

**A STUDY TO EVALUATE SUPPORT FOR THE HEALTH SECTOR
DEVOLUTION POLICY IN ZAMBIA:
AN ACTOR ANALYTIC PERSPECTIVE**

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**A Mini-thesis Submitted in partial fulfilment of the requirements for the degree of
Master of Public Health Specialising in Health Economics in the
Department of Public Health and Family Medicine**

HEALTH ECONOMICS UNIT

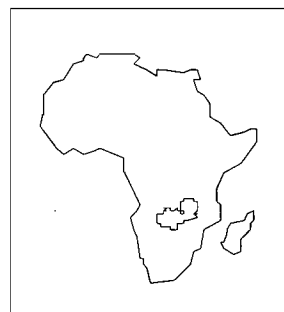
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ADMINISTRATIVE MAP OF ZAMBIA WITH THE 9 PROVINCES



DECLARATION

I declare that the *Study to Evaluate Support for the Health Sector Devolution Policy in Zambia: An Actor Analytic Perspective* is my own work. That it has not been submitted for any degree or examination in any other University, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed by candidate

SOLOMON S. KAGULULA

This research paper has been submitted for examination with my approval as the University Supervisor.

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DEDICATION

To my beloved Country Zambia and all the people who live in it.

LIST OF ABBREVIATIONS

CBoH:	Central Board of Health
DDH:	District Directors of Health
DHB:	District Health Boards
DHMTS	District Health Management Teams
HRIT:	Health Reform Implementation Team
MOH:	Ministry of Health
NGO:	Non-governmental Organisations
PHC:	Primary Health Care
PHD:	Provincial Health Director.
LG	Local Government
HSAC	Health Sector Advisory Committee
NHC	Neighbourhood Health Committee
IMF	International Monetary Fund
GDP	Gross Domestic Product
CSO	Central Statistical Office
SAP	Structural Adjustment Programme
SA	Stakeholder Analysis
PSC	Public Service Commission
PDCC	Provincial Development Coordinating Committee
DDC	District Development Committee
DA	District Administrators
MDG	Millennium Development Goals
PSRP	Public Service Reform programme
PSCAP	Public Service Capacity Building Project
EPI	Expanded Programme against Immunisation
NHSA	National Health Services Act

ABSTRACT

This study is an evaluation of Support for the Health Sector Devolution Policy in Zambia. The study adopts a stakeholder analytical approach and its central objective is to study characteristics of key stakeholders, analyse how these influence support for implementing the devolution policy in the Zambian Health Sector and recommend strategies for taking forward the decentralisation process.

The primary sources of research material include policy documents and qualitative interviews. Qualitative analysis was conducted using coding derived both from conceptual framework and from a more grounded review of interviews. Coding of interviews was done both manually and with qualitative research software, NUDIST.

The results showed that stakeholders' characteristics are a threat to a successful implementation of the health sector devolution policy in Zambia. This is partly due:

- Low levels of knowledge of devolution policy among stakeholders and
- Fear that the Ministry of Local Government and Housing may fail to prioritise health in resource allocation budgeting and divert money to non-health programmes.

The research concludes that stakeholders characteristics are likely to have a negative impact on the implementation of the devolution policy and that most concerns raised by stakeholders over implementation of devolution policy in the health sector require special attention from policy makers. All the main health sector specific actors perceived devolution policy as affecting it negatively while politicians and Ministry of Local Government and Housing perceived devolution policy positively. Given the above, Decentralisation Secretariat should work out mechanisms of engaging other stakeholders fully in the consultation process and try to re-evaluate the design of the National decentralisation policy given the current strength of opposition. Further, it is expected that government action will lead to more effort to educate the actors on this policy reform issue.

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CHAPTER ONE: PURPOSE AND SCOPE OF THE STUDY

1.0 INTRODUCTION

This chapter gives the background to this study. Here, the study approach is given, as well as its objectives. The chapter concludes with an outline of the organisation of the rest of the chapters.

1.1 BACKGROUND INFORMATION

1.1.1 Decentralisation

Decentralisation is not a new concept, the term attracted attention in the 1950s and 1960s when British and French colonial administrators prepared colonies for independence by devolving responsibilities to local authorities (World Bank, 2000). In the 1980s, decentralisation came to the fore of the development agenda along side the renewed global emphasis on governance and human centred approaches to human development. Today both developed and developing countries are pursuing decentralisation policies (ibid).

The concept of a strong and empowered local government has not only appealed to Zambia alone but to many governments throughout the world, and increasingly so over the past two decades. Decentralisation is neither good nor bad it is just a means to an end, often imposed by political reality. Successful decentralisation improves the responsiveness of the public sector while unsuccessful decentralisation threatens economic and political stability thus ending up in disruption of delivery of public services (World Bank, 2000).

According to the World Bank (1999) decentralisation is intended to enhance the efficiency and responsiveness of government in service delivery by positioning the provision of services closer to communities and authorities that best understand local needs. According to Cheema and Rondinelli (1983), decentralisation is the transfer of

responsibility for planning, management, resource raising and resource allocation from the central government and its agencies to the lower levels of government.

There are, as this definition would suggest, different organisational forms of decentralisation namely; deconcentration, devolution, delegation and privatisation (Cheema and Rondinelli, 1983).

Deconcentration is the transfer of resources, responsibilities and authority from centre to periphery whilst the main line management control is maintained. It is the allocation of responsibilities by national government to regional or field offices but not to locally elected and accountable government (World Bank, 2000). This therefore means a shift of workload to the periphery. There are also two forms of deconcentration namely: functional deconcentration and integrated deconcentration. In the former, a ministry deconcentrates on functional lines for example, from the centre to a Provincial Health or District Health office. Whereas in integrated deconcentration, the same exists, but the province or district health office is given overall coordinating authority.

Devolution is where the transfer from the centre is to a separate level of government (e.g provincial or local). That is it is the assignment of responsibility for finance, management and administration of national government roles to sub-national levels (Rondinelli, 1983). The devolved level is not under the main line managerial authority of the centre but has its own political autonomy in terms of recognised responsibilities and use of resources. It is appointed at the respective level and not by the centre, has its own source of revenue, its own recognition in law and is multifunctional. Although these systems may not always be clear-cut in practice and any one system might combine different aspects of these systems (Thomas. et al, 1991).

Under **delegation**, managerial responsibility for a defined set of functions is transferred to organisations outside government such as parastatals. Whilst central government retains authority over some services and delegated agencies are accountable to government, that is they are only indirectly controlled by it (Collins, 2001).

Finally, **privatisation** (or divestment) involves the transfer of all decision-making power for some functions to for profit or not for profit organisations. Given the degree of

authority transferred, it is critical that government retains a strong regulatory role in monitoring quality and ensuring accountability (Rondinelli, 1990). Decentralisation thus deals with varying degrees of political, administration and financial empowerment at sub-national levels.

Decentralisation is pursued in order to increase service delivery effectiveness, efficiency of resource allocation, health worker motivation, financial transparency, community participation, equity and private sector participation (Bossert and Beauvais; 2002). Although decentralisation is often seen as a technical matter, intended to improve the above-mentioned issues it also has an explicit political dimension. The establishment of local governments, for example, might create a new layer of government aimed at consolidating national political system, broadening the pattern of political participation within a country and strengthening local accountability (Hambleton, 1988).

Three elements have been found to contribute to the efficiency of the local government (World Bank, 1995), namely; (i) clear division of functional responsibilities between various levels of government, which is a prerequisite for accountability to communities, (ii) revenues that correspond to functions and (iii) clear accountability, put in place by centralised regulation. However, Pru'homme (1994) argued that despite theoretical advantages favouring decentralisation, there are some dangers that go along with it and these include; (i) decreased central control and coordination over macroeconomic environment and (ii) asymmetrical developments in areas where there are capacity constraints. Decentralisation in reality hinders inter-jurisdictional redistribution and macroeconomic stabilisation (Pru'homme 1994, in Cameroun 2000).

1.1.2 International

Decentralisation is a global trend: It is a highly popular reform in the public health sector and has become one of the key elements of contemporary health sector change. An increasing number of countries are adopting or considering the adoption of devolution as a form of decentralisation. These include; Bolivia, Brazil, China, Colombia, Denmark, Ghana, India, Malawi, Uganda, Tanzania, Nigeria, Pakistan, Philippines, Spain, Sweden, Zimbabwe and South Africa (Collins, 2001). Decentralisation (including devolution) is an important change for the programme development of the health sector. Health sector

devolution is diverse and it takes on a different strategic context according to how it fits into broader programmes of health sector reform and can adopt different organisational forms (ibid).

It is also important to note that the record of decentralisation has not been good. In some cases it has met with major resistance and obstacles leading to implementation failure. In others it has caused major problems for provision of health care services. That is, if poorly formulated and implemented, devolution can have a negative impact on health sector development (Collins, 2001).

1.1.3 Zambia

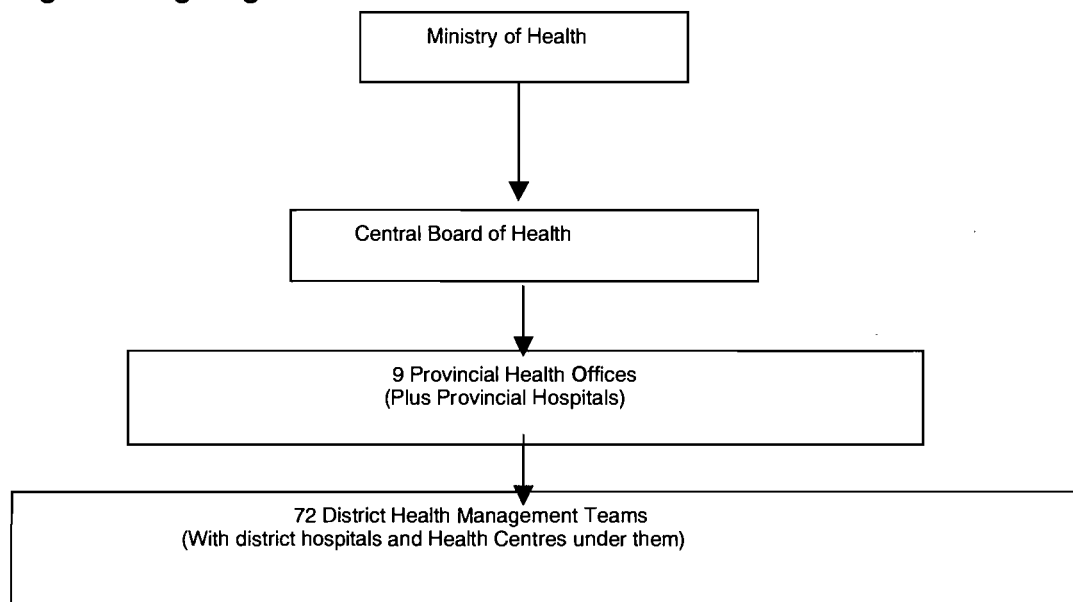
The Zambian government initiated the process of decentralisation in the early 1980s and only managed to launch the national decentralisation policy in 2004. Health sector deconcentration however, followed its own separate process with roots of its reform programme dating back to the Medical Services Act of 1985. From then onwards emphasis has been on strengthening of the lower levels such as District Health Management Teams (DHMTS) (Mpuku and Zyuulu; 1997).

In 1992, further legislation was passed to enable districts to establish their DHMTS and 1993 saw the establishment of the Health Reform Implementation Team (HRIT) at a National level to act as a co-ordinating board to promote the full implementation of the legislated reforms (MoH, 1997).

In 1994, the DHMTS were followed by the creation of the District Health Boards (DHBS), which were to act as the supervisors and ultimately, employers of the DHMTS. The DHBS were set up side by side with the hospital boards. In 1995, the National Health Services Act was passed, calling for significant changes in the role and structure of the Ministry of Health and for the establishment of an essentially autonomous health services delivery system. This gave birth to the semi autonomous Central Board of Health (CBOH) whose functions were to “ monitor, integrate, and co-ordinate programme of Health Management Boards”(Mpuku and Zyuulu; 1997:116). This meant that functions of the “new” Ministry of Health (MoH) were policymaking and regulation of statutory bodies. The MoH was to have no direct health service delivery responsibilities

and would instead contract these services from the CboH (Foltz; 1997).

Figure 1: Organogram for Health Services in Zambia



The reform programme also provided for the creation of a number of structures for popular participation including area health boards, health sector advisory committees (HCAC) and neighbourhood health committees (NHCS). Thus the new organisation of the MoH and CBoH formed the basis for a significant decentralisation of health service management and planning (Fielded and Nielsen 1998). Opposed to this deconcentration mode of decentralisation, which Ministry of Health embarked on from 1985, the government of Zambia now intends to decentralise through devolution and enshrined in the decentralisation policy document are objectives aiming at giving the citizenry the opportunities to exercise control over its local affairs and foster meaningful development. The decentralisation will cut across all sectors and local government (LG) will be entrusted with management of resources. The local government functions will include the co-ordination of decentralised structures, including health boards, provision of primary health care services and management of human resources. To that extent, it is envisaged that local government shall receive funds from the line ministries (Ibid).

This therefore means that the provincial functions will mainly be co-ordination and monitoring implementation by local government. Thus, it will be the duty of Provincial Health Directors (PHDS) to report to the central government on the implementation of policies whereas the central level Ministry of Health will remain with functions of policy

development, setting standards and attending to other functions of national importance such as control and management of epidemics, pandemics and other disasters.

It is recognised that a long period of capacity building is necessary before the LG takes up the above-mentioned tasks and a period of 10 years is foreseen from 2005.

1.1.4 Policy and Practice

In most countries health reform policies are introduced in an uncoordinated manner. Normally, there is a tendency to introduce and implement several policies at the same time. Furthermore, there have been policy "collisions" between new policies and old ones and in certain instances, some policies impacted negatively on implementation of others (Mac Laughlin, 1998).

Although many policies offer frameworks, clear guidelines for implementations are not provided. This makes room for other actors to shape the policy to their context and their own objectives. Thus lack of clear implementation plans can result in gaps between intended objectives (vision) and reality (Ball, 1994).

Adopting or declaring a policy is not the same as its achievement. Policy may be adopted but it is not a guarantee that it will be implemented. The major challenge is how to turn the policy into reality (Jansen, 1998). Since policy is mediated at various levels it is subject to various interpretations by different actors (Mac Laughlin, 1998). Policy is a political process; it needs understanding of the power relations and the conflict resolution that go with the policy process. This is why Ball (1994), stated that policy doesn't enter a social vacuum; it enters an existing set of social relations which impact on power relations. Local conditions determine how policy is received and this differs from country to country.

Since values, beliefs, interests and other characteristics differ from place to place; policy cannot prescribe the same meaning and will not be implemented the same way in different places. Certain parts of policy may be selected, rejected, ignored or recreated to suit local conditions. This process of policy modification often takes many years before a policy is finally implemented (Jansen, 2001). Other than looking at the

resources allocated for implementation, different interpretations and responses to the policy will impact on the rate at which it is implemented. Policies therefore, challenge assumptions and practices in organisations by providing a future orientation rather than an inherited routine and tradition (Ranson, 1993).

Policy implementation requires knowledge of the consequences that a particular policy may have on the public and the bureaucratic implementation constraints associated with it. There are specific features of a policy that influence the dynamics in its implementation. For instance, a decentralisation policy may require a great deal of time and effort and may not have an immediate impact on the public as such. This in itself tends to build different types of public and bureaucratic responses (Gustafson and Ingle, 1992).

1.2 JUSTIFICATION OF APPROACH

Health Sector decentralization is a worldwide trend and a key concern in developing countries. Though the proposed decentralization of services within individual countries differ in terms of design, cultural, historical, social and political circumstances, they pursue common goals. These goals include; improving services, local accountability, distribution of resources, winning public support and staff development (Hambleton, 1998).

After experiencing a process of decentralization for close to two decades, Zambia is currently reorienting its health care reform and decentralization policy to resolve cumulated problems and to improve overall quality and efficiency of health care. Just as in any reform, support of key stakeholders within the system will impact significantly on the success of the decentralization process. Cheema and Rondinelli (1983), suggests that decentralization can be implemented most successfully if the reform process is incremental and interactive. For instance in Zambia, where decentralization of health sector has been initiated in a context of strong political and popular support, following the multi party elections in 1991, included specific steps to develop public awareness of need for reform (Gilson and Mills, 1995).

Actors in the reform process are important as these ensure that objectives of reform are achieved. Experience indicates that reforms that conflict with values of actors ends with limited and unpredictable impact (Cassels, 1995; Ovretveit, 1994; Mills et al 2000). This is why it is important to know: who the relevant policy actors are?, what their interest in reform is? And how influential they are? (Gilson and Mills, 1995). Since the actors play an important role in achieving the objectives of decentralization their role can thus not be underestimated. It is therefore necessary that the government have a comprehensive understanding of how actors perceive the decentralization policy and respond to changes in order to prepare an effective strategy for successful implementation of the policy.

Currently, there are no studies on stakeholder analysis and decentralization policy conducted in Zambia. Some studies conducted on decentralization in Zambia, focussed on other issues and not stakeholder analysis that we intend to explore. The objective of these studies and issues of interest are therefore different from ours. Therefore, we conduct this study to examine stakeholder characteristics towards support for devolution policy in the interim. Because of the technical nature and complexity that goes with decentralisation policy; "knowing who the actors are, their knowledge, interests, positions, alliances, and importance related to the policy will allow policy makers and managers to interact more effectively with key stakeholders and increase support for a given policy" (Schmeer Kammi, 1999).

1.3 STUDY OBJECTIVES

The major objective of this proposed research work is to study characteristics of key stakeholders and how these influence support for implementing the devolution policy in the Zambian Health Sector.

The specific objectives were:

- To identify important stakeholders and their influence on devolution policy.
- To identify the level of knowledge among stakeholders pertaining to devolution policy.
- To assess the amount and ability of stakeholders to mobilise resources.

- To identify possible stakeholder alliances.
- To analyse their strategies in the development of the policy reform.
- To recommend strategies for taking forward the decentralisation process.

1.4 ORGANISATION OF THE REMAINING CHAPTERS

Chapter 2 starts by giving a brief description of the socio-economic and demographic background on Zambia. This is followed by analysis of the existing health system as well as the development of the decentralisation policy.

Chapter 3 reviews background literature on policy implementation, stakeholder analysis and the key concepts of decentralisation. This is done to elicit and draw lessons that this research intends to take forward in terms of making recommendations for evaluating support for devolution policy in Zambia. The chapter also looks at the design and methods used in the previous decentralisation policy studies, as well as their limitations.

Chapter 4 focuses on the conceptual framework of the study. In this chapter explanatory variables, which explain the stakeholders' characteristics on policy implementation, are defined.

In chapter 5 the methodology of the study is explained. This chapter describes the study design, the sample size, and sampling techniques and data collection techniques including ethical consideration. The chapter concludes with potential weakness and biases of the research and well as action taken to rectify them.

Chapter 6 presents the study findings. A full description of the results is presented and explained. The chapter also discusses the broader view of findings presented.

Chapter 7 analyses the results presented in the previous chapter. It evaluates the extent to which the study objectives have been realized. Finally, based on the findings of the study, policy recommendations and suggestions for the future research are made.

CHAPTER TWO: INFORMATION ABOUT ZAMBIA

2.0 INTRODUCTION

Chapter 2 provides background information on Zambia, which includes the geography, country's population, brief description of the economy and economic policies. The chapter goes further to discuss Zambia's national decentralisation policy on health service provision. Finally, the chapter 2 concludes with a brief situational analysis of the health sector in Zambia.

2.1 ZAMBIA'S BACKGROUND INFORMATION

2.1.1 Geography

Zambia is a landlocked country, rich in agricultural and mineral resources that are yet to be exploited (World Bank; 2002). Zambia has a medium to high potential for agricultural production, but only 14 percent potential arable land is cultivated. The country is prone to drought, partly due to erratic rainfall and inefficient use of its abundant water resources. The country has some of the largest copper and cobalt deposits in the world. The mining sector lacks viability partly due the aging of the mines infrastructure, exacerbated by decades of under-investment and rising extraction costs (ibid).

Zambia is a sparsely populated country, although over the years its population density has slowly been increasing from 5.4 in 1969 to 13.1 in 2000. There are regional variations in terms of density settlement ranging from 63.5 persons per square kilometre in Lusaka province to 4.6 persons per square kilometre in North-Western Province (CSO; 2003). Copperbelt and Lusaka Province, covering, only 7.1 per cent of the nations land area, accommodated about a third of the population in 2000 while Northern Province with the largest land mass (19.6 percent) had only 12.7 percent of the population (ibid).

The country is one of the most urbanized in Sub-Saharan Africa with an average population proportion higher than the African average (28.8 percent). The proportion that

lived in urban areas in 2000 was 34.7 percent of which 49.7 percent were males and 50.3 percent females (CSO; 2003).

2.1.2 Population

Since 1992, the population growth rate has been falling. Results from the past five national census show that there were 3.5 million people in 1963, 4.1 million in 1969, 5.7 million in 1980 and 7.8 million in 1990. By 2000 the population increased to 9.9 million and was projected to be 10.7 million in 2005 (CSO; 2003).

The level of mortality in Zambia is generally high. For example, Infant Mortality Rate was 95 per 1000 live births in 2000 and life expectancy was 50 years. In 2000, HIV/AIDS prevalence rate of the total population stood at 16 percent. At the time of census, 45 percent of the population was below 15 years of age. Labour force participation among those aged 15 to 64 years was close to 43 percent and subsistence agriculture was the biggest employer followed by informal trading. Formal employment only constituted 13 percent of the total labour force (ibid).

Trends in fertility and mortality have led to a population that is young. In 2000, 46.3 percent of the population was under 15 years of age while 17.1 percent was under 5 years of age. The overall age dependency ratio in 2000 was 96:2 (CSO, 2003).

2.1.3 Economy and Economic Policies

The standard of living and income levels in Zambia have been declining since the late 1970s when the economy started experiencing declining economic growth rates. From 1990 to 1999, Zambia's average annual rate of economic growth was 1 percent. Due to poor performance of the economy, coupled with a high population growth rate, per capita income and economic opportunities declined at levels of society. This increased the incidence of poverty to 73 percent in 1998 (CSO, 2002).

In an effort to redress the trend of falling standards of living, Zambia has so far tried four different economic policy regimes since independence. The first being the free market policies (1960 to 1972). The era of free market policies was a period of fairly liberal,

political and economic policies. During the period, there were no state controls and the focus then, was on provision of infrastructure and services for the entire population.

The second era involved state controlled economic policies between 1973 and 1984. During this period government created a large number of parastatals in the mining, telecommunication, energy, finance and agricultural sector, which together produced 80 percent of Zambian GDP and employed about 140,000 workers (Rakner et al.1979: McCollouch et al.2002). In addition, the government actively pursued import substitution on one hand whilst protecting local products by tariffs on finished goods on the other hand.

The third phase, dubbed third period of economic transition, covered the period 1985 to 1990 and was characterised by introduction of unsustained stabilization and structural adjustment policies. The government abandoned earlier agreements with the IMF/World bank and re-imposed numerous controls after political discontent had resulted in food riots countrywide (ibid).

The current phase, the stabilisation and structural adjustment phase commenced in 1991. To date, government is pursuing policies that facilitate private sector growth and more responsible fiscal and monetary policies. In addition, agricultural output and input markets are now liberalised with significant privatization and other institutional reforms are being undertaken (Francis and Milimo, 1997).

2.2 THE NATIONAL DECENTRALIZATION POLICY IN ZAMBIA

Zambia's efforts to decentralize its structures can be traced as far back as independence. Thus decentralisation efforts can be divided into five phases; Phase 1 (1964-1970), Phase II (1971 – 1979) Phase III (1980-1990) Phase IV (1991 -2000) and Phase V (2000 to date) (Cabinet Office; 2004).

2.2.1 Phase I

In phase I we see that Zambia inherited a dual system of administration at independence. The system comprised the field and local government administration.

Experiences under this phase were that authority was centralized and this led to inefficiency in terms of service delivery. For example, district heads were controlled from the province and district officials were appointed by public service commission (PSC) with assistance of permanent secretaries. At that time institutions such as; like PDCC and DDC had neither authority to make decisions nor capacity to source funds. The financial resources were sourced and allocated by the centre (Cabinet Office, 2004).

2.2.2 Phase II

During phase two, government retained the structures established between 1964 and 1970 with the exception of the national authorities, which were abolished in 1965. In addition, the government created the ward and village development committees. The village became the primary focus for local development with emphasis on self-reliance and this enhanced mutual cooperation. The experiences under this phase were not different from those in the first phase in that inefficiency levels increased and the PDCC and the DDC remained dependent on the province in terms of funding (ibid).

2.2.3 Phase III

In 1980, the Central and Local government administration was brought under party administration (UNIP). Under this arrangement, the ministry of decentralisation was created in the office of the Prime Minister. The experience was that merging United National Independence Party (UNIP) with local government administration enhanced supremacy of UNIP as opposed to facilitating the coordination of the development programmes (Cabinet Office, 2004).

2.2.4 Phase IV

During phase iv, the reintroduction of multiparty politics from one party state saw transformation of the Ministry of Decentralisation to Ministry of Local Government and Housing. Further, in 1995, the government introduced the Provincial and District Development Coordinating Committees (PDCC and DDCC) to coordinate activities at respective levels (MOLGH, 1996).

The experiences under this phase were that centralisation of authority continued to be a bottleneck for effective decision making at lower levels. For instance, the provincial heads of department were controlled from the centre and their budgets determined from there.

From 2000 to date the structures have remained the same. The functions and reporting relationships have not changed except that in addition, District Administrators (DAS) were appointed in 2000. While the District Administrators report directly to the appointing authority- the president, the Town Clerks/ Council Secretaries report to the councils who are their employers (Cabinet Office, 2004).

In addition, the councils remained autonomous, operating independently from field administration at district level. The District Heads of sector ministries continued to report directly to their ministerial headquarters through their provincial heads. These experiences in phase IV are the same as those alluded to under the previous phase (ibid).

Since Zambia is in the process of devolving with the sole aim of giving its citizens the opportunity to exercise control over its local affairs and foster meaningful development, it is desirable that some degree of authority be devolved to provincial, district and sub district levels as well as councils.

2.3 IMPACT OF DECENTRALIZATION ON THE HEALTH SECTOR

As stated earlier in section 1.1.3 the Zambian government initiated the process of decentralisation in 1980s but only managed to launch the national decentralisation document in 2004. The Health Sector however went ahead with decentralisation from 1985 through creation of hospital boards. Although no comprehensive assessment was undertaken, the creation of the hospital boards never seemed to have led to expected improvements in the quality and efficiency of hospital services (Kamwanga et al, 1999).

The macroeconomic situation then, continued to deteriorate and delays in privatisation of the parastatal mining companies led to withholding of donor support during most of 1998. Further, the overall funding for health care was not favourable leading to a decrease in per capita terms. Shortages of drugs and other supplies became

widespread (Kamwanga et al, 1999). Provincial and district hospitals reported delays in receiving their grant, and the amount received was often less than the planned amount (ibid.). Management systems in hospitals remained weak and the actual extent of autonomy exercised by hospital managers was limited. For instance, the much promised delinkage of civil servants to health boards never materialised and this made it difficult for hospital managers to have control over the human resources.

Hospital efforts to increase the prices of their “high cost” services to cost recovery levels were not been approved by the Minister, for fear of political reprisals (Kamwanga et al, 1999). Further, budgeting guidelines from the centre continued to impose limits on the production of the grant that can be spent on specific line items. In sum, Zambia provided a good example of the paradox of how efforts to increase autonomy were accompanied by increased controls from the centre (ibid), meaning that a strong centre was needed in order to decentralise well.

2.4 HEALTH POLICY AND SERVICE PROVISION

In order to improve health service delivery, Ministry of Health introduced radical health reforms in 1992. The challenges included; access to and quality of health services, the need for increased equity in resource allocation, insufficient resource and inefficient utilisation of those resources, increased demands on the management capacity at all levels of the health care system and a huge disease burden compounded by HIV and AIDS (MoH, 2004).

The government response to these challenges was to reform the health sector. This was to be done using reform policies enshrined in the National Health Policies and Strategies of 1992.

The vision of the reform was “to provide Zambians with equity of access to cost effective quality health care as close to the family as possible”. The core strategic intervention of health reforms in Zambia was decentralization of health services through delegation and deconcentration. Health Sector decentralisation was coupled with “democratization” of the sector to ensure that ordinary Zambian citizens had a legitimate “voice” in running the delivery of health services (MoH; 1997).

The objectives of the reforms were:

- To transform the Ministry of Health from a centralized hierarchical command institution to a policymaking and advisory institution.
- To enhance the purchaser provider split. The Central Board of Health was established as an institution separate from Ministry of Health following an Act of Parliament. Its main mandate was to enhance the purchaser provider split as well as commissioning health services.
- To strengthen community participation in Health Service Delivery, through creation of popular participatory structures. In 1994, Health boards and DHMTS were created to manage and provide health services. The boards were technically accountable to CBoH (Sumaili and Milimo, 1996).

Although this strategy helped to put systems in place, indicators for health still remain a major source of concern. The maternal mortality rate remained high at 729 deaths per 100 000 live births, while infant and under-five mortality rate stood at 95 per 1000 live births (ZDHS2001/2002). Nevertheless, there have been some positive trends; for instance, the proportion of supervised deliveries went down to less than 50 percent in 2004 while measles and polio cases have almost been eliminated.

In order to respond to these challenges, in February 2004 the Government made a policy decision to restructure the Ministry of Health and Central Board of Health (CBoH Annual Report, 2005). In order to implement this policy decision, a number of policy actions were undertaken including the following:

- Dissolution of the Central Board of Health,
- Commencement of the amendment of National Health Services Act, and
- Undertaking a total restructuring of the Health Sector.

This was done in order to effectively facilitate the restructuring of the MoH and repeal of the NHTSA (CBOH, 2005).

CHAPTER THREE: LITERATURE REVIEW

3.0 INTRODUCTION

This chapter reviews background literature on policy implementation, stakeholder analysis and the key concepts on decentralisation. This is done to elicit and draw lessons that this research intends to take forward in terms of making recommendations for evaluating support for devolution policy in Zambia. The chapter looks at the design and methods used in the previous decentralisation policy studies, as well as their limitations.

3.1 BACKGROUND TO POLICY

The establishment of relationships is an important aspect of policymaking, and is crucial to successful implementation. Such dynamics are necessary to enhance the structural and procedural changes that may result (Anderson et al, 1975). There are several definitions of policy for instance Dye (1975), defined policy as "all what government choose to do and not to do". Becker (1972) defined policy as "organised social control". Hogwood and Gunn (1984) as the "label of field activity or an expression of general purpose or desired state of affairs". Ignatief (1992), defined policy as a "threat of conviction that keeps a government from being prisoner of events" whereas Walt (1994), defined policy as a collection of sub processes intended to change that part of reality to the will of policy makers.

This study adopts the definition given by Dye (1975) which states "policy is what government choose to do and not to do". This definition is broad, it also means a "conscious" decision by government not to take action, can be considered as policy. It is also important to note that although government does play a key role in policymaking, this role is not exclusive and independent. That is policymaking is not only limited to government officials but also involves other actors at various levels. It is for this reason that the impact of policy is measured not only by attainment of the intended results, but

by effect on other actors (Anderson et al, 1975). Policy is not only objectives and goals; policy includes both actions and intentions (Hogwood and Gunn; 1984 Harrop; 1992).

3.1.1 Policy Process

According to Thomas Birkland (2001), there are four main stages that can be distinguished in the policy process and these are:

- Problem identification and issue recognition, or agenda setting
- Policy formulation, which includes preparation and the approval or determination of policy.
- Policy implementation, which involves the development of policy into programmes and budgeted activities.
- Policy evaluation, which reviews progress, made towards objectives.

3.1.2 Agenda Setting

The Process of prioritising a problem is defined as agenda setting. In general terms an agenda is "a list of issues to which, at a certain point in time or during a certain period, attention is being paid to by an actor or group of actors in the policy field"(Kingdon et al; 1984: Hogwood and Gunn; 1984). Cobb and Elder (1971), observed that the broader the social support of an issue, the greater the chance that the issue will reach the political arena and finally become an issue on the political agenda.

3.1.3 Policy Formulation

The policy preparation process and the policy determination or approval process together establish the policy formulation process. During the policy preparation process, options on a particular course of action which policy intends to address are chosen. These options normally include; choice of instruments that would be used in implementing policy (Kingdon et al; 1984).

According to Corkery J.,A. Land and D. Osborne(1997), Policymaking is an interactive and cyclical process. The initiative for a policy change may come from politicians, for

example, resulting from an election manifesto, from officials in response to new information about changing situations or difficulties in implementing present policies, or from organs of civil society. It may also come from the requirements of international and supranational organisations, such as the Organisation of African Unity (OAU), the Economic Commission for Africa (ECA), and the Southern Africa Development Community (SADC). (Corkery J., A. Land and D. Osborne 1997).

The stakeholders within the policy cycle differ in each stage of policy formulation namely; agenda setting, determination stage, implementation and evaluation stage. For instance to consider the government, as a coordinated, purposive individual is a simplification of matters as government consists of individual policy makers and institutions with different roles and functions and sometimes with competing interests. The role of various actors implies that there is a shared responsibility for policymaking. This responsibility requires an increase in coordination and policy planning, without this coordination and policy planning, it is possible that overlapping activities and conflicting activities are carried out by individual elements of the political system (Grindle and Thomas; 1991).

3.1.4 Policy Implementation

Leighton (1996) suggested that there was value in distinguishing the design of policy and phase of policy implementation. This is due to the fact that the nature of the obstacles to reform differs between the two. Similarly Cooksey and Krieg (1996) isolated institutional weaknesses and information obstacles as key obstacles in design phase. Since these two phases of reform were interlinked rather than distinct, he observed that implementation occurred before design. As a result, the linkage between implementers and designers of policy was critical for a successful policy reform (ibid).

According to Van der Ploeg (1989), the inception point of the implementation process is the approval of the policy. Policy formulation gives birth to publication of an official document and implementation thus finds a point of reference in that policy document. Therefore, successful implementation is not guaranteed by the approval of a policy document. That means to evaluate policy care must be taken to focus on the results of the policy and not the document, which is repeatedly regarded as the result itself (Van der Ploeg, 1989). Hence, approval of a policy does not necessarily mean successful implementation. Instead, government officials responsible for the execution and

implementation of the policy must be committed to the goals and intentions of the policy and have the means to be able to achieve them.

Whitaker (1980) emphasized acknowledgement of a target group (or beneficiaries of intended policy) as actors in the policy field. He said it was important to see members of a target group of a policy as co-producers of the effects and performance achieved by the policy. Policy makers as having their own, unique and independent ways of operating and behaving often neglect citizens and private enterprises. Policy makers are therefore cautioned that if a policy does not relate to these ways of operating and behaviour of target groups implementation may be unsuccessful (ibid).

3.1.5 Policy Evaluation

Evaluation is the assessment and comparison of activities and plans based on their performance, values and interests. There are two types of policy evaluation; ex ante and post evaluation (Anderson et al: 1975). Ex post evaluation takes place subsequent to policy implementation. The ex ante evaluation takes place during the implementation process. Policy evaluation is critical aspect in the process of determining the effectiveness of the policy.

Policy evaluation should consist of: information collection and assessment of learning points. Evaluation should also focus on the process of policy development and the effects of the policy. The evaluation that takes place during the implementation phase can be useful in that it can provide an "early warning" (Van der Ploeg; 1989).

3.1.6 The Actors

During the policy preparation process it may help to have few actors (Glasbergen, 1987). According to Cleaves (1980), consensus is not easily reached when there are many actors and this makes policy formulation costly as well as increasing barriers for implementation. It is important to note that the establishment of a new organisation responsible for policy implementation does not overcome this problem as such organisations need time to establish their standard procedures and routines and

discover a place within the existing network through establishing channels of dialogue (ibid).

The political “willingness” to approve a policy document does not only apply to the institution tasked with the responsibility to implement, but to all the other organisations and institutions involved in the implementation. However, other organisations involved with the implementation might have other interests that contradict the goals of policy and thereby affect implementation. Eventually, this could result in purposive delays in the implementation process as a result of withholding crucial information (Glasbergen, 1987). It is therefore important that the implementation of policy is assigned to an organisation, which supports the objectives of the policy so that it can be given a higher priority on its agenda (Van der Ploeg, 1989).

3.1.7 Number of policy Goals

Multiple goals complicate the implementation of a policy and where there are several objectives, priority should be given (Mazmanian and Sabatier, 1981). Multiple goals are a characteristic of ideological policies as these strive to realise a multitude of goals at the same time (Quick, 1980). For example people of different ideological persuasions may have varying ideas about the proper purpose of policy.

Clarity of goals and objectives is fundamental to the implementation of a policy when moving from the current situation to the near desired state. Lack of clearly stated goals is a key limiting characteristic in the implementation of policies (Quick 1980; Pyle 1980; Sussuman1980). Although of course, some governments would deliberately use this strategy to achieve consensus in the face of potential opposition.

Glasbergen (1987) brings to the fore the issue of communication. According to him, communication between the policy actors determining the policy and the actors responsible for the implementation is important. That is, the frequency of communication and the clarity of the communication are important. In the event that actors responsible for policy implementation confronted with unclear or vague policy objectives they are likely to give their own interpretation of policy, resulting in a different policy being implemented than instead of the one which was initially intended. Of further importance

is thus, the extent of detail or specificity of a policy. A policy needs to reflect clearly what is expected from the implementation actors. Therefore, a certain extent of detail is required. Too much detail, however, will limit the flexibility of the policy and leave little room for adjustment to unforeseen circumstances (ibid).

3.1.8 Time frame of implementation

Cleaves (1980), cautioned that the longer the implementation takes, the greater the possibility of alterations of the goals by existing actors, and the more are the chances for new actors to enter the policy field and this may result in more chances for leadership turn over. The time programmed for the implementation of a policy plays an important role in the success implementation of policy. The initial stages in policy formulation are of crucial importance, since the policy implementation process is fed with the out-put of the preceding processes and therefore, the initial preparation process should be run thoroughly to avoid a snowball effect of failures (Glasbergen, 1987). Policy implementation calls for time, financial and human resources. Monitoring of policy implementation requires financing and should receive a budget allocation. These resource implications of policymaking should fit within existing resource constraints (Hall; 1998).

3.1.9 Assumptions and the targets

Each policy is based on certain assumptions with regard to behaviour of a target group. It is assumed that implementation of certain policy instrument would lead into a change in behaviour in the desired direction by a particular target group. If assumptions are incorrect, often the result is that there is an inconsistency between the means and the objectives of a policy (Glasbergen, 1987). Policy therefore should be based on a valid causal theory (Gulhati, 1990).

3.2 STAKEHOLDER ANALYSIS

3.2.2 Defining Stakeholders

Stakeholders are the people who matter to a system and have rights or interest in the future of a system (Mayers, 2001). That is, a stakeholder is any person, group or institution that has an interest in development activity, project or policy. This includes both intended beneficiaries, intermediaries, winners, losers and those involved or excluded from the decision making process.

There are two broad groups of stakeholders namely;

- **Primary stakeholders:** those who are affected and expect to benefit from the policy.
- **Secondary stakeholders:** those with some intermediary role. These groups may also be direct beneficiaries.

Key stakeholders comprise of both primary and secondary stakeholders. Key stakeholders are those who can significantly influence the policy (Mayers, 2001). That is when looking at who the stakeholders are, it is useful to distinguish between the “target group” and the broader group of stakeholders. The target group are those who are intended to be direct beneficiaries. On the other hand, broader group stakeholders include both the target group and other institutions or organisations that have an interest in the policy (AusAID, 2004).

3.2.1 Purpose of stakeholder analysis

Stakeholder analysis is a process of systematically gathering and analysing qualitative information to determine whose interests should be taken into account when developing or implementing a policy (Schmeer Kammi, 1999). Stakeholder analysis can be used to generate knowledge about the relevant actors, to understand their behaviour, intentions, interrelations, agendas, interests and the influence or resources they could bring to bear on decision or policy making processes. This information can then be used to develop strategies for managing these stakeholders (Brugha and Varvasovszky, 2000). Before conducting a stakeholder analysis there is need to define purpose and identify uses of

the results. This is important because analysis of the most powerful players, who either support or oppose policy, can help to develop strategies for creating change.

3.2.3 Uses of Stakeholder analysis

Stakeholder analyses can be used to:

- Identify and define the characteristics of key stakeholders to increase the likelihood of efforts to influence change being effective
- Draw out the interests of the stakeholders in relation to the problem that devolution is seeking to address (at initiation stage).
- Identify the conflicts of interest among stakeholders, to help manage such relationships during the course of policy design and implementation.
- Help to identify relations between stakeholders that may enable a “coalition” of policy sponsorship, ownership and cooperation.
- Assess the capacity of different stakeholders and groups to participate (Allen et al, 2001)

3.2.4 Key Steps in Conducting Stakeholder Analysis

There are several techniques used in stakeholder analysis and these include:

- Defining purpose and use of study results- This includes understanding the goals and boundaries of the analysis and the scope of issues to be included.
- Determining focus of analysis by identifying opportunities for influencing how decisions are taken in a particular context.
- Identifying the principle stakeholders'- The analysis process must recognise the risk of missing key stakeholders and work to avoid these risks. Using a combination of approaches can reduce the risks associated with any one particular approach.
- Investigating stakeholders' roles, interests, relations to power and capacity to participate. This can be done through useful methodologies such as: brainstorming among key informants, semi-structured interviews, analysing policy documents and through direct observation.
- Identifying the extent of cooperation or conflict, who supports or opposes.
- Interpreting the findings of the analysis and defining how this should be incorporated into policy design (Mayers et al, 2001).

3.2.5 Force-field Analysis

Forcefield analysis is one method that can be used to conduct a stakeholder analysis. According to Kurt Lewin, (Lewin, in Edgar Schein, 2002), Force-field analysis identifies forces that help and those that hinder reaching a desired outcome. It depicts a situation as a balance between two sets of forces; one that tries to change the status quo and the other trying to maintain it.

According to Schein (2002), “ An issue is held in balance by the interaction of two opposing set of forces; those seeking to promote change (driving forces) and those attempting to maintain the status quo (restraining forces)”. In order for any change to occur, the driving forces must exceed the restraining forces, thus shifting the equilibrium. The Force-field diagram is a model built on this idea.

Force field analysis can thus be used to focus attention on ways of reducing the restraining forces and encouraging the positive ones. Further, Force-field analysis encourages agreement and reflection on stakeholders through identification of causes of a problem at hand (ibid). Force-field analysis can also be used to study existing problems or to anticipate and plan more effectively for implementing change. When used in problem analysis, it is helpful in defining subjective issues, such as morale, management effectiveness and environment.

Force field analysis also keeps the researchers grounded in reality when they start to plan as it makes them systematically anticipate what kind of resistance they would meet. Thus conducting a force field analysis can help build consensus by making it easy to discuss stakeholder objections and by examining how to address these concerns.

3.2.6 Key steps in conducting a forcefield analysis

- State the problem in terms of factors working for or against a desired state
- Brainstorm the positive and negative forces
- Review and clarify each force or factor. What works to balance the situation or what is behind each factor.
- Determine strength of hindering forces, whether high, medium or low
- Develop an action plan to address the largest hindering forces.

It is important that no significant forces are left as these may impact negatively on the plan of action (Schein, 1997).

3.2.7 Strengths and weaknesses of stakeholder of analysis

Roy (1997) cautioned that one problem with stakeholder analysis, when carried out in a participatory manner was it often confused the techniques that facilitate stakeholder involvement in formulating policies. That is although stakeholder analysis was part of the "stakeholder approach to policy formulation it was not synonymous with it (ibid)".

According to Mayer (2001), stakeholder analysis can get to the heart of the problem, but on its own is unlikely to provide full solutions. Therefore, it is important that those who conduct these studies ensure that the consequences are not left hanging, but link them to mechanisms that can continue to deal with them. The possible challenges with these studies include:

- Interests and Agendas of those doing the stakeholder analysis need to be explained and transparent.
- Stakeholder analysis finds it difficult to get to grips with the internal dynamics and conflicts within stakeholder groups.
- Stakeholder groups have a tendency to overlap, and even within one group people take on multiple identities.
- Stakeholder analysis alone may identify little common ground. However, where people are at odds with one another, it can result in greater richness of debate and of needed checks and balances.
- Whilst stakeholder analysis can bring to light the interest of marginalised groups, it cannot in itself guarantee them stronger representation. Casual rankings of stakeholders according to power and potential can sometimes lead to misunderstandings and under representations of lesser-ranked groups. Where analysis reveals information about less powerful groups, this can be very dangerous as it might lead to inequitable actions on the part of the more powerful groups in the process (Mayers et al, 2001).

3.3 DECENTRALISATION

Today most countries are increasingly turning towards the practice of decentralisation to assure democratic governance for human development (UNDP, 2002). Decentralisation is a complex process that reaches beyond structural reforms proposed in institutional frameworks. Decentralisation can also address poverty, gender inequality, environmental concerns, the improvement of health care, education and access to technology (ibid). Decentralisation does not only affect government and civil service, but is conditional on the involvement of community organisations, stakeholders in the private sector, international aid organisations and civil servants (World Bank; 2002).

According to Susan (2001), decentralisation can have the following benefits:

- It brings decision making closer to the people and therefore yields programme and services that address local needs better.
- It improves community participation and boosting grassroots development. Decentralisation plays a key role in the sustainability of programmes and improves quality of life.
- It supports open dialogue and participation between local authorities and civil society
- It ensures the accountability of the elected local government officials.
- It empowers and supports women and the under privileged to improve their economic conditions and make progress in alleviating widespread poverty.

3.3.1 Types of Decentralisation

There are three broad types of decentralisation: Political, Administrative and Fiscal decentralisation. There are also four major forms of decentralisation: devolution, delegation, deconcentration, and divestment or privatisation. These are explained below.

3.3.1.1 Political Decentralisation

This refers to situations where political power or authority is transferred to sub national levels of government. These are elected and empowered sub-national levels of government ranging from village councils to state level bodies. Devolution is a form of political decentralisation (UNDP; 2000).

Political decentralisation requires a constitutional, legal and regulatory framework to ensure accountability and transparency. It also necessitates restructuring of institutions and developing linkages with civil society and the private sector. Political decentralisation encourages universal participation and new approaches to community institution and social capital (World Bank, 2000)

3.3.1.2 Administrative Decentralisation

This aims at transferring decision-making, authority, resources and responsibilities for the delivery of select number of public health services from the central government to the other levels of government, agencies and field offices of central government. Administrative decentralisation is often carried out with civil service reform. The two major forms of administrative decentralisation are; deconcentration and delegation (World Bank, 2001).

3.3.1.3 Fiscal Decentralisation

This is the most comprehensive and commonest type of decentralisation. It is directly linked to budgetary practices. Fiscal decentralisation involves resource re-allocation to sub national levels of government. Arrangements for resource allocation are often negotiated between the central and local authorities based on several factors including interregional equity, availability of resources at all levels of government and local fiscal management capacity (World Bank, 2001).

3.3.2 Forms of Decentralisation

3.3.2.1 Devolution

Devolution refers to the full transfer of responsibility, decision-making, resources and revenue generation to a local level public authority that is autonomous and fully independent of the devolving authority. Units that are devolved are usually recognised as independent legal entities and are ideally elected (UNDP, 2000).

3.3.2.2 Deconcentration

Deconcentration refers to the transfer of authority and responsibility from one level of central government to another while maintaining the same hierarchical level of accountability from the local units to the central government, ministry or agency, which has been decentralised. Deconcentration can be seen as a first step by a newly decentralising government to improve service delivery (UNDP, 2000)

3.3.2.3 Delegation

Delegation redistributes authority and is responsibility to local units of governments or agencies that are not always necessarily branches or local offices of the delegating authority. While some transfer of accountability to sub national level units to which power is being delegated takes place, the bulk of accountability is still vertical and to the delegating central unit (UNDP, 1997).

3.3.2.4 Divestment (Privatisation)

The transfer of planning and administration responsibilities from government to voluntary, private or nongovernmental institution with clear benefits to the involvement of the public. Divestment often involves contracting out partial service provision or administration functions, deregulation or full privatisation (UNDP, 1997).

3.4 SUMMARY: POINTS TO TAKE FORWARD FOR THE REST OF THE STUDY

In summary, the following lessons have been learned from the literature review:

- That there are several definitions of policy and these include actions, non-actions and intentions.
- That policy is not only aims objectives and goals, but also includes the way these aims and goals are interpreted and exercised.
- That successful policy implementation is not guaranteed by the approval of the policy document.
- That health policy is about process and power. It is concerned with who influences whom and how that happens
- That policies sometimes do not achieve what was intended because of power and processes. That means understanding power and processes is critical in implementing change in policy and practice because actors have power to bring about change or block it.
- That stakeholder analysis finds it difficult to get to grips with internal dynamics and conflict within stakeholder groups
- In addition, that stakeholder groups have a tendency to overlap, and even within one group people take on multiple identities.

Before conducting a stakeholder analysis there is need to define purpose and identify uses of the results. This is important because analysis of the most powerful players, who either support or oppose policy, can help to develop strategies for creating change.

CHAPTER FOUR: CONCEPTUAL FRAMEWORK

4.0 INTRODUCTION

The purpose of this chapter is to outline the analytical framework, which will be used in identifying the key stakeholders' characteristics that influence support for a successful implementation of the devolution policy. This is given together with hypothesized causal relationships. In this chapter, the assumptions made are outlined and discussed in section 4.1. This is followed by definition of variables and their hypothesized causal relationship in section 4.2.

4.1 CONCEPTUAL FRAMEWORK

A conceptual framework provides a distinctive frame of reference for its adherents, telling them what to look at and speculate about. Most importantly, a conceptual model determines how the world is viewed and what aspects of that world are to be taken into account (Redman, 1974; Chanter, 1975). Conceptual Models thus have the "basic purpose of focussing, ruling some things in as relevant, and ruling others out due to their lesser importance" (ibid).

According to Walt and Gilson (1994) an analytical framework about policy should highlight the central role of various actors in the policy process (in this case formulation and implementation of devolution policy) and in influencing the content of policy. Actors are influenced by relevant historical, economic, political and social cultural trends i.e. content within which policy is developed and implemented (Brijlal et al, 1998). When trying to isolate effective strategies for decentralisation it is useful to consider all the elements of policy development and implementation (ibid).

This conceptual framework explores characteristics of stakeholders that influence support for implementation of the devolution policy upon the broader health care system and how this can be measured. The hypothesis advanced is that the variables; power,

knowledge, interest, alliances, resources, influence and support have either a positive or negative relationship with the response variable (support for devolution policy).

This research focused on identifying effects of stakeholder characteristics on devolution policy in Zambia and strategies that could be used to support policy implementation. The study focused on the thematic areas dealing with the characteristics of actors such as interest, power, alliances, support, knowledge, resources, participation and influence. These attributes were studied as they were key in shaping and identifying stakeholders who had competing sets of interests and those with differing sets of capacities to perform specific tasks (Brijlal, et al, 1998).

4.2 DEFINITION OF EXPLANATORY VARIABLES

The Force-field diagram was used to visualize the forces that work in favour and against change initiatives. The diagram helped to see the “tug of war” between forces around given issues (Kurtin Lewin, in Edgar Schein, 2002).

In this study the following are the explanatory variables and definitions of stakeholder characteristics were used:

- 1) **Interest** – refers to the support or opposition of policy by a stakeholder in relation to the perceived advantages and disadvantages of a policy, which is to do with whether a stakeholder support or opposes a policy and why.
- 2) **Influence**- was defined as a stakeholder’s relative power over policy. Stakeholders with high influence have ability to control key decisions related to policy and are able to facilitate its implementation by inspiring others to take action.
- 3) **Importance** – importance of stakeholder is the ability of stakeholders to affect implementation of the policy. Power and leadership are the characteristics that determine a stakeholders ability to affect or block implementation of a policy.
- 4) **Knowledge**- level of understanding and ability to define terms pertaining to policy under analysis.
- 5) **Alliances**- Union or relationship with other organisations in meeting the objectives.

- 6) **Resources**- the source of support or ability to raise aid such as financial, technological, human, political or other.
- 7) **Power**- The extent to which stakeholders were able to persuade or coerce others into making decisions. The capacity or ability to accomplish something
- 8) **Stakeholder participation**- The extent to which the stakeholders with rights, responsibilities and interest play an important role in policy making and consequent realisation of policy goals.

The study was analysed to a lesser degree the **policy content** and **policy context**. Analysis of devolution policy in Zambia was done based on an assumption that the design of the devolution policy had a clear set of guiding principles which included the purpose, rationale and objectives of decentralisation within the context of Zambia. Further, it was anticipated that the following design issues would be addressed; levels to which functions were going to be devolved, the balance of power between various levels, provision of guidelines on responsibilities and accountability and that careful planning to support all aspects of decentralisation including financial resources were made available (Kohlemainen, Aitken and Newbrander, 1997).

4.3 ASSUMPTIONS

The first assumption behind our conceptual framework was that the process and the environment in which the new devolution policy was developed and implemented shaped the design of devolution policy. The two factors; context (process) and content (environment) were in turn expected to shape and set direction of the impact of devolution policy.

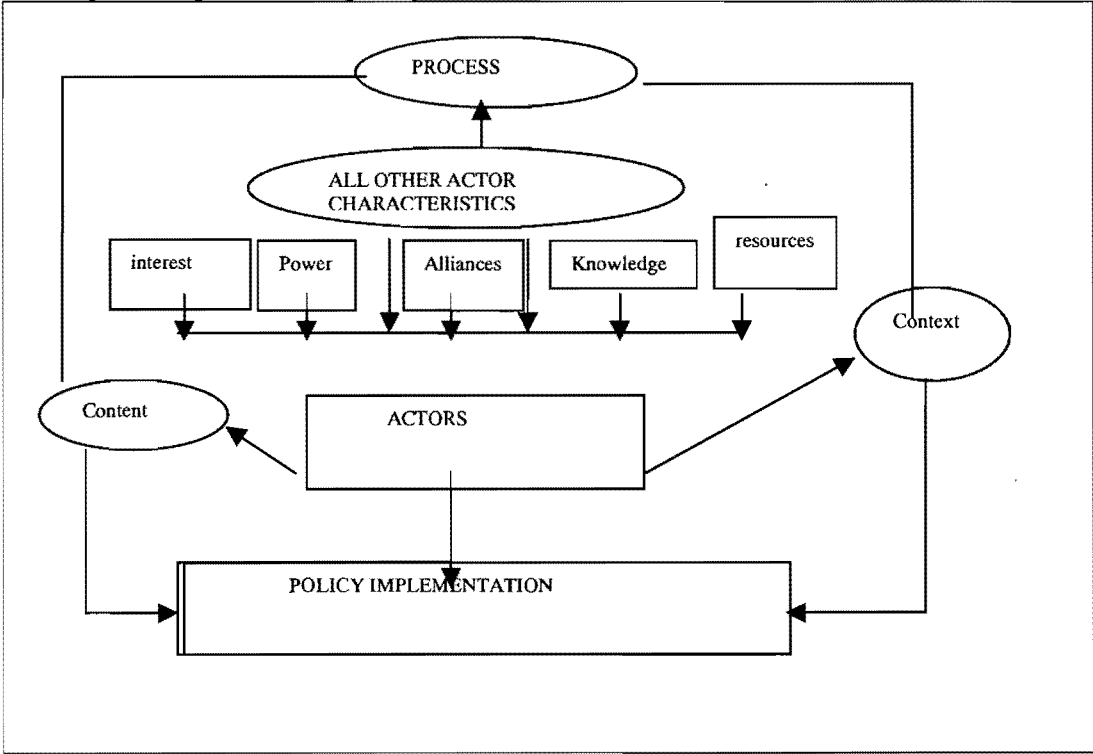
Analysing stakeholder characteristics on devolution policy would elicit bottlenecks that may hinder a successful implementation of this policy. Information on the values and objectives of key players was used to predict whether they would support or block the implementation of reforms; and develop strategies to promote supportive actions and decrease opposing action before attempting to implement major reform at all levels.

The second assumption behind our conceptual framework was that, analysis of stakeholder characteristics on this policy would help elicit the gap between the current

deconcentration policy within Ministry of Health and the newly launched devolution policy. The national and local environment where the devolution policy was developed and implemented was examined. This helped to explore how contextual factors shaped policy design and consequently the impact on distribution of health services.

The third assumption was that, risks are manifest when there are conflicting needs and expectations. For instance when interests of stakeholders with high influence are not in line with policy objectives and they can block its positive progression. Figure 2 below highlights some of the key stakeholder characteristics and their influence on policy.

Figure 2: Diagram illustrating Policy Environment



CHAPTER FIVE: METHODOLOGY

5.0 INTRODUCTION

This chapter discusses the methodology that was used in the study. It explains the study design, study site, the sampling framework and sampling techniques used in collecting the data and data analysis. The chapter further explores the reliability and validity of the study and its ethical implications. In conclusion, the chapter attempts to identify potential weakness and biases of research and measures that were taken to correct these biases.

5.1 METHODOLOGY

5.1.1 Study Design

A descriptive research design was adopted. This design was chosen because, "it gave an accurate account of the characteristics, feelings, views and perceptions of the persons interviewed" (Bless and Achola, 1990). The phenomenon of devolution has received minimal empirical examination in Zambia and, as such required descriptive exploration. As stated earlier, this research study was undertaken on key stakeholders that have an interest in the devolution policy of the Ministry of Health. A total of 12 one to one in-depth interviews were conducted over a span of 2 months and each interview lasted 30 to 40 minutes. These interviews were conducted during working hours in offices of the respondents. Interview appointments were made 3 to 4 days prior to the actual interview as the target group comprised of busy persons.

During each interview, the researcher sought consent from respondents and ensured that consent forms were signed. He further explained to each respondent that the tape recorder was only meant to capture ideas that emerged from the discussion. He emphasized to all respondents that they were not going to be identified by name.

Participants were also assured that written reports and tapes would not include names and that they would not be shared outside the research. Participants were made to understand that there were no wrong or right answers and that any opinion was welcome.

Qualitative research techniques were used to enable the researcher to appreciate views, norms, beliefs, and the participants' attitudes and record them accurately. Qualitative research design was found more appropriate for the study than quantitative research design in that it enabled the researcher to observe, discover, describe, compare and analyze the characteristic attributes, themes and underlying dimensions of particular units (Seaman, 1987). Since qualitative data collection methods are flexible and usually unstructured, it was hoped they would capture verbatim reports or observable characteristics and yield data that usually do not yield numerical form (Brenner, Brown and Canter 1985). Thus a qualitative research design enabled the study to gain insight into the stakeholder's own perceptions towards decentralization and policy process (Hastings, 1990). In addition it was envisaged that a descriptive qualitative research design would fundamentally enable the researcher to view events, actions, norms, values and characteristics from the perspective of people being interviewed (Bryman, 1988).

5.1.2 Study Site

This study was conducted in Lusaka the Capital City of Zambia where most stakeholders dealing with various ministerial policies are found, including multilateral and bilateral cooperating partners.

5.1.3 Sampling

Theoretical sampling was employed to identify key informants from Multilateral and Bilateral cooperating partners, Decentralisation Secretariat, Directorate of Health Policy, Ministry of Health, Local Government Association of Zambia, Provincial Health Offices, District Health Management Teams, Directorate of Planning, Hospitals and Training

Institutions, Statutory Boards, Medical Personnel and Medical Doctors Association of Zambia.

The researcher had also planned to interview officials from Ministry of Finance and National Planning (MoFNP), Cabinet Office, Local Government and at least 3 Donor Agencies. Unfortunately, it was not possible to interview such officials as they all referred the researcher to the new Decentralisation Secretariat, which was mandated to oversee the national decentralization policy implementation. Further, out of the 3 sampled donor agencies, only one was willing to be interviewed.

Using the snowballing techniques most other possible respondents were identified for possible interviews. Appointments were made but the respondents always appeared not willing to be interviewed or rescheduled appointments, which were later, not honoured. Despite reassurances, some stakeholders were not willing to discuss anything related to government policy issues.

Of the total number interviewed, only one respondent declined to be tape-recorded whilst the rest accepted. All the respondents signed the consent forms willingly. The fact that MoFNP, Cabinet Office and LG dropped out and referred the researcher to the decentralisation secretariat had an adverse effect in that, as the researcher stated earlier on, it was a purposive sample and stakeholders were selected according to their characteristics. This also posed a problem on the validity of the sampling method. However certain individuals that were sampled were interviewed and used as proxy to these institutions.

5.1.4 Study Population

The researcher conducted twelve one to one in-depth interviews in various stakeholder institutions based in Lusaka. The interviews were conducted with the Heads of departments or, where possible, Directors of organisations.

The respondents were drawn from the Decentralisation Secretariat, Ministry of Health (Directorate of Planning, Directorate of Health Policy, and Directorate of Human Resources), District Health Management Team, Statutory Boards, Hospitals and

Training Institutions, Medical staff, Medical Doctors Association of Zambia, Donors, Provincial Health office and Local Government Association of Zambia. These were into four categories: (1) International Agencies, (2) Public entities within Ministry of Health (3) Public Entities other than Ministry of Health and (4) the Labour Sector.

International Agencies were chosen in these provide external support on both economic and political terms. International Agencies have also been very influential in determining the direction of the reform.

Second, Public entities within Ministry of health were included in that these will be responsible for planning and implementing devolution policy. Equally the provincial and local levels of the Ministry of Health will be responsible for implementing the devolution policy.

Third, public entities other than Ministry of Health such as Ministry of Finance and National Planning and Cabinet office were included as these control allocation of resources. Their support for new policy is imperative to implement change. Further under this category we have institutions such as the Local Government Association of Zambia, which promotes the interests and autonomy of Local Government authority, and the Decentralisation Secretariat, which is an institution, mandated to carry out and monitor the implementation of National Decentralisation Policy.

Finally, the labour sector which includes professional Associations and Medical personnel is very powerful in that labour groups can work together against policy that they consider to be threatening their interests.

5.1.5 Access

The researcher being a Health Planner/ Economist, working for the Ministry of Health had no difficult in arranging for these one to one interviews partly due to the fact that these institutions liaise with Ministry of health from time to time. All the 12 interviews were conducted between November 2004 and January 2005. Data collection process was characterized by booking and cancellation of appointment as most stakeholders had tight schedules. Most interviews were conducted in offices of respondents and these were quiet ideal despite occasional telephone calls.

5.1.6 Data Collection Techniques

Since the data that was collected varied by objectives and in order to achieve the goals of the research, two data collection techniques were employed namely; interviews and review of available documentation.

In-depth, semi structured approaches were employed to interview key stakeholders. That is, since there was a possibility of interviews to affect individual freedom, of key stakeholders and the fact that some of these people were very busy and that their individual freedom could have been affected through giving views related to policy. Since it was expected that the stakeholders would differ in terms of interest, and their perception to policy and power in their respective organizations, face-to-face interviews were found most suitable.

Primary and secondary data collection was done. At the same time, published and unpublished reports from previous studies relevant to our study were consulted.

5.1.7 Data collection instrument

Each interview was guided by a list of questions derived from the Stakeholder Analysis Interview Protocol recommended by Schmeer (1999). This included an introductory section that was read by the researcher to stakeholders. The introductory notes in the questionnaire stated; the objective of the interview, identity of researcher and explained purpose of information. Stakeholders were assured that all responses would remain anonymous.

Further, during the interview the definition of policy under analysis and any other terms that were ambiguous or unknown to stakeholders were explained. However, definitions and clarifications were only provided after exploring and establishing the stakeholders' level of understanding and knowledge of policy in question.

The researcher solely conducted this study and no research assistants were engaged. During interviews, note taking and tape recording was done. Consent to take notes or record the interview, was obtained at each session from the respondents.

5.1.8 Pilot Study

In line with Polit and Hunglers (1989), assertion that a “pilot study provides information, which enable the researcher to improve the study or assess its feasibility and that it is useful in refining the wording, ordering and layout of questions, even cutting down the length of the interview schedule, a pilot study was conducted.

Permission to conduct a pilot study was sought from the Ethics Committee of the University of Cape Town (UCT), prior to the research being carried out. Permission was granted for the study to be undertaken, after a full review of the research protocol. Pilot study was conducted on a few MPH students at UCT. They were both male and female. The sample was purposively selected prior to each interview and respondents were talked to on issues of confidentiality and the purpose of the study (see respondents’ information sheet). Although this is not been the ideal pilot sample (i.e not constituting policy stakeholders), students were used to find out whether the questions in the interview schedule were clear and not difficult to understand.

5.1.9 Findings of the Pilot Study

The results of the pilot study illustrated the need to modify the interview schedule for the main study. Modifications to the interview schedule for the main study were largely made under the guidance of the supervisor.

An initial interview schedule for conducting stakeholder analysis interview was adapted from Kammi Schmeer. The interview schedule consisted of closed and open-ended questions. The researcher conducted the one to one interviews to test this interview schedule, after which the schedule was further modified in response to the pilot study. In this study, it was found necessary to remove most of the closed ended questions and remain with open-ended questions after a few adjustments (See Appendices ii and iv). This involved refocusing the question to this study and modifying some closed ended

question to open ended questions. This produced an interview schedule comprising of 20 open ended questions from the original 24 closed and open ended questions.

5.1.10 Data Analysis

The purpose of data analysis was to ascribe meaning to the information that was collected. This was done through grounded theory, which is the discovery of theory from qualitative research data (Strauss and Corbin, 1990). By employing grounded theory, inductive and deductive methods were used.

Further, data were transcribed and analyzed by coding into emerging themes. Identification of themes helped to isolate issues that were frequent and observed to happen in a specific way (Bless and Achola, 1990). Data analysis began after each interview was conducted. After interviews the researcher set aside time to examine the information collected. This helped to classify data according to objectives as well as identifying information that needed verification or discussion in details. The emerging themes formed the basis for data categorization and analysis.

To examine overall stakeholder characteristics towards deconcentration policy, descriptive data was analyzed for each of the research questions describing the interest, level of knowledge, influence, importance, alliances, resources, power and stakeholder participation in support for or against policy and the impact this had on devolution policy. This was done by initially translating the interview responses into a stakeholder's table using information gathered from document reviews and one-tone interview transcription sheets. The exact responses as written in the transcriptions were later analysed.

Further more data was analyzed using a qualitative software NUDIST to come up with a coding tree. A theory building program NUDIST was used. The Reseacher had to store and organise files. This involved converting the files from word to a NUDIST program. The document files contained the information from the interview transcripts, and then the researcher went on to search for themes, by creating categories called family roles. Selected texts of transcripts with similar words were merged into family role nodes. Later, the researcher retrieved information from these nodes to explore the different ways in which stakeholders talked about devolution policy. The next step was to cross

themes by relating one node to another node. Later, developing categories that display their interconnectedness did diagramming. Thus a hierarchical tree of categories based on a "root" node at the top of a parent tree and siblings in the tree was developed to depict the major categories, minor categories and how the information from the text is grouped. The themes that emerged included stakeholder characteristics and their positions in support of devolution policy. Thus the analysis helped to describe stakeholder influence in the process of supporting devolution policy. Thus NUDIST was found useful in the analysis, reporting and writing of the report by locating useful words and phrases of dialogue.

Further, the following documents were used for documentary analysis:

- Central Board of Health Annual Reports
- Ministry of Health Annual Reports
- Central Board of Health District Planning Guides
- Comprehensive Review of the Zambia Health Reforms
- Independent Review of Health reform Technical Reports, vol 1, 2 and 3.
- National Health Services Act
- Zambia National Decentralization Policy Document
- And other related government documentation.

These documents were used to gather information on key stakeholders, this included information on the stakeholders regarding their position on policy, their organisational objectives, position with specific reference to their control over resources and the actual type of resources stakeholders had. This information was used together with the interview information to fill in table 6.1.2.

5.1.11 Validity and Reliability

In exploring validity and reliability of this study, several definitions were used, for example, terms used by Patton (1990) and Pretty (1993), like trustworthiness and credibility were used to address the concept of validity in this study. This study further embraced qualitative research definition on reliability and validity to mean openness, and willingness to listen and to "give a voice" to respondents, Thus the researcher had to listen to what others had to say, see what they were doing and represent these

observations as accurately as possible. The researcher acknowledges that being a member of the policy community may influence the response of interviewees. The study was also mindful of the limitations on the part of the researcher to bring understandings that were based on the values, culture, training, and experiences which were more likely to be different from those of their respondents (Bresler 1995, Cheek, 1996 in Strauss and Corbin, 1998).

In this study, reliability and validity also meant the ability to achieve a certain degree of distance from the research material and to represent them fairly; thus the ability to listen to the words of the respondents and give them a voice independent of that of the researcher (Strauss and Corbin, 1998).

5.1.12 Ethical Consideration

Ethics attempts to distinguish between what is right and what is wrong in order to give people guidance on how to behave (Katzenellenbogen, Joubert and Abdool; 2002). The Nuremberg code of 1947, and subsequently the declaration of Helsinki adopted by the World Medical Association in 1964, made voluntary informed consent a central requirement of ethically conducted research (ibid).

In conformity with the provisions of the Helsinki declaration, permission to conduct this study was sought from; The Ministry of Health in Zambia and the respondents. The research study was explained to all respondents before their participation. Issues that had to be clarified included the following:

- (1) The purpose of the study.
- (2) That participation was on voluntary basis (informed consent).
- (3) Information about the use of the tape recorder and duration of each interview.
- (4) Anonymity and confidentiality, which was assured through transcription of tapes under code numbers instead of names of interviewees.

In addition, the following ethical issues were considered:

1) The subjects were notified of their right to refuse or withdraw from at any time and they were allowed to ask questions

2) The researcher committed him to act upon findings through the distribution and discussion of results with relevant stakeholders. Section 5.1.15; And

3) Potential emotional risks to participants were eliminated through development of appropriate implementation measures. It was hoped that at the end of the study participants themselves would benefit through improved understanding of other stakeholders.

5.1.13 Stakeholders

The Stakeholders in this study were;

- Directorate of Human Resource and Administration,
- Decentralisation Secretariat,
- Directorate of Health Policy,
- Local Government Association of Zambia
- Directorate of Health Planning
- District Health Management Team
- Hospitals and Training Institutions,
- Statutory Boards,
- Medical Personnel,
- Medical Doctors Association of Zambia,
- Donors
- Provincial Health Offices

5.1.14 Dissemination of Findings

It is hoped that the results of this study will be passed on to all stakeholders. A formal report will be given to; Ministry of Health Zambia and other stakeholders involved with implementing support for health sector devolution policy in Zambia. The report will

outline the design, results and recommendations of the study. Recommendations will be practical and specific in order to facilitate implementation.

Particular care will be taken to ensure that the respondents involved in the study are given appropriate feedback. This will be done through information sheets and PowerPoint presentation at one of the in-house meetings such as the Monitoring and Implementation committee meeting.

Attempts will also be made to publish the study in a peer review Journal.

5.2 POTENTIAL WEAKNESSES AND BIASES OF THE RESEARCH

Every research is constrained by varying factors ranging from logistical to financial constraints. These constraints tend to inhibit the gathering of research data (Kuye, 1989). In light of the above, this study was not exceptional; it might have encountered the following limitations:

i) **Cross-cutting problems:** Since Stakeholder analysis is a cross-sectional or “snapshot” study and reflects experience only at one point in time (Gilson and Thomas, 2001) this study could have ignored the long-term dynamics of change and potential for learning effects to change the pattern of impact between two points in time. It is possible this stakeholder analysis have encountered a limited ability to look within.

ii) **Data incompleteness:** There is a possibility that some of the data used, both secondary and tertiary might have been incomplete and inaccurate. This is likely to have been compounded by reluctance on the part of some senior government officials to divulge information.

iii) **Tendency to overlap:** As is always the case stakeholder groups tend to overlap, and people tend to take on multiple identities, this might have given another weakness to the study in terms of judgement and interpretation.

5.2.1 Study Limitations

Potential biases and limitations that need to be considered in the study included the following;

- i) The sampling of stakeholders as earlier mentioned was theoretical and here accessibility to the key stakeholders was one of the factors that were considered in this choice, as most of the respondents were busy people. In the choice of key stakeholders however, all-important stakeholders on devolution policy were included in order to try and make the sample as representative as possible. More so, given the research question this may not be an important bias as the aim of the study was to determine the influence stakeholders would have in terms of supporting devolution policy.
- ii) Tape recording was done at these stakeholders workplace; this could have introduced some bias, as some actors may have felt uncomfortable to discuss some of these sensitive issues particularly about the new devolution policy. As a result of this, some information may have been missed.
- iii) Given the sensitivity of issues being investigated, the possibility of the respondent being reluctant to discuss and provide accurate information was high. Thus building rapport and confidentiality prior to the interview was therefore critical although this may not have been sufficient to ensure that respondents give accurate information.
- iv) Researcher alone collected data, therefore biases that could arise from the researcher and his position in the policy community cannot be ruled out.

5.2.1 Measures taken to correct biases

Despite these foreseen constraints and limitations, the researcher however, did not find them a hindrance to the production of a quality stakeholder analytical study in evaluating support for health sector devolution policy. The research made full use of authentic primary, secondary and tertiary data to complete the study. This was aided by

snowballing techniques that helped identify proxy respondents in case of one to one interviews.

CHAPTER SIX: RESULTS

6.0 INTRODUCTION

This chapter presents the findings of the study in terms of stakeholders' characteristics and their views concerning the devolution policy. Each characteristic is discussed with respect to the questions that were formulated to address the objectives of the study (see Chapter 4). The results indicate the overall level of support and opposition for the devolution policy from key actors and help to identify strategies for policy development.

6.1 RESULTS

6.1.1 Level of Knowledge

Questions 1, 2 and 3 were asked to assess how accurately stakeholders understood the policy and whether respondents were able to define the policy correctly. Exploring stakeholders' level of knowledge is important in that it helps identify stakeholders who support or oppose the policy on the basis of misunderstanding.

The study revealed that most respondents understood the general concept of decentralization very well, although some actors had difficulties in distinguishing the four different modes of decentralisation (noted in Chapter 1). Most of them were aware of developments in the health sector and followed closely the debates of the recently launched national decentralisation policy, which advocated for the devolution mode as opposed to the Ministry of Health's deconcentration and delegation modes of decentralisation.

Fig 6.1.1 below presents a profile of the understanding of different actors. Responses to questions 1, 2 and 3 were rated from low to high. Since questions 1 and 2 were very basic, question 3 carried much weight and thus was used for the purposes of ranking. That is stakeholders responses to question 3 in particular were ranked as follows; (1) High if answer was correct (2) Medium if answer was partly correct and (3) Low was

answer is wrong. This information was important in that it would help us later on to inform subsequent communication strategy for specific groups of stakeholders, especially if those opposed to the policy have a consistently low level of knowledge or vice versa.

Figure 6.1.1: Stakeholder’s Level of Knowledge of Devolution Policy

Actor	Knowledge Level
Decentralisation Secretariat	H
Directorate of health Policy	M
Directorate of human resource	M
LGAZ	H
Directorate of Planning	M
DHMT	M
Hospitals and TI	L
Statutory Boards	L
Medical Personnel	L
MDAZ	M
Donors	M
PHO	M

*(H) High (M) Medium (L) Low

In Figure 6.1.1 above, we see that only respondents from the Decentralisation Secretariat and the Local Government Association Zambia had high levels of knowledge of the devolution policy. By contrast, those from Hospitals and Training Institutions, Statutory Boards and Medical Staff demonstrated lower levels of knowledge of devolution policy.

The study illustrated that a number of stakeholders had different definitions of devolution policy. Most respondents felt sufficiently strong to offer independent definitions on what they thought was meant by the devolution policy for the health sector. The following examples provide some illustration:

- *“Well this means that instead of health services being concentrated along the line of rail, they are now taken up to rural areas. That is from central hospital to general hospital and thereafter district hospital. So what I understand by devolution, away from the line of rail to rural areas”* **Provincial Health Office.**
- *“The basic idea is to delegate powers from the ministry to peripheral DHMTS. That is to have powers to hire and fire”* **Directorate of Human Resource**

- *“Decentralisation or devolution? Mmmh, what I understand by that? It’s a form of restructuring where services will be taken to the districts”* **Medical Staff**
- *“It is reallocation of duties in order to meet community needs. We are not supposed to concentrate much on central level”* **Statutory Board**

The above quotes mostly capture some elements of decentralisation but all tend to miss the political element that devolution implies and the structural shift of power to local government.

It is possible that many stakeholders who failed to define devolution policy are not yet fully aware of the difference between deconcentration and devolution policy, which is being advocated for in the newly launched decentralisation policy document. It is most likely that the existing awareness and dissemination campaigns of devolution policy have not adequately communicated the policy to key stakeholders. Yet poor understanding of the policy by an influential Directorate such as Human Resources may be important (See fig 6.1.1) The Directorate of Human Resources was rated as having medium level of Knowledge, that is they had a general idea of what decentralisation was, but were not able to define to an acceptable level what devolution policy was. Even when responding to other questions that followed it was evident that they did not really know the key tenets of devolution policy and how it works. As a consequence of misunderstanding, it may happen that in carrying out the duties they might make uninformed decisions, which do not conform to the objectives and strategies for decentralisation.

6.1.2 Relation of Stakeholders to Interests, Importance and Influence on Policy

Fig 6.1.2 below summarises the findings from both one to one personal interviews and document review on interests, influence and the importance of policy to stakeholders and their potential to effectively participate in its implementation.

Importance of stakeholder is the ability of stakeholders to affect the implementation of the policy (Schmeer, 1999). Power and leadership are the characteristics that determine

a stakeholder's ability to affect or block the implementation of a policy. These two characteristics are the basis of the "importance" analysis.

Interest refers to the support or opposition of policy by a stakeholder in relation to the perceived *advantages and disadvantages* of a policy, which is to do with whether a stakeholder support or opposes a policy and why. Determining the stakeholder's vested interests in policy will help policy makers to better understand the stakeholder's position and possible ways to address his or her concerns.

Influence refers to stakeholders' *relative power over policy*. Stakeholders with high influence have ability to control key decisions related to policy and are able to facilitate its implementation by inspiring others to take action. Influence will be judged on the basis of power and leadership, as these are characteristics that determine a stakeholder's ability to affect or block the implementation of policy. These two characteristics are further used in the importance – influence analysis.

Figure 6.1.2: Relation of Stakeholders to Interest, Importance and Influence on Policy

STAKEHOLDERS	IMPORTANCE OF STAKEHOLDERS TO POLICY	INTERESTS	INFLUENCE ON POLICY
A.PRIMARY			
Decentralisation Secretariat	An institution mandated to carry out and monitor the implementation of National Decentralisation policy. It will have to ensure that Local government transformation and implementation of devolution policy is completed.	DS anticipates that policy will help secure active participation by local people as well as achieve quality leadership.	Will have influence on all aspects of policy; provide overall leadership and political support.
Directorate of Health policy(MoH)	DHP will ensure that new devolution policy result in improved health service delivery. As part of the central level of the ministry of health it will also be involved implementing the devolution policy.	Directorate of health policy is scared that implementation of this policy might create room for LG to misallocate funds targeted for health to non health programmes.	Will have influence on policy and provide overall leadership. Has a key role to play in terms of formulating policies and acts governing the health sector. Also responsible for development of guidelines and systems.
Directorate of Human Resource(MoH)	DHR will clarify extent to which devolution policy will affect human resource in the health sector. As part of the central level of the ministry of health, it is responsible for planning human resources for health.	Concerned with the difficulties involved in handling medical staff during the transfer to local authorities.	Will provide technical know how and labour.
Local government association of Zambia	Will clarify the direction and pace at which devolution policy is implemented	Interested in seeing improved responsiveness of government through	Will provide input into all systems and guidelines developed.

Directorate of Planning(MoH)	Expected to strengthen the sustainability of devolution policy. As part of the central ministry of health is responsible for planning and implementing policy.	devolution policy. Scared that implementation of devolution policy may result into creation of parallel structures and that given the poor economy, this might cause a threat on health care delivery.	Will provide input into policy coordination and implementation as well as mobilise resources.
District Health Management Team	DHMTS will ensure proposed PHC structures are appropriate in terms of equity objectives and minimise aspects which could hinder implementation. Local levels are responsible for planning and implementing the policy being analysed.	Devolution policy would require DHMT to support the current low capacity in LG so that this does not hamper health service delivery.	Will support provided and coordination for implementation.

B. SECONDARY			
Hospitals & Training Institution	Hospitals and Training Institutions will support district Health systems in terms of consultation referral and provision of human resource.	The policy will require Hospitals and Training Institutions to help arrest human resource problem through training of medical personnel.	Will cooperate and by providing support to policy executing organisations where necessary.
Statutory Boards	Statutory Boards will evaluate changes in utilisation prompted by the policy.	Their role is to ensure that managers and other elected officials do not take advantage of devolution policy through employment of non core staff.	Will cooperate through regulating services being provided.
Medical personnel	Will require to evaluate the conduciveness of the new environment in which they will be required to work.	Policy creates anxieties on what will become of them and their terminal benefits.	Will be responsible for policy implementation. Successful policy implementation depends on their performance.
Medical Association	Protection of interests of members. Since labour sector is very powerful, labour group can work against policy they consider to be threatening their interest.	The policy might play down the morale of health workers as well as induce unrest.	Will lobby for better conditions of service for medical personnel.
Donors	Might be required to collaborate in implementation process through provision of resources.	Introduction of devolution policy will stimulate them to watch for accountability and transparency in devolution policy implementation process.	Will provide inputs in the implementation phase
Provincial Health Offices	The Provincial Health Offices are responsible for planning and implementing the policy being analysed. Therefore, they may need to clarify how hospitals should be linked to implementation of devolution policy	Policy seizes some of their powers over district health boards.	Will be involved in policy implementation.

Source: Own analysis of various documentation on Zambian Health Reforms and information gathered from one to one interviews.

Figure 6.1.2 is a summary of review of secondary information that was gathered on twelve stakeholders. The source of this information included written and spoken statements regarding the stakeholders' position on devolution policy and the goals or objectives of the organisation, which the stakeholder represents. In drawing figure 6.1.2 special attention was made to : the position of the stakeholder within the organisation with specific reference to control over resources and the quantity or type of resources the stakeholders or organisations have. As stated earlier on, this secondary information was used in conjunction with interview information to fill in figure 6.1.2.

In Figure 6.1.2 above, stakeholders' are grouped into two categories namely: Primary Stakeholders and Secondary Stakeholders. The Primary Stakeholders are those who are affected and expected to benefit from the policy, whereas Secondary Stakeholders are those with some intermediary role. The table further itemises the key interests, the importance of stakeholders to devolution policy and their influence in the devolution policy cycle.

Analysis of figure 6.1.2 focuses on comparing information and developing conclusions about the stakeholders' relative importance to policy, interest and influence regarding devolution policy. Key findings of figure 6.1.2 follow in section 6.1.3 and 6.1.5.

6.1.3 Influences and Importance

Determining stakeholders' influence and importance of policy to them was established through: information directly reported by each stakeholder in the interviews, indirect information gathered from other stakeholders, secondary information (i.e. others perceptions) and interest information.

Figure 6.1.3 below is an analysis drawn from figure 6.1.2 above. Thus, figure 6.1.3 presents a summary of the importance influence analysis among key stakeholders. Attributes of influence and importance were further used to rank stakeholder institutions and organisations. On developing figure 6.1.3 emphasis is put on understanding the relationship between the importance of stakeholders to devolution policy and the influence stakeholders have over devolution policy for the health sector. That is to come up with fig 6.1.3, we looked at issues relating to importance and issues pertaining to

interest in figure 6.1.2(i.e column 2 &3 of fig 6.1.2) to come up with a final summary of importance (vertical axis) in figure 6.1.3 and we also looked at issues related to influence and interest in figure 6.1.2 (i.e column 2 &3 of fig 6.1.2) to come up with a final summary of influence(horizontal axis) in figure 6.1.3.

Figure 6.1.3: Ranking of Stakeholders' according to relative influence and importance to Policy

High importance													DS
	12				Medics							DHP	HR
	11											DP	DHMT
	10	PHO											LGAZ
	9				Hosp & TI								
	8				Donors								
	7												
	6												
	5												
	4	SB											
	3												
	2												
	1	1	2	3	4	5	6	7	8	9	10	11	12
Low importance	Low influence												High influence

Importance: 1= Lowest importance 12= Highest importance

Influence: 1=Lowest influence 12= Highest influence

Key to acronyms and abbreviations in the table

- PHO Provincial Health Offices
- SB Statutory Boards
- Hosp & TI Hospitals and Training Institutions
- DHP Directorate of Health Policy
- DP Directorate of Planning
- HR Directorate of Human Resource
- DHMT District Health Management Team
- LGAZ Local Government Association of Zambia
- DS Decentralisation Secretariat

In Figure 6.1.3 we see that DS, DHP, DHR, DP, LGAZ, MDAZ and DHMT have a lot of influence. DS has high influence, the reason being that all resources from cabinet office, MFNP and LG pass through it to advance the national devolution policy. On the other hand, Ministry of Health, DHMT and MDAZ have the skills, human resource and infrastructure, which are necessary for policy implementation.

Figure 6.1.3 demonstrates that devolution policy is important to DS, which is also seen to have significant influence. This was followed by: DHR, LGAZ, DHP, DP and DHMT. Statutory Boards and Provincial Health Offices ranked low in terms of both importance of the policy to them and their level of influence. It is likely that the results came out this way because the most influential institutions (DS, DHMT, DHR, DHP and DP) have some experience of policy formulation and these will directly be involved with implementation of this devolution policy.

Statutory Boards, Hospitals and Training Institutions in this respect are seen to have low influence, as their participation is indirect and done at a much later stage. (i.e. regulation and provision of health services).

6.1.4 Resources, Leadership and Power

Resources- the source of support or ability to raise aid such as financial, technological, human, political or other. The amount of and ability to mobilise resources is an important characteristic that is summarized by a power index and will determine with what force a stakeholder might support or oppose policy. That is since "power" is defined as the combined measure of the amount of resources a stakeholder has and his or her capacity to mobilise them (from chapter 4), the two resource scores viz amount and capacity should be averaged to get a power index.

Leadership- the willingness and ability to *initiate* or lead an action for or against devolution policy. Establishing whether or not the stakeholder has leadership will help policy makers and managers to target those stakeholders who will be more likely to demonstrate their position for or against policy.

Power- the extent to which stakeholders are able to persuade or coerce others into making decisions and their capacity or ability to *accomplish* something.

In figure 6.1.4 below, we see that Directorate of Human Resource, Directorate of Health Policy, Directorate of Planning and Decentralisation Secretariat are ranked highly in terms of possessing these three attributes (resources, leadership potential and power) to contribute to devolution policy. On the other hand, statutory boards and medical staff possess the least of this attribute.

Figure 6.1.4 below ranks stakeholder according to power and potential to contribute to devolution policy. The position of each stakeholder was established through: (i) information directly reported by the stakeholder in the interviews (ii) and indirect information gathered through other stakeholders and secondary information. To obtain indirect information, specific questions about stakeholders' opinion of others were asked (see interview schedule).

In this study as stated earlier on, power refers to the ability of the stakeholder to affect the implementation of the policy due to the strength or force he or she possesses (Webster, 1984 in PHR Plus). On the other hand, leadership is defined as the willingness and ability to initiate or lead an action for or against the policy (ibid).

The main source of a stakeholder's power is his or her resources and ability to use them. The power index was derived from analysing the quantity of resources stakeholders have (whether many, some or few) and the ability of stakeholders to mobilise these resources. This was quantified in terms of whether stakeholders can make decisions regarding use of resources in his or her organisation i.e. whether a stakeholder can make decision regarding use of resources or not.

Figure 6.1.4: Rankings of Stakeholders According To Power and Potential to Contribute to Devolution Policy

Name of Stakeholder	Amount of Resources	Leadership Potential	Power
Decentralisation Secretariat	12	11	12
Directorate of Health Policy	8	9	8
Directorate of Human Resources	9	12	11
Local Government Association of Zambia	4	1	10
Directorate of Planning	10	10	9
DHMT	6	5	4
Hosp and TI	5	4	3
Statutory Boards	2	2	2
Medical Personnel	1	3	1
Medical Association	3	7	5
Donors	11	8	7
PHO	7	6	6

The numbers in figure 6.1.4 above are used to rank resources, leadership potential and power that each stakeholder has on devolution policy. In this case 1 means fewer resources, leadership potential and power and 12 refers to more of the respective characteristic. Note that numbers in table are given as final aggregates arrived at in the data analysis and therefore calculations cannot be deduced from here'

Responses from questions 8 and 9 were used to establish the amount of resources the stakeholders would dedicate to this policy and their capability to do so. The amount and

ability to mobilise resources is an important characteristic used to determine with what force the stakeholders might support or oppose the policy.

An important point also identified in the study was that most respondents expressed desire to provide funding, technical support and participate in policy dialogue.

For instance, when asked what support he would render to devolution policy, **one donor representative** responded: *“Well, I would provide funding....., I will provide funding....., I will provide technical support and participate in dialogue”*

In addition to information from secondary sources and fig 6.1.2, Question 15 was used to establish leadership and power. Establishing whether the stakeholder has leadership will help policy makers to identify which stakeholders have leadership and oppose policy. This is because those who already support policy and have leadership skills are not a threat, they are already mobilised and cannot collude with others to oppose policy, whereas, it is important to know the stakeholder who have leadership skills and not mobilised as this can coerce their colleagues to form alliance in opposition to policy.

For instance, to the question “would you take the initiative to support the policy or wait for others to do so?” a respondent from **Directorate of Health Policy** had this to say:

“Talking from experience, I will not wait for others. I will take a leading role”

This shows some desire to initiate, which in a way describes leadership attribute. Further from figure 6.1.4 we see that Directorate of Health Policy where the respondent belongs, apart from his influential position, the directorate also ranks relatively high in terms of power and potential to contribute to devolution policy.

In support, a respondent from the **District Health Management Team** had this to say: *“I will definitely take the initiative yes. And if I see potential, I will definitely knock on their doors and say I think you guys I think we have the same ideas. This is what we are come in and help”*

From the above quotes backed by information from secondary sources, we conclude that most stakeholders demonstrated leadership skills and power to affect the implementation of the policy.

6.1.5 Stakeholder Interests

Interest in devolution policy refers to the perceived advantages and disadvantages that implementation of policy may bring to a stakeholder or their organisation. This information can be used for developing strategies for dealing with stakeholder concerns.

Questions 4, 5, 11, 12, 13 and 20 were asked to elicit the interest of stakeholders and what they thought were advantages and disadvantages of the devolution policy. Determining the stakeholders' vested interests helps policy makers and managers better their understanding of the stakeholders' positions and explore possible ways to address their concerns with respect to the advantages and disadvantages of devolution policy:

Document analysis and one to one interviews revealed that: DHP, DHR, DP, PHO and DHMT had high interest in opposition to devolution policy. The main reason for opposition is summarised in figure 6.1.3 and these are: fear that implementation of devolution policy may create room for local government to misallocate funds targeted for health to non health programmes, concern of the difficulties involved in handling medical staff during transfer to local authorities, fear that devolution policy may result in creation of parallel structures and that given a poor economy, this may cause a threat on health care delivery. Further PHO was scared that the policy may seize of their powers over district health boards while DHMTS were scared that local unqualified officials may be elected to run health services.

Decentralisation Secretariat however expressed high interest in support of devolution policy. The Secretariat anticipated that successful implementation of policy would secure active participation by local people as well as achieve quality leadership.

Stakeholders perceived advantages and disadvantages in relation to policy come to light when conflicting needs and expectations arise. For example, when interests of stakeholders with high influence are not in line with the policy objectives this may result in blocking further progression of policy.

In order to iron out perceived disadvantages, the Decentralisation Secretariat needs to clarify unspecified stakeholder roles and responsibilities and bring to light positive aspects of devolution policy in relation to interest of stakeholders.

The stakeholder interests given in figure 6.1.5 are in part perceptions that stakeholders hold about the likely impact or process of a policy. This information of interest provides a critical portion of policy because of the negative perceptions that some stakeholders hold.

Tied to the interests is the balance of power and potential of actors to block reform process, the balance of power between the directorates in the Ministry of Health (DHP, DP and DHR) and Decentralisation Secretariat is critical to support for Health sector devolution policy in Zambia. For instance, the excerpts below express the kind of support that may exist:

"If you look at our vision which is to provide equity of access to health services to the people, it takes decision making to the people. From that perspective I think we do support the policy because it will allow many people to be involved and thus resulting in more ownership of the policy. However, if health services went to local government in its current state, the answer is NO. But with modifications we expect changes or improvements" **a respondent from Directorate of Health Policy.**

The respondent from the Directorate of Health Policy further expressed fear that LG may fail to prioritise health in resource allocation budgeting and may divert money for health to non-health programmes.

A respondent from **Directorate of Planning** also had this to say: " we have recorded some landslide in the decentralisation process that has been taking place through the strengthening of the districts and provinces, but the creation of another centre to

supervise the districts is not necessary because the ministry of health should be able to monitor directly and supervise these”.

This quote illustrates that the DP will want to ensure that implementation of devolution policy does not result in the creation of another parallel structure.

On the other hand, a respondent from **Decentralisation Secretariat** commented: *“the newly launched devolution policy is important because we want to see improved public service delivery that can accelerate the pace of national development. The general initiatives that the government has taken over the years are also an indication that government is convinced of the value of decentralisation.”*

The Decentralisation Secretariat is thus keen to promote the policy to help secure active participation by local people and quality political leadership.

From the comments above, it is clear that whilst interest in the devolution policy is high amongst key stakeholders there are contrasting positions. This is shown more fully in figure 6.1.7 (a) and (b) below:

Figure 6.1.7 (a): Summary of Arguments for Ministry of Health Devolution Policy

DEVOLUTION POLICY	
For	Against
To secure active participation by local people****	Poor economy pose a threat on health care delivery
To achieve quality political leadership	Local Government is non performing even in its core functions. ****
Enhance accountability	Local Government not good at prioritising health.
To improve responsiveness of government	Local unqualified officials may be elected and that would lead to chaos.
Helps develop plans tailor made for specific areas	This will make handling of medical staff difficult.
Empower local communities by devolving decision making authority	Non core staff may be employed at expense of medical personnel.
Ensures “bottom up “ flow of integrated planning and budgeting	This will result in creation of parallel structures
	LG fails to prioritise health; therefore money allocated for health may not be used for the intended purpose.
	Low capacity in LG can hamper health service delivery.

**** The most important forces

Figure 6.1.7 (b): Summary Arguments for Ministry of Health Deconcentration Policy (The Status Quo)

DECONCENTRATION POLICY	
For	Against
Ministry of Health has a strong National Health Policy, strategies and other legislation which is guiding the entire Health sector. The policy is broadly recognised as valid and relevant for improvement of Health. ****	Ministry of health policies remain in draft stage, no capacity to implement them.
Ministry of Health has adopted the Government MTEF Planning process and it has established benchmarks for the government budget support.	Management systems are not well developed.
Indicators for monitoring the health sector are in place	Unfocussed ad-hoc programmes get more attention than planned activities.
Ministry of health facilitates Health management boards	Ministry has no capacity to cope with all the demands.****
Ministry of health has created trust with Donors and is moving in the direction of creating a health support fund.	Human resource problem still an issue , there is mass exodus of health personnel. Ministry has failed to arrest this situation.
Ministry has developed a 10 year human resource plan to arrest mass exodus of health personnel from the sector	

**** Most important force

6.1.6 Alliances

Questions 10, 14, 17, 18 and 19 were asked to ascertain the alliances among different stakeholder organisations. According to Webster (1984), alliances are formed when two or more organisations collaborate to meet the same objective, in this case to support or oppose devolution policy. Identifying possible stakeholder alliances is important because alliances can make a weak stakeholder stronger, or provide a way to influence several stakeholders by dealing with one key stakeholder. For example, the strong Directorate of Human Resources may encourage the weak medical personnel to remain immobilised to devolution policy. Since Directorate of Human Resources belongs to the Central level of the Ministry of Health, it may find an incentive to in encouraging the medical personnel to resist moving to local authorities by using all the resources available at its disposable.

The following two excerpts point to the importance of different alliances. One respondent from **Provincial Health Office** had this to say:

“Okay for us there has been a lot of support, because we are not working in isolation. We work alongside the donors and cooperating partners because at the end of it all we are reaching up to the rural areas. In fact, we are working with all the line ministries. For

example in the case of HIV and AIDS, the line ministries are involved and also in my place donors have given us money to rehabilitate 21 hospitals”

Similarly, respondent from **Directorate of Human Resource** made similar sentiments:

“Within the Ministry we have support from all statutory boards, hospitals, and Central Board of Health. In terms of externals we have MFNP, Cabinet Office, Donors and Local Government.”

In general most respondents believed the following organisations would work together: Ministry of Finance, Cabinet office, Local Government and Housing, Decentralization Secretariat and Donors. This alliance includes stakeholders who have control over allocation of resources. Support by these stakeholders for the new devolution policy is imperative to implement change. However Ministry of Health, which is a major stakeholder in the implementation process, is of the perception that this policy affects it negatively and as such withdraw of funds or reduced support to ministry of health either by ministry of finance or donor will result in undermining the very policy they support. This is partly because Ministry of Health equally has a lot of influence and has ability to block policy implementation.

Figure 6.1.8 below shows that all the main health sector specific actors perceive the devolution policy as affecting it negatively while politicians and ministry of local government and housing perceive devolution policy positively.

Figure 6.1.8: Stakeholder Matrix (Devolution Policy)

Proposed Action: Policy on devolution of MoH	<u>Positively</u> affected	<u>Negatively</u> affected
<u>Directly</u> affected	A Politicians (+) Local Government and Housing (+)	B DoHP (-) DHRA (-) DoPD (-) DHMT (-) PHO (-)
<u>Indirectly</u> affected	Decentralisation Secretariat(+) Local Government Association of Zambia (+) C	Medical Personnel (+ -) Hospital and Training Institutions(+ -) Donors (non) MDAZ (-) D Statutory Boards (+ -)

Adapted from Mayers et al (2001)

(+) Positive impact (-) Negative impact (+ -) either positive or negative or both. The symbols (+) or (-) denote estimated impact of devolution policy on the actor.

Quadrant A

In the stakeholder matrix, we notice that only politicians and Ministry of Local Government and Housing is directly and positively affected by devolution policy.

Quadrant B

These stakeholders are in constant touch with other policy makers. Their main fear is that they will lose the progress the health sector has made over many years.

Quadrant C

The role of these stakeholders ends at policy formulation and provision of resources. They are not involved in implementation although occasionally may participate in evaluation. They will benefit from the devolution policy.

Quadrant D

Except for Donors, the rest of the stakeholders in Quadrant D are not in constant touch with policy makers. However, when decisions to devolve are made, they get involved in implementation.

The implication here is that whereas DS has a lot of influence and views this policy positively, the major directorates of Ministry of Health equally have high influence and view the importance of this policy negatively. This is likely to lead to inadequate support for devolution policy for the health sector despite DS being in the driving seat. Further, statutory boards, hospitals and training institutions who have relatively low influence may become strong as they are likely to form an alliance with the central directorates of ministry of Health, potentially forming a formidable opposition.

Figure 6.1.9: Force Field Analysis for Devolution Policy

		Proponents			Opponents	
		High Support	<< <<	Not Mobilised	>> >>	High Opposition
1	Decentralisation Secretariat	H(12)				
2	Directorate of Human Resource				M(11)	
3	LGAZ	H(10)				
4	Directorate of planning					H (9)
5	Directorate of Health Policy				M (8)	
6	Donor			L (7)		
7	Provincial Health Office		M (6)			
8	Medical Doctors Association					H (5)
9	DHMT					H (4)
10	Hospitals & Training Institutions				M (3)	
11	Statutory Boards			L(2)		
12	Medical Personnel				M (1)	

*Numbers denote power

Figure 6.1.9 brings together the stakeholders positions into a force field analysis. The results were drawn from questions 6, 7 and 16 to identify the position of stakeholders on the policy. Stakeholders who agree with the implementation of the policy are considered supporters whereas those who oppose it are considered opponents. Those who do not have a clear position, who are undecided or whose opinion could not be discerned are considered neutral or not mobilised. This summary is key to establishing the likelihood of success of the policy.

From the table above seven actors are seen to oppose the introduction of the devolution policy, of which six are internal to Ministry of Health and one is external. All these opposing stakeholders have a lot of resources, power and leadership. In contrast the Decentralisation Secretariat (DS) and Local Government Association of Zambia (LGAZ) have significant power and are highly mobilised in support of devolution policy. Only two actors were not mobilised, of those interviewed, only one was deemed to be powerful and had resources.

The excerpt below demonstrates how marked the opposition to the devolution policy is:

The **Directorate of Planning** had this to say: *“Decentralisation poses a lot of risks to the health sector in Zambia. It has a lot of opportunities but for now to the health sector there are so many challenges for instance: we made many investments in systems and management of health services. Unless these are protected, Ministry of health stands to loose.”*

Similar sentiments were raised by a respondent from the **Medical Doctors Association Zambia** *“In a developing country like Zambia we can not use a failing system. Ministry of health is doing better than local government. Ministry of health which is doing fine should not go under local government that is failing.*

Results from figure 6.9 imply that, in order for the devolution policy to be implemented successfully, there may be need to defend it against actors in the Ministry of Health, District Health Management Team and Medical Doctors Association of Zambia. There may be need also to initiate collaboration with Statutory Boards and Donors who are not mobilised

According to Gilson and Thomas (2002), one of the aims of reform drivers in developing policy such as the health sector devolution policy is to get as many supporters as you can who are of high importance with an attribute of influence. In this respect, it is important that the stakeholders see reform as promoting their interests as this will in turn give them the impetus to support reform. A clear starting point for managing stakeholders should involve mapping out the key actors around the reform issue and get their views on it. (Gilson and Thomas; 2002).

Since policy reform is never a simple matter of the right technical design, it is important to consider the potential for opposition and to offset it by managing actors in ways that promote support. Stakeholder management is particularly important for a national policy such as this devolution policy (ibid). In case of Zambia, it appears despite considerable efforts put into technical design, and finally the launch of the devolution policy. No amount of persuasion on the part of decentralisation Secretariat has secured support towards mobilising actors in the health sector.

Probably this scenario reflects weakness in the strategies employed to manage actors. It is likely that government attempts to draw in and control some actors in policy advisory committees backfired or that limited efforts were made by policy analysts to understand which stakeholders were important to consider and address key concerns. In case of Ministry of Health, there is need to employ strategies for managing actors to this institution. Its power is hard to ignore given that it is responsible for the entire health service delivery in the nation. To leave the ministry of health out of the policy process is to risk it blocking the process at a later stage, while to include it risks losing control of policy direction.

A key feature of the Zambian health sector devolution policy is the creation of the Decentralisation Secretariat. The secretariat is responsible for developing devolution policy as well as managing stakeholders with divergent interests. This unit is an important vehicle for motivating stakeholders and carrying forward policy reform.

As Huxham puts it, one justification of institutions such as the decentralisation secretariat is that of collaborative advantage (Huxham, 1993). If decentralisation secretariat works together with officials from various ministries and organisations, it can solve problems pertaining to devolution policy or produce something unusually creative which otherwise would have been unattainable (ibid). In this case decentralisation Secretariat should be used in Zambia to draw in outside expertise where it lacks relevant knowledge. Parsons (1995) suggests that extra technical expertise allows government to develop better policies and goals for health policy reform. That is including stakeholders on committees should not only be seen as a way of being fair and or soliciting support.

CHAPTER SEVEN: DISCUSSION AND CONCLUSION

7.0 INTRODUCTION

Section 7.1 of this chapter discusses the results presented in the previous chapter. This discussion is an evaluation of the extent to which the research objectives have been realised. The chapter outlines the general conclusions derived from the study, and go on to present policy recommendations in section 7.3. This is followed by suggestions for possible future research in section 7.4.

7.1 DISCUSSION OF THE RESULTS

The study has revealed that in terms of knowledge only respondents from the decentralisation Secretariat and Local Government Association of Zambia had high levels of knowledge on devolution policy. By contrast, those from hospitals and training Institutions, statutory boards and medical staff demonstrated lower levels of knowledge of devolution policy. This is not surprising as decentralisation in respect of health emerged in the wake of Primary Health care (PHC) Conference at Alma Ata in 1978(Mills 1990,Green, 1992) it thus by no means a new concept. However, it has received a great deal of attention of late due to increased interest in health sector reform (ibid).

An important finding also identified in this study was that most respondents expressed desire to provide funding, technical support and participate in dialogue. This is a good development as decentralisation of health sector is meant to be about strengthening health systems performance, about improving ability of health systems to deliver better health services and programmes that are more efficient, equitable and responsive to local needs (WHO, 2000). The decentralisation reforms initiated during the late 1980s and 1990s in Africa have generally been donor-driven and largely motivated by the perceived need to enhance health system performance and improve management (WorldBank, 2000).

Despite the efforts made so far, one of the challenges is that while decentralisation aims at improving health systems performance, its implementation relies on capacity of health systems. Experience show that decentralisation will fail in absence of skilled staff, adequate finances and appropriate health system implementation. (Hardee and Smith, 2000).

Further, the finding that most departments of ministry of health had high interest in opposition to devolution policy is consistent with other studies such as those of World Bank where local levels of government did not support decentralisation efforts by their governments as to each advantage of decentralisation, there was potentially a corresponding disadvantage (Mills, 1990 and World Bank, 2001).

It is also important to note that decentralisation of human resource requires careful planning, this is so because from the lessons learnt so far, and sentiments raised by most stakeholders, classified daily employees (CDES) were employed in most district hospitals at the expense of core staff and this was noted to be at variance with government personnel emolument budget. This means therefore that the decision by Government to restructure and redefine the role of all the service commission in order to ensure that they do not deal with recruitment, promotion and transfer of personnel may need revisiting as careful planning for human resources to any developmental process is very important (UNDP; 2000).

Capacity building both in terms of human resources and financial support is a principal obstacle to the furthering of the decentralisation process. In this aspect, preservation of critical human resources in the meantime remains vital and this cannot be relegated to individual ministries, as there is ongoing need for capacity building and technical assistance.

From the research findings, most key actors were not clear on the new policy. They just knew it was transfer of other ministerial functions to Local government. It is important to remember that low levels of knowledge can impede the implementation of the well-intended and well-meaning policy. As Barker (1986), puts it "policy implementation involves the framework of understanding and conceptualising the desired situation. Considering the consequences of current social development and the turning of ideas

and ideals into more practical objectives and pursuing the desired situation. Thus, training of most stakeholders' on decentralisation issues will help improve the implementation of policy objectives.

It is important, in this respect, that government take time to sensitise all the stakeholders on the grassroots on this important policy that has taken almost two decades to emerge. Stakeholders should be sensitised because the concepts of decentralisation mean different things to different Stakeholders. For instance, in terms of Mawhood classifications, decentralisation is equivalent to the stated definition of devolution whereas deconcentration seems to cover both the stated definitions of deconcentration and devolution (Mawhood; 1983).

Awareness campaigns should be conducted because they improve on the understanding of policy objectives and statements. Exercise and interpretation of policy objectives are crucial if policy implementation is to be successful. (Hogwood and Gunn; 1984; Harrop; 1992). Decentralisation policy should not only end at production of the national policy document. Since policy is larger than a decision and involves a series of specific decisions that involve more than one actor. It is important that government starts the process of implementing the national decentralisation policy now as any delays in doing so may result in unintended results being attained.

7.2 STRATEGIES FOR TAKING DEVOLUTION POLICY FORWARD

In order to be effective, certain strategies may need to remain confidential, known only by a select group of policy makers implementing the policy. There may also be need to develop general strategies. Thus the working group should analyse the interests, concerns and misunderstandings common to stakeholders pertaining to this policy. Gilson L et al (1999) , proposes nineteen strategies that can be used for working with stakeholders in taking reforms forward. Among others these include:

- Seeking common ground with other organisations, identifying common interests, inventing new options and making decisions for opponents easier.
- Creating an atmosphere of shared values, unified leadership and respective roles for all stakeholders;

- Define the decision making process as well as legalise formal process around a particular reform.
- Mobilise and prepare Key Actors for their roles in reform debates as well as identify those who can influence support or opposition by taking a clear position and providing them with appropriate information for discussion;
- Create strategic alliances with key actors not usually involved in health sector policy debate (e.g Unions, NGOs); and
- Involve different groups in designing reforms and in developing implementation strategies.

These strategies should be developed further through concrete action plans, communication plans and negotiation packages (Gilson L. et al (1999)).

7.3 CONCLUSION

This study, both in terms of one to one interviews and documentary analysis has shown that most respondents understood the general concept of decentralisation very well, although some actors had difficulties in distinguishing the four different modes of decentralisation. Most of them were aware of the developments in the health sector and followed closely the debates of the recently launched national decentralisation policy, which advocated for the devolutionary mode as opposed to the Ministry of Health deconcentration and delegation modes of decentralisation.

Given this finding, it is possible that many stakeholders who failed to define devolution policy are not yet fully aware of the difference between deconcentration and devolution policy, which is being advocated by the newly launched decentralisation policy document. It is most likely that the existing awareness and dissemination campaigns of devolution policy have not adequately communicated the policy to key stakeholders.

Further the study has revealed that devolution policy is important to DS, which is seen to have significant influence. This was followed by: DHR, LGAZ, DHP, DP and DHMT. Statutory Boards and Provincial Health Offices ranked low in terms of both the importance of the policy to them and their level of influence. In this respect, statutory boards, hospitals and training institutions are seen to have low influence, as their participation is indirect and done at a much later stage.

Since DS has a lot of influence and views this policy positively, the major directorates of the Ministry of Health equally have high influence and view the importance of this policy negatively. This scenario is likely to lead to inadequate support for devolution policy for the health sector. Further the statutory boards; hospitals and training institutions that have relatively low influence may become strong as they are likely to form an alliance with the central directorates of the Ministry of Health, thus potentially forming a formidable opposition.

In terms of resource, leadership and power possession, the three Directorates of MOH are ranked highly while statutory boards and medical staff possess the least of these attributes. The same was true in terms of interest for the policy.

Finally the study has revealed that most respondents were of the view that MFNP, Cabinet Office, LG and Donors would work together. This alliance includes stakeholders who have control over allocation of resources. Support by these stakeholders for the new devolution policy is imperative to implement change. However, Ministry of Health which is a major stakeholder in the implementation process, is of the perception that this policy affects it negatively and as such withdraw of funds or reduced support to Ministry of Health by Ministry of Finance or donors will result in undermining the very policy they support reason being that Ministry of Health has a lot of influence and ability to block policy implementation.

The research concludes that in general, stakeholder characteristics imply that implementation of the devolution policy will be difficult. Most concerns raised by stakeholders over implementation of devolution policy in the health sector require special attention from policy makers. It is hoped; more extra effort will allow the citizenry more information and enlightenment on this policy reform issue. Given the above, Decentralisation Secretariat should work out mechanisms of engaging other stakeholders fully in the consultation process and try to re-evaluate the design of the National decentralisation policy given the current strength of opposition.

7.4 POLICY SUGGESTIONS AND RECOMMENDATIONS

Given the results of this study, we recommend the following strategies for carrying forward health sector devolution policy:

- The decentralisation secretariat should mobilise the ministry of health by explaining the modalities through which the newly launched devolution policy will be implemented. Since modalities of implementation will take a form of deconcentration, DS should take advantage of this by highlighting similarities to what is currently the status core in Ministry of Health. Failure to do this may result in the impasse among stakeholders from the health sector.
- The DS is strongly encouraged to form an alliance with Ministry of Health and closely work together with them. This will increase the influence and technical power for policy implementation and might be sufficient to offset opposition of the Ministry of Health.
- Further, the DS must coordinate interested stakeholders, develop a shared vision and take action to support policy implementation. Even in instances where other stakeholders are generally supportive of the policy, it may be important to unite the stakeholders so as to give them collective power.
- The DS should also deal with individual stakeholders with dissenting views along the line of their argument. This may help to deal with individual groups of stakeholders adequately.
- Government should also clarify and outline the services to be provided at each level; national, provincial, district and sub-district and specify the resources to be availed for the performance of these functions.
- Government should itemise the functions, powers and resources that it has decided to deconcentrate at provincial and district levels. Further, a roadmap should be made regarding the process of capacity building in the councils.
- It is also important to sensitize the masses on the various modes and types of decentralisation including the actual policy statements and objectives relating to the newly launched national decentralisation policy.
- There is need to urgently review the National Health Services Act of 1985. At the moment there is no legislation that can guide the formation of the district health system. It is not certain when national legislation will be introduced. In the

absence of national legislation each local authority might introduce its own legislation resulting into significant variability between local authorities.

- There will be need to adequately inform those affected by the policy of setting up a completely new system of primary level care delivery of the implications. Health workers need to know how their work will be affected and what will happen to their personal benefits. Users of the health system need to be kept up to date regarding any changes in service delivery.
- At present the bulk of funding for primary level funding comes from donors and is allocated using a special resource allocation criteria, which takes into account issues of equity based on need. In this respect, the route and mechanism of funding, the level of funding, the sustainability of the funding and the monitoring of funding between provinces and the local authorities in this respect of health services still needs full discussion before decisions can be taken.

7.5 SUGGESTION FOR FUTURE RESEARCH

Further work is needed to understand better when and how to manage these stakeholders in policy reform.

- Given the move to devolve primary health care service provision to local government level, and evidence that most local authorities experience inequities in allocation and distribution of government grants, it is critical that an equity assessment of overall district services is undertaken. This should be complemented by a case study analysis for the local authorities.
- There may be need to assess the impact of devolution on human resources. That is what impact will devolution have on the ability of the health system to redistribute human resources within the health delivery system and what will be the likely implication on human resource planning and policy.

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APPENDICES

APPENDIX 1: CODING TREE

(1) /stakeholders
(1 1) /stakeholders/characteristics
(1 1 1) /stakeholders/characteristics/position
(1 1 1 1) /stakeholders/characteristics/position/all are mobilised and strong
(1 1 2) /stakeholders/characteristics/resources
(1 1 2 1) /stakeholders/characteristics/resources/MoH, MFNP, Cabinet, CPs
(1 1 3) /stakeholders/characteristics/knowledge
(1 1 3 1) /stakeholders/characteristics/knowledge/moderate knowledge on decentralisation
(1 1 4) /stakeholders/characteristics/power leadership
(1 1 4 1) /stakeholders/characteristics/power leadership/Al fairly powerful and high level of leadership
(1 1 5) /stakeholders/characteristics/interest
(1 1 5 1) /stakeholders/characteristics/interest/mobilised for deconcentration and not mobilised for devolution
(1 1 6) /stakeholders/characteristics/alliances
(1 1.6 1) /stakeholders/characteristics/alliances/LG, MFNP, Cabinet Office, Decentralisation Secretariat
(1 2) /stakeholders/values
(1 2 1) /stakeholders/values/International agencies
(1 2 1 1) /stakeholders/values/International agencies/influential on health reform direction
(1 2 2) /stakeholders/values/Ministry of Health
(1 2 2 1) /stakeholders/values/Ministry of Health/responsible for planning and implementation
(1 2 3) /stakeholders/values/Other line Ministries
(1 2 3 1) /stakeholders/values/Other line Ministries/their support imperative to implement change
(1 2 4) /stakeholders/values/Labour Sector
(1 2 4 1) /stakeholders/values/Labour Sector/very powerful can work against policy
(2) /policy
(2 1) /policy/process
(2 1 1) /policy/process/Satisfactory problem identification
(2 1 2) /policy/process/Good policy formulation

(2 1 3) /policy/process/Policy implementation yet to be done,
still concerns on modalities

(2 1 4) /policy/process/Policy evaluation pending

(2 2) /policy/content

(2 2 1) /policy/content/Devolution transfer of authority to LG
not favoured

(2 2 2) /policy/content/Deconcentration, strengthening of lower
levels within MoH favoured

(2 3) /policy/context

(2 3 1) /policy/context/Deconcentration on the part of MoH

(2 3 2) /policy/context/Devolution on the part of the National
decentralisation policy

APPENDIX 2: STAKEHOLDER INTERVIEW SCHEDULE

Date:.....

City:.....

ID:.....

INTRODUCTION

I am a Masters Student in Health Economics from the University of Cape Town and I am conducting a Study to explore the opinions of several important actors who are interested in the improved management of the Ministry of Health (MoH). As an important actor in the health sector, it is crucial for us to obtain your opinion and that of your organisation.

The information obtained through these interviews will be for the direct use in the analysis, and will be presented in a general report the Ministry of Health without identifying individual opinions.

I would like to ask you a few specific questions about your opinion regarding the implementation of devolution of the MoH.

YOUR OPINION:

1. Have you heard of the Ministry of Health Policy on "Devolution"?
2. If so, how did you hear of it?
3. What do you understand "Devolution of the MoH" to mean?
4. What are the potential benefits to you and your organisation of the Devolution of the MoH?

5. What are the potential disadvantages to you and your organisation of the devolution of MoH?
6. What is your opinion on devolution of MoH?
7. Which aspects of devolution do you support?
8. In what manner would you demonstrate this support?
9. Would you have many, some, or no resources to dedicate to supporting this policy?
10. What other organisations, do you think would support devolution of MoH? (*probe for MoH and non-MoH stakeholders*)
11. What do you think these supporters would gain from the devolution of the MoH?
12. Under what conditions would you choose NOT to support devolution?
13. Which aspects of devolution policy do you oppose?
14. Would you ally with other persons or organisations in these actions?
15. Would you take the initiative in supporting devolution, or wait for others to do so?
16. Under what conditions do you think these actors would come to oppose devolution?
17. What other organisations, departments within an organisation, or persons do you think would oppose devolution the MoH?(*Probe for MoH and non- MoH stakeholder*)
18. Which of these opponents would take the initiative to actively oppose devolutration?

19. Which of these actors would work together to demonstrate their opposition to devolution?

20. Under what conditions do you think these actors would come to support the devolution of the MoH?

APPENDIX 3: SPECIMEN RESPONDENTS CONSENT FORM

This study in which you are being requested to participate is aimed towards improving the implementation process of health sector devolution policy in Zambia.

The information being volunteered will be treated as confidential. As a participant you have the right to withdraw from the process of the interview/ study whenever you wish to. The questionnaires will only be accessible to the persons responsible for the study, and will be destroyed after completion of the study. For the protection of your identity, no names or other personal information is required from you.

The study will help contribute towards generation of the knowledge base for use by policy makers. Thus, the knowledge generated by this research and others of relevant significance if any progressive review and successful implementation of devolution policy is to take place.

DECLARATION

I have read and understand the nature of the study in which I am participating. I therefore agree to participate.

Signature of Respondent..... Date.....

APPENDIX 4: STAKEHOLDER INTERVIEW QUESTIONNAIRE

Date:.....

City:.....

ID:.....

INTRODUCTION

I am a Masters Student in Health Economics from the University of Cape Town and I am conducting a Study to explore the opinions of several important actors who are interested in the improved management of the Ministry of Health. As an important actor in the health sector, it is crucial for us to obtain your opinion and that of your organisation.

I plan to conduct about 35 to 40 interviews to produce a general report on the opinions of the major health sector actors. The information obtained through these interviews will be for the direct use in the analysis, and will be presented in a general report to the Ministry of Health without identifying individual opinions.

I would like to ask you a few specific questions about your opinion regarding the implementation of devolution of the MOH.

YOUR OPINION:

1. Have you heard of the Ministry of Health Policy on "Devolution"?
2. If so, how did you hear of it?
3. What do you understand "Devolution of the MOH" to mean?

4. What are the potential benefits to you and your organisation of the Devolution of MoH?
5. What are the potential disadvantages to you and your organisation of the devolution of MoH?
6. Which of these categories best describes your opinion on the devolution of the MoH? (Read answer options and circle answer given.)
 - a) I strongly support it
 - b) I somewhat support it
 - c) I do not support nor oppose it
 - d) I somewhat oppose it
 - e) I strongly oppose it

If stakeholder answer a, b, or c, continue below. If stakeholder answers d or e, pass to question #10.

For those who answer "a," "b," or "C" to question #6:

7. Which aspects of devolution do you support?
8. For those aspects of devolution that you do support,
 - a) In what manner would you demonstrate this support?
 - b) Would you have many, some, or no resources to dedicate to supporting this policy?
 - c) Would this support be public?
 - d) Would you ally with any other persons or organisations in these actions?
 - e) What conditions would have to exist for you to express this support?

- f) Would you take the initiative in supporting devolution, or would you wait for others to do so?
 - g) How quickly would you be able to mobilise your support?
9. Under what conditions would you choose NOT to support devolution?
10. Which aspects of devolution do you oppose:
11. For those aspects that you oppose:
- a) In what manner would you demonstrate this opposition?
 - b) Would you have many, some, or no resources to dedicate to opposing this policy?
 - c) Would this opposition be public?
 - d) Would you ally with any other persons or organisations in these actions?
 - e) What conditions would have to exist for you to express this opposition?
 - f) Would you take the initiative in opposing devolution, or would you wait for others to do so?
 - g) How quickly would you be able to mobilise your opposition?
12. Under what conditions would you come to support devolution?

I would now like to ask you a few specific questions about your opinion regarding others' opinion of implementation of devolution of the MoH.

OTHER SUPPORTERS

13. What other organisations, departments within an organisation, or persons do you think would support devolution the MoH? (probe for MoH and non-MoH stakeholders)

14. What do you think these supporters would gain from the devolution of the MoH?
15. Which of these supporters would take the initiative to support to actively support devolution?
16. Which of these supporters would work together to demonstrate their support for devolution?
17. Under what conditions do you think these actors would come to oppose devolution?

OTHER OPPOSERS

18. What other organisations, departments within an organisation, or persons do you think would oppose deconcentration the MoH?*(Probe for MoH and non- MoH stakeholder)*
19. What do you think these opponents would gain from preventing the devolution of the MoH?
20. Which of these opponents would take the initiative to actively oppose devolution?
21. Which of these actors would work together to demonstrate their opposition to devolution?
22. Under what conditions do you think theses actors would come to support the devolution of the MoH?