-owned enterprises were ultimately a huge cost to most governments (Rondinelli et.al, 1983). Further, lending institutions criticised governments in the developing world for concentrating more on macroeconomic policies and political stability rather than investing in local social services. In many countries, poor roads, poor sanitation, poor staffing in schools and run-down infrastructure were blamed on the government management of resources centrally (Ribot, 2002).

While the drivers of decentralisation in developed and developing countries are explained only briefly here, the common ground between them is a shared understanding about the failures of central governance. The bureaucratic structures of central governments were mainly criticised for delayed decision making, thus impeding development programmes and innovations (Hartmann and Crawford, 2008). In addition, central governments' grip on power and the political process resulted in reduced political participation and neglect of grassroot views and needs. Corruption was also seen to flourish where central governments dominated (Rondinelli, 2017).

However, this set of ideas was also questioned. Some doubted whether highly centralised structures resulted in greater corruption, since corruption was also found in countries with highly decentralised structures (see Smith, 1985, p83, Olowu, 1989). For some, the pressure for western style decentralisation was influenced by colonialism (Olowu, 1989). Others highlighted the practical difficulties: because many central governments were unwilling to relinquish power to local governments, for fear of losing their control of resources and/or empowering opposition groups, it was difficult to implement decentralisation (Fesler, 1965, Ouedraogo, 2003).

Why was decentralisation supported?

This section, expanding on the brief discussion in the introduction, reviews the literature to more fully understand why decentralisation has been so widely supported (i.e., what its supposed benefits are). However, in doing so it is important to note that empirical findings on decentralisation policy outcomes are contradictory across different contexts (Adams, 2016). As already explained, the thesis believes that analysis of structural and institutional arrangements within case specific contexts will generate much more value that theorise decentralisation's effectiveness in general terms. In doing so, it is important to understand how a particular decentralisation process was arrived at, its specific aims, and the environment in which it was meant to operate. As Smoke contends, if decentralisation arguments are left at just investigating the advantages and disadvantages in general terms, it becomes problematic because such arguments are based on limited appreciation of contextual and processes factors that affect decentralisation. As Smoke states (2003):

"Much of the decentralisation literature focuses on its often-problematic performance and positive writings tend to be based on anecdotal instances of success or enthusiastic rhetoric about its benefits".

Nevertheless, the presumed benefits of decentralisation are essential to understanding why, despite decentralisation policies being in existence for more than five decades and in many cases having yielded minimal results, they continue to be supported.

The is no single reason – and indeed, among academics and technocrats, there has often been a lack of agreement regarding the benefits and positive outcomes that decentralisation is thought to produce (Saltman and Bankauskaite, 2006). Broadly speaking, for advocates, the benefits and positive outcomes associated with decentralisation are that it: reduces administrative and decision making burdens at the central level; creates unity and stability via local 'buy-in'; enhances political participation; improves the mobilisation of resources; improves coordination of local development activities; empowers the poor; enhances efficiency in the delivery of public services; improves responsiveness to local needs; and creates social cohesion (Smith, 1990). The remainder of this section examines how these benefits have been portrayed in the academic literature.

First, decentralisation is argued by advocates to improve administrative efficiency, as it lessens the burden of micromanagement by central government (Rondinelli, 1981, Smith, 1990). The underlying principle of pursuing decentralisation is that, on one hand, it lessens the burden of micromanagement from central governments, and, on the other hand, it encourages participation and self-governance at local levels (Rondinelli et.al, 1983; Mills, 1990). Philosophically and ideologically, decentralisation is deemed by its proponents to be a sensible political tool for governments to improve participation and encourage self-sustenance at community levels (Mills, 1990).

Second, decentralisation is seen to foster democratic governance in undemocratic countries - especially in developing countries (Romeo & Spyckerella 2014). It is seen as a tool that can build national solidarity because, politically, decentralisation is a means by which central governments can distribute power more evenly across geographic territories (Smith, 1985, p22), enhancing the democratic rights of local communities. Hence advocates believe that decentralisation is an effective enabler of power sharing and a means to promoting democratic governance because it builds confidence in local leadership, by which citizens participate to build national unity (Schneider, 2003). Further, within the context of the international development literature, decentralisation is also perceived as a means of attaining good governance and strengthening accountability. Other literatures advance the ideas that decentralisation can work to create peace and stability in fragile states by creating

and strengthening federal governance systems, especially as opposed to having unitary or authoritarian states (Smoke, 2003). Bossert and Mitchell (2010) state that decentralisation legitimises the power of locally elected officials, who can in turn influence and contribute to policy design. This understanding of decentralisation resonates with arguments that suggest that a key aspect and positive of decentralisation is that it enhances development through local participation (Magnussen et.al, 2007), helping government to communicate directly with local people. This apparent promotion of local participation is a key reason that donor agencies continue to promote decentralisation as an approach to localised development (Ribot, 2003).

Third, it is widely argued that because decentralisation encourages local participation it leads to better delivery of services as accountability is enforced by local/grassroot structures (Adams, 2016). This belief fits in with literature that states that local authorities/structures tend to be more responsive and less corrupt than central level structures (Crook,2003). Although such expectations are held to be true by supporters of decentralisation, it has been argued that they can create problematic beliefs about what decentralisation can achieve in broad terms (Prud'homme 2003), overlooking the fact that these benefits, according to Smoke, only emerge *if there is adequate governance through elected councils and other accountability mechanisms, and adequate capacity of local governments to meet their responsibilities* (cf. Smoke, 2003, p. 9). These arguments relate closely to literature that states that community/local empowerment generates social cohesion (cf. Walsh et.al, 2012).

Fourth, many advocates of decentralisation feel that it speeds up decision making and promotes innovative means of mobilising resources (Smoke, 2003, Olowu, 2003). These arguments are further accentuated by claims (often made by multilateral and bilateral organisations) that it improves effective resource utilisation (See Osei-Kufuor et.al, 2013). The assumptions here are that local communities become more responsible in the use of resources because they are involved in mobilising the resources and fully participate in their use (Bae 2016). In turn, this is seen to increase client satisfaction, increase quality service provision, increase service utilisation, and ultimately contribute to national economic development (Lindblom, 1965; Rondinelli et.al, 1983).

Fifth, decentralisation is said to result to better planning of social services because the involvement of local voices in managing service delivery is often seen to lead to a system more likely to meet service needs and demands (Rondinelli et.al, 1983; Mills, 1990). In other words, that local people know their problems best and are thus in a better position to address them and to promote their own welfare (Hutchcroft, 2000).

It is for these reasons that decentralisation came to be interpreted by multilateral and bilateral agencies as a pathway to initiate economic and political goals in developing countries

(cf. Agrawal and Ribot, 1999). As discussed in the section on history above, these claims follow from a series of prior claims about the inefficiencies of centralisation and the ineffectiveness of national-level public sector bureaucracies (cf. Olowu, 2003) Although authors such as Smoke (2003) have critiqued the pressure exerted by donor agencies, and the fact that a compelling evidence base for many of these claims is lacking, it is certainly the case that a belief in these arguments meant that the promotion of decentralisation in countries like Zambia (where public services were in a deplorable state, yet the government clung to power (see Simutanyi, 1996) was rational.

Critiques of Decentralisation

Detractors of decentralisation argue against decentralisation because they deem it too ambitious and vague to produce the benefits and outcomes that are claimed for it (see De Vries, 2000). Specifically, detractors of decentralisation generally make five arguments against the benefits of decentralisation.

First, administratively, staff at local levels will not possess the expert knowledge required to address complex policy issues, and as such it is argued that local levels will always depend on the centre to provide policy direction (De Vries, 2000).

Second, decentralisation does not in practice translate into increased local participation because bureaucrats and politicians at local levels seek to control decentralisation functions rather than to facilitate wider distributions of power. As a result, decentralisation at local levels will tend to favour certain individuals and groups that are politically aligned to local party politics and power, in many cases those supporting the central government and acting as local power brokers for central elites. In short, decentralisation is said by its critics to reinforce elite politics (Smith, 1985 p42).

Third, although decentralisation claims to promote good governance through distributing political decisions and operations to lower levels, critics argue that decentralisation can be overshadowed by local political elitism (Crook, 2003, Smoke 2003) which can create fragmented power elites pursuing separatist tendencies at local levels. What happens is that due to the emergence of local elites, these elites tend to side with central powers to shore up strength, or, become separatist. Either way, these local elites consolidate central power, not decentralise it (Johnson, 2002).

Fourth, whilst it is often suggested that local ownership of service can help in the mobilization of resources (Smoke, 2015), critics argue that often local governments do not have the capacity to raise resources to fund the delivery of some social services, such as primary health care, which are a huge cost that may not be met by local financing. In some instances, this

leads local governments to demand more from the community so as to meet the costs of providing services (c.f. De Vries, 2000; Smoke, 2015), for example through charging of out-of –pocket user fees – a feature of many developing countries health systems. As a result, 'local ownership' can often in practice further marginalise poor people, making it more difficult for them to access basic social amenities, therefore defeating the purpose of more effective delivery of social services (Andrew and Schroeder, 2003).

Fifth, as already pointed out, despite decentralisation's popularity, there is very little empirical evidence to support its effectiveness, and lit benefits in practice that it purports to deliver (see Smoke, 2003). The result has often been a series of experiments conducted in developing countries, with real implications for the health and wellbeing of populations. As Agrawal and Ribot (1999, p. 1) observe:

> *"Decentralisation is a word that has been used by different people to mean many different things. But what do we see in practice? Experiments with local government that end in chaos and bankruptcy; 'decentralised' structures of administration that only act as a more effective tool for centralising power; regional and district committees in which government officials make decisions while the local representatives sit silent; village councils where local people participate but have no resources to allocate*".

Too often, critics argue, decentralisation in developing countries ends up not fulfilling the goals of poverty reduction or improved delivery of services at local levels, but instead creates bloated structures at lower levels which are poorly funded by central government, given very little power to mobilise resources to operate, or worse still may not have any means to generate income to initiate the needed development or support the programmes that they may want to run. In other words, central government may use decentralisation as a way of getting out of its responsibilities – '*passing the buck*' (Wunsch and Olowu, 1989; Wunsch, 2001). Some literature further states that if decentralised structures lack the necessary power and resources to exercise grassroot governance, they fail to deliver services to communities (Tordoff, 1994). Because this is a common feature in many developing countries, it has led to many critics of decentralisation concluding that decentralisation doesn't work (see, Crook, 2003).

In a nutshell, critiques of decentralisation suggest that decentralisation is not an absolute good as is often suggested, since the state plays a greater role in determining development programmes, while the community plays an obscure role. Furthermore, the state may use decentralisation to dominate subnational political entities (cf. Adams 2016). In the end, as argued by Smith, it is likely that resource distribution will reward those that have local political influence and who remain loyal to the top (Smith, 1985, p40).

However, Smoke warns that these criticisms should not lead to blindly supporting centralisation, since that may perpetuate authoritarian regimes who deny people basic rights such as democracy and the right to education and health. He concludes that decentralisation *can* work if properly designed and applied, though he recognises that it is "*certainly not a panacea for public sector ills or a natural enemy of effective government"* (2003). Olowu argues for the same, citing that tight fiscal central controls have not worked well in African countries, but have rather advanced dictatorial tendencies where the central government delays the release of funds to local governments as a means of settling scores. This has impinged on the democratic rights of local governments. He notes that "*the common failure of such accountability arrangements is one of the most important grounds for reform"* (2003 p46). Lastly, an array of literature highlights the fact that the experience of decentralisation is not uniform across all countries, or indeed within all parts of a country, or within all sectors Prud'homme, 2003; Pollitt, 1991). In other words, context matters. As described above, the aim of this thesis is to examine decentralisation within the Zambian health system so as to generate insights on the aforementioned debates and their saliency to 'lived practice' in this particular case.

Contextualising decentralisation

Despite its relatively long history in theory and practice, the debates around decentralisation sketched out above remain inconclusive and keep evolving. Yet, despite this, decentralisation of various kinds has been, and continues to be, widely applied in African countries. Countries have introduced a range of different policy approaches, involving mix of delegation, privatisation and deconcentration (although generally leaving out devolution (Adams, 2016)).

A wide range of literature has recently been generated that highlights the difficulty of modelling experiences of decentralisation (Bossert and Mitchell (2010); Brinkerhoff, 2015; Kelly, et.al, 2016), and has (like this thesis)) attempted to understand the contexts in which decentralisation has been attempted – and how process of policy transfer via multilateral and bilateral donors often do not reflect local politics, grassroots interests, power relations and institutions, which tend to be contextually specific (see, Adams, 2016; Kelley et.al, 2016). This lends credibility to the argument that the reason that most African countries have not benefitted from globally popular decentralisation policies is because the inherent conditions of their domestic institutional arrangements are not taken into account as critical elements (Olowu, 1989). Smith (1990) furthers this critique, suggesting that weak administrative structures and weak fiscal capacities are inherent features in most developing economies, but the need to strengthen them prior to policy implementation are ignored. Schneider (2003) concurs, arguing that states with strong institutional capacities are necessary as decentralisation functions to facilitate national development. The assumption is that when institutions are strong the necessary legal frameworks stipulating the roles and functions to

be played by central and local government can be created, which in turn promotes the successful implementation of decentralisation policies and programmes.

However, this is not to say that policy transfer attempts to deliberately ignore these existing factors. Rather, they underplay the active agency of African governments. In relation to that, this thesis (see Chapters Five and Six) makes the argument that one of the factors that has led to the failure to implement decentralisation successfully in Zambia political patronage politics (cf. Norad, 2008).

Another interesting debate around the implementation of the concept of decentralisation is whether decentralisation should be discussed within the confines of vertical processes that entail shifting responsibilities and resources from the central state level to designated territorial sub-national levels of government, or whether the concept should also include the horizontal process of decentralising abilities and resources at a given level of government through processes such as delegation and privatisation (Hartman and Crawford, 2008). Rondinelli et al.'s (1983) persuasive works first suggested a wide-ranging typology of decentralisation to include both the horizontal and vertical dimensions and the importance of embracing specific types where needed. However, Rondinelli et.al, came under strong attack by Slater (1989) who criticised him for having ignored some of the fundamental questions of decentralisation, such as to whom power is transferred and whether capacity exists within the structures to which power and responsibilities are transferred. This highlights the fact that, to provide meaningful conclusions regarding the pros and cons of decentralisation, empirical research needs to be grounded in a theory that generates research questions and hypotheses addressing the specific causal mechanisms at play when decentralisation is attempted. To add to the debate, De Vries (2002) discusses how the experience of decentralisation in some European countries generated mixed results, where what was seen in one country as a positive experience would be deemed as negative in another. This adds to the ways in which decentralisation can be context specific.

Although these more case specific debates are quite recent, the old arguments regarding questions about the concept of decentralisation – particularly its legitimacy, use, application and prerogatives - still dominate the discussions (see Ohemeng and Ayee, 2016). As decentralisation has rooted itself in most African countries, it seems that its detractors have lost the argument. However, their critiques provide an important contribution to examining the operation of decentralisation specific political, economic, social and cultural settings (Hartmann and Crawford, 2008).

Health sector decentralisation

Just as the experience of decentralisation can vary widely across different national contexts, so can it differ between different sectors. This section examines why, in the context of decentralisation's popularity as a form of political, fiscal and administrative restructuring, it

has taken on a particular significance in the health sector – helping explain this thesis' focus on *health sector* decentralisation in *Zambia* (i.e., a particular sector within a particular national context).

Low-income countries have long struggled to ensure the provision of adequate health care to their populations as a result of a variety of factors including adverse economic circumstances and limited government capacity, as well as a challenging international policy environment (Mohammed et.al, 2009). In countries like Zambia, the situation has been further compounded by the fact that health sector reform has been driven by wider macroeconomic policy; for example, the health reform programme in Zambia was driven by implementation of structural adjustment programmes which required reductions in public expenditure and changes in public and private sector institutional structures (World Bank 2001).

Despite these limitations and the problems African countries are faced with, they continue to attempt to implement decentralisation programmes in the health sector, of one kind of another. Mills states that that the type of decentralisation that a country decides to implement for its health sector will determine the outcomes. She details the implications of deconcentrating, devolving, delegating and privatising, and relates them to fiscal, political and administrative decentralisation. For example, she states that;

> "*In developed countries devolution tends to give power to local hospitals with high technology and they in turn tend to influence public opinion and thus weakening the decisions of central governments whilst in a developing country deconcentrating may disfavour the local community because the decisions will be made by the higher authorities at hospitals who are seen as having the expert knowledge therefore divorcing local participation. As such in developing countries devolution is preferred because it encourages local participation by engaging of local bodies and community in the management of health services" (1990)*

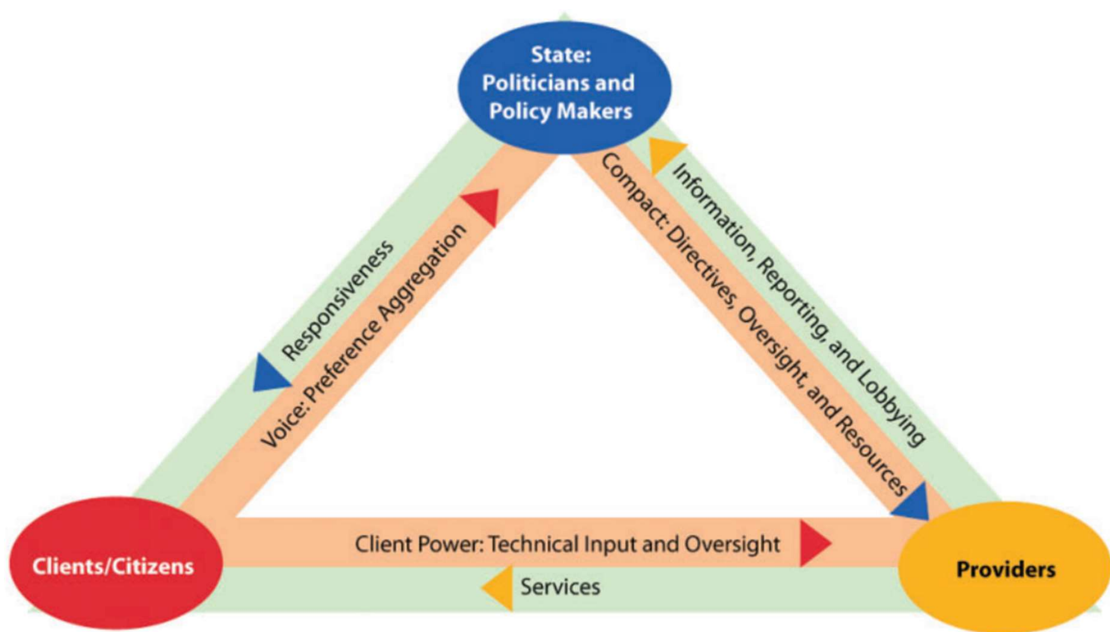
For the World Bank, a key advantage of health sector decentralisation relates to health infrastructure development at local levels (i.e. within districts and provinces) that can help address existing health infrastructure disparities, where rural areas are underserved compared to urban ones (see World Bank, 2011, 2018). Thus, for the World Bank, one of the key premises of decentralisation is to take services closer to the people and to tap into local resources and knowledge to enhance the welfare of communities (Walsh et.al, 2012). The purported benefits of decentralisation described earlier in this chapter are still prominent in discussion of health sector reform in SSA to this day: (i) from an administrative point of view, decentralised health systems are seen as responsive and bring about innovative service management to meet local needs; (ii) from a fiscal point of view, decentralised health systems are seen to reduce resource wastage by optimising resource utilisation; and (iii) from a social

capital perspective, decentralised health systems are believed to foster citizen participation in planning and provision of health needs (see, Dwicaksono and Fox, 2018).

Based on these understandings, health sector decentralisation is continually being promoted by the WHO by placing emphasis on strengthening district health systems. As briefly introduced in Chapter one, health sector decentralisation was affirmed by the Alma Ata declaration of 1978 as a way of engaging not only governments but also citizens in health services delivery, with the goals of achieving equity and improved service delivery (WHO, 1978). This arguably set an agenda according to which health systems decentralisation is justified to date. Lately, this has aligned with thinking on health service governance that puts an emphasis on governance not being about governments alone, but a combination of processes, institutions and citizens participation (WHO, 2014). In this regard, the United Nations Development Programme (UNDP) explains governance to be means by which a country is managed politically, administratively and through which citizens' rights are expressed (UNDP, 1999). Evidently, by putting an emphasis on citizens participation, literature on health governance mirrors the ethos of the Alma Ata declaration, and contributes to the continuing popularity of health sector decentralisation as a policy approach.

Contemporary health governance literature focuses on explaining the functions exercised by multiple actors within the health systems and how they each express their agency. Brinkerhoff and Bossert (2013) posit that the needs of citizens are expressed both to government and bureaucratic actors – to governments through voting and payment of taxes, and to bureaucratic actors through accountability mechanisms and expressions of needs, as figure 1 shows (c.f. Brinkerhoff and Bossert, 2013). Thus, the thesis is also interested in interrogating the agency exercised by local levels and communities and the resulting effects on health decentralisation (see Chapters Five and Six).

Figure 1: Health Governance Framework: Brinkerhoff and Bossert (2013)



A key concern for this thesis is whether and how heath sector decentralisation can possibly lead to the attainment of health systems goals in Zambia. In Chapters Five and Six, the focus is on outlining factors that may influence and support the attainment of decentralisation's stated goals at local levels, such as the design of the policies. In reference to case studies such as Walsh et.al (2012) that evaluated the sustainability of Community Based Organisations for HIV/AIDS in a rural district in Zambia, the main argument is that communities will always respond to their own problems even in the absence of outside intervention (state, donors, civil society etc). As such, outside interventions will only work when in agreement with community principles and needs. Thus, for decentralisation policies to work they should be designed in such a way as to harness already existing social structures, not to replace them.

Conclusion

As we have seen in this chapter, the arguments for the benefits of decentralisation (including health sector decentralisation) are contested. It seems clear at the very least that the purported benefits are not being automatic or guaranteed. Many scholars have advocated for more thorough theoretical and practical evidence that can drive health sector decentralisation to achieve desired outcomes (see, Bossert, 1998; Bossert and Mitchell, 2010). Elsewhere, it has also been argued that the continuing weakness of health systems in many countries in SSA is not only about decentralisation failing to deliver the needed improvements to health services, but also the influence of the wider policy environment

(Conyers, 2007). What is needed, and often missing, is focused study on decentralisation in practice. Its local rationales, drivers, and contextual factors as these either aid or limit its ability to act as an effective or useful reform tool. Thus, this thesis is interested in establishing how health sector decentralisation has been (and can be) implemented in Zambia, taking into account the readiness of the Zambian economy and health sector to facilitate decentralisation.

In summary, the case of health sector decentralisation in Zambia will allow for the thesis to explain why decentralisation was chosen as a policy option by several successive Zambian governments, and why it has produced the results that it has. Zambia provides a useful case in which to study decentralisation because the health sector decentralisation process has been the main feature of the long-running health sector reforms, which commenced in 1992. However, the agenda has inadvertently been implemented in isolation of the broader national decentralisation process that is yet to be implemented. As explained in the introduction and the later theory chapter, these discussions will be embedded in the health policy triangle framework where the policy objectives, and key political, managerial, technical and structural issues that have characterized the health sector reforms and decentralisation processes in Zambia will be reviewed.

Of interest to this thesis is how decentralisation has been employed over time as a reform tool for improving health services; garnering local participation; creating local institutions for governance; and above all as a political power sharing tool. Specifically, from an empirical point of view, the primary interest of the thesis is the governing and management of the health sector.

From the foregoing discussions in this chapter several key issues have been established, all of which are important foundations for subsequent discussions in the thesis:

a. The history of decentralisation is useful or understanding why decentralisation was introduced in the development lexicon and how it has been used over time as a policy management tool.

b. The various arguments advanced in terms of support of decentralisation, and the critiques of it, provide an important set of questions that can be applied to the empirical case. In the later chapters of the thesis, we examine questions related to health sector decentralisation in Zambia based on the foundations of the support and critiques highlighted.

c. Debates on the merits and demerits of decentralisation have too often been at an abstract theoretical level and have not been sufficiently based on case country studies. In this thesis, we therefore note that the merits and demerits of decentralisation should not be generalised. In response, Zambia will be used as a case study to provide

useful information in examining health sector decentralisation in this particular context. By doing so the thesis aims to generate rich contextual data based on practical backgrounds on the nature of decentralisation policies. Our aim in this regard is to contribute to better understandings of decentralisation in context.

d. There are several arguments as to why and when decentralisation policies succeed (or fail). As the literature suggests, institutional capacity and political support are paramount to the success of decentralisation, and these stand out as prerequisites for successful decentralisation.

e. In this thesis, one of the key elements is how to differentiate what is deemed as successful or unsuccessful decentralisation. Considering that Zambia has implemented different forms of health sector decentralisation and is still attempting to do so, the case study that this research has embarked upon will be useful to highlight policy dynamics and contextual moderators involved in more or less successful decentralisations. Thus, this thesis embarks on an intellectual journey to assess how decentralisation models in sub-Saharan African (SSA) countries like Zambia are shaped by the economy, income level, social structure and political choices.

f. Ultimately what the thesis attempts to do is to bring to bear the lessons of theory and of historical experience to help countries like Zambia define their own health system reform strategies (Prud'homme, 2003). Decentralisation in SSA will remain on the agenda for many years—a key task is to identify the ways in which it can be implemented to deliver the hoped-for health benefits.

Chapter Three

Historical analysis of decentralisation Policies in Zambia

Overview
Positions the rise of decentralisation policies in Zambia in a historical context
Traces the roles played by actors in fostering the decentralisation agenda
Discusses why and how decentralisation has been promoted on the agenda to govern health services – what factors promote decentralisation?
Reflects how these factors have influenced how policymaking is construed and used to embed decentralisation on government agenda

Introduction

As argued in Chapter One, decentralisation has persistently featured as a policy reform tool to govern health services by successive Zambian governments. Although decentralisation was practised earlier in Zambia, pre- and post-independence, it was not explicitly associated with good governance, as it came to be in the late 1980s through to the early 1990s (Quedraogo, 2003). Decentralisation rose to prominence as a health governance tool after what has been called the '*third wave*'[6] of democratisation in sub-Saharan African countries (see Schraeder, 1995). The importance attached to it by multilateral and bilateral organisations was signified by both technical support and monetary investments that were committed to implementing decentralisation policies (cf. Smoke, 2003). In addition, during the same period, from early 1980s through to the late 1990s, the World Bank and World Health Organisation (WHO) had conducted several extensive studies to justify the need to implement decentralisation in developing countries' health systems, including providing guidance on how developing countries could design decentralisation to achieve optimal results. Scholars provided consultancy for these organisations; for example, Mills (1990), provided case studies for WHO on how decentralisation should be implemented, while Litvack et.al's (1998) work for the World Bank focused on designing and overcoming the institutional challenges that were identified to have been a deterrent to implementing decentralisation in developing

[6] "Third wave" was signified by the removal of governments that had been in power since Africa's wave of independence during the late 1950s to early 1960s, through the introduction of multi-party politics (see, Nicolas van de Walle, 1999).

economies. Other case studies supported by WHO were specific to Zambia. For example, Kalumba (1994) assessed the state of primary health care, including the need to implement health reforms in Zambia, and Kalumba et.al again (1997) justified the implementation of health reforms in Zambia and the need to continue with such an agenda.

By understanding these earlier episodes of decentralisation in Zambia, we may better appreciate the diverse international and local political relationships that continue to define contemporary decentralisation efforts. This chapter reveals how international policies have historically had an upper hand in promoting decentralisation in Zambia under the rubric of political and socioeconomic reforms (just, as will be shown in later chapters, international policy frameworks continue to run through contemporary decentralisation issues in Zambia). Although the thesis does not attempt to argue that the poor state of health systems in developing countries like Zambia rests entirely on the problems of international policy transfer, it will be argued here that the evolution of the decentralisation policy agenda in Zambia has to a great extent reflected donor ideologies (see, Attaran, 2003). This is why tracing the history of decentralisation is so important to this thesis; because that history shows how actors have consistently exercised their power and interests in pursuit of implementing decentralisation. As will be seen in the examination of contemporary decentralisation policies in Chapters Five and Six, donor programmes continue to dominate health sector programmes. This means that lessons that can be learnt from the history of decentralisation efforts that have relevance for contemporary problems of health system governance.

Henceforth this chapter demonstrates how successive Zambian governments have appeared to be in conformity with the ethos of decentralisation of health services, yet systemic weaknesses have continually undermined their ability to implement decentralisation successfully. The first sections of the chapter give a historical account of decentralisation in Zambia demonstrating how decentralisation policies have been included in national development plans, adopted and implemented at a national scale by three political regimes: the United National Independence Party (UNIP), the Movement for Multi-Party Democracy (MMD), and the Patriotic Front (PF). The intentions of the various decentralisation plans, and the factors that enabled or impinged the processes of decentralisation, will also form part of the discussions. In doing so, the Chapter demonstrates how attempts at policy reform under the one-party state (UNIP government) were frustrated, while with the introduction of multi-party politics (the MMD government), despite having showed commitment to implementing decentralisation, weak political institutions undermined the outcomes of the reform agenda. Finally, with the PF government, the delays in proceeding with the decentralisation policy agenda and the effects on policy legitimacy provide evidence of how political obstacles tend to undermine reform. The final sections of the chapter begin a critical analysis of whether these historical decentralisation efforts have been progressive or regressive in the Zambian

context, using the arguments of the norms of policymaking (according to the policy cycle). In doing so, the chapter reflects the politics of 'doing policy', that is to say how local actors in developing countries like Zambia draw on what is presented to them – *ideas* - and how they navigate through these ideas considering their interests and relationships (both existing and new ones) in the policy arena that may promote/constrain policy legitimacy (cf. Buse et.al, 2012, p.195).

The discussions in Chapter Two explored the arguments have been made for decentralisation, and the positive outcomes that it's intended to produce in the health sector – although it also showed that some are wary of decentralisation, arguing that it does not necessarily improve service provision and that its success/failure is moderated by contextual factors (Prudhomme, 1995; Lankina, 2008). In addition, it was argued that there is little concrete evidence that exists to date that tracks the specific impacts of decentralisation on particular health care systems (Mohammed et.al, 2016).

This is true of Zambia: although decentralisation has been a main feature of health policy for decades, there is limited literature that examines why decentralisation policies continue to be pursued by various Zambian governments despite the failures recorded. Given this, this chapter describes the series of attempts at decentralisation processes that Zambia has previously embarked upon at different periods in time. The chapter describes the rationale for these health reforms and the end result of the reforms in the Zambian context so as to deconstruct the decisions that influence the choice of decentralisation policies by successive Zambian governments.

As already established in Chapters One and Two, the arguments surrounding decentralisation as a policy choice suggest that its successes are dependent on the type of decentralisation used in specific contexts (Rondinelli et.al 1983) and how these strategies relate to in-country institutional arrangements and capacities (Lankina, 2008). It should be noted that three successive Zambian governments embraced decentralisation policies as means to improve health service delivery, from the mid-1980s to 2016. Some of these attempts to decentralise are considered not to have yielded the expected results, but others are seen as a having achieved pockets of success (Chikulo, 2010b). Thus, in this chapter narratives of what is/was deemed as successful and/or unsuccessful in the Zambian context by various political regimes are provided as a foundation for later arguments (in Chapters Five and Six) that examine why decentralisation in the health sector still matters in Zambia today. despite having yielded so few previous successes.

Central to this chapter is that decentralisation in the health sector in Zambia has surpassed all other sectors. But even the health sector has not had a single, monolithic experience: as will be discussed below, HIV/AIDS services were decentralised in isolation from the broader

health sector and national decentralisation plans. Furthermore, there have been other organisational and institutional reforms within the health sector that equate to decentralisation, for example the creation of additional districts and the attempted reorganisation of maternal and child health services that were implemented by the PF upon having formed government in 2011.

To understand these key issues, the next three sections of this chapter focus on explaining how decentralisation was/has been addressed by three successive political parties (focusing on their approach to policy in general and governing of health services in particular) that have ruled Zambia since independence in 1964.

Health service governance during the UNIP era: 1964 – 1991

Like many other countries in Africa, Zambia's governance system in the early post-colonial period fostered centralisation (Olowu, 2003). As already highlighted in Chapter Two, centralisation was seen by central governments as more favourable because they felt threatened by local authorities that often represented ethnic and religious groupings that were potential sources of opposition (Smith, 1985, p61). In the context of fears of reprisal and social upheaval, centralisation offered a means of consolidating governance by controlling funds, administration and political authority from the centre (Conyers, 1981). The period also coincided with the dominance of 1950s and 1960s development theories that advocated for tightened centralised resource control to drive development (Mills, 1990).

Due to the centralised resource control, the Zambian government in the post-independence era emerged as the sole provider of social services, including health, education and water and sanitation (see, Chikulo, 2009a). The economy was dominated by state-owned industries and parastatals, which were also used as avenues for service provision. For instance, the mining industry was chiefly a parastatal industry with a mandate for providing social services, with health being one of the key services provided (see, Craig, 2000).

Since independence from Britain in 1964, Zambia's territorial administration was (and is still) divided into provinces and districts, with the central government at the helm (GRZ, 2009). The provinces are a larger unit of administration, each of which is divided into several districts. Administration at provincial and district levels has continuously transformed according to political interests and ideologies that successive central governments have adopted (GRZ, 2009). The operational relationship between central level and the lower levels are described in a range of policy documents and strategic plans (cf. Fifth National Development Plan; First National Health Strategic Plan; Poverty Reduction Strategy Paper and Vison 2030).

According to the Zambian constitution, as first adopted by the UNIP government, central government primarily consists of government ministries and its agencies, while the provinces and districts are deemed as administrative wings of central government. After independence

in 1964, the UNIP government's approach to provincial administration was through appointed officials, while the districts were run by elected officials (this has remained the same through successive governments). The key difference between then and now is that, in 1964, the country had inherited a robust economy that many cite as a reason for the efficient delivery of public services at the time (Chikulo, 2009a). However, by the mid-1980s there was an economic downturn that led to a significant reduction of service provision by both the central government and local authorities, which influenced government's policy shift at district level to a mix of locally elected officials and appointed party officials (Conyers, 1981). This led to the introduction of reforms aimed at increasing public participation through a system that was referred to as 'integrated' to manage local administration. The councils largely provided social services and were adequately funded by central government to do so. This situation changed in 1973 as a result of the decrease in their financial base as central's government resources were drying up, which in turn reduced the funds available to local government (see, Freund, 1986).

In the health sector, meanwhile, the services provided in the colonial era were deemed to be more curative than preventive. This recognition led to a shift in the organisation of health services after independence. When health care organisational structures were established in 1966, they consisted of the *Central Administration, Provincial Administration and coordinating committees. The Central Administration (Medical, Preventive and Administrative divisions) was responsible for formulating health policy, planning, issuing policy guidelines, and allocation of funds* (Freund, 1986 p. 879).

This centralised structure meant that the apparent failures of councils to provide services are mostly attributed to Central Government (MLGH, 2009). The decline in funding for councils to provide social services affected the health sector in various ways – the lack of infrastructure development, failure to respond to the disease burden, poor medical supply chain and poor human resource management (MoH, 2001). The councils that were formally managed by locally elected officials were replaced by district councils that were composed of a combination of locally elected councillors and officials appointed by the UNIP party headquarters under the chairmanship of the district governor, an appointed official who was the head of the party and the government at district level (Conyers, 1981). Although this was referred to as decentralisation, the centre seemed to have had an upper hand in administrative control due to the presence of party elected officials at local level.

The result was that, although the reforms were presented as a decentralisation with the aim of improving public participation through participatory democracy and at the same time enhancing administrative efficiency, the reforms did little to achieve the intended outcomes (cf. Conyers, 1981). Thus, by the late 1980s, there were massive calls to reform government as service provision was in a deplorable state, especially in sectors like health and education

(Chikulo, 1993). Furthermore, the provincial and district administrative officers were seen by critics as nothing more than loyalists to the party that strengthened party structures at lower levels, rather than enhancing democratic participation (Mushingeh, 1994). As already highlighted in Chapter One, the call for change of government in Zambia coincided with Structural Adjustment Programmes (SAPs), economic reforms that the Bretton Woods institutions were promoting as means to enhance economic growth in developing countries (Loxley, 1990). Hence the main opposition party, the Movement for Multi-Party Democracy (MMD), gained political ground on promises of economic reforms based on economic liberalisation and better delivery of and access to social services for the Zambian masses (Baylies & Szeftel, 1992). The economic failures and the deplorable state of social services were blamed by the MMD on the UNIP government's hesitation to implement SAPs. As Simutanyi (1996) notes; "economic grievances were used to express political grievances".

Although the decline in service provision and the quest to improve the operations of provincial, district and council administration in dispensing services triggered the UNIP government to implement decentralisation policies, the way it was structured failed to meet the purpose, partly because of the poor economy and also the dominance of local party officials at district level. Chapter Five returns to these issues of how UNIP loyalists undermined the decentralisation reforms. Therefore, in this case, the failures of decentralisation are closely related to political practices and weak socio-economic conditions (See Chapters One and Two).

Decentralisation under the MMD Government (1991 – 2011)

The MMD was elected to government in 1991. Although the MMD ran its campaign based on restoring Zambia's economy, some academics point out that problems that emerged later during their administration were a result of their campaign having over-promised, with no clear policy clarity: the promises were many, but how they were to be achieved was not clear. (Chikulo, 1993; Simutanyi, 1996).

By the time the MMD assumed power in 1991, the UNIP government had implemented three national development plans. The Fourth National Development Plan had been launched in 1989 but was abandoned in 1991 in preference for an open market system that brought significant changes in Zambia (Kalumba, 1994). One of the important lessons learnt from the 1990s was the realisation that, even in a liberalised economy, development planning is necessary for guiding priority setting and resource allocation (cf. Bossert et.al, 2003). The absence of planning drove the country to concentrate on short-term needs representing narrow sectional interests, thus denying the country the opportunity to attain broad based socio-economic development (FNDP – 2006 -2010)

While the MMD government introduced the Public Service Reform Programme (PSRP), which triggered a number of reforms intended to improve efficiency in public service delivery and strengthen involvement of citizens in the local decision-making processes, execution of these

plans depended on external funds - and were constructed with the help of external technocrats (World Bank, 2018). These included, among others, the National Decentralisation Policy (NDP) whose thrust was on sectoral devolution or transfer of functions, power and authority with matching resources from the centre to autonomous local bodies. The NDP was approved in 2002 and launched for implementation in 2004. It was revised and re-launched in 2012. As indicated in the introductory chapter, the devolution plan continues to be under revision to date (revised DIP, 2009)

From the NDP, the Sector Devolution Action Plan (SDAP) for primary health care (PHC) functions was developed to provide the framework for the health sector to devolve PHC functions; that is, to designate responsibilities to local councils as well as to identify and clarify those functions which are to be retained by the Central Government through the Ministry of Health (revised DIP, 2009). To do so, the SDAP first assessed the organisational structure, human resource, financial, assets, policy and legislation implications of devolution on the Ministry/Department and councils and then recommended policy actions or directions for dealing with all identified implications. This was followed by an implementation (devolution) plan which indicated how and when the Ministry will devolve the identified specific activities of PHC to the councils, and with what resources. The plan also identifies and lists the specific activities or elements of PHC which should be devolved to councils and those which should remain with the Ministry. Consequently, the organisational structure of the Ministry of Health was to change, and councils were expected to alter their structures to accommodate the operations of the new Department of Health Services (Health sector devolution Plan; unpublished).

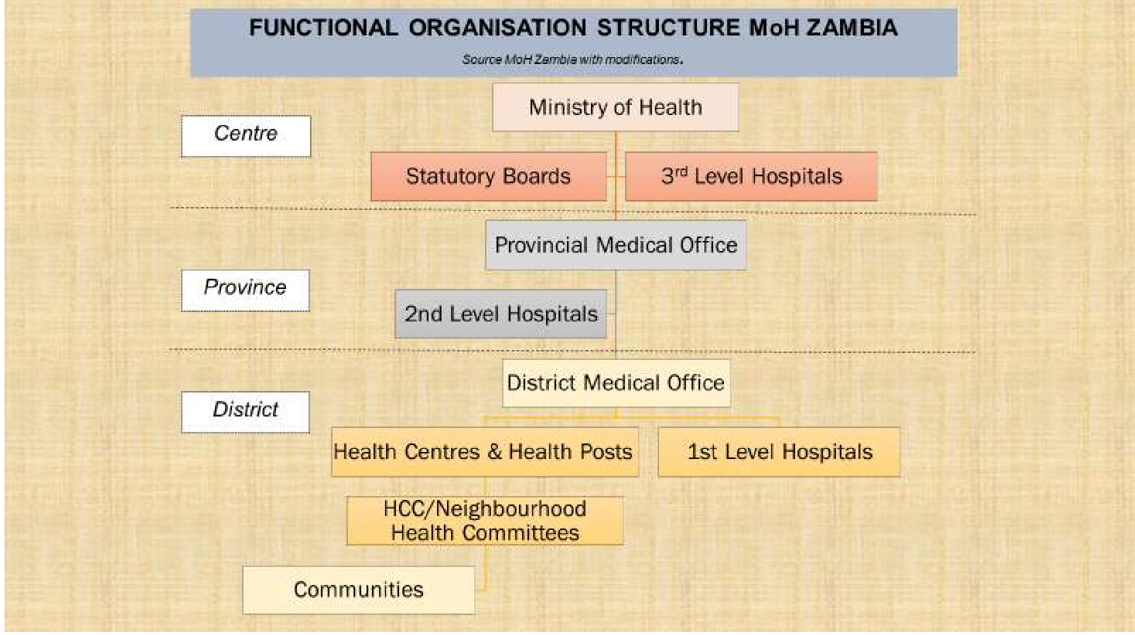
Although health and education were a priority for the MMD government from the outset, they were a challenge for the new government to address both in monetary and structural terms as the country was undergoing radical reforms such as reduction of the size of the civil service, privatisation of parastatal companies, and the withdrawal of funds from large city councils so that they could raise revenue through rents, rates and fees to support their operations (Baylies & Szeftel, 1992, Crook and Manor, 2001, Chikulo, 2009a). The operations of councils were already resource constrained under the UNIP government and it is claimed that with the MMD government the situation worsened (MLGH, 2003). The implications of these reforms meant that service provision did not in fact change much, and the new government continued to struggle to provide adequate social services. Indeed, by the early 1990s the health system was near collapse, characterised by poor performance of primary health care services, with the problem having been further compounded by the emergence of the HIV/AIDS scourge.

Consequently, various reforms were adopted as means to improve government functions at all levels, with the health sector being one of the target sectors. The health sector reforms aimed to address the widespread poor health indicators signified by poor maternal and child health services and a reduction in life expectancy generally (MoH, 2001). Government was

also faced with a decline in human resources for health as a result of poor conditions of service and HIV/AIDS. Thus, the MMD government painted the situation as dire and sought to transform the health sector by coming up with the Zambia National Health Policies and Strategies (ZNHPS: 1993) that spelt out how the operations of the health sector were to change. But at the time, Zambia was experiencing high poverty levels due to economic reforms coupled with the burden of HIV and AIDS. (MoH, 1993).

As already discussed, evidence shows that the health reform process targeted to build systems as figure 2. demonstrates. The structures built by the process were also legally bound by Zambian law through an Act of Parliament but still success was not attained (See Chapter Three). Although Brinkerhoff argues that policy should not focus on debating what success consists of but should look at who gains and who doesn't, in the health reform process losses were widespread because the health workers resisted and communities could not afford to spend on health services out of their pockets (Brinkerhoff, 2015). However, such arguments are difficult to substantiate decentralisation policy operations in Zambia because the gains of improved health service delivery are rarely attained.

Figure 2: Ministry of Health Structures - Health Reforms Period



However even though the decentralised systems were designed to be legally binding, they failed to achieve the mandate and to a large extent could not operate within the legal frameworks in which they were designed to (see, Chapter Five). This is because the health reforms were implemented together with economic reforms as argued throughout the thesis, which significantly affected the purchasing power and livelihoods of individuals and households - a situation that led to more expenses on health needs (MoH, 2011). Details of

how the plan succumbed to the existing household poverty levels during implementation will be discussed in Chapters Five and Six.

Political implications of Health Sector Reforms and Decentralisation (Moving from one Party to multi-party: 1991 – 2011)

In reforming the health sector, the main concern for the MMD Government was to develop policies that would fundamentally guide and address the problems that were inherent in the health sector. The aim was to put in place strategies for improvement in Primary Health Care and Hospital services across the country as well as better management and improvements in quality of service (NHSP, 1992).

This was so because evidence pointed to the fact that, since attaining independence from British rule, Zambia inherited a health system focused on curative care and with public health facilities distributed in favour of urban populations (which is still the case to date) (Freund, 1986; Chansa, 2009, p, 22). The public health system was also characterized by centralized planning and decision-making, in which primary health care programmes (especially for rural areas) were not prioritized. As a result, health planning and service delivery were not linked to the needs of the communities. There were also issues with governance, including poor accountability and transparency, and a proliferation of externally funded health projects (WHO, 2009). These projects were being implemented outside the public health system and were not linked to the national development goals (MoH, 1996). Although the UNIP government between 1964 and 1990 had responded to some of these challenges by providing free medical care and constructing new health facilities in rural areas, with the situation improving in the initial years, by the end of the 1980s the health care system had crumbled and was characterized by a chronic shortage of drugs, run down infrastructure and equipment, and migration of health personnel to foreign countries. This in turn led to a rise in disease related morbidity and mortality indicators (NHSP, 1992).

The MMD government's first comprehensive health sector reforms in 1992 had a vision of "providing equity of access to cost-effective, quality health care, as close to the family as possible" (MoH, 1993). The health reforms were centred on the delivery of primary health care through a decentralized health system, including planning for health services with community involvement and fiscal decentralisation (direct disbursement of funds to the districts). The health reforms also initiated a purchaser-provider split through a re-definition of the role of the Ministry of Health, whose mandate remained that of policy development, strategic planning, legislation, resource mobilization, external relations, and monitoring and evaluation (MoH, 1996). Through the reforms, the Central Board of Health (CBoH) was created in 1996 as an autonomous body responsible for the delivery of health services. Its functions included the commissioning of health services to district and hospital boards. The articulation of such a vision set the impetus for the health reform process with defined guiding

principles. This commitment to reform was reaffirmed in the MMD's 1996 manifesto (MMD Manifesto 1996).

Since the aim of the reforms was to decentralize health service delivery, based on the primary health care approach (MoH, 1992), new community structures were established, including Health Centre Committees and Neighbourhood Health Committees (MoH, 1992), and district management structures (Health Management Teams and Health Boards) were created to support the community level structures (MoH, 1992). The provincial and district health structures were also given new mandates through Cabinet Circular No 1 of 1995 to facilitate planning and co-ordination of development at the provincial level through Provincial Development Co-ordination Committees (PDCC). At District level, the performance of public functions was split between the District Administration and a democratically elected Council. Cabinet Circular No 1 of 1995 also provided for coordination between the District Development Co-ordination Committees (DDCC) and the local councils.[7] The operational structures within the Ministry of Health were revised to accommodate the reforms, with strong emphasis on community engagement (MoH, 2000)

The MMD government were highly commended by the donor community for the bold steps they took towards improving health service provision (WHO, 2010). Notably the health reforms were praised for: (i) articulation of the National Health Policies and Strategies, which was developed through a higly consultative process in 1991 and was approved by Cabinet Office in 1992; (ii) the enactment of the National Health Services Act of 1995 by Parliament and subsequent development of the National Health Strategic Plan, where the Act provided for the establishment of autonomous health boards through which the Central Board of Health (CBoH) was formed as a technical arm of the Ministry of Health with the mandate to interpret and implement policies and; (iii) the creation of District Health Boards and Hospital Management Boards. The aim of these was to transfer management for quality to district level through managerial, and professional, autonomy (MoH, 2001).

Indeed, as the health reforms commenced, Zambia became recognized globally as a model for the health sector reform movement (WHO, 2008). Besides gaining international recognition, the reforms prompted expectations locally, and the Zambian public expected all health problems to be solved (Gilson, 2000). When that was not forthcoming, there was a public outcry calling for the health sector reforms to be halted. The MMD government, which referred to itself as a 'listening government', was under pressure to heed to the people's call (see Chikulo, 1993). Consequently, the Health Services Act was repealed in 1995 with the

[7] The operations of councils had already been amended under the Local Government Act of 1991, under which councils were charged with responsibility for delivering a broad range of services including Housing, Urban Land Development services, Water and Sanitation as well as Urban and Feeder Roads development and maintenance as (MLGH, 1996).

abolition of the CBoH. A report by the Swedish International Development Cooperation (1998) pointed out that the health sector reform in Zambia had been attempted at a time when the internal and external environment was not very favourable to reform.

The difficulties faced, however, may not all have been contextual – they may also have been political. Evidently the anticipation surrounding the health reforms had been quite high, with policy observers having noted that the MMD's vision for the health sector embodied the ideologies of leadership, accountability and partnership (see Lake and Musumali, 1999). However political scientists as early as 1992 were wary of such reforms being implemented by inexperienced government structures. For example, Bratton (1992) questioned the stability of the MMD government because the politics they employed seemed to resonate most with the urban elites. In addition, Brinkerhoff and Goldsmith (2002) questioned the rapid transformation of politics from a one-party to a multi-party system, especially within the context of weak democratic values that would require a significant amount of time to become established. He noted that the transitions to multiparty politics were not enough to protect countries like Zambia from resource looting and abuse by the executive.

While decentralisation had been the main feature of the health sector reform process in Zambia, this agenda was largely implemented outside the broader national decentralisation process – as stated earlier on in Chapter One. This was to change in 2004 when the National Decentralisation Policy was launched. Yet, as we will see below. this policy remains unimplemented. The impetus for decentralisation after 2002 withered. Some scholars attribute this to what was happening on the global level, where decentralisation was no longer seen as a priority (Prudhomme, 2003). However, this was the period during which HIV and AIDS was highly prioritised on the global agenda. Countries like Zambia with high prevalence of HIV and AIDS were required to create structured country response mechanisms. The community was considered as the centre of response, and hence the decentralisation of HIV/AIDS sector was prioritised. What arose, in effect, was a separate and disease-specific decentralisation process which happened within the HIV/AIDS sector, and in a way that was largely separated from the broader context of health sector reforms (and which overlapped between the MMD government discussed in this section, and the PF government that followed it and is the focus of the next section).

HIV/AIDS Decentralisation Implementation– 1987 – 2014

The development of a national response to HIV/AIDS and the creation of decentralized HIV/AIDS systems and structures began in 1986 when the Zambian Government established the National AIDS Prevention and Control Programme (National AIDS Council, 2003). Thereafter, three short- and medium-term HIV/AIDS plans were developed and implemented between 1987 and 1998 (MoH, 2003). In 2002, the Zambian Government and other stakeholders realised that HIV/AIDS was more than a health problem and concluded that a

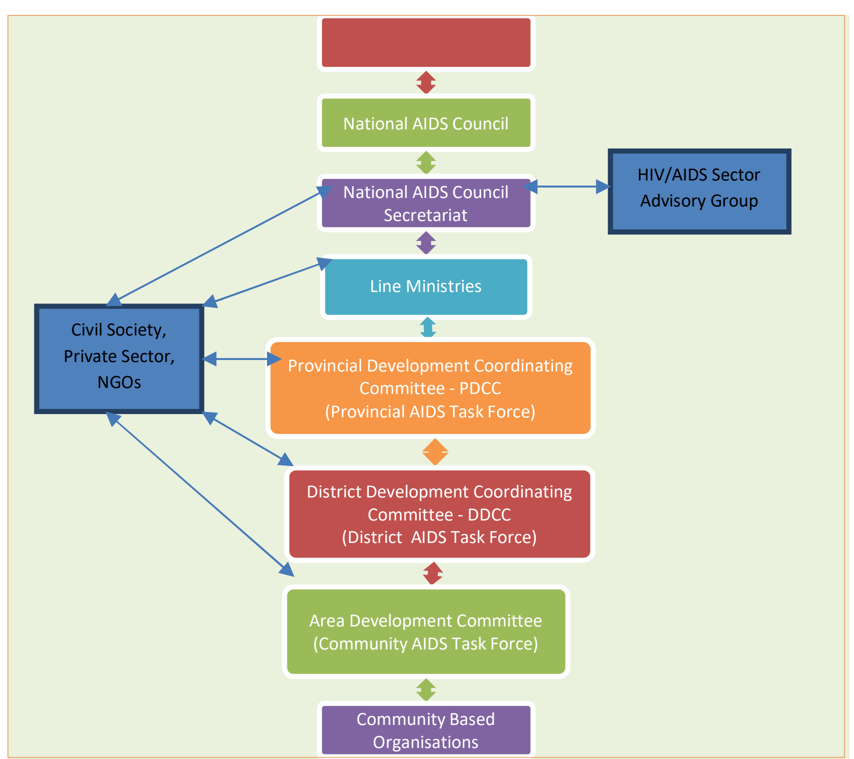
multi-sectoral approach was required to address the epidemic (National AIDS Council, 2006a). At the same time, the WHO was urging countries ravaged by HIV/AIDS to mount responses that were broad-based (WHO, 2006).

Parliamentary Act No. 10 of 2002 established the National AIDS Council (NAC) and its Secretariat to co-ordinate a multi-sectoral response against HIV/AIDS (National AIDS Council, 2006b). The NAC was created as a 'quasi-government' corporate body with powers to coordinate, monitor, and evaluate the impact of HIV/AIDS programmes and interventions (WHO, 2006). As part of the strategy, a Cabinet Committee on HIV/AIDS was created to provide policy direction, political leadership and advocacy. As can be noticed, the NAC was created as a horizontally decentralised structure delegated with governing HIV/AIDS services.

The establishment of the NAC in 2002 prompted the development of a multisectoral approach and the creation of decentralized HIV/AIDS systems and structures, which together aimed to reduce the personal, social and economic impacts of HIV and AIDS (Ndubani et al, 2007). As part of its mandate, NAC was given the responsibility of coordinating HIV/AIDS activities within line ministries, and at provincial, district, and community levels (NAC, 2000), which was often a very difficult task because Ministries were mandated to form an HIV/AIDS taskforce headed by a focal point person, however these focal point persons had other responsibilities making it difficult for them to conduct HIV/AIDS activities. It prompted the United Nations Against HIV/AIDS (UNAIDS) to employ focal persons stationed in key ministries to effectively meet the mandate (Ndubani et. al, 2007).

NAC sub-structures at provincial and district level operate through the Provincial and District Development Coordinating Committees and consist of: Provincial AIDS Task Forces (PATF), District AIDS Task Forces (DATF), and Community AIDS Task Forces (CATFs); see Figure 3 (National AIDS Council, 2006b). The HIV/AIDS decentralisation process ran alongside the health sector decentralisation process. However, it should be noted that these functions were performed largely outside the health sector.

Figure 3: Decentralized Structures for HIV/AIDS Programme implementation in Zambia



Source with modification by Author: National AIDS Council, 2006b

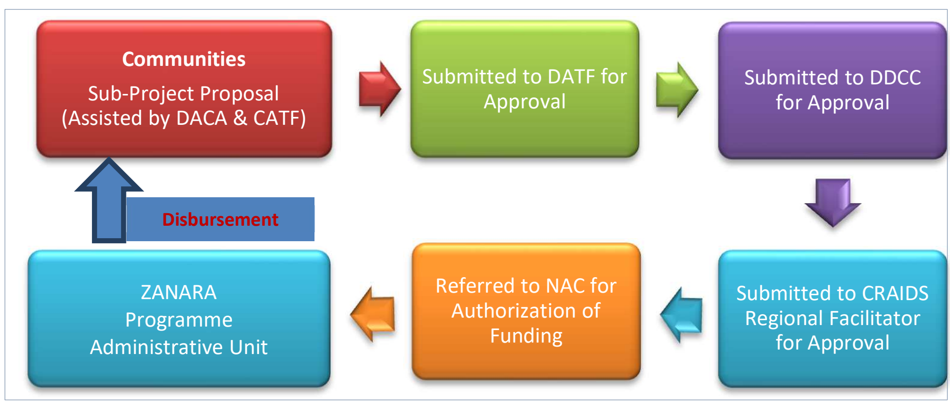
Planning and Funding for HIV/AIDS programmes in Zambia

The 2002 legislation led to the development and implementation of a National HIV/AIDS Strategic Framework 2001-2003, and a National HIV/AIDS Intervention Strategic Plan (NAISP) 2002-2005 (National AIDS Council, 2006b). This Plan built on political commitment at the highest level, and also outlined a broad framework and specific interventions for multi-sectoral, participatory, and rights-based approaches involving all sections of society (MoH, 2000). Its main goal was to reduce the HIV prevalence rate among Zambians by 10% and to improve the health status of people living with HIV/AIDS (National AIDS Council, 2003). This was to be achieved by reducing HIV/AIDS transmission, mitigating the socio-economic impacts of HIV/AIDS, and by developing multi-sectoral coordination mechanisms. After the expiry of the 2002-2005 National Plan, the National AIDS Strategic Framework (NASF) 2006-2010 was developed, focusing on service delivery and promotion of community-led life-saving activities (National AIDS Council, 2006a).

The Zambian Government applied for and received a grant of US $42 million from the World Bank through the Zambia National Response to HIV/AIDS (ZANARA) project to implement HIV/AIDS activities over a period of five years, beginning in 2003 (World Bank, 2009). The ZANARA project was part of the World Bank's Multi-Country AIDS Program in Africa (MAP),

which was launched in 2000 (see, World Bank, 2009). The MAP was different from traditional World Bank lending in that it was designed to be community oriented and demand-driven, and without the long planning cycle that typically characterised World Bank loans (MoH, 2000). Projects were intended to fit within the country's existing development strategy and the Bank's strategy for overall lending in that country (Ndubani, et. al, 2007). The ZANARA Project had four components: support to the National AIDS Council and secretariat, support to line Ministries, Support to the MoH National Programme, and the Community Response to HIV/AIDS (CRAIDS), which was designed to respond to the HIV/AIDS crisis at community level in line with the 2002-2005 National Strategic Plan (World Bank, 2009). The main objective of the CRAIDS Initiative, which ran from 2003 to 2008, was to mobilize and strengthen the capacity of communities and the private sector to respond to the HIV/AIDS epidemic (World Bank 2009, Miyano et.al, 2017). At community level, the focus was on the provision of financial and technical support to Community Based Initiatives which were to be identified, planned, managed and operated by the communities themselves. The appraisal, approval and disbursement mechanisms are outlined in Figure 4 below.

Figure 4: CRAIDS Appraisal, Approval and Disbursement Mechanisms



Source with modification by Author: National AIDS Council, 2006b

Zambia's approach to HIV/AIDS control, supported by the World Bank MAP, was grounded on there being strong collaboration, coordination, partnerships and networking with stakeholders at all levels; and on a decentralised response. The World Bank *'Implementation Completion and Results* Report' (2009) reported that CRAIDS was a success and that it provided a lifeline to the decentralized HIV/AIDS structures through the NAC. The report identified the need for a case study on CRAIDS to shed more light on the enabling factors for community initiatives (World Bank, 2009). Some of the issues which were suggested for review were: the nature of the involvement of community members in CBOs; CBOs' activities; effectiveness of accountability mechanisms; and cost-effectiveness of CRAIDS and its activities (World Bank, 2009).

The perceived success of this programme offers some insights for decentralisation more widely. First, the success of the HIV/AIDS model mounted by the World Bank to support HIV/AIDS programmes at community level relied on the structures that were established under the 1996 health reforms (which, as the MoH (2007) noted, had some success in creating solid community structures for health service delivery). This fits with literature that highlights the coherence of key policy decisions that were undertaken locally, nationally and internationally. A range of steps that were undertaken have been stated, which include: meeting donor set requirements and conditions, sufficient resources, government's commitment to provide leadership, comprehensive plans that identify the needs and how the needs are to be addressed, the right skills and an empowered community willing to get involved (see, for example Smoke, 2006; Crook, 2003).

Second, decentralisation supports community development when it delegates responsibilities, and especially resources, to local governing bodies and other community entities, thereby enabling communities to identify priorities, which is the starting point of a development cycle (Gaye, et al., 2001). Pollack (2015), states that decentralisation is good for communities only if communities are given the power to control the resources. In the case of the HIV/AIDS sector, the resources were externally provided with pre-set conditions by the World Bank. One of these conditions was to set up funding mechanisms to disburse funds directly to communities, which the Zambian government was obliged to do (World Bank, 2002). As reported by Walsh et.al (2012), communities felt empowered to lead the response to HIV/AIDS to address local priorities since funds were directly disbursed to CBOs.[8] In the absence of resources, it is much less likely that decentralisation will foster community participation.

Decentralisation under the PF government – 2011 to 2019

It is worth reiterating at this point that the decentralisation witnesses in the HIV/AIDS sector in Zambia worked in isolation of any wider national health sector decentralisation plans for more than two decades.

Nevertheless, a renewed impetus for the wider decentralisation plan came with the election of the PF government in 2011. Although the plan had been there since 2004, the PF government made several steps towards implementing decentralised service delivery - especially health services. According to the PF manifesto, good health is an essential prerequisite for national development. Through its manifesto, the PF government declared its intent to develop the health sector in Zambia using the six health systems building blocks as recommended by the World Health Organisation (PF Manifesto, 2009). These 'building

[8] Although communities in Zambia felt that they addressed some of the needs through empowerment projects as part of CRAIDS, the sustainability of most of the CBOs beyond the CRAIDS programme was seen to be a challenge (Walsh et.al, 2012).

blocks' are service delivery, human resources, medicines and technology, health financing, health information systems, and leadership and governance. Determined to 'put more money in people's pockets', the PF government outlined a number of policy measures and strategies designed to reduce catastrophic health expenditures and the impoverishing effects of ill-health. This included the abolition of user fees and co-payments; increasing the government budget for the health sector according to the Abuja Target of 15% of the government national budget; promoting public-private partnerships in the financing of health services; and providing basic health care based on need and not ability to pay. The PF government had clearly outlined their intent to improve health service provision, and decentralisation lay at the heart of this promise (PF Manifesto, 2010).

The above notwithstanding, it was recognised that the PF government had taken over government at a time when there was weak governance and accountability, reduced donor support to the health sector, and a looming global economic crisis. The PF government inherited structural and functional problems from the MMD government, which had set the course through the Sixth National Development Plan 2011-2015, and the National Health Strategic Plan 2011-2015. Nevertheless, the PF government was committed to take forward the implementation of decentralisation across government, not only in the health sector. The Revised National Decentralisation Policy (R-NDP) was launched on 16th June 2013 with the mission statement: "to promote a decentralised and democratically elected system of governance which enhances community participation in decision-making" (LG Parliamentary Committee, 2014). Cabinet Office Circular No.10 of December 2014 provided guidelines on the implementation of the R-NDP based on a sector-wide phased approach over a period of three years (2015-2017).

While the R-NDP had been presented to parliament and was waiting for ratification, the PF government went ahead to re-organise the roles and functions of the Ministry of Health and the Ministry of Community Development and Social Services in 2011. This process was not subjected to a comprehensive restructuring procedure as outlined by the Management Development Division at Cabinet Office. The Government made it clear that the assignment of some functions of the MoH to the MCDSS (which was later renamed the Ministry of Community Development, Mother and Child Health - MCDMCH) was transitional.

Consequently, there were two scenarios playing out simultaneously: the MoH and MCDMCH realignment of functions; and the pending devolution of health services to local government. But there was no clear plan of how the two ministries and the government in general were going to be coordinating activities (Chansa, 2013). For example, from 2011 through to 2013, the creation of additional districts (which had already been embarked upon as part of the decentralisation process) was no doubt going to affect health financing (especially resource mobilization and allocation); management support systems (finance, procurement, and monitoring and evaluation); inputs (human resources, drugs, infrastructure and equipment);

and overall service delivery. In this respect, clear guidance, change management, and capacity building was key. On another front, the health sector devolution plan was fully fledged with assessment having been completed with regards to organisational structure, human resource, financial, assets, policy and legislative implications of devolution on the Ministry/Department and councils, and the recommended policy actions or directions for dealing with all identified implications.

The MoH presented a plan to parliament that showed how the Ministry was to devolve specific activities of Primary Health Care (PHC) to the councils, and with what resources (LG Committee Parliament Report, 2011). The plan presented by MoH further indicated that the organisational structure changes within MoH and their implications were not yet figured. However, it was agreed by government and stakeholders that the councils had to alter their structures, including the creation of a separate and new department of health services, to accommodate the devolved PHC functions (MoH, 2014)

On human resources, the MoH had stated that they were to devolve responsibility for personnel to district level, including those serving at the District Medical Office, health centres and health posts. On finance and assets, councils were to receive enhanced funding directly from the treasury. Recommendations were made for the development of new infrastructure especially for the newly created districts. Under legal and policy issues, within the health sector devolution plan it was recognised that there are policy and legislative implications for both the MoH and Councils - and thus it was recommended policy be amended at both National and Council level (MoH, 2012).

On the financing reforms, Zambia abolished user fees in all public and mission health facilities in 2006 (rural areas), 2007 (peri-urban areas), and 2012 (entire primary health care services). This move was meant to increase the utilization of health services by the poor, after evidence showed low utilization and poor health outcomes among the poor (NHP, 2010). Relatedly, an earmarked tax on the interest on savings (medical levy), which had been introduced in 2003 to raise additional revenues for the health sector, was abolished in 2013 in an attempt to restore the culture of saving and investing among the general populace (cf. GRZ, 2009; Chansa, 2013). Despite all this change in the health sector, the National Decentralisation Plan that was developed in 2004 is yet to be implemented.

Conclusion

This overview of Zambia's history of attempts to decentralise the health sector reiterates the claim made in the previous chapter that decentralisation is a highly contextualised tool and that in studying decentralisation there is a need to examine a wide range of factors such as time, money, political will, commitment and capacity to implement the reform, people's trust

in the government and vice-versa, solvency of the district councils, and local resource mobilisation potential etc. (see Rondinelli, 1990, Mitchell and Bossert, 2010). In addition, for a policy to successfully operate within such a framework there has to be strong commitment from the various actors involved. However, Zambia presents a weak case in that regard. A study conducted by Transparency International revealed that Zambia's political systems are weak and foster centralisation, in that the government is a powerful machinery that operates within weakened civil society. Furthermore, the previously strong media which Zambia boasted to have built in the last two decades has evidently been weakened (TIZ, 2008).

The public sector reforms that the Zambian government has implemented have been supported by various bilateral and multilateral agencies. This continues to this day. For example, the UK Department for International Development (DFID) is currently supporting human resource reforms within the public sector. The European Union is supporting the reform and strengthening of Public Financial Management (PFM). PFM has often been cited in the literature as a key determinant of the success/failure of decentralisation policies (Andrews and Schroeder, 2003). But as well as providing resources and technical support, donors also criticise the Zambian government. For example, the Norwegian government describes Zambia as a 'neo patrimonial state' that is detrimental to development because power is centralised, and access to resources is for a privileged few who are not accountable for the misuse of resources. Though development agendas may appear strong, the implementation is often weakened by the lack of wider representation of stakeholders (Norad, 2008, Cheeseman 2016). While this is in many ways true, it is also important to understand that central government still has a key role to play even in a decentralised system. The role of central government as funder and steward of health service delivery cannot be over emphasised. Furthermore, the nature of mobilising resources for health requires massive experience and a more coordinated central response. However, in a highly centralised state, central governments use the very excuse of being the funder and steward to tightly control lower levels (Pollack, 2015). Ideally in a decentralised plan, the roles of each entity are clearly spelled out and are not static over time. To elaborate on the argument, (Mitchell and Bossert, 2010) highlights that decentralisation should not be seen as a form of governing in itself but as a subset of centralisation.

While the health reforms of 1996 were hyped by government and were widely expected by the public to improve health service delivery, the current devolution plan (that can be traced from 2002) is much more low-profile, and most senior servants remain in the dark about how it will be ultimately implemented.

To conclude the chapter, the implementation of numerous reforms within a short period of time has, to some extent, weakened the legal and regulatory environment, leading to inconsistency in governance of the health sector and a fragmented health system. Successive Zambian Governments have claimed that they wanted to achieve a fully decentralised and

democratically elected system of governance characterised by open, predictable and transparent policy making and implementation processes, effective community participation in decision making and administration of their local affairs, while maintaining sufficient linkages between the central level structures and the periphery (MoH, 2015). The will to do so seems to be strongly held by parties when in opposition, but when the party forms government the inertia sets in. For example, the National Decentralisation Policy was launched in 2004 having been earlier approved in 2002. The policy was revised by the PF government after it came to power in 2011 and was approved for implementation in 2013. Yet the policy has not been implemented to date. The reasons could be that decentralisation policies are complex to implement, and also require significant resources. Despite the various reforms, the legal and regulatory provision as it exists today in Zambia is largely inappropriate. Throughout the health reforms process (1990s to 2000s), most of the statutory (service/regulatory) boards have not really been part of the health reform agenda. Consequently, the statutory systems and structures required in the districts and hospitals have not been established at all. The coordination challenge has been exacerbated by the repeal (without replacement) of the 1995 National Health Services Act. The lack of an Act to provide a framework for the organisation of health services has created a legislative 'vacuum' i.e., all the institutions in the health sector currently operate without a legal mandate. Chapters Five and Six demonstrate the impact that these historical factors have had on decentralisation in practice, highlighting actors' perspectives with regards to their participation in decentralisation programmes

Chapter Four

Methodological Approach

Overview
Explains the research strategy and methods used
Justifies the importance of the research to Zambia's development aspirations
Explains the significance of the research to decentralisation policy development and to Zambia's health systems development
Introduces the empirical discussions in Chapters Five and Six

Introduction

The two previous Chapters provided the essential background for the remainder of the thesis. Chapter Two examined the conceptual difficulties around decentralisation and the consequences that may arise from these debates. Chapter Three examined the history of decentralisation efforts in Zambia, and the factors that have ensured decentralisation remained on the agenda, as well as those that have hindered its implementation. A key insight of these chapters is that the outcomes produced by decentralisation policies will depend on the ideas that are introduced and the context into which they're introduced.

For this thesis, the key approach draws on critical realism to address the central research question, which is:

> *Why has decentralisation persistently featured in policy discussions over health service delivery in Zambia, and how have decentralisation efforts affected, and been affected by, the governance of health service delivery in practice?*

This question is based on *what* ideas decentralisation introduces, *how* and *why* they are introduced, and *how* they function according to the existing social, political and economic conditions (cf. Pawson and Tilley 1997; p56). The study is exploratory in nature as it is investigating a problem which is not clearly defined, - how decentralisation efforts affect/have been affected by health service governance (Yin, 1994). Nevertheless, it's being conducted so that we have a better understanding of why decentralisation persistently features in policy discussions in the Zambian context to govern health services. The underlying principle of this study is to interrogate policy changes bound by context yet shaped by politics,

and actors that work to design and implement decentralisation (see Chapter One). As Chapter Two highlighted, decentralisation is a generalised concept that is often claimed to promote several development goals but is also highly contested. Therefore, the ontological orientation of the research is driven towards understanding the views and perspectives of actors in health decentralisation policies so as to make meaning of why decentralisation has yielded the results that it has in Zambia and whether it's accepted norms and values reflect with how it has been practiced in Zambia. Thus, Chapter Three set the background for how we can understand the Zambian context by proving a historical analysis (the value of historical analysis to this research has been highlighted in the later sections of the chapter). In addition, policy and document reviews and interviews were conducted as epistemological stand points so that we can know about the social processes, changes, actors' views and how we can make meaning of them, as detailed later in this chapter.

The study has not set out to provide conclusive or generalisable results: that was not the aim. Instead, it identifies and explores issues that can improve (or hinder) health service governance, the way decentralisation is implemented and, ultimately, health service delivery. In the conclusion, it also identifies issues that can be the focus of future research (see, Yin, 1994; Gilson et. al, 2018).

Yin (1999) posits that good case studies should employ an operational framework. As briefly described in Chapter One, to introduce and situate these discussions, the study used the health policy triangle framework developed by Walt and Gilson in 1994 (see also Buse et.al, 2012, p.4) to generate ways of understanding the complexities and contexts of phenomena, and capacities to build social explanation and generalisation (see, Yin, 1999).

Thus, the Zambian case study was designed to answer the stated research question using a qualitative research strategy with the aim of providing some critical thinking towards knowledge development within the Zambian context (See, Yin, 2016, p.4). In this regard, it's argued that the qualitative approach was used because qualitative studies are said to attend to the contextual richness of case study settings that can derive insights on *how* and *why* the phenomenon came to exist. (Yin, 2016, p.4). Qualitative methods were appropriate for use in investigating the research question because they provided rich and unique historical contexts to understand the evolution of decentralisation processes in Zambia for example the views from the key informants were important in determining how policy actors see themselves influencing the decentralisation agenda and how they relate with other policy actors in driving the decentralisation agenda in Zambia. Additionally, the literature review enabled the study to systematically analyse the debates surrounding the worth of implementing decentralisation policies , while reviewing decentralisation policy documents – the HIV/AIDS /STI/TB policy (MoH, 2002), National Health Policies and Strategies (Health Reform) policy (MoH, 1991), Health Sector Devolution Plan (unpublished) and the Revised National Decentralisation Plan (Cabinet Office, 2002) enable the study to locate the content of decentralisation policies and their evolution over time. As Mason explains the strength of

document review is its ability to address the research question in a more focused way. Considering that the research needed to focus on locating the context of decentralisation in Zambia, the content of the policies, the central role of actors, and the processes initiated to implement decentralisation, the methods provided the pathway to do so because through the review of documents the study was able to understand the actors that have been involved in decentralisation processes, why the policies were/are implemented and why they produced the results that they have had.

Thus, the purpose of this Chapter is to explain in detail the approaches that have been utilised to address the research question. The Chapter begins by justifying why a qualitative research strategy was suitable to answer the research question. It then moves on to discuss the research design in more detail: the specific methods that were used in order to generate data and insights into decentralisation and why it remains popular as a health sector management tool. The chapter concludes by outlining how the research framework (the policy triangle) fits within the research strategy, providing a lens for answering the research question using the empirical data presented in Chapters Five and Six.

Justification of a qualitative research strategy

As already highlighted above, the research applied a qualitative research strategy because such a strategy provides the techniques and methods required to answer the given research question, and to arrive at the conclusions discussed in the conclusion Chapter (Seven) (cf. Strauss and Corbin 1998, p. 8). Before going further into making justifications on the appropriateness of the qualitative study approach to the research, it's important that we first understand what qualitative research entails in the conduct of research.

Yin (2016, p. 4) postulates that doing qualitative research means conducting original research with three important objectives: transparency, thorough methodical approaches, and adherence to evidence. This is because qualitative research in the past has been deemed to lack rigour, and thus has been criticised for the failure to critically outline what was done, how and why (see, Bryman 2008, p.392). For the purposes of this thesis, to offset the identified weaknesses of qualitative studies, a flexible study approach was used to allow for freedom of movement between the steps of data collection and data analysis, an iterative approach, that helped the research in using new information to fine tune concepts, sampling and analysis (see, Sarantakos, 2005). For example, when conducting the initial analysis for interviews, the researcher sought clarity from interviewees if the information given was either not very clear or did not match or was in conflict with other sources of data, for example data obtained from document review.

An additional important point about qualitative studies is their ability to incorporate case studies as a method. For this research, which is a case study, the method defines the boundaries within which the study was conducted. Specifically, the Zambian case study in this thesis uses two decentralisation processes – i) the health reforms of 1992–2006, and ii) the

current devolution plan which started in 2002 but is yet to be fully implemented. These two processes serve as examples of how decentralisation has been used to manage health services in Zambia.

Case studies are also suited to explain historical and contemporary events (Yin, 1994), and in the case of this thesis, a historical analysis was given in Chapter Three. Historical analysis is currently said to be popular with health policymakers because of its ability to improve policymaking and service delivery (Sheard, 2017). The assumption is that:

> *"…by focusing on the actual process of policymaking and implementation, especially what happens when earlier policies have been forgotten or deliberately side-lined, historical analysis helps to open up wider opportunities"* (Sheard, 2017)

In the case of this thesis, a historical analysis was applied to understand how and why decentralisation policies were introduced in the Zambian context. The basic assumption is that by tracing how decentralisation was introduced, the thesis was able to locate some normative goods that were intended to change the governing of health services (i.e. what the intended benefits of decentralisation were). By tracing how decentralisation progressed in practice in these two time periods, the other half of the research question can be answered: how have decentralisation efforts affected, and been affected by, the governance of health service delivery in practice? Ultimately, the interest was to point out what went wrong and how future decisions can be improved to yield better outcomes.

To summarise, the case is an exploratory study focusing on understanding decentralisation in the Zambian context and not really concerned with making generalisations (see, Lazar and Hochheiser, 2017.)

Yin (1984, p.23), considers a case study to be:

> "…*the most flexible of all research designs, which allows the researcher to retain complete characteristics of real-life events while investigating empirical events.*

In general, he considers a case study as an empirical inquiry which:

> *"…investigates a contemporary phenomenon within its real-life context: when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used"*.

He further adds that case studies are:

> "…*best suited to considering the how and why questions, or when the investigator has little control over events*" (Yin, 1984, p.24)

Yin, (2016, p.9) summarises why qualitative studies are suitable, because they:

1. *Study the meaning of people's lives, in their real-world roles*

2. *Represent the views and perspectives of study participants*
3. *Ability to account for real world contextual conditions*
4. *Contribute to insights from existing or new concepts that may help to explain social behaviour and thinking and*
5. *Acknowledging the potential relevance of multiple sources of evidence rather relying on a single source alone*

Having set out what qualitative studies entail and their ability to encompass case studies, the next section detail how they were applied in this research.

Research design

One of the highlighted strengths of case studies is their ability to generate understandings of how people relate to their settings, as well as the ability to appreciate the contextual richness of settings and how people relate to them – so to say; how people respond to situations under the circumstances they find themselves in (cf. Yin, 2016, p. 4). As suggested above, the thesis is a case study focusing on decentralisation and governance of health services in Zambia. The thesis projects two case studies of decentralisation in discussing how decentralisation policies have been implemented in Zambia for the benefit of the health sector – the health reform programme (1992 -2006) and the devolution process (2002 -to date). A case study design was suitable due to the complex nature of the topic under consideration. Keen and Packwood (1995, p.444), state that;

> "…*case study evaluations are valuable where broad, complex questions have to be addressed in complex circumstances*".

The research study area would be deemed as complex because of the debates surrounding the implementation of decentralisation policies in developing countries like Zambia. Critics often view the failures of decentralisation as being a result of over-optimism about what it can deliver, which fails to provide a solid basis for making informed judgements (Smith, 1985, p71). In addition, the institutional arrangements and structures in countries are varied, and decentralisation has also been criticised for not taking into account these factors. It's often said that international institutions that advance decentralisation in developing countries fail to appreciate the unique contextual moderators to which it may be subjected (Smoke, 2003). Another factor that makes the study complex is that it studies the institutions and structures – the socio-political/socio economic factors.

Despite the positive attributes of case studies, Park (1992) criticises them with regards to the difficulties they present when gaining access to interviewees, because interviewees for case studies are selected based on specific knowledge that they possess or their familiarity with the subject of inquiry. Moreso the research study had set parameters in selecting interviewees as they were required to have worked with decentralisation processes in Zambia

at any level, national, provincial, district and community to qualify as a participant. As such there was a uniqueness to the interviewee's characteristics as they were all '*actors'* in decentralisation processes and that the results discussed their actions and perceptions; so to say, interviewees were considered as insiders to the processes. Therefore, the views discussed in the empirical chapters were about; their actions/reactions; relationships with the institutions and systems; views about their responses to the systems; relationships with other actors etc.

Ayres et.al (2008), bring out another criticism stating that case studies are weak because the researcher has no control over the data collected. The weaknesses presented are not inherent to this research because the research study used the snowballing technique to identify interviewees and relied upon the researcher's strong professional network built over time. In addition, the researcher was able to examine data closely through the steps outlined in the data analysis approach section (below), and hence was able to critically analyse the data and triangulate with other sources where doubts were raised.

Nevertheless, despite the weaknesses highlighted, the strengths of case studies were deemed ideal in which to situate the study. Decentralisation and health service governance is a useful topic on which to focus the research for both academic and practical reasons. From an academic perspective, decentralisation of health services in Zambia is within what Bryman (2004, p. 51) pronounces as a typical case, as the context is ideal to answer the research questions and give useful explanations, given that Zambia has been grappling with implementation of the broad decentralisation plan since 1992, as well the health sector decentralisation plans which also commenced during the same period (c.f. Chapter Three). For practical reasons - as highlighted in Chapter One - the thesis concerns itself with understanding various contextual issues within the Zambian context: socio-political processes - power and politics being a central concern in understanding policy processes, including power relations amongst actors; economic conditions; and how these factors affect the operations of health decentralisation, and in turn how health sector decentralisation affects their operations.

As observed by Sriram et al. (2018), policy processes are engulfed by power. Therefore, understanding how power replicates itself in the Zambian policy field explained how and why successive governments have employed decentralisation policies in an attempt to transform the health sector (see, Gilson et. al, 2018). In addition, there is also a recognition that power and policy processes in developing countries are continually shaped by international institutions in terms of policy formulation and resource mobilisation (Walt et.al, 2008). Some of the issues the research was faced with were: what should we know about decentralisation in Zambia and how it's influenced by politics; how does power emerge and manifest itself in policy production; why do certain policy actors have more influence than others – including external actors? In concerning itself with these issues, the thesis on one hand helped to

generate discussions on how political influence can lead to successful transformations of health systems in developing countries if the right ideas are applied to the right context; and on the other hand, how politics can lead to policy failures (Walt et.al, 2008).

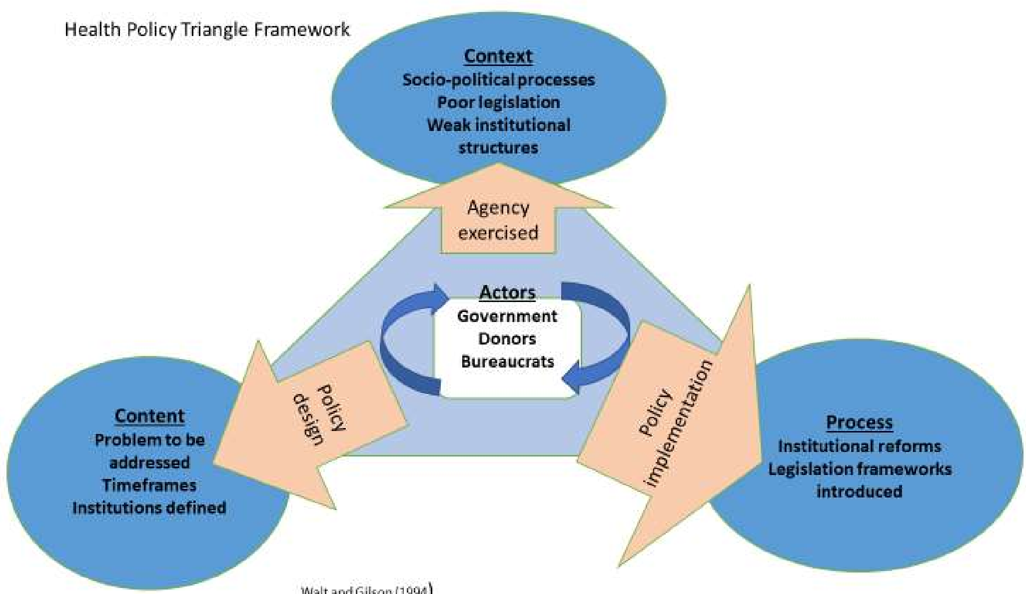
In addition, and specific to Zambia, the thesis provided explanations as to why decentralisation has failed to yield the needed development for the health sector despite repeated attempts by various governments to achieve better health outcomes. The discussions recognise that although decentralisation policies have yielded limited results in Zambia, they are conducted within comprehensive national development plans that are developed prior to the implementation process (See Chapters One and Three). These interrogations shaped the foundations of the intellectual journey that helped to focus more on how political power has promoted and inhibited the progression of decentralisation for health services through the provision of historical tracing of decentralisation, as outlined in Chapter Three, while leading the researcher to understand the ideas of power; how it's exercised and how actors wield power with regards to policy implementation (Buse et.al, 2012, p.12). Chapters Five and Six use the health policy triangle to explore these issues empirically. In addition, the historical tracing of decentralisation policies helped to locate their evolution within broader fields of socio-political ideals and institutions that are subject to changing historical events within the Zambian context (see, Grundy et.al, 2013).

How the policy triangle is applied to the case study.

Yin (1999) highlights that good case studies should include some operational framework to establish what is to be studied, the questions to be asked, and subsequently provide logical explanations of how and why certain things happened. This thesis employed the health policy triangle framework to set the boundaries of what was to be studied and the questions to be asked (see, Appendix One). But most importantly, the health policy triangle framework was used as an analytical framework into which the debates of the research results were embedded.

As outlined by Walt & Gilson (1994), the health policy triangle is a framework that explains three interactions of: i) what a policy stipulates and what it's supposed to do (content); ii) the environment in which the stated policy is implemented and why (context) and; iii) *how* the policy is/will be actualised (process). At the centre of the three are actors. In this thesis, the approach to the study recognised that actors being at the centre, first, determine the content of policy at design stage, second, shape and are shaped by context through the agency exercised and third, they guide, control and shape policy processes at implementation stage as figure 5 demonstrates. In summary the framework explores the roles, interactions and influence of actors on each other and how their relationships and interactions ultimately affect health policy processes (Buse et. al, 2012).

Figure 5: Application of Health Policy Triangle Framework in conducting the study



Within decentralisation policy's development and implementation in Zambia, the thesis identifies the relevant actors as: (i) politicians (politicians that hold the power to direct the course of policy action at national level, such as a Minister of Health); (ii) high level civil servants (bureaucrats, who are often appointed by politicians, such as permanent secretaries, directors in ministries and high ranking civil servants); (iii) mid-level civil servants (directors at provincial and district levels and managers within ministries, some of them appointed by politicians); (iv) external actors (individuals working in donor agencies, both expatriates and local); (v) politicians at lower levels (district commissioners, mayors and councillors etc) and; (vi) community (ward chairperson and neighbourhood health committees). This categorisation of actors is specific to this thesis in order for it to advance the arguments that it intends to; ordinarily health system actors are identified differently from those identified in this thesis (see, Frenk 1994; WHO 2000). This thesis' categorisation of actors is based on the mapping of actors prior to conducting fieldwork and confirmed through the empirical fieldwork findings. The categories define and differentiate roles, responsibilities and interactions among actors that enable pathways through which decentralisation becomes operational – the *choices, implementation* and *outcomes*. Beyond the identification of actors, analyses from interviews further provided direction on the level of influence that actors possess in decentralisation policy regarding choice, implementation and outcomes.

In health policy, the policy triangle framework has been used in several studies to interrogate the validity of assumptions and ideas about policy change, and to understand not only the outcomes that are produced by interventions, but also how they are produced, and the significance of the varying conditions in which interventions take place (see, Walt et, al, 2008).

Most studies posit that, through focusing on context, the assumptions about the process through which change occurs is normally the focus of investigations, while also specifying the ways in which the early and intermediate outcomes related to achieving the desired long-term change associated with policy change is actualized and documented (cf. Buse et.al, 2012 p. 4 - 6). Such an approach is applicable to this thesis because it falls within the boundaries of critical realism, which form the philosophical underpinnings of this research.

In the production of policy outcomes, "programs work (have successful outcomes) only in so far as they introduce the appropriate ideas and opportunities (mechanisms) to groups in the appropriate social and cultural conditions (contexts); mechanism + context = outcomes" (Pawson and Tilley 1997; p56). And thus, for this thesis to embed the discussions of results in the health policy framework, Ritzer's integrative theory of social analysis (Ritzer, 2008) provides a useful starting point in which to situate the study. It presents two axes for understanding context: one ranging from objective (society) to subjective (political, social and economic conditions); the other ranging from the macro-level (social change) to the micro-level (ideas represented). Following Ritzer's integrative steps, the discussions of how decentralisation policies have been employed to manage health services in Zambia are discussed according to the varying degree of policy change across the national level setting in reference to how national institutions transform to accommodate the introduced policy (Sheard, et.al, 2018).

As already mentioned, the thesis considers that power dynamics are a central consideration in framing debates within the policy triangle. Therefore, taking into account the commitments of this research, the model provides for opportunities to conduct analysis that incorporates the *content* (or rather the intentions) of decentralisation policies as designed by stakeholders; the *contexts* (that is the socio-economic and political factors, disease burden etc); the *processes* by which decentralisation policies are designed, promoted and initiated (including resource availability and from whom); and the *actors* involved. By applying this framework, the research was able to make valid assessments of how reform is conducted in Zambia as well as critically analyse why reforms have produced the results that they have. The model can be used both retrospectively and prospectively (Walt and Gilson, 1994): in this thesis it has been used to understand multiple decentralisation policy experiences in Zambia using descriptive narratives and empirical data. The health policy triangle framework is used to explain how political actors in Zambia create ambitious health decentralisation policies prior to ascending to power. Furthermore, the framework explains the complex interactions between political actors in power and technocrats in legitimatising and implementing decentralisation policies. Two key debates arise in this regard: (i) how political actors engage with technocrats; and (ii) how technocrats react to political decisions in policy making. The two arguments create an understanding of *why* 'good' health policies on paper tend to fail to achieve health system goals like community engagement to propel improved service delivery.

Another attractive feature of the health policy triangle framework is its ability to draw in ideas from public policy analysis and the political economy of development (see, Walt et.al, 2008). In doing so, it provides wider knowledge and explanations of policy and policy processes that are contested, involving multiple actors with different concerns, interests and values, often in competition with each other and influenced by a range of contextual factors and also by, for example, the timing of policy change and the content – the forms and focus – of specific policies (Gilson et.al, 2018).

As will be demonstrated in the next section, a combination of qualitative research methods was used as a mechanism for triangulation. The specific attributes of using a case study research design added value to the research process by providing a variety of different insights into the research context, which may not have been possible using one method alone. It also challenged perceptions, or verified impressions, thereby forming a broad basis upon which conclusions could be formed (Bryman, 2004; Manheim et al., 2006, p.334).

To summarise, the study design for this research involved: A case study addressing historical and contemporary examples of how decentralisation has repeatedly appeared in policy discussions to govern health services in Zambia (see Chapters One and Three). Two decentralisation cases are used to demonstrate how decentralisation works according to what the context presents: how decentralisation affects socio-political processes and vice versa how socio-political processes affect the implementation of decentralisation. The arguments about how decentralisation is presented takes into consideration why the ideas are introduced, the context into which they are introduced, and how the processes evolve to achieve (or not) what decentralisation programmes intend to produce as the empirical chapters Five and Six will demonstrate.

Methods

Before moving forward, it is important to establish the specific methods that were used to generate data on how decentralisation processes have operated in practice within the Zambian context.

Qualitative research is highly regarded for its ability to develop new concepts which may help to explain social processes, provide useful explanations and to form platforms for debate and new inquiries (Yin, 1999). Qualitative studies also represent contemporary varied cultural and social commonalities and differences and how political and social institutions respond to these conditions; these attributes of qualitative research contribute to understanding of interactions between actors within social contexts (cf. Yin, 2016)

In addition, Yin (1994) indicates that the strength of qualitative study designs is that they are not automatically associated with any one data collection method. The result is that they can incorporate various methods to generate data which provides a richer context to the data

obtained, thereby adding more meaning to data triangulation (see, Yin, 1994). Because the research question had two broad thematic areas for discussion – establishing i) *why* decentralisation policy discussions persistently feature on government health service delivery agenda (this is about *interpreting policy implementation, actions and experiences)*; and ii) *how* decentralisation affects/and is affected by the governance of health services (this is about interpreting the results of policy action and experiences). Thus, they fit within the logic of qualitative research that calls for multiple methods to be used to address a research question. For this research the methods that were used are justified below.

Literature Review

First, a literature review (presented in Chapter 2) was conducted between November 2016 – May 2017 to understand the conceptual debates over decentralisation; identify the claimed benefits of decentralisation; and identify the critiques it has been subjected to. The literature review was carried out by adopting a systematic approach that is by searching literature of published articles using google scholar. The search results were then indexed in a diary by author and title. The next process involved a further search of the actual article or book either by title or author's name using the University of Sheffield library. The process was conducted according to Hart (1998); Petticrew and Roberts (2006) recommendations on conducting systematic literature review.

The literature review process resulted in a narrative review of why and how decentralisation is applied in general as a development tool. Through reviewing the literature, the theoretical underpinnings of decentralisation were understood, and why the concept is popular yet subjected to numerous criticisms was revealed. Literature reviewing also helped to gain an understanding about what decentralisation claims to do and how it's applied to attain health system goals especially in developing countries. Overall, some of the key literature that was reviewed was based on:

- Public policy reform
- Decentralisation and health systems policy reform
- Decentralisation and politics of managing health care services
- Health sector reform in Africa/Zambia – key empirical data for the thesis
- Decentralisation of health systems – most useful to determine why decentralisation is implemented
- Change and reform and impact on health systems development – key literature to determining the impact of decentralisation, both good and bad.
- Zambian politics – key to asserting the context of decentralisation policy implementation

Fieldwork

Site selection [9]

Miles and Huberman (1994, p. 34) suggest six site sampling strategies based on: relevance to the conceptual framework; ability to generate rich information; ability to enhance generalisability; ability to produce believable descriptions; ethical considerations; and feasibility. Although site selection for the study took into account most of the issues proposed by Miles and Huberman, what prominently stood out is that the sites were selected based on their ability to generate rich data because of the presence of interviewees and uniquely placed characteristics in terms of socio-economic transformations related to delivery of health services.

- Lusaka, the capital city of Zambia, was an automatic selection because central government agencies, all the donor agencies, big Civil Society Organisations are all based in Lusaka.
- Copperbelt Province is a Metropolitan province with a combination of City and Municipal Councils, urban and peri-urban areas which provided unique characteristics in determining the readiness of Local authorities to manage health services.
- North-Western Province, although predominantly rural, is one of the fastest growing Provinces, run by Municipal Councils but the presence of big international mining corporations signifies the potential for local councils' resource mobilisation. In fact, historically, mining has been an important activity in Zambia, comprising of a sector that has contributed to health care service delivery and financing (see, Freund, 1986).

Interviewee selection

Interviewees were initially identified through a stakeholder mapping process conducted by the researcher[10]. Interviewees were identified through academic literature, donor reports, researcher's professional networks, and previous professional interactions. The research used a purposive sampling strategy as explained by Bryman (2008, p.458) - purposive sampling implies being strategic as it requires that the researcher interviews people who are relevant to the subject of inquiry. Thus, interviewees were purposively selected, in that interviewees needed to have previously worked with or were currently working with decentralisation processes. Hence, having prior knowledge was key to selecting interviewees. Interviewees included both former and current officials/post-holders.

The process of referral, or 'snow-balling', was also relied upon while in the field, in order to reach a much broader network of interviewees than would be possible relying on the data bases at Ministry of Health and the Decentralisation Secretariat. And in addition, as Etikan

[9] See Appendix six
[10] See Appendix six

et.al, (2015) state; the snowballing technique helps to reveal hidden interviewees that the researcher may know but may not be able to locate. Considering that the period of study spans as far back as 30 years ago, most interviewees were either retired or former politicians out of the limelight. Hence the researcher heavily relied upon the snowballing technique to reach out to them. In some cases, certain interviewees pointed the researcher to other potential interviewees that the researcher did not intend to meet with or were not identified as key stakeholders in decentralisation processes.

National level (Lusaka): Interviewees from the cabinet office, which is a direct wing of the government in charge of structural and organisation reforms within the government sector, were regarded as key, as well as individuals representing, the National Assembly of Zambia, donor agencies – both bilateral and Multilateral - the Ministry of health, Ministry of Local Government and Housing, the Decentralisation Secretariat – a body constituted by government to oversee the implementation of the devolution plan - and representatives from NGO's and academic institutions. Other key interviewees included retired politicians, government officials and academics. Most of these interviewees were regarded as National level interviewees because they worked at national level or they previously held positions that are regarded to be at national level (see Appendix three for the comprehensive list of organisations represented).

Sub-national level: Other interviewees included Ministry of Health District Health Directors, Local Government District Directors, Councillors and Community Ward Development representatives in the selected districts. District and community interviewees were selected based on the assumption that they held important views with regards to how the national devolution plan has been conducted in terms of transferring power and responsibilities from national to local levels. Retired government officials and politicians were regarded as key to giving information on historical evolutions and understandings of decentralisation processes, including the relationships among actors in the health policy arena, although it depended on the length of time they had served in their positions for them to provide relevant information to the research.

The limitations to the stakeholder mapping of interviewee selection were that some key interviewees had moved on to other countries (especially donor agency interviewees). Some worked on decentralisation more than twenty years ago, and hence were not able to accurately recall certain details. In such instances, the researcher asked the interviewee if they could suggest individuals who were able to give an accurate picture of what they could not recall, or an alternative source to obtain the missing information.

<u>Data collection: Semi-structured interviews</u>

In-depth interviews with those who were currently or had previously been involved in decentralisation processes were conducted. Interviews are considered the most suitable for an exploratory research like this one, so as to investigate opinions, values and motivations

(Sarantakos, 2005). Individuals from government ministries, civil society and donor agencies involved in decentralisation in Zambia were interviewed by the researcher. Informed consent was obtained in all cases. The interview guide[11] was developed based on the literature review, and a stakeholder analysis using the policy triangle framework (specifically actors' involvement in decentralisation processes).

Each interviewee was pre-approached *via* email, letter, telephone or face-to-face contact to set an appointment date and venue at their convenience. The researcher would then follow-up with an email to remind the interviewee to keep the appointment date. The researcher kept the appointment dates on written file as well as on google calendar and set a reminder for that. On the day of the scheduled interview, the alarm was set to remind the researcher an hour before the interview would take place. The researcher would then make a phone call to the interviewee to remind them of the interview time.

Interviews lasted approximately one hour, depending on the availability of the interviewee. All interviews were recorded except for one conducted with an interviewee from a bilateral agency who requested that the interview not be recorded.

Research Population and Sample Size

The interviewee sample size was initially estimated at 50 as the maximum. Ritchie et al's (2003:84) seven criteria for potential sample size was taken into consideration including: heterogeneity of the population; groups of special interest that require intensive study; and the need for multiple categories and therefore multiple sub-samples within one study. The approximate figure of 50 was large enough for a qualitative sample and certainly reflected the likelihood of diversity of views and wide range of experiences given the different characteristics of the interviewees such as: professional backgrounds, level of involvement in the decentralisation processes, and length of experience with decentralisation processes (i.e. those who have been involved in the processes with successive political regimes and various donor support programmes).

In the end, a total of 43 interviewees were interviewed and this met the estimate of the number of qualitative interviews required in order to identify and explore the key issues arising for understanding experiences of decentralisation processes in Zambia (i.e. to reach the point of data saturation – that is the point where an appropriate sample size has been reached with no additional perspectives or issues emerging from additional interviews (Mason, 2010)). This was in line with keeping estimate sizes of good practice for qualitative studies (Mason, 2002; Morse, 2000). The aim was to select participants with a wider representation of views based on their characteristics, roles and experiences, and not to generalise across the public, but to shed light on the range of issues relevant to the research

[11] See Appendix Six

questions. Thus, the research was cautious to select interviewees with a rich background of experiences in implementing decentralisation policies in a variety of sectors within Zambia. Therefore, exact numbers were not rigidly fixed prior to the commencement of the study (Mason, 2010).

All the interviews were conducted at secure premises mostly at interviewee's offices within working hours. Confidentiality and anonymity of interviewees was adhered to throughout the conduct of the study as required by ethical practices.

Limitations of the interviews

There were a number of difficulties encountered in securing key informant interviews. First, the interviewees that were initially identified, including donor agency staff, government officials and NGO staff, were hesitant to commit to interviews or to supply information. In many cases it took persistence and several visits to their offices for them to consent to the interview. In this regard the skills acquired as a researcher for the last ten years became handy to secure the interviews. Bilateral agency interviewees were the most difficult interviewees to persuade, often citing busy schedules as the reason for their unavailability. However, when contacted by the researcher's networks from a bilateral and a multilateral agency, they generally willingly consented. The researcher was also able to tap into previous scholarship (Beit/Chevening) networks to secure interviews from donor agencies.

With other interviewees, especially retired high-level politicians, persistence and creativity paid off to gain access. For example, the researcher interviewed two former very high-level politicians as a result of using the snowballing technique. Given that the fieldwork period was a total of 6 months, it provided sufficient time to conduct an appropriate breadth of interviews across different actors involved with decentralisation processes. Fortunately, I managed to interview two key people who were the pioneers of health reforms and were spoken about by nearly all the interviewees interviewed in the Ministry of Health.

As with any interviews, the researcher was cautious of the possibility of dishonesty in the responses of interviewees. The researcher was aware that such issues would lead to inaccuracy in data analysis and presentation. Thus, the problem that these issues presented were minimised by the strategy of triangulating sources of evidence and also by employing judgement in the interpretation and analysis of the responses. For most of the recorded interviews, interviewees were given a copy of the recorded audio and some interviewees made an effort to give additional information where they felt that they were gaps in the information given. The researcher also sought clarity through second interviews where the information given was not clear. Although taxing, most second interview processes were conducted effectively by email, telephone conversation or in person.

Ethics Clearance

Ethical clearance was obtained from the Universities of Sheffield and Zambia, which is a requirement to conduct any health-related research in Zambia[12]. The two ethics clearance letters were presented to the Permanent Secretary (PS) at the Ministry of Health Zambia (MoH) along with a letter written by the Director at the University of Zambia, Institute of Economic & Social Research (INESOR) to introduce the researcher and the study stating that the research findings were important to Zambia's health sector development agenda. The PS then wrote a letter to authorise the study[13], which had to be submitted to the Zambia National Health Research Council (ZNHRC) for Approval. Subsequently, a letter was issued by ZNHRC to all Provincial and District Health Directors in the study sites to inform them of the imminent study and that the researcher should be given the required support[14].

With regards to gaining access to local authority bodies, Cabinet office and donor institutions, a generic letter was written by the Director at INESOR to be presented to donor and government agencies along with ethical clearance letters, with the exception of Parliament where a letter had to be specifically written to the Clerk of the National Assembly in order to gain access. To that, Cabinet Office through the Decentralisation Secretariat then issued written directives to all local authorities in the study sites to allow the researcher to gain access to documents as well as interviewees from province to community level[15]. The process of gaining access to institutions lasted for a month due to delayed ethical clearance by the University of Zambia, because the designated Ethics committee could not be convened on time due to technical difficulties.

Interviewee anonymity and confidentiality was maintained throughout the research. At the interview appointment, the interviewee was given the opportunity of confidentiality and/or anonymity. A research information sheet that outlined the key areas of study was made available to all the interviewees before the interview. Consent was sought before the interview took place, where the information sheet and consent form were read to all interviewees and were signed as proof of them having consented to the interview. A copy of the information sheet was left with the interviewee for them to keep.

Before the interview took place, the researcher assured the respondent that the interview material would be treated with strict confidentiality considering that most respondents were high level government and donor agency officials, thus whatever they say with regards to health and politics have a huge impact on their personal relationship with other actors and the institutions they represent. And thus, the researcher was cautions of what was at stake.

[12] See Appendices One and Two
[13] See Appendix Four
[14] See Appendix Five
[15] See Appendix Three

The researcher was also sensitive to interviewees who insisted that anonymity be maintained to the highest level because some of the issues they brought up were political and went against the ethos of being serving government officials – where they asked the researcher to speak off record. One interesting thing about maintaining confidentiality in the health sector relationships is that donor representatives were mostly sceptical of bringing out the negative experiences of decentralisation processes in Zambia. The researcher too was sensitive of the stakes involved when it comes to government and donor relationships.

Document analysis

Document analysis comprised of a comprehensive review of national, provincial, and district level secondary and raw data on decentralisation in general, and decentralisation of health service delivery in particular. Materials were gathered from global and national health systems development groups and websites like the World Health Organisation, from Google Search Engine, academic studies, government statistics, as well as from reports generated by donor agencies and NGOs.

Most of the documents were accessed easily, especially those from the Ministry of Health where the researcher previously worked and has established contacts. Reports from donor agencies were fairly difficult to access but having had experience in research and networking with individuals from donor agencies, the researcher was able to build rapport over time and managed to obtain the required documents. With other government agencies, the researcher sought help from the institution where she works - University of Zambia, Institute of Economic & Social Research. The institute's support in drafting the letters in support of the research made it easy to obtain documents; in this regard institutional support/affiliation is key to conducting research in the Zambian context.

The analysis process involved detailed mapping and contextual analysis of policy and other documents on decentralisation processes in Zambia. Analysis of the documents also included an understanding of how and why the documents were produced, in order to minimise bias (Patton, 2002 p498). To understand how and why decentralisation policies are/were introduced and by whom, and to generally fully grasp the evolution of decentralisation processes in Zambia, analytical content of the following policy documents was conducted: the Vision 2030 (2012); the Revised National Decentralisation Policy (Ministry of Local Government and Housing, 2013); National Health Policies and Strategies (MoH, 1991); and the National Health Policy (MoH, 2012). Furthermore, textual analysis of national and health sector strategic plans, and thematic plans on decentralisation was conducted being: the Fifth National Development Plan (Ministry of Finance, 2006); Sixth National Development Plan (Ministry of Finance, 2011); Seventh National Development Plan (Ministry of National Development Planning, 2017); Fifth National Health Strategic Plan (Ministry of Health, 2011); Sixth National Health Strategic Plan (Ministry of Health, 2011) and Seventh National Health

Strategic Plan (2017), National Decentralisation Implementation Plan (2009-2013) Ministry of Local Government and Housing, (2009); and the Health Sector Devolution Plan (unpublished).

Data Analysis Approach

Data analysis was undertaken on an ongoing basis starting with the data collection phase. The process of ongoing data analysis enabled the researcher to locate emerging themes to which she familiarised herself with. The approach followed is in line with the deductive-inductive approach. The themes were arrived at both inductively – obtained gradually from the data; and deductively – at the beginning of the study. Further familiarisation took place after the data collection phase via analysis of interview transcripts. For the analysis, the policy triangle framework was applied, which assisted in identifying the key emerging issues, concepts and themes (Pope et al, 2000). The five steps of the Framework Approach as set out by Pope et al (2000) were followed. This involved: familiarisation: immersion in the raw data; developing a thematic framework; indexing; charting; mapping and interpretation.

Researcher's positionality and disposition

As highlighted above, the qualitative research strategy used to approach this study has its strengths for its abilities to attend to the contextual richness of the subject settings (see, Yin, 2016, p.4). Attending to contextual richness implies the researcher's connection to study a subject that they care about in their personal or professional life, for example studying organisations and cultures and how the phenomenon the researcher wants to study came to exist (c.f. Yin, 2016, p.4). And because the research strategy requires the researcher to immerse themselves in the research processes, reflexivity is an important practice in this regard. Finlay (1998) refers to reflexivity in research as:

> "*The examination of one's own beliefs, judgments and practices during the research process and how these may have influenced the research".*

In Chapter One, it was stated that the research question for the PhD thesis emerged as a result of the researcher's professional and personal interests in health systems development in Zambia. In addition, the professional experience of the researcher, being a researcher in health promotion programmes and having worked at the Ministry of health, may affect interpretations of results as many scholars posit that any good research should not entirely be influenced by the values and beliefs of the researcher but should be guided knowledge of the wider discipline (see, Winter, 1989). And thus, reflexivity in research should go beyond a researcher's conduct while taking into consideration their knowledge and interests in the subject of inquiry.

Thus, in conducting the research, positionality and dispositions of the researcher were considered to be of great importance. In this regard, being a researcher from an academic

affiliated institution (the Institute of Economic and Social Research), a former Ministry of Health mid-level official, a former member of Ministry of Health Technical Working Group on HIV/AIDS resource tracking, a Commonwealth Scholar and a PhD student at the University of Sheffield Department of Politics and International Relations and the School of Health and Health Related Research (ScHARR).

Positionality by definition is concerned with relationships in reference to concepts such as insider/outsider. It can also be understood through a *"wider range of complex intersectional categories such as ethnic and class background, and gender*" (Fasavalu and Reynolds, 2019), while disposition concerns itself with the issues that may arise from positionality – which should be resolved to ensure that ethical conduct is adhered to in doing research (Fasavalu and Reynolds, 2019).

Considering that the researcher was aware of the many problems faced by the health sector in Zambia with regards to governance and the intersection with politics, no assumptions were made prior to formulating the research questions; about selection of interviewees; which questions to ask or not; or which data to review or not according to the knowledge possessed. But caution was applied during all the processes to ensure objectivity in conducting the research, for example with regards to the interview guide, each question was considered carefully and was included on the guide because it contributed to answering the research question. In distancing from such biasness, the interviews elicited some responses that the research would have not benefited from, had it been assumed that such knowledge was already known to the researcher. More so, historicism and critical realism into which the study embeds itself requires the researcher to understand what is being studied to make meaningful interpretations (see, Dobson, 2002).

Being an 'insider'

Being an 'insider' (as a researcher in health promotion and a former member of staff in the Ministry of Health), served as an advantage when it came to obtaining clearance for health research at the ZNHRC due to familiarity with existing protocols regarding obtaining research clearance and in addition the presence of colleagues within the systems played a role in accessing people to sign letters of introduction and documents that needed to be reviewed as part of the research. Established networks within the health system also played a role in enabling the snowballing technique because so often colleagues within the Ministry of Health served as contact points to access interviewees.

Considering that INESOR is a quasi-government institution, interviewees were more responsive to the research in that the letters of introduction stated the benefits of the research to the institution, health systems development, and to Zambia's development agenda in general. As Amundsen et.al, (2017) points out, "*a researcher's access can closely depend on the power dynamics of a gatekeeper or guide's relationship with the researcher and research participants and their status or influence in their specific context"*.

However, the position of being an insider also served as a disadvantage with some interviewees because of familiarity outside the professional context, whereas it was appreciated with familiar interviewees that informal discussions were conducted, the researcher had to ensure that the interviews were not regarded as casual chats. The point being underscored here is that being an insider within the Zambian contexts lessens the burdens of accessing the required resources to conduct research. Networks and familiarity play a key role to navigating the research systems which ordinarily take a longer period of time and thus may have cost implications on the researcher and the research as well the timeframe in which to conduct the research.

Being an 'outsider'

While carrying out the PhD research, I was based at the University of Sheffield as a Commonwealth Scholar under the Zambian government scheme. Some of the key questions a prospective Commonwealth scholar has to answer to are: the relevance of their research to Zambia's development agenda; the impact of the study and; how the impact will be initiated. In addressing the responses, the relevance of the study was given prominence because the research addresses key issues with regards to health sector development because of the repeated decentralisation programmes and the absence of a guiding legal framework to govern health services. Therefore, the researcher stated that it was the intention of the research to advocate for effective implementation of the Zambia National Decentralisation Policy, specifically the health functions which are supposed to be devolved to the local government. It was envisaged that the results from the PhD study would provide the historical perspective, implementation readiness, and status of implementing the new decentralisation policy. The researcher hoped to use the results from the PhD to provide guidance to counterparts/networks within government and the health sector on implementing the imminent devolution plan as the researcher has an already existing platform on which to advocate for decentralisation implementation being a Research Fellow at INESOR.

Being a PhD student at the University of Sheffield at the department of Politics and International Relations and the School of Health and Health Related Research also added merit to conducting the study because some actors were of the view that international knowledge would add value to solving some of the problems that the Zambian health sector is faced with. Indeed, the supervisors and lecturers (whom the researcher interacted with at various forums) were able to relate to political developmental problems in Zambia - both theory and practice, and this helped the researcher to sharpen skills and knowledge in political studies. In addition, the department of Politics and International Relations at the University of Sheffield has a strong track record in health policy studies in African countries including Zambia hence the researcher's skills and knowledge were shaped in a way that they were able to confidently approach the study area. However, some actors were sceptical of the study being based in a foreign country, based on the grounds that the researcher may concentrate more on personal development on an international level than to acquire skills to

address local health sector problems. One of the interviewees stated that: "…*I hope that this study will focus on generating results to inform the health sector here in Zambia than most of the international PhD's I am familiar with where individuals focus more on their personal development by attending numerous conferences without bringing back the ideas from the study to develop Zambia"* (Inter. 24 May 2018, former high-level politician). Nevertheless, considering that the researcher acquired sufficient training to conduct the PhD studies, results for the study will be disseminated in various meetings at national level in Zambia.

Familiarity with the research context and genesis of the project

As already highlighted in Chapter One, the PhD research project was conceived as a result of the researcher's interests in health systems functioning in relation to politics and policy development in Zambia. Having the knowledge on how health systems are managed both at professional and personal levels served as a great resource in enriching the study findings but was not without difficulties. Speaking from such a perspective Yin (2016 p. 7), points out that researchers can also bring their own belief systems or world view as the motivating force for defining and constructing qualitive research studies in the first place but should apply objectivity in data collection and analysis.

Considering the background of the research idea, in constructing the research question, opinions and world forms of the researcher largely played a role in setting the study parameters. When the idea was first expressed to senior colleagues at INESOR, including a Research Associate Professor in health promotions, it was criticised for raising issues that were past with no possibility of being revived. One colleague pointed out that health reforms in Zambia had reached their ceiling and there was no way anyone would be interested in hearing about them again.

However, the convictions of the researcher were that the study was highly relevant considering that the PF government were seeking re-election in 2016, so, again, the devolution agenda was at the fore of their campaigns in 2015. The timing of the PF messaging regarding devolution coincided with the United States 2016 election campaigns where Donald Trump repeatedly threatened to repeal Obama Care upon winning the 2016 election. Hence in reference to health care reform reaching its ceiling in Zambia the assumptions were not practical because even a relatively developed country like the USA was still debating health care reform.

Such cases added to building up the research parameters and led to questioning how policy agendas emerge in the Zambian context. In this regard, the researcher was led to believe that there is little attention given to policy pronouncements that political parties make when campaigning to be elected partly because accountability mechanisms to hold politicians to fulfil their campaign promises are weak and/or because no one pays attention, implying that Zambians are used to party-political rhetoric regarding policy change. As such, the research took interest to interrogate why donor policy agendas seem to be more popular than

initiatives that start from within Zambia. Is it because donors have the resources to implement the programmes? Is it because donor agenda are backed by powerful political forces? If so, why it is that several literatures (written by Zambians) criticise donor aided programmes for implementing programmes that do not reflect local aspirations, while neglecting considerations of how local policy entrepreneurship emerges/fails to emerge (c.f. Chitah, 2006).

And when donor programmes are implemented, who benefits the most? Is it the implementers or the populations being served? What do the repeated corruption scandals in the Ministry of Health tell us about agency exercised by bureaucrats to address the needs of the population? And if donors withdraw their funding in the health sectors what are the effects? Chansa and Negin (2015) observed that when donor funding was withdrawn in 2008 in the health sector due to corruption allegations, government expenditure on health increased but overall funding for health services remained insufficient.

Conclusion

This chapter has outlined the methodological strategy upon which the parameters of the research were set and upon which the research question was addressed. The chapter provided justifications to why the qualitative research strategy was suitable to answer the substantive research question. The chapter explained how the broad research strategy relates to the study designs and the specific methods utilised by the research. The chapter also explained how the analytical framework fits within the research strategy to make valid and conclusive results as outlined in Chapter Seven. The analytical framework is now utilised to present/discuss the results of the research, which are presented in the next two Chapters.

Chapter Five

Decentralisation and health service governance in practice: Health Reform Process (by delegation) 1992-2006

The first of the empirical chapters about the practice of decentralisation and health governance (Contextual matters) Analyses how decentralisation ideas emerged in Zambia as it relates to practice (Content and Context) Considers how various local actors contribute to decentralisation processes in terms of how they understand and interpret the policy ideas in practice (Actors' involvement). Explains how decentralisation as a policy practice shapes health sector development (Processes) Explores how actors respond to institutional transformations brought about by socio-political processes that facilitate health decentralisation processes (Actors and Context) Analyses the failures of health policy and health reform processes in Zambia

This chapter discusses the impact of the health reform process that began in 1992 and repealed in 2006 on health service governance in Zambia. Having established in Chapter Three that the economic downturn and the lack of good policy practice led to poor social services in Zambia, the politics of the day had also largely influenced policies such as decentralisation of health care that aimed to localise decision making (see Conyers, 1981). Although the poor state of health infrastructures and the lack of consistent policies to manage health services did lead to poor delivery of health services post-independence in Zambia, that is the period between 1972 – 1990, policies that were implemented after 1991 to remedy the previous inadequacies in the health sector were highly influenced by external agendas determined by the political practice of the incumbent government. However, like much of the literature that critiques the neoliberal policies that drove the development agenda in sub-Saharan Africa in this period, this thesis recognises that the health reforms were embedded in neoliberal political and economic ideas both at the national and international levels through policies, and the resulting efforts were inadequate to fully address the problems in service delivery and to achieve better health outcomes.

This Chapter examines the process that led to the adoption and implementation of decentralisation in the Zambian health system. The discussions in this chapter are based on empirical data that was collected between February 2018 to August 2018 and textual analysis of government of Zambia health policy documents. They highlight: first, from a macro level, the social changes that were expected and what eventually happened as a result of having introduced the health reform process; and second, from a micro level, the ideas that were represented (see, Chapter Four). The approach to the discussions is according to Ritzer's integrative theory of social analysis (Ritzer, 2008), as explained in Chapter Three. As the chapter explores, *how* and *why* decentralisation policy agenda was popularised in Zambia (see, Chapters Two and Three), the analysis is presented using the health policy triangle framework (HPTF) in line with the analytical framework for the research. In framing the discussions, the chapter approaches the analysis as follows:

1. Context: examines the socio-political conditions that led to the appearance of the health reforms on national agenda.
2. Content: examines what contained in the health reform agenda in relation to the context – that is in relation to the socio-political conditions to aimed to address.
3. Process: examines how the health reforms were introduced on the national agenda leading to its acceptance by stakeholders national wide and more specifically within the health sector.
4. Actors: Who were the actors that shaped the policy and how did they get to be key players in the process? How did they respond to each other and the institutions that were formed to implement the policy process? According to the HPTF actors are at the centre of driving policy process and thus the thesis will examine actors' roles in the health reform process as follows:
    - ***Context*** ⇄ ***Actors:*** how did actors express their agency in response to the policy ideas (processes and the institutions)?
    - ***Content*** ⇄ ***Actors:*** How did actor relationships form at agenda setting? Which actors had more influence in designing policy ideas and why?
    - ***Process*** ⇄ ***Actors:*** Which actors were involved in the implementation process and why? How did actors' relationships evolve at implementation stage through to policy termination? What (f)actors changed in comparison to the agenda setting stage? (cf. Figure 5, Chapter Four), (see, Buse et.al, 2012, p. 1-9)

The analytical approach conforms with the HPTF as it outlines how actors are at the centre, determine the content of policy at design stage, second, shape and are shaped by context through the agency exercised and third, they guide, control and shape policy processes at implementation stage as figure 5 demonstrates. In summary the framework explores the roles, interactions and influence of actors on each other and how their relationships and interactions ultimately affect health policy processes.

The Chapter begins by discussing why the health reforms appeared on the Zambian government agenda. In this regard, the chapter examines what those involved were hoping to achieve through the reform process. Nonetheless, as the legislation that facilitated the operation of the health reform process was repealed in 2006, the thesis is also interested in establishing why that happened – why did the reforms fail and what factors led to the failure?

Thus, the overall aim of this Chapter is to demonstrate how and why the health reform process was created, and why it failed, in Zambia and contribute to answering the following sub questions: (a) what has driven the adoption of decentralisation policies in Zambia's health sector? (b) what factors have enabled/inhibited Zambia's health sector decentralisation processes? (c) how has political and bureaucratic action at different governance levels influenced health decentralisation policymaking? (d) how has political and bureaucratic action at different governance levels influenced health decentralisation policy implementation?

Contextual Factors: Political and socio-economic crises – the background to the MMD's reforms in the 1990s

As Chapters One and Three already highlighted, the economic turmoil experienced in Zambia from the early 1970's to the late 1980's was a total opposite of the robust economy that had been inherited just after independence in 1964. This economic turmoil drove the country to become one of the most heavily indebted countries in the world (c.f. Burnell, 2001, p.142). Because of the poor economic conditions, coupled with the debt crisis, social sectors - especially health and education - were in a poor state and were unable to meet the demands of the citizenry (see Freund, 1986; Craig, 2000). As already established in Chapter Three, Zambia was a one-party state at the time, run by the United National Independence Party (UNIP) which was in power for twenty-seven years from 1964 to 1991 under the leadership of Kenneth Kaunda. Some interviewees reported that the checks and balances in the way government planned for services was poor. For example, an interviewee who had worked as a planner for local authorities in various districts reported that:

> *"…planning for health services by the UNIP government was basic. The health policy guiding document was three pages that simply outlined that health services were to be provided for free…"* (Inter. 15 June 2018, former high-level manager MoH).

Another interviewee reported that there were attempts by the UNIP government in its later stages to improve health services. For example, they had drawn up a health policy called the ten-year health plan which embedded the ethos of decentralisation out of which community structures such as village health committees were created (Inter. 24 May 2018, former high-level politician). Furthermore, the interviewee reported that, at the same time, the WHO and UNICEF also introduced a ten-year primary health care plan. As such, two things were going

on which created confusion at implementing levels because health care providers were more attentive to the WHO and UNICEF guidelines which did not put much emphasis on incorporating community voices in health services delivery (Inter. 24 May 2018, former high-level politician).

Hence the UNIP government's lack of robust health policy was a contributing factor to the poor governance of the health sector. Returning to the issue raised in Chapter Three, with regards to how the UNIP government attempted to implement decentralisation policies for the purposes of governing health services, their political interests surpassed the need to implement working policies for the health sector (see Freund, 1986). For example, although on a macro level the UNIP government was struggling with structuring policy to deliver health services, on a micro level they were trying to incorporate community participation in service delivery, as documented by Twumasi and Freund (1982), in recognition that socio-economic factors limited the achievement of primary health care goals. This is because while the UNIP government was interested in pursuing socialist policies which were supposedly for the benefit of the population, they were also trying to stay relevant to the electorate. But in practice their decentralisation policies included appointing unelected party officials to be part of the district level management, and these party officials were more loyal to the centre than serving the interests of their localities (see, Conyers, 1981). In addition to poor policies and uncoordinated efforts to implement decentralisation, the situation was further worsened by falling government revenue due to falling of copper prices on the international market in the mid 1970's[16]. Ultimately, all these factors worked against the UNIP government's ability to effectively implement health decentralisation policies (see, Freund, 1986).

The UNIP government had sought help in 1973 from the International Monetary Fund and the World Bank to address the tumbling economy and began implementing Structural Adjustment Programmes (SAP) (Simutanyi, 1996). However, as Simutanyi highlights, the UNIP government was not fully committed to the reforms and conditions of the SAP, often failing to meet the agreed targets and cancelling or suspending the agreements (Simutanyi, 1996). As a result, Zambia's debts were getting to unsustainable levels with the economic situation worsening. One of the main deterrent factors to implementing the SAPs were the socialist philosophies of humanism of the UNIP government, which ran contrary to the SAPs' neoliberal free market agenda (Craig, 2000). As it was, the UNIP government's socialist principles faced wide criticism both home and abroad. As earlier alluded to, the economic conditions that existed failed to satisfy the wider population and thus heightened political tensions with repeated riots. Many commentators regarded this period to have opened up a window of opportunity for political change as Simutanyi (1996) states that the demand for

[16] Zambia's economy depended and still depends on copper as a foreign exchange commodity (see, Freund, 1986). As a result of falling copper prices on international, it significantly affects the revenue for Zambia's economy, a situation that has persisted to date.

democratisation of governance in Zambia (like many other African countries) can be attributed to the promises of SAPs, such as improved governance and economic conditions.

Thus the UNIP government's failures to decentralise health services were as a result of (i) their socialist policies where services like health were regarded as essential and were supposed to be accessed by the wider population for free (see, Freund, 1986), (ii) their political interests that led them to practice 'centrist decentralisation' where unelected officials served as party watchdogs at lower levels (see Conyers, 1981), (iii) the economic crisis due to the falling of copper prices that led to low government revenue (see, Simutanyi, 1996), and (iv) inadequate policies to effectively govern the health sector (Inter. 15 June 2018, former high level manager MoH-pioneer of health reforms).

Therefore, the existing contextual factors paved way for SAPs agenda and values because at the time, not only did the UNIP government face pressure from international organisations to introduce economic and political reforms, but they also faced domestic pressure with most of the population calling for change of government (see, Chapter Three). The UNIP government eventually succumbed to the pressure, initiating constitutional and governance reforms that paved way for plural politics (Baylies & Szeftel, 1992). Presidential and parliamentary elections were held in November 1991 and the UNIP government was defeated by the Movement for Multi-Party Democracy (MMD).

Upon attaining power, the MMD government had the zeal to implement the SAP economic reforms, and straight away hit shifted the country from UNIP's socialist principles to capitalist principles (Burnell, 2001, p.146). State owned companies, especially the mines, were privatised (mostly to foreign investors) and the state rolled back the provision of services to allow private entities to emerge (Tordoff and Young, 1994). The MMD government further reduced health expenditure and initiated public sector wage freezes (Lake and Musumali, 1999). The economic reforms not only implemented massive changes in the economic sector but also in the social sectors and civil service structures as well (Craig 2000). The idea of health sector reform resonated with the ethos of rolling back the state. The ideals that influenced the health reforms can be seen from this quote by then Minister of Health Dr B. Kawimbe in affirming the first ever health policy comprehensive document – the national health policies and strategies document:

> *"The Movement for Multiparty Democracy Government (MMD) has developed a radical and reforming policy for the future direction of health services. The ruling party manifesto amounts to a fundamental change towards improvements in Primary Health Care and in Hospital Services. The main thrust of the reforms is for better management and improvements in quality of service. We wish to avoid adopting an autocratic approach and for this reason extensive powers for operational management have been delegated to the new autonomous District Health Boards and Boards of Management in certain hospitals. This process will provide opportunities to eliminate waste, to achieve better*

value for money and above all improvements in quality and quantity of services. We wish to see more initiative, more enterprise and much great flexibility (MoH, 1991 p. 1).

Because of the widespread economic and political grievances at the end of the UNIP government, the MMD had gained support from the trade unions and bureaucratic actors within which the group of experts emerged. Thus, as a result of the contextual factors (low investments in the health sector with regards to planning and financing), the reforms were a priority of the MMD government agenda. As the reforms had widespread appeal both locally and internationally, a group of experts (as I will refer to them in the chapter because of the knowledge and technical skills they possessed; a mix of bureaucratic, political and international actors) had emerged to be at the fore of directing the course of health services delivery (their central role as actors as stipulated by the HPTF will be discussed later in the chapter). The group of experts had the goal of reforming the health sector to align with global standards. An interviewee reported that:

> "…*as most of us who had been exposed to the outside world where we experienced how service planning should be conducted, we knew that UNIP was not willing to engage with what we were suggesting. So, for us, the new MMD government paved the way to put those ideas to use*" (Inter. 14 June 2018, multilateral representative, former high level MoH official).

Another interviewee reported that:

> "…*although I was a bureaucrat, I had a hand in drafting the MMD manifesto's plan on health service delivery and it emerged as the strongest statement of intent"* (Inter. 15 June 2018, former high-level manager MoH-health reforms).

Thus, equipped with the political capital, affirmation of international agenda and the confidence of the electorate, the MMD embarked on charting the way forward for the health reform agenda as documented in the 1991 Ministry of National Health Policies and Strategies Paper (cf. MoH, 1991). The next section outlines the content of the national health reform agenda and how the whole agenda was constructed to address the in adequacies of the health sector.

The content and actors of the health reform process – shaping agenda setting

The 1992 -2006 health policy reform agenda was shaped from several points. First, the MMD had already built a critical mass in support of reforms by identifying like-minded individuals domestically, coupled with donor support. These groups provided strong leadership for agenda setting of the health reforms. This started with the first ever policy guiding document for the Ministry of Health, the 'Health Policies and Strategies', that set out to provide direction

in governing health services in Zambia. The development of the document was financially supported by the Swedish International Development Agency (SIDA) while technical assistance was given by WHO and United National Emergency Children's Fund (UNICEF) (MoH, 1991). The document reflected the intentions of the government to refocus on health service provision. The drafting of the document was followed by its launch to which all health system stakeholders were invited. However, the government's primary aim was to align health services with the public service reform agenda of reducing costs in service delivery while maintaining effectiveness and efficiency (MoH, 1991), while the donors were more interested in accountability both for resource utilisation and improved health service delivery (MoH, 2005). Together with the donors, the government aimed to design health services that were more responsive to the needs of the population as the health services that were provided by the UNIP government were considered to have failed the objective of meeting individual and community health needs (MoH, 1991). Henceforth, these aspirations met with those of high-level technocrats, among which two played an instrumental role in designing the health reform agenda. The involvement of the two individuals in the reform process propelled them to take on key positions after the MMD came to power: one became a senior manager within CBoH, and after it was dissolved, he went on to work with the World Health Organisation's Southern African Region as an expert on health reforms. The other became a politician and, since Zambia was respected as a pioneer of health reforms, also served as consultant at WHO headquarters. He reported that he coined the mantra which the Ministry of Health in Zambia uses to this day "taking health services as close to the family as possible" (cf. Inter. Inters. 24 May 2018, former high-level politician).

These two high-level technocrats recognised that the guiding policy frameworks and regulatory policies were insufficient to manage and improve health sector performance (MoH, 2006). The influence of these two individuals mentioned by almost all interviewees from the health sector, who saw them as the architects and proponents of the health reform agenda in Zambia (i.e., inters. 12 June 2018 bilateral representative, former mid-level manager MoH; 14 June 2018, high level central level bureaucrat). The two individuals as interviewees gave their perspectives on how they got involved in the reform agenda, including their perspectives on how they are/were regarded by other actors (cf. Inters. 24 May 2018, former high-level politician; Inter. 15 June 2018, former high-level manager MoH-health reforms). The two played a key role in designing the health reform agenda and identifying how health problems could be addressed from central to community levels. Their views coincided with the wave of demand for political change that was being demanded both home and abroad as the UNIP government was deemed to be both autocratic and failing to deliver (Lake and Musumali, 1999).

Consequently, the guiding document that shaped the health reforms policy, the National Health Policies and Strategies document, was developed through a highly consultative process in 1990-1. As one interviewee reported, the consultative process was important so as to get local buy-in from civil society and other key organisations responsible for health

services provision like the Catholic Church (Inter. 24 May 2018, former high-level politician). The policy was later approved by Cabinet Office in 1992, followed by the enactment of the National Health Services Act of 1995 by Parliament where the Act provided for the establishment of autonomous health boards through which the Central Board of Health (CBoH) was formed as a technical arm of the Ministry of health with the mandate to interpret and implement policies and; creation of District Health Boards and Hospital Management Boards to manage health services in districts by linking district management teams, hospital boards, health centre Committees and Neighbourhood Health Committees (NHCs). The aim was to transfer management for quality to district level through managerial, and professional autonomy (MoH, 2001), as one respondent stated:

> *… the MMD Chiluba's government was a strong agent of change in that, the way the health reforms were initiated was for the purposes of promoting the medical profession, to create a pool of medical professionals to run health services and at the same time promote community ownership of health services, … what the MMD government implied is that people should look after themselves, run the services themselves, each person should be a mini ministry of health supported by a pool of professionals" "* (Inter 14 June 2018 former mid-level manager, MoH).

"it was important that the health reforms were legislated by an act of parliament because that process legally legimated the mandate of the board and the premise was that it was given autonomous powers and permanence at least for the moment" (Inter 14 June 2018 former mid-level manager, MoH).

Thus the aim of the health reform process was to provide democratised public health services by fully implementing the concept of popular participatory structures legimated by the National Health Services Act, of 1995 (cf. NHSP; 1998 – 2000). Henceforth, it entailed that the district health management teams were to independently manage the provision of health services in the districts and provide oversight to district and hospital boards and health facilities. The district health boards had to establish area boards of health within their jurisdictions. In addition, all referral hospitals within the districts were to be managed autonomously (MoH, 1991).

Referring back to the discussions in Chapters One and Two, the architecture of the health reforms reflected the ethos of the Alma Ata declaration of promoting communities/individuals having a say in their own health. To ground the ethos of the Alma Ata declaration, the health reforms were implemented in such a way that health facilities supervised and met regularly with the NHCs. In return, the NHCs reported to the health facility regarding the state of health in their communities and also provided feedback to the facilities regarding the health needs of the community. Together with health facility staff, the NHCs planned and budgeted for service delivery according to the needs identified in their catchment areas. The plans and

budgets were submitted to the district health boards to be aggregated at provincial and national levels by the ministry of health (MoH, 1991). The inclusion of participatory democracy in service delivery was seen as a key component to improved service deliver as several interviewees believed that the UNIP government's failure to deliver better health services was as a result of having divorced itself from the communities. As one interviewee stated:

> *"…when designing the reform in 1990 we took into consideration the historical failures of primary health care approach. We considered that some populations were underserved, especially the rural areas, and then we also considered that we had squatter settlements and low-income housing in urban areas with very poor sanitation that needed health education. We felt that the best way to understand community challenges and deliver services appropriately was to move the institutions of planning and management of healthcare to the districts through the district health management boards being the institutions of governing health in terms of decision-making authority, then also have a technical team called the district health management team to be responsible for implementing health care services. We believed that these structures would foster popular participation at all levels of the health care delivery system.* (Inter. 24 May 2018, former high-level politician).

Although the content of the health reform processes reflects the ideals of primary health care ethos promoted by the Alma Ata declaration as discussed above, the thesis recognises that the formulation and legitimatisation of the policy's content mainly involved central level structures. According to Walt (1991, p.4) structures that formulate and legitimise policy content possess the mandate of generating ideas to respond to the identified problems which the policy aims to address. Walt further elaborates that if the ideas are coming from actors representing different institutions/ideas each presents ideas that correspond with their interests (Walt, 1991, p.4). Thus, with the health reform process politicians in the MMD government were more interested in fostering an agenda that set them apart from UNIP's socialist policies and in that way they managed to gain donor confidence as well as create a model of decentralisation that supposedly addressed the inadequacies of community participation. Consequently, because the ideas were a reflection of the political system and that of cooperating partners they generated policy outcomes that are viewed differently by interviewed actors that worked with the health reform process; for example one actor reported that: the donors were mostly interested in meeting their targets and seeing results of the 'new thing' but little was taken into consideration of how the whole concept was going to be received by the health workers (Inter, 27 February 2019, former mid-level Manager MoH), while another interviewee reported that the whole health reforms was failed by MoH bureaucrats to convince the donors that it would not work when the health reforms were actually working (Inter. 24 May 2018, former high-level politician). Though the two interviewees had conflicting views on the failure of reform, it is important to note that the health reforms had been designed with a heavy load of tasks to achieve and to measure

success. Henceforth, the politicians and high-level actors were faced with the task of designing reforms that intended to achieve a mixed of measures, ranging from institutional to structural issues. As reforming the health sector required restructuring human resource, improve infrastructure, provide incentives for health staff, improve staff retention, create efficiency in service delivery, engage with the community in health service provision, create innovation and the task of raising revenue the actions/reactions of actors were neglected in this regard. As theoretical underpinnings posit, health developmental processes require embracing relevant culturally, historically, socially, and economically processes that can respond to local needs than injecting techniques that are highly complex (Rifkin and Walt, 1986).

The conflicts on the way the health reforms were designed also existed within the health sector despite the consensus sought out of the sector to legitimise the reform process, for example one out of the two key experts lamented on how the component of community accountability was weakened because of the inside conflicts in the health sector with regards to legitimation of district health boards being institutionally accountable to the district councils that have the legal mandate of governing with locally elected officials (the councillors) by the people at local level. Within the design of the health reforms, the proposal was that the district health plans formulated by the district health team and approved by the district health board would be submitted to the council for legitimation and further approval before being submitted and funded by the central board of health, which was to be guided by ministry of health policies (cf. Inter. 24 May 2018, former high-level politician).

Although the principle reflected the ethos of community participation in decentralisation, the key expert reported that:

> *"My superior in the Ministry (him having been minister of health with me being his deputy) accepted and approved the structures of the district boards and management teams, but he rejected the idea of the two institutions submitting the plans to the councils for approval because he thought that the ministry of health was going to be subservient to local government. He plainly voiced out that he would not subject the 'educated' medical doctors to reporting to local council officials with very little education… As much as we tried at parliamentary level with intervention of the republican president for him to accept that clause, he ignored it and did not table it before parliament. The president had intervened that he includes that particular clause but since he was the minister and the only one by law who could table the bill before parliament, he ignored that clause and that is how it was lost in the design"* (Inter. 24 May 2018, former high-level politician).

…relating to Howlett et. al (2009, p.142); negative decision making, demonstrating that some decisions as part of the policy do not move into the implementation stage because some actors will not agree to certain decisions, and usually it is the actor with more power that succeeds. As such the less powerful actor's contribution to agenda setting was defeated. He thus reported that:

> *"I felt that we lost an important component of accountability at district level by failing to include the councils as channels where the two health bodies at district level could report to. The minister felt that the Ministry of Health was under him, and it should not be subjected to other institutions"* (Inter. 24 May 2018, former high-level politician).

Related, the interviewee also felt that that's how central power - political power – can distort a technically sound plan because according to him, what they had in mind when designing the reform proposal was to have a technically sound and politically acceptable plan that could deliver better health services. To the architects, especially the two experts, technical soundness of the plan included the principles of accountability which were denied in the political acceptability that the minister considered at that time. The Minister didn't think that subjecting his ministry to local government to approve plans for health care was appropriate. For the interviewee he felt that it was a question of turf politics and thus reported that:

> "As *a deputy minister of health, I could only help with formulation of the policy document, but the burden of legitimation and approval was with the senior minister. The relationship between us was tense which I had to manage as a technical person and that was the struggle, I had with formulating the health policy reform. I was very technical, but he was a better politician than I was"* (Inter. 24 May 2018, former high-level politician).

Thus, as reported by the interviewee, although he had emerged to be a key actor in shaping the reform process his influence on the point of legitimation was limited. His position and views in shaping the reform process provide novel insights to the discussion regarding local practice of policy shaped by prevailing relationships embedded in local politics within the Zambian context. Thus, the thesis is of the view that the discussions above demonstrate how narrow the health reform process was in shaping the agenda and implementation processes, and hence problems emerged during implementation to the point of the process being repealed. It also shows that donors allowed narrow views to prevail, in the first place, leaving the power of policymaking in the hands of political figures who could also not agree to terms they felt uncomfortable with. Typically, the health reform agenda reflected the political principles that the MMD government had pledged to deliver, which in turn reflected the democratic and economic principles demanded by the World Bank and the IMF (Lake and Musumali, 1999).

The political and cooperating partners/donor actors shared much of the economic rationale in designing the health sector reforms in that it was widely believed that the reforms embedded within the neoliberal agenda could generally grow the economy that could trigger improved public service delivery (Lake and Musumali, 1999). To that, the National Health Policies and Strategies paper (MoH, 1991, p.9) had stated that:

> *"Without adequate and sustainable financing, health services cannot be produced. The need to improve the relative value of resources available to the health sector is crucial. While external assistance will continue to fill many gaps, the basic needs of our national population must be met on the strength of our national government to come up with locally sustainable modes of financing. At local level, many communities make contributions to health services, but these are often uncoordinated inputs and vary throughout the country. We are proposing a comprehensive system of health sector financing".*

Henceforth the principle of the introduction of user fees in all public and mission health facilities was to raise more revenue for the health sector.

To that an interviewee reported that:

> *"…what the government wanted to do was to let the boards grow into a modernised technical bodies that could manage health services independently without interference from government while the donors were more interested in seeing their ideas put to use to increase efficiency and deliver health services effectively that is why the user fees were very important to the reform process…for the donors, user fees were a form of empowerment of giving a voice to the citizenry on the assumption that when people pay for services, they tend to demand to be served in a better way "* (Inter 14 June 2018 former mid-level manager, MoH).

Another interviewee reported that:

> *"I was one of the key discussants during the stakeholder consultative meetings by MoH prior to the implementation of the health reforms. One key issue that donors repeatedly emphasised upon was that fee for service was a form of community empowerment model, that when citizens pay, they become active participants in decision making for health services delivery. In short, the emphasis was that community participation also fosters accountability, making health structures more responsive to the needs of communities. During the meetings, everybody seemed to have agreed with such a model, but we did not foresee that it could go wrong as it turned out to be* (Inter. 14 June 2018, multilateral representative, former MoH mid-level manager).

Although the intention of having introduced user fees were for the purposes of strengthening community ownership and participation in health services delivery, user fees turned out to be a deterrent factor to accessing health services for the majority of Zambians especially the rural populations (cf. Chansa, 2013). Despite user fees was having been designed to operate based on the primary health care approach (MoH, 1992), with the establishment of community structures, including Health Centre Committees and Neighbourhood Health Committees (MoH, 1992), and district management structures (Health Management Teams and Health Boards) to support the community level structures (MoH, 1992), the context into which they were introduced failed to support the idea. Looking at what the design of the health reforms were in relation to the introduction of user fees, it suffices to point out that the structures were elaborate because the operations of councils were amended under the Local Government Act of 1991, under which councils were charged with the responsibility for delivering a broad range of services including housing, urban land development, water and sanitation, as well as road development and maintenance (MLGH, 1996). The operational structures within the Ministry of Health were revised to accommodate the reforms with strong emphasis on community engagement (MoH, 2000).

Thus, this thesis is of the view that the design of the health reform process mostly adhered to the principles of primary health care approaches as suggested by the Alma Ata declaration however much of the economic and social rationales – that is the context could not match with the suggested principles.

Process factors that shaped the health reform implementation

As already stated above the ideas of the health reforms processes were largely shaped by politicians and high-level bureaucrats intersecting with donor agenda. And again, as already highlighted, the Ministry of Health having convened a stakeholder conference to share the vision of the MMD government regarding reforming the health sector was for the purposes of disseminating their intentions of rolling out the process (cf. MoH, 1991). The MoH argued that the health sector was one of the key indicators of the Zambian economic recession, marred with poor infrastructure, poor staff retention, and a shortage of essential medicines and equipment (MoH, 1991). Coupled with that, the lack of health policies in Zambia prompted several actors - politicians and bureaucrats - to call for reforms (Int. 15 May 2018 former mid-level manager, MoH). The purpose of the conference was to take stock of the existing situation in the health sector by reviewing the performance of the Ministry of Health, and to attempt to realign resources and commitments towards objectives which would improve the effectiveness and efficiency of the health Care System (MoH, 1991). The impact of the planned changes was to reduce the size of the MoH, which in future was to be responsible for policy development, setting national goals and targets, reviewing performance, overall control and financial audit, quality assurance and statutory compliance (MoH, 1991). The health policies

and strategies document provided future direction for the health reform operations pending publication of the programme for health reforms, which was to contain the timescales and action plans (MoH, 1991).

One of the most prominent arguments brought forward by interviewees was that the structures established through the health reform process were well thought out and suitable to rollout the health reform plans (in other words, the content of the plan was good). The thesis does agree to this, considering that the structures were designed to accommodate the basic tenets of community participation (cf. Smoke, 2003). Despite such an argument being supported by this thesis, the structures created through the legislation of the health reform process were limited in achieving the health reform goals. For example, the NHCs are cited to have been the most successful component of the process by most interviewees, but, some interviewees disputed that, saying that the process did succeed at creating structures (which are used to date to deliver community health programmes) but failed to enhance accountability (Inter. 5 June 2018, former senior manager MoH). And because of the failure to effectively initiate accountability mechanisms, the vision of the reforms as articulated in the Health Policies and Strategies paper - to create effective leadership, partnership and accountability - were deemed to have failed at all levels. In addition, the Ministry of Health as the primary lead and manager of the reform process was supposed to effect collaborations with consumers and service providers on how to improve health service delivery and to provide an environment that was supposed to foster accountability for consumers, providers and government but as said by some interviewees they failed in their mandate. Instead, differences arose between MoH and CBoH staff (Inter. 18 May 2018, former mid-level manager Ministry of Health). Another interviewee added that: *"…the bone of contention were renumerations but ultimately that created so many misunderstandings that MoH staff advocated for CBoH to be dissolved*" (Inter. 16 June 2018 academic; former mid-level manager CBoH). Another interviewee pointed out that: "*the fact that CBoH was a subordinate body to MoH meant that MoH had more legitimacy and power. So how can a boss accept to be remunerated lower than their subordinate? I regarded that as a joke. Whoever thought that could work was very wrong*" (Inter, 12 June 2018, lower-level Manager MoH).

Although the two actors who were the architects of the health reform process argued that there was nothing wrong with the way CBoH was structured and how staff were remunerated because the rationale was to encourage high professional standards and motivational levels within the health profession – that is the frontline health workers (Inter. 24 May 2018, former high-level politician; Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms).

However most former MoH interviewees disputed that the clause that government had initiated to foster the culture of integration and to ensure that the systems that were created worked adequately, by putting in place attractive conditions of service to retain professional staff such as doctors, pharmacists in the country and endeavoured to develop initiatives to

attract professionals that had migrated to work abroad to return to Zambia including better conditions for CBoH staff at central level was costly (see, Van Der Geest et. al, 2000). An interviewee highlighted that it was a waste of money by government to have had such a high wage bill while health services at local levels were still deplorable.

> *As a mid-level manager at MoH at that time I thought that it was pure daylight robbery for CBoH staff to have been getting such huge renumerations while hospitals were struggling with basic equipment and infrastructure and most importantly the wage bill did not help to retain health staff (Inter. 18 May 2018, former mid-level manager MoH).*

Indeed, another interviewee confirmed that despite government's efforts of improved renumerations towards CBoH health facility staff, they were still leaving Zambia to go and work outside (Int. 15 May 2018 former mid-level manager, MoH) while in retrospect, the intention of better renumerations was to ensure that the health sector maintained a pool of motivated health personnel. Thus, the decision in itself was overstated as it failed to expose the underlying issues of what incentives would retain health workers. In the beginning, the purposes of delegation (health reforms) were first, to take the decision-making process closer to service delivery points, the service delivery points being the district themselves and the hospitals; secondly in creating the health boards the government wanted to create a pool of health cadres who were not civil servants. So ultimately what the government wanted to be done was to retire all the civil servants who were health workers, make them sign contracts so that they could be recruited by the health boards (cf. Inter. 14 June 2018, multilateral representative, former MoH mid-level manager). Inherently of decentralisation approaches, localised decision-making fosters decision space – where local structures are expected to make decisions that suit them or respond to localised needs – in short, make rules to suit themselves so as to respond effectively to what the local situation presents (see Bossert, 1998).

But as Bossert highlights decision space is difficult to achieve because the political and social environment may insulate actor's relationships and responses to what is presented before them (c.f. Bossert, 1998). And thus, in the Zambian context, it was acknowledged by a number of interviewees that the problems that had to be addressed were multifaceted that localised decision making could not foster health worker motivation and retention. As reported by an interviewee:

> *"…incentives for health workers failed to work because what ended up happening was that there were two types of health workers, those employed under civil service conditions and not well paid and then the well paid recruited under health board conditions, but they were all doing the same amount of work. So, the ones employed under civil service conditions ended up getting frustrated and then government had to raise $400 million dollars to retire all the civil servants so that they could be employed*

> *under board conditions. Government managed to achieve that task at the very minimum and most of the workers that were retired ended up leaving Zambia after they got their benefits because working outside was better than being rehired under board conditions. Based on that, the boards had to be dissolved contributing to repealing of the health services act"* (Inter. 14 June 2018, multilateral representative, former MoH mid-level manager)

Ultimately the processes that were initiated to achieve local decision making envisaged to promote retention of human resources for health fell short. It happened that the plans were enmeshed in socio-political issues that could only be resolved centrally, for example, human resource retention was more of a national issue that was supposed to be resolved by central government and not at district level because central government for long possessed the power to train and retain health workers. And in addition, the differences in salaries and emoluments in the health reform process that created sour relationships between MoH and CBoH staff to the point that it contributed to weakening the reform agenda was more of a national level issue. Most interviewees attributed the problems that ensued around renumerations during the implementation process to how the reform agenda was structured that it favoured CBoH staff especially those that held management positions than health workers at health facility levels. In addition, it also failed to address the grievances of central level MoH staff.

Based on what was happening with regards to actors' response to the idea of CBoH, the discussions above demonstrate that actors responded to it based on theoretical underpinnings of agency. The theory of agency suggests that "agents *often pursue interests which depart in material ways from those of the principal"* (Wiseman et.al, 2012). In this regard actors (health facility staff) as agents and the CBoH institution as the principal. The understandings are that actors' relationships intertwined with the ideas that the health reform policy presented, and thus the concepts of renumerations and allowances were resisted to the point that it contributed to the breakdown of the health reform process. Health workers through their unions were more interested in bargaining for better conditions of service than sustaining the existence of CBoH, and when that did not happen, it led to repeated strike actions, to the point where the matter was taken to court. To that the politician actor, an architect of the reform process reported that:

> *"…the issue of salaries and emoluments was my biggest battle, and I was defeated on those terms. The unions mobilised very strong strikes as result of having misinformed the nurses that the benefits that they had worked for were going to be lost and that was another contentious issue which was not true. Though I won the case in court I was defeated by the massive strikes. The pressure was such that Cabinet through the President felt that my leadership was creating too much tension and was posing danger to the party and its government for their political mileage, so I was moved from*

being Minister of Health to Minister of Tourism. At the time I was moved, we had implemented new financing and administrative systems, new quality assessment systems, the financing administrative systems became the standard flag carrier not only for the CBoH and the MoH but for the whole civil service" (Inter. 24 May 2018, former high-level politician).

Evidently allowances and emoluments were and still are a contentious issue in the health sector. With the current devolution plan, district health actors both from the health sector and the local governments feel that MoH central level staff are not only afraid of losing the power and authority but also the monetary benefits if health services are devolved – these issues will be expanded on in the next Chapter (Six).

Henceforth the concept of extra incentives within MoH central level structures have failed to translate to tangible policy action for health sector development. For example, for a long time since 1992, Zambia has benefited from several global health initiatives' resources, but the health sector remains underdeveloped. As the health reforms and the MMD government instigated the origins of donor financial dependence to finance health sector governance, how has the health system reacted to that, what synergies have evolved and what behaviours have such trends evoked (cf. Dwicaksono and Fox, 2018)? Within the Zambian national settings, the understandings are important because they can help to inform a more consistent approach to improve health service governance. The thesis is specifically interested in understanding the responses by actors to the influx of donor funding and their impact on the transformations of health institutions.

Central role of actors in policy action: Actors' understandings and participation in health sector development and reforms

Evidently, as earlier discussed in this chapter, actors' involvement in agenda setting was propelled by the political climate and for the two experts, their involvement was more to do with their experiences and skills possessed with regards to health sector development which were recognised both at local and international levels. Hence their involvement in agenda setting is reported to have set course and direction for the health reform process. One of the two experts felt that his experiences of having worked as a health planner in several district councils throughout Zambia during the UNIP era largely influenced his views with regards to health sector development. Coupled with that, his experiences around health sector development were also shaped by his academic qualifications that he obtained from the United Kingdom with support from the World Bank. Clearly, his experiences of having been a pioneer of the health reform process shows that donors have for a long time been the lead in charting the course of health services delivery in Zambia and this tells us that it is the expertise of ideas that they worked to

develop that were at the fore of agenda setting of the health reforms. For example, the expert reported that:

> *"…my contributions were recognised because I had gained a lot of practical knowledge. Hence in 1985, while working at the ministry of health headquarters, I was sponsored by the World Bank to study an advanced postgraduate degree in health planning management policy at the University of Leeds. In 1986 I studied my master's degree at the University of Leeds again and my dissertation was on decentralisation of health services in Zambia. Upon my return to Zambia in 1988, I wanted to change things because there was no health policy in the Ministry of Health. The health policy was within the UNIP government booklet with minimal details; therefore, I began to make a case. However, what I was working on could not be implemented by the UNIP government because that was the time there was the change of government" (*Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms*).*

The second expert also expressed similar experiences with regards to his involvement with health sector reforms. He reported that:

> "*Health reforms have a long history in Zambia since 1945 during the colonial era. The minister of health then tried to put forward policies on decentralisation but at the end of five years he lamented the failure to implement reforms on account of financial stringent from the Ministry of Finance. Later, the public health act was enacted, and the central board of health was then formed as a technical body which would help coordinate issues of public health… the central board of health was not a foreign concept as popular thinking has it. The central board of health did call upon capacities from different fields, so it was multisectoral in its conception I think those features attracted me personally to reconsider the ideals for health reforms in the 1990s" (*Inter. 24 May 2018, former high-level politician*).*

Clearly the ideologies of the two experts were similar. Prompted by donor enthusiasm and the change of government the two experts were central to agenda setting of the health reform in Zambia as reported by the first expert:

> *"…Luckily for me there was a colleague with similar interests, a young man coming from Canada armed with a PhD, so we linked up. For him he was more interested in politics, and I was more on the technical side. Let me say that policy change is a partnership, and it cannot work without the political platform. So, we began with writing the health component of the MMD manifesto. Our ideas within the manifesto proposed that we decentralise health service provision. We worked together until the elections in 1991 where the MMD won and later formed government. Thereafter we continued to work together in designing the health reform agenda (*Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms*).*

The central role played by the two experts is highly recognised in Zambia such that all the interviewees who work or had previously worked in the health sector referred to them as key drivers of the health reform process. But like any other policy process, the health reform's agenda shaping did not go without any resistance or conflicts between the actors. As reported by the bureaucrat turned politician, the only way he could get things done was to get involved in politics at the highest level. He reported that, first he secured the position of Chairman on the Health Committee within the MMD party structures where he could influence establishment of policy and legislation. He also held the position of Deputy Minister of Health.

The research found actors were central to the operation of the health reform process in Zambia, starting with agenda setting to the point the policy was terminated. Actors' level of involvement is tabled in chapter Seven where the thesis examines the reasons behind policy failure in Zambia. The relationships of actors in the health reform processes were conceived as a result of the creation of the structures that functioned to deliver health services through delegation. The government having created the CBoH as an autonomous body to provide health services, while policy and supervision were left with the MoH tasked CBoH with the responsibility for day to day running of the district health and hospital boards (MoH, 1996). CBoH received more attention and funding due to it being a new institution in which both the donors and government were invested. It was the belief of all the actors that had worked in the health sector prior the health reforms implementation that the landscape of delivering health services needed to be reconsidered taking into account the poor state of health services delivery as reported by an interviewee:

On the history of health reform proposal

> *"The landscape of health service provision in Zambia were such that before independence they mostly served the needs of the white population while after independence the rural areas were underserved. Hence the primary health care approach to service delivery in the 1970's was designed with the essence of making health institutions accessible to service users at the level of planning. However, the professional aspect of medical care was more dominant than the social narrative of participation. Hence health care did not involve the input of the communities that were being served. In addition, the late 70's through to the 80's was challenging for health sector financing in Zambia due to the economic crisis. That led to poor health outcomes with the prevention aspect of health weakened".* (Inter. 24 May 2018, former high-level politician).

Actors' understanding of policies and reforms is important because of their personal relationships with the national context and policy environment, which shapes the way they relate to the policy or make contributions to its life (cf. Bernstein, 2017). The ideas expressed

by Bernstein corroborate the conceptualisation of the HPTF of actors being at the centre of policy action. Considering that the historical context of the Zambian health policies presents a rich background, one with a number of decentralisation implemented under different political regimes and having benefitted from global health initiatives at a large scale, actors views form a key aspect of policy emergence and sustenance invoking their ability to/not to support policy agenda as will be demonstrated in Chapter Six. Moreso, Walt suggests that: "*the exercise of power is central to understanding and explaining the process and outcome of policy*" (Walt, 1994). In addition, models of policy analysis recognise the intricacies that actors are faced with in interacting with policy actions (Berman, 2005). The models recognise that actors may be motivated to act in the way they do for the benefits of the group/organisation they represent. Actors may also respond in line with their professional ethos to which their action may not be of benefit to policy success.

So, one of the fundamental problems the research found out about actors in health decentralisation is that they had no uniformity in their understanding of health reforms. For example, a high-level politician who served as a key reformer in the health reforms outlined that the health reforms were drafted within the manifesto of the MMD with the elements of taking health services closer to the people, he also outlined the fact that the formation of the 1992 health reforms emanated from the Health Services Act in the precolonial era and hence the MMD government borrowed some of those elements to include in the drafting of health reforms (Inter. 24 May 2018, former high-level politician). Other actors describe it as something that the MMD government picked up from outside and implemented without wider consultation. For example, a former MoH mid-level interviewee insisted that the health reforms were an architect of donor agenda and that the MMD government had little input in the agenda (Inter, 27 February 2019, former mid-level manager MoH).

The conflict over understanding the history of health reforms led some actors to believe that policies are just made by politicians without any consultation, and that political interests rather than a desire for health improvement drive reforms. A number of interviewees commented that frontline health workers regarded the health reform policy as having been a mere political interest than what it said its intent was of improving health services and improving retention of staff (Inter. 12 June 2018, former high-level manager at ministry of Health). However, this research points to the lack of continuity among actors, and a lack of institutionalisation of reforms, as having led to these misunderstandings. So, what has happened is that the reform agenda has been seen as something new with each political regime, yet the basic policy approach has been in existence since the mid 1970's under the UNIP government (Chapter Three). If actors have understood that history, it can lead to the realisation that the aligning of health services to the community has been attempted at several points, suggesting a continuity of approach rather than health reform just being perceived as a political tool.

Actors' contributions to institutional transformation through the health reform policies

Clearly decision making was not a simple, technical and apolitical process but was shaped by central political power, as demonstrated above. Thus, it fits within the literature of incremental models in decision making that explain that decision making is a political and competitive process among actors, and that actors make decisions out of self-interest (Howlett, et. al, 2009, p.146). The incremental model departs from the rational actor models that assume that actors are rational and seek to make decisions with the best overall outcome (Howlett, 2009, p.32). As evidenced by the reform process, actors sought to be rational in the choice of policies but exhibited self-interests to push through agenda. For example, the health minister who had more power than his deputy discounted the clause on health personnel reporting to local authorities on the premise that health personnel, like medical doctors, were too well educated to report to council workers who had minimal education (Inter. 24 May 2018, former high-level politician). The accountability was thus missed at that point.

Bernstein (2017) suggests that health systems should be viewed as "*dynamic social constructs shaped by changing political and social conditions"*. One of the central concerns of this thesis is to determine how decentralisation operates in practice (cf. Chapter One). The health reforms examined here were implemented through delegation (see Chapter Two on models of decentralisation). Pollack (2002) points out that with delegation, it often remains unclear whether the bodies to which authority is delegated implement the mandate of government without distortion, or whether they implement their own preference, thereby disregarding the mandate given to them. The latter is particularly likely if oversight is ineffective and weak. In line with this, most interviewees highlighted that district and hospital board managers were so often reckless in spending and there were a number of audit queries that ensued as a result (Int. 15 May 2018 former mid-level manager, MoH). Perhaps the point being stated here is that political actors' notion of reform had wide appeal, but the ability to ensure effective implementation lower down the chain was weak. Although the commitment to formulate and legitimise the health reforms by the MMD government was there at the highest level, it presented difficulties for lower-level actors who were not invited to add ideas to the process. While all this was happening at the national level, there were no mechanisms put in place to ensure that actors at lower levels understood the policy rationale.

And thus, the agenda came to be set by central political actors, donors, and high-level managers in the health sector. The three had a shared vision. The political actors provided the commitment by government while donors provided the link with the international community that assured the donor community that Zambia was committed to reform and was on the right trajectory (c.f. Human Rights Watch, 1997). It should however be stated that without the support of the public and the donor community such a wide political space could not have existed. The government strategically formed relationships with the public and the

donor community within which they could express their intentions for governing the country (cf. Lake and Musumali, Chitah et.al, 2018). Their platform was mainly their willingness to readily initiate economic, social and public service reforms. Key to economic reform was the structural adjustment programme. The commitment to the various reforms produced donor and public confidence and hence to meet their obligation the MMD government embarked on the health reform agenda in 1992.

The realities are that actors are at the centre of policy processes, as espoused by the health policy framework, as key drivers of policy. They work to translate policy ideas and knowledge into action regardless of the unequal and hierarchical power relations that may exist (see, Walt, 1994, p.154; Howlett, et. al, p160). Other political realities that existed in the reform process were that political and bureaucratic actors were working more to appease donors than their own citizens, in order to avoid facing the situation that the UNIP government found themselves in by failing to meet donor obligations and falling out with them (Int. 15 May 2018 former mid-level manager, MoH). Certainly, the MMD government was aware of the power of donor voices because those voices helped to build their political legitimacy (cf. Human Rights Watch, 1997). To make matters worse, the MMD government was showing political cracks as some party members broke away from it to form another party citing growing corruption within the party (Human Rights Watch, 1997).

While donors', involvement in agenda setting was more aligned with fostering accountability, perhaps they concentrated more on accounting for improvement in health indicators than the responsibility of the health systems to build resilient mechanisms to interact with the populations they serve. For example, a national level interviewee explained that:

> "…*before the health reforms, there was a large presence of Swedes in the Ministry of Health working in the planning departments at central, provincial and district levels. When we started advocating for legislation to change the health sector landscape there was so much support from the donors, for them they wanted to see their resources put to good use. But the problem was that all this was playing out at national level. Perhaps the Swedes should have insisted the inclusion of districts because they had the experiences of working with them*" (Inter. 5 June 2018, former high-level manager MoH).

The donors' main interests were to shape the resource utilisation and sustained programme strengthening, mainly at central level. Henceforth the problem of accountability at lower levels emerged - as most interviewees reported. Other interviewees also reported that the accountability problem was also present at central level because the central level was responsible for providing oversight to the boards and management teams but were not accountable to the local public and it turned out that resource utilisation was ineffective Inter.

5 June 2018, former high-level manager MoH. This is one of the reasons cited by almost all the interviewees as having led to the failure of the reforms, *accountability*. Therefore, the thesis questions whether accountability would have been more effective had it been that the boards and management teams were accountable to local authorities. This is an important question to the thesis because the design of the current devolution plan is based on local accountability, to which there is a lot of resistance from central level citing the ineffectiveness and corruption within local authorities as will be discussed in Chapter six.

Drawing on these discussions, the policy window for health reforms emerged because of the shift in political context and the interests presented by donor and bureaucratic actors aligning themselves with the MMD party even before they formed government, a sign that the UNIP government had weakened, and that their political and socio-economic belief systems had eroded the trust of key actors. Thus, the opportunities that emerged presented the key actors with the power to turn their ideas into policy action. For example, as stated by an interviewee:

> *"I was aware that the UNIP government had difficulties in achieving health sector goals because their health policies were poor…since I was educated in the UK and when there was an opportunity for me to draft policy ideas, I turned to my academic supervisors in the UK to help with putting my ideas into perspective. For me, my interests were to see a pool of empowered health workforce, making decisions and planning for services in their localities"* (Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms).

Typically, there were various justifications for the reform process by pioneers and advocates, but what was prominent was that the citizenry did not see any benefits. Crucially, strikes by health workers caused the MMD to lose popularity, with them being compared to the autocratic approach to manging service delivery of the UNIP government. The Minister of Health also had to repeatedly justify the functioning of the reforms because, for many, they were pointless as health services were deemed to have plummeted (Inter. 14 June 2018, multilateral representative, former MoH mid-level manager). In the end there were calls to review the act that legislated the reforms and the whole reform agenda.

Health reform agenda evaluation and repeal -an issue of contextual matters, policy content, implementation processes and actor's influence.

Thus, the political capital and government capacity to reform that existed when the health reforms were introduced in 1992 cannot be overemphasised. The reforms were deemed to have been 'brave' by most of the interviewees spoken to at national level. However, what should be emphasised is that the health reforms were embedded within the broader economic reforms that the newly formed government had undertaken with the then incumbent President, Fredrick Chiluba, persistently warning the Zambian people to tighten their belts (see, Chapter Three).

As the MMD's reforms called for the country to cut spending in the social sectors, in 1992 the international donor community granted $1.8 billion to Zambia which was reportedly three times the average aid package to other African countries. And in addition, donors continued to back President Chiluba's reform programme with annual aid contributions of up to $1 billion a year until early 1996. Aid became the largest source of foreign exchange for the country and accounted for 70 percent of Gross Domestic Product (Human Rights Watch, 1997). Despite the increase in aid, the reduction of state expenditures in the social sectors negatively affected the functioning of health services and education. As expenditures were reduced it was expected that social services were to be self-sustaining through revenue collection such as user fees (c.f. Lake and Musumali, 1999). One interviewee pointed out that once reforms introduced user fees at health facilities people could not afford to pay, not least because there were job losses because of the reforms. Arguably, the end result was that most people were too poor to access health services (Inter. 14 June 2018, multilateral representative, former high level MoH official). So, although there was an influx of funding in the health sector, coupled with implementation of health reforms to govern health services, the health sector remained challenged (MoH, 1998). Some interviewees stated that the health reforms were implemented needlessly because they came at a huge cost to the government, yet they achieved so little.

Nevertheless, some interviewees who worked closely with the government at the time the reforms were introduced reported that the reforms needed to happen because service provision under the previous government run by the UNIP had been deplorable (Inters. 5 June 2018, former high-level manager MoH; 14 June 2018 former mid-level manager, MoH), given that health expenditure by the UNIP government had significantly reduced due to the falling of copper prices in the mid 1970's through to the 1980's (see, Freund, 1986, Burnell, 2001, p.152)[17].

The MMD's health sector reforms did not produce the intended outcomes but instead problems emerged, which can be attributed to a variety of factors: a newly formed government that was initiating new institutions of governance, poor economic conditions, a rising appetite for human resources for health in developed countries (which made retention more difficult), and a sudden influx of donor funds (cf. Lake and Musumali, 1999). These discussions will be revisited in the next section when discussing how the health reforms shaped health governance in Zambia. Policy evaluation entails policy actors determining the

[17] Since the early 1930s, Zambia had been one of the key producers of copper and continued to depend on copper till today. However, by the late 1973 as a result of the world economic recession copper prices fell and having been a major contributor to GDP at 30% and accounting for at least 95% of foreign earning, the recession significantly affected Zambia's economy such that after 1974 the economy began to stagnate (see, Freund, 1986)

extent to which the implemented policy delivered what it intended to (Howlett et.al, 2009). The key actors who played a major role in evaluating the health reform process were high level management and development partners. Though there were a number of successes scored by the health reforms, the failures were commonly deemed to have outweighed the benefits. The health reforms were seen as costly in terms of the amount of money that was spent on salaries and emoluments. They were costly in that service delivery did not improve, especially with maternal and child health indicators (though this is disputed because one interviewee said they did improve health indicators as shown by the Zambian demographic health survey whilst another disputed that they did nothing to improve service delivery). The health reforms were a deterrent to access, in that the fee for service did not foster good health seeking behaviour because of a lack of affordability for many people, especially in rural areas. The health reforms also defied the code of 'lean top and heavy bottom' because the high-level structures became bloated. Such critiques led to calls for the re-evaluation of the whole concept. Eventually the reforms were halted, and the legislation repealed.

One of the interviewees from Ministry of Health charged with reviewing the health reforms reported that:

> *"…decisions that were being made by the hospital management through the appointed boards were in conflict with most of the civil service conditions and procedures. CBoH also had a bloated workforce at the central level and government was spending huge amounts of money to run it. Keep in mind that all the employees of the CBoH were on contract and they were on very superior conditions of service: at the end of every three years they had to be paid gratuity and even just their operations to carry out their activities it was found that most of the money which was supposed to be spent in the districts for district health services, and at the hospitals for health services ,was actually being retained at CBoH headquarters to meet the high operational budget. So again, that was the other reason for the failure of the decentralisation" (Int. 15 May 2018 former mid-level manager, MoH)*

However, interviewees who were proponents of the health reform process viewed their repealing differently. For example, a proponent of the reform process reported that:

> *"…the conflicts that existed between MoH and CBoH staff were inconceivable that things like furniture and office space were big issues. MoH staff complained that CBoH staff had better office space and furniture than they had. So, all those things had to be resolved. But the bigger issues like emoluments could not be addressed and there was so much animosity towards the CBoH as a body. They were complaints that too much money was being spent on staff emoluments, things like the Permanent Secretary who is more senior cannot be getting a lower salary than the Director at CBoH. But these*

are professionals and had to be remunerated accordingly. The Director at CBoH was appointed because he was an acclaimed medic and that is the trend aimed to set up. We aimed to create an expert body of medical staff that could direct health services in Zambia, but that chance was never allowed to grow and flourish".

Another high-level interviewee who worked at the central board also reported that there were a lot of personal conflict between ministry of health workers and those that belonged to the central board at district and facility levels and that was a source of strife such that there were frequent strikes by health workers. One of the architects of the reforms who was the minister of health at the time of the strikes reported that:

"*We aimed to create different structures for remunerating health staff because if we had kept it within the structures of the civil service, we would have not been able to remunerate our health workers differently from the rest of the public service. That was the key issue in the failure of the health reforms because it threatened fundamental interests of public service unionism, the public service unions felt threatened fundamentality with the idea of not linking with health workers, we were to move the health workers from the civil service bargaining; as you know when the nurses and doctors are on strike its easy and quicker for the government to respond. (Inter. 24 May 2018, former high-level politician).*

Ultimately the calls to review the existence of the CBoH were based on the following reasons:

1. Justification by government to continue the burden of holding huge wage bills generated by central board.
2. Over expenditures and bloated central level
3. Duplication of functions by ministry of health and central board
4. The health service structures did not offer much in terms of improving service delivery it was said that instead of money going for service delivery it was used for wages and administration.
5. The incentives for health workers created by the boards did not deter health worker migration. The brain drain was still a problem. In this thesis I attribute the problem to other poor socio-economic conditions. By merely improving the salary of a health worker will not guarantee the health worker does not leave the country. They have to think about the education and general welfare of their families and foreign countries were seemingly more attractive that the packages that the CBoH was offering and hence that was an oversight by the system.

Henceforth the team that was composed to review the health reforms concluded that they should be repealed. An interviewee who played a key role during the agenda setting lamented that the boards and the health services act had to be repealed. For him, their

failure was a result of individual conflicts and people not wanting to acknowledge the strengths of the boards. He reported that people who were opposed to the health reforms from the outset had personal interests. He also reported that the detractors of the central board managed to convince the World Health Organisation (WHO) that it was a bad concept, and WHO also composed a team for themselves to assess the efficacy of central board. To this he reported that*:*

> "*When they were reviewing the central board of health, it was a funeral for me. By then I was in Botswana and the worst thing for me was that they asked me to be part of the team to review the central board of health. They used WHO to come and look at the central board of health and rubber stamp their decision when they had already made up their minds that central board of health was not needed. It was a political assassination. There is nothing to me that was technical about abolishing the central board*" (Inter. 15 June 2018, former high-level manager MoH-pioneer of health reforms).

It is clear that the evaluation process was a crucial stage where the different actors' interests and ideas interacted in terms of forecasting whether the health reform policy had yielded the intended results. Evidently, the interests of those who favoured the termination of the health reform provided compelling evidence to terminate the reform agenda. Unlike at the agenda setting and legitimation stages, where the ideas of actors with the power go through, at evaluation stage it is the ideas of those with evidence - especially if the evidence hinges on political legitimacy or threatens the political popularity (cf. Marsh and McConnell, 2010).

Drawing on a comparison by Marsh and Rhodes (1992a) stating that the failure of the Thatcher privatisation policies in the UK were a result of political objectivities clashing with economic and ideological objectives; the health reform's political objectives in Zambia clashed with the economic objectives in that although the health reforms aimed to foster efficiency, accountability and participation to improve service delivery, the context could not support attaining the objectives. Furthermore Cairney (2012p 37) explains that policy evaluation entails assessing how successful a policy was. He further explains that if a policy is being assessed from the top as it were for the health reforms, the approach used is primarily to identify if there was any compliance to the implementation process. For the health reforms, the committee that was set up by the Ministry of health to review the implementation process ultimately concluded that there was no compliance with the ethos of the reform, especially at district levels, and hence recommended that the health legislation that enacted the health reform process be terminated (Inter. 14 June 2018, multilateral representative, former MoH mid-level manager). Another interviewee reported that:

> *"…I played a crucial role in the reviewing of the decentralisation process, fundamentally looking at the challenges that the government was facing with the decentralisation process and the recommendation of that was that the health services*

> *act be repealed. I did support the idea to repeal the health services act because of the duplication of functions between the MoH and CBoH, … additionally government could not afford to manage the wage bill demanded by the health reform process"* (Int. 15 May 2018 former mid-level manager, MoH

Frenk (2004a) observes that it is unfair to hold health systems accountable for things that they are not completely in control of. Although it was observed that the health reforms were not functioning as efficiently as they were supposed to, there were other contextual factors that led to the failures (see also McConnell, 2015 on defining policy failure). For example, some interviewees reported that some of the failures were institutional and infrastructural related (Inter 14 June 2018 former mid-level manager, MoH). The ministry of health often could not afford to buy drugs for the hospitals. That created lack of confidence between communities and points of service delivery. The interviewee continued to say that that communities did not see any value for money: "*they would pay service charges, yet there were no drugs at the hospitals. The infrastructure was also in a deplorable condition, coupled with shortage of health staff. HIV/AIDS had also taken a toll on the community"* (Inter 14 June 2018 former mid-level manager, MoH), hence the health reforms could have gathered as much leadership and as much momentum, but in essence generated very little to avert community health problems. There needed to be a leveraged level of response for the health reforms to work.

The health reforms were deemed to have drained government resources, yet there was nothing substantive to show for their achievement. Hence there were incessant calls to repeal them. After the repeal of the Health Services Act there has not been any legislation to date to replace it - and hence the health sector has been operating without any guiding legal framework (Chansa, 2013). The quest to decentralise health services did not end with the reform process, as already discussed in chapter two the delivery of HIV/AIDS did manage to initiate decentralisation (although contested) and in addition there have been several other organisational reforms and decentralisations that have had an impact on health service governance in Zambia. A high-level politician interviewee stated that he was repeatedly attacked for defending the health reforms during parliamentary debates and once, he was prompted to ask the house: "*is it the failure to reform or the failure of the health reforms that Zambia was struggling with*?" (Inter. 24 May 2018, former high-level politician).

Conclusion

The Chapter has established that the health reforms were designed with good intent to improve the delivery of health care, where health was supposed to be taken closer to the citizenry so that they could provide accountability to the systems as well as take part in service planning. Although in most sub-Saharan African countries policy agenda is driven by external

influence, the health reform process in Zambia demonstrates that what is key to policy success are local contextual factors. The Chapter established that the health reform process operated under difficult socio-economic conditions – economic restructuring meant government spending cuts towards health services delivery. Before moving on to conclude on how the health reforms have shaped future decentralisation policies and the governance of health services, it is perhaps useful to briefly summarise the key points that have been made in this chapter, that is to explain how the chapter has answered the four key sub questions of the thesis: (a)what has driven the adoption of decentralisation policies in Zambia's health sector? (b) What factors have enabled/inhibited Zambia's health sector decentralisation processes? (c) how has political and bureaucratic action at different governance levels influenced health decentralisation policymaking? (d) How has political and bureaucratic action at different governance levels influenced health decentralisation policy implementation?

The chapter has made substantive arguments in answering the four questions. First, decentralisation policies for the health reforms were adopted as a result of the political and economic shifts that gained prominence in most developing countries, mainly driven by the neoliberal agenda. The whole idea of reform gained prominence in the midst of a failing UNIP government and a dissatisfied population in terms of the economic and political situations. In short, the whole governance system was questioned by various actors both home and abroad. Second the chapter shows that political reform paved way for economic reform in which the health reform was embedded. There was a '*window*' of opportunity for such reform to be undertaken (cf. Cairney, 2012, p.3). Clearly the government had popular support from actors within the civil service and from the donors. Central level actors were responsible for shaping the health reform agenda, but that caused the lower levels to resist at the implementation stage. This is because CBoH was seen to be benefiting more from the process than any other structures. Consequently, there were strained relationships between the CBoH and MoH staff. As reported by interviewees, MoH despised the whole concept of the health reform process because it did not seem to benefit them. Although the health reforms were based on international norms of primary health care, the ideas promoted failed to fit within the Zambian context.

Third, the chapter shows that bureaucrats are key to driving policy implementation and, in the health reform process, their role as agents between government and the citizenry determined the fate of the implementation process. (cf. Walt et. al, 1994, p74; Howlett et.al, 2009 p.160). Rational choice theories as used in the chapter demonstrate that the actions of bureaucrats contributed to the breakdown of the reform implementation process where board management staff interests were cited as having contributed to inefficiencies in health reform operation as well as the hidden conflicts between staff at Central Board of health and Ministry. While it is recognised that actors were at the centre of driving the reform process,

it is also recognised in the chapter that other contextual factors contributed to the difficulties that emerged in implementing the reform process. For example, HIV/AIDS was on the increase, and the continued declining economy and austerity measures that were adopted by the government as part of economic restructuring limited the available resources. In the end, the context in which the health reforms were created was unfavourable and meant that the reforms could not achieve some of the key objectives such as retention of human resources. Furthermore, actors such as trade unions that felt they were outside the policy process and did not understand the essence of the reform process generated their own understandings and agenda that contributed to the failure of the reforms. In addition, a key aspect of accountability was omitted from the outset of the reform process (the clause on bureaucrats reporting to locally elected officials) which caused problems where accountability was concerned in implementing the reform process. Smoke (2003) highlights that for decentralisation to work, local bureaucrats should be accountable to locally elected officials and more crucially local people. Finally, the chapter showed that context matters in policy implementation. Mosse (cf. 2004) emphasises on understanding the failure and success of policy as determined by organisational relationships and inherent interests of implementers.

The observations made in this chapter show that most of the trends that were set by the health reform process continue to exist, that is policy making is mostly in the hands of politicians with the involvement of a few central level actors. There are conflicting views between actors in governing health services, as will be discussed in Chapter Six. Donors continue to play a key role in policymaking and financing the health sector. Lately, government spending towards health has decreased while donor funding has remained steady. Donors continue to innovate other health models, such as bypassing the central level to provide services at district level, but so often such models have been criticised for duplication of functions and undermining the sovereignty of African governments (see, Kelley, et. al, 2017). The discussions established in this chapter are important for the subsequent chapter (Six) as it looks at the delayed implementation of the devolution plan, because some of the policy trends that manifested in the health reform continue to affect policymaking in the health sector and have contributed to stalling of the devolution plan.

Chapter Six

Decentralisation and health service governance in current practice: National Devolution Plan (NDP) – 2002 to date

Overview

- The second of the empirical chapters about the practice of decentralisation and health governance
- The chapter is about the delayed implementation of the devolution plan – specifically the context, content and actors involved in the implementation plan.
- Shows how historical trends entrench themselves in policy practice – contextual issues
- Shows that changes in political systems affects/directs/determines capacity to implement reforms – structural issues concerned with policy processes
- Highlights the complexities of implementing decentralisation policies within weak institutional contexts
- Shows that changes in political systems affects/directs/determines capacity to implement reforms
- Demonstrates how donor actors continue to exert influence in the health sector – actors being central to directing policy action
- The chapter considers how political context and actors (politicians and bureaucrats) have caused the stalling of the devolution implementation plan
- Discusses how decentralisation policies work in context and how actors determine the success and failures of decentralisation processes.

Introduction

Chapter Six is the second of the two empirically grounded Chapters. While Chapter Five focused on discussing the evolution of the health reform process, this Chapter is on the current National Devolution Plan (NDP) that was launched in 2004, specifically the devolution of health services as a form of decentralisation process. Generally, the devolution plan stems from the Zambian government's interest to utilise a multi sectoral approach to planning and programme implementation. As already stated in Chapter One, decentralisation policies are not new to Zambia, with previously implemented decentralisations - the decentralisation of

HIV/AIDS programme and the health reform policies discussed in Chapters Three and Five respectively.

The HIV/AIDS policy discussed in Chapter Two demonstrated how decentralisation can be utilised to achieve health systems goals in that several goals were achieved through community participation that triggered community responses to address the HIV/AIDS problem. Significantly, applying the HPTF to HIV/AIDS policy reflects how the *context* supported by a global agenda successfully set course for the *content* of the policy, and the structures that were created to roll-out the process. *Actors* in HIV/AIDS policy were varied and each had a role to play according to the sectors they belonged to, for example the Zambia National AIDS Network (ZNAN) at national level, funded by the Global Fund, established funding mechanisms to disburse funds from the national level to the community level to support Community and Faith Based organisations to dispense HIV/AIDS services at community level (see Edstrom et.al, 2010; Walsh, et.al, 2012). Clearly the implementation process leaned more on fulfilling the global agenda to address the HIV/AIDS problem supported by Zambian domestic policies and politics, for example the Mwanawasa government in 2002 had pledged to increase budgetary allocations to fight HIV/AIDS for prevention programmes (The New Humanitarian, 2002). This supported the literature that suggests that decentralisation initiates democratic participation in health services delivery if there are adequate mechanisms to support it, leading to improved services (see, Crook, 2003, Walsh, et.al, 2012; Adams, 2016; Chapter Three).

Meanwhile, with the health reforms, implementing the agenda was anchored on political change and transformations from a one-party state to multi-party democracy through creation of new institutions with a wider agenda of economic adjustment (c.f Simutanyi, 1997). Consequently, the *context* in which the health reform policy was introduced was challenging, leading to its failure despite having been a good policy supported by new institutional structures to implement it. Thus, the health reforms case is a demonstration of literature on the critiques of decentralisation - specifically that it does not necessarily foster accountability and local participation unless the context into which its introduced allows for local participation to emerge to foster accountability (see, Chapters Two and Five). Therefore, the two discussed decentralisation efforts in Zambia demonstrate the success and failures of decentralisation, but in both cases the results depended on unique contextual factors (although the specifics of content, process and actors were nevertheless important).

This Chapter brings an additional case of a policy that has been approved on paper (since 2004) but has failed to be implemented by several governments. Like the previous chapter, this chapter draws on an analysis of primary commentaries about the stalled devolution plan from various actors that were interviewed (See Chapter One). Specifically, the analysis uses the policy triangle framework (Walt & Gilson in Buse et.al, 2012, p.9) as follows;

1. Content – demonstrates how the devolution plan has evolved over a period of sixteen years, with revisions to suit different governments' aspirations. In addition, it demonstrates that the delay in implementing the devolution plan in Zambia has been as a result of: i) problems with structuring the implementation plan, for example doubts about how the government will go about in transferring human resources management from central level to district levels due to lack of funding and capacity of government to build the required human resource pool.
2. Context - the political context in which the devolution plan has been pursued (including the fact that since its introduction there have been four presidents from two different political parties
3. Process – how the plan should be implemented effectively for example there are doubts about the capacity of the local councils to manage health services in general.
4. Actors being at the centre - the limited involvement of non-elite actors in the policy process as politicians, external partners and bureaucrats at central level have driven the whole policy reform process, while the local level and civil society actors have been left out, even though they are important stakeholders in the implementation processes.

The first section of the chapter introduces the NDP and how it has prominently featured in several governments' strategies for improving the functioning of social sectors. Second, the intentions of the NDP to achieve/deliver coordinated efforts for improved service delivery are highlighted, along with how politics has affected NDP implementation. Third, the Chapter outlines how actors have affected the implementation of the policy and how they have been affected by it. The chapter concludes with highlighting how the devolution agenda has failed to be implemented for a long time while the HIV/AIDS and decentralisation agendas were implemented with ease – a key lesson to learn from on how external influence has largely driven the success of policy implementation in Zambia as the devolution agenda anchors on locally driven principles, that is – to be funded by the government of Zambia.

The rise of the devolution agenda - Policy Content

As Chapter Two of the thesis explained, aspects of public administrative modelling provide helpful baseline analytical tools for case study analysis and for helping to determine the various ways that contextual factors create unique forms and delivery of decentralisation - as this chapter will go on to demonstrate, the devolution plan aims to transfer primary health care responsibilities to local authorities, but the engagement between the health sector (Ministry of health) and the local government (Ministry of Local Government and housing) at central level appears to be fragmented as there has been no effort to bring the two ministries to work closely together, yet at district levels the District Health Offices and the Local Councils have begun to consolidate their operations. At central level, most of the interviewees in the MoH reported that they were not comfortable with transferring primary health care services

to local councils because council structures are currently weak and poorly funded. Not only that, but they also reported that councils have no financial capacity to manage the volume of funds that primary health care requires to be managed, hence the disinterest at central level ministry of health (Inter, 12 June 2018, lower level Manager MoH; Inter. 15 June 2018, mid-level manager, MoH).

As this chapter contributes to answering the key question for the thesis (that is the justifications for the use of decentralisation policies in managing health services and the sub-question on factors that have enabled/inhibited Zambia's health sector decentralisation processes), the considerations here are on how key contextual factors moderate the effect of decentralisation in Zambia. As already stated, considering that the changes in government have entailed changes in policy direction, the devolution plan is one such policy that has undergone various governments each with their plans on how the policy was/is to be implemented. In addition, besides the resistance by health sector actors, other bureaucratic actors who are supposed to build the process have contributed to stalling the process, in that most of them have not supported the process, especially actors that have worked or work in the health sector. While this has been the case with bureaucrats, the reform process has received bilateral support in terms of capacity building and creating trust in the process.

The quotes below express the perceptions towards the devolution plan:

> "*…honestly harnessing opportunities to improve health care services have been very poor by government. You and I are sitting here asking each other about donor involvement in promoting the devolution of health services, why is that? There are opportunities for Public-Private Partnerships which can be utilised to fulfil health care needs for the Zambian people because the model of devolution cannot work. The councils have no capacity to run primary health care services*" *(Inter. 16 June 2018, Political Appointment, former high-level manager at MoH).*

> "*I find it difficult to answer some of the uncertainties surrounding the implementation of devolution. I have worked in the Public Service for close to 26 years and this is an agenda I am familiar with, yet I do not know some of the answers to the questions like the capacity of local authorities to manage health services. I think you need to speak to the Vice President to get a well-informed approach with regards to what the government has been doing to build local councils' capacity because it's a highly charged political matter that so many of us are afraid to comment on. But what I know is that there is a waste of resources when it comes to management of local authority funds. There are opportunities for them to raise resources but that is not being encouraged, let them generate their own resources because they are capable of doing*

that, that is when we can say they can manage primary health care" (Inter. 16 May 2018, high level manager, Cabinet Office).

"…I do understand why the health sector does not want the devolution of health services. It could be rooted in the past failures of the health reform process. They have been so cautious to engage with us in devolving health services, but we have been proving the support that they need" (Inter. 20 June 2018 bilateral representative).

Although there are widespread criticisms towards the devolution plan as expressed above, the NDP has succeeded in designing a considerable DIP and taken further steps to call for implementation legislation, the actual implementation process has been far from being achieved. As will be discussed in the next section, this is largely due to the types of uncertainties expressed by actors in the quotes above. As earlier stated, the policy was first approved and launched in 2004, with the official document stating that the plan was to be implemented from 2009 to 2013 (see NDP – 2009 -2013). Key to this shift in the agenda was the change of leadership under the MMD government from Fredrick Chiluba, who had concluded his ten-year term amid controversy and corruption allegations, to Levy Mwanawasa, who termed his government a "*New Deal*" to distance himself from his predecessor who had hand picked him to run as president of the MMD party [18]. (See Larmer and Fraser, 2007).

The government issued Cabinet Circular number ten to amend the public sector operations to include devolution in 2002. Lately, the national development agenda (Seventh National Development Plan 2013 -2018), the national budget and the constitution were anchored to the decentralisation agenda (*see figure 6*). However, the set period for implementation was not achieved, with the policy further revised and relaunched in 2013, while the target implementation plan was set for 2016. The 2016 target was also not met until 2019, when the Act of Parliament that provided for devolution of services was proposed to be revised, resulting in further delayed implementation.

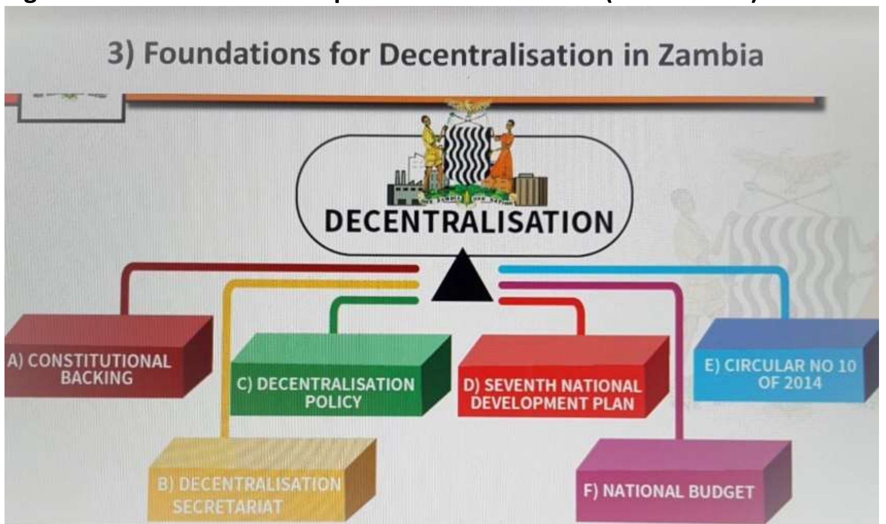
The policy content goes further to state that to achieve the set objectives of the NDP the following will be done: (i) community empowerment through the devolution of decision making with matching resources; (ii) foster mechanisms for a bottom up approach in budgeting and service planning; (iii) improve political and managerial authority at all levels

[18] At the time the MMD government was divided and struggling with the party presidency because the incumbent president Fredrick Chiluba had declared interest to stay on as party leader and contest the national general elections despite the move having been unconstitutional. Chiluba had already served his initial two terms of five years each and was not eligible to stand for a re-election. There were divisions within the party with one camp having offered support to Chiluba while the other was opposed the move. Chiluba ended up handpicking a successor Levy Mwanawasa which led to the party breaking up with one faction going ahead to form the Patriotic Front (PF). The MMD government led by Mwanawasa won the 2001 general election, despite Chiluba having handpicked Mwanawasa for party presidency, Mwanawasa initiated corruption investigations against Chiluba and most of his political allies. A move that earned him popularity with the masses.

(central, province, district and community) to ensure effective service delivery; (iv) improve accountability and transparency in management and resource utilisation; (v) capacity building of local authorities and communities in development planning, financing, coordinating and managing the delivery of services in their areas; (vi) build capacity for development and maintenance of infrastructure at local level; (vii) introduce of integrated budgeting for district development and management; (viii) initiate legal and institutional frameworks to promote autonomy in decision-making at local level (NDP, 2009 – 2013). The ethos outlined for the NDP were embedded within the constitution.

Obviously, constitutionalising decentralisation was intended to counter the arguments that African governments decentralise, yet the lower levels of government are not constitutionally entrenched, hence the weaknesses in most decentralisation agendas in African states (see Conyers, 2015). The decentralisation process has also been aligned to the Public Financial Management agenda supported by the European Union. The premise by the German Government, which is spearheading the devolution plan, is that the prudent application of resources provided by the government through the treasury should be effectively utilised so that social services are provided to citizens efficiently (see, GIZ, 2018).

Figure 6: Decentralisation Implementation activities (2004 – 2017)



Source : Zambia National Decentralisation Secretariat, 2016.

Within the revised decentralisation plan (2009-2013) it was acknowledged that the implementation of decentralisation policy by devolution had in the past faced structural challenges, and therefore a number of propositions were outlined to minimise future risks as well as address the past challenges. Key to the risks outlined was the lack of trust in the decentralisation reform by actors across government who were resisting the process (revised DIP 2009-2013). Therefore, the government proposed to sensitise actors/stakeholders to the benefits of the reform process and how it was to affect governing structures across government levels. The intention was to allay concerns that had been expressed in the past

that contributed to the non-implementation of the devolution plan. Overall, the government intended to initiate and restore trust in the reform, with political commitment being the overarching characteristic to achieve the task (cf. revised DIP 2009 -2013). Thus, the claim was that the decentralisation agenda was to receive renewed political commitment and involvement of relevant stakeholders, which was to be achieved by the established national decentralisation secretariat.

Contrary to these claims, most interviewees reported that in the period after the publication of the revised implementation plan the decentralisation agenda appeared to be more fragmented than before, yet politicians both from government and the main opposition party kept emphasising the importance of devolving functions and services to local levels. Clearly each party had its own agenda in calling for devolution, but the fact was that government made little progress, while the main opposition at the time (the PF) seized the opportunity to chart a plan for how they were going to devolve functions and services when in power, given that government was clearly not keen to implement the policy (see PF Manifesto 2010). These events are similar to what happened with the health reform process, the widespread political impetus propelled stakeholders, including the electorate, to believe in the reform (see Chapter Five)

The life of the National Decentralisation Plan in policy development (2002 – 2019) – Contextual factors

As discussed in Chapters One and Two, decentralisation had been the main feature of the health sector reform process in Zambia between 1992 to 2006. Meanwhile, the broader National Decentralisation Policy (NDP) with its implementation plan, the Decentralisation Implementation Plan (DIP), was launched in 2004. But so far it has failed to be implemented (see, GRZ, 2002), with repeated attempts to make revisions to the implementation plan. Usually, these revisions have aimed to reflect the aspiration of the ruling party, as since the inception of the policy there have been four presidents from two ruling parties, with different approaches to the plan. Significantly this section demonstrates that the content of the plan is suitable but the mechanisms and processes for implementation have been challenging to create. Additionally, the context into which the devolution plan has been operating has largely been influenced by political dynamics, that have otherwise determined the funding landscape, institutional reforms, relationships with external partners, and shaped actor's behaviours and response to the plan (see Chapters One and Three). Therefore, the discussions around the devolution plan recognise that the HIV/AIDS policy and the health reforms were mainly externally funded and were a result of global advocacy of decentralisation agendas (cf. Chapter Three).

What specific political factors has the devolution agenda been subjected to?

Analysis shows that the content of the current devolution policy is well designed - as discussed in the section above, - but implementation has failed for the last sixteen years due to changes in government and the lack of capacity of local councils to manage the services that are supposed to be devolved to them. This was stated by most of the interviewees that have worked with the process since its inception (Inter 23 May 2018, high level manager district level: Inter. 24 May 2018, senior manager local government).

Therefore, interrogating why there has been delayed implementation of the national decentralisation policy as it relates to health sector management is a key concern for this thesis. This is because, whereas in the past decentralisation efforts in the health sector had been in the forefront of implementing decentralisation policies, with the NDP the health sector has lagged behind in engaging with the policy. Equally important, the intentions of the NDP and DIP presented a new and formalised opportunity for enacting a regulatory framework for health service governance through the development and initiation of the health sector devolution plan. The DIP maps the intent to transfer management and control of selected social services to local authorities and in the case of health services the intentions are to transfer the management and control of primary health care to local authorities, while tertiary health care, the drug supply chain, supervision and policymaking are to be retained by the Ministry of Health at central level.

As explained in Chapter One, the two previous decentralisation processes examined in this thesis were initiated with donor funding, but with the NDP Zambian governments have always insisted that it should be locally driven, implying that the government of Zambia has the sole responsibility for charting how the plan is implemented by aligning it to other development agenda and plans (see, GRZ, 2017, 2019). However, this chapter questions the concept of a *domestically driven policy agenda* because evidence shows that the government has no capacity to implement the reform, technically or financially. And thus, the German government has been involved at higher levels of government through the cabinet office to provide technical support.

Given that the devolution agenda has been used as a political campaign tool, thus deemed as highly politicised, with the main opposition party (the Patriotic Front (PF)) having used it to gain popularity in 2011 while the incumbent Movement for Multi-Party Democracy (MMD) government had struggled to get on with it, interviewees who have been privy to the Zambian decentralisation agenda for the past sixteen years or more pointed out that, ironically, politics were the reason why the decentralisation agenda has repeatedly failed: the political context continues to distort the ideals and ideas of devolution (Inter.15 March 2018 former high-level manager MoH; Inter. 16 May, 2018, high level manager, Cabinet Office). While some

interviewees attributed the failures to the demise of two presidents while in office, with their successors perhaps not having fostered continuity with the policy implementation plan or having taken different routes[19], it was admitted by most interviewees that political patronage at central level that characterises Zambian governance[20] has largely held back the decentralisation agenda. For the interviewees, they stated that because the agenda is always politically charged, politicians have not worked out the modalities to implement the devolution plan besides using it to promise the electorate with grassroot empowerment (Inter. 14 June 2018, high level central level bureaucrat).

Evidently, there has been a rising and falling of decentralisation policy implementation in Zambia for more than a decade due to the political dispositions of different political parties towards the devolution plan. For example, interviewees attributed the surging up of the devolution plan by the second republican president Mwanawasa in 2002 to his stand against corruption in the civil service, with the intention to enhance accountability in service delivery. As one interviewee said,

> *"…for the Mwanawasa government, a corruption free civil service was very important and thus we saw government convincingly preach decentralisation to improve service delivery through accountability at lower levels" (Inter 16 June 2018 high level manager cabinet office).*

As a result, one notable achievement by the Mwanawasa government was the establishing of the national decentralisation secretariat to oversee implementation of the policy, as well as to coordinate sector devolution plans at national level.

However, the plans that were supposed to proceed with the implementation process stalled, as many interviewees commented that the government did not weigh the political costs when they were keenly advocating for devolution. It was when they realised that they were going to lose politically that they decided to hold back, because the main opposition party (the PF) had more councillors in key urban areas, so the government knew that if they were to devolve power it would be to key councils controlled by the opposition party. As expected, the failure to implement the plan sparked criticism from the PF. The PF made repeated calls for the plan

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[19] President Levy Mwanawasa initiated the devolution agenda. He died in 2008 whilst in his second term of office, he had served a total of seven years. He was succeeded by his Vice President Rupiah Banda who was completely silent about the devolution agenda. He was defeated in the 2011 elections by Michael Sata's Patriotic Front. Unfortunately, Sata died in 2014 having served three years of his first five-year presidential term. Sata's successor, Edgar Lungu upon assuming office backtracked on the decentralisation decision of transferring mother and child health services to Ministry of Community Development; a directive was issued that the services be returned back to the Ministry of Health. Under his tenure the devolution agenda has been revised pending implementation.

[20] The Norwegian Evaluation Development Support to Zambia (1991- 2005) highlighted that Zambian politics are characterised by centralisation of power in the hands of the president supported by a small elite group that fosters informal policy decision making and are rarely held accountable.

to be implemented because it was going to benefit them politically. As one academic interviewee reported,

> "*The devolution plan was not implemented for political reasons, and if we take a look back the Minister of Local Government at one point made a surprising remark that if the President wanted the devolution plan to be implemented it is going to be implemented" (Inter. 16 June 2018 academic).*

The interviewee went on to say that despite the minister having made such a bold ironical statement, she was not reprimanded by the government or the President, implying that the government was not ready to implement the plan. A former high-level manager at the Ministry of Health said that:

> *"…the prospect of implementing the devolution plan by government was exciting for the PF because they knew that the local councils that generate revenue would be in their hands and the electorate would have given credit to them, and that's what the government didn't want because they were already struggling with popularity" (Inter. 14 March 2018, former high-level manager MoH)*.

The demise of Mwanawasa in 2008 left the plan unimplemented with his successor saying little about going ahead with implementation.

With the PF having formed the next government in 2011, based on their political message of putting more money in people's pockets, it was expected that they were going to be enthusiastic about implementing devolution. However, this was not to be, despite having had the majority votes both at national and local levels. Their political mantra of more money in people's pockets was tied with taking service delivery closer to the people (see PF Manifesto, 2010). In addition, their fierce opposition to the MMD government not implementing the plan raised expectations that the decentralisation plan was going to be delivered. In fact, the campaign for the Patriotic Front was anchored on their promoting empowering local authorities for effective local governance and people participation.

Seemingly with the PF government having promised to initiate changes within ninety days of government their preferred strategy was to leave behind the devolution plan in preference for geographical decentralisation by creating smaller units of administration through creating additional districts such that within two years, the country had moved from having 72 to 114 districts (GRZ, 2012). Meanwhile the health sector was also reorganised outside the devolution plan by integrating mother and child health services with the Ministry of Community Development and Social Welfare (NHSP, 2015) Although the PF government fiercely opposed the previous government for not implementing decentralisation, theirs was also a similar route when they formed government.

With the PF government in power, a number of interviewees reported that their political stance on decentralisation led many to believe that decentralisation was going to be

implemented (Inter. 16 May 2018, high level manager, Cabinet Office), because in addition to the PF having preached decentralisation while in opposition, their President had a historical legacy of being a decentralisation advocate. He was a pioneer of the health reform process while he served as Minister of Health during the initiation of the health reform process and the success of the health reforms were largely attributed to the political leadership he had exercised. However, it was realised that the PF government could not implement the devolution plan as expected by many. A senior manager interviewee stated that, because he was so confident in the ability of the PF government to implement devolution, he reminded many of his colleagues who had been sceptical of the process that the PF government was going ahead with implementation looking at the commitments that had been outlined towards implementing devolution (Inter. 24 May 2018, high-level manager MLGH). As that was not the case, he expressed disappointment that he unfortunately had to join the devolution sceptics movement.

With other interviewees, (Inter. 24 May 2018 bilateral representative, former mid-level manager CBoH; Inter. 5 June 2018, former high-level manager MoH), their assertions were that because other forms of decentralisation were being mixed with the strengthening of the devolution agenda, it was going to get increasingly difficult for the PF government to implement devolution because the other forms of decentralisation like the creation of additional districts were typically going to require a huge amount of resources for infrastructure development, human resources deployment, and establishment of systems. The implication was that few resources were going to be allocated for devolution strengthening and implementation. As another interviewee pointed out,

> *clearly most of us could see that even if the PF government was tabling to parliament the revisions of the national decentralisation plan and establishing new legislation and at the same time creating additional districts and reorganising the Ministry of Health, the capacity to initiate everything at once was limited. It was a question of either/or. (Inter. 6 July 2018 mid-level manager, MLGH).*

Another interviewee with a historical legacy of implementing reforms in Zambia echoed the sentiments expressed by the former, he reported that:

> *"I got concerned when the PF government started initiating other forms of decentralisation while at the same time advocating for legislation review of the devolution plan…As it was, before they were in power, I was consulted a number of times on how devolving sectors like health could yield better services… they were even talks of me being given a position in government if they won the elections, but I was not interested. After they won the elections, I saw that the plans had changed regarding decentralisation. Developments that I did not expect started happening, like the reorganisation of maternal and child health services by shifting it to the Ministry of Community Development and Social Welfare. I saw that as a reflection of the*

conviction that the President had in decentralisation, but in my eyes, those were abrupt decisions" (Inter. 5 June 2018, former high-level manager MoH).

Related, another interviewee reported that he was confident that the devolution plan was going to be implemented by the PF government because of the plan being aligned to the constitution and the development agenda, which meant that the failure to implement devolution was to amount to the failure of the national development plan and the constitutional agenda (inter. 14 March 2018, mid-level manager, Parliament).

As a result, most interviewees felt that, in as much as the PF government had accused the MMD government of fearing to promote local autonomy, they had also fallen in the same trap. Worse still, interviewees felt that the PF government had manipulated the electorate by using persuasive speech on how decentralisation was going to be implemented yet when in power they subverted the very idea they had promoted as an opposition party. Henceforth the slowed implementation of the devolution plan has been attributed to political preferences by different governments. For example, a number of interviewees from cabinet office, the health sector and academics were of the view that the Mwanawasa government was interested in implementing the devolution plan going by the commitment shown in setting up the National Decentralisation Secretariat (cf. Inter. 16 May 2018, high level manager, Cabinet Office; Inter. 15 June 2018, mid-level manager, MoH, Inter. 16 June 2018 academic; former mid-level manager CBoH). However, the political threats posed by the opposition PF hindered progress in implementing the plan.

However other interviewees felt differently and argued that there was nothing wrong with the PF having started to implement geographical decentralisation, for example an interviewee from a multilateral agency pointed out that;

> *"I don't even know why people want to devolve services in Zambia because the numbers are small. So, I supported the PF decentralisation of creating additional districts because with additional districts you create smaller units of administration and at the same time more jobs for the people, so resources are spread across the country, whereas with devolution fewer people consuming more resources to perfect the systems like trying to get the human resources component perfectly so that it aligns with our governance systems (Inter. 14 June 2018, multilateral representative).*

Another interviewee pointed out that devolution by sector was not ideal because councils in Zambia do not run at the same levels in terms of capacity and resource utilisation. For example, there are a lot of disparities between urban and rural councils, yet when one looks at sectors like health, they tend to be uniform across districts in terms of staffing whether it's a rural or an urban district. Overall, most of the interviewees from the health sector felt that devolution was not going to improve health services delivery with an interviewee pointing out that:

"…local councils are broke and cannot manage health services effectively. In health services we fence our resources, concepts which probably would not be understood at local government level and in addition we all know that government pays the least attention to council workers. We know that council workers go without receiving their salaries for more than six months. Imagine that they have not received their salaries for six months, but they receive the grant for health services delivery. Do you think that they will stay unpaid, yet they have some money which can be used for salaries? That is the catastrophe we are afraid of in the health sector. If government became serious with local council workers, then everyone would be comfortable to let them run primary health care." (Inter 14 June 2018 former mid-level manager, MoH).

In summary all the interviewees attributed the delay in implementing the devolution plan to the context shaped by political actors, for example different presidents approached the implementation process in correspondence to their interests. Thus, the design details of the devolution plan correspond to the problem it intends to address but has been inhibited by the power possessed by political actors.

Implications of the delayed devolution plan

Overall, the repeated failures of implementing decentralisation have been both a source of concern and disappointment amongst bureaucrats and those working within the Zambian development agenda. While planning activities have been achieved, it goes without saying that the failure to implement activities has significantly affected the trust in the reform process amongst actors. The supporters of decentralisation in Zambia emphasise that it is a worthy process for sectors like health because of the integrated planning process where the health sector will not plan in isolation of other sectors that have an impact on health indicators. They emphasise that it is an opportunity to bring the determinants of health under one umbrella and this will likely lead to improved health service delivery (Inter 12 June 2018, former high-level manager, MoH). As for the detractors, they felt that the politics, structures and institutions in Zambia have no capacity to conduct such as reform. As suggested by an interviewee from a multilateral agency, perhaps Zambia could implement what is suitable as opposed to devolving sectors and functions to weak structures at lower levels?

Decentralisation seemed to be a tired topic across all levels of government, with the national decentralisation secretariat seen as an irrelevant institution. An academic who had worked with the health reform process reported that:

"*I was doing some work on the devolution policy in 2005 and interviewed staff at the national decentralisation secretariat…and then in 2016 the same staff were presenting the national devolution plan at a national development plan meeting. It was surprising to me that the roadmap for implementing the devolution plan I heard from them*

> *almost ten years ago was the same they were presenting at the meeting. I then realised that the devolution plan had not made any progress over the years (Int. 12 March 2018 academic interviewee).*

Others felt that the secretariat had no relevance and capacity to implement decentralisation, as cited by an interviewee from a multilateral organisation:

> *"The decentralisation secretariat is a joke, there has not been enough investment from government because the staff working there are part time, they have other responsibilities elsewhere within the local government…it shows how government is not willing to go ahead with devolution because even the sensitisation is not there. Decentralisation is a big thing and it cannot be transformative with a skeleton staff managing the process" (Inter. 14 June 2018, multilateral representative, former MoH mid-level manager).*

Perhaps the concerns expressed by the interviewees were similar with the government's future plan as since the time the interviews were conducted from early to late 2018 the decentralisation secretariat has undergone considerable changes. For example, there has been a change of staffing levels and management at the national decentralisation secretariat and in addition, a few months after the completion of fieldwork, the government introduced new legislation to parliament that was to alter the provisions of the 2013-2019 revised NDP. (*Source: My observations and communication with staff I interviewed, for example the Director at the National Decentralisation Secretariat I interviewed during my fieldwork in May 2018 was transferred in 2019 to work in another province in a different capacity).*

However, it is doubted whether cooperating partners/donors will be satisfied with such changes because an interviewee from a bilateral agency with the experience of working with the devolution agenda since its inception had complained about staff retention at the decentralisation secretariat stating that:

> "*Working with the national decentralisation secretariat in terms of staff retention had been frustrating because when he builds capacity in staff at the secretariat, the government transfers them to work elsewhere. He pointed out that this was a source of frustration for him because it derails the efforts of moving forward with the process" (Inter. 20 June 2018 bilateral representative).*

In expressing his concerns, the interviewee felt that governments deliberately move staff away from the secretariat to slow down progress. Echoing these concerns, and that of a multilateral interviewee, a former mid-level manager at MoH pointed out that since staff at the decentralisation secretariat are not permanently stationed there, it's easy for any government to move them away. The interviewee cited his experiences with the health reform agenda:

> *"…there was a full-time secretariat prior to implementing the reform process with individuals on full employment contracts to work on the process with support from Swedish technical experts" (Int. 15 May 2018 former mid-level manager, MoH).*

Like that he felt that strong institutional capacity, capital and capital investment and commitment to the health reform process served as key to drivers to its implementation. He pointed out that with the current devolution plan, staff being part time at the secretariat and tasked with other government responsibilities, has been a very big weakness in the process because government can simply move the staff away from the secretariat to elsewhere. He concluded that this is one thing that donors have failed to engage with government to pinpoint that it's a very big weakness because if a country intends to implement such a big reform, staff cannot be going in and out of an institution that is building the foundation of reform, such inconsistent activities erase institutional memory he reported (Int. 15 May 2018 former mid-level manager, MoH).

Other interviewees who were sceptical of the devolution process expressed relief that it has not been implemented and were hoping that it will not be implemented – most of them felt that it was an unnecessary process for Zambia. For example, an interviewee pointed out that the local councils have in the past failed to provide basic social amenities in their localities like garbage collection, and hence he wondered how they can manage a complex sector like health without capacity building (Inter. 14 March 2018, former high-level manager MoH). However, an interviewee working as a manager in the local council pointed out that:

> "… *there will be nothing that will change with services like health at district levels because it will be the same staff working under the Ministry of Health that will be transferred to local government in the same capacities, only they will be reporting to the district councils as opposed to the central level at the Ministry of Health as it is at the moment"* (Inter 23 May 2018, high level manager district level).

The sceptics all pointed out that the devolution process can never work in Zambia because the current systems will not support the process.

Overall, political dominance over the devolution process has regressed its implementation process owing to the decisions taken by political parties and presidents when in power. Undoubtedly the windows of opportunity to drive decentralisation were presented, the first one being the transition of MMD presidencies from Chiluba to Mwanawasa in 2002 and the second opportunity being the changes in governments from the MMD to the PF under Sata. Mwanawasa's inclinations towards devolution were due to having had adopted hard-line policies towards fighting corruption and preferring more accountability in service dispensation (Bwalya and Maharaj, 2017), while Sata's PF government leaned more on democratic approaches to service dispensation, thus the PF discoursed inclusiveness and service delivery driven by local structures as the basis for advocating for devolution. While both presidents with their political parties had principles that had wide appeal, that general

appeal could not resolve structural and institutional problems let alone dissipate the political insecurities they were faced with, for example Mwanawasa feared Sata's PF dominance in managing urban Local Councils. With Sata, his was a case of weak institutional structures[21] because as Mwanawasa held back on devolving; the capacity and time to build the reform process were eroding, and in addition, after his demise, his successor paid the least attention to the devolution agenda. Henceforth both governments were faced with unique problems, Mwanawasa with the fear of losing power to his opponent in some localities while Sata was faced with weak institutional structures and capacity to conduct reform, for example the failure to resolve the human resources transfer from central to district levels. Therefore, when Sata's government went in power they inherited a weakened basis for devolution that they had to lobby renewed legislation in parliament that was supposedly aimed at fostering institutional capacities on the side of government to build reform.

The discussions in this section demonstrate that the political context provided windows of opportunity at certain times, but ironically, the actors trying to implement devolution have been frustrated by political decisions. Evidently politicians have been more concerned with the loss of political territorial power that may be brought about by devolving administrative functions at district levels.

Delayed Devolution in Comparison with the health reform process

It is clear, then, that the political context has affected the way the NDP has operated. As discussed above, interviewees cited several reasons why Zambia has found it difficult to implement the NDP. Looking back at the history of decentralisation in Zambia since 1991, health sector decentralisation plans have always surpassed progress in other sectors. But the popularity of health decentralisation policies in Zambia typically reflects the international normative consensus on decentralisation of health services, as pronounced by the WHO (Kalumba, 1994). And thus, while the governments of Zambia had aspirations of implementing a broad national decentralisation agenda across sectors, the impetus to do so was absent internationally. The exception was health, signified by the availability of donor funding for health sector decentralisation, as noted by an interviewee:

> *"…strictly speaking many African countries like Zambia were in an administrative mess in the early 1990's… but as you may be aware, international health experts place an emphasis on improving health for all globally and that set the agenda for WHO to push for decentralisation. In short, everything was muddled together, some experts were*

[21] The PF had admitted that institutional structures and capacity to conduct reform were weak as evidenced by the caveats stated in the Sixth and the subsequent Seventh National Development Plans, however they consistently maintained that they were going to implement devolution because they wanted to assure the electorate that theirs was a government more interested in the grassroots welfare and devolution was to make provisions to fulfil that mandate.

advocating for political liberalisation, others were offering solutions for improved public service management and that was complicated for Zambia. Keep in mind that we were implementing Public Service Reforms Programme together with health reforms, but no one can account for the improvements or what was achieved with both reforms" (Inter. 16 June 2018, Political Appointment, former high-level manager at MoH).

The views expressed by the interviewee also reflect what literature on political reform in Africa highlights that, in the early 1990's, the prevailing economic focus by African governments like Zambia was to create a highly functional civil service that was to efficiently deliver public goods (cf. Van De Walle, 1999, p:21). And thus, in the quest to achieve the goal of effective public service delivery, several reforms were initiated by the Zambian government post multi-party democracy in 1991. Key to that was the health reform process, so to say is that the health reform process Some of the reforms that were initiated are still in operation to date. As already mentioned in Chapter Two, and as quoted above by an interviewee, the Public Service Reform Programme (PRSP), launched in 1993, was one such reform that was initiated by government to effect change in the management of public services, build capacity and increase performance in the public sector, and implement various forms of decentralisation (GRZ, 2012).

Thus, the idea of the NDP was/is to transfer decision making authority from central government ministries to local authorities, using devolution as a form of decentralisation (See, Chapter Two on the theoretical underpinnings of devolution). According to the development literature, governments opt for devolution on the premise that the transfer of decision-making to local authorities translates to participatory governance, which is believed to trigger increased community participation and representation of recipients of services, while on the provider's side it's associated with efficiency, responsiveness and responsible service delivery (see Chapter Two; Crook, 1993).

Indeed, the Zambia NDP typifies these principles. For example, the main objective of the decentralisation policy states that:

"*Government aims to achieve a fully decentralised and democratically elected system of governance characterised by open, predictable and transparent policy making and implementation processes, effective community participation in decision-making, development and administration of their local affairs while maintaining sufficient linkages between the centre and the periphery" (NDP, 2009 -2013 p12).*

While four governments had expressed their commitment to implementing the NDP, their intentions did not result in implementation compared with the health reform process. The PF government in 2015 went ahead and revised the plan so as to set a revived agenda aligned to existing development plans. This was conducted with wider consultation of bureaucrats

because they were identified as a risk to the implementation process (cf. Inter. 24 May 2018, high-level manager, decentralization secretariat). But some interviewees still felt that the doubts surrounding implementing devolution remained unaddressed by the PF government. For example, an interviewee stated that:

> "*Most of us in the civil service see the current national decentralisation agenda as nothing but political speech. If we analyse the situation, the policy should have been implemented a while ago and if it was suitable, it is something most of us would have supported. But as it is, it will continue to remain in political speeches because there is little that is being done to change the structures that should enable the agenda" (Inter. 14 June 2018, high-level Cabinet Office bureaucrat).*

Another interviewee stated that,

> "*…there is no conviction among politicians that devolution can work. For example, the PF government grew cold feet towards moving the devolution way, perhaps politicians should continue to consult widely whether to proceed with it or not because we developed the sector devolution plans and that was it." (Inter. 15 June 2018, mid-level manager, MoH).*

The views were also similar at community levels. At Ward Development Committee (WDC) level (the structures which are supposed to engage the community in local service governance), interviewees mostly expressed scepticism with regards to government commitment in engaging them as stated:

> *"…having lived and worked in this community for more than 40 years, I have seen development promises come and go. …being a former primary school teacher people regard me as a key contributor to community development. My involvement in the WDC committee was by chance. There was no dissemination of information whatsoever about what the government was intending to do. My name was proposed by someone who is close to the ward Councillor that I needed to be part of this committee. I have repeatedly questioned if at all the government wants this to work because if they are interested, they should have widely disseminated information to the community of their intentions" (Inter. 10 May 2018 WDC member Lumwana District).*

Thus, the weaknesses identified by interviewees, show that there is a gap in what the devolution plan intends to achieve and the activities that have been conducted thus far by government and the local authorities which was not the case for the health reform process. An interviewee who was privy to have taken part in the health reform process at local level had this to say:

> *"…I am one of the key pioneers of the Neighbourhood Health Committees. When we were doing that a very long time ago, maybe 20 years or so ago, there was wide*

dissemination of information. The health workers used to hold meetings in the area with representatives from government. Sometimes even the area Member of parliament would be present because they wanted us to be aware that health was a community issue and they needed our leadership as a community to get involved in health matters. But when I compare to this thing they want to bring; I find it difficult to understand. Help me to answer this; is it because governments have changed? ...you see what happens now is that we just hear people talking about this thing and how people should organise themselves" (Inter.10 May 2018 former WDC member Lumwana District).

In addition, the interviewee also complained about the attitudes of local council workers in his area, stating that they do not show commitment to the process they have been tasked with because they arrive late for meetings and there has not been enough sensitisation to the community.

To echo his sentiments another interviewee reported that:

"This WDC has no power and mandate. When we go for meetings where the council workers ask us what development we would like to see in the community, it's always been about brainstorming. The situation has been the same for the last four years or so. And then the councils encourage us that we should start working with the community to initiate change. In my community there is a lot of malaria because rubbish is dumped everywhere and those are breeding grounds for mosquitoes, then we also have a problem of disorderly behaviour. …but how do I go and tell people to do the right thing when the councils with the legal authority have not informed the community about our existence and mandate as WDC? It's disappointing that the council cannot solve any problems with us… you know we are a vulnerable community that lives very close to the council dumpsite for the whole Ndola district. Factories dump expired goods and chemicals very careless and what happens is that we have a group of unemployed youths who operate more like a gang and manage the dumpsite" (Inter. 4 June 2018 Community Representative, Retired teacher -Ndola)

Other doubts expressed towards reform relate specifically to the MoH. Having gone through numerous organisational reforms all aimed at decentralisation, high level Ministry of Health workers reported that they felt that they were at the mercy of politics, despite having an interest in ensuring that policy was implemented successfully. Hence their feelings of being inhibited by political contexts to perform their duties led some of them to worry more about their job security than performing their roles as bureaucrats. The high-level bureaucrats also reported that Ministry of Health reorganisations were not about attaining health systems goals but job creation for unqualified political party loyalists, which alters the whole essence of reform and reorganisation. As one interviewee reported,

"…the change in governments changes the mood with everyone playing out to be a party loyalist to earn or keep their jobs. On one hand you have genuine party loyalists that are not qualified seeking to earn top positions in government, and on the other hand you have those that are qualified and seeking to maintain their jobs, they control the system at all costs to protect and safeguard their job while performance as a technocrat does not come as priority" (Inter. 5 June 2018, former high-level manager MoH).

The views expressed have led to criticisms of the essence of reform in the health sector because it targeted qualified people, some of whom were driven out of the health sector and others transferred to ministries to work in unrelated professions.

The views expressed by the interviewee takes us back to Chapter Five where the HPTF demonstrated the interrelationships that existed in the health reform processes where actors and resources where mobilised both locally and externally to attain implementation stage (cf. Buse et.al, 2006, p:9), here, the evidence that the HPTF demonstrates are the complexities that the devolution plan has encountered to be implemented. It shows the constraints generated by actors, structure and ideas present at given political and social periods (cf. Howlett et.al, 2009, p.8). And thus, the thesis has understood how the dynamic interplay of mechanisms and context produce outcomes (cf. Pawson and Tilley 1997; p56). For example, it has been understood that because of the presence of donor resources and commitment to the health reform coupled with a new government that had shown commitment to reform, the health reform process went ahead to be implemented while with the devolution plan it has been lost within several government's agenda of broader reform. It is for these reasons that the thesis believes that the content of the policy is well outlined but what lacks are the implementation mechanisms and the environment constraints into which the ideals it promotes have been subjected to. The section below discussed the details of what the devolution plan contains.

External influence on the devolution agenda in comparison with the health reform process.

While policy implementation on the Zambian government's side is still undergoing changes having made minimal progress, the activities on the side of cooperating partners have continued to be implemented. For example, the United Kingdom Department for international Development (DFID) in 2017 was reported to have invested an equivalent of $430 spending for every Zambian citizen (based on the population of 16.6 million people) into the decentralisation process (UK Zambia Facebook Page, 2017). The German government bilateral support to Zambia (through German Gesellschaft für Internationale Zusammenarbeit (GIZ) also made significant progress through its Decentralisation for Development (D4D) project in collaboration with the Ministry of Local Government. By 2018, the D4D project had

provided support at central and provincial levels of government and eight local councils as part of a pilot to roll out support to strengthen multi-level system of government structures for the provision of devolved services (D4D II, 2018). However, the implementation of the devolution has not gone without structural challenges. Seemingly to respond to the criticisms of accountability, GIZ from 2016 has constantly engaged with the Cabinet Office to provide support with regards to strengthening local authorities' fiscal management. In addition, the European Union has also been engaging with the National Assembly of Zambia in building capacity among lawmakers to understand the budgeting process (see, NAZ, 2017). GIZ has also been conducting capacity building programmes to local councils signified by the workshops they hold (GIZ, 2016). Similarly, as with the previous health reform, donors have found it difficult to implement policies within weakened financial structures, which has led to the repeated attempts to conduct a key reform with several other reforms within the public sector, that is while GIZ is supporting the NDP implementation process, it's also been conducting programmes on strengthening financial capacities of local government structures through the cabinet office. The EU has also been implementing programmes on Public Financial Management (PFM) to promote efficiency in planning and use of public resources (see, Parliament of Zambia, 2016). However, this thesis notes that there is also a failure on the part of donors to coordinate previous activities. For example, the HIV/AIDS structures had built the Provincial AIDS Task Forces (PATF) and the District AIDS Task Forces that were directly involved in community responses to HIV/AIDS. Perhaps they could have been a starting point? The thesis also notes that capacity building between government and donors also comes with initiating new institutional structures and thus the problem of continuity has presented challenges to implementing reform in Zambia.

The UK government had clearly stated that the primary interest of such an investment was to primarily build effective human resources for service delivery in Zambia; services that should respond to local needs and effectively reach poorer communities (UK Zambia Facebook Page, 2017) see figure 7.

Figure 7: UK-DIFD Representative launching the Human Resource Project as Part of the Zambian Decentralisation Process

Source : https://www.facebook.com/dfidzambia/posts/government-expenditure-in-zambia

Unequivocally, the commitment to implement decentralisation is strong from the side of cooperating partners. However, despite such milestones being achieved by cooperating partners, mixed feelings were expressed among interviewees - especially from current and former ministry of health senior and mid-level managers. Some of their expressed dissatisfactions were attributed to the past experiences of failures of decentralisation, especially the human resources component of the health reform process. Others were wary of the German government's position on decentralisation: put simply, they felt that the German government has/d not engaged with the health sector to understand the past failures of the health reform process and therefore the technical capacities of councils are not apt to manage primary health care as the Germans may presume. It was thought by the interviewees that if the health reform process was such a well thought out plan but failed to manage the human resources component then the councils are far worse off to manage such a complex process. The interviewees, they had this to say:

> "*DfID is correct that decentralising human resources will create a pool of staff that are directly accountable to the districts… I also agree with the rationale of creating and promoting responsive human resources at district levels because right now there are ghost workers in districts who do not work in the physical locations as listed by government. You find that they work in urban areas, yet they are listed as working in a rural district. This starves the rural areas of the needed human resource. However, what DfID is trying to do has been tried before in Zambia during the health reforms and it failed the health workers lamentably. I am sure that even the secretary to the cabinet who has had experiences with the failures of decentralising human resources in hesitant to proceed with the process. How will health workers for example be*

delinked from the Public Service Management Division, the Trade unions and their pension contributions? This is a huge puzzle considering that the Zambian government does not have money to retire workers and then rehire them. I wonder why people are insisting that health workers be transferred to local government? I think in Zambia we have amnesia" (Inter, 27 February 2019, former mid-level Manager MoH).

"… what is the contribution of the German Government to the Zambian health budget? …very little...what project has the German government done in Zambia that is health related that you can point to? …almost nothing. At the moment the Ministry of Health owes drug companies millions of dollars, so why isn't the German government coming forward to provide capacity within the Ministry of Health to offset such problems? … you see the coin is one sided, how can they build capacity in the local councils while they do not want to engage with the health sector"? (Inter, 15 March 2018 former high-level manager MoH).

It is worth noting that while I was still conducting my fieldwork in July 2018, the human resources decentralisation component was piloting in Chibombo rural district, with an interviewee pointing out that I was conducting the study during a historical moment[22] (Inter. 20 June 2018 bilateral representative). However, there appeared to be no optimism in the process for the health sector, as it did not go ahead to be part of the pilot as planned (note: the process was conducted outside the health sector led by the decentralisation secretariat and donors). A bilateral representative interviewee charged with overseeing the process indicated that the Ministry of Health had taken a deliberate decision not to get involved in the piloting to which they had cited that they were not ready, and that the directive was made at ministerial level. To that the interviewee indicated that the pilot was to move ahead without the Ministry of Health (Inter. 20 June 2018 bilateral representative). Whereas evidence and arguments suggest that less developed countries like Zambia have no ability to push back reforms initiated/led by donors (See Barnes et.al 2015: p. 65), the human resources devolution piloting phase indicates the contrary. Perhaps it's the weakened position of the devolution plan that gave room to the MoH to exercise such agency, moreover there were/are no direct benefits that the MoH was/is to gain from the process (for example, Barnes points out that less developed countries like Zambia go along with donor preferences so as to access funds to address health problems but in this case the benefits were/are not

[22] Institutional and human resource capacity building is a key component of the DIP. The rationale is to create and strengthen institutional capacities to implement, manage and support decentralized governance, development and service delivery. And since the NDP entails the transfer of primary health care to local councils where district health structures will be transferred from MoH to district local authority structures, where the local authorities will have the mandate to manage its own human resources within their jurisdictions, with the power to hire and fire departing away from the current practice where human resources for health is centrally managed by the Public service Commission. The reasoning follows the ethos of devolution where power and authority to manage service delivery is placed entirely in the hands of local authorities. To that, DFID has been working with the Zambian government through the decentralization secretariat on the human resources component to develop mechanisms through which human resources can be efficiently transferred to local authorities.

directly aligned to addressing health priority problems and as already cited, a former ministry of health high level manager criticised the German government for not offering direct support to address health priorities yet they have the interest to see councils manage primary health care) (Barnes et.al, 2015; *Inter, 15 March 2018 former high-level manager MoH)*. Looking at the criticisms openly expressed by interviewees close to the health sector towards the German government's involvement in devolution suggests that Zambian actors in the health sector are more responsive to cooperating partners' ideas and ideologies if they offer direct benefits to the sector. For the thesis this speaks volumes with regards to power that the MoH possesses over health service delivery which seemingly can be tied to the existing volume of donor support that they receive, thus in a way shapes, contorts and constrain the participation of other ministries yet the emphasis of the NDP has been a multisectoral approach to service delivery.

Regarding the pilot of the human resources component, it was Interesting and perhaps a puzzle that information about the pilot implementation was withheld from key stakeholders as the interviewees who work within the civil service, MoH, local government and a multi-lateral agency that funds health programmes in Zambia that were interviewed and some that were subsequently followed up for a second interview expressed ignorance that such a process was to be conducted.

While cooperating partners have/had been working to resolve the problem of lack of capacity within local councils and the general difficulties that come with sector decentralisation, and more broadly decentralisation, the PF government was seemingly more interested in maintaining popular support, evidenced by the low level of investment in the devolution process and by opting to quickly fix the systems through geographical decentralisation and health sector reorganisation of maternal and child health services, as pointed out by an interviewee:

> *"…clearly no Zambian governments in past 15 years have made deliberate efforts to drive devolution, they have been more interested in political appeal to the electorate. Take for example compared with the health reform process, the health reform was widely disseminated and the efforts of both government and cooperating partners were coordinated…. Another excellent example is the decentralisation of HIV/AIDS look at how massive the support was from government where Mwanawasa made an effort that the Zambian government budget was to include HIV/AIDS programme support and it was done. Political commitment was great, and bureaucrats worked to ensure services were delivered… now, am asking you who is studying this devolution, has any government shown such commitment to devolve services? Have you heard of a budget for devolution or any media sensitisations?"* (Inter. 15 March 2018 former high-level manager MoH).

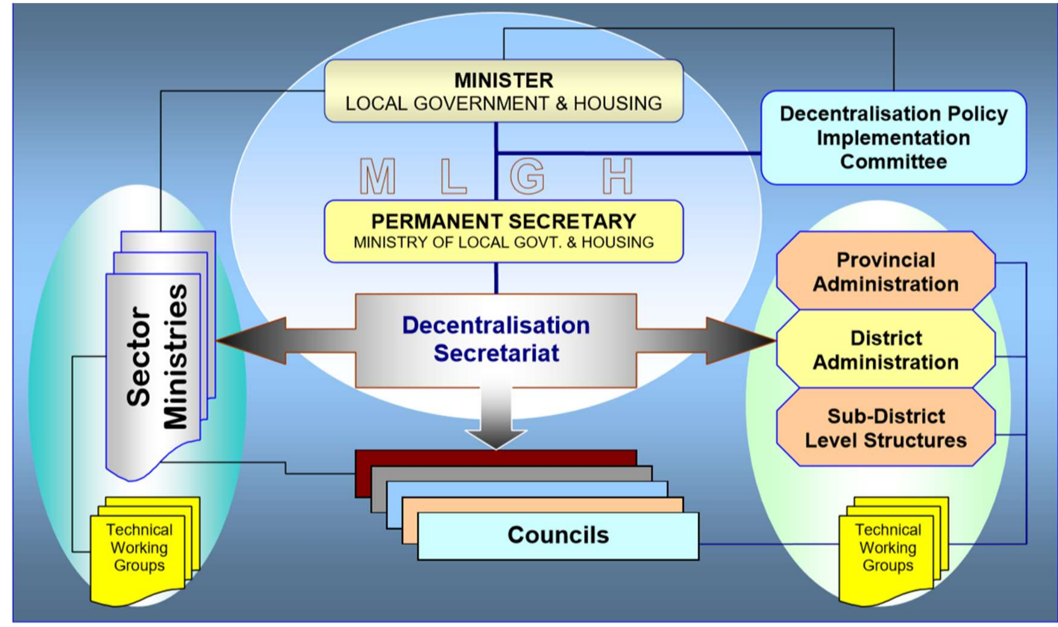
Nevertheless, an interviewee directly involved in working with the NDP pointed out that the concern should not be about whether the devolution plan is externally driven or not but about whether service delivery is shaped to address the needs of the population (Inter. 12 March 2018 high-level manager Decentralisation Secretariat). Generally, similar views were expressed by interviewees from MLGH at national and district levels. For this thesis the concern in this regard is also about the utilisation of donor resources to effectively shape service delivery in the social sectors as the interviewee stated and not to judge whether donor involvement is right or wrong. The thesis is mostly interested to unearth how donor funds in the health sector have continued to be enmeshed in local political dynamics that may sometimes conceal the realities behind actors supporting or resisting reform.

Evidently this section demonstrates that actors are central to policy action and in this case, the discussions specifically highlight the key role of international actors in policy reform and development. Even though the devolution agenda is principally based on locally driven ethos, the role of international actors plays an important role in resource constrained contexts like Zambia because international actors engage in generating resources and provide the required networks to address health needs and to drive complex policy systems, for example the DfID has engaged to resolve the human resources component of the devolution agenda and the Zambia government has for the last three years depended on their expertise.

Context (f)actor's influence on devolution implementation.

In sum, the discussions highlighted in the previous two sections show that the efforts of devolution have all been conducted within central level structures overshowed by centrist politics and bureaucrats, despite the fact that the reform intends to transfer power to the lower district levels. Olowu (1989) points out that these are inherent failures of decentralisation policies in Africa and to this, he concludes that decentralisation has failed in most African countries mainly as a result of the conceptual difficulties of decentralisation because for most African governments decentralisation means extending centralist power to lower levels (Olowu, 1989). The thesis agrees with the assertions made by Olowu that conceptual difficulties of decentralisation have contributed to the failures of decentralisation in African countries, as the Zambia devolution agenda provides evidence of fundamental weaknesses of centrist approaches to reform that aims to share responsibilities with lower levels. Ironically, the introduction of decentralisation reforms in Zambia originated from accumulating evidence of the weaknesses and failures of centrist approaches in delivering public goods and services (see, Kalumba and Freund, 1989) and the intentions are to shift service delivery to district levels. However, patronage by central level to roll out the process largely inhibits its progress. This patronage can be traced in the way that the central level controls the agenda and leaves out the lower levels. For example, the decentralisation implementation plan clearly lays out the structures that have been formed, some of which already existed, and strengthened to roll out the devolution plan from central level to local councils' level (see figure 8).

Figure 8: National Devolution Structures



Source: Revised DIP – (2009 -2013)

To that, an interviewee at ward level (a member of the Ward Development Committee) stated that:

> *"…I really don't feel that what the council is doing makes any sense… let me tell you that council workers convene meetings with us and discuss nothing substantive, we know that they get allowances to hold meetings with us and one can tell that it's their primary interest. This agenda of giving us power to control development is our areas is so vague, how do I just get up in the morning and tell people not to litter the environment… I wish you could come to one of the meetings, the proposed plans are not logical" (Inter. 11 April 2018. WDC member Solwezi district).*

Clearly the beneficiaries of the reform do not have much information about the implementation plan, neither do they feel that it's attainable. Evidence from district health staff further elaborates that capacity has not been built at district levels to enable devolution. For example, a district medical officer was concerned that reporting to the local councils has not added any value as far as he was concerned. He reported that even though they were required to report to the councils, as demanded by new protocol, he had not seen the benefits besides increased workload for him due to dual reporting to the Provincial Ministry of Health and the District Council Offices. He went on to state that the councils needed a better understanding of the services to be devolved to them and how they are to work with the communities for better integration (Inter 23 May 2018, high level manager MoH district level).

The views were not the same among district health staff because a staff from another district reported something different. He said that:

> "…*I have found it very efficient to work with the local council on health matters in our district. The sharing of resources is so efficient. For example, I am aware of all the activities at district level by other sectors through our district weekly briefings. So, what happens is that we plan in such a way that we share the use of vehicles as this is a rural area and some of our catchment areas have poor roads and extend as far as 120km. If Ministry of Agriculture plans to conduct their agriculture extension activities, we plan together so that our staff and theirs use the same vehicle and we allocate resources to other things like we reserve the use of fuel for our ambulances. So, I find it to be very efficient and a good way to efficiently manage health sector resources" (Inter. 11 April 2018. high level manger district level MoH.*

Therefore, it suffices to point out that because politics and central bureaucrats have been the main drivers of the reform with lower levels (as implementers and beneficiaries) having very little to no involvement, the process has not received the required attention from lower levels to enable progression such that even the positives that have been recorded at lower levels are rarely spoken of by the central level. The implications of this for the reform have been that the process has not been clearly understood, especially by district health staff, as some of them reported that they were not sure was going to happen to them as frontline health workers. With the looming uncertainties at district level among health workers, the majority of staff felt devolution was going to impact the delivery of primary health care negatively, while some felt that it was going to have a positive effect.

Interviewees who were in support of the CBoH with the previous health reforms were more critical of the politics surrounding the whole idea of devolution because they felt that there were missed opportunities with the health reform process:

> *"…consider the environment in which these governments expect the devolution of health services to operate. I think it doesn't make sense. The delegation instituted by the health reforms was the best model that could have improved health service delivery because you concentrate on growing a single sector and develop the technical expertise of the staff than being everywhere as the devolution plan suggests where you involve so many sectors. Where is the money going to come from? …and strictly speaking the devolution is the same as the politics of the UNIP government. You give power to local levels, yet they manage nothing" (Inter. 16 June 2018 academic former mid-level manager CBoH).*
>
> *"I am not a politician, but I studied that this devolution in Zambia will imply the pretext of giving power to local councils yet in the real sense it will be perpetuation of power at the centre. How will local councils hire and fire staff in the absence of expert staff and resources? …first of all, we really need to have a proper local governance, you have*

to have people who are elected, yes, they are there but they still interfere with them a lot at the centre. Secondly, you should not have appointees like district commissioners within the local authority structures, people who should run the local authorities are the elected officials, so you can see what all these governments have been scared of. Just like UNIP, President Kaunda was so scared that if elected people managed local authorities obviously there were not going to be telephones from State House to instruct who to hire and fire. So, at the moment, the district commissioners are a thorn in the flesh to local authority development because they are agents of the central government, to put it simply agents of the President and the ruling party, so for me that is the greatest failure of what we have at the moment" (Inter. 15 June 2018, former high-level manager CBoH-pioneer of health reforms)

"…all I can say is that in as much as the devolution agenda is a puzzle it has taken too long to figure out how to do things. You see with the health reforms, people knew that we needed something to govern health services, and I can tell you that not everything was bad about the health reform process, but corruption in government affected it so much although people would not like to admit that. There were opportunities for the government to strengthen fiscal management and that was done through the health reforms with donor support" (Inter. 24 May 2018 bilateral representative, former mid-level manager CBoH)

Evidently interviewees expressed themselves in this way because power is in the hands of politicians, thereby inhibiting participation of other relevant stakeholders in policy decision making, which apparently creates resistance and insecurity among top bureaucrats. One interviewee, for example, reported that:

"*…the devolution agenda has been hard to achieve at all levels. The changes in governments over short periods of time brought so many uncertainties. When I was serving in my position, I had to be cautious of the advice I provided to the new government for fear of being deemed as an opposition to their agenda. This was the case with a number of my colleagues" (Inter. 18 May 2018, former mid-level manager Ministry of Health).*

Given the multiple interpretations of the effects of politics on the devolution agenda expressed by interviewees, their views of the failure of the decentralisation policy by devolution as a reform tool have been shaped by their expectations and past experiences. Clearly actors across different government levels adjust to political moderations as opposed to performing their functions as bureaucrats, therefore this supports the assertion that policy implementation reflects a country's political system. Clearly, the devolution agenda in Zambia is dominated by the political elite - as the next section of the chapter discusses.

Effects of political dominance on the devolution agenda for the health sector

Decentralisation demands the readiness and capacity of the institutions that are to receive the power and responsibilities (Prudhomme, 2000). Going by what most interviewees reported, this thesis believes that the health sector has been hesitant to devolve primary health care partly because they have the fear of losing power which is very difficult for central structures as most literature outlines (cf. Smoke, 2003; Conyers, 2015; Litvack, 1998); but it has also been about the lack of capacity of lower levels to run health services (which is true in the sense of Zambia) which is also supported by several arguments concerning sector devolution (cf. Prudhomme, 1995; Crook, 2003). In some way, both arguments partly reflect the power of central actors to shape policy action.

From the foregoing discussions the health sector is clearly not ready to decentralise primary health care. Most interviewees attributed the unwillingness to engage to the weaknesses within government structures and systems. For example, as already mentioned, the lack of capacity of the local councils, the inability of the decentralisation secretariat to engage key sectors like health for them to see the benefits of decentralisation. Not only does the blame fall on the decentralisation secretariat, but key government institutions, some of which are controlled by high political offices. For example, the devolution agenda is driven by the office of the vice president and therefore with such high-level political involvement it is expected that the agenda should have moved forward.

Furthermore, looking at the current National Health Strategic plan which runs from 2017 – 2021, it does not fully acknowledge that decentralisation has been on the agenda for a while, and therefore the health sector should prepare for the shifts in governance structures of health service delivery. Instead, it offers narrations on decentralisation and how it's supposed to be conducted (NHSP 2017 -2021; p.63). This thesis notes that these were missed opportunities for the decentralisation process to engage with the health sector because as government is aware of sector plans, ministries earmarked for devolution should have been encouraged to submit strategic plans that recognised government intentions to implement devolution in the future.

With the Ministry of Local Government and Housing (MLGH), for example, the picture is totally different from that of the health sector. The MLGH articulates how the devolution process has received support from the national decentralisation secretariat, bilateral support from the German government (GIZ) and the UK Department for International Development (DFID). MLGH states that GIZ at central level has supported them through the Departments of Local Government Administration and Housing and Infrastructure Development. They also state that the support extended to the Decentralisation Secretariat, Ministry of Finance, Local Government Association of Zambia (LGAZ) and Local Government Service Commission (LGSC) to create effective linkages. Furthermore,

its stated that GIZ has supported Provincial Local Government Officers (PLGO), and eight partner councils in two provinces. The support was initiated in April 2015 to March 2018 at a total of 4.5 million Euros of German contribution (MLGH, 2018). The work was conducted with the help of technical advisors of project teams and support staff.

Furthermore, the decentralisation secretariat reported that GIZ has facilitated implementation of intergovernmental fiscal architecture and strategic management processes and cooperation relations for service delivery at local government level (D4D II, 2018). Undoubtedly bilateral support has helped to build capacity to build the devolution plan, including creating effective systems linking with the Ministry of Finance. Therefore, it was up to the Zambian government to strengthen the process because, as far as GIZ is concerned, their pilot projects under the local government have been successful and they feel that local government has the capacity to run services efficiently (GIZ, 2015).

Clearly there is a mismatch to what is going on in the health sector compared to claims made by the MLGH regarding the strides made towards devolution. It is also clear that the decentralisation secretariat is more aligned with the functions of the MLGH, which operates more within the framework of the planned devolution while other sectors earmarked for devolution seem to be operating outside. It should also be noted that the decentralisation secretariat is an extension of local government (all the staff at the decentralisation secretariat hold official positions in the MLGH) and therefore other ministries may see is as pushing the agenda on behalf of local government.

Critics of the devolution agenda also raised arguments that too many structures are involved on the local government side, thereby posing a threat of bloated structures. GIZ feels that their mandate has been achieved and considering the investments that have been channelled to the process it is understood why they want devolution to happen in Zambia. However, GIZ has not considered whether central government in the foreseeable future will have the capacity to maintain the bloated structures (Inter. 14 March 2018, former high-level manager MoH). Therefore, this thesis believes that, the arguments by almost all the interviewees in the health sector both current and former that devolution of the health sector will not likely succeed may be justified because one of the major causes of the breakdown of the health reform process was that government could not continue to fund extended expenditures at district levels as well as at Central Board of Health (cf. MoH, 2009). The structures were deemed to have been bloated with exaggerated monetary incentives for staff which negatively impacted on fiscal management and, to an extent, as reported by interviewees, that there was alleged fiscal irresponsibility and dominance by top management at district level. As reported by an interviewee who was on the panel to review the operations of the central board of health:

structures were bloated at district level and government could not afford to spend so much on the boards both at central and district levels…so it was a question of luxury spending meanwhile some health indicators were dropping…with the district health boards there were those employed by the boards and were receiving huge salaries while others were still working under old terms and conditions pending board conditions and that caused strife among workers. The other thing is that top managers had luxurious conditions of services and to an extent some abused the systems, some mangers would decide to sell board vehicles to themselves because such decisions could be approved locally…I mean there were a lot of irregularities that we found in fiscal management (Inter. 12 June 2018, former high-level manager at ministry of health).

Therefore, the MoH is wary of what might happen at local levels regarding financial management and sustainability. However, there were two arguments brought forward regarding possible financial risks within local government, one was that there are fewer financial leaks posed and reported by the local government sector with a local government interviewee arguing that;

"I don't know why the ministry of health keeps talking about possible fiscal mismanagement within the Ministry of local government because if you look at the current auditor general's report there are more misappropriation of funds reported from the Ministries of Finance and Health with very few cases at Local Government Ministry" (Inter. 9 July 2018, high level manager local government district level).

The second argument is that economic conditions may not adequately support financial needs for social services provision by local governments. As started by an interviewee from a multi-lateral organisation:

"…there has been a lot of debt contraction by government recently and as you can see the government owes the Chinese government a lot of money that the Chinese government has started controlling key parastatal companies especially the energy sector. This shows that the Zambian economy is very unlikely to invest more in the social sectors, and this leaves the health sector to external support. *… two years ago, we were talking about graduating the health sector from donor dependency but it's highly unlikely that we will be moving towards that direction"* (Inter. 14 June 2018, multilateral representative).

The second argument segues into the fiscal demands that the transfer of human resources for health may require to sustain at district levels. For the health sector, devolving human resources for health was repeatedly compared to the health reforms which the government failed to sustain on one hand and on the other hand the health workers were dissatisfied with the conditions of services.

Undoubtedly, the planned transfer of the health work force from the central government reporting systems to the local authorities is unsettling amongst a wide range of actors. While the transfer of human resources to local authorities has been cited as a key component in the current NDP to drive accountability and improved managerial capacities at district levels (NDP, 2009 – 2013), its one that has cast uncertainties with regards to how the government will restructure the current operations to what the devolution plan proposes. Some actors also questioned whether the health work force with their unions will agree to the proposed plans as contained in the devolution implementation plan with concerns that in may lead to discontent amongst health workers, like it was with the health reforms. The widespread apprehension within the health sector has led the sector to lose trust in the devolution plan as evidenced by the concerns expressed by most of the current and former actors.

Perhaps what to question regarding the structuring of human resources for health are the dispositions of civil service administration within the ministry of health and broadly in Zambia. Considering that the aim of human resources component of the NDP is to create strategic human resources control at district level, where district levels will be tasked to recruit, manage and fire staff it's expected that the capacity to conduct the tasks should be developed to a level in comparison with what currently exist at central level because in the absence of that it may create similar misunderstands that had ensued during the health reform process. Therefore, district councils' capacity to manage human resources for health should match the current expertise by the Public Service Commission; which is why it's important to interrogate the concerns expressed by actors within the health sector questioning the capacity of councils to conduct several tasks that are supposed to go along with devolution of health services.

In addition, although government plans to align the functions to be transferred to local authorities with matching resources, there have been no attempts to do so by any government since the introduction of the devolution plan.

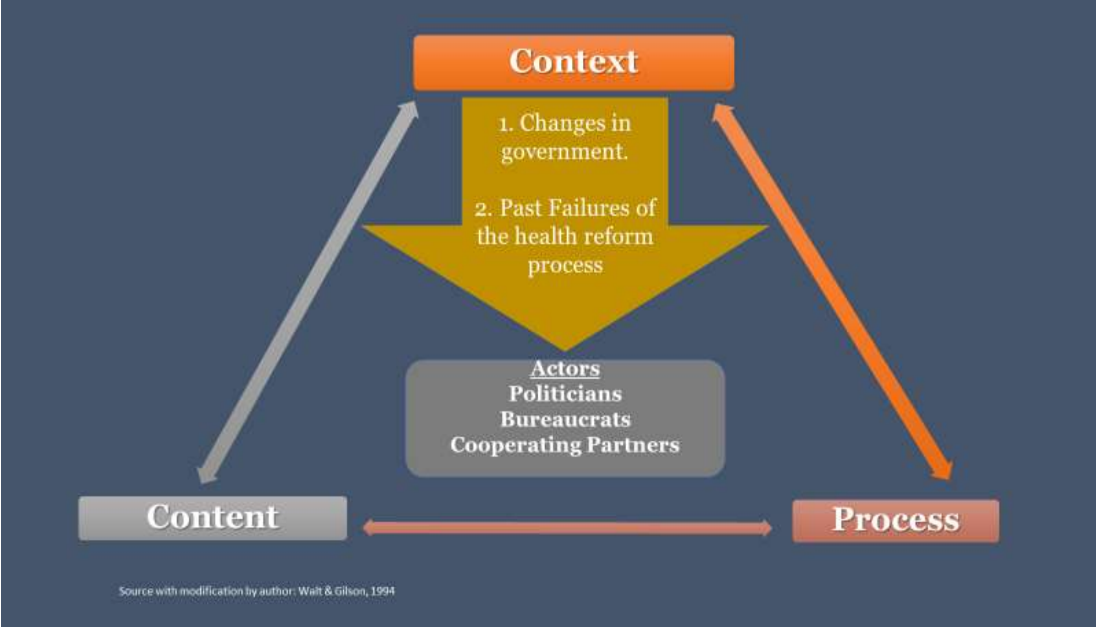
What is significant about the delayed devolution of services specifically in the health sector is that: the capacity of councils is doubted; local councils are financially crippled and underfunded; the top structures at the MoH have not attempted to transition to local government, including the funding architecture; while there are attempts to pilot human resources management at district level the central levels remains unyielding and; the

changing leadership within the central government and the MoH have altered the direction of the devolution plan.

The dominance of the highlighted challenges in implementing the devolution plan are highly significant here, because they: (i) provide an insight into the power relations between central government and lower level actors; government and donors; and ministry of health and local government actors (ii) show that policy implementation is affected by several contextual factors and, (iii) that successful policy implementation is a negotiated process that intersects the elements of content, context and process.

Therefore, it will be useful to frame these characteristics using the policy triangle (figure 9) as it provides relevant analyses of health sector governance by devolution, primarily on: what the plan is concerned with achieving and the power relations between actors and, how actors negotiate policy processes within contexts. The devolution plan has largely been influenced by politics and like all health policies it's linked with politics and who influences policy making (cf. Walt, 1994, p.1; Buse et.al, 2012, p. 7).

Figure 9: Devolution plan context and actors



Implications of the delayed devolution on health sector governance

The content of the devolution plan places emphasis on efficiency and accountability in planning, coordination and implementation in service delivery and specifically the health sector devolution plan (HSDP). Most reformers around the world would agree with such intents because the belief is that such goals lead to improved citizens' quality of life by

encouraging democratic participation in service delivery (cf. Faguet, 2014; p.3). For the devolution plan the premise is that when health officials are accountable to the local representation electorate there will be more of people's voices in prioritising, planning, budgeting and reporting health services delivery at community/local levels. But the concern for this section of the thesis is that despite the positive attributions of the decentralisation plan the process failed to be implemented in Zambia and consequently this section seeks to explain why the case has been so.

As this thesis has identified three major actors being politicians, bureaucrats and cooperating partners, the recognition is that each of them has different interests and perception towards the plan. As with the policy triangle, actors are at the centre of all policy actions - that is to say they decide what policies should be implemented at a specified time and how that policy will be implemented and justify how policy action will benefit society (Walt, 2004; p. 54). The agency they have exercised has had varied impacts on the progress of the implementation plan. For example, while cooperating partners have continued to invest and push to implement the plan, politicians and bureaucrats have held back.

Even though politicians lead the way in policy formulation, the case with the decentralisation plan in Zambia has not been favourable because the nature of multiparty politics are that there are competing agendas between political parties and the decentralisation agenda has been subjected to that. And because of the competing agendas, it has come to be known that no political party is interested in power sharing with lower levels - and thus the failure to implement the plan. Consequently, politics limit the power and functions of other actors both at central and lower levels. For the bureaucrats it has been the case of politicians distorting the power to implement. The fact that top level bureaucrats are more interested in securing their jobs makes it difficult for them to exercise any power to control the implementation plan. More so, as already highlighted politicians in Zambia choose whom to work with at bureaucratic level and as a result, with the decentralisation implementation plan, the staff attrition rate due to transfers within the Ministry of Health and the Decentralisation Secretariat has been high, as reported by most interviewees. Each time a new government comes in, it brings along with its new top bureaucrats with different views on the decentralisation implementation agenda. An interviewee from a development agency reported that "I understand that every government has their own policy agenda, but decentralisation has been difficult to implement because we always start on a new chapter whenever there is change of government" (Inter. 13 June 2018, bilateral representative). Therefore, the control exercised by politicians has driven bureaucrats to believe that decentralisation cannot work in Zambia.

Despite the opportunities that the devolution plan offers of transferring power and functions to lower levels to enable citizen participation, there has been inadequate resources provided by government to drive the purpose. In addition, there has been no close cooperation

between the MoH and the MLGHS at central and local level, to the extent that devolution of human resource development and management has proved to be difficult regardless of the involvement of cooperating partners. The divide between the two ministries has also gone along the lines of which cooperating partners are involved in the sectors. As already highlighted, the local councils are seen not to have the necessary human resource capacity to manage services like health and indeed the government through the Local Services Commission had embarked on rationalising deploying staff ensure appropriate HR management and development; rationalize deployment of staff to local councils to ensure key positions are filled with appropriately skilled personnel, including by redeploying staff from central government to local councils. The above explanations are illustrated in fig 10.

Figure 10: Devolution in Zambia

<u>Context: Challenges</u>

a. Changes in government – have not favoured the continuity of the devolution agenda
b. The low functional capacity of local authorities
c. Underfunded local authorities
d. Failure to work out the transfer of human resources to local levels
e. Highly centralised planning of devolution of services

<u>Opportunities</u>

a. The changes in government with renewed agenda
b. Availability of external support.

c. Change is legislation

Conclusion

This chapter has highlighted a number of significant points with regards to how the devolution agenda was conceived and how implementation has stalled. Using the HPFT, it demonstrates that the content of the devolution plan intends to address key issues of improving service delivery and most importantly, the transfer of primary health care management to local authorities – a key component that can trigger community participation (cf. Smoke, 2003). However, the other components of the HPTF have proved to be difficult for the devolution agenda to operate. First the context has not favoured the implementation plan because the policy implementation plan has undergone several political regimes who have each approached the implementation process differently from their predecessors. Second the process is one that has been subjected to financial constraints and difficulties on how to structure institutions and functions to be performed when health services are devolved. Third, actors being at the centre of driving policy agenda have largely influenced the evolution of the policy for example although the policy is considered as a local policy initiative, external actors have played a key role in developing some aspects of the policy as well as playing a key role in driving the agenda forward. With local actors, there are existing silent conflicts between the local authorities and the health sector, but it was admitted by most of the actors who are outside both sectors that the local authorities are currently incapable of managing health services because they have no capacity to do so in terms of skill, knowledge and are underfunded by central government at the moment.

Generally, this chapter provided an understanding of how mechanisms and context produce outcomes. The chapter analyses literature on policy development in relation to how policy decisions were arrived at and the influence of certain actors at a given point. The chapter also explained the constraints generated by actors, structure and ideas presented at given political and social periods (cf. Howlett et.al, 2009, p.8). Looking at the previous and existing efforts shown by various Zambian governments to implement the national decentralisation policy and how it relates to health sector management, it shows that political actors have constrained devolution implementation. Interviewees, especially those opposed to the idea of devolution, stated that the failures of the national decentralisation policy are embedded within the political and institutional contexts. Like most arguments that challenge decentralisation, detractors of decentralisation argue that most decentralisation policies in developing countries seem unimplementable because of several incapacities within systems (cf. Wetterberg and Brinkerhoff, 2016).

Therefore, the evidence in which the decentralisation by devolution agenda has evolved demonstrates the greater need to understand how decentralisation can benefit health

services delivery considering the institutions and structures in which it operates. The design of the NDP is seemingly a good plan, but it's a plan that cannot fit within the frameworks of Zambian institutions and also the political happenings. As one interviewee stated, the civil service has not been spared by multi-party politics because each time there is a change of government there are reshuffles with senior bureaucrats, with the party in power preferring to work with people whom they feel will support their agenda. Evidently, multi-party politics have weakened the civil service in Zambia, and it has had a large bearing on the success of a big reform like the devolution agenda.

The uncertainty of implementing decentralisation dominates the current devolution plan of primary health care in Zambia. Other literature suggests that most failures of decentralisation in developing countries have to do with flaws in the design of the process. However, in the case of the Zambian NDP the design of the devolution policy is sound, but what makes it fail are the contextual factors. In the quest to decentralise, Zambia seems to focus more on the outputs rather than the outcomes. For example, in the creation of additional district to improve health services, the number of districts has increased but the quality of health care services seems to have remained the same if we go by the health indicators - especially with maternal and child health services. Human resource capacity has also not increased to the capacity needed in the newly created districts.

Politically we can say that there is decentralisation but in terms of democratisation that is yet to be established. The key issue is that when engaging in decentralisation you look at changes in government relationships and changes in relationships across devolved structures and sectors involved (See Peckham 2008). The role of government as funder and steward of health service is key to these discussions.

Chapter Seven

Conclusion - What interpretations can be made about decentralisation?

Overview

- Revisits the main research question (and sub-questions) and how they have been addressed in the thesis
- Identifies the contribution of the thesis to the study area
- Discusses the key conclusions of the thesis
- Discusses the implications of the research for decentralisation policy and practice in Zambia

Introduction

Revisiting the Research Questions and analytical framework

This thesis set out to contribute to addressing gaps in the body of literature on Zambia's repeated attempts in implementing a variety of decentralisation policies to manage health services delivery. Specifically, the study aimed to answer the following research question:

> Why has decentralisation persistently featured in policy discussions over health service delivery in Zambia, and how have decentralisation efforts affected, and been affected by, the management of health service delivery in practice?

To answer this research, question the thesis utilised the health policy triangle framework to situate arguments that put forward explanations of why and how decentralisation processes get to appear on the national agenda. This framework provides a means of exploring the evolution of policy over time using four thematic areas: content, context, processes and actors (see, Buse, et.al, 2012; p.4). For the purposes of this thesis, the framework provided explanations of why and how health policies appear on the agenda (international or national) and the factors that make them work more or less well in the real world. Specifically, the framework pointed to explanations of: why decentralisation of health services has been favoured; how it has evolved within the political contexts of Zambia; who has been involved in decentralisation processes and why; what pre-existing conditions have determined how decentralisation processes have evolved - specifically how pre-existing conditions have influenced how decentralisation has been designed and who has had the most/least influence in decision making.

In the empirical chapters, with the structure provided by the policy triangle's four thematic areas, the thesis first generated explanations as to why decentralisation policies have been pursued by different Zambian governments to address health systems inadequacies.

a. What has driven the adoption of decentralisation policies in Zambia's health sector?

Second, in recognition of the fact that the persistent presence of decentralisation agendas in Zambia has not resulted in desired improvements to health outcomes, the framework's emphasis on context (existing conditions) being a key determinant of policy outcomes helped explain how practises of politics and policymaking within established structures and systems in Zambia have played a key role in determining the results of processes.

b. What factors have enabled/inhibited Zambia's health sector decentralisation processes?

Third, the interactions of actors with their environment and with each other was identified as one of the factors that has driven (or inhibited) these policy processes, highlighting how actors in Zambia's decentralisation processes have exercised individual agency. Three main actors in Zambian decentralisation processes were mapped as government, donors and bureaucrats.

c. How has political and bureaucratic action at different governance levels influenced health decentralisation policymaking?

d. How has political and bureaucratic action at different governance levels influenced health decentralisation policy implementation?

In the discussion below, this concluding chapter discussed the fifth and final of the thesis' sub-questions:

e. What implications do the answers to a, b, c and d have for arguments for arguments about decentralisation as a health sector reform tool (in Zambia, and elsewhere)?

Thesis contribution: Overview of key findings

Here I briefly set out some of the key points arrived at using the health policy framework, which constitute original contributions of the thesis.

First, focussing on content and context, decentralisation policies were introduced primarily for economic reasons, with political persuasion from development partners. However, in countries like Zambia decentralisation took a different path because of local structural and institutional infrastructures that differ from those of developed countries where

decentralisation ideas originated. For example, although decentralisation is intended to allow a wider range of actors to contribute to shaping the functioning of health services (Walt, 1994 p.62), the nature of politics practised in Zambia did not in fact foster wider citizen participation. Zambia (like many other African countries) is geographically sparse (highly decentralised), yet the governance system is centrally managed, and thus there is poor integration between state structures and wider society, especially rural areas, resulting in poor delivery of services (see Olowu, 2003).[23] Decentralisation policies have not succeeded in addressing this, or realising the idea of participatory policymaking at local levels. Power remains centralised. Second, focussing on actors and process, the framework highlighted the entrenched historical processes behind the introduction of decentralisation polices, which in turn spurred a variety of reactions from the three key actors (government, donors, bureaucrats) that have ultimately shaped decentralisation's outcomes (see Howlett et.al, 2009, p.50). The findings have demonstrated how actors get to interpret and translate decentralisation into action (or how they can use their agency to inhibit change) (cf. Howlett et.al, 2009, p.51).

Some of the key points made in the thesis are mapped onto the health policy triangle framework in *figure 11*. The main point underscored by the framework is that despite the persistence of decentralisation policies in the Zambian health sector, the sector still faces a number of challenges. This thesis provides analysis of how those challenges have hindered health sector development and what can be done to improve the implementation of decentralisation policies in future.

[23] African communities are diverse divided along ethnicity, cultural and religious lines. Thus, some remain isolated because of their belonging.

Figure 11: Key thesis arguments

Context
Declining health systems
Weak Economy - Heavily Indebted
High disease burden
Poor health indicators

What were the resulting effects of having introduced decentralisation

Actors
Government
Donors
Bureaucrats

How did relationships form and affect the response to decentralisation processes?

Content
Empowerment of lower structure through deconcentration, delegation and devolution

What was the rationale behind local structures empowerment?
What was planned to be addressed
How was it to be addressed?

Process
Political reforms
Socio-economic reforms
Legal Framework

What were the wider effects on actors?
How did the reforms shape policy practice.
What was/was not achieved and why

Adapted by the from Walt and Gilson (1994)

Using the thematic areas of the framework as a guide, the thesis arrived at its conclusions by analysing decentralisation policy documents and through the use of data generated from the interviews. The analysis focused on understanding the political and socio-economic forces imbued in decentralisation programmes. Perceptions of the selected key informants involved in decentralisation with regards to how they perceived their roles and those of other actors that engage with in implementing decentralisation programmes in Zambia were considered. In the process, the analysis revealed the dynamics of actors' involvement in decision making, and why actors at lower levels tend to resist the implementation of decentralisation (see Chapters Five and Six).

Actors, who sit at the centre of the policy triangle, were indeed found to be fundamental to the repeated attempts at decentralisation in Zambia. The findings highlighted how central level (including sectors and Ministries) and donor actors dominate relationships, and how this impact on the participation of lower-level actors. The thesis found that in Zambia, power over decentralisation programmes is held by government and donor actors who have the mechanisms to adopt (or, in the case of donors, encourage the adoption of) policy and who hold the resources. Meanwhile, actors at lower levels have crucial roles to play in actually implementing policy to ensure that it produces the intended outcomes. These arguments were mainly presented in the empirical chapters (Five and Six). These Chapters argued that,

as the relationships between the actors are so centrally and narrowly focused, and only a few actors are actually involved, decentralisation processes in Zambia have so often not reflected the ideals of greater inclusion in health policymaking. Chapters Five and Six further highlighted how actors have used their power and influence to navigate the opportunities/challenges (i.e., the systemic and cultural context).

This concluding Chapter reviews the arguments that have been made throughout the thesis. Its central point is that although decentralisation policies in Zambia have largely emerged as a result of the influence of international trends, local factors have largely determined the outcomes of the processes (cf. Kalumba, 1997). In addition, this chapter identifies a series of learning points with regards to the importance of the research to decentralisation and policy practice in Zambia both practically and academically onto which to develop future research agenda on the value of implementing decentralisation policies in Zambia, given the specific opportunities and challenges.

The chapter now goes on to provide a high-level review of the thesis structure and then moves on to discussing a series of more substantive points important to the thesis.

Thesis High level Review

The first three Chapters, Chapters One to Three, introduced the reader to the research inquiry - Decentralisation and Health Service Governance in Zambia - then Chapter Four went on to state the importance of conducting the study and how the health policy framework was embedded within the study to address the research questions. Broadly speaking, while Chapter One gave a general overview of the study, Chapter Two introduced the concept of decentralisation; its general meanings and what it entails in the development lexicon; its historical emergence; the debates surrounding its merits and demerits as a policy practice; and why it is a useful tool for health services management. Chapter Three introduced the reader to how decentralisation policies emerged to become popular in governing health services in Zambia. It discussed why and how decentralisation has consistently remained on the agenda since 1992. Chapter Four outlined the research methodology and how it fits within the framework of the study inquiry.

Generally, the first four chapters of the thesis highlighted the intellectual focus and the rationale for studying decentralisation using Zambia as a case study. As it is, the current literature focuses more on analysing what decentralisation can/cannot (or does/does not do) while neglecting the effects brought about by decentralisation's heavy dependency on unique contextual moderators - that is, the pre-existing socio-political conditions and institutional structures in which decentralisation implementation processes are attempted. Thus, Chapter Four showed that applying the health policy framework helps demonstrate how decentralisation shapes (and is shaped by) policy outcomes in the health sector.

The health policy framework was integrated with the research sub-questions to highlight four important areas of the research focus: (i) the rationale for the promotion of decentralisation policies by development partners, what that means for governments in developing countries, and how these meanings are interpreted locally; (ii) how policymaking defines relationships and interactions of actors according to the existing situational factors - including how expectations are moderated; (iii) how politics and relationships shape/are shaped by opportunities and challenges that health service provision comes with, and; (iv) how policymaking is a continuous negotiation process. Thus, both the limitations in the literature and why Zambia's health decentralisation attempts provide a useful case study in which to study decentralisation of health services were investigated.

A total of forty-two (43) interviewees who have worked in decentralisation programmes as far back as 25 years ago were interviewed at the National, District and Community levels to ascertain their views on decentralisation processes in Zambia. A literature review was also conducted on decentralisation, approaches to health policy management and primary health care services, health sector reform in Africa/Zambia, and decentralisation of health systems. In addition, an analysis of decentralisation policy documents in Zambia was also conducted - how the policies were formed (how they are conducted and legislated), the rationale behind their formation, how they were implemented, and what/who promoted the implementation at every stage. Thematic areas for document review focused on understanding the power relations (who calls the shots?) and how that impacted on policy success (and, ultimately, the effectiveness of health services delivery).

Having laid the foundation of the study in the first four chapters, Chapters Five and Six moved on to demonstrate how decentralisation has been implemented in the Zambian health sector in relation to the official policy agenda, and how it has shaped/been shaped by existing local conditions (i.e., health financing architecture, local policy practice, relationships between actors etc). These later chapters focused on giving empirical evidence using case studies of various health decentralisation policies that have been implemented in Zambia since 1992. Although the Chapters generally focused on two case study couplets – the health reforms of 1992 -2006 and the devolution plan of 2002 – to date, other decentralisation efforts are also referred to: the HIV/AIDS decentralisation policy (whose implementation plan of 2002 was strengthened by the HIV/AIDS global agenda); the 2011 shifting of Mother and Child Health functions from the Ministry of Health to the Ministry of Community Development and Social services (although that decision was later rescinded in 2014); and the creation of additional districts that meant additional district health offices. While the health reforms and the devolution plan each detail specific arguments about the influence of contextual factors on the successes and failures of decentralisation processes, they each provide unique understandings of the relationships in setting policy agenda and how that eventually has a bearing on the future success/failures of policy implementation.

Although more detailed and specific conclusions are drawn in the discussions below, at a high level the chapters do the following: First, they show why decentralisation has been pushed through development aid in recipient countries. Second, they show how developing countries (in the case of this thesis with a focus on Zambia) came to adopt the decentralisation agenda. Third, recognising that decentralisation often fails to produce the expected outcomes in developing countries, the chapters show that local practise supersedes the prescriptions/recommendations of academics and development agencies. Lastly, the chapters show that decentralisation will continue to remain on the policy agenda for the foreseeable future in managing health services in Zambia, and thus the chapters highlight the gaps in the previous policies that should be researched to advance future decentralisation policies - mainly that the implementation of decentralisation programmes could be more decentralised, so as to provide opportunities for different actors to engage with the processes to contribute to shaping local practice (cf. Kalumba 1997). In other words, one of the key problems' decentralisation has faced in Zambia is that, ironically, attempts to implement it have been highly centralised.

The idea of Decentralisation in governing health services: origins and effects

A key conclusion of the research is that decentralisation was idealised by development agencies as a positive step for the health sector in developing countries like Zambia in the context of declining economies coupled with poor service delivery and debt crisis in the mid 1980's through to the early 1990's (cf. Freund, 1986; Simutanyi 1996; Kalumba, 1997). At the same time, within Zambia, decentralisation seemed desirable as the economy could not support effective health services delivery. Decentralisation formed a converging point for both recipient country governments and development agencies as there was ample evidence to suggest that earlier efforts by government to meet populations health needs had failed (cf. Walt et.al, 1986) – and that a change of approach was therefore needed. Furthermore, the widening gaps in health status between developed and developing countries was a major concern - and that situation still holds to date. It was within the context of these perceived crises that economic reforms were proposed for developing countries because, for many development thinkers, transformation of health services could only effectively occur within strengthened economies (see, Walt et.al, 1986, Kalumba, 1997). Thus, a number of negotiations began between development agencies and developing countries, starting with political reforms to usher in governments whose reformist agendas were aligned to the international normative consensus with regards to economic and health sector development.

These negotiations culminated in significant political changes in most sub-Saharan African countries. For Zambia, the health reform agenda was one of the first to have had gained prominence. The negotiations between the Zambian government, individual actors and the donors set trends with regards to health sector policy production that are still in existence

today, i.e., policy change is largely driven by donor resources, donors' significant presence in decision making and the formation of health policy. Implementing decentralisation has effectively come to be synonymous with the pursuit of health sector development goals within the health sectors of low- and middle-income countries like Zambia. But the context is very different. In developed countries, decentralisation focussed on sharing responsibilities, in contexts in which government was overwhelmed with the responsibilities of distributing resources – which were relatively plentiful. Thus, the situation prompted the need to involve lower structures of government and other entities to distribute resources and implement services effectively (cf. Slater, 1989). But when decentralisation policies were transferred to SSA countries (Berman, 1986, Walt et.al, 1987), the result was that both structural and institutional rehabilitation took place at the same time to try and mirror the contexts of developed countries, and in addition were conducted using donor resources without necessarily involving and empowering national governments to raise their own resources or design mechanisms to fund their health systems (See, Walt et.al, 1987). As Chapters Two and Three of this thesis shows, these historical dynamics of decentralisation in developing countries affected the way decentralisation has consequently evolved over time. As such, because decentralisation policies were introduced in the midst of socio-economic crises that prompted structural and institutional reconfiguration to host decentralisation, they were conducted hurriedly because, as it were, bilateral, multilateral organisations and academics were eager to implement their ideologies (see Lake and Musumali, 1999). For the Zambian health sector, these actions played a part in solidifying donor dependence, which still holds to date.

Then, as Chapter Five shows, institutional reforms in the Zambian health sector introduced other donor driven concepts, including financing mechanisms like the Sector Wide Approaches (SWAps), that worked to improve the relationship between donors and governments in terms of efficient use of donor funds (cf. Chansa, 2009). At the same time, the WHO and UNICEF through the Bamako Initiative of 1987 promoted economic approaches to health services delivery for SSA through cost sharing (cf. Masiye et.al, 2010). As all these initiatives were internationally led, national sovereignty in terms of ownership of health programmes by Zambian governments was significantly weakened[24]. These reforms were being pushed by external actors, and countries like Zambia had to look at how best to adopt them, in order to benefit from the influx of external aid for implementing the reforms (see Masiye, et.al 2010).

These trends have been reproduced over the last two decades, signified by the low budgetary allocations to the health sector by successive Zambian governments because donors have set

[24] It should also be noted that Zambia had just started practicing democratic politics and at that point political institutions were relatively new and local and international pressure were mounting in anticipation to see the change that was projected through reforms.

a pattern of heavily investing in the health sector. Consequently, it led to the emergence of negative perceptions such as '*donor fatigue'* and repeated calls to wean developing countries' health sector budgets off donor support (Chitah et.al, 2018). As Chapter Five discusses, it was within the context of these ideas that the devolution of health services aimed to refocus its approach to decentralising health services by insisting that the devolution agenda be solely driven by Zambian government resources. But this idea has been difficult to achieve, largely due to the vast amount of resources and expertise needed to implement it, and naturally donor involvement has come in to fill in the financial and technical gaps (see, Chapter Six). Thus, it appears that the trends that were set at the point of transferring decentralisation policies to weak institutions coupled with young democratic political practises have contributed to subverting decentralisation processes.

Decentralisation in the life of local political practice: what it entails for health systems development

Although the contemporary life of decentralisation was propelled by international donor agenda entwining with local politics, it does not fully explain why successive Zambian governments have continued to rely on it to manage health services with minimal success with regards to attaining health system goals. Chapter Four and other Chapters of the thesis provided relevant explanations here that there are actually several reasons why the situation is so.

To begin with, it was shown that decentralisation in Zambia has been problematic as a result of the overenthusiasm of global institutions for its merits while neglecting the context of the local political contexts and interpretations into which the ideas were being transferred (cf. Olowu, 2003). It was as if global institutions assumed that, because they had an upper hand in the processes, they could also exercise control over the outcomes. It is for this reason that Chapter Three argued that although decentralisation policies were in existence under the UNIP government, prior to the period of socio-economic reforms of the early 1990's, donors were not willing to commit their funds to the *supposedly* 'broken' political systems that were governed by UNIP, which had resisted their policies either by not adhering to the terms or by cancelling the agreements. Henceforth, donors prioritised *fixing* the political system by initiating *multi-party* democracy (see, Simutanyi, 1996, Van de Walle, 2001). It's obvious that it was the UNIP dominance of political power and policymaking processes that donors aimed at reconfiguring, as UNIP operated on a one-party political ideology (see, Chapter Three). These views - that power concentration within the hands of government was the reason why service delivery was deplorable - became widespread among the elite (politicians and bureaucrats). In addition, the Zambian populous also bought into these ideas and were also calling for complete economic and political transformation (see Chapter Five).

While it is true that the provision of health services in Zambia had declined by the 1990s, the push to initiate health reforms were mainly driven by the Structural Adjustment Programmes (SAPs) agenda. However, as shown in Chapter Four, the Zambian government and most bureaucrats warmed up to the idea of reforms because of the widespread economic grievances of the masses. So, the agenda proposed by the World Bank and the International Monetary Fund to implement socio-economic reforms was accepted without question, as they were seen as the answer to poor service delivery that existed especially in the health sector (cf. Simutanyi, 1996). As a former bureaucrat interviewee pointed out: "*the reforms were inevitable because the recommendations to reform the health sector matched with the poor economic conditions that existed, and in addition, local ideas corresponded with the donor agenda" (Inter. 14 March 2018, former high-level manager*). Seemingly, the Zambian environment was ready to reform – at least on paper - based on the promises that the reforms were going to improve livelihoods and generally deliver better health services. Therefore, as seen in Chapters Four and Five, it was not purely a case of external imposition: political moves in Zambia also promoted decentralisation ideologies. The two chapters heightened debates on how political ideas around decentralisation travelled and eventually how they were seen to *symbolise*[25] improved health services delivery.

Nonetheless, the apparent acceptance of decentralisation ideas in a way concealed competing interests that existed in the Zambian context. But because there was widespread belief in the reforms, the situation generated unintended governing effects (see Chapter Five) that continue to dominate decentralisation and health service governance. These points will now be expanded upon in the discussion below and their implications emphasised.

During the 1990s, decentralisation policies were widely recommended in developing countries as a democratisation tool. They were supposed to initiate effective means to economic management and service delivery, yet at the same time they concealed the existing deep-rooted structural inadequacies within African countries like Zambia (cf. Gilson & Mills, 1995). Consequently, Chapter Three argued that decentralisation in African countries was proposed by external partners (donors) as a panacea to address development problems without considerations of longer-term implementation issues. Thus, the reforms introduced overlooked how actors at lower levels would be affected, and also underestimated their political power. This is, however, not to suggest that donors' agenda were entirely responsible for the failures of decentralisation policies in countries like Zambia - but rather what should be understood are the reasons behind the policy agenda and the effects on domestic policy life. In short, it should be understood that the values and interests of donors may not necessarily be reflected in the context in which they introduce their ideas. Although (as Chapter Five demonstrated) the health reform process was adopted because it represented

[25] It was a constituent of shared views and values. Many were converts to these popular views including the electorate. Thus, the MMD mantra *'the hour'* depicted that the hour had come to transform all socio-economic ills which was pithy and appealing to the electorate

shared understandings and meanings of policies that could possibly deliver the goals needed for attaining better health services in Zambia (cf. Kalumba, 1994), it later represented a chaotic situation for the health sector. While there was apparent consensus among central level actors towards the decentralisation of health services, an indication that their perspectives are dominant in shaping the practice of decentralisation, lower-level actors were not as passive as it seemed. What ensued later in the process was that actors at lower level exercised their power to push back the reform as it did not address their interests; one of the key reasons behind the breakdown of the process.

Because decentralisation processes were confined to a high level - that is to say they incorporated the views of actors with political connections and actors who spoke the language of donors – the effect was that those that were left out sought to further their own interests at the point where they have the influence to do so. For example, as Chapter Five shows, because the health worker's trade unions rejected the MMD government's approach to health workers' emoluments (as they were not consulted at decision making point), they mobilised countrywide strikes which had a huge impact on health services delivery. This prompted the government to issue repeated threats against the health workers to the extent of having fired some that didn't comply with government orders to return to work (Inter. 12 June 2018, former high-level manager at Ministry of Health). However, the actions taken by government did not deter further strike actions. An interviewee who was among the key actors in negotiating the reform process implementation was led to believe that the unions did not understand the reforms, which led them to spread misinformation to health workers regarding job security (Inter 24 May 2018). The interviewee further stated that it caused concern and agitation amongst health workers and eroded their trust in the reform process (see Chapter Five). The government tried to salvage the situation through Ministerial reshuffles, by transferring the minister of health to the Ministry of Tourism, to appear as though they were responding to the grievances expressed by health workers (Inter. 15 June 2018; former senior manager CBoH). In this case, it was argued in Chapter Five, government and donor power were overtaken by lower levels whose voices were not accounted for in drafting the policy texts. Although governments and donors in Zambia find ways of navigating such difficulties without engaging with the lower levels, again these processes tend to replicate the nature of decision-making in policy matter, which is confined to donors and government at central level, but is ineffective at improving the management of health services because as long as certain key actors (excluded from policymaking) feel that they are not benefiting from the process, they are bound to attempt to protect their interests.

Related, Chapters Three and Five demonstrated that these dynamics were even a problem with the two successfully implemented decentralisation processes in Zambia (HIV/AIDS and the health reforms). Again, these were externally supported, and central government agency was key in determining the course of decentralisation policies. In the case of the health reforms, political will was demonstrated through donor confidence and the commitment

expressed by government to initiate the processes. But due to poor engagement with the lower levels and poor fiduciary[26] structures, there was incoherence within the civil service that led to relationships breaking down between staff at MoH and CBoH, staff at health facilities and staff at CBoH and MoH, and between health facility workers and the government.

So, in practice, while the Zambian government holds the obligation of mobilising resources to improve service delivery, they also need to continue maintaining a positive image to the electorate and at the same time maintain good relationships with their donors. In Chapter Five it was discussed that, faced with implementing the health reform programme, the government had to adhere to international norms of decentralisation in responding to local demands to address health problems and a way of cementing donor relationships. This relationship is important to government because it projects a positive image to the larger population (the electorate) about its commitment to develop the health sector. Therefore, continued donor support works for government in three ways. First, it provides continuity for bilateral relations (good for both). Second it cements and perpetuates the existence of patronage between senior level bureaucrats and government. Because senior bureaucrats possess the power to control resources, they are the ones who get the benefits through various channels, such as trainings and allowances. As a result, they tend to support and align themselves with the government of the day even when health policies have little impact on the larger population. Third, when citizens get the health benefits in their localities, their interpretation is that their elected government is working, even when it’s solely funded using support from external sources (see Chapter Six).

Thus, because of government’s paternalistic ways of expending donor resources, they tend to use the funds to reward party loyalists indirectly and directly through employment favours and things like awarding of contracts (see Chapter Six).

While it’s true that donor confidence is associated with good government leadership, and in that light the Zambian government can claim that it is because of their good leadership that donor presence in the health sector continues to exist, it confirms some contemporary literature that states that actors deepen resistance to policy change in some instances rather than facilitating it (see, Hill, 2014). This is evidenced with the health reforms, as discussed in Chapter Five: that the reform was resisted at lower levels because it was seen to benefit actors at central level, including politicians.

[26] Zambia’s fiduciary structures were weak to manage an influx of donor funds and as such there were several reported financial leakages within the health system that led to funds ending up in private hands. In addition, drug procurement systems were also very weak.

Thus, although politicians on one hand may be seen to comply with donor requirements (which has not translated to improved health services) and on the other hand claim to initiate change by showcasing donor projects, in reality they seek to safeguard and promote their own political interests both to their electorate and the donors. Going back to the point made at the beginning of this section with regards to decentralisation's outcomes being dependent on its historical trajectories and the existing environment, the section argues that decentralisation processes that have been implemented in Zambia have functioned within weak structural contexts where allegiance to the ruling party is considered key to participating in policy processes. It is a complicated environment where policy is made and implemented. To this, the Norwegian government recommended that attaining good governance was a prerequisite to improving policy legitimacy in countries like Zambia (Norad, 2008). Thus, the question that still remains is whether there is room for local policy entrepreneurship to grow when the patterns after failed reforms in African countries is to blame outsiders who initiate the reforms for the failures such that recently, subsequent reformers are always wary of initiating reforms (see, Barnes et. al. 2014 p.60).

Given the arguments highlighted above, it's evident that the political landscape in Zambia has been an obstacle to the decentralisation processes. First, given the context into which the policy transfer under the MMD government occurred, it proved difficult for the health reform process to work because political interests clashed with the ethos of promoting decentralisation. The patronage over national resources by politicians and bureaucrats deepened during the life of the implementation process such that community health needs and interests remained unattained. Specifically, the ethos of community empowerment through taking governance structures closer to the people to alleviate corruption and enhance accountability remained unachieved (Chapter Five). There is mounting evidence demonstrating that the Ministry of Health is an *elite* (or, to put it plainly, a *rich*) ministry which has been treated in a very special way regarding external funding, at the expense of communities.

Going back to the arguments in Chapter Two that because of the ambiguity of decentralisation as a concept, it's construed differently in developing countries, the thesis has identified some of the problems that flow from this in the Zambian case. Looking at Chapter Three, where the history of decentralisation policies and decentralisation of health is traced, offers a beginning to understanding how politics have dominated the rise and evolution of decentralisation policies.

Much of the literature suggests failed public polices in sub-Saharan African countries like Zambia are a consequence of the neoliberal agenda and global capitalism (cf. Tandon, 2008, p.144). Contrary to this, the argument here is that the Zambian government as an actor has the ability to determine the extent to which decentralisation policies are implemented (and

do or do not yield positive outcomes). But because of *client* politics (see Norad, 2008), the government as an actor has failed to utilise the opportunities that decentralisation presents. Again, the historical progression of decentralisation agenda, especially with the current devolution plan, are instructive here: the government has successfully pushed away donor propositions with regards to devolving health services. If that agency had been used to direct resources to where they are needed, perhaps decentralisation could have led to greater success in health sector development (See Chapter Six). This point will be expanded upon in the next section, which discusses the role of actors in promoting/inhibiting the progression of decentralisation policies.

To conclude the section, a number of novel insights have been provided. Decentralisation and local policy practise continue to be a challenge in Zambia because their introduction was tied to multiple reforms in a country with low human and technical capacity. Second, because too many reforms were introduced at once, governments found/is finding it overwhelming - as some literature states, SSA has often been like a laboratory for structural reform (see Olowu, 2003). Not only did the reforms restructure policy and political life but also shaped the way policy is conducted, which has had a long-term effect. Third, the political interests of ruling parties override their ability to implement reforms because they find that what decentralisation proposes threatens their political existence (i.e., centralised control), so they only implement some aspects of decentralisation that work to cement their political position. Fourth, because policy negotiations are kept closed between government and donors, the process neglects other important actors and excludes citizen participation, which leads to the emergence of resistance from lower government levels and citizens.

Thus, this section of the thesis has established that reform agenda in the health sector should be relevant to the context; be effective in achieving health system goals and have impact and sustained long term policy goals. The understandings provide lenses from which academics, development practitioners and politicians alike can seize the opportunity to shape and influence decentralisation policies to yield positive outcomes.

Manifestations of donor power in decentralisation

Evidently donors have considerable influence in and interests over Zambia's domestic health policy, signified by their continued presence in the sector. As discussed throughout the thesis, donors' interests in domestic health policies in Zambia reflect international policy trends. Thus, the thesis sought to understand the various international perspectives about the value of (and the right way to initiate) decentralisation of health services. In this respect, the thesis was interested in understanding how ideas travel from the global level to countries like Zambia.

Chapters Three, Five and Six demonstrated how donors' decentralisation agenda have penetrated the policy arena in developing countries, including how relationships are formed (cf. Howlett et.al, 2004, p.12). Chapter Three focused on understanding the relationships of donors with developed countries and how they (donors) construct the ideas and how they seek to use those ideas, while Chapters Five and Seven showed how donor support in health sector development has dominated the decentralisation agenda for the past two decades with repercussions on relationships between actors for example because political actors hold the privilege to shape donor action, some of the key decisions arrived at in governing health services threaten the existence of key bureaucratic actors. The patterns of dominance by political actors are deeply rooted in a way that they are difficult to challenge and resist. For example, a bilateral interviewee stated that the Minister of Health in 2016 reported to cooperating partners in the health sector during a meeting that the ministry was to be restructured to a lean top structure meaning that the ministry of health central level was to be reorganised to fewer staff and departments, but the opposite happened after the reorganisation took place. In addition, key staff were transferred to go and work in other ministries for example some senior health economists were transferred to work at the Ministry of Works and Supply. The transfer of high-level bureaucrats to other ministries to work in positions unrelated to their professions is also an indication of how difficult it is to challenge political actors and continues to isolate key actors from the policy making processes. Chapter Three provided a good starting point for understanding how decentralisation ideas were facilitated through HIV/AIDS policy demonstrating that agenda that brings together a wide range of actors produces better outcomes. Chapters Four and Five explained how donor activities have affected the operation of the decentralisation policy, and to some extents have inhibited the progression of the policy, especially with regards to government continued dependency on their resources so to say the narrowed participation of actors has constrained the achievement of decentralisation's goals.

As noted in the previous section, this is not to suggest that donors are entirely responsible for the failures of decentralisation policies in countries like Zambia, but the thesis provided understanding with regards to how decentralisation should be understood as follows: (i) donors' influence over domestic health policy in Zambia, and how that influence is used; (ii) how donors' promotion of decentralisation coincided with domestic appetite for it. The two highlighted arguments provided insights as to why, despite donors having invested heavily in decentralisation, it still hasn't led to successful implementation of the policies.

Having established in Chapters Four and Five (and reiterated in the section above on the origins of decentralisation) that decentralisation policies during the 1990's travelled to developing countries as a democratisation tool through which to improve health services delivery (cf. Gilson & Mills, 1995), it is also true that donors have had long term effects on how decentralisation policies have evolved and worked in Zambia over time. This can be seen in the way decentralisation policies have continued to be donor dependent; that is to say that

decentralisation policy implementation in Zambia cannot be talked about without mentioning donor involvement. Donors have the resources, and thus they possess the power to control the course of policy. As Buse et.al (2012) laid it, donors possess 'relational power' - including financial and technical resources – and they therefore possess the power to control what is to be done and how. This helps in understanding the discussions in Chapter Three regarding the successes that were achieved by the HIV/AIDS decentralisation policy – a demonstration of how (at least in that case) donor power reinforced decentralisation for health services in Zambia using several disbursement mechanisms to finance the process. That policy succeeded because of the presence of global commitment which demanded that countries establish broad multi-sectoral responses. Despite HIV/AIDS having ravaged Zambia for almost a decade from the early 1980s to the 1990s, it the Zambian government had little capacity to address the problem until scale-up models and resources were designed and provided by powerful international institutions and countries (cf. Ndubani et.al, 2007; Walsh et.al, 2012). It was in the context of a public health crisis with resources and intervention models transferred to Zambia that decentralisation yielded positive results such as community empowerment.

Undoubtedly the introduction of massive external resources for scaling up HIV/AIDS services helped align stakeholder interests, including government's political commitment (cf. Ndubani et.al, 2007). The commitment that was exercised consciously embedded models to address the HIV/AIDS problem at community levels and therefore effectively harnessed community resources (Walsh et.al, 2012). However, despite the supposedly robust HIV/AIDS structural architecture, the HIV/AIDS decentralisation came with its own problems of structural limitations such as poor infrastructure, poor absorption capacity of the funding influx, and limited human resources for health to implement HIV/AIDS programmes (see Brugha et.al, 2006). This resulted in cooperating partners firefighting to bring the human resources to an acceptable level. And since such efforts were centrally led by the Ministries of Finance and Health (as already discussed in the above section that argued how centrally led decentralisation continues to undermine the success of programmes), it led to misappropriation of funds such that the communities did not benefit as expected, and in fact often felt that funds were held at the top level and the community was being used by top bureaucrats and politicians to obtain funding from external sources (cf. Edstrom and MacGregor, 2010). Again, this demonstrates that decentralisation policies' success in Zambia are inhibited if they are implemented in an attempt to fix structural insufficiencies, and that donor expertise and funding can perpetuate structural problems. In this case, though, donor funding proved to be useful in addressing the HIV/AIDS burden through effective community decentralisation structures, even though there was still a problem with the highly centralized mechanisms which were used by global institutions to disburse funds to lower levels

Although the discussions in Chapter three regarding HIV/AIDS policy demonstrated that the policy succeeded to an extent, the HIV/AIDS sector in Zambia has continued to depend on

donor funds for sustainability, with sporadic reports of misappropriation of funds, while funding to communities has significantly reduced. (Chapter Three). This reveals the implementation difficulties that donor power succumbs to - an indication that their power does not completely override local institutional cultures. What has happened in Zambia is that the HIV/AIDS decentralisation policy itself created a sort of elitism in which central level institutions were adequately funded to manage HIV/AIDS programmes, yet communities received meagre support (cf. Usher, 2010). Thus, Chapter Three argues that although the HIV/AIDS decentralisation processes supported by external funding donor support *did* create change for the health sector – unlike the devolution plan discussed in Chapter Six – this was because the policy ideas came with resources attached, and also because donors also provided resources to engage with local communities.

While the opportunities for elites created by the funding influx led actors in the health sector to capture space that exhibited weaknesses, it should be borne in mind that these actors in the Ministry of Health had limited power as recipients of the HIV/AIDS policy - and in fact the creation of the National AIDS Council (NAC) represented a horizontal decentralisation where the new body was independent of the Ministry of Health even though the ministry of health was charged with oversight on providing treatment through health facilities and was expected to implement guidelines according to donor stipulations (see, Walsh, et.al, 2012). Perhaps donor power conceals difficulties in decentralisation policy implementation that are difficult to resolve – where national actors feel powerless in driving the policy agenda, yet they are given the mandate to implement policies which enables them to gain access to resources. As Barnes et. al (2015) highlighted, in many Sub Saharan African countries it is hard to determine who is responsible for making choices for health, the funders or the elected government, and this is because "the piper calls the tune" yet the government commands geo-space and political sovereignty (cf. Edstrom and MacGregor, 2010).

In Chapter Five, where the health reforms were discussed, a combination of politicians, technocrats and donors were responsible for driving the reform process and as reported by interviewees, a very strong alliance was formed where two individuals, a technocrat and a politician, pushed the reform agenda (Int. 15 May 2018 former mid-level manager, MoH; Inter. 14 March 2018, former high level manager MoH). Prior to that, the two individuals had formed networks outside Zambia with the interest of reforming the health sector. It was in this context that the health reform process thrived because the essential relationships, networks, resources and skills were present. Coupled with that, the politician (who was also an interviewee for this study) pointed out that initiating policy change is a complex process and it was because of his academic background, technical know-how, and his position as a senior politician at party and government levels that he was able to push back the detractors of the process. He added that he was able to earn credibility with donors such that he was invited to be part of the international technical working group on health reforms at the World Health Organisation and he was also invited to speak in Congress in the United States, and in

return a group of US Senators visited Zambia to learn how the country had succeeded in implementing the health reforms process (Inter. 24 May 2018, former high-level politician).

It was because of such massive international support that the health reforms did make significant achievements in health services delivery, chiefly among them being the creation of District Health Boards and Hospital Management Boards which provided channels to transfer resources at service delivery points as well linking communities to health services structures, which is said to have had improved community-level health indicators such as immunisation coverage (MoH, 2001). However, despite the success in implementing the reforms with involvement of cooperating partners, Chapter Five also discussed a variety of reasons why the health reforms were halted. Key among them was that overall service delivery did not improve, and indeed was worsened by the introduction of user fees. (cf. MoH, 2011). This demonstrates that external partners' power and influence can prove to be useful in designing and implementing policies but is less reliable in guaranteeing success.

Although donors continue to fund decentralisation programmes in Zambia, they are wary of the future because of the minimal gains that decentralisation has achieved so far (World Bank, 2001, 2018). Moreso, and as already discussed in Chapter Six, in the recent past there is compelling evidence that donors in countries like Zambia are fatigued regarding financing the health sector. For example, the midterm health expenditure review conducted in 2016 showed that health expenditure by the Zambian government falls far below the national and regional targets, and way below the *Abuja* declaration[27] (World Bank, 2016). The relationship between the Zambian government and donors is most certainly strained, shown by the failure to initiate effective partnerships over the past years. So, what does this tell us about the future of health services in countries like Zambia? How can decentralisation effectively introduce resource mobilisation mechanisms to improve health financing? Perhaps these are valid questions that warrant future research.

While the devolution plan has not been allocated the required resources and support by successive Zambian governments, there seems to be little enthusiasm on the donor side either. Different donors continue supporting various areas of their interests – The UK Department for International Development (DfID) supporting the human resource component for devolution, while German Gesellschaft für Internationale Zusammenarbeit (GIZ) supports the local authorities with capacity building (Chapter Five). One interviewee noted that donors are not interested in decentralisation anymore because it's no longer on the top of the global agenda *(Inter. 16 June 2018, former high-level manager MoH, Political appointment position)*

Indeed, the devolution plan has not had the donor support that was seen with the health reforms and HIV/AIDS. There are a variety of reasons for this. First, there has been a general

[27] Target set by African Union countries pledging to allocate at least 15% of their annual budget to improve the health sector when they met in 2001 in Abuja – Nigeria.

consensus that donor funds distort health systems in developing countries more than they strengthen them (Edstrom and MacGregor, 2010; Kelley et.al, 2016). As a result, it was witnessed in this research that the donor approach to implementing programmes in Zambia has changed, for example donors in Zambia have indeed not been in the driving seat with regards to devolving health services, partly because health reforms proved to be contentious, and also because the Ministry of Health is resisting the idea of merging primary health care within local authority structures (see Chapter Six). In this case donor power has been limited in terms of convincing the Ministry of Health to accept having primary health care transferred to local authorities. For example, an interviewee from one bilateral donor reported that the Ministry of Health decided not to take part in the piloting of devolving human resources despite resources having been provided to conduct the activity (Inter. 20 June 2018 bilateral representative). So, as it is, while other ministries that have been earmarked for devolution launched their pilot projects in Chibombo district (Central Province of Zambia) in July 2018, the Ministry of Health has stayed away. An interviewee also reported that donors were hesitant to get involved with the devolution of health services because of their past experiences with the failed health reforms (Inter. 14 March 2018, former high-level manager MoH).

Regardless, the activities being undertaken under devolution are being supported by donor resources from GIZ and UK-DfID. Even though high-level government interviewees claimed that the Zambian government owned the devolution process, while at the same time admitting that government lacks the resources to take the process forward, it is clear that currently government cannot function without support from donors - especially when it comes to implementing such a big reform. The argument was substantiated by a multilateral interviewee who stated that "... you have to understand that currently the government is broke because they failed to meet the national target expenditures on health budgets, so how can they implement reforms?" (Inter. 14 June 2018, multilateral representative).

Most technocrats are conscious of the situation, and there is evidence to suggest that their trust in the devolution plan has eroded. Most of those interviewed doubted whether devolution was ever going to be implemented due to the lack of resources and commitment by central government (Chapter Five). As presented in Chapter Six, the Zambian government claims that the process is locally driven, while they have not provided resources, with donors providing fragmented support. This has caused the devolution plan to stall. Although actors in the decentralisation processes mainly disagreed that the processes have stalled mainly because of the lack of donor support, it's evident that the Zambian government will not implement devolution without a specific programme funded by donors, especially in the health sector. For these reasons, the academic literature that criticizes donors for distorting policymaking in low-and-middle-income countries (i.e., Edstrom and MacGregor, 2010) should consider how withdrawing/withholding support can also be distorting, by preventing governments implementing reforms that they want to implement.

Donor power will continue to manifest in various forms in the near future with regards to health sector governance in Zambia, as demonstrated in some of the arguments highlighted in the next section. However, this is not to say that the thesis supports donor dependence. Instead, what is needed is to continue remodeling the modes of support.

***Actor Participation in the Decentralisation Agenda and the effects on decentralisation and health governance*.**

Having established understandings of why decentralisation appeared to be compelling in improving health services delivery in developing countries in Chapters Two and Four, Chapters Three, Five and Six demonstrate how these decentralisation ideas were received and appropriated to the Zambian Context through the HIV/AIDS, health reform process and the current devolution plan respectively. The policy triangle situates actors at the centre of policy operations and in this regard the thesis provided understandings of how various actors involved in the processes shaped/constrained the operations of decentralisation. The arguments in Chapter Six also highlighted how actors continue to exert their influence on the operation of decentralisation in Zambia.

This section of the thesis concludes on the roles/contributions of actors to the way the health reforms and devolution of health services were/are produced within the rubric of decentralisation and health service governance. Chapters Five and Six also showed that the outcomes of the two processes were determined by the dynamic interactions between actors - that is to say the way their ideas were expressed and how their interests manifested according to the context into which the ideas were implemented (this point takes us back to Chapter Four – the methodology Chapter – remember the research strategy was embedded within critical realism, with the belief that the production of successful outcomes by actors will depend on whether the appropriate ideas and opportunities are/were introduced within an appropriate social and cultural context (cf. Pawson and Tilley 1997)).

The unequal relationships between policy actors were highlighted in the discussions around how the HIV/AIDS and health reform policies were implemented, that demonstrated that donors and national level actors seemingly engage in unconscious relationships where national level actors claim that policies are driven by *'us'* (Zambian actors), masked under the commonly used language of '*donor buy in'* and a variety of transitive verbs: 'ownership', 'authority', 'command' and 'control'. This language has come to be accepted by both the donor and national level actors, although (as discussed above) national level actors engage in these relationships in order to create room to access funding (cf. Barnes et.al 2015, p. 65).

These relationships demonstrate the inherently unequal ways in which decentralisation of health services is governed. The relationships in a way have (unintentionally) morphed into

client politics among top level bureaucrats, where national level actors exercise patronage over resources meant for health development programmes (see, Chapter Six). As already established in chapters Five and Six, this happens because Zambia is typical of a neopatrimonialism state. Henceforth, in policy negotiation processes lower levels have received less attention, meaning less resources to implement programmes and isolation from the processes. So, the question is how and why the situation continually repeats itself in Zambia's decentralisation policies.

To draw a comparison to these discussions, Barnes et.al (2015, p. 65) made similar observations (which this thesis is in agreement with) in assessing the politics of participation in health reform in Zambia through a Word Bank led Performance-Based Financing (PBF) project. They stated that:

> *"…there is evidence that there is formal and informal participation in the design and implementation of PBF as a tool of health system reform in Africa. African actors are engaged in the formation of PBF as a means of health system reform; however, participation is often limited to specific elites working in the health system whose continued pay is dependent on alignment to the positive bias of PBF. These elites engage in a skewed principal-agent relationship with donors through whom they gain materially or politically as individuals"*

As discussed in Chapter Six, donors recognise these issues and some of them channel their resources towards policy implementing at lower-level structures such as the District Health Offices (DHO), while others have directed their funds to NGOs, CBOs and FBOs. But there have been outcries citing duplication of functions and programmes (MoH, 2006). Thus, in discussing actor participation and the influence it has on decentralisation, the thesis recognised that it's important to establish why and how actors are key to moving the processes. Using the policy cycle, the research identified the actors and their roles in the two main decentralisation process – the health reform process and the devolution plan (see figures four and five). The point underscored by the processes of mapping actors is to provide evidence on how reform has been promoted/undermined by actors. The data used to populate the diagrams was obtained from the National Health Policies document for the health reforms (1992) and the Devolution Plan 2009 – 2011 for the devolution process. The two documents gave an indication of which actors were involved in the respective policy cycles. Given that actors are at the core of policymaking processes, identifying various roles that they play in the policy cycle helps to explain why some of the tensions mentioned above existed and continue to. The information plotted was also confirmed through interviews with stakeholders.

Figure 12 demonstrates the level of actors' engagement at the point of having introduced the health reform process through to the point of where it was repealed, while Figure 13 demonstrates how the devolution agenda has been implemented so far. Although the

arguments have been detailed in Chapters Five and Six to how actors responded, this section cements conclusively the dynamics that surround the politics and practices of actors in the decentralisation of health services. Before going into detailed discussions, a reminder that for the purposes of this thesis actors in Zambian decentralisation processes were categorised as Government (politicians) segmented into national, provincial and district levels. Community levels represents ordinary community structures whose power and influence are so often not recognised formally but does exist, especially in rural areas; then donors (bilateral/multilateral agencies) and bureaucrats segmented into national/central (mainly at Ministry level – high level management), then provincial and district levels bureaucrats were identified to have similar roles of being in middle management. With regards to the level of engagement, ***0*** signifies no engagement at all, ***1*** - low, ***2*** - average and ***3*** – high as demonstrated in Figures 12 and 13.

Figure 12: Policy cycle – Health Reform Process (1992 -2006)

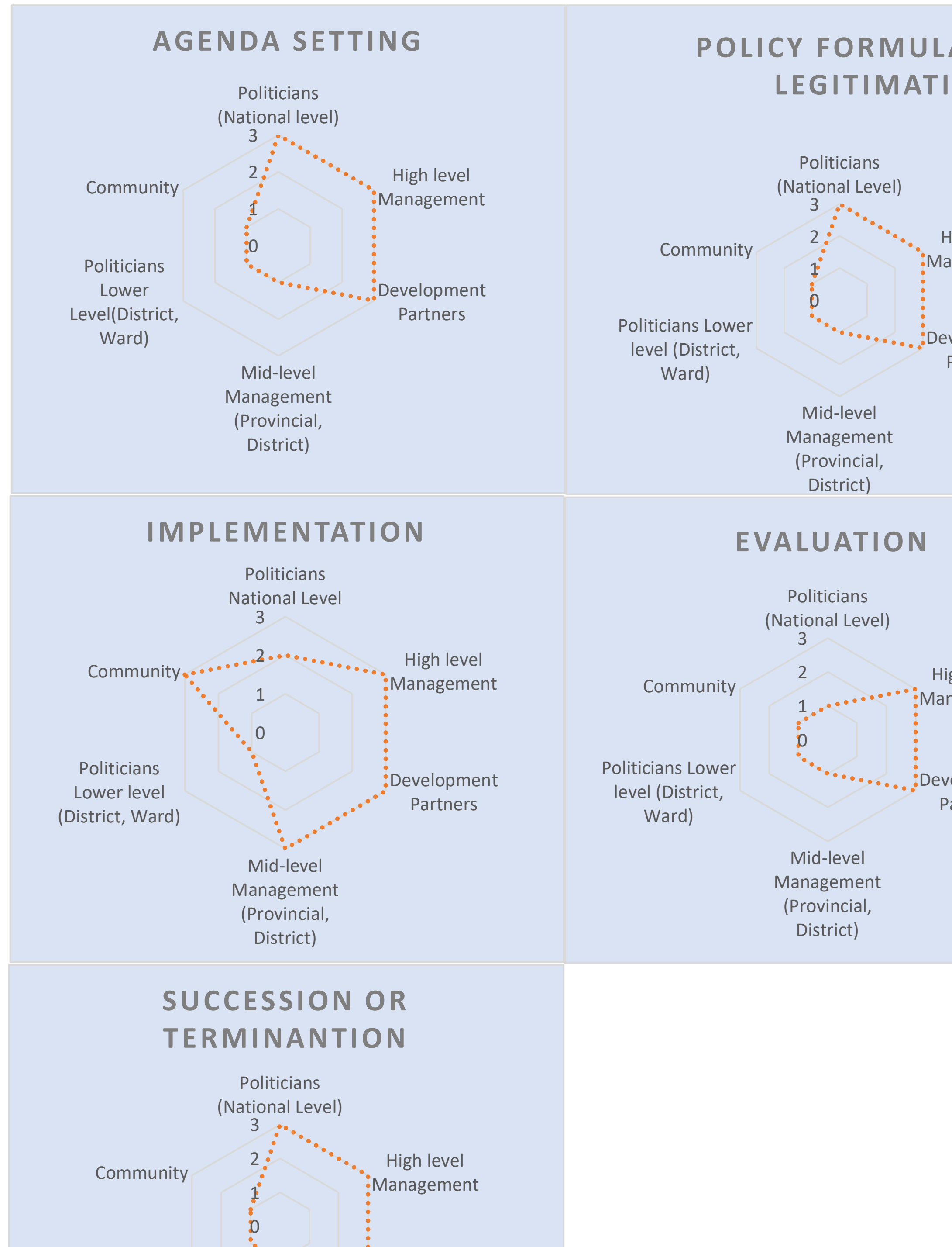


Figure 13: Policy Cycle – Devolution Process

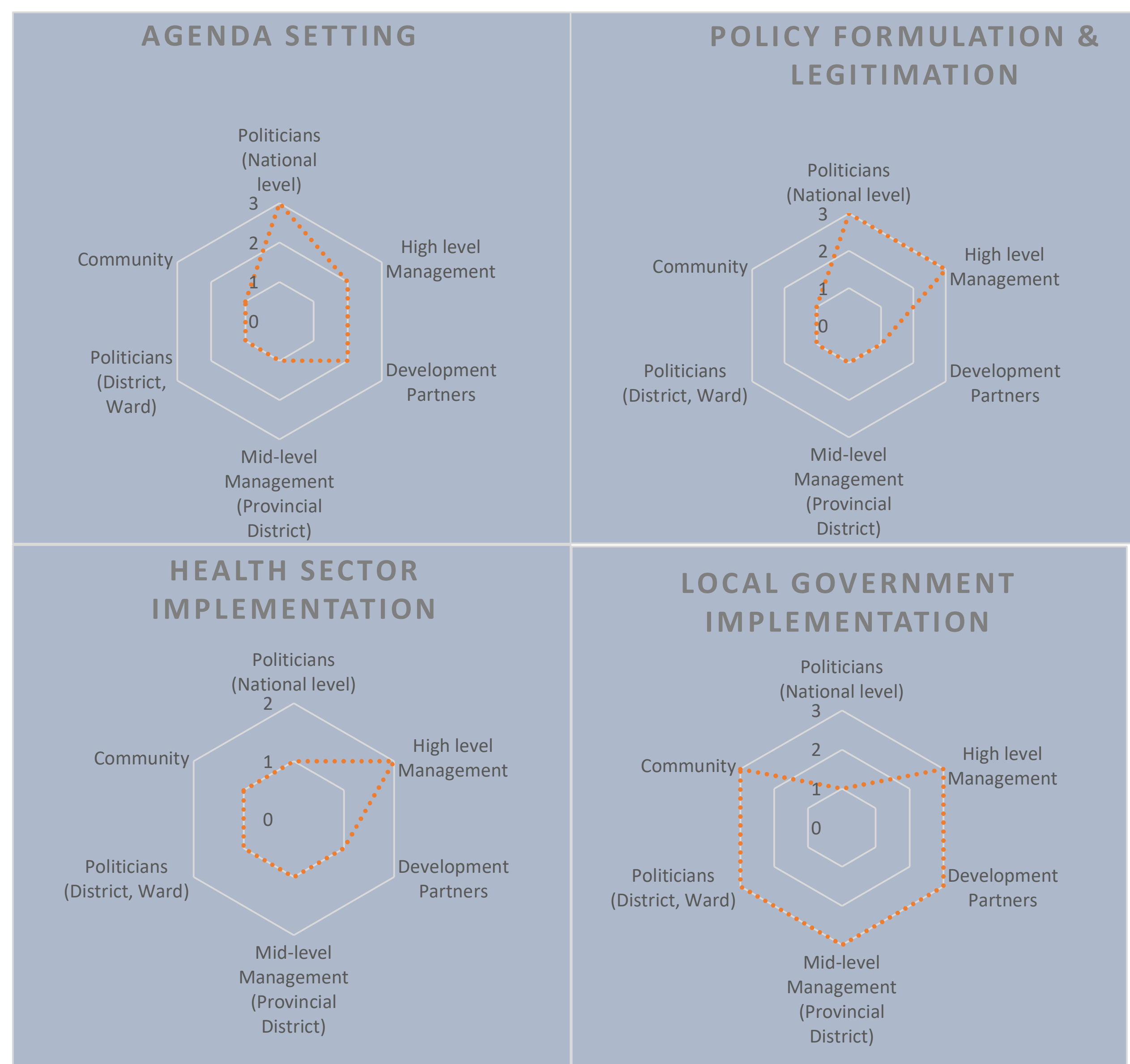


Figure 12 demonstrates that donors did indeed dominate the health reform process throughout its existence – implicitly, to advance their interests and to guard their resources. The dominance was extended to the political arena as it was used as a channel to penetrate the policy space to begin with (see Chapter Three). Thus, the way donor and political dominance manifested itself in decentralisation's local practice was that it limited opportunities for lower-level actors to engage in health reforms. In the case of communities, while the reforms served to bring governance structures closer to them, implementing mechanisms deeply isolated them, further limiting opportunities for them to hold accountable those who were in positions of power to manage the processes, let alone to demand better services.[28] It was within the context of actor isolation that the health reform failed because it operated in a top-down manner, concentrating power and policy oversight at higher (central) levels of the public sector bureaucracy, as opposed to in a bottom-up, interactive and negotiated process (Barrett and Fudge 1981, p. 25).

Figure 13 shows the progress of decentralisation of health services by devolution. Again, agenda setting was dominated by central level politicians with central level bureaucrats and donors backing the process. And since the process is based on the principles of Zambian government ownership, the policy legitimation process was conducted by politicians and central level bureaucrats, which again has left out key actors at lower levels in the health sector. The devolution agenda presents interesting findings to the research because it's being conducted under two ministries. As discussed in Chapter Six, primary health care being transferred to the Ministry of Local Government and Housing is the main thrust of the devolution agenda. While in the case of the health reform agenda actors were all within the health sector, in the devolution plan actors are split between two sectors under the leadership of GIZ (although government claims that they are leading the process). Within the Local Government sector, actors have been effectively engaged, but at lower-level interviewees complained that they had limited relationships with the higher levels (See Chapter Six).

Evidently, at national level there are competing interests between the Ministry of Health and the Ministry of Local government. The competition stems from the fact that the health sector actors have resisted the transfer of primary health care to the local government ministry (see Chapter Six). There could be a variety of reasons for this, but as discussed in Chapter Six, health sector actors claim that local government structures are too weak to manage primary health care. However, this thesis concluded that the reasons given by health sector actors for not wanting to transfer responsibilities over primary health care to local authorities conceal their fears of the loss of power, as well as ceasing to be a *'darling'* of the donors. Thus, going back to Chapters Three and Five, where the thesis underscored how donor power has long

[28] Figure 12 shows that political actors at lower levels were completely missing in the decentralisation process when they could have played a key role in augmenting community participation – a key function to implementing decentralisation policies

term effects over legitimacy of policymaking, actors in the health sector have continued to be motivated by the control of resources rather than focusing on improving health service governance.

Although the devolution of health services has been on the agenda for the last ten years, most actors are not comfortable with the process - including donors and central level actors outside the health sector - as many of them feel that local councils have no experience in managing an influx of funds and therefore will struggle without robust financial management skills and strategies. However, the scale of what lies ahead seems to be downplayed by actors in the local councils as they perceive their counterparts in the Ministry of Health as just uncomfortable with the loss of power and resources (Inter. 16 April 2018 high level Manager district Council). This reflected at district levels as well as at national level within the Ministries of Health and at Local Government and Housing. For example, local authority workers were more focused on justifying the reasons why primary health care should be under their jurisdiction without necessarily admitting to some of the real concerns, such as the low level of investment by government in their ministry but were quick to point out how corrupt Ministry of Health officers are at central level. Ministry of Health officials in turn expressed concerns over the lack of financial management capacity of local authorities and concerns over emerging audit queries from the Auditor General's office. Although all these sentiments are justified, the key agent, the community, was seldom mentioned as having a role in accountability. This reflects the neopatrimonialism nature of politics in Zambia, where community voices are silent (Chapter Five and Six).

So, the social political effects brought about by relationships between policy actors contributes significantly to the failures of decentralisation: the structural inequalities between higher and lower levels, and the dominance of the central level where lower levels are too weak/disempowered to challenge the status quo. Indeed, in practice actors at lower levels do not participate in any form of policy negotiations, despite that supposedly being one of the goals of decentralisation. As with the devolution plan, whereas GIZ support to local authorities has tried to empower local councils, politics has inhibited the participation of local actors. One of the districts where the research was conducted is predominantly an opposition stronghold. The local ward councillor pointed out that there are conflicts between the District Commissioner (DC) (an appointed civil service position mostly given to party loyalists with basic education and no civil service experience or background) who is an extension of the political arm at the district level, while the town clerk is a bureaucrat (Inter. 11April, 2018. Ward Councillor Solwezi District).

Implementation readiness for future decentralisation processes in Zambia

What are the implications if these findings for the future of health service delivery in Zambia? Because of the slow progress of reform in the health system as a whole, the thesis expresses

concern for the future of the current devolution plan (see, Chapter Five). These concerns were also expressed by a number of donors reflecting on how health systems in Africa should reform to accommodate the changes necessary to achieve better population health (World Bank, 2018). Specifically, this thesis recognises that the area of reforming health systems in Zambia is muddled such that every government since 1994 has attempted to implement reforms, including decentralisation policies, but always with limited success. These reforms have failed to produce mechanisms to empower communities, who continue to be in a weak position to hold high level actors to account and to challenge ideas that have perpetuated poor health services delivery. The long-term implications will be that health services will continue to operate in fragmented manner. While the donors are attempting to depoliticise health care, government at all levels is embracing neopatrimonialism and populism which fail to allow for the independent functioning of the civil service.

In terms of corruption, while there have been sanctions in the past, there is a long way to go and the misappropriation of funds continues to occur. For example, in 2009 the Dutch and Swedish governments froze $33 million in aid for HIV/AIDS and other health programs in response to allegations that senior health ministry officials had stolen almost $2 million (KFF Daily Global Health Report, 2009, May 29). In 2018, DFID froze aid to Zambia after the government admitted that $4.3 million of aid money meant for social cash transfer programmes had gone missing. Ireland, Finland and Sweden followed suit - and the Ministry of Health was part of the scandal (BBC, 2018). Recently (June 2020), the current Minister of Health, Dr. Chitalu Chilufya, appeared before the Courts of Law for alleged misappropriation of public funds meant for use in the health sector (Gagne-Acoulon, 2018). Similar pilfering in local government or within the health sector seems inevitable because the centre continues to set a bad example regarding the (mis)management of public funds.

This underscores the fact that decentralisation’s outcomes are dependent on the wider context. In this regard, the context is that actors at central level have been seen by actors at lower levels to have benefited personally from their power to control resources. Thus, there is a high likelihood that the same attitudes about patronage over resources will be transferred to lower levels. Certainly, this is how it is seen by actors at the Ministry of health who complained that councils had weak financial accountability mechanisms. At all levels, corruption cannot be prevented without implementing sound fiscal controls to deter it.

Unsurprisingly, interviewees at community level working with local council officials to develop capacity for local services delivery expressed dissatisfaction with the conduct of middle management council officials, saying that they look to be more interested in getting allowances than finding means to strengthen community involvement (Chapter Five). According to the observations of this research, community empowerment was only successfully promoted in the case of HIV/AIDS policy, but even then, the resources that were devolved to communities to run HIV/AIDS programmes were not of the same magnitude as those accessed at national level.

Key research findings

In view of the discussions above, the key findings of the research are:

1. Understanding donor-government relations. The successful implementation of the health reforms (1992 -2006) decentralisation plan was hinged on the political euphoria that had swept across sub-Saharan African countries in the late 1980s to the early 1990s, supported by external development partners. Within the Zambian health sector, two individual actors played a central role in driving the health reform agenda - largely because they had formed good relationships with the donors and were seen by government as key figures with the technical expertise and knowledge to drive the process. Although it's claimed that the health reforms were locally initiated, the presence of the Swedish government and other donor technical and monetary support had an influence on the architecture of the reform process. Thus, the process was successfully implemented because of the resources and technical support provided by the donors, and the relationship that existed between the donors and the new MMD government. The relationship was cemented by trust, and the desire to depart from how the UNIP government had approached policy making and development of health services. Bureaucratic actors trust in the reform process is key – a useful finding for future research.
2. The weaknesses of the Zambian context in embarking on big reforms like devolution because of inadequate resources to do so. Previous successfully implemented reforms depended on external resources, an indication that local mobilisation of funding to implement health sector reform using domestic resources remains a challenge.
3. Technocrats are crucial actors in driving (or inhibiting) decentralisation in Zambia, and in this regard, they can be used as conduits to harmonise policy processes. For example, in the health reform process, the tensions among technocrats from the Central Board of Health (CBoH) and Ministry of Health (MoH) with regards to benefits played a part in subverting the process. In the case of the devolution agenda, the process has also been subverted by the different expectations between civil servants in the MoH and the Ministry of Local Government and Housing of what devolution intends to achieve.

Thesis Contributions

Decentralisation in Zambia has been affected by actors, institutional arrangements, financing mechanisms. In short, context matters. Care is therefore needed in extrapolating wider lessons from Zambia. Nevertheless, the thesis makes wider contributions to:

1. Literature on decentralisation**:** The thesis makes a contribution to literature that states that in implementing decentralisation policies, context matters. The research illustrates how political and bureaucratic actors in Zambia have each shaped the

operation of decentralisation policies. Actors at all levels of the domestic health system, from the national down to the district, have been shown to play important roles in forwarding or resisting decentralisation, including 'non-political elites' such as street-level bureaucrats and local health service administrators who are often overlooked in the literature.

2. African agency is key in this regard. How donors have influenced policy through money and technical support but their influence in getting results has been limited due to context. So, donors can do so much but what will determine the results are the key actors, the structures and the local political practice.
3. The use of the Health Policy Triangle Framework (HPTF) as a useful framework in locating a constellation of actors and their roles and influence in policy processes. For example, in the health reform processes the HPTF located two actors not only as formal bureaucratic actors and politicians but as mediators within the donor community and within political party structures.
4. Documenting the roles of donor ideologies within the Zambian health policy context – and how donors and the state have related to one another. Despite current literature advocating for more African influence in policymaking agenda within their own settings, it has been common in the decentralisation literature to attribute significant agency to donors, and less to the state. This thesis presents a more nuanced picture in which donors certainly were influential, but often failed to get their preferences met or achieve their policy goals.

Implications of the research

The thesis has provided some original insights on the attempts to implement decentralisation policies in Zambia. At the beginning of the thesis it was noted that decentralisation has been widely promoted (and adopted) in low-and middle-income countries to fix the perceived inefficiencies in delivering public goods.

The thesis' finding on the agency exercised by governments in Zambia are likely to apply equally to low- and middle-income countries, especially in SSA. Whereas Barnes et.al (2015) assert that governments in these countries have limited agency, they nevertheless do exercise agency, including pushing back against donors' agenda. Some scholars blame donors for having so much influence in African countries, but this thesis suggests that view of outside imposition is too simplistic.

Furthermore, although it is not necessarily the intention of donors to promote incumbent political parties in power, their funding boosts public confidence in the government, especially where the public are more interested in accessing improved service delivery. It's this confidence that governments capitalise on to get re-elected, which in turn drives donor

confidence about the stability of government. Therefore, it is the belief of this thesis that donor ideas succumb to local political contexts, not just the other way around.

There is clearly a lot to learn from Zambia's experiences in implementing health sector decentralisation policies for the last three decades. This thesis has undertaken valuable steps to begin filling the gaps in knowledge that exists on decentralisation and health service governance. It has shown that decentralisation will produce results according to the context that it's subjected to. Thus, for decentralisation to produce positive outcomes for health services delivery, there are specific contextually relevant (f)actors that enable it to do so. But unquestionably, it's not a panacea to health sector development, to reiterate Smoke (2003), "*certainly decentralisation is not a panacea for public sector ills or a natural enemy of effective government*. These insights generated have been backed up by empirical analysis, so they therefore form the fundamental basis for future research on decentralisation and health governance in low-and-middle income countries.

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Appendix One: University of Sheffield Ethics Approval

Downloaded: 08/09/2017
Approved: 08/09/2017

Chishimba Mulambia
Registration number: 160126839
Politics
Programme: Politics Research Training Workshop

Dear Chishimba

PROJECT TITLE: Decentralisation and Health Service Governance in Zambia
APPLICATION: Reference Number 016024

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 08/09/2017 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 016024 (dated 06/09/2017).
- Participant information sheet 1034918 version 3 (06/09/2017).
- Participant consent form 1035332 version 1 (06/09/2017).
- Participant consent form 1034920 version 2 (23/08/2017).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Yours sincerely

Edward Hall
Ethics Administrator
Politics

Appendix Two: University of Zambia Ethics Approval

THE UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND GRADUATE STUDIES
HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Telephone: +260-211-290258/293937 P O Box 32379
Fax: +260-211-290258/293937 Lusaka,
Zambia
E-mail drgs@unza.zm.

Ethical Appraisal of Study

1st June, 2018

Ref. No. 2018- March - 008

The Principal Investigator

Dear Mrs Chishimba Mulambya.

RE: "Decentralisation and Health Governance in Zambia"
Reference is made to your resubmission. The University Of Zambia Humanities And Social Sciences Research Ethics Committee IRB resolved to approve this study and your participation as Principal Investigator for a period of one year.

Review Type	**Normal Review**	Approval No. **2018 - March - 008**
Approval and Expiry Date	Approval Date: 1st June, 2018	Expiry Date: 31st May, 2019
Protocol Version and Date	Version-Nil	-
Information Sheet,	• English.	To be provided

Consent Forms and Dates		
Consent form ID and Date	Version	To be provided
Recruitment Materials	Nil	Nil

There are specific conditions that will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

Conditions of Approval

- Provide information sheets and consent letters as these were not attached. The information sheets should have had the essential features included. Please use the WHO templates which you could download at www.who.int/rpc/research_ethics/informed_consent/en/). REC would appreciate if the PI could customise the WHO templates and include the domains of what the submitted protocol is positing on tools and the sampling units (people who have been or shall be participating in this study.
- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved by an application for an amendment prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address or methodology and methods. Many modifications entail minimal risk adjustments to a protocol and/or consent form and can be made on an Expedited basis (via the IRB Chair). Some examples are: format changes, correcting spelling errors, adding key personnel, minor changes to questionnaires, recruiting and changes, and so forth. Other, more substantive changes, especially those that may alter the risk-benefit ratio, may require Full Board review and approval. In all cases, except where noted above regarding subject safety, any changes to any protocol document or procedure must first be approved by the IRB before they can be implemented.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review

process. Any documents received less than 30 days before expiry will be labelled "late submissions" and will incur a penalty.

- Every 6 (six) months a progress report form supplied by The University of Zambia Humanities And Social Sciences Research Ethics Committee IRB must be filled in and submitted to us. There is a penalty of K500.00 for failure to submit the report.
- The University Of Zambia Humanities And Social Sciences Research Ethics Committee IRB does not "stamp" approval letters, consent forms or study documents unless requested for in writing. This is because the approval letter clearly indicates the documents approved by the IRB as well as other elements and conditions of approval.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of The University of Zambia Humanities and Social Sciences Research Ethics Committee IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,

Dr. Jason Mwanza
BA, MSoc, Sc., PhD
CHAIRPERSON
The University Of Zambia Humanities and Social Sciences Research Ethics Committee IRB

C.c. Director – DRGS
Assistant Director - DRGS

Appendix Three: Examples of Cabinet Approval Letters

Telephone: +260 211 251 375 / 251 388 / 251 483
General Inquiries:
Secretary to the Cabinet
Telegrams: CABINET

In reply please quote:

No.:.............................
DS/1/6/2

REPUBLIC OF ZAMBIA

OFFICE OF THE PRESIDENT
CABINET OFFICE

P.O. BOX 30208
LUSAKA
ZAMBIA

14th May 2018

The Town Clerk
Lumwana City Council
LUMWANA

RE: INTRODUCING CHISHIMBA MULAMBIA – PhD PROJECT ON DECENTRALISATION AND HEALTH GOVERNANCE

Reference is made to the subject matter above.

I am writing to introduce to you Chishimba Mulambia, a Research Fellow at the University of Zambia, Institute of Economic and Social Research undertaking her PhD studies at the University of Sheffield, under the Commonwealth Scholarship Schemes.

Her research study seeks to examine and provide a wider evidence base to decentralisation as a health system reform tool as it is practiced by analysing how decentralisation has been implemented in Zambia. As a way of meeting the objectives of the study, she requires to conduct interviews with selected local authorities being Ndola, Luanshya, Lumwana and Solwezi.

I am therefore requesting that you accord her the necessary support she requires to conduct her study.

Ndashe L Yumba
PERMANENT SECRETARY
MANAGEMENT DEVELOPMENT DIVISION

cc. Mrs. Chishimba Mulambia,
LUSAKA

Telephone: +260 211 251 375 / 251 388 / 251 483
General Inquiries:
Secretary to the Cabinet
Telegrams: CABINET

In reply please quote:

No.:.............................
DS/1/6/2

REPUBLIC OF ZAMBIA

OFFICE OF THE PRESIDENT
CABINET OFFICE

P.O. BOX 30208
LUSAKA
ZAMBIA

14th May 2018

The Town Clerk
Luanshya City Council
LUANSHYA

RE: INTRODUCING CHISHIMBA MULAMBIA – PhD PROJECT ON DECENTRALISATION AND HEALTH GOVERNANCE

Reference is made to the subject matter above.

I am writing to introduce to you Chishimba Mulambia, a Research Fellow at the University of Zambia, Institute of Economic and Social Research undertaking her PhD studies at the University of Sheffield, under the Commonwealth Scholarship Schemes.

Her research study seeks to examine and provide a wider evidence base to decentralisation as a health system reform tool as it is practiced by analysing how decentralisation has been implemented in Zambia. As a way of meeting the objectives of the study, she requires to conduct interviews with selected local authorities being Ndola, Luanshya, Lumwana and Solwezi.

I am therefore requesting that you accord her the necessary support she requires to conduct her study.

Ndashe L. Yumba
PERMANENT SECRETARY
MANAGEMENT DEVELOPMENT DIVISION

cc. Mrs. Chishimba Mulambia,
LUSAKA

Appendix Four: Ministry of Health Approval

All Correspondence should be addressed to the Permanent Secretary
Telephone: +260 211 253040/5
Fax: +260 211 253344

In reply please quote:
MH/101/23/10

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

NDEKE HOUSE
P. O. BOX 30205
LUSAKA

11 June, 2018

Chishimba Mulambia
University of Zambia
Institute of Economics and Social Research
Department of Politics
LUSAKA

RE: AUTHORITY TO INTERVIEW DISTRICT HEALTH DIRECTORS

The Ministry of Health is in receipt of your request for authority to interview District Health Directors in Ndola, Luanshya, Lufwanyama, Solwezi and Lumwana Districts.

Kindly note that before permission is granted, you are required to attach copies of your proposal, ethical clearance and authorization from the National Health Research Authority.

Dr Jabbin Mulwanda
Permanent Secretary- Health Services
MINISTRY OF HEALTH

Appendix Five: Zambia National Health Research Authority Approval

THE NATIONAL HEALTH RESEARCH AUTHORITY
Paediatric Centre of Excellence
University Teaching Hospital
P.O. Box 30075
LUSAKA

Telephone: +260 211 250309 | **Mobile:** +260 95 5632726

21th June, 2018

The Principal Investigator
Ms. Chishimba Mulambya
University of Sheffield
United Kingdom

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled **"Decentralisation and Health Service Governance in Zambia".**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance including the amendments made, this study has been approved to carry out the above mentioned exercise on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

Yours sincerely,

Dr. Godfrey Biemba
CEO/Director
National Health Research Authority

All correspondences should be addressed to the Director and Chief Executive Officer

Appendix Six: Details of semi-structured interviews

Site Selection

SN	Site	Reason for Selection
1.	Lusaka Province/District/Town	• Capital city of Zambia where all bilateral, multilateral, Central Government Offices and Ministries are located.
2.	Copperbelt Province (Ndola & Luanshya)	• Metropolitan province with a combination of Cities and Municipal Councils, urban and peri-urban areas • Previously used a combination of public and private service providers to deliver health services
3.	North-western Province (Solwezi & Lumwana)	• Rural but one of the fastest growing provinces run by Municipal Councils • A growing presence of private (mine) service providers that deliver health services

List of people interviewed by date and type of interviewee

27 - February - 2019, Bureaucrat.
2 - March - 2018, Academic.
14 - March - 2018, Bureaucrat.
14 - March - 2018, Bureaucrat.
14 - March - 2018, Bureaucrat.
15 - March - 2018, Bureaucrat.
11 - April - 2018, Community representative.
16 - April - 2018, Civil Society representative.
10 - May - 2018, Politician.
10 - May - 2018, Community representative.
10 - May - 2018, Community representative.
14 – May - 2018, Bureaucrat district representative
14 – May - 2018, Multilateral agency representative
15 - May -2018, Bureaucrat
16 - May – 2018, Bureaucrat
18 – May – 2018, Bureaucrat
23 – May – 2018, Bureaucrat
24 – May – 2018. Bureaucrat
24 - May – 2018, Former Politician
24 – May – 2018, Bilateral representative
4 – June – 2018, Community representative
4 - June - 2018, Community representative
4 -June – 2018, Community representative

4 – June – 2018, Community representative
5 – June - 2018, Bureaucrat
12 – June – 2018, Bureaucrat
12 - June - 2018, Bilateral representative
12 - June – 2018, Bureaucrat
14 – June – 2018, Bureaucrat.
14 - June - 2018, Multilateral representative
14 – June - 2018, Multilateral representative).
14 – June – 2018, Bureaucrat
15 – June – 2018, Bureaucrat.
15 – June – 2018, Retired Bureaucrat
16 – June – 2018, Academic representative
16 - June – 2018, Former Bureaucrat – Political Appointment
20 – June – 2018, Bilateral representative
6 – July – 2018, Bureaucrat
6 – July – 2018, Bureaucrat district level representative
6 – June – 2018, Bureaucrat district level representative
9 - July – 2018, Bureaucrat district level representative
9 – July - 2018 Civil Society representative
9 – July- 2018 Politician

Examples of organisations from which interviewees were affiliated

1. Apex university – Medical School
2. Cabinet Office
3. Caritas Zambia
4. Decentralisation Secretariat
5. Department for International Development - UK
6. German Gesellschaft für Internationale Zusammenarbeit (GIZ)
7. Jesuit Centre for Theological Research
8. Kafue District Health Office
9. Luanshya Municipal Local Council
10. Luanshya Ward Development Committees
11. Lusaka Ward Development Committees
12. Lusaka District Health Office
13. Lusaka District Ward Development Committees
14. Ministry of Local Government and Housing
15. Ministry of Health
16. National Assembly of Zambia
17. Ndola District City Council
18. Ndola District Health Office
19. Ndola Ward Development Committees
20. Solwezi District Council
21. Solwezi District Health Office
22. Public Service Commission
23. University of Zambia

24. Transparency International Zambia
25. World Bank
26. World Health Organization

Interview Guides.

Interview Guide A- National Level stakeholders; Government Officials (Decentralisation Secretariat Staff, Ministry of Health staff & Local Government Staff), Civil Society, Donor Agency Staff, Politicians,

A- Background and introductory Questions (National Level Respondents)

Respondent Background:

- Education, profession/discipline, title/sector involvement in decentralisation e.g. Health sector, education sector etc
- Can you tell me about your professional background to date? Probe: Involvement in Decentralisation processes, when did you begin to get involved in decentralisation/ How did you get involved?
- Have you worked in health sector decentralisation before? Probe: Have you ever worked outside Zambia? Any other involvement in decentralisation outside Zambia, how the processes are similar/different to Zambia? How decentralisation in other sectors differs from health sector decentralisation?

B –Understanding the delivery and management of Health Service decentralisation

- How is decentralisation of health services delivered and managed? – Probe: Institutional architectures for delivering decentralisation and the specific policy instruments (i.e. projects, donor support, sector budget support, general budget support)?
- What documents are available to guide the various decentralisation plans? Probe: how they are disseminated and whether relevant stakeholders do approve of them?
- Are there consultations in the production of these documents?
- What are the justifications for the use of particular ways of delivering and managing decentralisation?
- How have decentralisation policies been implemented in Zambia specifically the health sector?
- What have been the motivations for implementing health sector decentralisation? Probe (1992 Health Sector reforms; creation of additional districts; and 2011 realignment of maternal and child health services
- How can decentralisation policies be compared, Probe: across sectors, time periods?
- Do Zambian decentralisation policies conform to global expectations?
- How do the different stakeholders come together to support decentralisation policies, Probe: role of the Decentralisation Secretariat, Parliamentary committees, Community involvement and the Health Sector Technical Working Groups.
- Are there mechanism that are put in place to involve all stakeholders in decision making Probe: At Provincial, district and community levels
- How did previous decentralisation plans affect the management of health services?

- What worked well/ what didn't?

C- Current Decentralisation Plan

- How different is it from the previous decentralisation attempts and plans?
- What are the intended outcomes?
- Will they be achieved?
- Will staff structuring and distribution of resources be affected? If so how?

D- Stakeholder Management and Relationships

- How do different ways of delivering and managing decentralisation policies affect the relationships between different actors in the Zambian health sector? To what extent do these reflect the normative goal of 'equity of health service delivery? (identify actors and how linked, network analysis, power/influence)
- How do different ways of delivering and managing decentralisation plans meet the normative goal of 'ownership' of health service delivery in Zambia? How do these perform to help strengthen the institutional and individual capacities and management systems in Zambia to identify, design, monitor and coordinate their 'own' health services?

E- Sustainability

- What are the prospects for the long-term effectiveness for delivering decentralisation plans in terms of their contribution to sustainable health outcomes in Zambia? (recognising that sustainability is a function of ownership and capacity)
- What were the gains in the old decentralisation policies ***(for respondents who have previously been engaged in decentralisation)***
- How different is the new decentralisation policy from the previous ones?
- What specific objectives does the new decentralisation seek to achieve and how?

F- Policy Relevance (use of decentralisation policies in managing health services)

- Are decentralisation policies effective in managing health services in Zambia? Explain
- What lessons can be learnt from previous decentralisation policies to contribute to a better understanding of how the pending decentralisation plan could be more effective in delivering health services in the future?

Specific Questions for Donor Agency Staff.

- What are the motivations behind decentralisation policies in Zambia?
- What mainly underpins these policies?
- How will the new decentralisation plan benefit Zambia?

Interview Guide B- Provincial Health staff, District Commissioners, District Health Staff, District Stakeholders (NGOs,) , District Council Staff

Specific Questions

A- Engagement with National levels
  - Level of involvement in decentralisation design, planning, management and implementation Probe: channels of engagement. Degree of involvement
  - How does the planning process work?
  - Are the processes well understood?
  - Is there any support received from the national level in implementing decentralisation plans?

B- Current Decentralisation plan
- Have you been consulted on the impending decentralisation plan? What have been your contributions to the imminent decentralisation plan?
- Was the consultation something you felt satisfied with?

- How different is it from the previous decentralisation attempts at Provincial/District levels
- How will it affect the staffing, resource distribution at Province and district levels?
- Do you think the current decentralisation plan will be achievable, if yes why, if not why?

Interview Guide C - Community Level (Civic leaders, Traditional; Community Leaders etc)

Specific Questions

  - How long have you lived in this community?
  - What is your role in this community?
  - Are you aware of the changes in delivery of health services? (if yes how did you become aware?) Probe for awareness in local government involvement
  - Are you involved in the current transitions of health service provision? If yes, probe for how
  - How will the transitions affect the community?
  - Do you think health services should be managed by local councils? Probe for why
  - Do you think this will help to deliver health services in a better way?
  - Do you think this community has the ability to manage health services? If so how?

Is there anything else you would like to add?