Health Sector Decentralisation at District Level in Ghana: A Case Study in Reform Implementation

A thesis submitted to the University of Manchester for the degree of PhD in the Faculty of Humanities

2007

Emmanuel Kojo Sakyi

SCHOOL OF ENVIRONMENT AND DEVELOPMENT

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

TABLE OF CONTENTS

List of Figures

List of Tables

List of Abbreviations

BMC	Budget Management Centres
CDD	Centre for Democratic Development
CHRAG	Commission on Human Rights and Administrative Justice
CHAG	Christian Health Association of Ghana
CSPIP	Civil Service Performance Improvement Programme
CSRP	Civil Service Reform Programme
DAs	District Assemblies
DDHS	District Director of Health Service
DHMTs	District Health Management Teams
DHC	District Health Committees
ECA	Economic Commission for Africa
ERP	Economic Recovery Programme
GHS	Ghana Health Service
GIMPA	Ghana Institute for Public Administration
IMF	International Monetary Fund
OHCS	Office of the Head of the Civil Service
NPM	New Public Management
NOC	National Overview Committee
NDC	National Democratic Congress
NPP	New Patriotic Party
NGP	National Governance Programme
NIRP	National Institutional Renewal Programme
MDAs	Ministries Departments and Agencies
MMD	Movement for Multi-party Democracy
MOH	Ministry of Health
MTHS	Medium Term Health Strategic Framework
PAMSCAD	Programme of Action to Mitigate the Social Cost of Adjustment
PHC	Primary Health Care
POW	Programme of work
PSMRP	Public Sector Management Reform Programme
PSC	Public Service Commission
PNDC	Provisional National Defence Council
PPM	Procurement Procedure Manual
PUSERMO	Public Sector Re-invention and Modernisation Strategy
PUFMARP	Public Sector Financial Management Reform Programme
QR	Qualitative Research
QRM	Qualitative Research Method
RSIM	Research Statistics Information Management
RHMT	Regional Health Management Teams
RDHS	Regional Director of Health Service
SAP	Structural Adjustment Programme
SAIS	Structural Adjustment Institutional Support
SFO	Serious Fraud Office
SDHMT	Sub-District Health Management Teams
THs	Teaching Hospitals
USAID	United States Agency for International Development
UNICEF	United Nations Children Fund
UNDP	United Nations Development Programme

WHA	World Health Assembly
WHO	World Health Organisation

List of Appendices

ABSTRACT

This study presents findings on the challenge(s) confronting the implementation of health sector reform in Ghana. It examines the influence of a lack of: staff capacity, leadership, staff commitment and communication on the implementation of health sector decentralisation at district level. The study's guiding proposition was that the characteristics of an implementing agency influences effective implementation. To explore this proposition, a multiple research method combining interview, survey and policy document analysis was used to gather data. The study was conducted through three case study districts in Ghana; the sample consisted of 59 people who participated in semi-structured interviews and 142 respondents who took part in the survey component; and the data obtained was analysed using qualitative and quantitative techniques.

Out of four working propositions put forward by the study, three were generally supported by the evidence from the findings, while one was not. The findings indicated that lack of staff capacity and staff commitment and communication are the major obstacles to implementing health sector reform in Ghana. Regardless of what the literature says about the important role of leadership in implementation, the evidence from the findings did not support the working assumption; and respondents did not believe that leadership has any constraining influence upon the implementation of health sector decentralisation at district level.

The findings pointed out that the challenges confronting the implementation of health decentralisation at district level needed to be viewed within a wider historical, geopolitical, economic and institutional context of the country and its health service in particular. The study emphasised the need for reformers to give equal attention to structural and behavioural and attitudinal changes, rather than overemphasising the former alone. It advocated broad support for strengthening district health management teams, especially in relation to the number of staff, motivation and skills training, improved logistical support and workers' welfare and personal career development, in order to increase the level of affective and normative commitment in the health service. The study concluded that, to improve reform implementation efforts the MOH would have to address the issues of capacity, commitment and communication.

DECLARATION

I, Emmanuel Kojo Sakyi, hereby declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

COPYRIGHT

Acknowledgements

A number of people have directly or indirectly supported me in the course of this research project, I am indebted to them and therefore wish to express my thanks. Firstly, my thanks go to my supervisor Dr Willy McCourt, who read the draft and offered insightful suggestions. Secondly, my appreciation goes to Professor J.R.A. Ayee, Dr Ronni Ramlogan, Dr K.A. Domfeh, Mr Kofi Drah, Mr Takyi-Asiedu and Mr Azunu Rich (aka GB), who, in diverse ways, all supported me during this study.

The study would have been impossible without financial support from the Ghana Education Trust Fund (GETFUND), Ghana High Commission in UK and the University of Ghana; to all the helpful officials, I say a big thank you. I also extend the same thanks to my colleagues in the Department of Public Administration and Health Service Management, University of Ghana for their support. Thanks also to all my colleagues in the PhD community at IDPM for their support. My special gratitude goes to Jenny Peterson, Dr Hassanah Johari, Ellie Sandercock, Sobona Mtisi, Joseph Adjei and Kwame Anson-Yevu. I appreciate and enjoy your company and intellectual interaction; you all will be remembered.

Lastly, I am grateful to my dear wife, Olivia, for her support and forbearance; and to my other brothers and sisters, especially Xolali, John and Joseph who were also supportive. It is impossible to name everyone who helped the author with the research work, but everyone who has helped has my heartfelt gratitude.

Dedicated to:

Christoph, Victoria, Olivia and Kwaku

Chapter 1: Introduction

1.1 Background: the challenges in public sector reform implementation

This study presents an analysis of the challenge(s) confronting the implementation of health sector reform in Ghana, in order to draw lessons that will enhance the success of ongoing and future health sector reform. Basically, this is a study of contemporary public management reform implementation problems in developing countries. But more specifically, the study examines the ways in which issues of staff capacity, staff commitment, leadership and communication influence the implementation of health sector decentralisation at district level.

Public management reforms have become the norm of governments in developed and developing countries. Currently, in developing countries in Africa, virtually every nation is implementing reforms in health, education, agriculture, state-owned enterprises, public transport, post and telecommunication, ports and harbours, electricity and water, and many other service sectors. An underlying motivation for initiating these reforms is to make services more efficient, effective and accessible. But one problem facing most reforming governments across the globe is that many such reforms have either underperformed or failed to achieve their objectives. Although obstacles constrain the implementation of reforms in every country, the kind, degree, scope and enormity of these constraints appeared to be wider and more complex in developing African countries.

Generally, most of the reforms have laudable aims. For example, health decentralisation reform aims to: improve the performance and quality of services delivered to the population; redefine the role of central government in the provision of health services; create a platform for promoting a pluralist health system where public, private-for-profit, private-for-non-profit providers, alternative health service providers and communities will have enough space to participate in planning, managing and delivery of health services. The idea of a pluralist health system is intended to be established through an integrated, decentralised health system based on a decentralised managerial approach. Clearly and logically, the success of health sector reform therefore relies heavily on effective decentralisation of the roles and functions to District Health Management Teams (DHMTs).

Unfortunately, district health management teams' attempts to implement health development projects and programmes have failed or underperformed (Larbi, 1998; Agyepong, 1998; MOH, 1996). However, the problem of poor implementation on the part of public health agencies, at both central and district levels, was partially responsible for the collapse of the public health sector and the subsequent introduction of health sector restructuring in the wake of IMF- and World Bank-sponsored structural adjustment programmes. Structural adjustment and allied institutional reforms, including decentralisation, aim to rejuvenate the functioning and management of public health agencies; yet the implementation of reform goals, even in the reform era, is being severely constrained because of institutional and capacity problems (Hutchful, 1996; Ayee, 1997; Larbi, 1998; Jackson, 1999; Batley, 2004).

Considering the importance of District Health Management Teams (DHMTs) in health reform implementation, there is remarkably little work examining exactly how the characteristics of DHMTs influence the execution of health reform. This is the principal task of this study. Secondly, the study also examines the ways in which the characteristics of DHMTs as implementing agencies tasked with management of reform, can act as a brake on implementation. The central research question addressed by this research is: how have the characteristics of District Health Management Teams (DHMTs) influenced the implementation of health sector decentralisation reform at the district level in Ghana?

Various reasons have been put forward to explain the cause of poor public sector reform implementation. This study's viewpoint is that, while implementing many public sector reforms (including health sector decentralisation) is widely recognised as being complex and difficult (Haggard, 1995; Van de Walle, 1994), the failure of reform(s) can nonetheless be attributed to the characteristics of the agency in charge of implementation. In fact, the lack of any careful consideration of how the reform implementation effort is – or should be – organised is among the challenges confronting reform implementation in most African countries, including Ghana. As argued in the concluding chapter of the study, attention to the implementing agency's characteristics is critical to effective reform implementation efforts. This is because reform can only achieve the set goals where reform is effectively implemented by the relevant health sector agency. Thus, effective reform implementation will only be possible where public officials and organisations responsible for managing an

implementation process have the requisite capabilities and are adequately resourced. An analysis of the character of agencies tasked with managing public sector reform implementation is therefore one of the important ways to investigate and understand factors that impede or constrain reform implementation, so as to provide suggestions for enhancing the chances of future reform success. It is unfortunate that very little or no research work has been done on the influence of organisation characteristics upon reform implementation in developing African countries, including Ghana; and this explains the need, interest and motivation for this study.

This first chapter provides a foundation to the study and outlines the aims of undertaking this study. The chapter will provide a general overview of some of the issues in public sector reform; this will be followed by a profile of public service reform and the challenges to policy implementation in developing countries in Africa. The chapter will then continue with a brief history of Ghana, to provide some background to the research problem, before giving an overall descriptive outline of topics covered in the entire study. In the next subsection, some general comments about issues in public sector reform and challenges for its implementation are made.

1.2 Introduction: issues in public service management reform

The past two decades have seen a drive for reforming public services in developed, transitional and developing countries. In the developed countries, this move for reform started in the early 1980s as a result of a realisation that the public sector was confronted with profound problems in delivering public services well to their citizens. It was argued that, in many of these countries, public services were faced with a performance problem which called for new ideas, new initiatives and new strategies (Lane, 1996; OECD, 1995 and 2005). Apart from that, the impetus for public service reform came as a consequence of social, economic and technological changes in the latter half of the twentieth century. Furthermore, many countries at the time were faced with serious fiscal crises, which were also coupled with their governments' inability to cope with the ongoing changes in society, and resulting new social movements with different expectations (Minogue, 1998 and 2001; OECD, 2005).

Views differ about the reasons for initiating public sector management reforms. Firstly, some believe that public service reform was about improving public service; secondly,

others think it marked a point for a complete rethinking of the role of the welfare state or the administrative state (Caiden, 2006; Lane, 1996). Thirdly, public service reforms have been initiated partly because of a deep disaffection within the sector itself, meaning that the reforms were seen as a response to public employees' grievances. Indeed, public servants were unhappy with their situation, frustrated and fatigued, and lacking the resources to do their work. According to the World Bank and other international development agencies, public service reforms were being undertaken in the belief that governing states had become too large and overcommitted, and that the market offered superior mechanisms for achieving efficient provision of public goods and services (World Bank, 1997). This last viewpoint encapsulates the main tenets of the 'neo-liberal' approach to economic growth and development that has been promoted worldwide by the IMF and the World Bank. In summary, public service management reform was promoted based on the thinking that every problem of the state has a managerial solution. Managerialism, therefore, became a formula deployed to solve the performance crisis of the overextended public sector - to make it work better while costing less. This is the reason why public service reforms in OECD countries have concentrated on improving performance, promoting competition and providing responsive service (Lane, 1996; McCourt, 2001).

1.3 Public sector management reform in developing countries in Africa

In developing countries, especially Sub-Saharan African countries, the latest public service reform (PSR) initiatives were transferred from developed countries by international donor agencies. As Conyers (2006) argued:

> Since the end of the Cold War and the apparent failure of both the conventional 'socialist' model of development and its African variant, there has been little choice. Any country that requires substantial external assistance is required to subscribe to the orthodox model promoted by most multilateral and bilateral aid agencies, which comprises not only the package of economic and financial reforms known as structural adjustment, but also a western-style 'democratic' system of government and the adoption of 'new' approaches to public sector management (Conyers, 2006: p.614).

In the context of Africa, PSR can be grouped into two categories. The first reform initiatives came in the wake of the structural adjustment programme launched in the 1980s with support from the IMF and World Bank; the focus was on what the World Bank calls 'reform of the fundamentals of the public administration system' (cited in Kiragu and Mutahaba 2006). These reforms aimed to tackle the public service performance crisis by restructuring the civil service through retrenchment, removal of ghost-workers and down-

sizing and pay reforms aimed to reduce wage bills in the public service (see McCourt, 1998). The second set of reforms were much broader and sought to build on the achievements of the former and also to address some of the inadequacies associated with those earlier reforms (Bana and Ngware, 2006; Levy, 2004; Stevens and Teggemann, 2004; Caiden, 2006). The second phase of reform was more comprehensive and aimed at the total transformation of the public service into an efficient, effective and outcome-based institution. The emphasis in this phase of reform, therefore, was on improving government performance of its classic public functions, such as law and order, regulation, economic management and creation of an enabling environment for private sector and market forces to play a more active role in economic activities; and provision of pro-poor social services such health and education, especially in areas unattractive to private sector service providers. Reforms in the second phase involved the introduction of a multiplicity of measures intended to improve service delivery; and, a common element in the reform measures adopted by almost all countries was Performance Management System. It aims at improving service delivery through a result-oriented management, and to build a service management culture that focuses on results rather processes. Public agencies, ministries and departments were therefore not only pushed for structural reform, but they were also expected to develop strategic management plans that set targets identifying outputs and outcomes, against which performance could be measured (World Bank, 1997). The position of the reforms on the ground, however, is far from ideal in that the implementation of the reforms, especially in developing countries was not without problems; the next subsection examines the literature, to outline some of the challenges confronting policy implementation in general.

1.4 Overview of challenges in policy implementation

Studies of the problem of implementation started emerging in the early 1970s in the United States. Of special note is Pressman and Wildavsky's (1973) seminal work on the implementation experience of the Economic Development Programme in Oakland, California. During this era, implementation research focused on how policy or programmes, policy goals, implementing design, and availability of resources influenced the achievement of stated goals[1]. Throughout this era, most of the research into implementation problems focused on developed country case studies. But over time, the study of policies and programmes implementation in developing countries emerged as a topic of interest which

[1] See for example, Pressman and Wildavsky, 1973; Van Meter and Van Horn, 1975; Bardach, 1974; Sabatier, 1986.

attracted the attention of many students, academics and development experts[2]. This interest, in particular regarding the implementation challenges of public sector reforms, has increased particularly in the 1980s and 1990s following the economic crises and concomitant underachievement of several economic, political, social and administrative reforms initiated during the period of structural adjustment. This research work forms part of this generation of studies and aims to generate new ideas and insights in order to activate discourse about the relevance of organisational characteristics in PSR implementation in Africa, and Ghana in particular.

A review of the implementation literature in developed countries revealed that factors acting as roadblocks to policy implementation have generally been theoretically conceptualised in terms of content and context (Grindle, 1980; Grindle and Thomas, 1991). However, the question confronting the researcher is: does that mean that the same factors are at play in developing countries, including Africa? Grindle (1980: p.5) showed that the situation is quite similar, since the content of a policy and context of implementation affect the implementation outcome in every country, including African countries. She posits that the kind of policy in question stimulates certain kinds of politics and conflict which may have considerable impact on the implementation process or its 'implementability'[3]. Given the assertion that implementation is an ongoing decision-making process, then it is important to take a very critical look at the context or environment in which implementation occurs. It equally suggests that dealing with reform implementation is not simply tinkering with existing operating routines or refining the analysis of policy options. This is because global experience clearly shows that reforms do not proceed automatically or in a linear way; a 'jump-start' push is not enough (Brinkerhoff, 1996); policy implementation is an ongoing, nonlinear process that must be managed by an implementing agency or group of agencies or individuals. The issue is even more important in situations where longer-term reforms are involved, because implementation of such reform policy often requires many actors and institutions to make choices about authoritative allocation of resources, and many other actors may attempt to influence those decisions. Thus, the

[2] Until Grindle's 1980 mould-breaking work, studies on implementation problems in developing countries were concerned about the influence of administrative institutions and procedures and their bureaucrats upon implementation. See also Thomas and Grindle, 1990.

[3] The extent of change in social, economic, political and administrative relationships stimulates opposition which, in turn, affects implementation; so is the degree of behavioural change a policy consideration? Content also determines the site of implementation, and may indicate the organisation or group of individuals to be tasked with executing various programmes, which can affect the way the policy goals are pursued.

interaction of content, context, actors and process are crucial in understanding factors that affect policy implementation (Grindle, 1980; 1997; Walt and Gilson, 1994). Given this premise, the next section will now move on to review the factors that affect public policy reform implementation in Africa.

1.5 Profiling Africa's policy implementation challenges

When compared to other developing countries, there is no doubt that policy implementation failure is one of the defining features of Africa's development experience. Therefore, the question that has continued to puzzle many development experts and researchers is: why have most public policy reforms failed to achieve the goals set by their framers; and how can deviations from stated objectives be explained?

Various researchers have provided different answers to understanding the African implementation misery. For example, Brinkerhoff and Crosby (2002) pointed out that understanding the problem requires differentiating between the 'what' and 'how' of policy reform. They have argued that the 'what' refers to the policy content, while the 'how' refers to the implementation process. According to them, a lack of recognition that policy implementation is as much a process as it is content is a cause of the problem.

Juma and Clarke (1995) attributed the cause of the problem of reform implementation in Africa to three main issues:

1) governments have kept other institutions from taking part in the policy process;
2) policy making is mystified and treated as a secretive activity involving a small political elite; and
3) the tradition of perceiving the public not as a clientele, or even as a resource, but as a source of potential problems, which decision makers must somehow neutralise.

Grindle (1980) and Grindle and Thomas (1990), noted that part of Africa's implementation problem can be traced to the political and administration environment in which implementation occurs. At issue here is the role of politics in implementation – that is, the ways in which the structure of political institutions, political regime type and political leadership affect implementation. Grindle argued that, while in the United States and Western Europe in general, much of politics centres on the input stage of the policy process, in the Third World a large portion of political activity and its attendant conflict

occurs at the implementation and output stage of the policy process. This poses a great challenge to implementation, because implementers need to have high managerial capacity for implementation management; not just simplistic technical skills to shepherd reform policies through the complex and shifting geography of the political, socio-economic, and bureaucratic minefield. This point was reinforced by Stevens and Teggeman's 2004 study in Zambia, where public service reform suffered severely because of the breakdown of a political coalition between ex-President Chiluba's Movement for Multi-party Democracy (MMD) and the trade union leadership; and, in consequence, the government pursued a politically-reactive model of pay reform between 1985 and 2000 (Kiragu and Mukandala, 2004 cited in Stevens and Teggemann, 2004).

The noteworthy point here is that implementation involves actors and structures so cannot be a smooth process since it will create winners and losers, and will therefore have opponents and challenges. Some of the other potential challenges of policy implementation in Africa include: changes in public sector roles, institutional and resource constraints, new patterns of interactions with other agencies and citizens, demand from new constituents, and the pressure to show results in short time periods (Brinkerhoff and Crosby, 2002). These myriad change processes associated with public sector policy reforms pose a challenge to implementation, especially where resources are scarce, institutions are weak and implementing officers are inadequately qualified and resourced.

Other researchers have also identified external influences and lack of reform ownership as part of Africa's public policy reform implementation woes. Conyers, in particular, argued that African countries have little or no control over reforms, making the development of reform become a continuing struggle between the realities of Africa's physical, socio-economic and political environment and the aspirations and demands generated by external forces. This has hampered reform implementation in three ways: first, most of the reform initiatives turned out to be inappropriate and thus failed to have the expected impact; second, the dominance of external forces resulted in a lack of ownership, which meant that the commitment needed to guarantee successful implementation was lacking; and, third, lack of political commitment due to lack of reform ownership has contributed to the poor implementation of many externally-driven and funded reforms (Conyers, 2006: p.615). In addition, implementation is said to have suffered because external influence has put

unnecessary pressure on local management capacities, resulting in reform implementation miseries. In a damming critique of IMF policy interventions in developing countries, Joseph Stigliz (2002: pp.19 and 96) concludes that 'the IMF itself [has] become a part of the countries' problems rather than part of the solution'. Thus, in the view of some scholars, the large number of failed socio-economic and political reform projects in Africa stems in large part from their inappropriateness in the local environment (Conyers, 2006), and non involvement or appropriate consultation of local people from the design to the implementation stage of the reform. In fact, it could be argued the problem was that local ownership of reforms never meant local people leading the reform process.

In addition to these points, lack of capacity (Larbi, 1998; Bartley and Larbi, 2004; Mills et al., 2001); lack of proper consultation and lack of finance have all been cited as obstacles to public sector reform implementation in Africa. For example, Palmer (2000 study cited in Malama, 2003) found that stakeholders and Members of Parliament who were supposed to support reform in Uganda refused to do so because they were not consulted or informed about it. Generally, the cause of such lack of consultation during policy making is attributable largely to the perception that politicians and bureaucrats in Africa have about citizens; that is, they see citizens not as resources to be tapped, but as a 'nuisance' which should be avoided (Palmer, 2003). Gulhati (1989) asserted that a lack of funds was identified as the major reason for reform failure in Zambia.

Other factors identified in the literature as obstructing implementation emphasised the context, content, processes and actors involved in the implementation (Walt and Gilson, 1994; Ayee, 1994; Thomas and Grindle, 1991; Mills et al., 1990). For example, Kiggundu in a 1996 article identified four factors as being major obstacles to the implementation of management reforms in the public sector in developing countries:

1) limited basic research;
2) highly volatile environment;
3) weakness in the performance of the critical operating tasks; and
4) institutional weaknesses.

To these main factors he added:

5) incomplete conceptualisation of the external environment, emphasising socio-cultural rather than economic or technical factors (Sawyer, 1993);
6) lack of inadequate support for developing and sustaining a strategic management-enabling environment;
7) limited local ownership and commitment;
8) the tendency to separate policy formulation from implementation (See also Grindle, 1980; Grindle and Thomas, 1991; Ayee, 1997; Larbi, 1998.).

The Economic Commission for Africa's (ECA) summary of problems confronting the implementation of public sector management reforms in Africa is also a useful work which highlights some major obstacles to the implementation of new public management reforms in Africa and why it is necessary to undertake an in-depth study into the problem in specific countries and public organisations. Among the challenges to reform implementation identified were:

1) institutional capacity;
2) multiple accountability;
3) declining public service ethics;
4) declining social values;
5) declining civil service morale;
6) systemic corruption; and
7) lack of access to ICTs (ECA, 2003: pp.31-37).

Although some of these factors may differ from one country or public organisation to another, this study asserts that it provides a true picture of the implementation challenges confronting many countries in Africa. Generally, this study believes that they are among the major factors obstructing effective implementation of new public management reforms in many public organisations in sub-Saharan Africa. So, what do developing countries in Africa require for successful public sector reform implementation? Based on their recent comparative study of public sector reform in Ghana, Tanzania and Zambia, Stevens and Teggemann (2004) contend that three factors are crucial for successful implementation of reform:

1) the political and economic context must be conducive to reform;

2) reform must be driven by committed leaders in the public service, and implementation needs to be firmly embedded in the administrative and political domains; and
3) the design must be right and contain relative components that work.

In summary, the political and socio-economic context, reform leadership and structures, and implementation arrangements have implications for any effective implementation of public sector reforms in Africa (Stevens and Teggemann, 2004). Additionally and in line with Stevens and Teggemann's suggestion, Malama (2003) identified five key conditions for ensuring the successful implementation of public policies in the African context in a recent review of implementation in Africa:

1) political support;
2) sufficient funding;
3) appropriate institutional arrangements;
4) sufficient consensus building to gain enough broad-based support for the policy; and
5) proper monitoring of the reform process to make sure that it does not go off course.

Thus, in order to further understand the obstacles confronting implementation of public sector management reform in Africa, this study proposes to examine the experience of implementing decentralisation of the health sector at district level in Ghana. Before that, the next subsection will give a brief overview of Ghana's political and economic reform and the challenges that necessitated launching decentralisation reform. The discussion in this subsection sets the stage for a description of the research question under investigation.

1.6 Ghana: geography, politics and economic trends

Ghana is one of the countries in West Africa, located between latitude four and half (4½) degrees north and eleven and half (11½) degrees north. It is bordered to the south by the Atlantic Ocean, to the east by Togo and the west by Cote d'Ivoire, and in the north by Burkina Faso. Ghana has an area of 238,537 sq. km (92,100 sq. ml). According to the 2000 census; the population is approximately 19.9 million, with over 60% living in rural areas (Ghana Statistical Service, 2000). The climate is tropical, generally warm and humid except for hilly areas. Much of the southern part is covered by tropical rainforest, while the northern parts consist predominantly of savannah-type vegetation.

Ghana attained independence from British colonial rule in 1957, and was the first colony south of the Sahara to do so. Since independence, Ghana has experimented with various types of governments: the 'Westminster' model of parliamentary government (1957-1960 and 1969-1972); one-party dictatorship (1960-1966); military dictatorship (1966-1969; 1972-1979 and 1981-1992); a United States model of power separation (1979-1981); and the Fourth Republican Constitution (1992 to date), which is a combination of the Westminster type and the American/Presidential model[4]. After ten years of rule, the Provisional National Defence Council (PNDC) restored multiparty democracy in 1992 under the Fourth Republican Constitution. During its years in power, the PNDC and its predecessor, National Democratic Congress (NDC), have undertaken several reforms in the political, economic and administrative sectors of the country; these are reviewed briefly below.

1.7 The politics of public sector reform and decentralisation in PNDC's Ghana

As noted above, the coup of December 1981 brought the Provisional National Defence Council (PNDC) to power, and under the party's regime, major changes have occurred in Ghana's economic and political development, including the public administration system. For instance, the promulgation of the 1992 constitution and the subsequent return of the country to constitutional rule marked an important watershed in the country's political history. The then-National Democratic Congress (NDC) government, under the leadership of J.J. Rawlings, vigorously pursued a policy shift from state intervention and excessive regulation to a liberalised free-market economy. The novelty of this neo-liberal policy paradigm shift was transferred through globalisation of ideas about economic and public management, especially by the IMF and World Bank. It consisted in an outright revocation of the dominant role of the state in providing public services, and ensuring equity and correcting market failure in the economy. This shift was not a voluntary political choice but an imposition - in fact, it was a condition for obtaining monetary assistance from the IMF and World Bank.

[4] Ghana has had a chequered political history since independence. As well as the overthrow of its first elected President, between 1972 and 1979; Ghana has been ruled by a succession of military officers and organisations, including: (National Redemption Council (NRC), Supreme Military Council (SMC) I & II; and, in June 1979, by the Armed Forces Revolutionary Council (AFRC), headed by Flight Lieutenant J.J. Rawlings. Between December 1981 and 6 January 1991 the country was again ruled by a military dictatorship under Jerry John Rawlings and the Provisional National Defence Council (PNDC).

One corollary to these neo-liberal market reforms was the decentralisation of the political and administrative machinery of government. This decentralisation was extended to almost all public sector organisations, including health and education, and was designed to offload the overburdened state and to facilitate the implementation of ongoing social and economic reform programmes. Particularly for the health sector, the reform emphasised decentralisation of management and service delivery processes as a means to improve access and quality. Although decentralisation is not new in Ghanaian public administration; its introduction and application to political management and public service governance in the mid-1980s was unprecedented.

Three reasons are given in the literature for decentralising Ghana's administration system in the mid-1980s. Firstly, decentralisation was made a condition for accessing aid from donor agencies; it was therefore tied into the 1986 Structural Adjustment Programme (SAP), which itself was introduced to sustain the modest gains recorded after three years of implementing an austerity Economic Recovery Programme (ERP) from April 1983 (Ayee, 1996). Secondly, decentralisation was introduced as one of the goals of SAP at the time and aimed to remove structural impediments to ensure smoother implementation of the ERP. Thirdly, the decentralisation programme was meant to democratise the then-military government's political system and, as a consequence, improve both local and international legitimacy of the Jerry John Rawlings' government (Ayee, 1996; Ninisin, 1991). In short, the first objective for decentralisation was political, and the second was administrative and developmental.

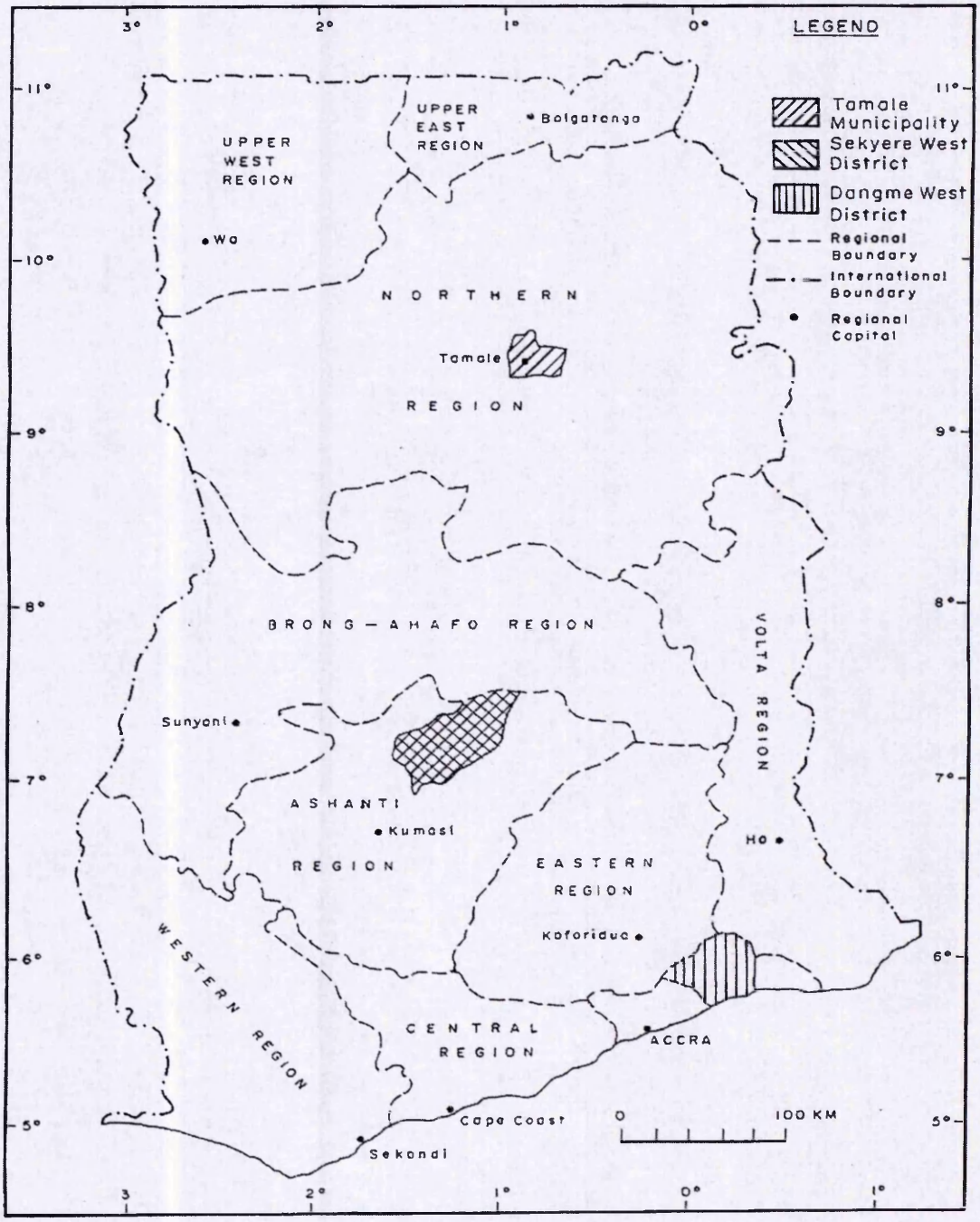
Apart from that, the PNDC launched decentralisation in order to win the support from donor agencies on which it depended for financial survival (Ayee, 1997: p.38). Ghana's decentralisation reform was of great value to the government because it was strategically deployed as an instrument to stabilise a regime in crisis and to secure some of the government's political objectives, including promoting grassroots democracy. In furtherance of this goal, the PNDC government ensured that decentralisation as a development strategy was later enshrined into the 1992 Constitution. Chapter 20 of the Constitution, entitled 'Decentralization and Local Government', recognises the crucial role of a decentralised political and administration system in the country.

This is how decentralisation as institutional reform strategy came to be applied to both political and administrative organisations in Ghana – a process which has been ongoing for nearly a decade and half. The Ministry of Health (MOH) is a notable public sector organisation which is being restructured through decentralisation and has been integrated into the Ghana Poverty Reduction Policy Strategy of the government's development programme. Perhaps the most popular and remarkable organisational change under the current health sector reform has been decentralisation; the transfer of decision-making authority and management from higher level of government – typically from central agencies – to agencies at the regional, district, or local levels. Supporters of decentralisation argue that, because decentralisation brings government and administration closer to the governed both spatially and institutionally, government will become more knowledgeable and responsive to the needs of the people.

The theoretical objectives and benefits of decentralisation are great, but are the realisation of these goals fashionable and practicable as postulated? In this dissertation, the degree of decentralisation in Ghana's public administration is examined, using the case of its health sector. The study fundamentally seeks to explore the major sources of challenges to decentralisation implementation in Ghana's public health sector. The next section describes the research problem and related research question(s). Before that, Figure 1.1 is a map of Ghana showing its ten political and administrative regions and the districts where the three case studies were researched: Tamale, Sekyere West, and Dangme West.

Figure 1.1: Map of Ghana

showing its ten political and administrative regions and the case study sites



Source: adapted from CGIS, University of Ghana (2001)

1.8 The research question(s)

As outlined in the previous section, many reforms have been introduced in the Ghana public sector since the mid-1980s. These reforms have aimed to make public services efficient and more responsive to the needs of service users. Decentralisation is one of such reform initiatives introduced by the government in order to improve the quality of the country's health service.

Since its introduction and implementation in the late 1980s, decentralisation has brought about significant changes, especially in the organisation, management style, structure and functional operation of the health system. The achievement of these modest results has not been unproblematic, especially at the implementation stage. In fact, the implementation of decentralisation in the health sector has been faced with critical problems which, to a large extent, have undermined the efficient and effective delivery of health services (MOH, 1996).

Evidence from the literature shows that some studies have been conducted into this decentralisation reform in Ghana and its related implementation problems (Larbi, 1998 and 1994). Most of these studies have analysed specific aspects of the problem which have hindered the effective implementation of decentralisation reform efforts (see Agyepong, 1998; Bossert and Beauvaiu, 2002; Smithson et al., 1997; Mills et al., 2001). A critical review of these earlier works revealed that they have focused more on analysing the problem of implementation at the central Ministry of Health level, giving little or no attention to challenges confronting reform implementation at the district level. Furthermore, most of these earlier studies restricted their analysis to structural and systems problems at national and regional level, with no or little attention to the organisational dimension of the implementation problem at the district level. In other words, previous studies overemphasised reform implementation challenges at the national level in comparison to the district level, and there is therefore a gap in the literature of understanding the sources of challenges to reform implementation at district level. This observation raises important questions about factors affecting the decentralisation process, as experienced by district health management teams. There is no doubt that the role of the central health bureaucracy (Ministry of Health) is key in both technical design and implementation of health reform and decentralisation (Stephen, Ndegwa and Levy, 2004); but it is equally important to

explore the difficulties of harnessing the district level health bureaucracy to the task of effectively implementing decentralisation.

The present study will examine the sources of challenges to, or factors that influence, the implementation of decentralisation at district level. Specifically, the study aims to explore how some selected factors internal to District Health Management Teams (DHMTs) influence the implementation of decentralisation reform in Ghana. Put in more practical terms, the study investigates the influence of characteristics of DHMTs on the implementation of decentralised health management practices in the daily life of district health systems in Ghana. The principal research question is: how have the characteristics of district health systems influenced the implementation of health sector decentralisation in Ghana?

Key to answering this question is an analysis of factors influencing the health decentralisation process at a district level, especially, but not exclusively regarding the factors influencing the entire health sector reform through decentralisation. A particular focus is on factors internal to District Health Management Teams in Ghana. Answers to the main research question were pursued through the following specific practical research questions:

1) how have staff capacity; leadership; staff commitment and communication affected the implementation of decentralisation reform at district level?
2) what lessons can be learned from examining the experience of district health management teams in implementing health decentralisation, and what are the implications for policy, practice of decentralisation and implementation research?

The study is organised around these three interrelated research questions, and also contains the literature review, methodology, results and discussion of findings, and a conclusion. The outline and description of each of the study's chapters follows.

Chapter 1 presents a brief overview of public sector reform issues and its adoption and implementation in Ghana in the 1980s and 1990s. Decentralisation was central to Ghana's political, administration and socio-economic reforms in the last two decades of the twentieth century. However, the management of decentralisation implementation,

especially in the health sector, posed a major challenge, leading to a gap between reform intention and outcome. It is against the backdrop of that brief overview that the chapter poses the research question and identifies the objectives of the study.

Chapter 2 presents a detailed literature review on the concepts of decentralisation and New Public Management (NPM) and the potential challenges in its application for restructuring public service organisations in developing countries. The focus was on administrative or managerial decentralisation in the public health sector and its implementation challenges.

Chapter 3 sets out the theoretical context of the study by reviewing the current debate on implementation. The chapter provides a theoretical insight into the debate on implementation based on both top-down and bottom-up perspectives. Insight from contemporary theoretical and empirical research, especially in developing countries, was useful in developing a working framework to guide the present study. Specific attention was given to the issue of the characteristics of the implementing agency and its influence in the implementation process. The focus was on four elements: staff capacity, agency leadership, staff commitment, and communication. Each was isolated for analytical purposes and the study was developed around them. The literature review was undertaken with the following questions in mind. What can the implementation literature teach us about implementing health decentralisation reform? Why do outcomes at the district level differ so greatly from the original objectives? How can the underachievement of decentralisation efforts be explained, from both the perspective of policy makers at the top and policy implementers at the lower level?

Chapter 4 describes the methods and techniques that were employed in this study, and the level at which the particular methods were utilised. Firstly, the chapter describes the epistemological orientation and the research strategy, which was a mixed research design involving documentary sources, semi-structured interviews, surveys and informal discussion, all used for data collection. Secondly, the chapter describes the major activities undertaken during the fieldwork in Ghana, the problems encountered and steps taken to minimise these. The chapter also describes the choices of each case study and how the data was processed and analysed.

Chapter 5 provides background information on Ghana's political and economic development trajectories and its linkage to decentralised management reforms in the health sector. The chapter attempts to answer the following questions:

1) what role have political and economic factors played in pushing Ghana's government to initiate public sector reform?
2) how has this reform performed so far?
3) what factors are challenging reform implementation? and
4) what lessons can be learned from reform this implementation management experience?

Chapter 6 gives an historical background to the evolution of Ghana's public health system and the factors that pushed for reform. The chapter examines the achievements of health decentralisation and the challenges for its implementation. The analysis was based primarily on secondary data collected from central government policy documents, official evaluation reports, district annual reports and reviews of sector performance documents from the Ghana Health Service and academic case studies. Official sources included reform evaluations undertaken by the central Ministry of Health and Ghana Health Service, evaluations undertaken by World Bank and World Health Organisation consultants, and experts inside and/or outside the country's health service.

Chapter 7 presents the research findings from both interviews and surveys of health officials and stakeholders. It aims to provide evidence from an in-depth study of district health management teams to help further an understanding of the challenges to implement health decentralisation at a district level. The data for the study was obtained through semi-structured interviews and small-scale surveys conducted with 59 interviewees and 142 health staff in the three case districts.

Chapter 8 adds depth to the findings by further discussion and analysis of topical issues within the context of the study's research question. The chapter revisits the underlying assumption informing the research in relation to its working framework for analysis, and draws out the most significant and interesting findings of the study. Thus, it undertakes a more critical analysis of the findings from the interviews and surveys, with reference to the

relevant literature. To conclude, the chapter provides an operational framework for studying implementation problems in developing country contexts.

Finally, chapter 9 summarises the study's findings and draws conclusions from these. It links the findings to the research question and study objectives, paying particular attention to the influence of agency factors in decentralisation reform implementation at district level and draws attention to lessons for future implementation management and research. It also outlines major limitations of the study and areas that require further research.

Chapter 2

2.0 Literature Review of Decentralisation and New Public Management Concepts and Issues in Public Sector Management Reform

2.1 Introduction

In chapter 1, the research problem, specific study objectives and the structure of the study were presented. As a continuation of the issues raised, this chapter reviews selected theoretical literature on the concepts of decentralisation and New Public Management (NPM), to provide a conceptual background for understanding the issues around which the research question being investigated revolve.

The chapter has four objectives:

1) to provide a theoretical literature for understanding decentralisation and NPM from a public management perspective;
2) to identify the theoretical justification for the appeal of decentralisation in current development and management thinking;
3) to give an overview of the global trend of decentralisation and NPM and the forces responsible for its transfer from developed countries to developing countries; and
4) to draw on relevant literature to show the various structures and processes through which decentralisation is being used to restructure the operation and functioning of public health systems.

The chapter is organised as follows: the first section examines the definition, types, benefit and values of decentralisation, looking specifically at administrative decentralisation. The next section discusses decentralisation in management and development thinking and highlights its linkage to the global trend of NPM-style reform, situating NPM reforms within a developing country context. The study then identifies and describes some specific structural, functional and process changes which decentralisation seeks to introduce into health care management. The last section summarises the discussion and concludes the chapter.

2.2 Background to decentralisation

Decentralisation has a long history[5]. There have been many studies on the theory and practice of decentralisation, much has been written and learned about the what, how, when and why questions of decentralisation. The question of interest here is: what are the insights that can be drawn from existing decentralisation literature for the purpose of this study? This question requires a definition of the concept itself.

2.3 Definition of the concept of decentralisation

There is much ambiguity surrounding the definition of decentralisation because various writers have defined the concept differently (Turner and Hulme, 1997). It is not possible to review all the definitions and meanings here, so a general overview of the concept and its usage in this study, particularly in relation to health service management, will be given. Following a recent approach adopted by Litvak et al. (1998), decentralisation will be defined in this study from a normative and functional perspective. The functional approach is associated with the works of Litvak and his [/her] colleagues in their 1998 World Bank study; their three broad functional dimensions being: political, administrative and fiscal. In line with recent research development management and public administration literature it is also important to incorporate New Public Management (NPM) as a subsection or subcategory of administrative or managerial decentralisation in this study.

It is important to state from the outset that this study adopts an administrative or managerial view of decentralisation and, therefore, the discussion will be heavily informed by that conceptual perspective. The next section casts light on the concept of decentralisation, giving prominence to managerial rather than political decentralisation.

Political decentralisation is traditionally said to be about shifting policy making responsibility from the central government level to the local level within a country. For example, Pollitt et al. (1998) define it as moving authority to lower levels of government. In the health sector, this may mean moving from the central Ministry of Health to regional or from regional to district and sub-district level. Other writers have expressed related views

[5] Every country in the world has undertaken some form of decentralisation within the past two decades (Turner and Hume 1997). By the early 1990s, all but 12 of the 75 countries with a population of more than five million had undertaken some form of decentralisation (Dillinger, 1994; Rondinelli, 2006). At the end of the 1990s, approximately 95% of all countries with a democratic political system had sub-national units of administration or government (World Bank, 2000 cited in Rondinelli, 2006).

about political decentralisation. Wolman (1994) viewed it as moving decision-making discretion with regard to the policy to be pursued, including financially-related variables such as the amount to be raised and the pattern of expenditure.

Administrative decentralisation is a process of creating space that allows lower level staff to have a stake in decision-making processes within an organisation. Administrative decentralisation can be seen as an administration and organisation approach which opposes the core ideas of traditional Weberian bureaucracy (Bossert, 1998; Saltman and Bankauskaite, 2004). Therefore, in place of a centralised, hierarchical style of administration, decentralisation encourages the granting of operational authority to front-line staff, as noted in Lipsky's 1980 seminal study of street-level bureaucrats. Essentially, administrative decentralisation came to be popular following the revelation that lower-level staff make important organisational decisions on their own every day (Lipsky 1990).

Fiscal decentralisation is simply a subsection of administrative decentralisation; and it is based on the belief that certain financial and expenditure activities of central government can be better undertaken by regional, municipal, district, sub-district or other lower level agent, rather than by central government. But since fiscal matters (e.g. taxation and public expenditure) are, by nature, political and important to central government policy making, there is a close linkage between political decentralisation and fiscal decentralisation. Until the 1970s, the idea and practice of fiscal decentralisation was popular in federal systems of government (see Musgrave, 1959), and was initially known as 'fiscal federalism', as in the case of the US compared to Western European countries[6].

From these three broad dimensions of the concept, it can be seen that, common to most definitions, is the agreement that decentralisation involves the transfer or spreading out of formal authority from a smaller to a larger number of actors (Pollit, Birchall and Putnam, 1998); who use this authority to perform some service to the public. The authority given can be given either from an individual or an agency in central government to some other individual or agency at a lower level and therefore closer to the public to be served (Turner and Hulme, 1997).

[6] For theoretical thrust and some benefits of fiscal decentralisation see King (1984); Bird (1999) and Brennan and Buchanan (1980); see also Saltman and Bankauskaite (2004).

Table 2.1 gives a brief summary of some conventional definitions of the concept in the literature[7].

Table 2.1: Summarised general definitions of decentralisation

Year	Author	Definition
United Nations	1961	The United Nations defines decentralisation as 'a plan of administration, which will permit the greatest possible number of actions to be taken in areas, provinces, districts, towns and villages where people reside'
Wolfers	1982, p.5	Wolfers et al. (1982: p.5) point out that 'decentralisation refers to one or both of the following: (a) the dispersal of government personnel, physical plant and/or services; and/or (b) the redistribution of governmental functions and/or powers. Governmental power may be decentralised into: (a) a political body as a sub-national government; and/or (b) an appointed official or a group of officials in the field, i.e. *political bodies* or *appointed officials*; (local government units or any bureaucratic organisations)
Mintzberg	1983	'When all the power for decision making rests at a single point in the organisation – ultimately in the hands of one person – we shall call the structure centralised; to the extent that the power is dispersed among many people, we shall call the structure decentralised' (Mintzberg, 1983 cited in Kiggundu, 1989: p.229).
Rondinelli and Cheema	1983	They define decentralisation as: '...the transfer of planning, decision-making, or administrative authority from central government to its field organisations, local administrative units, semi-autonomous and parastatal organisations, local governments or non-governmental organisations' (Rondinelli and Cheema, 1983: p.64).
Smith, B.C.	1985	Smith states that: '...decentralisation means both reversing the concentration of administration at a single centre and conferring powers
Smith, B.C.	2002	on local governments... decentralisation is a political phenomenon and it involves both government and administration' (Smith, 1985: p.1).
Mills, Anne	1990	Decentralisation can be defined in general terms as the transfer of authority, or dispersal of power for public planning, management and decision-making from the national level to sub-national level, or more generally from higher to lower levels of government (Mills, 1990: p.3).
Gaster and O'Toole	1995	Decentralisation 'involves a fundamental change from a centralised authority where... decisions are referred upwards and inwards (to) a decentralised and devolved authority where, within a corporate policy framework, managerial and sometimes political decisions are made nearer to the point of service delivery... to make services accessible in every sense of the term' (Gaster and O'Toole, 1995: pp.4-5).
Works	2002	Decentralisation is the transfer of responsibility for planning, management and resource raising and allocation from the central government and its agencies to the lower levels of government. Works said further that decentralisation is closely linked to the concept of 'subsidiarity', which proposes that functions (or tasks) be devolved to the lowest level of social order that is capable of completing them (Works, 2002).

Source: extracted by author from literature, 2007.

A quick glance at Table 2.1 shows that the concept of decentralisation covers a wide spectrum but the basic elements are essentially the same. Indeed, the various meanings and

[7] Despite its long history and popularity, there is no unanimity on a definition of decentralisation.

connotations have been extensively explored by many writers (Smith, 1985; Cheema and Rondinelli, 1983). But, for the purpose of this study as noted above, the concept of decentralisation is used along the lines of Mintzberg's (1983 cited in Kiggundu, 1989) definition; that is, the study essentially adopts a managerial viewpoint of decentralisation rather than a political one. Thus, when one mentions decentralisation in this study, it is taken to mean the delegation of formal responsibility and/or authority to an agency, either in the public or private domain where the agency remained under the control of the organisation which delegated the authority from a higher level (e.g. central government's Ministry of Health). Some scholars also share this view, defining 'decentralisation' to mean the transfer of formal responsibility and authority to make decisions, plan and manage people, resources and services to lower-level administrative units and officials in an organisation (see Vrangbaek, 2004; Work, 2002; Turner and Hume, 1997; Pollit, Birchall and Putnam, 1998).

The definition adopted for the study has many elements – for instance, it emphasises the importance of formal responsibility and authority to make decisions; and the shift in decision-making structures from a smaller number to a larger number of managers within the same organisation structure or different organisation level (Kiggundu, 1989). The transfer can be on a political level (devolution), administrative level (deconcentration), and institutional level, or to private or non-government organisations (privatisation) (Cheema and Rondinelli, 1983; Smith, 1985; Turner and Hulme, 1997). Also, responsibility and power as used in the definition are not taken to be absolute; rather, decentralisation is taken to be a movement between two poles (i.e. a continuum), where the degree of responsibility will depend on the specific institution or organisation. Thus, the degree of responsibility and/or authority transferred is an important issue when considering decentralisation.

For purposes of conceptual clarity, it is important to state here that delegation or administrative decentralisation is different from decentralisation from central government to local government units – the classical form of decentralisation popularised in the development literature (Smith, 1985). As will be seen in section 2.3.1 below, the emphasis in each of the forms or degree of delegation differ.

Having defined the concept of decentralisation, the next section focuses on some types of decentralisation. Not every type of decentralisation will be discussed in detail here, since this has already been done by a number of writers (Rondinelli and Cheema, 1983; Turner and Hulme, 1997; Smith, 1985; Kiggundu, 1989; Slater and Watson, 1989). A discussion on privatisation is also beyond the scope of this study.

2.3.1 Forms of decentralisation

Table 2.2 summarises the forms or nature of delegation. There is an element of delegation in every form of decentralisation, however, some scholars still consider delegation itself to be a type or form of decentralisation. For the purpose of this study, only devolution and deconcentration will be discussed in detail.

Table 2.2: Forms of decentralisation

Nature of delegation	**Basis for delegation**	
	Territorial	**Functional decentralisation**
Within formal political structures	Devolution (political decentralisation), local govt. democratic decentralisation	Interest group representation
Within public administrative or parastatal structure	Deconcentration (administrative decentralisation, field administration)	Establishment of executive/ autonomous agencies, parastatals and quangos
From state sector to private sector or non-state organisations	Privatisation of devolved functions (deregulation, contracting out, voucher schemes)	Privatisation of national functions (divestiture, deregulation, economic liberation)

Source: adapted from Turner and Hulme (1997: p.153)

Devolution involves conferring the power to discharge specified functions to formally-constituted local agencies or local authorities (Cheema and Rondinelli, 1983; Turner and Hulme, 1997)[8]. Devolution is the transfer of decision-making powers, resources and tasks to lower-level authorities which are democratically elected and largely, or wholly, independent of the central government (Manor, 1995; Slater, 1989). From a public administration perspective, under devolved administrative arrangements, central government frequently exercises only indirect or supervisory control over the devolved units. Devolution has statutory or constitutional status because the transfer of power takes place through constitutional amendments and legislative enactments (Smith, 1985: p.9)

[8] See also Mawhood, 1983; Smith, 1985 and 1990; Ayee, 1993 and 1992; Conyers 1990; Wunsch and Olowu, 1991.

Deconcentration is generally taken to mean administrative decentralisation. It is the transfer of authority and responsibility over specified decision-making, financial, and management functions by administrative means to different levels within a formal administrative structure (Cohen and Peterson, 1995). Work (2002) defines it as the transfer of decision-making authority, resources and responsibilities for the delivery of a selected number of public services from the central government to other levels of government, agencies, and field offices of central government line agencies (see also Rondinelli and Cheema, 1983). The exercise of decentralised authority under deconcentration is limited and subject to organisational controls and influence from the centre. Deconcentrated units are just extensions of the centre and are usually created by executive instruments; thus, the lower-level representatives have a less-comprehensive portfolio of functions both within and outside the organisation (Siddique, 1997).

2.3.2 General benefits of decentralisation

The increasing appeal of decentralisation has been rooted in its potential benefits (see Turner and Hulme, 1997; Kulipossa, 2004: pp.768-770). According to the literature, the general benefits of decentralisation can be summarised into three overlapping values: political values, governance values, and efficiency values (Wolman, 1990: p.30 cited in Kulipossa, 2004), each of which is discussed in the next section.

Political benefits

This view is traced to classical liberal democratic theories (especially Alexis de Tocqueville and John Stuart Mill), which saw decentralisation as a way to spread political power to a broad section of citizens, allowing them to participate in decisions that affect them (Smith, 1985; Turner and Hulme, 1997; Kulipossa, 2004). In essence, decentralisation is seen as good both for national and local democratic government, and local government is considered an important vehicle for promoting democratic aspirations in the modern state. Examples are: representative government, citizen participation, building local institutional capacity in supporting democracy; providing an appropriate environment for national political education; socialisation of prospective political leaders; and enhanced stability of the political system to ensure social equality and responsiveness as well as guaranteeing effective accountability (Litvack et al., 1998; Siddique and Hulme, 1994).

Governance benefits

Given that decentralisation disperses power across governmental structures, functions and processes, it has the potential to increase responsiveness, accountability, political participation, education, leadership development, political equality, and more flexible and speedy decision-making (Kulipossa, 2004). It may also improve the effectiveness of government operation through checks and balances on the performance of public institutions and officials and, in the process, curb official corruption and possible antagonism in central-local government relations (Saito, 2003; Smith, 1985; Tordoff, 1994).

Efficiency benefits

Using rational choice theory, economists contend that decentralisation promotes competition and efficiency. It is argued that, under conditions of reasonably free choice, the provision of some public goods is more economically efficient when a large number of local institutions are involved than when central government is the only provider. The competition associated with a large number of providers will offer citizens more choice and options and thereby create conditions for efficiency (Bailey, 1999: p.33 cited in Kulipossa, 2004: p.770).

Turner and Hulme (1997) bemoan that proponents of decentralisation rarely consider its disadvantages. It is argued that decentralisation can exacerbate the following:

1) importance of ethnic and regional identities, intensifying forces for secession and creating political instability;
2) capture of political power by local elites (Saito, 2003);
3) inter-regional income disparities, where locally-made plans are inconsistent with national resources and plans, where a large number of local governments require more resources and where there is a lack of committed administrative supervision and coordination;
4) increased pressure on government budget; and
5) breeding of corrupt, irresponsible and bad local governance.

These are all problems associated with decentralisation, and they are not difficult to find, in both developed and developing countries[9].

[9] See Turner and Podger, 2003; Saito, 2003; Prud'homme, 1995; Collins and Green, 1994; Tordoff, 1994; Ayee, 1994; Acheampong, 1995.

Management benefit

The administrative argument for decentralisation is of significance to this study because it focuses more on delegation within organisation and coordination between organisations (Turner and Hulme, 1997; Smith, 1985 and 1990). Often it is believed that administrative decentralisation would enhance managerial responsibility (Mintzberg, 1979 cited in Kiggundu, 1989). Administrative decentralisation gives lower-level workers the opportunity to participate in decision making and management of their organisations. The idea is that this would increase commitment and job satisfaction and impact positively on motivation, communication, creativity and, consequently, productivity. Mintzberg (1979 cited in Kiggundu, 1989) argues that administrative decentralisation enhances decision making by formalising the informal. Also, decentralisation is thought of as a way to attain better decision-making and to enhance efficiency and effectiveness in such areas as: lower-level planning; inter-organisational coordination; experimentation and innovation; motivation of field staff; and work reduction (Smith, 1996 and 2002; Kiggundu, 1989).

Furthermore, administrative decentralisation is seen as a useful strategy for transforming the locus of power in organisations. Typical effects concern the delegation of power, responsibility and functions within bureaucratic organisations, in both public and private sectors. Pollitt et al. (1998) observed that decentralisation is seen as having the potential to create opportunity for a managerial cadre in an organisation to share its authority with other groups (Minztberg, 1979 cited in Pollitt et al., 1997; Smoke, 2001). Similarly, Osborne and Gaebler, in their seminal 1992 work, *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector,* observed that decentralisation is the key to promoting 'participatory management', which is crucial for improved performance (see also Smoke and Olowu, 1993; Smith, 1997).

Clarke and Newman also asserted that administrative decentralisation is a means to organisational transformation because it is a means for dislocating bureau-professional regimes: 'Management in this case is no longer the sole province of the most senior organisational tiers where only top manager are to be found, but has cascaded down organisations to relatively low paid, low status service delivery functions, drawing more junior workers into jobs with managerial titles and responsibilities' (Clarke and Newman, 1997). In essence, administrative decentralisation is a strategy for restructuring the

command structure for controlling power in public organisations, and is a means to create a new organisational culture suitable for individual, group and organisational development.

Lastly, administrative decentralisation is said to enhance coordination. According to Maetz and Quieti (1987), one of the objectives for administrative decentralisation in developing countries is: 'more effective coordination of development activities at various spatial levels'. Administrative decentralisation through local government bodies is seen to contribute to efficient service delivery by providing this coordinating function. It is intended 'to apply a horizontal and integrated approach to matters pertaining to planning and development' (Commonwealth Secretariat, 1989 cited in Smith, 1990), to improve coordination between closely-related areas of administrative responsibility, to ensure consistency among policies of different agencies and reduce wastage and duplication of efforts.

However, because decentralisation is so contextual, it cannot be assumed that all these normative values and benefits will always and automatically result from it. Handy (1985) criticised some scholars' one-sided view, arguing that most proponents of decentralisation overlook its shortcomings. First, decentralisation has a tendency to result in a loss of central control, and it may increase operational costs because the diversity of work activities and processes in different parts of the organisation may lead to loss of economies of scale. Second, it may create coordination and supervision problems, especially in areas where there is a lack of capacity and work description is unclear (Smith, 1990). It is unlikely that it will create the required organisational culture needed for it to be effective. Decentralisation seeks to change organisations' performance, but it could be argued that poor organisational performance cannot be changed merely by changes in structures, functions and responsibilities; it needs more than that. For example, changes in attitudes, values, mindsets and relationships, expectations and constituencies must occur in governing the entire system, and this may take a long time.

As a World Bank study concluded, decentralisation is neither good nor bad; but rather its effects depend on institution-specific design (Litvack, Ahmad and Bird, 1998). In their Asian and African case studies, Crook and Manor (1998), also noted that decentralisation is indeed 'a policy forced to carry an unrealistic burden of expectations regarding its ability to

transform whole societies dominated by authoritarian or patronage politics' (Crook and Manor, 1998: p.302; Nijenhuis, 2003). This means that, for any meaningful analysis, the concept of decentralisation must be clearly explained and its application needs to be worked out carefully with due regard to the circumstances of each specific country or organisation.

2.4 Decentralisation in development thinking

What is the place of decentralisation in development thinking and practice? To start with, the development administration revolution of the 1960s and 1970s made the participation of citizens and stakeholders in decision-making become more desirable for sustainable development. In consequence, decentralisation became the 'latest fashion for development' (Conyers, 1983). Decentralisation in development is still seen to offer great opportunities to reduce the common problems of centralisation. The World Bank noted that:

> State institutions are often accused of being too remote from daily realities of poor people's lives, and decentralisation is often recommended as a solution. Decentralisation can be powerful for achieving development goals in ways that respond to the needs of local communities, by assigning control rights to people who have the information and incentives to make decisions best suited to those needs, and who have the responsibility for the political and economic consequences of their decisions (Conyers, 2000: p.106).

The World Bank argued that decentralisation may offer a successful means of solving the problem of underdevelopment and poverty in developing countries, especially in newly independent states in Africa and in developing countries in general. The attraction of decentralisation is not merely that it is the opposite of centralisation and can therefore be assumed to be capable of remedying the latter's defects. Smith (1985) asserted that what needs acknowledging is that decentralisation has a positive side; therefore it is seen in international development as an indispensable alternative to centralisation, because it is directly linked to increased participation of citizens, which is considered crucial for 'good governance' and 'good management'.

Global political economy ideas of development – especially in international development thinking during the 1970s and 1980s – shifted from 'macro-economics' to 'basic need' approaches, with an emphasis on good governance and participatory development planning. This shift has led to increasing call for the transfer of responsibilities to local governments and communities. Decentralisation is thus seen as a more effective way to meet the development needs of local people than centralised planning, because of the belief

that decentralisation will make governments more responsive (World Bank, 1989; Smith, 1993; Hume and Woodhouse, 1994). Thus, decentralised units are (at least in theory) perceived to be better placed to perform political and developmental functions more effectively on behalf of their communities.

Another dimension of the argument for decentralisation is that, especially in the case of rural development, it is a better way of making decisions more relevant to local needs and conditions because it involves local people (Crook and Manor, 1998; Crook, 2003; Conyers, 1983)[10]. The World Bank believes that decentralisation will lead to better public decisions reflecting local priorities (World Bank, 1997 and 1999).

Viewed within the context of African development history, it can be argued that decentralisation is not new; but its adoption as a development policy instrument, especially in the 1980s and 1990s, was due largely to pressure from international donor agencies. Combined pressure from external and internal pro-democracy forces and allied social movements resulted in a wave of democratisation reforms across developing African countries in the late-1980s. Working within this context donors, particularly the World Bank, made decentralisation and democratic reforms a condition for giving financial assistance to developing countries, including those of Sub-Saharan Africa. The World Bank and the IMF pushed further for democratisation and good governance, later adding poverty reduction; all of which should be pursued through the instrumentality of decentralisation. In the political sphere, therefore, decentralisation is seen as promoter of good governance and democratic values; and in the public administration sphere, decentralisation is seen as promoter of good, responsive and accountable administration. In short, decentralisation became a fashionable policy instrument for achieving multiple goals, which included economic development; increased public participation and accountability; responsible public stewardship; good administration; and good governance.

2.5 Decentralisation and poverty reduction

Perhaps the most persuasive of the arguments in contemporary development debate is that decentralisation has the potential to promote socio-economic development in areas where centralisation has failed. Decentralisation is, therefore, regarded not only as an alternative

[10] Again, the World Bank, the International Monetary Fund (IMF) and other donor agencies have contributed substantially to this dimension of the argument, emphasising the participatory element and its implications for empowerment and good governance.

approach but as a solution to the crises of underdevelopment and poverty reduction (see Rondinelli et al., 1981 and 1983; Chambers, 1983; Uphoff and Esman, 1982; Conyers, 1981; Smith, 1985; Wunsch and Olowu, 1991)[11]. Decentralisation was said to have the potential to accelerate development and improve the lives of poor people and disadvantaged communities. This argument made the United Nations (1962 and 1979), the UNDP (1998), the World Bank (1989; 1993 and 2001) and OECD (1997) mainstream decentralisation as a key priority policy for development and poverty reduction; and this was responsible for its inclusion in the strategies for pursuing the UN's Millennium Development Goals. In summary, decentralisation in contemporary development theory is viewed not only as a solution to the shortcomings of centralised administration and planning, but also as an alternative approach to promote sustainable development for poverty reduction.

2.6 The concept and issues in New Public Management (NPM)

As stated above, this study adopts a managerial view of decentralisation. This choice is based on the observation that, unlike earlier local government reform and decentralisation which emphasised popular participation in decision making at the district level, Ghana's public sector reform aimed to modernise public services through decentralisation. Also, although the government at that time had initiated local government reforms and created district assemblies as the highest political authority tasked with the implementation of development programmes at a district level, the government saw the reform of the public administrative system via decentralisation as being crucial to reengineering public services.

Essentially, NPM and allied public service decentralisation reform was considered very important both to the effective management of Ghana's neo-liberal economic recovery programme and to management of public services aimed at poverty reduction. Among other considerations, this explains why it is deemed necessary to prioritise NPM-style decentralisation in the discussion over the political literature on decentralisation. Indeed, managerial decentralisation formed an important component of NPM reform and seemed to have a wider vision for the countries undertaking it, in that it seeks to link reforms to broader political economy, macro-economic management and social development (Kiggundu, 1991; Barlow, 1997 cited in Bana and Ngware, 2006).

[11] Critics of centralisation and 'big development' argued that centralised development programmes initiated by governments were performing poorly, while worsening the conditions of poor countries. This argument, advanced by Robert Chambers (1983) and others, affected thinking in development circles, especially the World Bank/IMF, the UN and other international development agencies.

Another attraction of NPM-style reform is its emphasis on linking public service reform to good governance. A primary element of good governance is ensuring that citizens have a say in how they are governed: that is, having in place a democratic framework at both national and local levels, and creating space for citizens to participate in deciding which services they need and the standard or quality of those services. It also entails making service providers responsible and accountable for service delivery to citizens (see Kiragu and Mutahaba, 2006). NPM reforms seek to promote good governance through managerial decentralisation.

In light of this view, the following sections make a foray into the concept of NPM and how it is transferred to developing countries. Minogue (1997.) noted that most authors see NPM as something akin to a managerial revolution; a paradigm shift from old assumptions about the state to a new entrepreneurial government, a force seeking to drive out the devalued currency of 'old public administration'. Essentially, NPM seeks to change ideas about the state, government and governance in general. According to Lane (2000), NPM offers a set of new ideas about how government can get its work done. NPM seeks to transcend a pure theory of bureaucracy (Lane, 2000), where constant 'de-bureaucratisation' is considered a primary task of 'good management' (Aucoin, 1995); and where management of public operations is not seen as the 'administration of law' but as 'administration of services' to effect desired outcomes. In brief, NPM seek to inject private sector, market-oriented and entrepreneurial ideas and practices into the business of government[12].

More specifically, the application of private sector management strategies is seen as a way to cure traditional public administration of its 'bureau-pathologies' (Aucoin, 1990; Newman, 2002)[13]. Hood (1991) outlined the following as essential characteristics of NPM in a 1991 article:

1) reducing bureaucratic rules;
2) ensuring budget transparency and identifying the costs of inputs and outputs;

[12] See e.g. Flynn 2002; Pollitt and Bouckaert, 2000; OECD, 1995; Hood, 1991. With particular reference to developed countries of the UK, US, Canada, Australia and New Zealand, among others, NPM involves a shift in development ideology towards marketisation or quasi-markets and privatisation in government (Lane, 2000; Flynn, 2002).

[13] Pollitt also argued that the tenets of managerialism have replaced the ethos of public service as the motivating principle for public service (Pollitt, 1990: pp. 6-10), and that it has become almost palpable to refer to the transformation of 'administration' into 'management' (Hughes, 1994; Dunleavy and Hood, 1994). Many writers also refer to the changes as 'New Public Management' (NPM) (Hood, 1990).

3) using a network of contracts, rather than fiduciary relationships;
4) disaggregating organisations and their functions, introducing purchaser/ provider institutions;
5) increasing provider competition;
6) increasing consumer power through enhanced scope for exit and redress (Hood, 1994: p.3; Dunleavy and Hood, 1994: p.9)[14].

It can be seen from the above features that the primary goal of new public management reforms is to make public services work better; and the principal strategy suggested is to 'increase management capability by reinvigorating public administration' (OECD, 2005; McCourt, 2001). Unlike earlier reforms, NPM emphasis is not on reducing the role of public sector agencies, but on reorganising and restructuring it through processes of decentralisation (Farham and Horton, 1993; Elcock and Minogue, 2001).

2.6.1 The global trend of new public management reforms

This section discusses how NPM reforms started in late 1970s in industrialised countries and were transferred to developing countries by multinational organisations. NPM reform is presented here as a new global paradigm or formula for improving public administration and achieving 'a new form of government that works better and costs less' (Osborne and Gaebler, 1992; see also Cheung, 1997; Pollitt, and Bouckaert, 2000; Pollitt, 2002)[15]. According to Pollitt (2000), NPM is generally presented as a formula for improving the old public administration. Farazmand described it as a new ideologically oriented managerial theory; a new 'orthodoxy' of one size fits all in public administration, even though its proponents see it to be a response to the failing and discredited 'old orthodoxy' of the bureaucratic model (Farazmand, 2006: pp.554-555)[16]. The OECD notion of NPM pointed to a greater emphasis on results in terms of efficiency, effectiveness and quality of service; a decentralised management environment; alternative service delivery arrangements and

[14] Borins, S. (1997), 'What the new public management is achieving: a survey of Commonwealth experiences', in Jones Schedler, K. and Wade, S. (eds.) *Advances in International Comparative Management, International Perspectives on the New Public Management.* Greenwich, CT: JAI Press, pp. 49-70; Borins, S. and Warrington, E. (1996), *The New Public Administration: Global Challenges: A Report on the Second Biennial Conference of CAPAM.* London: Commonwealth Secretariat

[15] In their influential book *Reinventing Government*, Osborne and Gaebler (1992) referred to NPM as giving rise to 'entrepreneurial government' in the US, arguing that 'a similar process of modernising government is ongoing throughout the developed world and it was unavoidable.

[16] Cheung (2002) also observed that most public sector reforms across the globe in the 1980s were construed within the paradigm of NPM, first spearheaded by OECD countries and followed by the US, Australia, and New Zealand, then followed by several Asian and developing countries.

regulation; efficiency improvement through productivity targets and competition; and strengthening the strategic capacity of the centre (McCourt, 2002). From a global viewpoint, especially for OCED countries, NPM concerns two central challenges to government administration: 'capacity to respond' to multiple needs of citizens and businesses; and 'capacity to renew' government in order to cope with newly-emerging socio-economic and political realities of the new millennium. As a worldwide public management paradigm, NPM aimed to revive weak government and deficient administrative systems (Hughes, 1994; Borin, 1995; Aucoin, 1990)[17]. In addition, it is argued that NPM has risen as an 'intellectual arm' of the corporate globalisation of capitalism, serving goals of profit maximisation and accumulation of capital (Farazmand, 2006: p.555).

2.6.2 Decentralisation and NPM reforms in developing country context

Unlike western industrial countries of Europe and the US, NPM reform started in developing countries as part of a general policy transfer from developed countries, and was made a condition for receiving development aid from international financial institutions (Common, 1998; Hope Sr., 2002). Unlike the *first generation* reforms under structural adjustment which presumed that the 'good state is a small state' (McCourt, 1998: p.176), the *second generation* of reforms sought to rehabilitate the state and public agencies through various policy reform instruments (Levy, 2004; Stevens and Teggemann, 2004). In particular, the IMF, World Bank and OECD-assisted countries advocated total restructuring of public organisations' governance regime, by conjecturing that there is a positive correlation between 'good governance' and 'good management' and levels of successful economic performance[18].

The World Bank in particular supported a more responsive mix of central and local governance – mixing the strengths of centralised and decentralised strategies for public service delivery. The new emphasis in the NPM reforms from the World Bank's perspective is, therefore, not on reducing the role of the Third World state, but on

[17] Owen Hughes (1998) argued that NPM represents a paradigm change in the thinking and practice of public administration. He argued further that certain major political, socio-economic and technological factors are responsible for this paradigm shift (see also Hood, 1991; Cheung, 2002; Minogue et al., 1998; McCourt and Minogue, 2001; McLaughlin, Osborne and Ferlie, 2002). Some examples of this are: budget controls; spurring public sector reform and improving general economic performance; redefining and restating the mission of government; redesigning new policy instruments; promoting and engaging the private sector; modernising the civil service; educating people about the new role of government; and building strategic capacity to change attitudes and behaviours (Pollitt and Bouckaert, 2000).

[18] See World Bank (1996) World Development Report, *Towards Better and Slimmer Government*

reorganising, rehabilitating and redesigning it through decentralisation. In its 1997 World Development Report, *Bringing the State Closer to the People*, the World Bank posited that 'carefully managed decentralisation can do much to improve state capability, creating pressures for better matching of government services to local preferences, strengthening local accountability, and supporting local economic development'. However, the Bank was quick to contend that this strategy would only work if it was 'part of a larger strategy for improving the institutional capability of the state' (World Bank, 1997).

2.6.3 Drivers of NPM reforms

Whether in an industrialised or developing country, there is some level of consensus that NPM-style reforms evolved because of pressure for change (Minogue, 1995). These changes included:

1) financial pressure due to rising government expenditure, coupled with poorer than anticipated economic performance of most countries;
2) pressure from citizens on their governments to give them quality service for their money; and
3) the pressure for change due to policy makers' realisation of the need for new ideas and solutions to the management crisis in government.

In all its forms, the pressure was about change that required a redefinition of the state's role and re-demarcation of the boundary between the public and private sectors; and between government and non-government actors in the economy and in delivering public services (Aucoin, 1990; Borin, 1995; Politt and Bouckaert, 2000).

2.6.4 New Public Management reforms in Sub-Saharan Africa

It could be argued that all public bureaucracies have been severely criticised over the past few decades for being the cause of crises in government. For developed countries, which have the financial means and administrative capability, adjustments have been made through reforms and rethinking about what needed to be done to improve the quality of service at a reduced cost to citizens.

The situation is, however, different for African countries where experiences of severe economic setbacks for the last twenty years made some to described the 1980s as the 'lost decade' for Africa (ECA, 2003: p.2). The crises of the 1980s were worsened by rises in oil prices and falls in primary commodity prices for exports, the growing burden of external

debt, rapid population growth, long periods of drought, and mismanagement of scarce resources, official corruption and political instability (Ayee, 1997). Structural adjustment and other earlier neo-liberal economic reforms were introduced in the mid-1980s as a response to the crisis with the support of the World Bank and International Monetary Fund (Larbi, 1998; Ayee, 1994; Hope Sr., 2002; ECA, 2003). These reforms were directed not only at stabilising the macro-economy, but also to reform the public administration systems of the implementing countries. Overall, the reforms targeted the functioning and role of post-colonial states in economic development. The reforms also sought, inter alia, to redefine the role of public sector, private sector and non-public sector stakeholders in development as a whole. This first group of reforms produced some positive results but these were later eroded by the negative effects of SAP on social services such as health and education[19].

This situation led to the introduction of a set of reforms under the guise of NPM. The NPM reforms in Africa in particular placed more emphasis on reorganising or re-inventing the public sector through decentralisation. In addition to the three conventional pressures for reform mentioned above, African reforms were also driven by the realisation that the public administration system itself was:

1) centralised;
2) weak and bloated in size;
3) inefficient and unwieldy;
4) corrupt; and
5) lacking any sense of responsibility and accountability (Ayee, 1997, Hutchful, 1996)[20].

The lessons learned from the SAP experience made the IMF and World Bank realise that countries with weak public administration systems, especially the civil service, are not well prepared to implement NPM-style reform programmes effectively. Therefore, the pressure for NPM-type reforms in Africa (including Ghana) was largely due to weak administration, managerial inefficiencies and economic and governance crises. Also in the case of Africa, Hope and Chikulo (2000) argued that NPM-type decentralisation was seen as the means:

[19] For example, the adverse effects of reforms on the poor in Ghana forced the military government to introduce its Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD), with the support of the IMF/World Bank.
[20] The civil service in particular has been singled out as having contributed to the poor implementation of the SAP/ERP, particularly in Ghana, because it lacks the managerial capability needed to ensure reform success (Ayee, 1992).

1) through which governments are able to provide high quality services that citizen's value;
2) for increasing managerial autonomy, particularly by reducing central administrative controls;
3) for demanding, measuring, and rewarding both organisational and individual performance;
4) for enabling managers to acquire human and technological resources to meet performance targets;
5) for creating a receptiveness to competition and an open-mindedness about which public purposes should be performed by public servants as opposed to the private sector;
6) for empowering citizens through their enhanced participation in decision-making and development planning and management;
7) for improving economic and managerial efficiency or effectiveness; and
8) for enhancing better governance (Silverman, 1992).

The next section looks at decentralisation and NPM reform in the context of public health sector reform.

2.6.5 Decentralisation and NPM in public health sector management reform

As applied to the health care sector, decentralisation is expected to make the health system take on a more managerial posture. Decentralisation is here conceived as a tool for transforming the function and structure of the heath system. Table 2.3 below gives a summary of health sector reform from NPM ideas and the expected practical manifestations of structural and operational changes. For instance, decentralised health management requires structural, organisational and managerial changes to a public health service. Its application to health is aimed to 'debureaucratise' (Ingraham, 1995) or 'delayer' and break-up existing hierarchies within the health system. The aim is to 'make managers free to manage' their units, in order to achieve efficiency (Clarke and Newman, 1997; Mellom, 1993).

Table: 2.3 Health sector reform and the New Public Management

Policy shifts to address problems with old bureaucratic models	General reforms proposed (the NPM agenda)	Manifestations in the health sector (the health sector reform agenda)
Monopolistic	Deregulate and encourage pluralism	Enable regulation of the private sector
Increase competition	Contract out health services	Contracting-out clinical and non-clinical services
Increase manager's financial responsibility		Purchaser-provider split with contracts and internal competition
		Provider payment reform: money follows patient
Centralised	Contracts and performance agreement	Clinical and non-clinical contracting
Ensure clarity of purpose	Split policy making service delivery functions	Purchaser-provider split
Increase manager's financial responsibility		Reorganise central MOH
Increase upward accountability	Decentralise to cost centres and allocate financial responsibility to lower level managers	Decentralise responsibility to district and hospital managers
Increase responsiveness or accountability downwards to user, increase customer and community	Cost recovery	User fees, health insurance
	Increase community voice in management	Village, district or hospital level boards

Source: adapted from Russell et al. (1996).

As indicated in Table 2.3, decentralisation of health management aims to promote pluralism in health service management. And it seeks to do this by breaking up the monolithic health bureaucracy through disaggregation and separation of functions, leading to the creation of semi-autonomous agencies, which also involves a split between a small strategic policy core and large operational units within the health system. In the context of health reform, decentralised management reform is a strategic instrument which aims to promote 'organisational unbundling' or 'delayering' of vertically integrated organisations and to replace traditional 'hierarchies with flatter, flexible and more responsive structures' (Larbi, 1998).

Furthermore, NPM in the health sector entails a shift of power to health service managers, with a clearer responsibility and accountability relationship leading to a new form of

corporate governance. In this case it includes private sector corporate practices such as contracts, performance agreements, splits between the service purchaser and provider, customer payment through user fees, private finance schemes and increased voice for service users and communities in health decision-making. That apart, NPM and its concomitant decentralised health service management aims to bring services closer to consumers, improve central government's responsiveness to public demands, improve efficiency and quality of service delivery, and empower district/lower units by giving them more managerial involvement and control. As Mellon (1993) pointed out, decentralisation of health management aims to take authority away from the centre and delegate it more clearly to the service delivers – it is about de-bureaucratising health service planning and management.

2.7 Manifestations of decentralisation of health sector management structures and processes

This section attempts to illustrate the various manifestations of the forms of decentralisation at different levels of the health system. Table 2.4 shows how core functions and responsibility for organising, financing and actual delivery of health services can be distinguished in a decentralised health system. This distinction is important because it helps us to explain the links between the structural and process dynamics involved in NPM-style decentralisation in the health sector. This is discussed briefly, based on the information in Table 2.4.

Table 2.4: Typology of delegated responsibility and functions in a decentralised health system

Levels of transfer of functions	***Politicisation*** (zone 1)	***Bureaucratisation*** (zone 2)	***Delegation*** (zone 3) **agencification autonomisation, corporatisation and privatisation**
	***Political**	***Administrative**	***Institutional/Private**
Central Ministry of Health*			
Regional*	***Devolution*****		
Municipal/ District Health Managements*		***Deconcentration/ administrative decentralisation*****	***Managerial decentralisation/ privatisation*****
Community, citizens individuals**			
Institutional*			

Source: adapted from Vrangbaek (2004: p.4).
NB: *structural decentralisation; **process decentralisation.

Political dimension/issues

As indicated in Table 2.4, devolution (zone 1) suggests in principle that political decentralisation plays a part in health decentralisation. It is a well-known fact that local government and municipal authorities play an important role in health matters in their areas of jurisdiction. Political devolution in health care therefore concerns functional issues of financing, organisation and monitoring delivery. In this instance, the role of the central Ministry of Health is crucial for overseeing and regulating all the stakeholders (Vrangbaek, 2004: p.4). This also requires that some amount of capacity is retained at the central level, as suggested in Table 2.3.

Deconcentration (zone 2) suggests an inter-organisational transfer of responsibility and power from a central Ministry to an executing organisation, lower and district health

managements and health sector representatives under the remit of the central health administration. The district, sub-district and local level health managers may have more or less comprehensive functions, both within and outside the health system.

The bureaucracy

Bureaucratisation (zone 2) suggests a transfer of power from politically-elected representatives to regional health authorities controlled by an appointed board. Mills et al. describe this as 'bureaucratic commercialisation', where decentralisation is via the appointment of hospital management boards which are given considerable autonomy (Mills et al., 2001: p.68). But one important point here is that the transfer of the management of responsibility to representatives normally raises difficult organisational and political concerns, especially in situations where weak capacity challenges and political interference accompany the newly-delegated functions.

The executive agency

In Table 2.4, delegation and autonomisation (zone 3) involve the transfer of selected functions to, for instance, an autonomous organisational management. This is to some extent a form of deconcentration but here the functions would be limited and for a specific period. As indicated in Table 2.3, this type is manifest through the process of contract making with public hospital organisations and hospital boards through an executive agency system (Larbi, 1998; Smithson et al., 1997; Mills et al., 1999; Bartley and Larbi, 2004). Two basic Board types are identified in the literature: delegation of key health management decision-making responsibility to autonomous bodies – known as 'autonomisation'; and transfer to corporate bodies – known as 'corporatisation'. The latter is a more radical type of decentralisation as health managers have virtually complete control over most decisions, and the survival of the hospital depends on the Board's ability to raise revenue (Mills et al., 2001).

The private sector

Privatisation (zone 3) is the transfer of health functions to private sector stakeholders. This goal is often pursued through public-private partnerships, which combine elements of delegation and privatisation. This at times involves partnerships with non-government and mission hospitals. Further, it can, in principle, take place at all levels, for instance, the

privatisation of HIV/AIDS diagnosis services to private laboratories, or privatisation of supply of drugs and hospital equipment to private suppliers. One of the goals for undertaking health reform is to offload from government functions that it cannot perform efficiently, and the goal of private involvement is to divest a government of services that it cannot deliver where private providers have a comparative advantage. The provision of alternative financing arrangement is also essential in this regard and private insurance and voluntary insurance schemes are being introduced.

By virtue of dispersing power, responsibility and functions across health structures, decentralisation has the potential to make citizens and communities active participants in health decision-making. This is the picture Table 2.4 tries to show in the bottom left segment. This objective is being implemented through the process of introducing choice of provider and individualisation of health decisions, which may have a significant aggregate impact on finance and health delivery structures and processes (Vrangbaek, 2004) – what Table 2.3 refers to as an increased customer and community voice.

The structural, functional and process typology discussed above gives a broad framework for understanding how the traditional decentralisation typology espoused by Rondinelli and Cheema (1983) has been conceptualised by NPM reformers and been applied to reforming the structures and processes of health service delivery. However, it is important to look beyond this framework because in practice variations, combinations and the dynamics of the types described above are inevitable, and how these various types interact within the health system depends on many contextual and historical factors. For this reason, one has to be sensitive and conversant with the formal and informal functionality of the health system following decentralisation in order to determine the real level of autonomy that new structures and process arrangements with various organisational systems provide (Ham, 2003). This is because informal structural arrangements will emerge through an ongoing struggle within the system and this is likely to produce further challenges to reform initiatives. This will depend on historical conditions and path dependency, stakeholders' interests, power and innovation and negotiation skills, for example, between regional and district health managers and their political principals (Ham, 2003; Vrangbaek, 2004).

2.8 Chapter summary

This chapter set out to undertake a theoretical review of the concept of decentralisation and its relation to NPM reforms in the health sector. The discussion revealed that decentralisation is a difficult concept to pin down and the researcher must be clear in his/her mind which particular form of decentralisation is of interest to him/her. It also came to light that delegation is an important element in all definitions of decentralisation, and can take the form of transferring power, responsibility, functions and resources to lower levels in an organisation. For this study, deconcentration or administrative decentralisation is the focus of the investigation.

The review showed that the concept of NPM emerged as a response to governance and managerial problems confronting the centralised administrative system. Though considered as a new approach to public management through the application of private sector principles and values, it has been indicated that NPM needs old public administration virtues in order to succeed in rejuvenating public management (Manning, 2001; Rucucci, 2001). NPM-style decentralisation is manifest in many ways when applied to health care, but it is most visible in terms of structures and processes. The dynamics of health management structures and processes has implications for managers, governments, private sector providers, citizens and communities

2.9 Conclusion

The literature review showed how NPM-style reforms promised to redesign public administration (health administration) by reconciling the centralisation and decentralisation of managerial authority. Through decentralisation, new public management reform appeared to direct attention to a problem that had become apparent in academic research on policy implementation. Often the question concerning implementation studies is: what situations would bring about an optimal policy outcome, in which policy makers at the centre constrained local-level implementers so as to ensure that the desired policy reform objectives were realised, but not so much that implementers at the lower level would revolt and resist the policy? This question is at the confluence of decentralisation and implementation theory.

The next chapter will attempt a review of two debates on implementation and the associated assumptions, to answer the question. In addition to insights from other contemporary

research on implementation, this review will be used to develop a working framework to guide the present study.

Chapter 3

3.0 Literature Review of Top-Down and Bottom-Up Theories on Implementation: Towards a Conceptual Framework for Analysis

3.1 Introduction

This chapter is a continuation of the literature search started in chapter two. It reviews the literature on the top-down and bottom-up debate on implementation and examines contemporary literatures on factors challenging the implementation of development policies and programmes in developing countries. Based upon insight from the review, a reasonable fundamental working framework is developed to guide the study. This framework is informed by the assertion that 'the degree of effectiveness of any major implementation effort can be explained by a finite number of variables, which can be organised and examined within the context of a reasonably parsimonious conceptual framework' (Mazmanian and Sabatier, 1983).

The aims of the chapter, therefore, are:

1) to provide theoretical insight into the state of the art debate on implementation;
2) to further cast light on some of the theoretical assumptions about the challenges to effective policy implementation;
3) to give an overview of the strengths and weaknesses of the two perspectives and to review current empirical works, to provide a background for developing a framework for the study.

The literature review is undertaken with the following questions in mind. What can the implementation literature teach us about implementing public sector reform? Why do reform outcomes differ so greatly from their original objectives? What factors influence the implementation of policy in developing countries?

The chapter is divided into three main parts. The first part reviews existing literature on the top-down and bottom-up perspectives and highlights their strengths and limitations. The second section draws upon the review to produce a framework for analysis in the present study. The section also outlines the basic underlying assumption of the framework, with emphasis on the influence of implementing agencies' characteristics on policy implementation. The third section continues by discussing the conceptual issues surrounding the four characteristics to be examined within the context of the

working framework. It argues that each of the elements are closely related and should be seen as such.

3.2 Top-down views

Traditionally, the top-down approach is traced to the seminal work of Pressman and Wildavsky (Hill and Hupe, 2002)[21]. Thousands of studies utilise this approach[22]. A comprehensive outline and critique of the top-down approach is not possible here, and has already been attempted by several writers[23], so a succinct account of its main views on policy implementation will suffice here.

The top-down approach holds a rational-legal view of policy (Lindblom, 1959 cited in Hill, 1994), whereby elected officials are seen to have the prerogative for policy making. Advocates of the model draw distinctions between policy and action, policy formulation and implementation, policy framers from executers, and politics from administration. Implementation is viewed as a linear process, in the belief that 'policy' sets goals and 'implementation' is the act of executing those goals. The main issue in top-down views is how the policy objectives are implemented at the lower level. Pressman and Wildavsky defined implementation 'as a process of interaction between the setting of goals and actions geared to achieving them' (Pressman and Wildavsky, 1973: p.xiv). In essence, implementation starts where policy formation ends, and initial conditions have to be set before implementation can commence. According to Van Meter and Van Horn (1975: p.445), implementation refers to those actions by public or private individuals or groups that are directed towards achieving objectives set forth in prior policy decisions. In their book *Effective Policy Implementation* (1981), Mazmanian and Sabatier write:

> Implementation is the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decision. Ideally, that decision identifies the problems to be addressed, stipulates the objectives to be pursued, and, in variety of ways, "structures" the implementation process. The process normally runs through a number of stages beginning with passage of the basic statute, followed by the policy outputs (decisions) of the implementing agencies, the compliance of target groups with those decisions, the actual impacts – both intended and unintended – of those outputs, the perceived impacts of agency decisions, finally, important

[21]Though some academics have challenged this assertion, it is said that a distinct and rigorous approach to the study of the implementation phenomenon did emerge, following their work on the ODA project in California in the early 1970s (Hill and Hupe, 2002).

[22] For detailed discussion and further readings, see the following: Pressman and Wildavsky, 1973; Van Meter and Van Horn, 1975; Bardach, 1974; Sabatier, 1986; Sabatier and Mazmanian, 1979 and 1983; Sabatier and Klosterman, 1981.

[23] See, for example, Bardach, 1974; Elmore, 1980; Barrett and Fudge, 1981; Whitmore, 1984; Sabatier, 1986; Hill, 1984; Hill and Hupe, 2002; Hanf, 1982; Wittrock, 1982; Hjern and Porter, 1981; Ingram, 1977; Harrison, 2003.

> revisions (or attempted revisions) in the basic statute' (Mazmanian and Sabatier, 1981: p.5).

Generally, policy provides guidance for actions which are enshrined in legislation and government statements. The underlying assumption in this top-down approach is that a policy decision identifies the problem(s) to be addressed, stipulates the objective(s) to be pursued, and, in a variety of ways, 'structures' implementation. Policy decisions are made by those at the top, and, reflect the interest(s) and role of elected officials in the policy process. Policy is seen as the exclusive preserve of policy-makers at the 'top' (Ham and Hill, 1993), and influenced by politics among democratically-elected politicians rather than civil servants and implementing ministries, departments and agencies. Furthermore, top-down advocates assume that a clear articulation of the objectives of a policy exists, but the conceptual and practical difficulty lies in how to transfer these objectives realistically down the administrative chain of command to lower levels. Mazmanian and Sabatier (1989) captured this idea succinctly when they said:

> To understand what actually happens after a programme is enacted or formulated is the subject of policy implementation: those events and activities that occur after the issuing of authoritative public policy directives, which include both the effort to administer and the substantive impact on people and events (Mazmanian and Sabatier, 1989: p.2).

The consequence of this assertion is that any deviation from a policy's intended objectives during implementation is caused by implementers and not by policy formulators, and such deviations counts as a deficit or gap between stated objectives and what has been achieved. This approach introduced the idea of 'implementation deficit' or 'gap', and expresses a pessimistic tone about implementation outcomes (Pressman and Wildavsky, 1973). Pressman and Wildavsky observed that the attainment of policy goals becomes very difficult wherever there are multiple actors. It is therefore suggested that implementers should take into account the amount of change required from individuals and agencies and the level of consensus needed to initiate that change. In addition, 'implementation is likely to be most successful under conditions where only marginal change is required and goal consensus is high' (Mazmanian and Sabatier, 1989). Lastly, implementation is seen as a political process, and its success must involve full commitment from both elected officials and front-line workers (Van Meter and Van Horn, 1974; Mazmanian and Sabatier, 1983; Sabatier, 1986; Bardach, 1998; Hogwood and Gunn, 1984). Therefore, in analysing policy implementation challenges, top-down advocates look for deficiencies in the way policy objectives are

communicated, and standards of implementation enforced, by policy makers to lower-level implementers or implementing agencies.

The approach has some advantages: first, it is a good starting point in implementation analysis (Sabatier, 1991). This is because it offers researchers and analysts the opportunity to follow an original policy as it moves down the bureaucratic ladder to lower levels of government and out to related agencies and local government organisations. By tracing these developments over a period, it becomes possible to detect the processes which may have caused deviations or changes in the original policy goals.

The approach also has some inherent flaws – a few of which should be mentioned here. Firstly, the top-down model focuses on the role of the 'top' and tends to overlook the crucial role of other relevant policy actors, especially those at the lower level (Hjern and Hull, 1982; Barrette and Fudge, 1981; Elmore, 1980). As a model that upholds rationality in very high regard, it fails to appreciate the possible effect of non-rational variables on the policy process and implementation in particular. Also, top-down proponents see the policy process as a linear activity and, therefore, downplay the political and social interactions that shape implementation. Like any rational model, testing a set of conditions for successful implementation against what actually happens is no guarantee that remote factors responsible for implementation failure will be exposed, nor will the approach go beyond showing that the politics of implementation are nothing but messy, thus, quashing its rational assumptions. It seems doubtful whether the top -down approach can help the researcher do anything more than identify whether a policy has failed or succeeded. Instead, implementation analysis need not be limited only to issues of failure and/or success but it should help to explain how several other factors and activities can and do shape both policy 'goals setting' and 'goal attainment'.

Secondly, the emphasis on the dominant role of elected officials, i.e. those at the top, makes it difficult to adapt it to situations where no clear dominant policy makers exist, but a multitude of government and non-government policy actors are dealing with directives which are not necessarily fashioned by elected politicians (Elmore, 1980). This is mostly the case in developing country settings, particularly in the delivery of social services and rural development and poverty-related programmes (Grindle, 1980; Grindle and Thomas, 1990). Such situations would be very difficult to comprehend using this approach since the idea of causal theory and hierarchical integration set out in

the top-down framework may have very little applicability and prove difficult to predict implementation outcomes in such complex situations.

Thirdly, there is a tendency for analysts who apply this style to ignore or at least underestimate the strategy used by street-level bureaucrats and other stakeholders to divert policy from the 'top' to serve their own interests (Weatherly and Lipsky, 1977; cited in Hill and Hupe, 2002). There is also a tendency for researchers using this approach to overlook or only partially touch on what happens within organisations responsible for implementation – what might be referred to as the internal characteristics and disposition of the implementing agency and its officials[24]. In consequence, the top-down model has little to say about any counterproductive effects that agencies responsible for implementation are likely to have on policy results. Arguably, the issue of effectiveness and responsiveness of implementing agencies in executing the task given to them is treated somewhat minimally.

Fourthly, the approach's oversimplification of the distinction between policy formulation and policy implementation hampers a researcher's ability to explain the complementary role of relevant stakeholders in the design and execution of policy and programmes. This is seen as misleading (Nakamura and Smallwood, 1980; Hjern, 1982) because, in practice, there are organisations and individuals which are involved in both stages. Besides, there are instances where policy formulation and reformulation resurfaces at various stages in the policy process, and this requires collaborative inputs from both central government officials at the 'top' and local administrators at the 'bottom'. Therefore, policies change as they get implemented and most policies actually get refined after they are piloted for some time. In line with this evidence, Majone and Wildavsky (1978) argued that it is more feasible to see policy implementation as an evolutionary and learning process than a linear one.

Finally, the assumption that policy makers have a clear monopoly over policy processes undermines democratic values and the role of private sector, civil society organisations and international development agencies/consultants. In recent times, the pluralism of policy communities has increased to the extent that it is now difficult to believe that policy making is an exclusive preserve of elected political elites. In reality, contemporary policy making is made up of a network of several actors and interactions which go beyond the assumptions espoused by the top-down advocates. There are

[24] For more insight into this point, see Grindle, 1980; Grindle and Thomas, 1991; Cheema and Rondinelli, [or is it Rondinelli and Cheema?] 1983; Leonard, 1982; Sussman, 1980; Rothenberg, 1980.

instances where both policy making and implementation stages are dominated by a complex network of internal and external actors, whose contributions to the policy process largely overshadow the actual role of elected political elites, and where elected officials' roles tend to be ceremonial rather than influential. This is particularly common in the case of most developing countries, where the politics of policy making and implementation have been subject to international agencies like the World Bank/IMF, and several external consultants. The globalisation of policy making and implementation is not captured in the assumptions of the top-down perspective; but this aspect is crucial in understanding the political dynamics of multi-actor implementation processes.

3.3 Bottom-up views

In contrast, the bottom-up approach assumes that front line implementers in the field often face a difficult task. Implementation is seen as a complex social activity which cannot and should not be defined as one-time activity. Analysts in this group believe that, in real-life situations, policy may appear to be clear-cut at the initial formulation stage but may become complex as it is translated into action. Implementers are therefore faced with the perennial problem of difficulties in identifying precisely what is being implemented. Apart from that, policy makers may deliberately make a policy complex, obscure, ambiguous or even meaningless, because – in the most extreme cases – it is possible that not all policies made by politicians are intended to be implemented – the concern of policy framers may be merely 'symbolic' (Hill, 1997)[25].

The bottom-up style focuses on implementing agents, examining their behaviour and motivations, and personal and structural factors which encourage and/or force them to act in certain ways. The most important actors in the implementation of policy goals are officials at lower levels of the organisation. As Lipsky (1971: p.397) suggested, 'street-level bureaucrats' and lower-level implementing officials are an important unit of analysis in any implementation analysis, because their decisions and actions do more to influence outcomes than policies set by political elites. He advocated that the policy process should be 'turned on its head': implementation studies should concentrate upon 'what people do', not on an abstraction called policy and its fate (Lipsky, 1971: p.401).

[25] Smith et al. (2004) differentiate between instrumental and symbolic policies. The former are policies whose effects are 'constant with the original intentions and ideals behind them'. The latter may have no effect at all, because they 'function as symbols without any substantive instrument that logically could be expected to lead to policy goals'. Sometimes policies start out 'as instrumental and later become symbolic because the government agency failed to provide the means to the ends... policy effects may be unintentionally deleterious when the policy produces unanticipated effects or costs contrary to the policy goals'.

This focus on actions and interactions at a lower level is emphasised in the sense that goals framed at the top are sometimes unclear, often contradictory and not always backed by sufficient resources. Policy ambiguity, limited resources, and time pressure are some of the factors that make it difficult for front line bureaucrats to implement policy objectives as intended by their framers. Mostly, analysts respond to implementation problems by trying to understand the nature of the bureaucrats' work in relation to the tasks they are suppose to be undertaking and, more importantly, their personal and work limitations are taken into account. Whenever implementation falls short of the policy objectives, bottom-up proponents look for explanations in the lack of resources and incentives inherent in the implementers' internal and external institutional environment.

In summary, implementation is seen as a continuous process of interaction with a changing and changeable policy, a complex interaction of structures, an outside world which must interfere with implementation because government action impinges upon it, and implementing actors who are inherently difficult to control (Hill and Hupe, 2002).

The strength of this approach is that it provides a valuable complement to the top-down framework. By combining the two, analysts can forge a modified top-down method of analysis. As researchers evaluate government policies, they can review multiple national governmental actors, allied agencies and independent interest groups as active policy/political players and view how they influence the implementation process.

There are some limitations of the bottom-up view, however. First and most importantly, by completely disregarding the contribution of those at the 'top', the approach can be accused of not being about implementation as a distinct activity. The approach neglects the crucial role of elected officials and thereby leads to an overstatement of the capability of street-level bureaucrats to frustrate the centre. By focusing on goals and strategies of the vast majority of actors at a local level, this approach tends to ignore the top's indirect influence over those goals and strategies through its ability to affect the institutional and legislative structures in which individuals and groups operate (Harrison, 2004).

Secondly, it fails to clearly identify the factors that affect its subject of study, i.e. implementation. This gap in the framework may be due to its preoccupation with perceptions, interests, strategies and activities of actors at the lower level. Often users of this approach are tempted to overlook factors that, directly and/or indirectly, affect the

behaviour of local-level actors. There is, therefore, a tendency for proponents of this approach to sometimes fail to acknowledge that policy agendas and actors' interests are themselves products of negotiations and interpretation, not unchanging and unproblematic givens (Harrison, 2004). The bottom-up theorists' inductive methodology is a useful starting point for identifying stakeholders in a particular policy area, but this should be theoretically related to political, social, economic and legal contextual factors which structure the perceptions, resources and participation of actors within policy (Sabatier, 1986; Bardach, 1974).

The suggestion that the policy process should be 'turned on its head', so that analysts focus on what people do is questionable. This is because people cannot act unless they are given a responsibility, and people act in response to a policy and/or legislative instrument. Under any circumstance, legislative decisions have a very important role in the policy process, and suggesting that activity should be limited only to the strategies and actions of lower-level bureaucrats seems to provide an unrealistic view of what happens in the real world of politics and policy making. In reality, there is no way to distinguish the relative importance of elected officials and lower-level officials where there is no policy. And it is impossible to analyse democratic accountability and administrative discretion where there is no policy or a clear distinction between policy making and its implementation (Sabatier, 1986). Indeed, there is evidence that most policies are made at the top, and resources to support policies are appropriated by the top. Officials at the bottom do not always have as much discretion as the bottom-up approach would suggest, instead those at the top have several ways to structure the implementation process (Sharpe, 1985). There is, therefore, no doubt that the manner in which a policy is implemented has a significant effect on political outcomes, but the design of the initial policy undoubtedly and strongly affects the implementation process. Central government decisions, for example, are crucial in determining where the interactions between street-level bureaucrats take place, which actors are involved and what resources are available to them (Majone and Wildavsky, 1978). As a result of these inadequacies, bottom-up advocates run the risk of neglecting the undisputed role of those at the top in the policy process, and this is a clear omission, especially in developing country contexts[26].

[26] For a detailed discussion of this point, see the collection of essays in Grindle (ed.) (1980) *Politics and policy implementation in the Third World*, NJ: Princeton University Press. See also Fritzen (2003) 'The misery of implementation: governance, institutions and anti-corruption in Vietnam', paper presented at a conference on *Governance, institutions and anti-corruption in Asia*, New Zealand Asia Institute, University of Auckland, New Zealand Election Study Centre, National Chengchi University, Taiwan, 28-30 April, 2003 Auckland, New Zealand.

From the foregoing discussion it can be seen that each of the two approaches have their own strengths and weaknesses. Because of this, some scholars have suggested a synthesis of the two, combining the best features of both frameworks to analyse policy implementation[27]. That task is beyond the scope of this chapter; rather the next section will use the strengths of both views, in addition to contemporary views from empirical literature, to develop a working framework to guide the present study. Before doing that, the next subsection gives a general overview of theoretical and empirical research on which factors challenge policy reform and programme implementation in developing sub-Saharan African countries.

3.4 The study's argument

Insights from the review of both top-down and bottom-up debates show that there are several approaches and frameworks for studying implementation. But the framework considered most appropriate for the present study is modified after Van Meter and Van Horn (1975) and Grindle (1997). The framework is also inspired by the works of Sabatier and Mazmania (1989), Rondinelli and Cheema (1983), Goggin et al. (1990), and Fritzen (2003). Authors including Grindle and Thomas (1991), Fritzen (2003), Larbi (1998) and Batley and Larbi (2004) have adapted a similar approach in their study of public sector reform implementation in developing countries, emphasising the need to adopt an interactive approach (Grindle and Thomas, 1991) by considering the political, economic and institutional context of implementation. Although the present study is informed by the political economy analytic framework, it argues that any analysis of implementation in developing countries must look more closely into the operational context – hereafter referred to as the 'organisation character' (Grindle, 1997) of the implementing agency.

The available evidence from the literature review about top-down and bottom-up debates have shown that most studies on implementation primarily focus attention on analysing the vertical implementation of central government policy. Research into policy implementation are wide, covering a broad array of theoretical and empirical issues and questions. The issues addressed in these earlier studies are numerous and varied[28]. It is not feasible to capture all of these issues in this study, but it is important to

[27] For a detailed discussion of this, see Elmore, 1985; Sabatier, 1986; Whitmore, 1984; Ripley and Franklin, 1982.

[28] They included, among other points, that: complexity of joint action (Pressman and Wildavsky, 1973); implementation requires guidelines and drafting of better laws (Sabatier and Mazmanian, 1979 and 1980); implementation needs looking at from the 'bottom-up' (Elmore, 1980); implementation needs an understanding of the context or environment in which implementation takes place (Van Meter and Van Horn, 1975; Ingram, 1990; Grindle, 1980 and 1997; Grindle and Thomas, 1990); implementation needs to recognise the importance of feedback (Googin et al., 1990); implementation must examine the politics

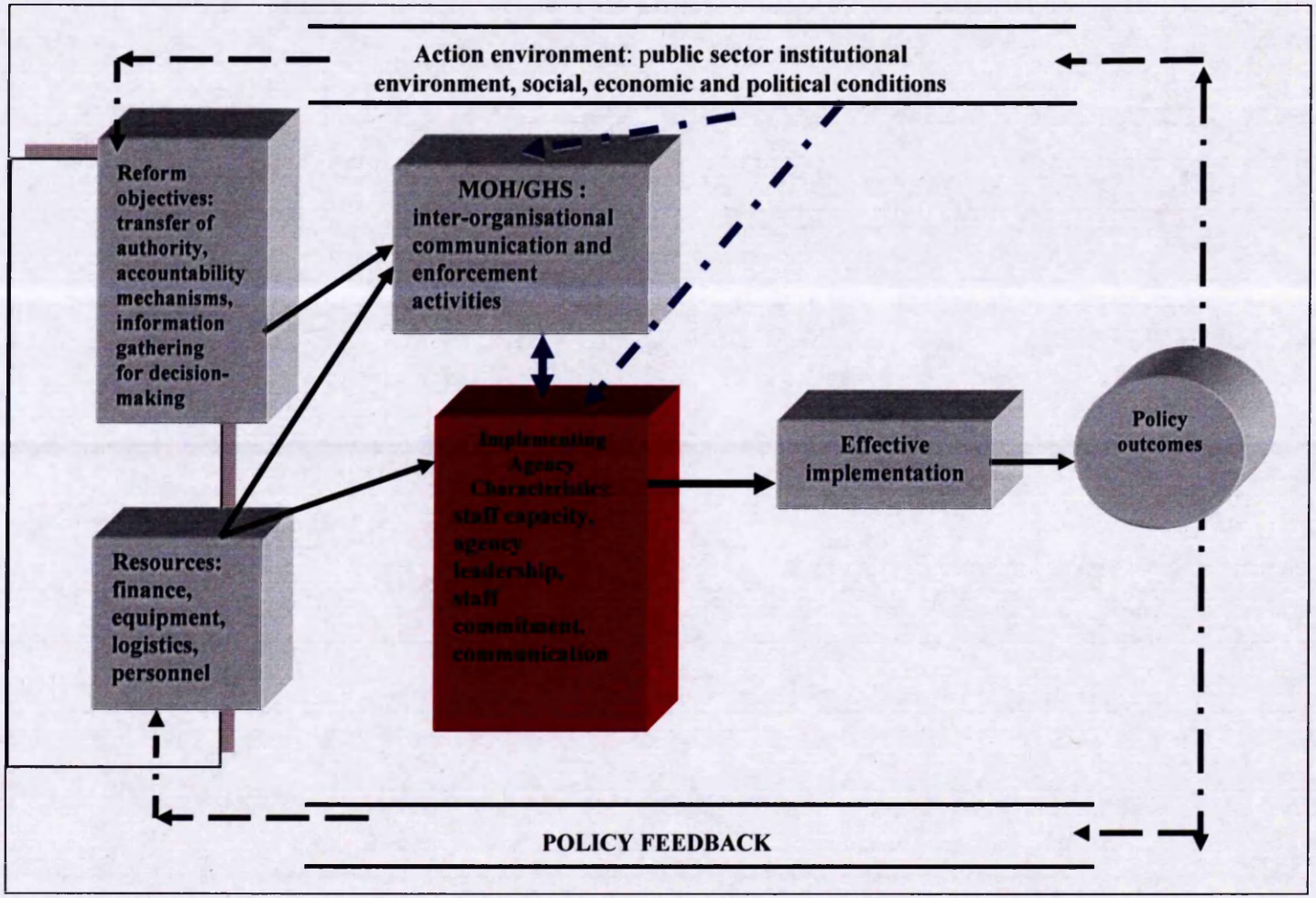
place these theoretical and empirical works within a broad context of implementation challenges in developing countries, in Africa in particular. This will be undertaken in the next subsection.

The question to be examined in this section is: how can we adapt recent developments in implementation research, especially in the context of developing countries, to help us understand the implementation challenges for health sector decentralisation? The objective of the analysis here would be the one shared (but not exclusively) by bottom-up proponents – to understand the conditions and sources of challenge that face district-level managers during implementation and how they affect implementation. Yet, it is also assumed that wider social, economic, political and bureaucratic institutional conditions at the national level will also have a significant influence on implementers of decentralisation at district level. Similarly, the near environment of implementing agencies will also be a source of challenge for implementation.

Figure 3.1 presents the general working framework for analysis, drawing on both bottom-up and top-down approaches to guide the researcher in undertaking the study. The framework outlines five broad categories of variables linking policy making on the left side and implementation processes on the right. The framework emphasises the characteristics of an implementing agency – that is, staff capacity, agency leadership, staff commitment and communication. Each of the categories identified in the framework can be expressed as a set of research questions aimed at identifying sources of challenge in decentralisation implementation. However, for the purpose of this study, agency characteristics are isolated as a set of elements associated with the research assumption for in-depth analysis. The categories of the working framework for analysis are described in the following section, and the discussion is along the lines of Van Meter and Van Horn (1973), Grindle and Thomas (1991) and Cheema and Rondinelli (1983).

generated by a policy (Lowi, 1964); and implementation must recognise the important of policy content and policy design (Grindle, 1980; McCourt and Bebbington, 2005).

Figure 3.1: Conceptual framework for analysing the influence of agency characteristics in implementation



Source: modified after Van Metre and Van Horn, 1975; Grindle, 1997; Rondinelli and Cheema, 1983.

3.5 Description of issues in policy making and implementation processes

1. Policymaking

The first stage in the policy making process is the identification of policy objectives and resources made available by government through the public agency (e.g. Ministry of Health) for implementation. The research questions here are: are the policy objectives and criteria for implementation clearly provided within stipulated law or a legal framework? (Mazmanian and Sabatier, 1989; Sabatier, 1986), and: are the resources provided sufficient for implementation? (Mazmanian and Sabatier, 1989; Grindle, 1980; Cheema and Rondinelli, 1983)

2. Inter-organisational communication and enforcement activities

The second stage is the inter-organisation relationship, consultation and communication on the policy objectives. The research question to consider at this stage is: how are the policy objectives communicated from the national level (Ministry of Health) to lower (district) level officials and within what performance targets or framework? (Grindle and Thomas, 1990; Cheema and Rondinelli, 1983; Grindle, 1980.), and: what is the nature and channel of communicating these policy goals to staff, stakeholders and communities?

3. Characteristics of the implementing agency

An agency is appointed and given the mandate to undertake implementation of the objectives set out by the framers. This level is the focus of the present study. The characteristics of an implementing agency have serious implications for how district level health workers understand, accept or reject the policy; and their reaction to directive from the headquarters (Van Meter and Van Horn, 1975; Grindle, 1980 and 1997; Grindle and Thomas, 1990; Cheema and Rondinelli, 1983; Hill and Hupe, 2002). Implementing agency staff capacity, leadership, level of understanding and commitment and communication of objectives to staff are all internal to the agency, and all have an influence on implementation.

4. The implementation process

This is the level at which various programmes are put into action to realise the policy objectives. Implementation involves interaction, actors and structure, and this is affected by whatever happens at levels 1, 2 and 3 and is therefore linked to outcome. The issue of how well the process is linked to the other three categories is also important for

policy learning and feedback, as shown in the framework (Barrett and Hill, 1981 cited in Hill and Hupe, 2002: p.70).

5. The wider social, economic, political and bureaucratic institutional environment

The action environment (i.e. both far and near), is linked to all three stages of the policy making and implementation process. The wider external environment consists of the social, political and economic, and legal framework of a country and its overall public administration institutional context (Crosby, 1996; Brinkerhoff, 1996; Kiggundu, 1996; Larbi, 1998; Grindle, 1997). Each of stages 1 to 4 are directly or indirectly a product of the wider environment in which the implementing agency (i.e. Ministry of Health and district health management teams) is embedded and operate.

The underlying assumption of the working framework is that the wider environment affects both policy formulation and implementation. It is important to add that it is possible the policy being implemented may also impact the structural and institutional environment, leading to unintended change either for better or worse. For example, decentralisation may change the system of management and number of stakeholder participation in health planning over time, which in a way might create support or opposition to decentralisation implementation. It may also create conflicts which could alienate staff, communities and stakeholders from the reform programme.

The working framework presented in Figure 3.1 provides a conceptual framework for this study, incorporating some elements from both top-down and bottom-up views. The framework is intended to help the researcher ask specific implementation question(s) and to identify implementation problems or challenges at the national and, more specifically, at the lower level. This study emphasises the characteristics of an implementing agency, its elements are conceptually defined and the related literature regarding their influence on implementation is presented in the following subsection.

This section of the chapter attempts to define the key concepts and assumptions that formed the basis of the conceptual analysis framework. The primary underlying assumption is derived from a broad range of implementation research studies, especially regarding factors influencing implementation in developing countries and, in particular, public sector reforms in Africa. The framework is based on the argument that factors internal to the implementing organisation (and external factors) have a significant influence upon implementation. The section is divided into three subsections: first, it provides an operational definition of implementation, including a definition of the

effectiveness of policy implementation and how implementation can be judged as effective or not. Next, four implementing agency characteristics are identified as suggested in the working framework, and the ways through which they may influence effective implementation (of health sector reform) are examined.

3.6 Clarification of some issues in policy implementation analysis

As noted in the first section of chapter 3, there are as many definitions of implementation as there are researchers of the phenomenon[29]. There is no need for further definition of 'implementation', since this has been done in the preceding sections. Rather, it should be noted that there is a general assumption that, once a policy is formulated and resources provided, its implementation will be straight-forward. However, policies often fail to achieve their expected goals, some policies are not implemented at all, and others – even if implemented – take more time or cost more than expected in terms of money and other resources. Therefore implementation researchers should seek to understand the reasons why policy outcomes are so often at odds with the goals set by policy makers.

One issue that needs clarification and which has been noted in the implementation literature is that it is important, especially for purposes of analysis, when doing implementation research to draw a distinction between implementation analysis and evaluation analysis (Hill and Hope, 2002). This is because the two activities have quite a different focus and objective – typically, implementation analysis is about 'how policy is put into action', while policy evaluation examines 'how policy and the people who deliver it may be appraised' (Hill and Hupe, 2002). This study comprises implementation analysis, focusing on health sector reform and decentralisation in particular.

Another important issue that needs to be clarified is the objective of undertaking implementation analysis and the form that the research activity will take. The literature identified four objectives to study through implementation analysis:

1) the policy process;

[29] Implementation means carrying out a basic policy decision made by legislation (Mazmania and Sabatier, 1989). Pressman and Wildavsky defined implementation as 'a process of interaction between the setting of goals and actions geared to achieving them' (Pressman and Wildavsky, 1973 cited in Hill and Hupe, 2002). In essence, implementation starts where policy formation stops, and initial conditions have to be set before implementation can commence. According to Van Meter and Van Horn (1975: p.445), implementation refers to those actions by public or private individuals or groups that are directed at the achievement of objectives set forth in prior policy decisions. Bressers and Dinica (2003) defined policy implementation as the activities and interactions that are connected to the employment of a preconceived set of policy measures.

2) policy output;
3) policy outcome; and
4) analysis of any causal connection(s).

Policy process refers to the interactional activities in executing a policy. Policy output refers to programmes, legislation, and institutions that governments employ in dealing with a policy problem (Grindle, 1980; Mazmania and Sabatier, 1989). Policy outcome refers to the enforcement of the policy through specific programmes of activities leading to required changes; for example, changes in structures, operations, procedures and behaviours of organisations and people. Causal connection refers to identifying and explaining the cause of either implementation success or failure.

Table 3.1 Implementation and evaluation research

Activity	Object	Research activity
Implementation analysis	Process/behaviour	Description
	Output	Explanation
	Outcome	Theory testing
	Cause	Analytical judgement
Evaluation analysis	Outcomes – value-links	Value judgements

Source: adapted from Hill and Hupe (2002: p.12).

This study is concerned with policy process and outcome. But since it is difficult to separate output and outcome in practice, the analysis will also indirectly be influenced by output dimensions of implementation. This is because whether implementers (e.g. district health managers and workers) respond to reform positively depends on the content of the policy and organisational context in which reform is being enforced, which is through the process of designing and implementation of policy (i.e. the health sector reform).

3.6.1 Sources of relevant literature for undertaking the present study

Another issue of importance is how to identify and collate relevant literature for the study. There is a vast amount of literature on policy implementation and quite a number of studies are relevant for researching health sector reform implementation in Ghana. This includes, at least:

1) general literature on policy implementation, mainly concerned with policy implementation problems in developed countries[30];

[30] Pressman and Wildavsky, 1973; Van Meter and Van Horn, 1975; Bardach, 1974; Sabatier, 1986; Sabatier and Mazmania, 1989; Sabatier and Mazmania, 1983; Sabatier and Klosterman, 1981.

2) general literature on policy implementation, mainly concerned with political, economic and institutional constraints in policy implementation in developing countries[31];
3) literature concerning policy implementation in particular, mostly focusing on developing countries of Africa[32];
4) literature on implementing decentralisation reform in general and the health sector in particular in developing countries[33];
5) literature on policy implementation in Ghana, including work on health sector reform and decentralisation implementation in particular[34].

This study will focus on categories three to five, since the contributions in these categories largely build upon theoretical insights from the former two categories, applied to a specifically African and Ghanaian context.

As indicated in the first section of this chapter, traditionally writers suggest a dichotomous relationship between top-down and bottom-up approaches to implementation analysis. However, as Hupe and Hill (2002) noted, both approaches have advantages and disadvantages. This study therefore chooses factors eclectically from both in a balanced way, so as to benefit from the merits of each approach. Since this study aims to delineate implementing agency factors in order to explain the outcomes of certain public sector reforms at a lower level, analysis of reform implementation will be at a micro-level. But because the politics of policy making in developing African countries – specifically Ghana – are different from those in developed countries, the analysis will focus more on processes than on a single authoritative or legislative decision. Given Ghana's traditionally centralised top-down approach to policy making, it appears reasonable that the analysis will highlight elements of central government control in the implementation process.

3.6.2 Factors affecting effective policy implementation

Perhaps the most important issue for this study is what the implementation literature says about factors that affect implementation. The general factors that emerged from the literature differ in terms of the 'context of implementation' and 'content of the policy' (Hupe and Hill, 2002; Grindle, 1980). Thus, several factors affect implementation and

[31] Grindle 1980 and 1997; Grindle and Thomas, 1990; Larbi, 1998; Cleaves, 1980.
[32] Cheema and Rondinelli, 1983; Grindle and Thomas, 1991; Larbi, 1998; Brinkerhoff and Crosby, 2002; McCourt and Sola, 1999; Quick, 1980; Malama, 2003.
[33] Larbi, 1998; Gilson, 1995; Brinkerhoff and Leighton, 2002; Jeppsson et al., 2003; Mills et al., 1990.
[34] Batley and Larbi, 2004; Annan, 1999; Ayee, 1997; Larbi, 1998; Mills et al., 2001.

they differ from one country or organisation to another. For example, Mazmania and Sabatier (1989) indicated that effective policy implementation is influenced by three sets of factors:

1) tractability of the problem being addressed by the policy or statute;
2) ability of the statute to favourably structure the implementation process; and
3) the net effect of a variety of political variables on the balance of support for the statutory objectives.

Van Meter and Van Horn (1975) identified six factors that influence effective implementation:

1) policy standards and objectives which elaborate on the overall goal of the policy decision so as to provide concrete and more specific standards for assessing performance;
2) resources and incentives made available;
3) the quality of inter-organisational relationships;
4) the characteristics of the implementing agencies, including issues like organisational control and inter-organisational relationships, especially 'the agency's formal and informal linkages with the policy making or policy-enforcing body;
5) the economic, social and political environment; and
6) the disposition or response of implementers, involving three elements: their understanding of the policy, the direction of their response to it and the intensity of that response.

Most of these considerations are general normative views of factors influencing effective implementation. But, for the purposes of the present study, it is pertinent to look for empirical studies on factors that affect policy implementation in developing countries in Africa. The review in the following subsection concerns this, and is informed by some of the issues raised in Chapter 1.

3.6.2 Factors influencing effective implementation in developing countries

The works of Grindle (1980) and Grindle and Thomas (1990) are particularly useful for studying factors constraining effective policy implementation in developing countries in Africa. They and other researchers identify some specific factors, falling within the broader domain of 'content', 'context', 'actors' and processes, and characteristics of the policy in question (Grindle, 1997; Walt and Gilson, 1994). It is not possible to examine all of these factors here, but the main points include:

1) lack of capacity (Conyers, 2006; Hilderbrand, 2002; Grindle and Hilderbrand, 1995; Larbi, 1998; Mills et al., 2001);
2) bureaucratic inertia (Brinkerhoff, 1996; Crosby, 1996; Brinkerhoff and Crosby, 2002; Ayee, 1992);
3) inadequate financial support (Malama, 2003; Ayee, 1997; Gulahati, 1989);
4) lack of political and bureaucratic commitment (Stevens and Teggemann, 2004; Grindle and Thomas, 1990; Grindle, 1997; Cleaves, 1980; McCourt, 2001; Ayee, 1997);
5) unclear policy objectives (Ayee, 1995; Grindle and Thomas, 1991);
6) policy characteristics (ideological policies) (Quick, 1980; Grindle, 1980; Grindle and Thomas, 1991);
7) lack of local ownership, consultation and commitment (Conyers, 2006; Kiggundu, 1996; Juma and Clark, 1995);
8) lack of local leadership (Conyers, 2006; Kiggundu, 2002);
9) the implementing organisation's environment and culture, and behaviour of officials (Pinto and Mrope, 1994 cited in Kiggundu, 1996; Kiggundu, 1989; Agyepong, 1998; Kuada, 1994);
10) politicisation of the implementing agency and its leadership (Quick, 1980; Ayee, 1994; Sakyi, 2004);
11) institutional and resource constraints (Batley and Larbi, 2004; Brinkerhoff and Crosby, 2002; McCourt and Sola, 1999; Cheema and Rondinelli, 1983; Quick, 1980)[35].

Having provided a general background to factors which enhance or constrain effective implementation, the next section discusses the influence of implementing agencies' characteristics upon implementation. The aim of this review is to locate the main four elements in the relevant literature.

3.7 Influence of agency characteristics on effective policy implementation in developing countries

Only a few studies have examined the influence of agency characteristics upon policy implementation in developing countries[36]. There has been little systematic research on factors affecting health reform implementation (Figueras et al., 1997). Walt

[35] Malama (2003) identified five key conditions for ensuring effective implementation of public policy: 1) political support; 2) sufficient funding; 3) appropriate institutional arrangements; 4) building of sufficient consensus to have enough broad-based support for the policy; and 5) proper monitoring of the reform process.
[36] See, for example, Thomas and Grindle, 1991; McCourt and Sola, 1999, Grindle, 1981: p.205; Cheema and Rondinelli, 1983; Kiggundu, 1989; Larbi, 1998; Turner and Hulme, 1997; McCourt and Bebbington, 2005.

acknowledged this and pointed out the importance of policy analysis in health sector reform, suggesting a model for analysing reform which identified three key elements: the actors involved in policy reform, the process contingent on developing and implementing reform change, and the context within which health policy is developed and managed. Walt and Gilson (1994) noted that health policy analysis wrongly focuses on reform content and neglects the actors involved in policy reform, the processes contingent on developing and implementing change and the context within which policy is developed and implemented. Cheema and Rondinelli (1983: pp.26-31) also made a similar point, arguing that effective implementation of reform policy in developing countries is influenced by four sets of factors, namely:

1) environmental conditions;
2) inter-organisational relationships;
3) resources for programme and policy execution; and
4) characteristics of implementing agencies.

In their 1983 typology, Cheema and Rondinelli conceptualised the characteristics of implementing agencies as comprising the following sets of factors:

1) technical, managerial and policy implementation skills of the agency's staff, the agency's capacity to apply all the principles of management to the implementation;
2) the ingenuity of staff in integrating decisions from all sections/departments plus the benefits gained from both political and bureaucratic leadership and making good use of the strength of professional and other clientele groups;
3) tactical approach that the agency adopts in dealing with its clients, stakeholders, beneficiaries, the private sector and opinion leaders and allied civil society groups;
4) the quality of leadership within the implementing organisation, the acceptance, cooperation and commitment to the policy objectives among the organisation's staff and, often, the location of the organisation in the bureaucratic hierarchy.

Following Walt and Gilson (1994) and Rondinelli and Cheema (1983), the present study assumes that effective implementation of health sector reform will be associated with the characteristics of the implementing agency. Analysing how all four of these aspects relates to implementing the objectives for health sector reform specified later on in this chapter is outside the scope of this study. Therefore, the focus of this study is to assess whether planned outputs and expected results of health sector reform have been

produced through the implementation of reform at district level. Thus, in the empirical chapter, the reform implementation process and outcomes will be examined, according to the extent of implementation effectiveness, in terms of:

1) enhancing information flow from top-down and bottom-up for the purposes of decision-making;
2) establishing accountability mechanisms to hold health workers and officials accountable; and
3) transfer of authority to district and local health managers.

There are two approaches to studying health reform: direct and indirect (Figueras et al., 1997). In this study, the indirect approach is used, as the study does not set out to measure actual outcomes of health sector objectives for decentralisation, but rather seeks to apply a conceptual framework to provide grounds for exploring the effectiveness of reform implementation. Two steps are involved in using this indirect approach: firstly, the study outlines a theoretical assumption which must be satisfied for decentralisation reform at district level to be effectively implemented; and, secondly, the researcher follows upon that by examining evidence from the district level to ascertain whether the assumed conditions are being met in practice. Thus, the next subsection describes the framework for the study and the associated propositions that will guide the reform analysis.

3.7.1 Conceptual definition of the factors included in the working framework

Four elements of organisation characteristics are examined to understand the ways each affect implementation of health sector reform at district level in Ghana:

1) staff capacity;
2) agency leadership;
3) staff commitment; and
4) communication.

The next section reviews the literature on the relevance of capacity, leadership, staff commitment, and communication in health care reform implementation.

3.7.2 Staff capacity issues

Capacity is a very broad term, referring to the abilities of individuals and organisations to carry out their mandates according to stated objectives of the policy framers. According to the UNDP (2003), capacity is the ability of individuals, organisations and

societies to perform functions, solve problems, and set and achieve goals[37]. According to Batley and Larbi (2004), it is the factor that explains human performance within a given organisational framework and institutional environment[38]. Capacity may also relate to the quality of personnel, and institutional structures, rules and procedures. In the context of implementation for this particular study, capacity is defined as the availability of a required number of staff with the appropriate skills to undertake a task and achieve goals set in a prior decision.

Staff capacity has been identified as an important organisational factor required for effective policy implementation. This argument is based on the fact that quantity and quality of professional staff responsible for a particular policy can increase or decrease the chances of effective implementation[39]. Goggin et al. (1990) assert that the higher the quantity and quality of personnel devoted to implementing a programme, the greater the likelihood of prompt implementation without modification. In a World Development Report, the World Bank emphasised the need to strengthen implementer agency capacity in order to enhance reform implementation success (World Bank, 1983). The primary research question asked here is: how does the capacity of district health management teams influence the implementation of health sector decentralisation?

3.7.3 Implementing agency leadership

The concept of leadership has been defined variously by different people, but four main elements can be identified as being central to the phenomenon of leadership:

1) leadership is a process;
2) leadership involves influence;
3) leadership occurs within a group context; and
4) leadership involves goal attainment (Northouse, 2004: p.3).

Based on these defining features, leadership can be defined as a process whereby an individual influences a group of individuals to achieve a common goal (see Northouse, 2004). Thus, leadership as a *process* means it is transactional; leadership as an *influence*

[37] A similar instrumental view has been espoused by the World Bank (1996), which defines capacity as the ability to perform appropriate tasks effectively, efficiently and sustainably through the combination of human resources and institutions that permit countries to achieve their development goals. The emphasis here is on having certain levels of individual and institutional capability to bring about change. This is an instrumental view of capacity (Land, 2003).

[38] There are many dimensions to definitions of capacity, including financial, administrative and managerial, problem-solving, and technical skills. There are also internal and interactive capacities; the former refers to the ability to carry out management functions, while the latter refers to the ability to cooperate and coordinate in a network of state, civil society and private sector actors (Hilderbrand and Grindle, 1995).

[39] For other research findings on capacity in implementation in developing countries, see Stevens and Teggemann, 2004; Grindle, 1980; Grindle and Thomas, 1991; Mills et al., 2001; Larbi, 1998; Ayee, 1997. See also Batley and Larbi (2004) on the effect of capacity on reform implementation.

is concerned with the way a leader affects followers; and leadership occurs in *groups*, meaning that groups provide the context within which leadership takes place. Leadership is about attention to specific goals, and it is to do with directing a group of individuals toward accomplishing some common task or goal.

3.7.4 The role of leadership in managing the policy implementation process

Research into the issue of leadership is extensive, but the influence of leadership upon implementation, especially in developing countries, remains under-examined[40]. This observation is nowhere more evident and critical than within developing country public sector organisations, and in the health service sector in particular.

One critical question in examining the role and influence of leadership upon policy implementation is how to differentiate between 'leadership' and 'management'. Bennis and Goldsmith (1994) argued that the difference between the two concepts actually lies in an individual leader's style and action. Bass (1985) argued that managers tend to focus on systems and structures, but leaders focus on inspiring people to challenge the status quo (see also Kotter, 1990). Like Bass (1985) and Bass and Avolio (1994), Kotter (1990) drew a distinction between the role of a leader and that of a manager, describing the difference as 'transactional' and 'transformational'[41]. The literature on leadership is extensive and cannot all be examined here, so a short review of the salient features of the two leadership styles will be provided.

3.7.5 Transactional leadership and policy implementation management

The transactional leadership style does not individualise the needs of subordinates nor focus on their personal development. Transactional leaders exchange things of value with subordinates to advance their own, as well as their subordinates', agendas (Kuhnert, 1994 cited in Northouse, 2004: p.178). Two factors are associated with transactional leadership: *contingent reward,* which refers to an exchange process where effort from followers is exchanged for specified rewards; and *management-by-exception,* which refers to leadership involving corrective criticism, negative feedback, and negative enforcement (Northouse, 2004). The relationship between a leader and their employees can be both positive and negative (i.e. active or passive), provided that the leader sets goals, recognises and rewards those goals, and supervises employee

[40] McCarthy (1997) observed that there is a dearth of research examining the relationship between style of leadership and organisational type across and within organisational levels, both functional and hierarchical.

[41] Bass (1985) presented transformational and transactional leadership in his model as a continuum, with transformational and laissez-faire as the two extremes, and transactional between the two ends. Only transactional and transformational are discussed here (Northouse, 2004).

performance continuously so as to avoid failure[42]. The two factors comprising transactional leadership use negative reinforcement patterns rather than the positive reinforcement patterns suggested by Bass and Avolio (1994).

3.7.6 Transformational leadership and policy implementation management

Transformational leadership concerns the performance of followers or employees and developing them to their fullest potential (Avolio, 1999; Bass and Avolio, 1990)[43]. Given these factors, transformational leadership can be said to entail a particular type of behaviour, where leaders aim to build a positive relationship with employees and show empathy towards their needs, thereby enhancing employee confidence. Also, a transformational leader is one who consciously attempts to develop appropriate organisational structures to successfully change the old organisational culture and work behaviour of employees. More importantly, in transformational leadership both followers and leader are inextricably bound together in the transformation or change process[44]. Overall, leaders who adopt this style provide a supportive climate in which they listen carefully to individual followers' needs, and such leaders act as coaches and advisers while trying to assist employees in becoming actualised[45].

With particular reference to implementation, leadership roles and styles are seen to affect policy implementation[46]. Leadership is a critical human capital needed to mobilise other resources in order to encourage and sustain policy implementation. Leadership is also considered instrumental for successful implementation, especially in public sector organisations, which are facing enormous challenges in aiming to provide quality services to their clients and service users while operating with strictly-limited resources[47]. The increasing focus on the role of leadership in public management in the 1990s has been to improve upon the implementation of public sector reform. Leadership plays a crucial role in the implementation process and, thus, leadership has a significant

---

[42] An example of passive or negative management-by-exception is a senior manager who gives an employee a poor performance evaluation without ever talking with the employee about her or his prior work performance.

[43] Kuhnert (1994) argued that individuals who exhibit transformational leadership often have a strong set of internal values and ideals, and they are effective at motivating followers to act in ways that support the greater good rather than their own self-interests. In the literature, four defining features are identified with transformational leadership: a) charisma or idealised influence; b) inspirational motivation; c) intellectual stimulation; and d) individualised consideration (Kuhnert, 1994; Northouse, 2004: p.175).

[44] Bass (1990) argued that the chances for achieving desired changes under transformational leadership are higher because leaders successfully communicate the purpose and process of change to the actors involved.

[45] This was pointed out by James MacGregor: 'leaders are individuals who tap the motives of followers in order to better reach the goals of both leaders and followers' (McGregor, 1960).

[46] See, for example, Leonard, 1991; McCourt and Bebbington, 2005; Grindle, 1997; Grindle and Thomas, 1990; Kiggundu, 1989; Cheema and Rondinelli, 1983.

[47] Alimo-Metcalfe and Alban-Metcalfe (2004) observed, in their review of UK public sector reforms, that the UK Cabinet Office for Performance and Innovation Unit (PIU) (2001) placed leadership at the core of its modernisation agenda in its recent report, *Strengthening Leadership in the Public Sector*, explaining that the public service faced unprecedented challenges at the start of the new millennium.

influence upon policy implementation. This section of the study examines this premise with special reference to health sector decentralisation at the district level.

3.7.7 Staff commitment

Regardless of how well a policy is designed, it is always possible that policy will be poorly implemented. Staff commitment to a policy has a significant influence in implementation, and levels of implementer agency commitment to policy objectives has attracted the attention of many analysts. Most of the earliest studies on policy implementation noted the potential influence of implementers' commitment upon implementation[48]. Van Meter and Van Horn discussed two distinguishing features of effective implementation: the amount of change involved, and the extent to which there is goal consensus among participants in the implementation process. According to them:

> Implementation may fail because implementers refuse to do what they are supposed to do. Dispositional conflicts occur because subordinates reject the goals of their superiors... for numerous reasons: they offend implementers' personal values or self-interest; or they alter features of the organisation and its procedures that implementers desire to maintain (Van Meter and Van Horn, 1975 cited in Hill and Hupe, 2002: p.46)[49].

According to Goggin et al.:

> 'No matter how clear the policy message, no matter the level of capacity of a given state, and despite an appropriate formal organisational structure, skilful and committed programme management seems important for implementation success' (Goggin et al., 1990: p.51)

Commitment has been defined as identification and involvement with an organisation centring on, firstly, believing in the organisation's values and goals, secondly, exerting effort on behalf of the organisation, and, thirdly, a desire to remain with the organisation (Mowday, Steers and Porter, 1979 cited in McCourt, 2003). Commitment as used in this study adheres to this line of thinking[50].

Allen and Meyer (1991) discussed three types of commitment: affective, continuance and normative. Affective commitment refers to feelings of belonging and a sense of attachment to an organisation. This type of commitment relates to personal characteristics, organisational structures, and work experience, for example, pay and supervision, role clarity, and skill variety (Allen and Meyer, 1991). Continuance

---

[48] Pressman and Wildavsky, 1973; Goggin et al., 1990; Van Meter and Van Horn, 1975; Sabatier and Mazmania, 1989; Hogwood and Gunn, 1984.

[49] For more details, see also Sabatier and Mazmania, 1983. In *Getting Agencies to Work Together*, Bardach (1998) emphasised the influence of staff commitment on implementation, seen as 'craftsmen' committed to their work through collaboration and a problem-solving approach to enhance the attainment of policy goals.

[50] Even when the pecuniary and other tangible incentives are nonexistent, the employee will perform thankless tasks, go above and beyond the call of duty, and a make virtual gift of his/her labour, when the requisite rewards for undertaking the task are highly uncertain at best (see Dilulio, 1994 cited in Grindle, 1997: p.482).

commitment relates to the perceived cost of leaving an organisation – both financial and non-financial – and a perceived lack of alternatives; and normative commitment concerns the obligation employees feel to remain with an organisation and builds upon what Wiener (1982) described as generalised cultural expectations that 'a man' should not change his job too often or 'he' may be labelled untrustworthy and erratic.

Commitment– affective, continuance, and normative – is thought to contribute to a psychological state which characterises an employee's relationship with an organisation. This may be affected by different antecedents or have potentially different consequences with regard to issues concerning absenteeism, apathy towards organisational goals and job performance. Meyer and Allen (1990 cited in Swailes, 2004) argued that employees with high affective commitment continue to stay with an organisation because they want and desire to, those with normative commitment do so because they think they should, and those with high continuance commitment because they need or are obliged to. These three aspects of commitment are relevant for understanding staff attitudes towards organisational goals.

Contemporary analyses of public sector reform implementation emphasise the importance of commitment to successful reform implementation[51]. Although current literature acknowledges the importance of committed staff for implementation, the issue has not been examined thoroughly in Ghana's public sector reform implementation experiences, especially in health sector decentralisation reforms. This section of the study, therefore, examines the issue with the aim of filling this gap in health reform implementation literature, by analysing the effects of staff commitment upon decentralisation implementation at the district level.

3.7.8 Communication and policy implementation management

In this study, communication is defined as sharing quality information with staff and stakeholders. Information sharing refers to the extent to which valued ideas, strategies, decisions or directives about a policy are communicated to agency staff and participating stakeholders. By sharing information and by being knowledgeable about each others' roles, duties and responsibilities, implementers including staff are able to act cooperatively to ensure the successful implementation of a policy. Not only is communication quality important, but it is also is a key aspect of information

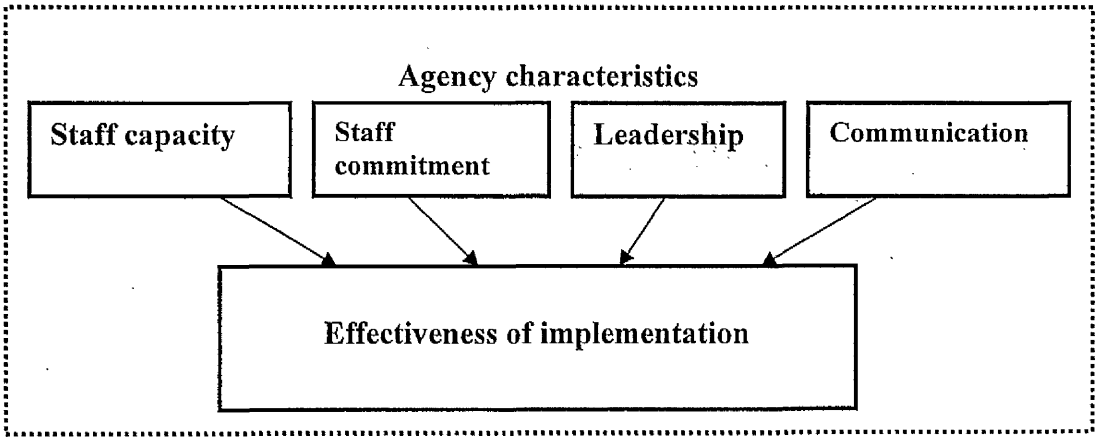
[51] For example, McCourt argued that there is a significant relationship between political commitment and successful implementation of reform (see also Clay and Schaffer, 1984; Killick, 1998; Nunberg, 1997; Campos and Esfahani, 2000 cited in McCourt, 2003). Mowday and Porter (1982 cited in McCourt, [2003): p.1017) argued that there is a positive link between leadership commitment and organisation outcomes, so commitment is seen as requirement for successful implementation.

transmission (Tourish et al., 1998). If information is freely available to all staff, the belief is that managing a policy will be relatively easier; responsibilities will be easier to share and implementation becomes faster.

Van Meter and Van Horn (1975) drew a link between communication and staff disposition towards a policy, especially their comprehension of the policy, the direction of their response towards its acceptance or rejection, and the intensity of that response. Mintzberg (1973 cited in Kiggundu, 1989) stated that informal communication 'is the only one that works under extremely difficult circumstances'. Goggin et al. (1990) also found that the more legitimate and credible the message was in the eyes of implementing agency officials, the more likely implementation was to proceed promptly and effectively. Thus, quality and method of communication affects staff understanding of the policy objectives in relation to their roles in achieving them. More importantly, inter-organisational communication is important for effective implementation. Communication among policy managers and staff (street-level bureaucrats) about the objectives of a policy, specific programmes and activities, and the methods of execution does influence the degree of implementation success. This section examines this assertion in relation to health decentralisation implementation.

The suggested relationship between agency characteristics and implementation is summarised in Figure 3.2 below.

Figure 3.2: Assumption of agency characteristics and implementation relationship



Source: prepared by author (2007)

On the basis of the foregoing review, the conceptual framework assumes that each of these four elements will have an influence on the implementation of decentralisation reform. The elements are considered as being combined, and their interaction forms part of the relational processes between the implementing agency and implementation. The emphasis is on the fit between an agency's characteristics and policy implementation.

Thus, policy objectives would not be achieved if the policy's operational environment was ignored.

3.8 Chapter summary and conclusion

This chapter reviewed the two major debates on implementation, and highlighted the flaws in each of them. Insights from the literature review formed the basis of developing a conceptual framework to serve as a guide for this study. The chapter also clarified some issues in undertaking implementation research which are of relevance to the study's objective. In addition, the chapter conceptualised the independent and dependent variables used in the study and discussed factors which influence effective implementation in general and developing countries in particular.

Five broad categorises have been outlined in the conceptual framework, and one has been isolated for in-depth study: the implementing agency characteristics. Within this category, four closely-related elements: staff capacity, leadership, staff commitment and communication have been selected for in-depth study in relation to implementation of health decentralisation at a district level. The relevant literature on each of these has been reviewed and properly conceptualised. The overall framework is based on the assumption that implementation is likely to suffer if these factors are not managed.

Having identified and conceptualised the variables of the study through this conceptual framework, the next chapter proceeds with a discussion of the methods and techniques used in the field for data collection.

Chapter 4

4.0 Research Method and Data Collection Techniques

4.1 Introduction

Having discussed the relevant literature and the conceptual framework that will guide the study, this chapter will discuss the method, strategy and techniques employed for collecting the data used in this study. The chapter describes the general epistemological orientation of the research, the research design, and the activities undertaken during data collection and discusses the problems encountered in using the various research techniques and steps taken in the field to reduce their potential effect on the finals results. The last section of the chapter presents the various tools used for data analysis, highlighting the limitations and problems encountered in undertaking the study.

4.2 Epistemological orientation of the study

This study was generally informed by pragmatist knowledge claims and adopted mixed methods for collecting data. Pragmatism is a collection of many different ways of thinking, which assumes that knowledge claims arise out of action and consequence rather than anteceding conditions (Patton, 1990). For many pragmatists, the problem is more important than the method, and researchers should employ every possible approach to understand the problem being studied (Rossman and Wilson, 1985 cited in Creswell, 2003). Thus, pragmatism is a suitable epistemological underpinning for a mixed research method, where the researcher can draw freely from both quantitative and qualitative data to help provide a better understanding of the research problem. Creswell (2003), however, suggests that any researcher using mixed methods should endeavour to establish a purpose and rationale for the reasons why quantitative and qualitative data need to be mixed. Thus, the choice of multiple research methods for the present study is based on the realisation of the difficulty of undertaking implementation analysis by statistical techniques alone (Hill and Hupe, 2002). In addition, Hill and Hope (2002) suggest that, in doing implementation research, it is important for the researcher to look for possible ways to include 'qualitative work' within the 'quantitative work'. Apart from that, it has been noted that there have been more quantitative than qualitative evaluations of recent health reforms to date (Figueras, Saltman and Mossialos, 1997).

While quantitative studies are important to determine health-related as well as financial outcomes, more qualitative research is necessary to understand how reform initiatives

affect the organisational and behavioural characteristics of health delivery and administrative systems. Therefore, the reason for combining both quantitative and qualitative data in this study is because the former would be particularly useful in measuring response rates, degrees of association between the independent and dependent variables, and in helping to explain cross-district variations in responses, while the latter would add thick description and depth to the study. The reasons for adopting pragmatism and multiple methods in this study have been explained, and the next section proceeds with a discussion of the study's methodological approach. Specifically, the section reviews the strengths and weaknesses of qualitative and quantitative techniques and the advantages of combining the two.

4.2 Methodological approach

Methodology refers to the choices made by researchers about cases to study, methods of data gathering, forms of data analysis and all the other processes involved in undertaking a research study (Silverman, 2005). Thus, the sections that follow will be devoted to the discussion of all the methodological issues of the study.

4.2.1 Qualitative research (QR)

Qualitative research is broad (Patton, 1990; Babbie 1995), and is a type of research that does not use statistical measure to produce its findings. Data for qualitative research is often generated through discussion, observation and conversation. It is therefore multi-method in focus and uses a number of specific data collection techniques, for example, participant observation, interviews, discourse analysis and documentary research (Brewer and Hunter, 1989; Creswell, 2003). Qualitative research methods are generally inclined towards using an interpretive paradigm, which views a world in which reality is socially constructed, complex and dynamic. It is generally an in-depth approach which focuses on close interaction over a period with relevant research participants at one or several sites (Glesne and Peshkin, 1992; Creswell, 1998). Overall, the methods used by qualitative researchers exemplify a common belief that they can provide a 'deeper' understanding of the phenomenon being studied than would be obtained from purely quantitative data (Silverman, 2005).

There are strengths in using this approach. First, it is useful for studying things in their natural setting and facilitates interpretation by ascertaining the meanings that people bring to a phenomenon (Silverman, 2000). Second, it is a useful method where the social phenomenon being studied is complex, context-bound, requiring an 'holistic' form of analysis and explanation (Merriam, 2001). Third, qualitative research was used

for this study because of its substantial flexibility, as it allows the researcher to undertake the study within the local context where the phenomenon occurs (Lee, 1999; Strauss and Corbin, 1998).

Despite the merits, it has some inherent weaknesses. It often uses small samples which are largely based on specific, non-representative cases, and this raises the problem of generalisability. Since qualitative research is stronger on long descriptive narratives than on statistical tables, a problem may arise with the difficulty of categorising the event or activities studied. This raises a problem known as reliability; referring to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Hammersley, 1992). Another weakness of QR relates to how sound the explanations it offers are – the problem of validity of much qualitative research. The concern with validity of the approach often arises because a researcher has made little or no attempt to deal with contradictory cases (Silverman, 2005). Despite these common problems, qualitative research has attracted praise from many researchers because of its commitment to field activities which does not necessarily imply a disregard for the use of statistics or numbers (Kirk and Miller, 1986).

4.2.2 Quantitative research methods (QRM)

QRM represents the positivist paradigm which dominates natural science investigations; it seeks to explain a phenomenon through a sense of solid and objective analysis. QRM is by nature a numeric approach, reducing data to numbers, and its typical techniques are surveys and close-ended questionnaires (Babbie, 1995). Its advantages are that: it is scientific; the research is based on objective laws rather than the researcher's values; measurement, analysis and interpretation are through quantitative measures and not impressions; and presentation of findings is numerical, using table and charts.

QRM has several weaknesses: it can amount to what Silverman (2005) referred to as a 'quick fix', involving little or no contact with people or the 'field'. This emphasis on the use of statistical correlations may be based upon variables that, in the context of naturally-occurring interaction, may be arbitrarily defined. The desire of QRM to rely solely on 'hard' data for explaining social phenomena, with no regard to people's everyday sense-making in specific settings can turn out to be a mirage (Silverman, 2005).

In the light of these weaknesses, it is important to note that the present research did not follow a purely quantitative logic for credibility, which would rule out the study of many interesting findings relating to factors which actually influence the management of health sector reform implementation by district health administrators.

Some social science researchers advocated a dichotomous relationship in using qualitative and quantitative approaches (Lincoln and Guba, 1985), but others hold the contrary view that it is possible to combine the two successfully (Patton, 1990; Creswell, 2003; Brewer and Hunter, 1989). This study adopted the latter view of possible compatibility between the two research methods, in order to gain the complementary advantages of words and numbers in the analysis (Howe, 1988; Morse, 1994; Creswell, 2003).

With this methodological approach and these methods in mind, the study attempted to link implementation challenges and agency characteristics in the form of ideas to analyse the real-life experience of health and non-health officials involved in implementation in their natural context. The study sought to achieve this goal by using both qualitative and quantitative research methods for data collection. More specifically, the study used three main data collection techniques: semi-structured interviews, review of documentary data, and surveys of district health officials. This data collection strategy is known as triangulation – the use of multiple methods and multiple data sources in a single research endeavour (Creswell, 2003; Tashakkori and Teddlie, 2003; Thomas, 1998).

The choice of triangulation in undertaking this study rests on the assertion that the weaknesses of each method or data would be compensated for by the counter-balancing strength of another (Jick, 1979; Morse, 2003). Triangulation was also necessary in order to enhance the depth of description and interpretation of the data, and to assist with the cross-checking, confirmation and validation of the findings. Triangulation also added an amount of vigour and breadth to the study and was a useful strategy for refining and strengthening the link between the conceptual framework and study findings (Farmer, Robbinson, Elliot and Eyles, 2006).

4.2.3 Research design

The research design of this study was based around the case study. The choice of case study research design was based on the fact that it is a useful research strategy for policy and public administration research (Yin, 1994), and it is useful in investigating a

phenomenon in-depth, especially when 'how' and 'why' research questions are being asked. A case study therefore provided an opportunity for intensive and holistic descriptions and analysis (Yin, 1994: p.1; Hamel et al., 1993) of the phenomenon of health sector decentralisation at the district level in Ghana in its natural context.

Decentralisation reform is a case with its own complexities, especially at district level and, thus, merits the need to be studied as a whole (Miles and Huberman, 1994). In order to follow the requirements of a case study approach, the researcher had to look at the particular character of district health management teams and health sector decentralisation at the district level (in Dangme West, Sekyere West and Tamale districts). As noted earlier, more than one method and data source were used, so it became imperative to use an inductive approach (Merriam, 1998) throughout the research, from the framing of questions, description of objective and literature search. Table 4.1 summarises the research questions and the methods of investigation used. Detailed descriptions of various research activities undertaken are presented in the ensuing sub-sections.

Table 4.1: Summary of research questions/objectives and methods of investigation

Research questions	Research objectives	Focus	Methods/techniques of investigation
1. What is policy implementation? What theoretical debates inform implementation research?	To put the study in proper theoretical perspective by linking it to contemporary state of the art debates and its implication for empirical studies	Top-down and bottom-up debates on implementation. Views on policy formulation-implementation relationships. Explanation of implementation deficit	Desk research, review of books, journal articles, commentaries and implementation research reports
2. What is decentralisation and what are the normative justifications for decentralisation? What is the linkage between decentralisation, NPM and implementation theory?	To give a profile of the various views on decentralisation and to show the theoretical profile of underlying arguments for and against decentralisation reform and linkages between them	Definition, forms of decentralisation and rationale for decentralisation. The impact of NPM reform in addressing the centralism-decentralism debate vis-à-vis top-down and bottom-up approaches	Review of relevant books, journal articles, reports and policy documents
3. What is the core idea/discourse on public sector reforms?	To put the reform in global perspective	Neo-liberal market reforms with the focus on public sector management reform	Desk research and review of the relevant journal articles, books and commentaries by experts on NPM reforms across the globe
4. Why choose to restructure Ghanaian public bureaucracy? What are the key features of the reform agenda?	To give a detailed profile of the political and economic context of the reform	To analyse the economic and political situation and deficiencies in public administration which called for reform	Review of books, World Bank/IMF policy reports, articles, country documents and expert reports
5. How is decentralisation in health linked to public sector restructuring?	To locate decentralisation within a larger country-specific institutional reform framework. To conceptualise decentralisation as an element of NPM	To identify features of public sector reform and the changes it seeks to bring into the old centralised, hierarchical and monolithic public health system	Review of articles, books, IMF/World Bank development reports, etc.
6. What factors influence policy Implementation in developing countries, Africa and Ghana in particular?	To explain the dynamics of the implementing agency and implementation relationship, with focus on political economy of developing countries	The operational context and its effect on implementation process The internal organisation context of implementation	Reviews of articles and research notes on the context of decentralisation implementation in developing countries. Also, factors shaping implementation politics in the Ghanaian setting
Research questions	**Research objectives**	**Focus**	**Methods/techniques of investigation**

7. What is the organisation's character and how does it influence implementation? 7a. How does the character of district health organisations influence the implementation of decentralisation reform objectives in Ghana?	To identify and develop a working conceptual model for understanding how factors internal to bureaucratic organisations shape implementation, with particular reference to Ghana's health sector decentralisation	The character of district health agencies in Ghana. The focus here is on staff capacity, staff understanding and commitment to reform goals, agency leadership and communication Political, legal, policy content and the bureaucratic setting	Individual interviews and key informant interviews. Semi-structured interviews with health managers and relevant stakeholders. Interviews and surveys of views of health officials at the case study sites: Tamale, Sekyere West and Dangme West districts of Ghana
8. In what way (s) does the general institutional environment impact on implementation of Ghana's health reform?	To show how the larger political, legal and bureaucratic institutional factors influence the capabilities of the district health authorities in Ghana	Political actors, bureaucrats, policy managers and their relations and attitudes to district health management teams in reform management	Informal discussions and conversations with researchers and consultants, academic works in the areas of public sector reform and decentralisation of health management in Ghana

Source: prepared by author (2007)

4.3 The research set-up/analysis unit

The research unit is described as 'implementation challenge(s)' and comprising 'agency characteristics', of organisations working on a particular reform policy, with the aim of identifying new ways for theorising implementation studies in developing countries. The experience of district health management teams (DHMTs) with decentralisation at the district level provided a setting within which to collect information that would explain and reveal how staff capacity, leadership, staff commitment and communication have constrained the implementation of public sector reform in Ghana.

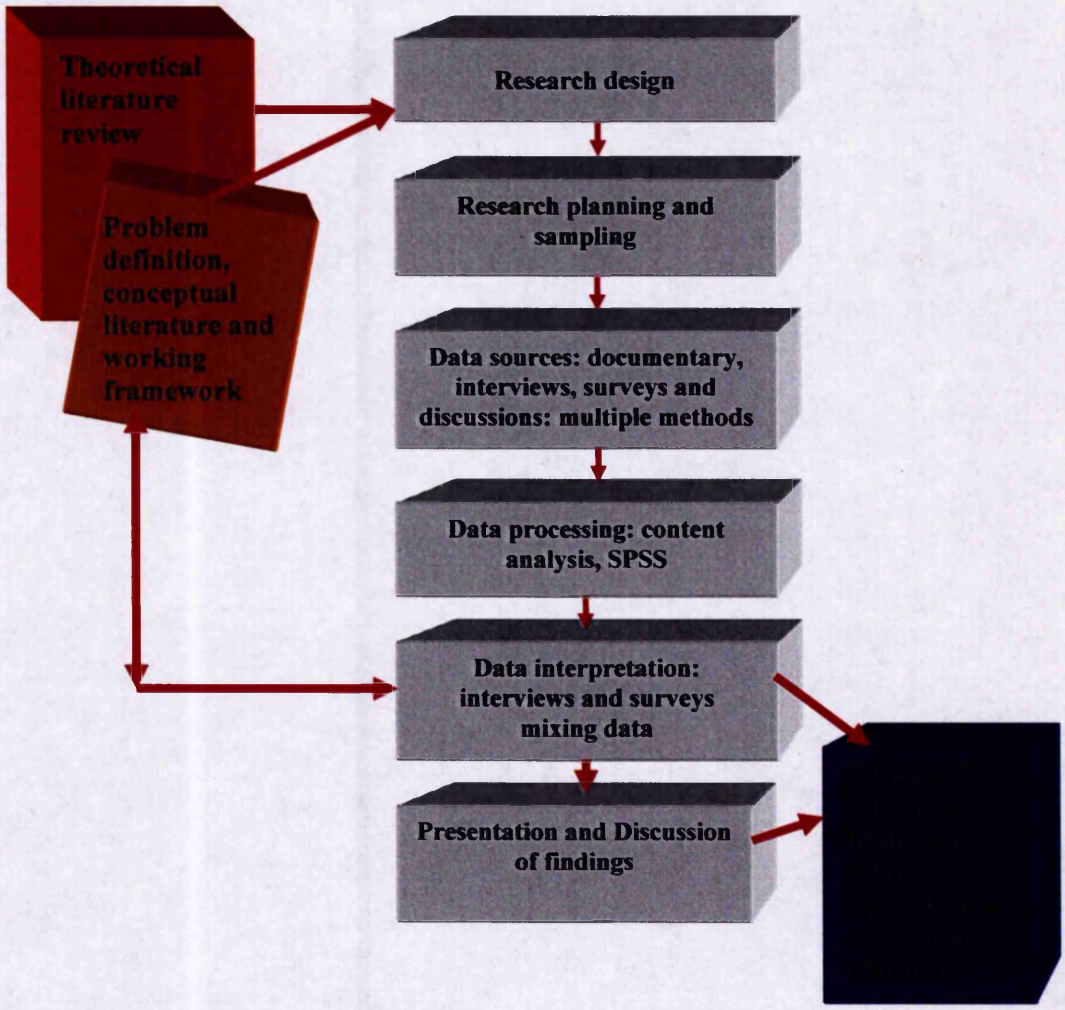
Decentralisation of public health service management is, by and large, a sensitive and topical issue in Ghana's political and public administration modernisation programme. It is highly political and, to some extent, ideological in its content and objectives. Throughout the 1980s and 1990s, public sector management modernisation was promoted and funded by international donor agencies such as the World Bank, the IMF and DFID. In Ghana, health was a sector that has attracted special attention from donors, government, non-government organisations, health professionals, private sector and other stakeholders in the policy community. Ghana's health policy management is therefore influenced largely by changes in the global political health care economy. Thus, the complexities surrounding understanding the challenges in managing public health reform implementation requires that the study must consider the issue of 'implementation challenges' from a broader social, economic, political, historical and

institutional perspective. To achieve this, the researcher undertook a retrospective study of Ghana's development trajectories, with a focus on changes in health policy and health management and identified factors that acted as a brake on effective reform implementation in general.

4.4 Outline of the research process

Figure 4.1 gives a diagrammatic description of the research process and various activities involved in carrying out the investigation, according to an ideal research process. Before undertaking fieldwork in the case districts, the relevant literature on implementation, implementation problems in Africa, decentralisation and new public management reforms were reviewed. This review helped to isolate the research problem and questions and further provided the basis for developing a conceptual framework to guide the study. The framework singled out four closely-related elements of implementing agencies and situated these in the literature for investigation. Both the theoretical and conceptual literature helped to clarify the research question and associated research propositions. The literature search also helped with the interpretation, discussion and analysis of the data.

Figure 4.1: Stages of activities in the research process



Source: modified after Creswell (2003). This is purely based on the activities and steps followed in undertaking the research.

4.5 Sampling technique and selection of respondents for semi-structured interviews

As stated in Chapter 1, the objective of the study was to explain the challenges in implementing health decentralisation at the district level with particular focus on the character of district health management teams (i.e. staff capacity, leadership, commitment and communication). Since the focus was on health it was necessary first to contact people within the health sector at national, regional and district levels, as well as contacting other stakeholders involved in health issues. The next section describes the method used to select respondents for the semi-structured interview component of the study. This is followed by a description of the specific research activities undertaken at various times and stages of the research.

4.6 Interview process and activities

The semi-structured interviews were issue-driven, and the phenomenon being investigated – decentralisation implementation – dictated the choice and type of participants (Hycner, 1999: p.156). Welmer and Kruger (1999) also suggested that purposive sampling technique is an appropriate kind of non-probability sampling for selecting key informants. This suggestion was followed for selecting interviewees, but based on the researcher's personal judgement and the research objectives (Babbie, 1995), and taking into account the following organisations and individuals:

1) personnel working in the health sector and involved in the design or management of health reform programme;
2) district health staff working in district administration and hospitals and clinics;
3) health professionals, administrators, professional associations and groups engaged in health service provision;
4) private health organisations, non-government organisations and individuals with knowledge of health sector reforms, for example academics and researchers;
5) persons or organisations associated with district health planning and service provision.

Table 4.2: Summary of semi-structured interviews conducted[52]

Districts	Key informants (MOH, GHS)	DHMTs	Stakeholders: Local govt., private providers and NGOs	Totals
Sekyere West	4	11	3	18
Dangme West	5	14	1	20
Tamale district	4	7	4	15
Informal conversations	6	0	0	6
	19	32	8	59

Source: compiled by author (2007)

4.6.1 Duration of the fieldwork

The fieldwork for data collection was undertaken between August and November 2005 in three districts, selected from the three geographical zones of Ghana: Dangme West district (in zone 1), Sekyere West district (in zone 2) and Tamale district (in zone 3). The need to choose three case districts was based on geographical variations, socio-

[52] Doctors, nurses and health administrators formed the majority of the officials interviewed.

economic diversity, inherent inequities in the distribution of health personnel and facilities and other disparities in the health system itself. A more practical reason for the selection was the financial and time constraints – it would have been impossible to cover all the 110 district health management teams (which have now increased to 138) in such a small study.

The fieldwork officially began after permission to access the case study sites was granted by the Ghana Health Service's Ethics and Research Committee. District Health Directors from the three districts were contacted via telephone, and asked to formally inform their staff about the study. This was followed by a formal letter from the Head of Department of Public Administration and Health Services Management at the University of Ghana Business School on behalf of the researcher, requesting directors and officials to help make the research exercise a success. Because of the volume of work, five experienced permanent fieldwork research assistants from the Ghana Centre for Democratic Development (CDD-Ghana), an Accra-based research think-tank, assisted with aspects of the data collection.

4.6.2 Key informant interviews

Table 4.2 above gives details of the organisations and interviewees surveyed. Key informant interviews were conducted with officials from the Ministry of Health, Ghana Health Service and local government officials, i.e. District Assemblies (DAs), staff at private health service providers and mission hospitals, staff at non-government organisations working in the area of health, and academics and researchers (see Appendix 2). Generally, these interview sets sought information about understanding decentralisation reform, the role of the private sector, communities, NGOs and health professionals in implementing reform. In section two of the interviews, interviewees were asked questions about district health management teams, their roles and capacity to implement the reform. Interviewees were also specifically asked to state whether they thought that leadership, staff capacity, commitment and communication affected decentralisation implementation at the district level. Furthermore, on the issue of implementation, respondents were asked to mention any specific factors impeding decentralisation in their districts. In the final section, interviewees were asked to give their general opinion on progress and prospects of decentralisation in the health sector. The questions required interviewees to mention particular factors outside the district health administration that constituted barriers to achieving the goals for decentralisation in their districts.

4.6.3 District health survey

A small-scale survey (see Appendix 3) was used to generate primary data of a quantitative nature, to supplement the qualitative data and enable the researcher to conduct a simple statistical test on associations between organisational characteristics and decentralisation implementation.

4.6.4 Study population, sample and respondents selection for the survey

In every quantitative research effort, identifying the study population and selection of the sample forms an important stage. A two-stage sampling technique was used to select respondents from the target population to be included in the sample. The target population to be included in the survey were district health staff; specifically, doctors, nurses, paramedics and administrative staff. Table 4.3 gives a detailed summary of the sample frame.

Table 4.3: Description of the sample frame

Tamale (Northern region)	Sekyere West (Ashanti region)	Dangme West (Greater-Accra region)	Population size (M)	Sample size (N)	Confidence level	Confidence interval
1,027*	2,001*	4,161*	7,188	191	95%	7%

*Approximate number of health officials working in the case districts.

Source: computed from MOH/GHS (2004) *Distribution of Health Professionals.*

As a first step, the official staff list of doctors, nurses and administrative staff from each selected region was obtained. This provided a total population size of 7,188. Then, based on the criteria of 95% confidence level and 7% confidence interval, a sample size (n) of 191 was calculated. (A computer-assisted sample size calculator was used).

Table 4.4 Sample distribution

	Junior staff	Middle-level staff	Senior staff	Sample (N)
Number of respondents in category	81	46	15	142
Percentage in sample	57.1%	32.4%	10.6%	100%

Source: computed by author (2007)

Next, the sample was further stratified into three groups, comprising junior staff, middle-level and senior staff. The appropriate number of officials was selected from

each group using simple random sampling technique. The selection was done in a way that the number of respondents selected was proportional to the population of officials in each of the groups.

4.6.5 Survey questionnaire, pre-testing and training of research assistants

The survey was restricted to doctors, nurses and administrative staff working in health facilities under the jurisdiction of the district health management teams (DHMTs). The questionnaire was divided into three parts: part one collected information on objectives for decentralisation, part two asked questions on leadership, staff capacity, communication and staff commitment; part three asked questions about obstacles in implementing decentralisation at the district level.

The questionnaire was pre-tested to ascertain whether the concepts used were well understood by respondents. The exercise also helped in finding out the flow and logic of the questions as well as the average amount of time needed to complete an interview. This latter procedure was useful in determining the amount of questionnaires to be allocated to interviewers during the main fieldwork. Pre-testing was conducted by the researcher with health officials at the Ghana Health Service in Ada in Dangme East District. All questions that had no direct bearing on the research objectives of the study were then eliminated, before a final version of the questionnaire was produced. Fieldwork started with a one-day intensive training course for the interviewers. They were trained in a group session by the researcher (author) with support from one Senior Research Associate from CDD-Ghana. The training focused on the rationale and objectives of the study, interview techniques, and ways to establish rapport and gain access to respondents.

4.6.6 Fieldwork and administration of the questionnaires

A questionnaire comprising 31 questions in English was administered to the sampled health personnel in the three districts by the research assistants. Although a total of 191 responses were expected based on the sample size, two hundred and ten questionnaires were sent into the field in case replacements were needed. Each district was assigned to two research assistants who were required to administer approximately a seventy interviews in each district. The interviewers visited respondents at their work places mostly during lunch breaks, and administered the questionnaire or assisted respondents to fill in the questionnaire. Gaining cooperation from officials was difficult, especially from senior staff, and interviewers had to make several return calls which took up most of their time. Regular research meetings were held, and during this time the field staff

discussed their experiences and carried out field editing together by cross-checking that all the questions were completed and answers clearly circled. The principal researcher assisted interviewers as and when necessary, e.g. with problems of locating interviewees and finding replacements for refusals, and this was done through daily visits and supervision. At the end of the survey period, a total of 142 (out of 191), i.e. nearly 74.3% of the questionnaires, were successfully administered and collected.

4.6.7 Problems encountered during fieldwork

There was an initial problem with the semi-structured interview. Because the semi-structured interview guide was problem-centred and focused on challenges in decentralisation implementation, some of the questions appeared confrontational. Although they were meant to prompt explicit answers they made some interviewees suspicious, so they refused to answer the questions or simply said they had no idea. This problem affected the response rate during the first phase of the interview process. This issue was addressed by offering a clearer explanation of the research objective to later respondents.

It was very difficult to prompt most of the sampled respondents to answer the survey questions. This called for several replacements, as many interviewees who were initially contacted refused to answer some of the questions, while others requested a lunch treat to be provided before the interview was conducted. The problem of refusal was solved by making several calls or rescheduling the interviews and, at times, asking permission to conduct some interviews during weekends. All of this caused delays and led to further extension of the planned period for completing the fieldwork. Coincidentally, fieldwork coincided with the preparation of the government's 2006 budget, so often most officials at national, regional and district offices in the various ministries and department were fully engaged in this exercise and therefore had no time to spare. Due to these problems, it took longer to complete the questionnaire than anticipated.

4.7 Documentary data collection and analysis

As Silverman (2005) argued, texts and documents are useful sources of data in both qualitative and quantitative research; documents therefore provided a useful source of data for the study. Ghana has undergone many political, economic and administrative reforms since the 1980s. Table 4.5 gives a detailed summary of the documentary data accessed and analysed for this study.

Table 4.5: Summary of documentary data/reports/papers

Evaluation reports/reviews and academic papers included in the documentary content analysis	Total of selected papers	Health reform implementation – related papers	
		N	
Ministry of Health evaluation reports	8	3	
Ghana Health Service – district annual reports and review of sector performance	9	4	
Expert evaluation reports	8	3	
Academic papers and journal articles	14	9	
Total	39	19	

Source: prepared by the author from documents accessed and examined (2007).

Documentary data were collected from four broad sources – official evaluation reports, Ghana Health Service districtt annual reports, reviews of sector performance documents, and academic case studies. The selected reports and papers were printed or photocopied in full text for analysis. These were initially classified as:

1) papers analysing the health system reform at macro-level;
2) papers analysing specific case districts; and
3) papers analysing general reform implementation problems.

Each paper was then categorised according to its primary objective, as illustrated in Table 4.5, and was divided into groups based on the topic and implementation issues raised. Each paper was read to determine if decentralisation implementation problems were directly or indirectly considered, particularly at the district level.

4.8. Qualitative content analysis and data processing procedure

Processing the interview responses was undertaken by following the conventional qualitative content analysis procedure. Qualitative content analysis was used because it is argued to be 'objective', 'quantitative' and 'systematic' in describing and interpreting manifest and latent content of communication (Neuman, 2000; Krippendorf, 1980), and it is also regarded as being flexible for analysing textual data (Cavanagh, 1997). Content analysis was used for processing the interview data because, as Abrahamson (1983) suggested, it is a data analysis technique that can be fruitfully employed to examine virtually any type of communication. Content analysis may also help the researcher to focus on either quantitative or qualitative aspects of communication messages (Berg, 2004).

Its merits aside, some researchers see content analysis as more limited to counts of textual elements. But Berg argued that it provides the means for identifying, organising, indexing, and retrieving data; furthermore, content analysis provides a method for obtaining good access to the words of a text or transcribed accounts offered by respondents (Berg, 2004). From this viewpoint, it can be said that content analysis is like a passport to listening to the words of communication and understanding better the perspective(s) of the respondent producing these words.

4.8.1 Stages in undertaking the qualitative content analysis of the interview data

The first step was transcription of the interview responses, followed by a rigorous reading of the transcribed text to identify the overall patterns and thematic areas of the interview responses. The second step involved grouping the interview responses under broad headings according to the interview guidelines used during data collection. The main analysis categories were identified, and based on that other related sub-categories which persisted in interviewees' answers were also set apart for re-examination alongside the main categories. The final step was assigning codes to the categories, and various themes of analysis were developed with due regard to the major issues that featured in the interviews. The themes were selected based on their analytical strength to bring out the required contextual meaning of the research questions (Weber, 1990). The themes were also singled out based on how useful they were for making valid and replicable inferences from the various interview responses. Essentially, the themes of analysis selected from the interview data were used to identify the presence, meanings and relationships between various words and concepts that emerged during the interviews; and this subsequently made it possible to make inferences about the comments and messages obtained from interviewees during the data collection (Hsieh and Shannon, 2005). Table 4.6 gives an outline of the coding units and categories.

Table 4.6: Categories and coding units used in analysing interviews

Category	*Coding unit*
1. Transfer of authority	Transfer, authority, (transfauth)*
2. Practice of accountability	Accountability, practicality, (pacct)
3. Information gathering and sharing	Information, report, share, (infos)
4. Staff capacity issues	Capacity, number of staff, skills (stacap)
5. Understanding of decentralisation	Understand, know, hear about (unstdecent)
6. Staff commitment	Commitment, devote, sacrifice (commt)
7. Communication and consultation	Communicate, consult, contact (comconsult)
8. District health leadership	Leaders, director, district management (dhlead)
9. Participation in decision making	Participate, involve, invite, attend (partici)
10. Bottom-up planning	Planning, plan (bottplan)
11. Stakeholder relationships	Stakeholder, other service provider, relate, (stakrelate)
12. Survival strategies and unethical issues	Extra-work, survive, strategy (survstrag)
13. Conflict among stakeholders	Conflict, disagreements, reject (conflt)
14. Finance and logistics	Money, funds, machinery, equipment (f&l)
15. Professional opposition	Oppose, disagree, resist (profoppose)
16. Private sector cooperation	Cooperate, support (coopert)
17. Control over personnel	Control, personnel (contrpersonl)
18. Control over expenditure decisions	Expenditure, budget, money (expditcontr)
19. Feedback and follow-up	Feedback, reports, work reviews (fedbak)
20. Political influence	Politics, influence, government (polit)
21. Delegation of responsibility	Delegate, assign, responsible (delgat)
22. Supervision capability	Supervise, give directive (super)
23. Staff motivation	Salary, allowance, working conditions (motivstaf)

*The letters in parenthesis indicate the search item used for the coding and also identify variations of the same coding unit, where the need arose.

Source: computed by author from the interview responses (2007).

4.8.2 Categories, sub-categories and themes from the interview data

Two broad categories were generated from the interview responses upon the basis that they were the most likely to exemplify interviewees' opinions on the degree of decentralisation and the influence of organisational factors upon its implementation. Based on these two broad groups, a total of 117 comments were set apart and were given codes. Consequently, 23 categories (see Table 4.6), and eleven themes of analysis were generated. The comments identified and coded were those specifically related to the selected three objectives of decentralisation and the four organisational characteristics of the district health managements singled out for examination. Being mindful of the study objectives, special attention was given to interviewees' comments on:

(1) the transfer of authority to district health managements;
(2) accountability practices;
(3) information gathering and sharing for decision making;
(4) staff capacity;
(5) staff commitment to reform objectives;
(6) district health management leadership and communication and consultation.

In order to further identify specific viewpoints on the above issue areas for analysis, the researcher employed the 'key word in context' approach (Webb, et al., 1981), which required the researcher to take note of every single instance of selected phrases, comments or words used that were related to the categories which emerged from the responses, within the context of the study objective and the coding unit. Through this approach, it came to light that 41 (35%) of the 117 comments identified were about implementing the decentralisation objectives and the remaining 76 (65%) comments were basically about the four selected organisational factors of district health managements.

4.8.3 Some practical limitations of the study

The data for the study was mostly collected from health staff. Despite the fact that it is common to use single sector key informants or respondents in social science research, the relative qualitative bias of the approach to data collection from most of the health-related organisations and staff to the exclusion of non-health related organisations like education, trade unions and households limited the extent to which the findings could be generalised across organisations in the public sector.

The study used questionnaires and an interview guide to solicit data at a single point in time and requested health staff to answer questions on the effect of agency characteristics upon implementation. Though the interview exercise was undertaken with care to minimise interviewer bias, the approach limited the study's ability to explore views of other respondents, especially households. The emphasis on the qualitative research method therefore limited the opportunity to undertake critical comparative analysis of the issues raised during the study; and thus rendered the possible replication of the study in other districts and generalisation of the findings difficult.

The use of qualitative content analysis has its own weaknesses which might also have affected the findings. In particular, the processing procedure had some limitations since

it was relatively manual in approach. Also, due to the large size of text transcribed, it was impossible to give equal attention to all the issues that emerged from the interviews, in fact it appeared that more attention was given to those responses that were directly related to the study objectives as outlined in the interview guide. In addition, the coding procedure was generally cumbersome and took several days.

4.9 Quantitative data processing and analysis procedure

The survey or quantitative data was captured and analysed using the Statistical Package for Social Sciences (SPSS). The first stage was data entry where responses were keyed into the SPSS software; this was followed by data cleaning and editing. The first stage of data analysis entailed the use of basic descriptive statistics, by generating frequencies to show the general characteristics of study variables and respondents' demographic characteristics. Since the data was non-parametric and comprised of questions on agency characteristics and implementation, which were categorical variables, and since the aim was to examine whether these two variables were associated, a two-way cross-tabulation involving the two variables was generated. Through this, the cross-tabs and chi-square test were performed as a test of independence on the two variables. In all, five different chi-square tests were performed for five variables, to test whether or not the variables were statistically significant. The chi-square tests were used to describe whether there was any significant association between agencies' characteristics and decentralisation implementation. An analysis of variance (ANOVA) was also conducted, which aimed to ascertain any observed variations in the viewpoints expressed about various questions across each district.

While this may seem to suggest a separation between the quantitative and qualitative research data analysis, it is important to note that this was intended solely to acquire conceptual clarity. In the study itself, the two research methods and the data collected were combined and triangulated, and the final analysis will attempt to integrate the findings from these two approaches.

4.10 Ethical considerations

It is a requirement for all research students to obtain ethical clearance before commencing their research project. Manchester University's ethics committee has reviewed and approved the ethical considerations of this research. It is also required by law in Ghana to obtain permission or ethical clearance before gaining access to public organisations as case sites for research. For this study, the Ghana Health Service's

Ethics Committee has reviewed and given ethical clearance and permission to access interviewees and participants. All the participants were verbally informed of the purpose and design of the study, and their participation was voluntary. Care was taken to ensure that data collected were treated with the utmost confidentiality, and the informants' anonymity was given attention

4.11 Chapter summary and conclusion

This study was approached from a pragmatist orientation to knowledge generation and situated within the context of a case study research design. A mixed research method and techniques was used and the study data were collected from multiple sources through interviews, surveys and documentary reviews.

Interviews were conducted with key informants and selected health staff at the district level. While the interview questions centred on the management of health sector reform implementation at the district level, the survey questionnaires were specifically concerned with the effect of a lack of staff capacity, lack of leadership, lack of commitment and lack of communication upon implementation efforts.

Data from documentary sources provided background information, first, on the modern health system, and second on the role of socio-economic and political factors in health sector reform. Qualitative content analysis was used to process the interview and documentary data, while computer-assisted software (SPSS) was used to process and analyse the survey data. Both qualitative and quantitative data were integrated in the final analysis; the latter provided the numerical/statistical advantage and the former provided the advantage of a thick description of DHMTs' experiences of health reform implementation.

Having described the research method and the techniques employed during data collection, the next chapter moves on to present the findings that emerged from the study. The chapter that follows gives some background information to public sector reform in Ghana, aiming to shed light on the challenges facing the implementation of public management reforms in Ghana.

Chapter 5

5.0 Background to Public Sector Reforms and Decentralisation in Ghana: A Qualitative Documentary Analysis of Reform and Constraints in Implementation

5.1 Introduction

This chapter aims to provide some background information on Ghana's political and economic development trajectories and to show the role this has so far played in public sector management reforms. The questions that the chapter seeks to address are:

1) what role have political and economic factors played in pushing government to initiate public sector reform?
2) how has the reform performed so far?
3) what factors are challenging reform implementation? and
4) what lessons can be learned from the reform implementation management experience?

To answer these questions, relevant information was obtained during the data collection phase from government reform evaluation reports, official evaluations undertaken by donor agencies and academic case analyses of the reform implementation process.

An important lesson learned from this chapter's consideration of the questions is that public sector reform needs to have support from committed leaders in the public service and that implementation arrangements must be firmly embedded into the administrative and political domains (see also Stevens and Teggemann, 2004).

5.2 Background to Ghana's political history

Ghana was the first country in Sub-Saharan Africa to attain independence, on 6 March 1957, (Austin, 1964). Kwame Nkrumah's biblical metaphor vividly captured Ghana's political and economic dream at that time: 'Seek ye first the political kingdom and all other things shall be added unto it'. Various political and economic development policies and programmes have been initiated in pursuit of this dream. Yet, after five decades, it seems that the dream is still a long way off. Several factors have hindered the realisation of 'the independence dream' (Foster and Zolberg, 1971; Bratton, Lewis and Gyimah-Boadi, 2001; Baynham, 1986), including Ghana's unstable political history and its failing economy.

Ghana has a chequered political history because the country's attempts to establish the sort of stable democratic political system needed for social and economic development has often been prematurely overthrown by military adventurers (see Chazan, 1983 and 1991; Ray, 1986; Agyeman-Duah, 1987; Ninsin, 1991; Hutchful, 1996; Gyimah-Boadi and Jeffries, 2000; Sandbrook, 2000)[53].

The democratic winds that blew across Africa in the mid-1980s and 1990s changed Ghana's political destiny, sowing a seed of change that germinated and brought forth democratic reform, resulting in the promulgation of the 1992 Fourth Republican Constitution and the eventual reintroduction of multiparty democracy on 7 January 1993. This time, Rawlings was no longer wearing a military uniform but was still leader of the ruling National Democratic Congress (NDC) government. The country has since had four successive elections and a peaceful transfer of political power from the incumbent National Democratic Congress (NDC) government to an opposition party – the New Patriotic Party – which is currently serving a second term under the leadership of President Kufour.

5.3 Economic development trajectories

Like the political experiment, attempts to attain economic prosperity ended in futility. The post-independence economic development policies pursued were fashioned according to dominant economic development theories at the time, especially Keynesian thinking on development economics. This implied a push for rapid industrialisation through state intervention, so the state played an entrepreneurial role in the economy by funding projects that put money in the pockets of the people (see Killick, 1978; Hyden, 2006). This strategy did not bring about the expected economic growth or a parallel improvement in the lives of ordinary people; rather it gave way for an unprecedented economic deterioration, with a falling gross domestic product rate, soaring inflation, untold hardships and devastating poverty. Against this backdrop of economic decline, Toye (1991, cited in Hutchful 1996) bemoaned that, despite Ghana styling itself as the 'black star' of Africa, it has, at various times, pursued economic policies which have proved to be self-destructive.

[53] After the overthrow of Nkrumah's one-party government, both the second and third democratically-elected governments, under the leadership of Kofi Abrefa Busia and Hilla Limann respectively, were forcefully removed by military coups. Between 1972 and 1979 Ghana was ruled by a succession of military governments, starting with the National Redemption Council (NRC), Supreme Military Council (SMC) (I & II) and, in June 1979, by the Armed Forces Revolutionary Council (AFRC), headed by Flight Lieutenant J.J. Rawlings. From 1982 to 1993, Rawlings again led the country under another quasi-military regime, from his Provisional National Defence Council (PNDC).

Various reasons have been given to explain the failure of economic development policies in Ghana. One popular argument was that the problem was caused by political leaders' failure to situate the management of development policies within an appropriate social, political and cultural context[54]. There is no doubt that, from the mid-1970s to 1980s, a combination of economic mismanagement and external shocks contributed to the deepening economic crisis in Ghana (Hutchful, 1996).

5.4 IMF-funded Structural Adjustment Programme (SAP) and Economic Recovery Programme (ERP)

The December 1981 military coup staged by J.J. Rawlings' Provisional National Defence Council (PNDC) was partly a response to the economic situation, and it marked a new era in Ghana's socio-economic and political history. The PNDC military government inherited an economy in crisis, a weak and fractured political system, and a weak and non-performing public administration system. The combined effects of these institutional weaknesses and the continuing deteriorating economic situation led in 1983 to the adoption of IMF/World Bank sponsored neo-liberal market reforms, in the hope of halting the deterioration and turning the economy around (Chazan, 1991; Rothchild, 1991). Initially, the reforms aimed to readjust prices, incentives and expenditure systems, stabilise the economy, and increase export sector production (Government of Ghana, 1987). The reforms resulted in a modest economic recovery in the short term[55] (Ayee, 1991; Tsikata and Amuzu, 1993; Hutchful, 1996; Gyimah-Boadi and Jeffries, 2000; IMF, 1991); but the longer-term objectives were not attained due to implementation bottlenecks. Among other problems, weak public administration was identified as being responsible for the underachievement of the reforms. The public administration was found to have several shortcomings and therefore required a radical restructuring before it could take on the task of managing the reforms and performing new public management roles. There were several aspects of the reforms, the core elements of which are discussed in the subsections that follow.

5.5 Background to Ghana's public service management reform

Ghana's public sector reform was the direct result of its structural adjustment experiences, supported by the IMF and World Bank and implemented in the early 1980s. The public administration of any country is established to assist elected and

[54] In addition, exogenous factors also caused economic crisis in the country's five decades of development history (Chazan 1983, Price 1984).

[55] Between 1984 and 1989, GDP average annual rates were restored to the levels of the early 1970s, registering growth rates of 5% per annum, with government revenue as a share of GDP rising from 5.3% in 1983 to 14.4 % in 1986 (IMF, 1991; Kraus 1991; Hutchful 1996). There was also a significant increase in the volume of export and import trade, with inflation falling by 90% between 1983 and 1985 (Aryeetey and Harrigan, 2000).

appointed political office holders with policy formulation and implementation. However, the Ghanaian public service failed to perform this role when it was most required to do so – during the implementation of the structural adjustment and economic recovery programmes. Thus, Ghana's move to reform the public bureaucracy in the late-1980s was due largely to the civil service's disappointing performance in managing the implementation of structural adjustment and economic recovery programmes which aimed to stabilise the ailing Ghanaian economy. This assertion was vividly captured by an expert's review report on the reforms in 1990:

> Weaknesses in public sector management and implementation have emerged as a serious obstacle to the full success of economic and financial policies. Key economic and financial management institutions are understaffed and suffer from severe shortcomings in organisations and equipment. In particular, policy analysis and planning process, budgetary control, and aid coordination, and debt management needs to be strengthened (Policy Framework Paper, 1987-1990: p.4 cited in Hutchful, 1996).

Problems in the public sector included:

1) overstaffing at lower grades and inadequate staffing at professional grades;
2) a weak central management system;
3) neglect of staff development and job-related training. Key aspects of personnel management were also lacking, particularly in the areas of performance appraisal, establishment control, accurate personnel records and low salaries;
4) over-centralisation and concentration of authority at the national level;
5) obsolete equipment and infrastructures;
6) unnecessary delays and apathy towards work;
7) corruption; and
8) obsolete rules and regulations (Hutchful 1996; Ayee, 1992; Marshall, 1990: p.7).

In addition, planning was virtually nonexistent in most of the ministries and it was found that none of them had data storage facilities or proper record management systems (Asante, 1991: p.3 cited in Hutchful, 1996). A large chunk of the civil service budget was being spent on salaries and recurrent expenditure and little on the means of delivering the public services. These problems, combined with pressure from the World Bank, paved the way for civil service reforms in the late 1980s and 1990s. Some of the major reforms undertaken in the 1990s are summarised in Table 5.1 below.

5.5.1 Civil Service Reform Programme (CSRP)

The Civil Service Reform Programme began in 1987, and focused on the public sector's organisational structure and functions, comprising all the government institutions as well as the processes and procedures associated with them. The reform was concerned with how public service organisations are structured and how they perform their functions. It aimed to improve efficiency, focusing on empowering public organisations to work in a transparent, competent, accountable and cost-effective manner (Ayee, 1991 and 1997; Haruna, 2003). The reform was facilitated through the Structural Adjustment Institutional Support Project (SAIS) special institutional support project.

The first step in the reform programme was to obtain accurate knowledge about the personnel situation in the civil service. This was then followed by specific reform instruments directed at the problems enumerated above. Among other things, the first sets of reform packages were intended to improve managerial and institutional capacity, initiate downsizing, identify and redeploy excess workforce, remove 'ghost names' from payrolls, rationalise staff organisation, and introduce information technology.

This was followed by a comprehensive manpower management and development scheme, which aimed to provide training, equipment and materials to strengthen the analytical and management capabilities of central government institutions such as the Office of the Head of the Civil Service, the Ministry of Finance and Economic Planning, the National Revenue Secretariat, and the Accountant-General's Department. All these initiatives were intended to improve the government's economic co-ordination capabilities (Hutchful, 1996; Ayee, 1991). In addition, the reform streamlined salaries, improved infrastructures and regularised logistic supplies to improve decision making. Other reform measures included freezing the civil service wage bill, implementing compensation reform, decentralising administration, introducing personnel data and management information systems. This formed the thrust of the first generation of civil service reforms in Ghana.

5.5.2 Civil service performance improvement programme (CSPIP)

CSPIP was the next major public sector reform initiative, which evolved out of the earlier reforms initiatives of the late 1980s and early 1990s. However, whereas the CSRP had focused primarily on supporting Ghana's Structural Adjustment Programme (SAP) and the Economic Recovery Programme (ERP) agendas of cost-cutting and containment, the objective of CSPIP was to improve the civil service's performance in terms of its cost-effectiveness, customer focus and response. Though the programme

received sponsorship from aid donors, it was basically conceived as 'home-grown' and was directed and implemented by a dedicated team of senior civil servants from the office of the Head of the Civil Service (OHCS).

Table 5.1: Summary of major public service management reforms launched in the 1990s

Year	Public sector reform programme	Reform objectives	Selected reform outcomes	Implementation problems
1994	National Institutional Renewal Programme (NIRP)	To give a renewed focus and strategic direction to the many reform activities already underway	Oversee the withdrawal of some agencies from government subvention, provide support for governance institutions and launch the poverty reduction initiative	Lack of political and technical support, lack of technical staff, inappropriate location of NIRP secretariat
1996	Civil Service Performance Improvement Programme (CSPIR)	To improve performance of the civil service, to make it cost-effective; customer focused and responsive	Establish capacity development teams as change agents, produce organisational manuals, republish civil service administration instructions and civil service code of conduct and ethics, introduce performance contracts	Lack of political support, NIRP failed to provide the necessary supervision, support and coordination Driven too much by targets and time
1997	Public Financial Management Reform Programme (PUFMARP)	To enhance efficiency, accountability and transparency of public financial management	Improve budget preparation and greater ownership in the MDA and improve accountability	Reform was too driven by technological concerns while basic reform measures were neglected
1997	National Governance Programme (NGP)	To support and strengthen key governance institutions and civil society organisations	Supported governance institutions e.g. CHRAG, Auditor-General and SFO in investigating allegations of corruption and economic fraud.	Programme was too grandiose without cost considerations, conflict over management responsibility, weak implementation capacity, poor coordination of sponsorship by donors
1999	Public Sector Management Reform Programme (PSMRP)	To reform subvented agencies, adjust central management agency structures and organisations	GIMPA and GRATIS are off government subvention	Lack of technical capacity, weak coordination; inadequate funding, conflict and apathy

Source: compiled by author (2007).

Table 5.1 summarises the major reform programmes introduced in the post-structural adjustment era. Unlike the earlier public sector reforms, CSPIP was launched ahead of its time because it started when the relatively modest gains of CSRP were being eroded; when the civil service wage bill was ballooning due to fiscal indiscipline and increased

headcount because of political expediency. These problems aside, the public service's incentive schemes were deteriorating because of the poor macro-economic framework (Republic of Ghana, 2003). Due to these conditions, the second sets of reforms were designed to incorporate specific attributes which aimed to counter the pitfalls of earlier reform initiatives. These attributes included:

1) the provision of a change management framework for implementing prescribed reforms;
2) strong ownership of the programme by the Head of the Civil Service, and the correct situation of the programme team in his office;
3) ownership and participatory implementation of reform objectives by affected MDAs; and
4) an incentive in the form of a fund to encourage MDAs to pursue the reform agenda.

Although the introduction of CSPIP brought significant changes into the structure and operations of the civil service, it also ran into the same problems that had bedevilled the earlier reforms. The major problems identified were a lack of political support, fragmentation of programmes and weak coordination and supervision of reform programmes due to capacity gaps. Pressure from the World Bank for a redefinition of the aims of public sector reform, through the introduction of good governance elements, resulted in further expansion of the ongoing reform beyond the capacity of the implementing agency, and this, to some extent, caused the reformers to loose focus. The realisation of these problems made the formation of the National Institutional Renewal Programme (NIRP) a necessity. The next section discusses that new initiative and describes how it aimed to harmonise both the first- and second- generation reforms in the mid-1990s.

5.5.3 1990s and beyond: National Institutional Renewal Programme (NIRP)

The failings of the earlier reforms led to the creation of the National Institutional Renewal Programme (NIRP) in 1994, to act as a supervisory organisation to give renewed focus and strategic direction to the many reform activities that were already underway. More specifically, NIRP was a programme for capacity building under a larger National Governance Programme (NGP), and it was introduced with the aim of rejuvenating all public service sector institutions, as well as autonomous institutions listed under the 1992 Fourth Republican Constitution, to assist them to discharge their functions in a transparent, competent, accountable and cost-effective manner. Overall,

the aim was to create an enabling environment conducive for increased stakeholder participation in the administration of development programmes, and to accelerate economic growth and equitable social development.

The establishment of NIRP was followed in 1995 by broader reforms under the remit of the Public Sector Re-invention and Modernisation Strategy (PUSERMO) for Ghana (motto: 'Transforming Vision into Reality') in 1997. The PUSERMO provided a framework for integrating, sequencing and monitoring a comprehensive set of what might be considered a set of New Public Management (NPM) reforms to address the weaknesses of the public sector. The reform agenda was based on a matrix of five service environments and five transformation areas. The service environments comprised: the central management agencies; the civil service; subvented agencies; local government and state enterprise. The transformation areas were: institutional structures; human resources; processes and systems of accountability and performance; and public-private partnerships and relationships (Government of the Republic of Ghana, 2003).

Additionally, the PUSERMO identified four key areas of the reform strategy:

1) Public Sector Management Reform Programme (PSMRP), launched with support from the World Bank;
2) Civil Service Performance Improvement Programme (CSPIP), launched in 1996;
3) Public Financial Management Reform Programme (PUFMARP), launched in 1997; and
4) the National Governance Programme (NGP) and decentralisation of major public services, especially health and education.

To ensure focus was maintained on the reform, the National Overview Committee (NOC) was put under the able chairmanship of the-then Vice President of the Republic, and mandated to provide strategic direction for the implementation of reform. The NOC was expected to receive technical support from the NIRP secretariat. Overall, it was hoped that NIRP would provide a new impetus for the implementation and supervision of all public sector reforms in Ghana. It was intended to create an enabling environment conducive for the application of new public management principles to public administration in Ghana, including decentralisation of service management to the district level. The next sub-section gives an overview of this decentralisation reform.

5.6 Public sector reform and decentralisation

Decentralisation legally became part of Ghana's public management following the promulgation of the Fourth Republican Constitution in 1992[56]. Because of its populist ideological inclinations, the PNDC had earlier introduced political decentralisation with the passage of PNDC Law 207, creating 110 district assemblies from the existing 65, and devolved 86 development functions to the newly-created District Assemblies (DAs), which became the highest political and administrative authorities at district level (Ayee, 1994)[57].

The decentralisation programme aimed to:

1) enhance regime legitimacy;
2) promote democratic governance to win the support of donor agencies;
3) provide a framework for cadres to exercise their democratic rights and be part of the decision-making process.

Overall, the move to decentralisation was not only concerned with 'bringing qualitative changes to the country's politics and administration', but also enabling 'administrative convenience, effective delivery of goods and facilities and the involvement of the people at the grassroots in decision-making (Ayee 2003). For this reason among others, the decentralisation of administration through the District Assemblies was described by Rawlings as:

> The pillars upon which the people's power would be erected... the focal points of development at the village and town level... The principle of popular participation was given meaning through the Assemblies, where decisions directly affecting the lives of the people were to be taken. The objective of the elections was for a system of local government of the people by the people and for the people... it was for a system that gave the voters power to exercise control over their own affairs (Rawlings, 1991 cited in Ayee, 1997).

The PNDC's decentralisation programme was – in theory, at least – a blend of political and administrative decentralisation. Whereas previous attempts at decentralisation had been interested in changing the structural arrangements of government machinery rather than in creating decision-making space at district and sub-district levels, the PNDC's

[56] It is pertinent to note that decentralisation was not a new strategy for public sector restructuring in Ghana. All past governments, including the British colonial government, made decentralisation a central component of their political and administration strategy (Ayee, 1994; Foster and Zolberg, 1971).

[57] The most comprehensive effort since independence to use decentralisation as a policy instrument in redesigning Ghana's political and public administration machinery was undertaken by the Provisional National Defence Council (PNDC) government's decentralisation programme, launched in 1988 (Ayee, 1994).

decentralisation programme went a step further, aiming to provide a structure capable of efficiently discharging the developmental functions entrusted to district political and administration authorities, while at the same time maintaining and pursuing its democratisation reform objectives.

5.6.1 Policy context of Ghana's decentralisation reform

The Structural Adjustment Programme, the 1992 Constitution, public sector reform, *Ghana Vision 2020* (see section 5.6.3 below) and its Poverty Reduction Strategy all provided a framework for decentralisation in Ghana. In fact, political reform and its related decentralisation was begun by the ratification of PNDC Law 207 in 1998, and the subsequent reforms of the 1990s were therefore a continuation of the one initiated by the PNDC government (Oquaye, 1995).

5.6.2 The 1992 Constitution and decentralisation

The 1992 Constitution and the various legislation on decentralisation articulate the explicit objectives of decentralisation, such as empowerment, participation, accountability, effectiveness, efficiency and responsiveness, decongestion of the national capital and slowing rural-urban migration (Ayee, 1991 and 1997). As noted above, the constitutional and legislative provisions depict a blend of political and administrative decentralisation. They show that decentralisation reform has been designed to achieve the following objectives:

1) devolve political and government power in order to promote participatory democracy through local institutions;
2) de-concentrate and devolve administration, development planning and implementation to local government (District Assemblies);
3) introduce an effective system of fiscal decentralisation to give the District Assemblies (DAs) control over a substantial portion of their revenue;
4) establish a national development planning system to integrate and coordinate development planning at all levels and in all sectors;
5) incorporate economic, social, spatial and environmental issues into the development planning process on an integrative and comprehensive basis;
6) create access to the country's communal resources for all communities and every individual; and
7) promote transparency and accountability.

Although earlier constitutional provisions on the structure of the relationship between decentralised government ministries and departments, statutory and public corporations

and the District Assemblies were criticised as vague because they failed to differentiate clearly between the choices of forms of decentralisation being pursued, the constitution nonetheless set the stage for reforming the country's public administration (Ayee, 1999).

5.6.3 *Ghana Vision 2020* and decentralisation

Another important strategic development policy instrument which provided a further framework for understanding Ghana's decentralisation programme in the mid-1990s was the policy document *Ghana Vision 2020: The First Step,* which was presented to Parliament in January 1995. It argued that a shift in public sector roles and responsibilities was expected to result in improved economic efficiency and growth through the operation of a market-driven economy. *Ghana Vision 2020* was conceptualised by policy makers as a neo-liberal development policy document, aiming to enable Ghana to achieve a 'balanced economy and a middle-level-income country status and standard of living, with a level of development close to the present level of the South East Asian countries of Hong Kong, Singapore, Taiwan and Malaysia' (Government of Ghana, 1995). Of the five main themes espoused in this important development policy instrument, decentralisation of public administration was accorded a pride of place. The five main development themes covered in the long- and medium-term objectives of *Vision 2020* were:

1) human development;
2) economic growth;
3) rural development;
4) urban development; and
5) an enabling environment that would ensure full implementation of policies for a 'decentralised system of public administration'.

Overall, decentralisation was expected to play an instrumental role in transforming the structure and functions of the government and public administration.

5.6.4 Ghana's Poverty Reduction Strategy (GPRS) and public sector decentralisation

In a similar vein, the introduction and integration of a poverty reduction strategy into Ghana's development policy and public management reforms started in the mid-1990s, that is, around the same time as *Vision 2020.* In actual fact, the need to readjust public administration through decentralisation became apparent and urgent when both the NDC government and donor agencies realised that the District Assemblies (DAs) had

failed to effectively perform the developmental functions assigned them, largely because they lacked the capacity to develop and effectively implement pro-poor policies. In order to bridge this capacity gap, the government decided to create more space for the participation of stakeholders, including civil society organisations (CSOs) – even those that were out of favour with that government – private sector representatives, trade unions, women's groups, direct representatives of communities, and non-government organisations. And, for the public administration system, decentralisation was intended to ensure a much closer involvement of sector ministries in formulation and implementation of pro-poor policies.

Thus, to ensure effective performance, 22 departments and organisations listed under the First Schedule of the 1988 Local Government Law 207 were placed under the control and direction of DAs. This further adjustment of Ghanaian bureaucracy to decentralisation was intended to ensure that the concerted efforts of both local governments and sector ministries would work towards the attainment of the development goals stated in *Vision 2020* and the GPRS.

However, in supporting local government, the public bureaucracy was supposed to limit its role under the reform programme, especially under the *Vision 2020* and GPRS, to:

1) establishing appropriate policies and regulatory regime for the efficient and effective operation of market reforms;
2) developing human resource capacity;
3) facilitating the building and maintenance of an appropriate physical infrastructure; and
4) facilitating the provision of appropriate services.

The PNDC argued that, although central government should be responsible for financing 'public' goods and services, it did not need to be directly engaged in the actual production of goods and service financed by it. Distinguishing between the financing and production of public goods and services is therefore one of the core functions assigned to the District Assemblies and their counterparts in the public services sector.

5.7 What has public sector decentralisation reform achieved?

Most evaluations of Ghana's public management reforms have focused on practical outcomes, highlighting labour retrenchment, logistics supply, and upward adjustment of

salaries, block grants and physical infrastructure (McCourt, 1998; Ayee, 1997; Gymah-Boadi, 1990). Some of these practical results are discussed in the following section. In his 1998 study, McCourt reported that civil service reform had uncovered 10, 000 'ghost' (i.e. non-existent) workers in the system, enabling job reduction targets of 15,000 to 12,000 to be met. Also, training in computer skills for junior and middle-level staff was acknowledged as one of the most successful aspects of reform (Hutchful, 1996).

In particular, CSPIP was described as having made a big difference, being instrumental in 'halting the decline', it 'breathed new life into the Civil Service' and 'started putting some of the important building blocks in place' (DFID/CSPIP Report, 2000). This reform also improved stakeholders' understanding of and engagement with the reform process and thereby gained a good understanding of the present tools and techniques of public service reforms. As a result, stakeholders are now taking forward the reform agenda under their own initiative.

Furthermore, public sector reform helped to provide a framework for planning and prioritising, based on expressed need, and started to address the necessary requirements for improving organisational performance through the creation of appropriate structures, manuals, objectives and priorities. The reform helped to build skills and strengthen team-based approaches, enabling senior and junior officers to plan and solve problems together; and this also reduced traditional departmental barriers. Other reform achievements included: delegation of recruitment and training to MDAs, improving opportunities to match staffing to skill shortages and budgets while strengthening the role of line managers.

The reform enhanced political engagement and cascaded incentives for change through the successful introduction of performance contracts with Chief Directors, Directors and District Assemblies. It also helped improved local governance and accountability by putting accountability mechanisms into effect between public officers and District Assembly members and between District Assembly members and their constituency members. In addition, it helped District Assemblies to look at reform issues in a more holistic manner (DFID/CSPIP Report, 2000; Republic of Ghana, 2003; Ayee, 1997). On the whole, the reform brought about positive changes in the motivation and behaviour of public sector employees.

The government also changed, divesting itself of service provision, especially from state-owned and government subvented agencies (SAs). The reforms succeeded in preparing reengineering plans for 45 subvented agencies, of which 16 were at various stages of implementation. Of the subvented agencies undergoing reform, the Ghana Institute of Management Public Administration (GIMPA) and GRATIS are highlighted as being the most successful, as both have been taken off subvention. Reform has helped researchers undertake diagnostic studies on subvented agencies and, as result, six SAs have been identified for closure. This exercise has been approved by the government, but the necessary action to carry out this instruction has however been delayed by technical problems at the Ministry of Finance (World Bank Report, 2001; Government of Ghana, 2003; CDD-Ghana, 2004).

5.8 Review and analysis of challenges in implementing public sector reform

There are many challenges in the implementation of public sector management reform. Successful reform implementation requires improvement in a number of areas. It is not possible to discuss all of these factors thoroughly here, so I will therefore concentrate on selected topical issues which are significant to the present study.

5.8.1 Lack of political support for NIRP

Ghana witnessed substantial administrative reforms under Rawlings' authoritarian populist rule in the 1980s. The PNDC was not an elected government accountable to the people, but nonetheless Rawlings was able to win support for reform within cabinet and the civil service and in civil society through government-supported populist-revolutionary organisations. As Stevens and Teggemann (2004) observed, this support collapsed with the introduction of multiparty politics in 1992; causing the entire reform to derail and stall. The ruling NDC government lost its unity and programmatic vision; and much energy went into sustaining patronage networks as a means for political support. NIRP suffered a lack of political support, especially following the electoral demise of its chairman and former Vice President Atta Mills during the 2000 elections. In the process, the reform – and NIRP in particular – was left orphaned, making the secretariat more able to respond to triggers set by the development partners rather than the demands of NOC (CDD-Ghana, 2003). Kufour's New Patriotic Party distanced itself from NIRP and has never provided any significant political support for it since taking over the reigns of government in 2000.

5.8.2 Paucity of capacity

The second factor which impeded reform implementation was the weak capacity and defective approach of NIRP in managing the reform implementation process as a whole. NIRP's unsatisfactory performance was due to its hands-off approach – not giving direction, promoting ownership or being involved as the supervisor and custodian of reforms from the very outset. A lack of information sharing and inadequate preparation before the Public Sector Reform process commenced was largely due to NIRP's inefficiency. The NIRP secretariat has generally demonstrated a common tendency to fail to deliver resources when promised. This had weakened ministries', departments' and agencies' trust in the secretariat.

Another factor was NIRP's over-reliance on appointing consultants to carry out diagnostic studies on agencies to be reformed, without consulting the individual organisations. This negatively affected trust, ownership and confidence in the work of the secretariat. Often organisations to be reformed were hardly involved in the formulation of reform strategies by the consultants, and in some instances were opposed to the recommendations made. Unfortunately, the NIRP secretariat seemed to be unaware of this situation and thus allowed resistance to reform to increase. Most of the individual organisations targeted for reform perceived the attitudes and competencies of their chosen consultants as being heavy-handed, with a lack of sensitivity to individual organisational needs. This alienated most officials from the reform programme which was particularly damaging concerning helping to transfer ownership to the agencies under reform (DFID/CSPIP Report, 2000).

5.8.3 Inter-agency conflicts

Graham Allison's observation vividly captured aspects of Ghanaian public sector reform implementation challenges. As he argued (1971 cited in Grindle and Thomas, 1991): 'where you sit frequently does determine where you stand'. Reform managers become committed to implementation by taking into consideration their individual interests and those of the organisations they serve in terms of political and bureaucratic influence, benefits and responsibilities. Most of the support officials give to reform tend to depend on their organisational position within government and the public administration hierarchy, and this has implications for reform outcomes.

The problems of NIRP and its attendant negative effects on reform implementation seemed to have deeper roots in inter-organisational and personal conflicts within the public sector. The ineffectiveness of NIRP was started at its inception by 'inter-agency

politics' or 'bureaucratic politics' between the Office of the Head of the Civil Service (OHCS) and the Public Service Commission (PSC).' This took the form of inter-organisational rivalry which developed into a sort of 'cold war'. The resultant effect was a protracted competition ensuing between the CSPIP, which was run by the OHCS, and PSMRP. Basically, PSMRP was perceived by the civil service as being imposed on Ministries, Departments and Agencies (MDAs) with political authority and backing from the National Overview Committee (NOC). There was disagreement between politicians and bureaucrats over who should exercise control over the various components of the reform, leading to conflict over positions, power and resources. In the process, NIRP was given an enclave status and perceived as a foreign Project Implementation Unit (PIU); and, therefore, regarded as a deviation from a conventional public administration control structure, which created resistance to the PSMRP reforms.

5.8.4 Paucity of human resource capacity

As with earlier reforms, the low level of critical human resource capacity within the public sector affected reform implementation, and, this led to a situation where reform initiatives were being implemented by external consultants. This loss of initiative to external consultants has resulted in non-ownership of changes by the civil service and implies that gains from the reform programmes were unsustainable. Conyers (2006), Kiggundu (2002), Olowu and Sako (2002), and Hilderbrand (2002) also lamented the negative effect of the dominance of foreign consultants on building the local capacity and ownership needed for project sustainability.

5.8.5 Fragmentation and lack of ownership of reform

Generally, there was fragmentation and lack of coordination in the implementation of the various reform programmes, both within the government and between different development partners. The lack of ownership of reform programmes can be blamed, to a certain extent, on the location of the implementing secretariat or agency (Ayee, 2003). For example, the PSMRP was managed by the NIRP secretariat, which was outside the domain of the civil service; and this led to resistance in the implementation of reform within the Central Management Agencies. Similarly, the PUFMARP secretariat was situated within the Ministry of Finance but might have been better sited at the Controller and Accountant-General Department, given that the controller will be the ultimate owner of the system (CDD-Ghana, 2003; Sakyi 2004). Similarly, it was widely acknowledged that the decentralisation process will need a higher level of sponsorship than that offered by the Ministry of Local Government and Rural Development, because other sector ministries had been unwilling to yield their authority to the local

government system. Thus, inappropriate locations of supervisory agency secretariats impeded reform success (Sakyi, 2004).

5.8.6 Reform programmes were overly technological

In many cases, reform programmes are perceived to have focused on high-level, technologically-centred solutions at the expense of basic processes and procedures that are a prerequisite for the efficient functioning of elaborate bureaucratic systems. This is because high–level technology-based reform will not necessarily cure bureaucratic problems, or resolve a weak and uncoordinated personnel management system. A case in point is the computerised personnel and payroll system, which has failed to deliver the anticipated benefits because the personnel management component was ignored during implementation. The effect is that the Comptroller and Accountant General have been left with a poorly-functioning payroll computer system, which unfortunately is not supported by proper personnel processes or procedures. The perennial problem of ghost workers and inaccurate service headcounts might have been made redundant if sufficient attention had been paid to the personnel components of the Integrated Payroll and Personnel Database (IPPD) during the reform design stage.

5.8.7 Absence of an overall framework for civil service reform coordination

Lastly, it became clear that all the above were due to the lack of any overall reform coordination framework. Even under the incumbent New Patriotic Party government, there does not seem to be any coherent civil service reform coordination framework. The government expressed the need for the reforms to be internally-driven through the National Poverty Reduction Programme, where some of the visions for the future of the civil service and improvements in governance are outlined.

Efforts such as setting up managerial and administrative arrangements in the form of advisory groups, creating a Senior Advisor post, the technical team and the programme secretariat are strategies to re-tool and support the general direction of the civil service reform. The recent establishment of a Ministry of Public Sector Reform and subsequent appointment of a Minister to oversee reform management are laudable initiatives; indeed, all these new arrangement were expected to enhance the implementation of the reform programmes. Yet, they seemed to have missed the mark because they have confined themselves to the earlier approaches to reform management and implementation where donors, especially the World Bank and DFID, dictated the terms of reform.

Currently, many programmes are taking place within ministries, departments and other government agencies but no agency seems to be coordinating these programmes and activities. For example, there is no coordination between the activities undertaken by the Governance Reform Programme and the Office of Accountability and Medium Term Expenditure Framework. Similarly, activities of the Privatisation Implementation Committee and the Ministry of Finance's Subvented Agency reforms do not seem to take into account other reform programmes and activities under the office of the Senior Minister. But as experience from previous reforms shows, where many activities are underway in the administrative structure in an essentially independent manner, and where there is no focused framework for decision-making, it is difficult to obtain commitment except at a general 'reform is good' level.

Lessons learned from developed countries such as the UK, Australia and New Zealand are that change or reform programmes often occur in phases, with a specific focus which the incumbent government embraces. But evidence from the Ghanaian experience depicts the direct opposite, where actions are taking place on many fronts and this makes reform implementation management, monitoring and evaluation very complex and ineffective (Haruna, 2003). The combined effect of these factors, among others, has continued to pose a major challenge to reform success in Ghana. The government and donors need to rethink a way to create a framework for harmonising the diverse ongoing reforms in order to improve the chances of reform success.

5.9 Summary and discussions

This chapter has determined that both internal and external forces contributed to the introduction of public service management reform in Ghana. The discussion set Ghana's public service management reforms against the backdrop of political, economic and social development experiences following independence. The chapter showed that the combined effect of these factors apparently paved the way for the introduction of economic recovery and structural adjustment programmes and democratic reforms. It continued to note some of the reasons suggested by analysts as contributing to the poor implementation of the first set of reforms.

Studies on implementation of reforms in Ghana emphasised political reasons as a major cause of reform failure (Sandbrook, 1993; Hutchful, 1996; Ninsin, 1996; Kraus, 1991; Ayee, 1991; Gyimah-Boadi, 1990). To some extent this is a plausible assertion, especially considering the circumstances that brought the PNDC government – which

launched the reforms – into power. But there is a need to interpret the reasons for reform implementation failure more vigorously and differently.

Firstly, it is believed that reform implementation failed because both the World Bank/IMF and the government had a narrow view of the country's development problems at that time. The reformers failed to appreciate the historical context within which Ghana's public administration had evolved and failed to understand that it therefore needed to be reformed first before it could manage to implement such grandiose development reform programmes. In consequence, public sector management reform was not factored into the first set of reforms but added as an afterthought, which came following the failure of civil service to effectively implement the first-generation reforms. This compelled the reform creators (both donors and government) to repeatedly return to the drawing board, to design a broader institutional reform package that took into account the structure, functions and operations of public service agencies and to integrate them into Ghana's long-term development policy framework.

Secondly, it is also argued, in line with Haruna (2003), that Ghana's reform of public administration placed too much emphasis on bureaucratic and managerial values which were transplanted from developed countries without any requisite modifications. This led to a neglect of historical, social, cultural and political realities, which have had much influence on local understanding and practice of public service management[58].

Thirdly, the factors acting as a brake on implementation of public sector reform are, to a large extent, due to the internal character and organisational culture of the public administration system, which has its roots in the country's larger bureaucratic politics (see Grindle, 1980; Ayee, 1994; Leftwich, 1993). As argued by Grindle and Thomas (1991: p.29), the autonomy of political and administrative actors plays a crucial role in bureaucratic politics of implementation because it is constrained by the power and bargaining skills of other bureaucrats and their own hierarchical positions of power, their political skill, and the bureaucratic and personal resources available to them.

Thus, implementation challenges to public sector reforms can be understood by examining the stakes, resources, and skills of various individual actors and implementing agencies involved in the process. In the case of Ghana, the public sector

[58] See Price (1975) and Kuada (1994) for discussion of the effects of cultural values on behaviour of public officials and bureaucrats.

reform programme was the result of competing activities within bureaucratic agencies and actors constrained by their organisational roles and limited capacities. Political, bureaucratic and international donor actors competed over preferred solutions to the reform problem and used resources available to them through their positions – e.g. hierarchy, control over information, access to key decision makers – in order to achieve their goals (Sanbrook and Oelbaum, 1997). In the process, public servants and reformers viewpoints' on the reform were influenced by their bureaucratic position and this in turn shaped the level of their support for reform.

For instance, the bureaucratic politics of Ghana's public management reform manifested itself in one of the following ways:

1) public officials involved in reform management at a point never saw themselves as partners but as rivals; they engaged in unwarranted and petty conflicts at individual, intra- and inter-organisation levels;
2) inter-agency conflict impeded reform coordination, information sharing, inter-organisation networking; building of trust and social capital needed for effective reform management; and
3) the inherent weaknesses encouraged and created another form of politics between government's consultants and donors whose consultants always had an upper hand or dominated the design and management of reforms; and in the process deprived the public sector of the opportunity to develop a cohort of public leaders with the requisite skills and managerial capacity and high level of commitment needed for local ownership and sustainability of reform.

5.10 Conclusion

Most of the problems which led to launching the reform are still prevalent, and in some cases the public sector seemed worse off than before the official introduction of the reform in the mid-1980s. Many of the roadblocks in implementation affect other public sector organisations undertaking reform, including the health sector The problems identified here also influenced reform implementation in the health sector, although the degree of impact differed. Many of the problems did not miraculously melt away with the launching of the public sector reforms. But the question to ask is whether health sector reform would defy the obstacles to reform implementation and impact upon the functioning and performance of the health system? Would the management of the health sector reform implementation process and the problems regarding the bureaucratic politics of implementation be critically different from the experience of earlier reforms?

The analysis in the next chapter will aim to provide evidence that supports earlier studies which argue that ineffective implementation of health reform is intractably linked to the problems of the public/civil service. Studies mentioned in the discussion have claimed that factors internal to the health system itself are potentially detrimental to effective implementation[59].

Having supplied a background to understanding the political, economic and institutional context of public sector reform in Ghana, the next chapter will continue along this line and undertake a critical retrospective analysis of the challenges in implementing similar reforms in the public health sector. Essentially, the next chapter will focus attention on the evolution and reform of the public health service; it will identify the achievements of reform and note particular factors that posed a major challenge to implementing reform. In doing this, the focus will be on the district health management teams and their role in the implementation of health decentralisation, as implied by the title of this thesis.

[59] Some examples of internal obstacles to health reform implementation identified in the literature are: internal capacity and weak implementation strategy (Larbi, 1998); persistence of an old governance structure in the Ministry of Health (Bossert and Beauvais, 2002); staff attitudes and workplace obstacles (Agyepong, 1998; Agyepong et al., 2004); lack of staff motivation and poor working conditions (Dovlo, 2003); loss of staff through the 'brain drain' from the sector (Dovlo, 2005; Dovlo and Nyonator, 2004).

Chapter 6

6.0 Health Sector Reform and Decentralisation in Ghana: A Retrospective Documentary Analysis of Reform and Obstacles Confronting Implementation

6.1 Introduction

Chapter 5 provided a broad overview of Ghana's public management reform and obstacles to its implementation. This chapter continues the discussion but focusing on health sector reform. Specifically, the chapter aims to give an historical background to the evolution of the Ghanaian health system and to discuss why health sector reform was necessary. Using a retrospective policy analysis approach (Walt and Gilson, 1994), the analysis was based primarily on secondary data collected from central government policy documents, official evaluation reports, district annual reports and reviews of sector performance documents from the Ministry of Health and Ghana Health Service, as well as academic case studies. Official sources included reform evaluations undertaken by the central Ministry of Health and Ghana Health Service, evaluations undertaken by World Bank and World Health Organisation consultants and experts inside and/or outside the health service. Other data sources included district annual evaluations, reviews of sector performance reports, and works published by academic and professional researchers which aimed to generate a large body of knowledge on health reform implementation with theory building and hypothesis testing in mind. Most studies on health sector reforms in Ghana fall into this category. These studies were preferred as source material because their scope and content allowed examination of the study's research questions.

The first section of this chapter provides an historical account of Ghana's modern health system and the effects of changes in global health policy on the reorganisation of health services since the mid-1970s. In discussing these changes, I show how external factors have contributed to the shift from a centralised, hospital-based approach to health care delivery, towards decentralised primary health care delivered through district health systems. In the second section of this chapter, health reforms will be contextualised as part of Ghana's overall development strategy and vision for the new millennium; and the drivers of the reform will be identified. In the third section, elements of the health reform are described, with a focus on decentralisation. The fourth section of the chapter gives an overview of the changes that have occurred so far and mentions factors which challenge reform implementation. In this last section, the key issues emerging from the discussion are summarised, before the conclusion. The lesson and conclusion drawn

from this chapter is that: 'successful implementation even under favourable circumstances, usually takes years, and often decades' (see Klinger, 2006: p.647).

6.2 Overview of Ghana's public health system

Historical, socio-economic, global and political trends and contexts have a direct and causal influence on Ghana's health service organisation and policy trajectories. Such factors also interact dynamically with each other. Following a brief discussion of the role played by each of these factors, Table 6.1 summarises important events in the course of the development of a modern health system in Ghana.

Smithson et al. (1997) have reviewed the history of the development of the modern health system from the colonial era to 1993. Very briefly, Ghana's modern health system dates back to the colonial period in the nineteenth century, when the British government established the Gold Coast Medical Department in the late 1880s. Health service provision was primarily curative and solely aimed at the health of the European population and government workers in particular (Dummet cited in Smithson et al., 1997). In the early part of the twentieth century, the colonial health service was expanded to cover the local population as well, and introduced preventative health measures as a means to providing public health care (Smithson et al., 1997).

The Ghanaian health system experienced its first organisational restructuring in 1953, four years before independence, when the Colonial Medical Department became the Ministry of Health. At independence in 1957, the new indigenous government took responsibility for the health of its citizens. Restructuring the colonial health service began in the heat of the anti-colonial struggle, was thus conceived as an integral part of the decolonisation process, and therefore became a major component of Nkrumah's Convention People's Party government's 'Africanisation' reform programme of public services.

6.3 Political and socio-economic forces

Ghana's health system and policies were intimately connected to and shaped by changes in the political economy of the country. Political developments in the country before and after independence heavily influenced the entire public service, including the organisation and management of health services. This was because the provision of health, education and other social services was viewed by the 'new political elites' as one of the gains of decolonisation as well as an essential tool and channel for gaining support and control over the population (Senah, 1989).

Table 6.1: Inventory of key events in the evolution and reform of Ghana's public health system, 1880s-1990s

1880s	Establishment of the Gold Coast Medical Department
1909	Expansion of health to indigenous population and establishment of Sanitary Health Unit responsible for preventative health care
1919	Establishment of Medical Research Institute (laboratory)
1917	First programme to train paramedical personnel began
1940s	Expanded programme for training medical staff
1940s to 1950s	Major hospital building and expansion programme started (e.g. Korle-Bu teaching hospital); and the establishment of Medical Field Units to strengthen preventative health service
1953	Gold Coast Medical Department became the Ministry of Health (MOH), led by a Ghanaian minister
1957 and after	Rapid increase in the number of health centres, although capacity to deliver preventative service remained weak
1978	Primary health care became part of the national health development strategy; decentralisation shifted attention to district health management teams for the first time
Late 1980s	Creation of the post of Director of Medical Services to correspond with change in the top civil service position from Principal Secretary to Chief Director
1988	Initial attempt at health sector reform
1994	Restructuring of MOH by creating seven directorates: Finance, Administration, Research Statistics and Information Management (RSIM), Policy, Planning, Monitoring and Evaluation (PPME), Human Resources, Procurement and Stores, and Traditional and Alternative Medicine
1995	The formulation of the Medium-Term Health Strategic Framework for Health Development 1996-2000
1995	Medium-Term Health Strategy: Towards Vision 2020
1996	Enactment of the Ghana Health Service and Teaching Hospitals Act, Act 525, 1996
1997	Creation of the Ghana Health Service, establishment of Regional Health Management Teams and strengthening of district health management teams
1998	Development of the Health Sector Five-Year Programme of Work:1997-2001

Source: author's own compilation, based on Ministry of Health Documents (2007).

As noted above, a significant change in post-independent health policy was the expansion of health services to cover the entire population, with an emphasis on the development of rural health facilities to meet the needs of Ghana's predominantly rural population. The politics of health reform, however, did not change the centralised and curative features inherited from the colonial period. Health financing, management, personnel training and regulation of the health system remained the sole responsibility of central government, with the involvement of a few mission health facilities which played a limited role in health policy making and management (Smithson et al., 1997).

Like many developing countries in Africa, Ghana experienced serious economic stagnation and decline in the 1970s and 1980s, which had a serious effect on all sectors

of the economy, including the health sector (Hutchful, 1996; Sandbrook, 2002). The crisis made it very difficult for central government to supply the financial and logistical support needed to continue providing health services to an ever-increasing population. In other words, the economic crisis made it impossible for government to sustain its health development programmes, being unable to fund large hospitals, provide hospital machinery and equipment, and train personnel to manage the country's health system. The most serious consequence of this problem was that the entire health infrastructure had virtually collapsed due to the lack of money required to maintain them and pay the salaries of doctors, nurses and other paramedical staff. The situation was so serious that it resulted in a massive exodus of health personnel from Ghana to countries such as Nigeria, South Africa, Botswana, Namibia, United Kingdom, Saudi Arabia and the Untied States, in search of better working conditions (Dovlo, 2005).

6.4 Global influences and reorganisation of the health system

Global trends also played a role in the changes taking place in the health sector at that time. This was reflected in changes in health policy and approaches to organisation and health systems management all over the world. In particular, a dramatic change in global health policy and approach to heath care delivery occurred in 1978. This worldwide change brought about the introduction of the Primary Health Care (PHC) programme popularised by the World Health Organisation (WHO, 1978 cited in Barneji, 2003). As a member of the United Nations, Ghana became a signatory to the 1978 Alma Ata Declaration and, in the process, adopted Primary Health Care as a national health policy (Ministry of Health, 1979).

Ghana's adoption of the World Health Assembly's (WHA) 1977 'Health for All by the Year 2000' programme, the 1978 Alma Ata Declaration on Primary Health Care (PHC) and the 1981 WHA 'Global Strategy of Health For All by the Year 2000' ushered in a new health policy direction in Ghana. A key principle of this new health strategy and PHC was decentralisation. PHC was advocated, based on the weaknesses identified in the traditional large, centralised hospital-based health system, which emphasised curative rather than preventative health care.

One of the underlying normative arguments was that health policy formulation and implementation under PHC could not be conducted through the existing centralised bureaucratic machinery in a top-down fashion (Collins and Green, 1994). Another argument was that, while central government control over the health service was needed principally to develop and implement the equity objective of PHC policies, the

programme required a significant degree of decentralisation in order to bridge the gap between the central Ministry of Health and health service users. Based on these normative arguments, emphasis was placed on strengthening district health systems and sub-district health institutions, being the agencies closest to the local population where support for PHC programmes could be built up. Decentralisation was one of the key policy reforms initiated to strengthen district health planning and management capacities. Decentralisation also aimed to increase community participation and inter-sector collaboration.

6.4.1 District health systems

A district health system is defined as 'a self-contained segment of the national health system. It comprises first and foremost of a well-defined population, living within a clearly defined administrative and geographical area, whether urban or rural. It includes all institutions and individuals promoting healthcare in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors' (WHO, 1978; se also Ackon 1994)). According to the WHO (1985, cited in Barneji 2003), the district health system includes self-care, all health care workers and facilities, up to and including hospitals at the referral level, laboratories, and other diagnostic and logistic support services. Its component elements and institutions need to be well coordinated by an officer assigned to this function in order to draw them all together into a fully-comprehensive range of promotive, preventive, curative and rehabilitative health activities (WHO, 1985 cited in Barneji, 2003).

In addition, the district as a generic term denotes a clearly-defined administrative area, which commonly has a population of between 50,000 and 500,000, where some form of local government or administration oversees many of the responsibilities from central government sectors or departments, and where a general hospital for referral support exists. In principle, the objective for strengthening a district health system through decentralisation is to enhance equity, accessibility, inter-sector collaboration, and community involvement, integration of health programmes and coordination of separate health activities (WHO, 1985; Newell, 1975).

6.4.2 Why strengthen district health systems?

Various reasons have been given for shifting attention from the central government Ministry of Health to district health authorities and systems. Firstly, the district health system is seen as the most appropriate administrative machinery for implementing decentralised health care programmes. Secondly, the district is seen as a possible bridge between central government ministries and the local communities and, therefore, seen as appropriate for coordinating 'top-down' and 'bottom-up' planning, for organising community involvement in planning and implementation, and for improving coordination of health care services. Thirdly, the district is close to the community so can better understand problems and constraints at the community level. Likewise, the district is seen to occupy a strategic position in the government's administrative hierarchy and therefore houses many key development sectors and their representatives, thus facilitating intersectoral cooperation and the management of services across a broad area. In this capacity, therefore, the district is expected to provide appropriate support for sub-district and community health activities.

In addition, district health managements have a horizontal relationship with ministries, departments and agencies between different health programmes, and are externally and geographically connected to the communities, stakeholders and organisations they serve. This therefore requires a clear differentiation between the district system and the district level. The district *system*, as used in relation to health decentralisation, refers to the entirety of the district covering all elements and thus, all levels. In contrast, the district *level* refers to the managerial stratum, usually placed in the district capital, which is hierarchically located between the national and regional or provincial levels and the communities. This level is often referred to as the intermediate level (Ackon, 1994).

6.4.3 Responsibilities of district health systems

With an increasing focus on the district health system, the question must be asked: what are the responsibilities of district health systems and what are the implications of these for the implementation of health programmes?

The scope of a district health system's management responsibilities depended, to a considerable extent, on the amount of political and administrative power transferred; which depended upon the degree of decentralisation that had taken place, and on the availability of qualified manpower. The transfer of authority for planning and implementing health policies to district authorities through decentralisation gave district

health administrations a very wide array of responsibilities (at least in theory). These included: organising, planning and implementing health policies; financing and resource allocation, intersectoral coordination, community participation and human resource development and management. Given this general description of the features and role of the district health system in a decentralised health structure, the next subsection provides a brief description of the organisational structure of the health district system in Ghana.

6.4.4 Organisation structure of the Ghanaian health system with a focus on districts

Ghana is divided into ten administrative regions and 138 districts (of which 28 were newly created by the ruling New Patriotic Party government). Within these divisions, health services are organised and administered at five levels: namely community, sub-district, district, regional and national (Ackon, 1994). It is not possible to cover all the levels here, but emphasis is given to the district health management system because of its importance to the present study.

6.4.5 District Health Management Teams (DHMTs)

In Ghana the district health system comprises four broad categories of health facilities: referral hospitals, health centres, health posts and clinics. The District Health Administrations (DHAs)' major function and responsibility is operational planning and implementation of government health policies and programmes. In the pursuit of its operational functions, DHAs are expected to develop their own strategies to be included in the larger health development policy of the country. Changes in the organisational structure of the health bureaucracy in the 1980s and 1990s through decentralisation resulted in further strengthening of District Health Management Teams, and subsequent expansion of their management and implementation government health programmes throughout the country.

6.4.6 Membership of the DHMTs

Each DHMT comprises:

1) the district director of health services;
2) the medical officer in charge of the district hospital (senior medical officer);
3) a district public health nurse;
4) a district disease control officer; and
5) a district environmental health officer.

6.4.7 Roles of DHMTs

Each DHMT is expected to take charge of planning, managing and implementing the entire government and non-government district health services, including managing resources and personnel and supervision of all health facilities in the district. In furtherance of decentralisation and its related PHC programme, and the need to improve quality and management of service, the Sub-District Health Management Team concept was implemented in most districts. However, the decentralisation discussion does not include the sub-district concept and therefore is not given attention in this study[60].

In addition to the Ministry of Health, missions, private-for-profit and non-government organisations play a very important role in administering public health services at the district, sub-district and community levels. Their services and outreach programmes are executed through a network of hospitals, health centres, health posts and clinics scattered across the country. The DHMTs collaborate with these various health institutions within the context of the overall organisation and management structure of the health system discussed above, but with central government still playing a dominant role even after decentralisation. This situation has implications for the system and necessitated a further redefinition of roles, not only for central government, but also for private and non-government stakeholders in the health care system. This issue will be explored in the next subsection. This state of affairs meant that, throughout the post-Alma-Ata reform period and its attendant shift to DHMTs, the Ghanaian health system still harboured vestiges of the centralised colonial system.

Despite the fact that considerable progress was made in transferring some authority to district health authorities, the health system as a whole not only remained centralised, but was weak and fragmented in terms of technical, functional, managerial and executing roles, especially between the centrally-managed and vertical programmes (MOH, 1996). This weakness affected the effective delivery of services. It was against this background that government – with prompting from donor agencies – decided to reorganise or overhaul the health system through structural and operational reforms, in order to make its performance more efficient and effective. The next section discusses some aspects of the reform programme and some of the policy instruments deployed in

[60] The sub-district is the third structure in the health administration structure, is under the supervision of the DHMTs, and is intended to provide basic health services including preventative and curative health services. A sub-district is a designated geographical area with a population of between 15,000 and 30,000, usually served by at least one health centre. The health centre therefore is the operational focal point from which services to the communities within the sub-districts are organised. Each health centre has a health team composed of: medical assistants and nurses, public health nurses, community health nurses, disease control and nutritional staff, and midwives. The Sub-District Health Management Teams (SDHMTs) play an advocacy role in ensuring the provision of health and other related services such as sanitation, provision of water and environmental protection in their area of jurisdiction.

pursuit of the reform objectives. The focus is specifically on the application of decentralisation as an NPM reform instrument upon the health system in Ghana.

6.5 The political economy of Ghana's health sector reforms

Health sector reforms in Ghana form part of a wider economic, political and institutional reform initiated and funded by the International Monetary Fund and World Bank under the guise of a structural adjustment programme (SAP) adopted by the-then military government in 1983 and intended to reverse Ghana's socio-economic crisis. The first sets of reforms focused on gaining tight control over government expenditure and stabilising the economy through measures aiming to contain costs and reduce budget deficits[61].

Towards the end of the 1980s, though, the reform became more wide-reaching than the government had anticipated, because it was realised rather belatedly that the civil service lacked the capacity to implement the first generation of reforms successfully (Kraus, 1991; Ayee, 1992). Based upon this realisation, the IMF and World Bank advocated broader institutional reforms, covering the entire public service and agencies in the country, including central and local governments. At this juncture the World Bank stressed the urgency of privatising and decentralising provision and management of public services, to significantly reduce the dominant role of central government (World Bank, 1989). However, it took some time and intense additional pressure from external forces for the military government to respond and agree to undertake the reforms proposed by donors. The introduction of these reforms, among other things, brought the health sector to the attention of the government and donors as one of the public service organisations that needed to be revamped. Reform of the health sector became crucial because of the new role assigned to health in the government's development strategy, coupled with the sector's inherent weaknesses; which are mentioned in the next subsection in order to situate the discussion in its proper context.

6.5.1 Weaknesses in the health system

In the health sector, all decision-making structures and processes remained centralised, especially regarding operational issues of resource allocation and finance (Larbi, 1998). The health system was weak and fragmented, and its organisational arrangement was a major roadblock to effective performance of the sector (MOH, 1996: p.2). These weaknesses were manifested in a confusion of roles and responsibilities between

[61] Some of the policy measures used were reductions in the public sector wage-bill through retrenchment or redundancy and redeployments, removal of 'ghost' workers from payrolls and freezing new recruitment into the public service (Hutchful, 1996; Ayee, 1997; Annan, 1997; McCourt, 1998).

technical and administrative staff, duplication and competition between centrally-managed vertical programmes, waste and under-performance of the entire service, and unclear relationships between the ministry's administration and teaching hospital boards (MOH, 1996; Larbi, 1998).

To address these problems, restructuring of the public health sector became part of the wider public sector reform programme advocated and supported, not only by the World Bank, but also by other international organisations such as the WHO, USAID, and UNICEF. Thus, it can be said that Ghana's health sector reform's emphasis on decentralisation as actively promoted in the *World Development Report of 1993: Investing in Health* (World Bank, 1993) had the full blessing of both bilateral and multilateral institutions. Like other global health sector reform, Ghana's health sector reform agenda was a logical response to the situation, and was linked to the broad set of public sector reform ideas and initiatives collectively known as the 'new public management' (Mills, 1999).

6.5.2 The health sector reform and *Ghana's Vision 2020*: policy to programmes

Initial attempts to reform the health service started in 1988. The objective of reform was to halt the deterioration of service quality caused by decades of economic decline. The reform also sought to readjust the health sector in line with long-term national development goals, and to modernise the system along the lines of changes taking place at the international level. In fact, the reforms gained momentum in the early 1990s, when the government identified health sector development as being crucial to the overall longer-term strategic vision for Ghana's future growth and development, as outlined in the document *Ghana Vision 2020*.

Having recognised health reform as part of the national development agenda, the Ministry of Health prepared and unveiled its first health sector modernisation policy document: *Medium-Term Health Strategy Framework for Health Development 1996-2000* (MTHS), with support from the World Bank, DFID and other donor agencies. In order to align health development targets with the national development strategy and vision, the MTHS policy was further objectified into specific project-based objectives with clearly-defined outcomes and output indicators, in the *Medium Term Health Strategy: Towards Vision 2020*. This strategic policy framework provided more comprehensive guidelines for the health sector's contribution to the developmental goals of *Vision 2020*. The strategy's mission was to improve Ghanaians' health by

increasing their access to services and also augmenting the quality and efficiency of services provided.

More specifically, the objectives outlined in the MTHS were to:

1) establish the Ghana Health Service (GHS), redefine the aims and management of the service by restating its mission and strategic vision;
2) provide an organisational framework that will enhance implementation of health programmes through the strengthening of regional and district health systems; with the aim of providing a sound framework for the growing degrees of managerial responsibility in all health service institutions;
3) change operational and functional arrangements within the service to ensure careful stewardship of resources;
4) establish clear lines of responsibility and control; and
5) decentralise structures and functions; and improve accountability for performance rather than inputs.

6.5.3 First and Second Health Sector Five Year Programmes of Work

The MTHS was implemented through sets of health sector programmes of work which were known as the First Health Sector Five Year Programme of Work (1997-2002) and the Second Health Sector Five Year Programme of Work (2002-2006). Five broad objectives and seven strategic action areas described the strategy through which the health sector reform was proposed to contribute to the achievement of government's development agenda, including:[62]

1) increase access to health;
2) improve quality of health service;
3) improve efficiency of service delivery;
4) foster partnership with stakeholders and build a pluralist health system; and
5) expand the resource base.

In order to facilitate the implementation of the First Five Year Programme of Work (POW-1) reforms, a broad programme of activities spanning 1997 to 2001 was produced, which detailed the principles, objectives, policies and strategies for the health sector and served as a guide for the Ministry of Health and its various implementing

[62] Three documents set out the government's health sector reform objectives and strategies: *Medium-Term Health Strategy: Towards Vision 2020*, MOH, Accra 1996; *Health Sector Programme of Work*, MOH, Accra, 1996; and [what is the third document?]

agencies and stakeholders. Every year, health sector progress was checked in sector-wide reviews which looked at both government and donor performance.

The POW-2, which is in its final year of implementation, covered the period 2002–2006. It was intended to consolidate the gains made during the POW-1 and apply the lessons learned to find new solutions to the problems confronting the health sector. The POW-2 targeted several health programmes, including dealing with the impact of HIV/AIDS by applying the national HIV/AIDS control strategy. It also sought to shift from facility-based services by emphasising community-based care and placing nurses in communities. This POW was also designed to reduce financial barriers and reform financing arrangements for the entire sector by replacing the requirement to pay at the time of service (cash and carry system) with prepayment and insurance arrangements. The POW also aimed to: promote the use of non-government and private health providers, reflecting the government's focus on private sector-led development; emphasise the control of malaria and TB; eliminate the Guinea Worm; strengthen reproductive, maternal and child health services; and improve staff motivation and health worker incentives (MOH, 2006).

Furthermore, the POW-2 proposed improving and establishing formal commissioning arrangements with non-government service providers and integrating them into the health system. This was aimed to ensure increased access to essential healthcare for the majority of Ghanaians and, under this programme, the private health sector was expected to enhance the equity focus of the sector by coordination, support and regulation through appropriate mechanisms.

6.6 Issues in the implementation of decentralisation in the health sector

6.6.1 Structural and organisational integration

In line with the theoretical justification for decentralisation, the first reform objective was to transform the organisational structure of the health system. Thus, the health reforms started with an organisational restructuring and integration strategy which merged technical and support divisions into one directorate structure. In consequence, seven directorates were created:

1) finance;
2) administration;
3) research statistics and information management (RSIM);
4) policy, planning, monitoring and evaluation (PPME);

5) human resources;
6) procurement and stores; and
7) traditional and alternative medicine.

6.6.2 Creation of the Ghana Health Service as executing agency

Another objective of the decentralisation of health management was to break the monolithic health bureaucracy into more manageable executive-type organisations with an emphasis on increased or full autonomy from the civil service and central Ministry of Health. It aimed for a major shift in organisation arrangements, operations, functions and management style. This objective of health sector reform culminated in the creation of the Ghana Health Service (GHS).

First and foremost, the restructuring transformed the GHS into a unitary organisation under the leadership of an appointed Chief Executive with an official portfolio under a Director-General of Health Services with budgeting responsibility. The health sector reform implementation was further boosted by the Ghana Health Service and Teaching Hospitals Act, Act 525, 1996. Although this was one of the last initiatives in the organisational restructuring process, its impact was vital on public health system reform.

6.6.3 Aims of the Ghana Health Service

Overall, the reform aimed to :

1) de-fragment the service by separating the GHS from the central MOH, ;
2) avoid conflict with general administration and to ensure that administrative, financial and technical policies/programmes were managed from a holistic perspective;
3) improve the delivery of services; and
4) ensure that the allocation of resources was responsive to user needs (MOH, 1996). This aim was specifically outlined in the legal framework, as:
   - to implement approved national health policies;
   - to increase access and to improve health services; and
   - to manage prudently resources available for provision of health services (MOH, 1996).

6.6.4 Implications of reform for policy formulation and implementation

First, the creation of the Ghana Health Service changed the role of the MOH from being a policy making and implementing organisation to that of overseer of all health services. Consequently, the MOH became the custodian of sector-wide policy formulation,

monitoring and evaluation of progress, ensuring that standards and targets were set and met. In the process, the MOH became the supervisor and monitor of the Ghana Health Service (GHS)'s performance. Second, the reform resulted in a clear separation between policy formulation and policy implementation – the delivery of health services. Third, the GHS assumed responsibility for the MOH's former executive functions with respect to planning, organising and managing health services. Fourth, the operating structure and managerial arrangements of the GHS was fine-tuned in accordance with the decentralised approach to service delivery, through the district health management teams and autonomous hospital and hospital board system.

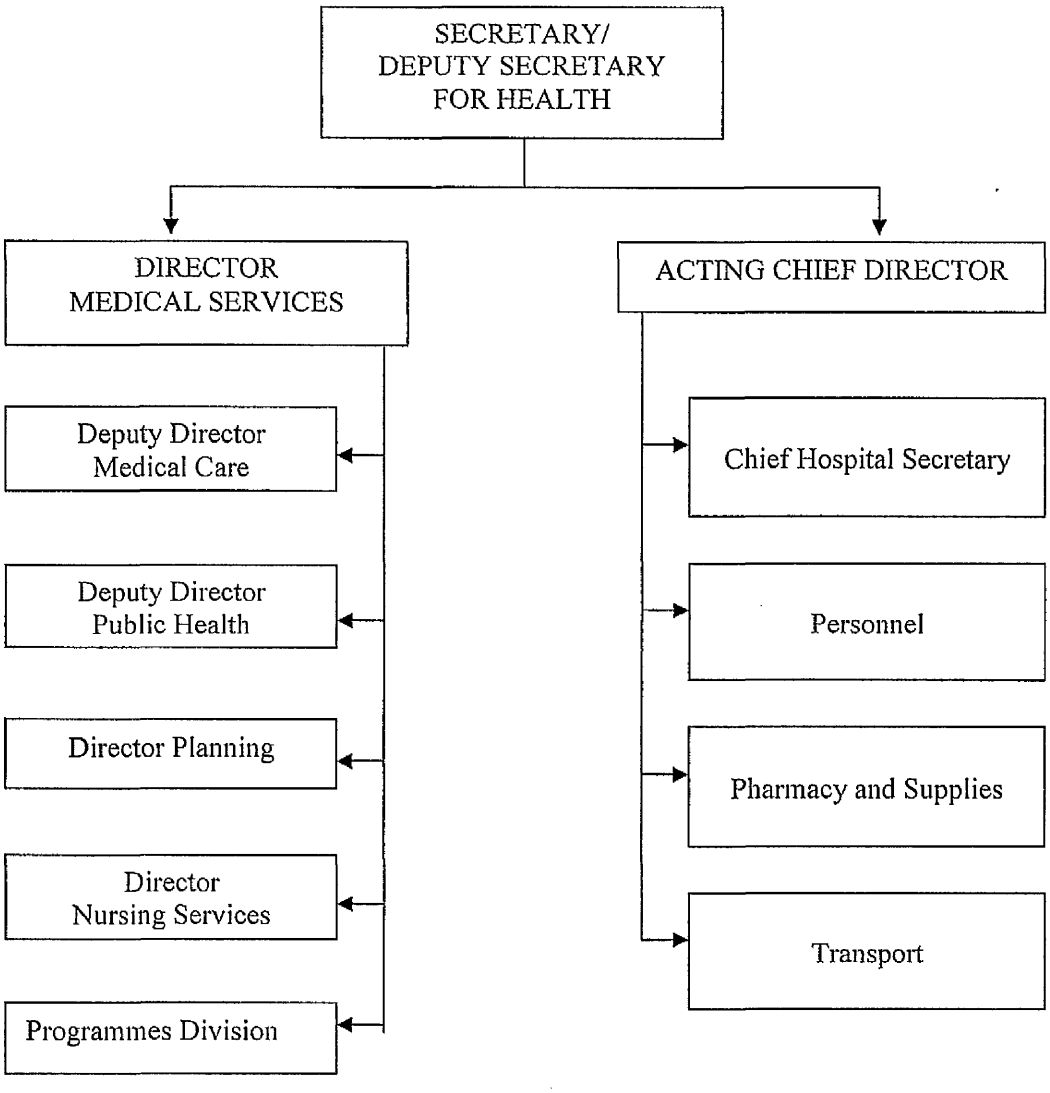
6.6.5 Health sector reform and Regional Health Management Teams

To enhance effectiveness in health service management, the GHS officially established offices in all ten administrative regions, each headed by a Regional Director of Health Services (RDHS; see Act 525, Article 20/1-4), who would be assisted by a team of health professionals constituting a Regional Health Management Team (RHMT). Regional Directors were put in charge of daily administration and organisation of health services, and reported directly to the Director-General on technical issues. Furthermore, they were expected to provide support and supervision for regional and district health programmes.

6.6.6 Creation of an integrated district health system through decentralisation

Reforms through decentralisation were not only intended to transfer health service management to district managers, but also sought to rejuvenate the district health system by mobilising public, private-for-profit and private-not-for-profit health providers and all relevant stakeholders into a stronger and an integrated district health system. To achieve this goal, the district health management teams were revamped in every one of the country's 110 districts and placed under the leadership of a District Director of Health Service (DDHS), who was responsible to the regional director and was in charge of planning, organising and implementing GHS policies and decisions at the district level.

Figure 6.1: Old organisational structure of the Ministry of Health (in 1989)



Source: Ministry of Health, *Health in Brief, (1998).*

The District Director of Health formed a strategic team of programme managers at the district level with the support of the District Medical Officer, District Public Nurse, District Communicable Disease Officer, Senior Medical Officer in charge of the District Hospital and the Health Superintendent for Sanitation, all of whom were responsible for the day-to-day management of health programmes in their district.

The DHMTs were responsible for supervising sub-districts and community health services and programmes. The DHMTS were also expected to partner with the Ministry of Local Government and Rural Development, private providers, and non-government organisations to implement government health policies. The DHMTs were more or less the GHS street-level health bureaucrats at the district, sub-district and community levels. Through decentralisation reform, the district health managements were

strengthened and given functional authority for planning and managing health services under the Ghana Health Service. Planning at the district level was made practical by establishing 311 Budget Management Centres (BMC) which assumed responsibility for planning, managing and implementing an agreed programme of work within a given budget. These changes are occurring very slowly but with encouraging results.

6.7 What has health sector decentralisation reform accomplished?

This subsection outlines the changes that have taken place since the start of the health sector reforms and decentralisation. It is not possible to consider all of these here, so the discussion is specifically on progress made so far in: structural and functional/ operational changes; planning and financial management; resource allocation; public and private provider relations; and stakeholder participation and accountability practices.

6.7.1 Functional/operational changes

Health sector reform has brought about modest changes in the structure and functional and operational activities of Ghana's health service. The restructuring of MOH into designated functional directorates, for example, the budgetary cost centres, and their counterparts the Budget Management Centres at the district level, have given officials much greater control over planning and budgeting.

The reform also enabled a shift to a board of directors model, with the creation of autonomous hospitals (the Korle-Bu and Komfo Anokye Teaching Hospitals (THs)), which enhanced managerial decentralisation and encouraged a greater degree of managerial flexibility in hospital and service administration (Larbi, 1998). In addition, reforms have helped to break the institutional relationship between teaching hospitals and the civil service, which has freed them from civil service rules and their associated delays. In this process, the relationship between the MOH and the THs was redefined and is now governed by a framework of contractual agreements which relates performance to hospital funding.

6.7.2 Increased bottom-up planning and decision-making

Providing opportunity for stakeholders, especially communities, to participate in health policy formulation and implementation is considered one of the pillars of Ghana's health sector decentralisation. Decentralisation resulted in the introduction of bottom-up, resource-based planning and budgeting as a means to this end. The reform has given district health management teams, communities and relevant stakeholders an

opportunity to contribute to the formulation of health policy in diverse ways (Asante et al., 2006). The formation of district health planning committees and the organisation of quarterly health forums are examples of changes in the planning process (Ghana Health Service, 2001). Although there was difficulty in reaching communities (and district assemblies and other stakeholders) through the bottom-up planning process, there is evidence that the process has reached the sub-district level and has thereby indirectly enabled health centres and community representatives to act as potential channels for community concerns (Asante et al., 2006; MOH, 2006; Ghana Health service, 2005).

6.7.3 Improvements in planning and financial management

Improvement in planning and financial management is one of the gains of reform. Planning and financial management systems have been developed, and staff at regional and district Budget Management Centres (BMCs) been trained, which has increased government confidence in the MOH's financial management system. It is difficult to determine whether reform has improved efficiency in the sector; nonetheless, it is certain that many of the health service's activities are being conducted in a more cost effective and accountable manner, especially expenditure which is being better recorded by Spending Officers and reported more accurately (MOH, 1997; Annan, 1999; MOH, 2006).

6.7.4 Ongoing change in resource allocation between the centre and district

The transfer of financial management responsibilities down to the district level has greatly changed since decentralisation. For example, in 1992 the MOH's head office in Accra administered two-thirds of total non-wage recurrent expenditure, compared with 10% by districts and and 8% by the teaching hospital. This trend has changed following decentralisation reform – head office's share of the non-wage expenditure has now reduced to 28%, whilst those of teaching hospitals and districts have increased to about 17% and 23% respectively (MOH, 1999 and 2006).

A change in central government's resource allocation policy following decentralisation is a further indication of the desire 'to manage down', transferring planning and budgeting responsibilities to district health management teams. Health resources allocated to district health services increased from 22.8 % in 1996 to 34% in 1997, and that of regional health services from 17% to 25%. Recurrent expenditure rose from approximately US$ 25 million to US$32 million from 1996 to 1997 – a 5% increase (MOH, 1998; Ghana Statistical Service, 1998). According to Foster (2000 cited in Xiao Ye, 2001), total administrative expenditure has been decreasing, and funds managed by

headquarters have declined from 40% in 1997 to 13% in 1999. Non-tertiary recurrent expenditures have also decreased at the tertiary level, from 18% in 1997 to 12.6% in 1999, but at the regional level these expenditures increased from 15% to 29% during the same period (MOH Financial Report, December 1998; Canagarajah and Xiao Ye, 2001)[63].

6.7.5 Enhanced public-private partnerships and stakeholders' engagement

Up to the start of health sector reform and the establishment of the Medium-Term Health Strategy (MTHS), national health policies did not promote public-private collaboration and partnerships. Changes brought about by the MTHS include: the establishment of a Private Sector Unit in 1997; establishment of a joint forum to discuss common problems; provision of support through supervision, training, equipment and involvement of private sector health staff in planning and delivery of health programmes (MOH, 1999).

Other initiatives included the drawing up and signing of performance contracts between the MOH and Church Health Association of Ghana (CHAG) institutions, while. some CHAG hospitals were designated District Hospitals and therefore treated like government district hospitals. Among the 45 CHAG institutions which have agreements with MOH, 21 hospitals are considered as certified Budget Management Centres (MBCs) and are receiving government support and pooled donor funds (GHS, 2001). The MOH/Private Sector Unit initiated the formation of the Ghana Coalition of NGOs in Health to promote partnership with health NGOs (MOH, 1999).

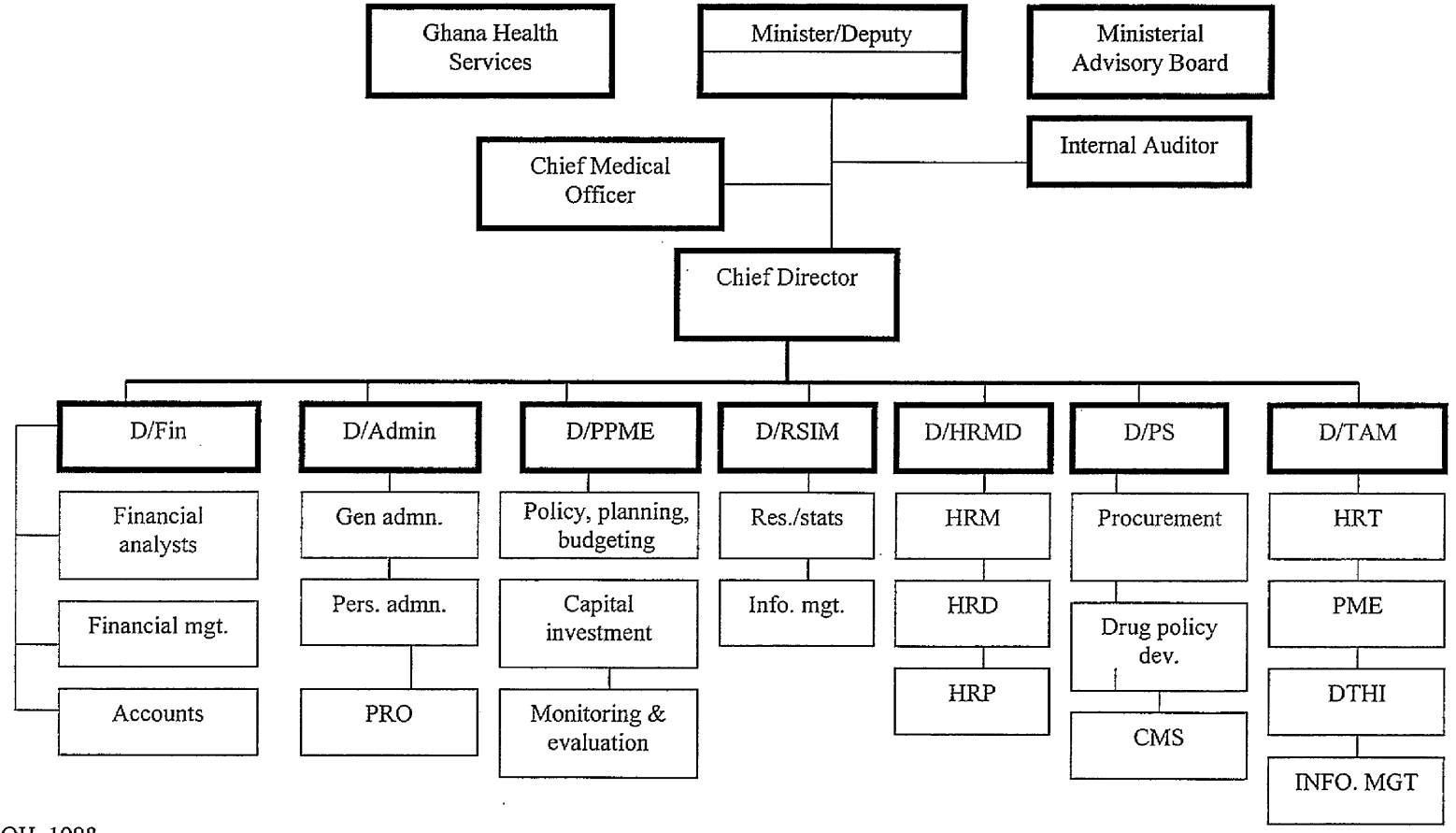
6.7.6 Improvements in financial and procurement management

Modest gains have been made in the area of accountability, especially regarding financial management and procurement practices (DANIDA/MOH, 2001). The MOH adopted the national procurement procedure with support from donors and went on to develop a Procurement Procedure Manual (PPM) and procurement indicators for different levels (MOH, 2002). This reform led to a growing interest within the service and among health providers to comply with standardised procurement procedures using the PPM (MOH, 1999; MOH, 2001; DANIDA, 2001). Reform also brought about significant improvements in financial management, manifested in the form of regular monthly reporting by all BMCs; quarterly reporting by all RHAs; regular dissemination of quarterly reports to partners, audit of consolidated MOH financial statements; and

[63] See also: *Health Policies in Ghana – Implications for Equity: A Policy and Literature Review*, MOH (July 2000); *The Health Sector in Ghana, Facts and Figures*, MOH (1999); and *Financial Report* December 31, 1998 (Draft), MOH (1998).

implementation of ATF rules by all BMCs, resulting in a more effective financial control environment (DANIDA, 2001).

Figure: 6. 2 New organisational structure of Ministry of Health



Source: MOH, 1998.

6.8 Challenges in implementing health sector reform

6.8.1 Influence of old organisational structure and culture

This section is devoted to an exploration of factors identified in the literature as constituting impediments to health reform implementation. The preceding discussion shows that some gains have been made since the start of the health sector reforms. However, management of the implementation process has been impeded or delayed by several factors. Table 6.2 summarises some of these factors, which are then elaborated upon in the following section.

Table 6.2: Classification of factors influencing implementation of health sector reform in Ghana

Unit/themes of analysis				
System/structure	**Implementation strategy**	**Staff motivation**	**Institutions/ resource capacity**	**Staff attitudes and behaviour**
Weak structure Fragmented operational system Centralised, hierarchical and bureaucratic structure	Defective implementation strategy Emphasis on systems, not people	Poor working conditions and low salary Inadequate logistics and obsolete equipment	Economic factors: inadequate budget; location; lack of internal funds to support reform Institutional conflicts between central agencies Exercise of multiple control over reform by central government agencies	Opposition from civil service staff Staff orientation and attitudes Adherence to old administrative culture
Inequitable geographical distribution of health staff and facilities	Administrative element overlooked in implementation	Lack of accommodation and transport	Weak and conflicting laws and weak governance structure Lack of qualified staff	Staff perception and indifference to reform goals Refusal to accept posting to rural areas
History and culture of public organisations	Top-down centralised, hierarchical approach to implementation management	Lack of funds and delays in transferring funds	Inadequate number of staff ; migration to private sector and 'brain drain' Cumbersome personnel mgt. procedures due to centralisation	Unethical behaviour: moonlighting, apathy, lateness, feeling of lack of ownership of reform, distrust and corruption

Source: prepared by author from evaluation reports and papers (2007).

The old structure has been difficult to break, even after decentralisation, and management relationships and decision making are still defined on the basis of

hierarchy. And geographically, health facilities and personnel have largely remained inequitably distributed in favour of regions in the south and urban centres, to the disadvantage of the northern regions and rural areas (Canagarajagh and Xiao, 2001). The persistence of the old structural arrangements has impeded the degree of involvement of district health managers, private-for-profit and relevant stakeholders in planning and implementation of health programmes (Annan, 1997; MOH, 1996). The essence of decentralisation is to increase the level of community participation in making health decisions, and this has not been fully realised since the start of the reform.

Promotion of vertical and horizontal accountability is another reason for decentralisation, but implementation of accountability mechanisms has been impeded due to the influence of centralist tendencies within the health ministry and the wider civil service. Though there has been some level of upward accountability from the region and district level, top-down and horizontal accountability has been difficult to implement because of inherent barriers in the old organisational structure and culture (MOH, 1996; Agyepong, 1998, Seddoh et al., 2000).

More specifically, the Ghana Health Service could not fully transfer control to district level and executive agencies because of the health ministry's old administrative structure, which remained centralised even in the era of decentralisation (Larbi, 1998). This issue was raised by Bossert and Beauvais (2003) who pointed out that, 'consistent with its overall decentralised centralism', the Ghanaian health system provided little mechanism for local governance and stakeholder participation in health sector decision making (see also Ayee, 1996; Herbst, 1993; Mohan, 1996 cited in Bossert and Beauvais, 2003). The district assemblies, in particular, failed to play any significant supportive role in enhancing the effective implementation of decentralised planning and management at district level because of the way the reform was managed by the centre. This partially explains the reason why the Ministry of Health (and Ghana Health Service) is undertaking decentralisation, yet is at the same time operating a centralised governance structure.

Other studies (Seddoh et al., 2000; Annan, 1997; Agyepong, 1998) also identified the health system's structure to be responsible for the difficulties encountered in sectoral coordination and implementation of reform programmes, at national, regional and district levels. Of particular interest was the influence of organisational culture and staff orientation and values, which were found to constrain health decentralisation at district

levels. There was a high tendency for health staff to perceive themselves and their tasks by division rather as a team trying to improve quality, coverage and utilisation of service, at the district level. Based on a study from the Dangme West district, Agyepong (1998) found that the majority of health personnel appeared unprepared attitudinally for reform. This was because staff still hold onto old administrative orientations about relationships and modes of service delivery and reporting styles. Moreover, the prevalence of old administrative values and attitudes were found to be further reinforced by command structures in the Ministry of Health itself. This was an reflection of the old civil service decision-making structures, where each unit directly controlled its staff members down to the lowest level of the health system, even when operating a decentralised health management reform. The persistence of this prior administrative orientation has significant influence upon implementing decentralisation (Larbi, 1998; Agyepong, 1998; Ackon, 1994).

The extent of staff receptiveness to information technology is another element of reform which suffered from the persistence of an old public administration culture. The direct effect of this was that the introduction of computers and information technology into health service management was received with indifference by staff, and this affected the application of the computer-based data collection systems, reporting and accountability mechanisms which were introduced during the early stages of the reform (Adjei, 2003).

Moreover, the absence of an information-based management culture also impeded efforts to change the old system of service administration which became snagged on hierarchy, centralised control, and command and duty. Phobias about information-based management were rife in the health sector and difficult to change. Thus, even in situations where consultants helped set up new information systems, it proved difficult for employees to accept the change and start thinking and operating in an innovative way with the new system. This has hindered data collection and information sharing, implementation of accountability mechanisms and information-based planning, budgeting and decision-making.

Successful implementation of public health service reform is improbable in Ghana without a proper understanding and considerable appreciation of the history, structure and culture of Ghana's public administration. The effect of history and prior choices on structures and, subsequently, upon reform implementation was not limited to the health sector alone. This was a common problem which affected all ministries, departments

and agencies under the ambit of the civil service. This was because, although civil service reform was part of the structural adjustment programmes, little had apparently changed on the eve of the Fourth Republic. As Leechor (1994 cited in Sandbrook and Oelbaum, 1997) noted, many of the earlier weaknesses had persisted to produce a limited institutional capacity in the civil service.

The lesson that emerged from the reform experience was that Ghana's inherited colonial administrative structure had constrained the implementation of health service reform – especially decentralisation reform – at the district level. Indeed, the effect of centralised health service management had more effect on reform implementation at the district level because the Ministry of Health's old hierarchical structure did not fit well with the decentralisation policy reform framework. This was because the sector ministries, departments and agencies of national government were not adequately adjusted to the decentralisation reform framework. Rather, it was implicitly assumed that the situation could be changed solely through structural reforms – an assumption, however, that has been questioned (Gilson, 1995; Ayee, 1997; Jeppsson et al., 2003).

6.8.2 Defective implementation strategy

Studies show (Larbi, 1998; Annan, 1999) that implementation of decentralisation in the health sector ran into serious problems because of a defective implementation strategy. For example, the strategy had a strikingly 'top-down' style, lacking consultation and consensus on the modalities for implementation, and restricting policy making to a small group of officials, which caused a lack of open deliberation between government, service providers and users. While the use of few consultants and technocrats proved worthwhile in boosting the chances of keeping reforms on track in other sectors, this approach to policy formulation and implementation failed to work effectively in the health sector. On the contrary, it caused implementer agency and stakeholder apathy, which had a debilitating effect upon support for health reform and its implementation. Furthermore, health officials, especially front line managers who were expected to implement the reforms, became indifferent because they saw the reforms as being imposed on them from donors with the support of top-ranking service executives who they believed had benefited so much from the reform(Annan 1999). Also, there were groups of political and bureaucratic officials at both national and local levels who opposed the reform through deliberate delays because they were apprehensive that it may weaken their power base, connections and influence over resources and subordinates. These mindsets against the reform affected the level of commitment and enthusiasm towards its implementation.

6.8.3 Inadequate planning and preparation for implementation

Another problem was poor planning for implementation. This was taken for granted and, as a result, potential implementation problems such as the availability of resources, capacity to implement reform, and human resource requirements were relegated to the periphery during the planning stage (Larbi, 1998). Particularly in the case of district health managers and teaching hospitals, there was absolutely no formal preparation for managing the reforms. In addition, the line of responsibility for managing various components of reform was non-existent, causing poor coordination and unnecessary conflict between officials at the ministry's headquarters. Annan (1999) found that there was no regular mechanism for consultation with stakeholders especially medical professionals, non-government organisations and private-for-profit health service providers. Although special interests could hope to influence the outcomes of health reform decisions affecting them at some stage in the policy process, there was no system for prior consultation with interested parties in the process, or any kind of structured relationship with professional groups and public interests.

6.8.4 Non-involvement of local consultants in the reform process

Similarly, the team of consultants and the health reform policy process in general had few links to domestic research and academic institutes and universities at the early stage of restructuring. Ghanaian medical professionals from the two research/teaching hospitals – Korlebu and Okomfo Anokye – and trade unions had minimal or nonexistent involvement, although several individual health professionals became involved later on in the restructuring programme. One reason was the perception that some of the professional associations and research institutions were opposed to the reform (Annan, 1997; 1999). Thus, for much of the early stages of the health reform the only sources of technical analysis and evaluation remained the Ministry of Health, multilateral and allied agencies, and various consultants associated with the reform programme. This monopolisation of the reform process alienated private-for-profit service providers in particular for a very long time, and the Ministry is still grappling with ways to integrate them.

While the availability of and quality of technical personnel and human resources from local health professional associations should not be exaggerated, the failure of the Ministry of Health to involve them from the early stages of the health reform deprived the health system of an opportunity to develop an indigenous technocracy and offset the technical dominance of expatriate consultants and donor agencies. This flawed reform

strategy has continued to affect implementation even after the Ministry took steps to correct the fault by making the reform more formal and institutionalised and extending an offer of partnership to all stakeholders.

6.8.5 Lack of ownership and commitment

A lack of ownership of the reform vision and objectives caused the lack of commitment noted above. Implementation suffered commitment because of an absence of local ownership. As noted in the literature, ownership of reform vision and objective is important; if the vision is conceived and imposed by an external force... the degree of commitment or quality of support at home is likely to be weak (Akash, 1998). On the other hand, a domestically-formed objective generally reflects a higher degree of commitment through a more realistic concretisation of the objectives. 'Ownership is necessary for commitment, and this requires that the executive authority must be united and firmly convinced of the necessity of reform' (Sanbrook, 1996; see also Conyers, 2006).

As already noted, however, the health sector reform was not a home-grown idea, but was undertaken because the World Bank and other donors pushed for it and provided the funds for its implementation. Although the government later tried to domesticate the health sector reforms objectives through mobilising support from stakeholders and extensive consultation, the reality was that it became more of a compromise between the World Bank/IMF assistance and the implementing ministry. The government policy makers who were involved in the initial stage of planning the reform were committed to its success, but the same level of commitment did not extend to MOH officials or the district health management teams, who were kept outside the planning process. Most MOH officials accepted the reform but did so reluctantly. The reform implementation suffered from lack of managerial commitment even at the national level where, at one point, it seemed officials were more interested in acquiring funds from donors than implementing the reform programme.

6.8.6 Institutional constraints

There were problems from institutional issues – effects of conflicting rules, government legislation and general bureaucratic institutional structures – upon implementation. To successfully implement health reform, central government was required to create an enabling institutional environment that would be supportive of reform objectives. In addition, interaction between the institutional networks and relations within the public

sector (especially the central agencies), civil service laws and procedures had potential effects on health sector restructuring.

The contention here is that factors impeding health sector decentralisation had deeper institutional roots directly linked to the Ghanaian bureaucracy within which the public health system is embedded. Larbi (1998) and Batley and Larbi (2004), for example, explored the negative impact of multiple central government agencies on implementing decentralised health management. Undefined roles for central control agencies in the reform process resulted in institutional conflicts which affected the transfer of control over financial and personnel decisions and resources to decentralised units. As a consequence, new management structures were created without any devolution of financial, logistical and personnel needed to support agency activities and programmes. In most situations where these central agencies exercised multiple control over decisions, it resulted in problems of policy confusion, conflicts of authority, and delays in appointments due partly to lack of proper coordination and information sharing. These institutional 'traffic jams', known in the implementation literature as a 'complexity of joint action' (Pressman and Wildavsky, 1973), placed insurmountable limitations on the freedom of newly-created executive agencies and decentralised units to decide on the right mixture of staff needed to carry out their health programmes. Arguably, institutional conflicts (see Larbi, 1998; Batley and Larbi, 2004) at both national and district level constituted a major brake on implementing new public management reforms in the Ghanaian public health sector.

Ayee (1995; 1997) indicated that conflicting laws and legislative instruments acted as a brake on the adjustment of public agencies to the principles of decentralisation. He showed that major obstacles to implementing health reform were traceable to the nature of the political and governance regime. For example, there was a conflict between the Local Government Act 462 and the Ghana Health Service and Teaching Hospitals Act (Act 525, 1996). Evidently, such conflicts at the time raised serious issues of both policy management and law – that is, whether the health service could and should be decentralised. Ayee's study is particularly significant as it shows how the law, especially the Local Government Act 462, gobbled up the entire public administration, thus making its adjustment to decentralisation and other new public management reform principles cumbersome. In fact, Act 462 provided a defence for many civil servants and local government officials who opposed the granting of autonomy and outright separation of district health management teams from direct control by district/municipal

assemblies at district level. As Ayee (1997) argued, the civil service law also conflicted with the decentralisation and local government law, which has given some senior civil servants grounds for opposing the separation of the health ministry from the civil service. The implication of these legal wars between the civil service and ministry of health impacted negatively on reform implementation.

6.8.7 Capacity constraints

Studies on health sector decentralisation suggest that capacity is a critical factor influencing the practice of decentralisation in the technical, managerial and logistical feasibility of its implementation (Bartley and Larbi, 2004; Mills et al., 2001; Rondinelli and Cheema, 1983). The key question addressed by most researchers is whether adequate managerial capacity and capabilities exist in Ghana to achieve the objectives for decentralisation. Although skills are crucial, the number of staff at a facility is equally important for effective implementation. For instance, Larbi (1998) found that district health management teams failed to implement several components of decentralised management because there were not enough technical and managerial staff to do so. Most of these studies argued that the public sector as a whole lacked adequate and qualified staff and the required management template for supporting public agencies tasked with reform implementation (see Smithson et al., 1997; Larbi, 1998; Annan, 1997; Ayee, 1997). This paucity of capacity was shown by the civil service's failure to regulate, enforce standards and provide an enabling institutional and administrative environment for effective policy implementation. Effective health reform would therefore require a new management strategy, new administrative template, and a crop of personnel with new skills, but this is lacking. For example, implementation of public health service contracting has been found to be ineffective because of a capacity gap both within the private and public sector health institutions (see Smithson et al., 1997; Batley and Larbi, 2004; Mills et al., 2001).

6.8.8 Human resource gap and the problem of migration

The effects of this poor capacity in the health sector on reform have been extensively explored in the literature (Dovlo, 2005a; Dovlo, 2005b; Dovlo, 2003; Dovlo and Nyonator, 2004; Dovlo, 1999). Studies have emphasised the importance of human capacity for effective implementation. The health service is a labour-intensive industry, and human resource remains a critical component for successful service delivery (Dovlo, 1999 and 2003). What needs emphasising is that the relevance of human capital to reform implementation is limited not only to the question of staff numbers, but also

to their mix of skills and competencies and how these are distributed and targeted towards attaining health reform goals at all levels. Migration and loss of staff to other sectors and countries is a major challenge to the health sector. Table 6.3 indicates the seriousness of the migration problem and its debilitating effect on staff capacity in the health sector.

Table 6.3: Overview of health staff migration in Ghana, 1995–2004

Cadres	1995	1996	1997	1998	1999	2000	2001	2002	2003	June 2004	Total
Doctors migrating	58	71	62	61	72	52	62	105	117	40	812
Nurses migrating	195	182	174	161	215	207	235	246	252	82	2,392
Pharmacists migrating	29	27	35	53	49	24	58	84	95	30	542
Allied staff migrating	8	9	4	6	9	16	14	0	N/A	N/A	N/A

Source: Review of POW 2004, Ministry of Health, Accra: Ghana.

The Council of Nurses and Midwives reported a loss of 328 nurses from their register in 1999 and around 198 the previous year. This is about 2.6% of the entire nursing group, approximately equivalent to the entire output of Senior Registered Nurses for the year 2000 (see also Dovlo, 2005). The loss of staff to the private sector and migration of health staff to other countries has created a human capital gap, and this is a factor acting as a brake on the implementation of reforms in the health sector.

The effects of migration and the shortage of health workers is that facilities are not staffed or poorly staffed, that there is inappropriate skill mix – fewer professionals, more untrained or semi-trained auxiliaries and an excessive load on the few remaining staff – which have led to reduced coverage of services as well as poor quality and low performance in the health sector (see Dovlo, 1999; 2004 and 2005; Buchan and Dovlo, 2004)[64].

6.8.9 Staff motivation issues

Closely related to the capacity issue is the question of whether staff are motivated enough to perform the tasks assigned to them. Staff motivation is an issue that features

[64] It is estimated that 1,200 Ghanaian doctors work in the US, UK, South Africa and Canada; and that 50% of Ghanaian professional nurses has left for the same countries the recent past to. See Dovlo, Delanyo (1999) 'Issues affecting the mobility and retention of health workers in Commonwealth African states', report prepared for the Commonwealth Secretariat, London. See also Akosa (2002), Ghana Health Service: memo – Staffing Situation in the Ghana Health Service, November.

in almost all the district health management annual performance reports. A review of the district reports, particularly between 2000 and 2003, revealed some of the major constraints in implementing health reform programmes at district levels are:

1) inadequate staffing;
2) staff attitudes towards work and clients;
3) inadequate staff accommodation;
4) aging vehicles and high maintenance costs;
5) irregular, sometimes very late, release of funds;
6) lack of laboratories at health centres;
7) staff refusal of postings to some of the districts;
8) poor health infrastructure; and
9) inadequate logistics and obsolete equipment.

The District Annual Report and Review of Sector Performance listed the problems above repeatedly in 2000, 2002, 2003 and 2004. Interestingly, most if not all, of these problems appeared in other evaluation reports prepared at the national level, and most were also mentioned by some academic studies on the health sector. Whether or not this is coincidental, it can plausibly be argued that the reports captured some human, financial and logistical dimensions of the capacity problems encountered by district health managers in implementing health programmes. The reports showed the status and progress of health reform implementation at the district level and pointed out significant factors militating against effective implementation.

Other revealing evidence on the issue of motivation was that workplace obstacles – such as low salaries, lack of essential equipment for work, delayed promotions, difficulties and inconvenience with transportation to work, staff shortages, housing and additional duty allowance – caused dissatisfaction and demotivated health staff (Agyepong et al., 2004). Workplace obstacles negatively influenced staff performance, leading to poor quality service. Further to that, the problems were complex and inter-related and therefore produced common consequences affecting other health programmes, including the implementation of health reforms at the district level.

6.8.10 Economic constraints

A fundamental but often understated constraint to reform was the harsh economic conditions faced by governments (Russell et al., 1999). The weak and unstable economic situation affected implementation. Like other African countries, Ghana launched its health reform at the time when the government's capacity was weakest due

to the economic crisis and concomitant resource shortages, salary erosion, low morale and poorly-functioning public administration. Weak economic capacity forced the government to adopt a World Bank/IMF Heavily Indebted Poor Country Initiative (it has just been granted debt burden relief from major bilateral and multilateral donors). The extent of the enormity of this economic weakness is the fact that over 60% of Ghana's annual economic development budget for the past five years was donor-funded, and the health sector reforms continue to be largely donor-driven. Ensuring a sustainable supply of funds needed to move the reform forward has been lacking or they have not been disbursed on time. Over-reliance of health sector reform on external funding, especially from the World Bank, gave government and the MOH very little leeway to negotiate financial support for health programmes that would have addressed the needs of the poor, especially at district level. Apart from that, a lack of internally-generated funds has compelled government to cut down its budget for the health sector to enable it provide for other equally important sectors such as education, agriculture and industry. Scarcity of financial resources made reform implementation difficult, rendering it open to political propaganda in the eyes of many health officials.

6.8.11 Public sector staff attitudes and resistance to reform

Another obstacle to reform of the public services through NPM and decentralisation in particular was opposition from within the civil service. Mills, Bennett and Russell (2001) and Polidano (2001) added a wealth of empirical information on this issue, which was more pertinent in the health sector than any other ministry or department[65]. Smithson et al. (1997); Mills et al. (2001); and Batley and Larbi (2004) all indicated that opposition from public agency staff at national and regional level has impeded the realisation of health reform objectives.

Generally, powerful public agency staff feared a loss of control over financial resources and political influence over subordinates, leading them to oppose reform through creating unnecessary delays. In addition, civil servants' attitudes to decentralisation also played a role; research findings suggested that officials at national and regional levels doubted the ability of district health managers and autonomous hospital boards to operate efficiently and independently from local and organisational pressure. This was found to be the situation in Ghana by Larbi (1998). Implementation was likely to suffer whenever there was misunderstanding and uncertainty over the policy objectives

[65] See also Gilson et al. (1995) and Jeppson et al. (2003).

because of a communication gap and failure on the part of central government staff to share information, due largely to power struggles amongst central agency staff.

However, civil servants' opposition to health decentralisation reform should not be seen as new in Ghana. A similar problem was encountered during the transfer of ministries and departments to support the District Assemblies in their development work. Civil servants' increasing tendency to resist reforms and administrative decentralisation in particular is widespread and serious, to the extent that former President Rawlings complained bitterly about it in the following words:

> Government is aware of the tendency of some departments to undermine the authority of the District Assemblies, claiming to report to their head offices. There have been cases where requests by the district assembly for vital information have been turned down because the personnel of the department concerned still refuse to understand the new order in local government administration. Some attitudes being displayed by the bureaucracy have tended to impede the process of grassroots participation and action will be taken to make the bureaucracy responsible to work for the people, and with the people (Rawlings, 1991: p.41 cited in Ayee, 1997).

This discussion was important for the present study because it provided insights into the decentralisation implementation problematic – which is about the ways in which external and internal factors impact upon decentralisation implementation.

6.9 Chapter summary

The chapter analysed the development of the health system and the Ministry of Health's approach to managing the health decentralisation implementation process. A retrospective policy analysis approach was used to trace the development of a modern health system in Ghana and how district health system became integrated into the health structure and assumed a pivotal role in implementing health policies and programmes. The analysis also cast light on the role of global and national socio-economic factors in shaping health policies and conceptualisations of health service management. The analysis showed that there was a move from a centralised to decentralised style of health management but with some continuity of centralising styles and tendencies. The carry-over of old administrative and technical staff into a system undergoing restructuring through several reform instruments, including decentralisation, meant that the old behaviours, thinking and ways of doing things also found their way into the reform era and recreated existing health institutions but with some modifications.

To summarise, in 1978 Ghana decentralised its health system through the Primary Health Care initiative, leading to the creation of district health management teams. Despite decentralisation, the health system continued to operate a centralised top-down

policy making and implementation structure, and the ministry's mode of operation was determined by civil service rules, regulations and procedures. This situation persisted until the late 1980s when government – prompted by donor agencies – integrated health reform issues into its overall development agenda, especially as part of its commitment to poverty reduction and as a means to attaining the millennium development goal. In consequence, decentralisation was deployed from a new public management reform aspect to change the governance structure, function and operation of the health system. This reform has continued throughout the 1990s to present. Based on an analysis of documentary evidence, the study can make five conclusions regarding the challenges in health reform implementation, especially decentralisation, in Ghana.

6.10 Conclusions

At independence, Ghana inherited and operated a colonial centralised top-down public administrative system. This old system left its mark on both the system and the people. When the time came for change in the development and organisation management paradigm, the old system became an obstacle in shifting from a centralised to a decentralised style of health system management. History and prior choice affected the structure and culture of the health system; and this in turn posed a big challenge to ongoing reform implementation, including decentralisation. However, it would be possible to use this history more positively, to enhance the chance of reform success. That is, reformers should learn from what is already there, and fashion responses that mitigate the effect of the 'old' on the 'new'; 'centralised on decentralised', 'hierarchical on horizontal and 'top-down on bottom-up'. Thus, through organisational and experiential learning, reform managers could reduce the influence of past choices upon current reform initiatives (see also McCourt, 2006).

Secondly, reforms have suffered delays and failure because of human factors, which plays a crucial role in policy implementation. Issues of worker attitudes, behaviour and interpersonal conflict among individuals and groups at various decision points have affected implementation. Also, paucity of staff in terms of skills and numbers have posed a challenge to health sector reform implementation. Further, a lack of motivation and poor working conditions have affected morale within the service, which has affected staff commitment, especially at district level. The growing migration of health workers to other sectors and countries is an indirect cause of the lack of motivation in the sector, and this has had serious implications for health reform implementation.

Thirdly, implementation has suffered because of the country's political and economic crisis. Ghana has experienced a decade of economic downturn, which has affected government budget for the health sector. The lack of financial resources made reform implementation difficult. Moreover, donor-funded public sector reforms implemented during the period created further problem for heath reform implementation. For instance, retrenchment of public health workers meant a loss of staff, especially at district level, and this created further capacity problems.

Fourthly, the political and bureaucratic institutional environment in which the MOH operates posed a great challenge in implementation. Again, evidence of prior institutional linkages to central government agencies affected the speed of reform; for example the Ministry of Health is still under the control of the Ministry of Finance and must take directives from it before undertaking major financial decisions. Similarly, the Public Service Commission is involved in making health sector personnel decisions, and the President is responsible for appointing top executives to the MOH and the Ghana Health Service. The decision points and actions involved in all these processes are by no means complex and certainly influence reform implementation.

Fifthly, the Ministry of Health initially adopted a monopoly approach to reform design and implementation. Most professional health associations and non-public health providers were not adequately consulted or integrated into the reform design and implementation process, which resulted in a lack of reform ownership and commitment, both within the health system and in wider society. This alienated some segments of health professionals and private-for-profit providers from the reform programme, limiting their support in ensuring effective implementation.

Lastly, it is concluded that reform in the health sector should be seen first within the context of Ghana's historical, political and economic dynamics and institutional trajectories (Collin et al., 1999) and, second, within the context of factors internal to the health system and their implications for reform implementation, especially at the district level. Similarly, reformers would have to give equal attention to the effects of administrative and human resource and institutional capacity issues, particularly at district level, for successful implementation of reforms. Some of these issues are pursued further in the next chapter, based on evidence from an in-depth study of district health management teams in three case study districts.

Chapter 7

7.0. Agency Characteristics in Implementation of Health Sector Decentralisation at District level: Presentation of Interview and Survey Findings on the Experiences of DHMTs

7.1 Introduction

In Chapter 6 the history and political economy of Ghana's modern health system and the circumstances that led to its reform were discussed, as well as the achievements of the reforms and challenges in implementation. To continue the discussion, this chapter is premised on the assertion that one of the crucial roles of implementation analysis is to identify the factors which affect the achievement of statutory objectives in the implementation process (Mazmanian and Sabatier, 1981: p.6). The chapter also aims to provide evidence from an in-depth study of district health management teams to help gain an insight into the challenges facing health decentralisation implementing at the district level. Chapter 7 is based on field data obtained through semi-structured interviews and surveys conducted with interviewees from public health facilities, private-for-profit and private-non-profit health providers, local government officials and non-government organisations engaged in health-related programmes in Dangme West, Sekyere West and Tamale districts in Ghana[66].

The chapter is divided into two parts. The first part presents findings from the semi-structured interviews, and the second part presents findings obtained from the survey of district health staff. The first section of the first part of the chapter presents findings on progress of implementing health decentralisation, as portrayed by respondents. The focus is on:

1) transfer of authority over planning and decision-making;
2) improving data gathering and management for decision making; and
3) implementing accountability mechanisms.

The second subsection of the chapter presents findings on the influence of:

1) staff capacity;
2) staff commitment;
3) leadership; and
4) communication on implementation.

[66] See Appendix for detailed information on the geography, socio-economic and health characteristics of the Dangme West, Sekyere West and Tamale districts.

The last section summarises the findings and lessons learned.

PART ONE: INTERVIEW FINDINGS

7.2 Progress on implementation of decentralisation at the district level

7.2.1 Transfer of authority for management decision making

The transfer of authority for decision making to district health managers is one of the main objectives of decentralisation (this was noted in Chapter 2 as one of the normative values for decentralisation), but often it is difficult to implement this objective fully in practice. The study asks interviewees whether this objective has been achieved. To measure the implementation of this objective, the focus was on changes in health planning and decision making at district level. The findings regarding these practices are presented in the immediate subsection below.

7.2.2 Health forum and bottom-up planning at the district level

District health fora have been established at the district level and are being held yearly in the case studies' districts. Interviewees said that participants were mainly representatives of relevant stakeholders of the District Health Committees, and the venue for most fora was the district. Respondents were sanguine about the introduction of district health fora and formation of district health committees, believing that they have largely improved stakeholder participation in decision making and planning of health activities at the district level.

Nevertheless, there was some level of dissatisfaction, particularly about the degree of participation in district health planning activities. Particularly, interviewees from local governments (District Assemblies), private health providers and non-government organisations complained that, despite positive signs about the health forum and planning, the planning process was overly dominated by district health management staff. The general perception among stakeholders was that, although planning responsibility had shifted from the centre to the district, the degree of stakeholder engagement and participation in district health planning activities had not changed significantly.

However, this allegation was countered by district health staff, who said that stakeholders and communities themselves should take the blame for low participation in planning activities. For example, the Sekyere West and Tamale district case studies revealed that some causes of this problem were:

1) apathy and non-cooperation from local governments and private health providers;
2) lack of communities' technical skills to make input into the health plan; and
3) protracted disagreements and conflict between some local government officials and district health authorities over who should be in control of policy and planning. Some interviewees said that inter-organisational conflict meant that local government officials and private health care providers refused to participate in district health planning programmes, even when officially invited to do so.

Table7.1: A summary of sample quotes of comments made by respondents on decentralisation implementation experience

Comments	No. of responses	% of respondents
• DHMT are allowed to prepare annual budgets, supervise health programmes and report to the region. They are not allowed to recruit, dismiss or determine salary or transfer	21	35.5
• Reporting, communication and information sharing at the district level is bad. Information from the region comes very late or none at all	18	30.5
• Bottom-up planning and the health forum is operational. The district is the venue, but the forum is mostly dominated by senior DHMT staff. Community participation is low • There are problems with the cooperation of District Assemblies, private service providers and communities	18	30.5
• There is a need to empower district and sub-district units to undertake planning and setting of health priorities, to increase participation of stakeholders in decision making	15	25.4
• There is a need to improve staff service conditions and salaries	14	23.7
• The flow of information form Accra is not the best. Staff need to call or travel to Accra for information and directives as to what to do	13	22.0
• There is upward accountability e.g. DHMTs report to the region quarterly and annually. Top-down accountability is absent; the process is like a 'one-way traffic'. Horizontal accountability and output accountability is not effective yet.	11	18.6
• Participation has seen change, involving local governments; private providers, church, NGOs and communities, but it seemed the process is dominated by health staff.	11	18.6
• DHMTs have little or not control over money, personnel and salary decisions.	8	13.5
• Accountability mechanism has started at the district level. But it is ineffective due to lack of feedback from the top of the pile. No top-down accountability	8	13.5
• To ensure that funds reach districts for providing service, and to make health service faster. "It is to remove bureaucracy"	7	11.8
• But DHMTs are not accountable to the service users but only to the Ghana Health Service	3	5.0

Source: extracted from interview data by author (2007).

7.2.3 Implementing accountability requirements at the district level

The second major area of progress made in implementing decentralisation in the health service was the enforcement of accountability mechanisms and practices. The study findings suggested that accountability mechanisms were being established, and were gradually becoming part of the daily management practice of the health service. As one interviewee put it:

> Because every action that every staff takes he/she is obliged to give account, for example thorough reports, monthly reviews and annual auditing based on output standards set from the very onset of the programme... people are becoming more careful about the way they manage health assignments entrusted to them (TMS06, Appendix 1).

Another key informant said that:

> Due to increasing participation of stakeholders, especially District Assemblies and foreign non-government partners and funding agencies, the operations of the DHMTs have become more open and transparent; this new development albeit minimal has improved accountability (SWS09, Appendix 1).

Despite this point, it was discernible from the results that there was no more than a superficial commitment to the implementation of accountability. This was because, whereas a significant number of interviewees said they have heard about accountability, the examples they gave bore little or no relationship to what accountability requirements are. More specifically, the majority of district health staff interviewees were unable to give practical examples of performance or output accountability; rather their perception of accountability was limited to issues of regular reporting on their work and the programme of activities undertaken. Furthermore, interviewees said that annual financial audits were conducted at the district level but were unable to say exactly what that entailed. For example, most of the district health workers interviewed could not explain the reasons for establishing Budget Management Centres or how they were used for financial management at district level.

There was some scepticism among key stakeholder interviewees about the efficacy of accountability procedures being established at district level. One popular belief was that the horizontal and top-down dimension of accountability was uncommon in district-regional and headquarters relations. District health staff pointed out that the practice of accountability was limited in several respects as, while the DHMTs were required to report or give regular account of their operations to the MOH headquarters and regional levels, those at the regional and national level rarely do the same. As one interviewee stated:

> Accountability is supposed to come from the top to the district and from district or bottom to the top... but as it is now, the pressure is always on the district to give

> account to the region and not vice versa... That aside, horizontal accountability, especially to stakeholders and service users, is also not in practice, leading to a lack of feedback needed for planning and decision making.... For example, there is virtually no feedback on annual reports sent to the regions and headquarters in Accra. Although the District Health Directors crosscheck plans and standards, there is no comprehensive mechanism set by the ministry for evaluating the extent to which such output standards are to be achieved (SWS08, Appendix 1).

Therefore, the general opinion was that the implementation of accountability mechanisms at the district level has been difficult. A key informant said that: 'Not all accountability mechanisms or requirements were put in place or are being implemented' (DWS16, Appendix 1). Another interviewee said that output accountability was not started because:

> There was absence of a clear description of targets, lack of effective oversight and sanctions for nonperforming staff and districts that violate the basic principle for practicing accountability by not reporting annually on their performance in terms of expected and actual output (IC05, Appendix 1).

The effect of lack of staff understanding of accountability requirements on its practice was further confirmed by some interviewees who said that district health managers were only required to report to the region and headquarters; and not to service users and stakeholders. In summary, based on interview responses, it was difficult to say that there was a well-functioning and smoothly-coordinated accountability system in any of the three case districts visited. What could be said is that accountability mechanisms were in the process of being fully established; but the implementation has run into many problems.

7.2.4 Information gathering and sharing for decision-making

The finding from key informants was that information gathering, processing and reporting mechanisms had been put in place, and this has improved since decentralisation. They were particularly enthusiastic about the establishment of a Centre for Health Information Management (CHIM) by the Ghana Health Service to promote information gathering and sharing to aid decision making. Key informants said that the CHIM, in conjunction with the Policy Planning, Monitoring and Evaluation (PPME) unit, had designed and established the health information management system with a broad objective to ensure that all managers collected data which could be used to plan for and deploy resources in the most cost-effective way, to meet their own objectives. Both key informant interviewees and district health staff said that some kind of information and data collection system was established at facility levels and all data collected were expected to be sent to the district headquarters for processing before being sent up to the regional office and headquarters.

Overall, the findings were that decentralisation had – at least in theory – given district health management teams responsibility for the collection and analysis of basic data for day-to-day management decisions. But interviewees believed that an apparent lack of motivation was the reason why health workers were unwilling to assume the health data collection task; some suggested that the problem might be due to a lack of data collection skills at district facility levels. In short, the finding indicated that data collection at the district level has been ineffective, and that most district health workers were unenthusiastic about data collection, since this was not an issue which many of them spontaneously referred to during the interview. As one interviewee noted:

> Staff at facility level felt they were already overburdened with service delivery work, and, as a matter of fact, did not consider health data collection as part of our job; we are not given incentive to do the data collection (TMS03, Appendix).

What the results showed was that implementation of data collection and processing for health decision making is lacking behind.

7.3 Views on the influence of agency characteristics upon health decentralisation implementation

This subsection presents the interview findings on perceptions of the influence of DHMTs' characteristics upon decentralisation implementation at the district level. The related interview comments are summarised in Table 7.2 below.

Table 7.2: Most prevalent comments on district health management characteristics and implementation of decentralisation

Comments	No. of responses	% of respondents*
• Generally, quality of staff is satisfactory, but the numerical strength of qualified staff is very low	37	69.4
• Financial/logistical support is not good, and equipment is in a bad state		
• Commitment is perceived to be satisfactory. Staff are generally committed, but the problem is the lack of motivation and poor working conditions	33	55.9
• Staff consultation, especially with junior staff, is not a common practice because we do not get prior notice on programmes or changes, when everything is ready then we are told what to do	27	45.7
• Coordination of sectoral activities has improved. There is more consultation amongst stakeholders, with DHMTs collaborating with district assemblies, private providers and NGOs	22	37.2
• The leadership is good. The present Director of the district as a person is a good leader. He is good at his profession but not as a manager of people, programmes and resources	21	55.5
• But we have to find ways to survive, e.g. taking jobs with private clinics or other sources available, or even travelling abroad when one gets the chance	18	30.5
• Communication is seen as improved but it is yet to be effective: this is through open durbars, discussion sessions and circulation of circulars on district health activities and programmes	11	18.6
• The District Director needs to draw closer to the front line staff. DHMT management is not very good, as one may expect	9	15.2
• Internal communication is not effective, seminars, workshops and health retreats are not regular and widespread	9	15.2
• Many staff left for other jobs outside the service or travel abroad. Most of us are still here because we have not found anything yet; any time a better opportunity comes we would leave	4	6.7

Source: prepared by author from interview data (2007).

7.3.1 Staff understanding of the objectives of decentralisation

Table 7.3 summarises the general understanding about decentralisation. Interview responses suggested that the majority of DHMT staff have heard about health sector decentralisation but they have different views and levels of understanding of decentralisation in relation to health sector management. Although different terminologies were used regarding decentralisation, the findings as summarised in Table

7.3 indicated that they were often referring to the same concept but with different emphases and degrees of understanding. The following are some examples of the objectives of decentralisation:

> 'Empower' district health authorities; 'give districts more responsibility for planning and setting health priorities'; 'remove bureaucracy'; 'encourage community and stakeholder participation'; and 'bring health services closer to service users'(SWS03; TMS04).

The views in Table 7.3 can be grouped into structural and understanding of decentralisation, and in certain instances, they referred to decentralisation either in terms of what it required or its outcomes.

Table7.3: Matrix of responses on objectives for health decentralisation

Structural objectives	Operational objectives	Requirements	Outcomes
Empower DHMTs by changing or reducing hierarchical structures between the central MOH and the districts	Allow district health systems to undertake planning and to set district health priorities	Change decision making structures and create space for DHMTs to make choices and exercise direct control over resources	Change the relationship between MOH, GHS, the district and stakeholders
Remove bureaucracy or obstacles to health service management	To ensure that adequate funds reach districts on time for efficient and faster service delivery	Transfer of control over money , staff and other resources to DHMTs	Make health management flatter and more flexible, effective, efficient and accessible
Increase stakeholder participation in health decision making, e.g. private providers and community participation	Participation in health fora, bottom-up planning and budgeting; improve information sharing for health policy making and performance evaluation	Transfer of planning and implementation responsibility to district, sub-district and community level; share information with and amongst stakeholders	Encourage pluralism in health provision and governance. Improve public-private partnerships; improve accountability of managers to users

Source: compiled by author from interview responses (2007)

The main perception was that decentralisation meant *'change'*; i.e. change in the

1) structure;
2) Functions; and
3) relationships and management of health services.

There were, however, differences in views about the expected change, with most emphasis on 'change in working conditions and salaries of health staff'.

One interviewee said:

> Decentralisation is to give those at the district level the power to make decisions because they know more about the health needs of the district (Appendix 1, DWS01).

Another interviewee noted that:

> In the past every decision was taken by those in Accra; this is what decentralisation seeks to change and, I feel it is good that contributions from the region and district health staff including those working in the private sector are considered when decisions are being taken. But I am not saying everything should be given to the district, what I mean is that those at the top should try and close the gap between the headquarters and the district (Appendix 1, TMS08,).

Other respondents defined decentralisation as:

> to remove all obstacles to health care delivery, for example, delays in giving money; transfer and hiring of staff that are badly needed by the districts (DWS19; SWS01; TMS15, Appendix 1).

Another interviewee said:

> Decentralisation was to give all service providers, users and communities the chance to participate in: health planning for their districts. Largely, it is a way to make health users assume some responsibility for planning but to also accept that services cannot continue to be free as was the case in the past (DWS03, Appendix 1).

Further cross-interviews on the question revealed that junior staff in particular have a shallow understanding of decentralisation. According to a key informant interviewee:

> Health personnel at the district level do have some level of understanding of decentralisation, but their understanding of what the objectives mean in practice was largely limited (Appendix 1, SWS02).

Another interviewee with the Ghana Health Service expressed similar reservations about the degree of staff understanding of reform objectives. He said:

> Junior staff are aware of the changes but what it means in practice regarding their work especially at the district level is another thing all together; even some senior staff have a limited knowledge of the practical changes of the reform (DWS02, Appendix 1).

7.3.2 Capacity issues in decentralisation

In chapter 3, it was noted that capacity has many connotation but capacity as used in the study refers to skills and numerical strength of staff. The study asked interviewees about the quality and quantity of technical and managerial staff at the facility levels in the district and their capability to implement decentralisation. Table 7.4 below summarises interviewees' viewpoints on the first two general questions on capacity.

Table 7.4: Responses on health worker capacity

Questions on capacity	Response*				
	Yes		No		N/A
	Y	YY	N	NN	-
Do you have the requisite technical and managerial staff in your district?	13	-	28	17	-
Are the numbers of health staff in post in your districts adequate?	-	-	36	21	15

Key: Y= positive response; YY= very positive response; N= negative response; NN very negative response; N/A= no answer or don't know. *The responses reported in this table represented views of health staff at the case districts; key informants views excluded.

Source: computed from interview responses by author (2007).

The general perception was that there were a number of qualified staff in post, but the number was inadequate for the tasks to be performed. With the exception of a minority of interviewees from Dangme West, the quality of technical and managerial staff (in the Dangme West, Sekyere West and Tamale case districts) was, on the whole, perceived to be below average. Twenty-eight out of 41 interviewees mentioned this issue and out of those, 17 gave a negative view of the situation as showed in Table 7.4 above. Interviewees felt that the quality and quantity of staff at the district level was inadequate. The following sample of quotes further illustrates interviewees' viewpoints about the paucity of staff capacity:

Table 7.5: Summarised statements on staff capacity of district health management teams

The number of professional and paramedical and support staff in the district is just bad (DWGI04; TMGI05).

Senior managers with technical skills are lacking in the service; e. g. accountants, statisticians and IT persons, etc. (DWS13; SWS08; SWS09; TMS15).

The DHMTs have less number of managers/technical and administrative staff. The number of this staff is inadequate. More training internally is needed (SWS02; SWS05).

Staff capacity at present is below average at the district level; this is due to lack of injection of qualified technical staff into the system. Although training programmes are being organised by GHS, it is not enough (SWS01; TMS06; TMS12).

The major problem is with the number of staff, that is the quantity is just too low. This is because such qualified staff refuse postings to the Northern region (TMS03; TMS15).

Source: prepared by author from interview responses (2007).

What emerged from the findings was that paucity of capacity at the district level was seen by some interviewees as part of a larger organisational deficiency of the Ghanaian health system, and that the situation is serious at the district level. It was said that, compared to the central Ministry of Health, staff capacity has improved considerably following several interventions through staff capacity training and granting of scholarships for senior staff to pursue further studies. Interviewees reported that this lack of capacity affects the implementation of health reforms at the district level in different ways. One key informant said:

> The delay in signing performance contracts with budget management centres was because of the fear that most of them presently lacked the technical team required to implement a specific programme of activities (DWS03, Appendix 7).

7.3.3 District health managers' capacity

There was a certain degree of unanimity among respondents, especially those in administration, that attention had been on building the DHMTs' capacities following decentralisation. The emphasis was said to be on training in the areas, among others, of planning and budgeting, information gathering and management, decentralised output and budget management and personnel management. Table 7.6 summarises respondents' levels of confidence in members of the DHMT as an executive entity responsible for managing the implementation of health decentralisation at district level.

Table7.6: Responses about DHMTs members' managerial capacity

Question on DHMTs' capacity	**Number of interviewees from the case districts which mentioned the answer choices**								
How much confidence do you have in the knowledge, skills and abilities of the leaders of DHMT in your district?	Not much			Moderate amount			Great deal		
	DW	**SW**	**TD**	**DW**	**SW**	**TD**	**DW**	**SW**	**TD**
	3	11	2	9	5	3	4	2	10

Key: DW= Dangme West District; SW= Sekyere West District; TD= Tamale District
Source: computed from interview responses by author (2007).

Table 7.6 showed that Tamale District members have the highest confident rating, with 10 out of 16 respondents indicating that they had a great deal of confidence in DHMT members' skills. This was followed by the Dangme West district with 4 out of 16 respondents having confidence. Only 2 out of 18 interviewees from Sekyere West district reported having a great deal of confidence in DHMT members' management skills. Confidence in the knowledge, skills and abilities of DHMT staff overall was moderate, especially for DHMT members in Dangme West and Sekyere West districts.

This finding needs to be interpreted cautiously because most respondents, especially from Sekyere West district, were unable to give reason(s) for their viewpoints when they were asked to do so. Nevertheless, while some interviewees could not explain their responses, respondents in the Tamale district case study readily gave reasons for their answer. Interviewees there said that they expressed great deal of confidence in the DHMT because of the particularly difficult circumstances of the region. In the opinion of one respondent:

> Given the limited amount of resources, the harsh and unattractive working environment and the many health problems which confront officials in the Northern region; I think staff are doing their best (Appendix 1, TMS04).

Another interviewee said:

> Their skill may not the best and not the worst either; but given the situation on the ground they are just trying to do their best (TMS0, Appendix 1).

And, in Dangme West district, interviewees also described a lack of skills in terms of adherence to old approaches to health service management. As one interviewee said:

> They continued to do things the old way, despite the fact that quite a number of the members were given training and therefore appeared to be qualified (DWS07, Appendix 1).

In summary, this lack of capacity was perceived as influencing decentralisation, both at management and facility levels.

7.3.4 District health management staff commitment

Staff commitment was another issue examined in the study. Two questions were asked:

1) if staff had a positive view of the health service; and
2) if staff were ready to stay or leave the service if they got a better opportunity outside of the health service.

The findings discussed here are solely based on interview responses obtained from interviewees working in public health facilities in the three case districts.

Table 7.7 shows that a clear majority of health staff appeared to have a positive perception of the health service; 34 out of 39 of those interviewed agreed with the statement that the MOH 'is a good place to work'. Although health staff seemed to be well disposed towards the service, describing it as a good place to work, the interviews found that a majority of staff were very keen to leave the health service for better-paid jobs, either within or outside the country, provided they got the chance. Thus, the level of staff commitment was low. Table 7.7 below showed that 28 out of 38 health staff interviewed openly declared their readiness to discontinue working with the health service any time a better opportunity arose. There was no difference in opinion across the three districts as shown.

Table7.7: Perceptions of level of staff commitment

Case study districts	**Is the health service a good place to work?**		**Would you leave the health service for another job if the chance comes?**	
	Yes*	No*	Yes*	No*
Dangme West district	11	2	9	4
Sekyere West district	13	2	11	4
Tamale district	10	0	8	2
N= 38	34	4	28	10

*number of interviewees who said yes or no

Source: computed from interview responses by author (2007).

The reasons given for this answer was basically economic, and the general perception was that, since government cannot meet staff desires or demands, (e.g. improve work conditions, increase salaries, provide equipment and general staff welfare), due to the country's economic situation, the option was to seek better paid jobs outside the service. The general opinion gained from the interviews was that staff commitment was low; and interviewees believed that low staff commitment was caused partially by the country's poor economic condition and concomitant unattractive working conditions within the health service.

Table 7.8: Comments on the health service as a place of work and staff commitment

Reasons why staff consider the health service to be a good place to work
• Respondents thought that, having worked in the service for a long time and nearing retirement, one could lose retirement benefits for leaving the service, so it was better to stay
• Some respondents hoped that, with ongoing changes in the service, service conditions would improve over time
• Others said that, although the salary was not good, they were assured of job security, especially nurses and other professional staff
• Some also said, when compared to other services like education, the health service was better
Reasons for staff desire to leave the health service when the chance comes
• Most staff expected that reform would bring about changes especially improvement in salary and service conditions, but this is not forth coming
• Poor salary, lack of equipment to work with and job dissatisfaction and uncertainty about the future
• Some also said the reform was only of benefit to people at the top (regional and national headquarters), and the majority said they were neglected by top health officials, hence their desire to find a better place of work
• The service in general was seen as improving but was of most benefit to top officials, because, apart from doctors and senior officials, other auxiliary staff were neglected, so they had to do whatever they can to survive.

Source: prepared by author from interview responses (2007).

7.3.6 Views on leadership in implementation

District health management leadership was another question examined in the study. Specifically, it asked a question on the influence of leadership on the implementation process. District health staff and stakeholders were asked to say what they thought about the leadership of DHMTs and what practical indicators they could give to say that the DHMTs were effectively in control of the decentralisation implementation.

It was expected that an overwhelming number of interviewees would express an opinion on the question of leadership and its implications for implementing reform at the district level. But most respondents were not able to express clear views on the influence of DHMTs leadership in decentralisation implementation. Leaders were rather vaguely described either as 'good' or 'strong'; and the interviewees were also unable to give practical example(s) of what they actually meant by 'good' or 'strong' leadership. What was realised from the interview data was that interviewees tended to regard the few

attributes named as symmetrical, thus a bad and weak leadership was simply the opposite of a good and strong one. Some of the common attributes mentioned included the ability to:

1) be concerned about staff needs and use scarce resources properly;
2) supervise staff under their control;
3) take decisions to solve health problems in the district;
4) show commitment to staff welfare and work closely with staff to deliver health service outputs.

Most respondents used the adjective 'good' to describe the DHMT leadership, with an emphasis on DHMT members' ability to use available staff and funds carefully to achieve health reform objectives – that is, to provide a quality service to communities. Interviewees perceived the effectiveness of leaders in their respective district health authorities in terms of the amount of power given to them from headquarters because, according to them, 'everything depends on regional and national headquarters'.

A sizeable number of interviewees believe that the DHMTs have a number of 'good' leaders who are ready to see to the implementation of the reform. Key informants, especially at regional and national headquarters, said that, with a few exceptions, directors and senior district health officials have thus far provided good leadership. Examples given to support this sentiment were:

1) improvement in the quality of quarterly and annual district health reports; and
2) the timeliness of report submission to the regional offices (interview with DWS01).

For example, in the Dangme West case study, particular reference was made to improvements in data collection; information sharing with staff, working with district health committees, and organising annual fora for health planning and monitoring of health activities at facility level, as well as a gradual increase in private provider and community participation in district health programmes.

Another finding from the interviews was that, while many of the people interviewed appeared to view DHMT leadership as mainly being concerned with the ability to provide quality supervision of health programmes, some respondents stressed the importance of giving attention to staff needs and concerns. This view was most succinctly stated by one interviewee:

> No health programme introduced by DHMTs can succeed without the backing and commitment of the health staff, so the director(s) have to be concerned about the welfare of health workers.

According to her, private-not-for-profit health facilities were doing well because of 'attention given to staff needs; and the resultant improvement in quality of service at these facilities, which is the result of incentive given to staff' (TMS04 Appendix 1).

Rather surprisingly, respondents could not draw a link between good or bad leadership and successful implementation. There was also no comment to the effect that the indicators given on leadership could be useful for increasing the success of decentralisation reform implementation. On the contrary, a requirement for implementation was articulated in terms of DHMTs' 'commitment', 'availability of resources' and 'staff motivation', especially improvement in salaries and work conditions. Thus, the general response to the question of whether leadership has enhanced or constrained the implementation of decentralisation was therefore unclear. Interviewees repeatedly and rather vaguely said that 'the leadership was good and that officials were assigned their responsibility because they were considered qualified and capable to perform at that level'. Overall, what could be gathered from the interviews was that staff thought that, as all DHMT members were health professionals with proven record and experience in their fields of specialty, therefore they would be able to perform the tasks assigned to them, and the interviewees thus did not consider them to be potential obstacles to health reform implementation.

A minority of interviewees reported that the matter was not about leadership but a lack of management skills. In fact, quite a few who mentioned the problem of weak management skills emphasised that decentralisation is a complex programme; and were of the opinion that DHMTs were overwhelmed by the changes associated with decentralisation reform and the challenges involved in managing its concomitant complexities. A senior health official at Sekyere West district remarked that:

> Actually the problem is not leadership as such because there is optimum leadership for ensuring the success of health decentralisation; rather the constraint to the implementation is the lack of a 'management-centred culture' in the health sector.

He explained this point further by stating that:

> ...decentralisation is a complex reform exercise, and health officials tasked with its implementation need special management skills to cope with the complexity, but this is not there. Presently, Health Directors and most senior health personnel at the district level are coping quite well with the changes that decentralisation has brought into health service management, but a minority are unable to cope with the

> associated complexities because this is far beyond their knowledge and experience (Interview with SWS02, Appendix 1).

A further analysis of interview responses showed that, unlike health staff, some stakeholder interviewees saw the district director of health services as the embodiment of leadership at the district level. Thus, the success of decentralisation implementation was said to rest on the shoulders of that individual. A stakeholder interviewee stated:

> The key to leadership at district level is the district director. The district director has the responsibility to make his team of staff work. The staff in the district needs a clear view of what they are supposed to do at the district level and at their respective health centres and clinics and this is supposed to come from the director's office (SWS14, Appendix 1).

Thus, in view of some stakeholders, leadership at district level largely refers to the personality of the district director of health and not the team of health managers.

7.3.7 Influence of communication on implementation

This research question on communication aimed to determine if district health managers communicated and shared information about health reforms at all with staff and other stakeholders involved in implementation of reform programmes at the district level.

7.3.7.1 Information received most, the channel and the adequacy

The finding was that the majority of staff received most information about their job, and this came most often from their superiors. Information was given through circulars and/or formal letters or verbally during meetings at facility level. Interviewees said that most information received included instructions on work schedules, health data needed for reports and programmes of activities, meetings and impending outreach programmes at district level. Interviewees perceived information they received as 'little' or inadequate. Rather surprisingly, some top health managers were of the view that staff did not need to be given all the relevant information about reform policy issues. One senior member of staff said:

> ...staff are not supposed to be given every information, only information that concerns them or what they need to know is made available to them (SWS02, Appendix 1).

This point leads us to further explore information sharing with staff, especially regarding major management decisions on decentralisation at district level.

7.3.7.2 Communication with staff and stakeholders about health management reform decisions

The main finding regarding staff awareness about health service reform decisions was that staff either receive *very little* or no information on major health management decisions. This perception was common among junior staff. Interviewees said that they had no prior information about major management decisions, they normally heard or saw it on a notice board some time after the decision had been taken. Many junior staff interviewed thought that decision making at district level was the responsibility of their directors and senior staff. Interviewees did not consider the issue of being informed a serious one. According to one interviewee:

> management decisions were made by our bosses, those decisions did not directly concern junior staff; information that concerned us was put on the notice board and even that most staff are either not interested in or may never took the time to read it (DWS7, Appendix 1).

7.3.7.3 Communication and information sharing on reform and work-related problems

Despite the fact that decision making was considered by interviewees to be the responsibility of health managers, there was a feeling that health workers were under-informed or given little information about how directors and senior staff were handling work-related problems. This was noticed when the majority of district health staff could not give an answer to the question how problems of logistics, equipment and salaries were being handled. The impression gathered from the interview responses was that information sharing at the district level was limited to the top hierarchy of the district health administration. This may possibly be due to the assumption made by some health managers that, even when information is given to staff, it may be of little benefit to them.

7.3.7.4 Sources and channels of communication and information sharing

The study found that often information was received from directors and senior staff at the district and regional headquarters. At times, however, some information also came directly from the MOH's regional office for dissemination to staff, and this was either put on notice boards or delivered by senior staff at unit meetings. Official letters, circulars and staff meetings were also among the channels mentioned as key official methods of communication and staff consultation. None of the interviewees made reference to annual reports, newsletters, workshops, health fora, seminars, retreats, team briefings or team meetings as channels of communication and information sharing; even

though these channels had recently become quite popular, following the health sector reform. In particular, the newly-created Ghana Health Service had been using these channels for information dissemination to staff, stakeholders and the general public about changes being undertaken in the health sector.

7.3.7.5 Timeliness of response, feedback and follow-ups

A number of issues were raised by health staff, regarding the effectiveness of formal channels of communication and information sharing at the district level. While there was a general opinion that official letters and circulars comprised the formal channels for gaining information, these were not always perceived to be effective or being used to the full potential. Many health staff interviewed expressed concern about the timing of information received from sources further up the district health management hierarchy. The general opinion was that information needed for their work seldom arrived on time. Also, it was indicated that very little or no feedback was received from the district health management managers. Health staff felt strongly that it would be helpful to receive feedback on information sent to their directors and senior staff. There was a perceived dissatisfaction among interviewees regarding feedback, follow-ups, information dissemination and utilisation.

What was astonishing about the views expressed answering the question on feedback was that, whereas district directors and senior staff complained about late response or very little feedback on information sent to regional and national headquarters, junior staff also blamed their immediate directors and senior staff at district level of being guilty of the same mistake of non-response and delays in giving feedback. This indicated the possible existence of an 'information or communication gap' between health managers and front line staff at district level. It is important to point out that, even though both middle management and junior staff reported that there was little feedback on information from their immediate managers and seniors, it was noticeable from the interviews that directors and senior managers were themselves perceived of not providing follow-up action or feedback to information received from subordinates.

In addition, it was reported that top mangers did engage in effective communication and information sharing at their level. It was noted from interview responses that there was more direct communication and information sharing among directors and health managers further up the district administrative hierarchy. Thus, the problem of getting feedback or follow-up on information did not appear prevalent amongst directors and senior managers themselves. According to one key informant:

> District health directors and managers communicate and share relevant information with senior managers, and they do so frequently; and, they do regular follow-up for feedback, either by telephone or written note. A member of staff remarked: 'My director briefs me always about what is going on' (DWS10 Appendix 1).

7.3.7.6 Consultation and implementation

Consultation with staff at the district level was said to be a 'some of the time' affair, that is, very little consultation went on between district health management and staff. Junior staff felt that they were rarely or never consulted for their contribution to the health reform or decision issues; interviewees said consultation only occurred when specific services were needed, not for management decision purposes.

7.3.7.7 Stakeholders' viewpoints on communication and consultation

District Assemblies and private sector providers were major stakeholders in the district health delivery system, so their views were solicited by district health management on a regular basis for their viewpoints and inputs into health decisions. Stakeholders' reactions to the question reinforced some of the sentiments expressed by health staff. The general feeling among stakeholders was that they received very little information on major health decisions from the district health management team. Interviewees reported that, quite apart from the annual health forum, they rarely participated in health decision making and that stakeholders were rarely consulted or invited to make contributions to major health decisions. Both local government and private health officials therefore felt under-informed about ongoing key health reform issues, and most of the respondents felt in need of much more information than they were currently being given. There was a general agreement of a dearth of information on many issues pertaining to their role and contribution to planning, management and delivery of health services to communities in the district.

7.3.7.8 District Assemblies' viewpoints

The District Assemblies (DAs) maintained that apart they were not invited to meetings and workshops organised by district health management; mostly the DHMTs, except for the yearly health forum. They were only contacted when the DHMTs needed assistance to carry out their programmes, and often ignored in the process of making health decisions. One local government official said:

> Our health people do not seem to appreciate the contribution of the District Assembly, they only ask for help when they need it but rarely communicate or consult with the assemblies on major health management issues... That is why the district assemblies are blamed for not cooperating with the health authorities; rather health management teams should be blamed for the lack of collaborative relationship (SWS17, Appendix 1).

This perception needs to be qualified because a smaller number of respondents from the Tamale case district thought the situation was gradually improving since the establishment of the District Health Committees. One interviewee admitted that:

> Although the district assembly has under-informed especially in the past, the situation has improved in the past two years, in the sense that they received some information about major health programmes going on in the district. The only problem was that mostly the district assembly received the information late (TMS14, appendix 1).

Opinion on feedback was no different, as respondents believed that district assemblies received little or no feedback from their counterpart district health managers. Apart from participation in district health committee meetings and health forum, district assemblies complained that they received no copies of reports or feedback on outcomes of meeting. Thus, some specific examples cited of the lack of information sharing and communication included: a failure to furnish district assemblies with copies of district annual performance reports and briefings on DHMTs' yearly health activities.

7.3.7.9 Private-for-profit health providers' viewpoints

Private-for-profit health providers considered themselves to be the most under-informed stakeholders because they received no or very little information from the district health management. According to one interviewee:

> The district management does not give information, or consult our clinic about any health management issues or major health decisions; we only hear of the programmes either on radio or when the programme is finished (SWGI04 Appendix 1).

Furthermore, private health provider institutions said that the district management did not provide feedback on district health programmes; instead staff got such information from other sources, for example, the mass media. More general concerns were raised about communication and consultation with respect of the current decentralisation health reform. Private practitioners maintained that they were not aware of the health reform – according to them, their first awareness was toward the end of 1997. It was obvious that this may have rendered their understanding of the whole reform nebulous as some respondents thought the reform meant the introduction of new funding through the national health insurance scheme.

7.3.7.10 Private-non-profit providers' views

The study found dissimilarities in the relationships between the MOH and private-for-profit and private-non-profit providers. The private-non-profit sector, represented by the Christian Health Association of Ghana, seemed to have a closer and better relationship with the MOH. This collaborative relationship was due to the fact that the sector

provided an estimated 30% of hospital beds and about 35% of outpatient care and received staff salary support from the government (MOH, 1999). Health staff in the sector therefore seemed to have a better understanding of reform and their envisaged role; primarily they linked reforms to changes that would come as a result of the creation of the Ghana Health Service. Unlike their counterparts in the private-for-profit sector, the indications were that the sector had more frequent communication and regular interaction with the MOH on health reform programmes and were therefore better informed about reform.

7.3.7.11 Communication and consultation with health professional associations

The general opinion was that little communication and consultation took place between the private sector and the central Ministry of Health, and relationships between them were perceived to be more informal. There are several health professional associations in Ghana such as the Registered Nurses and Midwives Association and Ghana Medical Association, and these associations play an important role in developing and shaping health care standards. An interviewee from the Northern region Pharmacy Council succinctly stated that: 'professional associations were not informed or effectively absorbed into the health reform programme' (TMS07, Appendix 1). There was a perception of a relational breach between the Ministry of Health and the professional bodies and private-for-profit providers, and this was perceived to have been reproduced in the operations of reforms at the district level. To some extent, this caused most district health managers to distance themselves from the public, hence the failure to share relevant reform information with these important constituencies of the health system.

In summary, the basic channels of communication were not used effectively, and there was little communication and consultation with either staff or stakeholders about important health reform decisions, which created a vicious cycle of poor communication at the district level. This possibly explains stakeholders' outlook of being under-informed and the general misunderstanding and flawed perspectives on reform goals. This may also explains the low confidence expressed in the reform and the increasing distrust that district health managements would implement reform objectives satisfactorily.

7.4 Other factors influencing decentralisation implementation at the district level

Several other factors emerged during the study but were not elaborated on by respondents. Some are summarised in Table 7.9 with supporting selected statements but not discussed in detail because that would be beyond the scope of this study.

Table 7.9: Other emerging issues in district-level decentralisation implementation

Other unexplored factors that emerged from research results	Summary of sample quotes
Feeling of lack of ownership of reform	Most of the decisions are taken by headquarters and, after decisions are taken, it is passed to the district and directors instruct staff about what to do; consultation before making decision is not a common practice in the service, but we at the district are trying to change the situation
Problem of survival strategies: divided-attention, unethical practices and institutional and individual corruption	Health staff are doing their best; the way out is to work part-time at other places, mostly with private sector or other jobs; take unofficial payment
Lack of managerial capacity due to medical professionals' opposition to the appointment of technical personnel into the service	Health professionals felt the appointment of non-health officials especially to managerial positions would deprive them of benefits, also the low salary being paid is not attractive to most highly qualified personnel, e.g. accountants, procurement and IT specialists
Conflict between District Assemblies and DHMTs	Mostly district assemblies give a lot of problems in terms of collaboration because they still think the district health management should be under their control although the law establishing the service has changed this. This is the reason why most the assemblies are reluctant to give financial support to DHMTs
Non-cooperation from private health providers	You see, from the beginning of this reform the private sector was not involved, now though things are changing, so I think it will take a long time for the private-for-profit providers to work closely with the public health sector. Since the public sector is not providing money for the private providers, then we should not be obliged to support government health activities

Source: prepared by author from interview responses (2007).

Feeling of lack of ownership

The study found that there was a feeling of lack of ownership of reform among some health managers at the district level. Interview statements seemed to suggest that district managers saw themselves as implementers of decisions made from headquarters, and what was expected of them was only to direct programmes at the district level.

Survival strategies: unethical behaviours and salary-augmenting activities

A further inquiry into the question about wishing to either leave or continue working with the service resulted in some rather interesting findings, which one interviewee referred to as 'survival strategies'. The opinion was that most staff that are with the service have, over time, developed strategies for survival, which basically meant resorting to salary-augmenting strategies. Common among these was undertaking multiple jobs with little or no regard to whether this would conflict with their regular work. One interviewee said:

> Taking part-time jobs is the only way to survive; our bosses and senior officers are all doing it... they know it is not supposed to be so but because of the conditions in the service they rarely cautioned staff about it (DWS20, Appendix 1).

Other strategies mentioned and which were said to be common among senior health staff included the practice of diverting patients or prescriptions that should be purchased from public health institutions into private health facilities or pharmaceutical shops in which they held interests. It was found that both senior and junior staffs were dissatisfied with conditions of work and pay in the service and this dissatisfaction seemed to have some linkage with their limited understanding of health reform objectives in general. This was indirectly a challenge in implementing health decentralisation at the district level. Interviewees also expressed a feeling of suspicion and distrust toward top officials, especially those at the headquarters in Accra. One interviewee said:

> Consultants and officials at national and regional headquarters are the direct beneficiaries of reform because they have been given preferential treatment in several areas including training, allowances and salaries, among others (TMS15, Appendix 1).

This feeling of neglect and distrust in the minds of staff, and the perception that top-officials were not doing much to help junior and other auxiliary personnel, were perceived by some interviewees to be the cause of low morale, lack of commitment and apathy among health staff at the district.

Professional opposition and politics of appointment

The issue of professional resistance from the medical profession was raised by some interviewees, who said that doctors were opposed to earlier attempts to include non-medical managerial staff into district health administration. According to some private sector interviewees, though decentralisation aimed to involve all stakeholders in the management of health services, few or no private-for-profit and private-not-for-profit

service providers were directly represented on most – if not all – the DHMTs, and no private sector health professional held a District Health Directorship position in the case districts. The perception of some interviewees was that doctors viewed the recruitment of too many non-health professionals and technically-skilled personnel into the service as a threat which might deprive them of their benefits and reduce their professional control over the health service.

Alongside the capacity problem at the district level, appointment to a district health directorship post was perceived to be unduly politicised. It was reported that, because appointments were made on political grounds and on the basis of who you know, health professionals who might be more suitable tended not to be appointed as members of the district management teams. As one interviewee said:

> The political culture of the country and the practice of pleasing political supporters through appointment is one of the causes of the poor quality of officials at the DHMTs... As you can see for yourself the DHMTs cannot find solutions to practical problems, rather they continue with old management style, which emphasises rules and regulations but lacks the ability to solve people's problems (IC06, Appendix 1).

Conflict between district health managers and district assemblies

Interviewees raised the issue of conflict between district health managers and district assemblies and intimated that this had an influence upon implementation of health decentralisation at the district level. Respondents, especially senior health officials, explained that, as district health managements were the highest political authority at the district level, district assembly officials thought they should be directly under their control, as it had been in the pre-reform era. Separating the district health system from the assemblies was therefore seen as undermining their authority. This was perceived to have affected cooperation and collaborative relationships between district health managements and district assemblies.

Non-cooperation from private-for-profit providers

The issue of non-cooperation was raised during the interviews. Several private-for-profit health providers expressed the feeling that, because they had not been integrated into the health sector reform programme from the beginning, for example, through funding or logistical support, it would take time for the public sector to attain full support with implementing public health programmes. These issues are taken a step further in part two of this chapter, by undertaking a statistical analysis of the responses obtained from the survey of health staff's views.

PART TWO: SURVEY FINDINGS

7.5 Challenges in the implementation of health sector decentralisation at the district level: a quantitative analysis of district health staff's views on the lack of staff capacity, leadership, staff commitment and communication

7.5.1 Introduction

This part of the chapter is a follow-up to the interview section and presents results from the survey component of the study. It aims to examine further factors affecting the implementation of health sector reform and decentralisation at the district level, and is intended to strengthen the interview findings through statistical description and analysis based on the survey of views of health staff from the three case study districts. Specifically, it aims to undertake statistical analyses that will support or disprove the study's assumption that health decentralisation implementation is associated with the characteristics of the (DHMTs) implementing agencies.

In all, a sample size of 191 was expected but, in fact, 200 questionnaires were distributed and 142 were successfully administered and collected from respondents – yielding a response rate of about 74.3%. Table 7.10 summarises the distribution of respondents according to district, staff position and profession.

Table 7.10: Summary of survey responses

	Junior staff	Middle staff	Senior staff	Sample (N)
Frequency (N)	81	46	15	142
Response (%)	57.1	32.4	10.6	100%

Source: computed by author from survey data (2007).

Table 7.11: Distribution of respondents of each district in sample

Case-district	Frequency	Percentage (%)
Dangme West	50	35.2
Sekyere West	42	29.6
Tamale	50	35.2
*(N)**	142	100

Source: computed by author from survey data (2007).

7.5.2 Overall district health staff views on decentralisation implementation at the district level

Table 7.12 below summarises the frequency of responses on the influence of lack agency factors in implementation. As expected, some of the frequency responses

supported the working assumptions. Firstly, 73.9% of respondents supported the statement that the lack of staff capacity was influencing the implementation of health decentralisation; out of this (73.9%), 53.5% agreed and 20.4% agreed strongly with the statement.

Table 7.12: Frequency of responses on the influence of organisational factors in decentralisation implementation at district level (N=142) *

Statements on organisations' characters	Disagree strongly (%)**	Disagree (%)**	Neither agree nor disagree (%)**	Agree (%)**	Agree strongly (%)**
Lack of staff capacity	7.0	14.1	3.5	53.5	20.4
Lack of leadership	12.0	45.8	13.4	25.4	3.5
Lack of staff commitment	8.5	47.9	19.7	21.1	3.5
Lack of communication of reform goals to staff	10.6	26.8	9.9	49.3	2.8
Unattractive work conditions and low salary	7.0	14.1	3.5	53.5	3.5

Source: computed by author from survey data (2007).

*The numbers reported here are frequency percentages of responses from the survey
** The responses reported are from the three district case studies

Similarly, nearly half of the respondents (49.3%) agreed that the lack of communication is a challenge in health reform implementation; and another 2.8% agreed strongly. As expected, a majority of 57% of respondents agreed that unattractive work conditions and low salaries were affecting health reform implementation at the district level. Contrary to this, nearly two-thirds (57.8%) of respondents disagreed with the proposition that a lack of leadership was affecting health sector decentralisation at the district level. Another 56.4% also disagreed with the assumption that the lack of staff commitment was a barrier to reform implementation. What the frequency responses suggested was that, despite more than half the health staff supporting the assertion that organisations' characteristics influence implementation, it did not mean that all factors noted about district health management were perceived to influence implementation. The fact that a higher percentage of staff disagreed with the statement on leadership, commitment and lack of staff participation in decision making in relation to implementation suggested that they did not perceive these factors as important for explaining implementation of decentralisation.

7.5.3 Chi-square results on DHMT characteristics upon implementation

This section describes chi-square test results on organisations' characteristics and implementation. It aimed to show the extent to which it can be proven statistically that

implementation is either associated with or independent of the organisational characteristics of district health management teams.

Table 7.13: Chi-square tests on the strength of association between organisations' characteristics and decentralisation implementation at the district level

Organisation characteristics and Implementation	Pearson chi-square value	(df)	Sign. (chi-square)*
1) Leadership and implementation	20.085	4	.000
2) Staff commitment to implementation	14.674	4	.005
3) Staff capacity and implementation	9.058	4	.170
4) Communication/consultation and implementation	5.165	4	.271

NB: In this study, the probability level of 0.05 was applied throughout for determining the significance of the chi-square results. * $p \leq 0.01$ or $p \leq 0.05$ significant

Source: computed by author from survey data (2007).

Table 7.13 above summarises the chi-square test results upon the implementation and agency characteristics. It was expected that there would be an association between organisational factors and decentralisation at the district level. The strength of the measure of association between these are analysed in the next section.

***Organisation leadership*:**

From the chi-square test results (of *p*-value =.000), leadership was positively associated with decentralisation implementation, meaning that the stronger and more effective leadership was at the district level, the higher the chance for effective decentralisation implementation.

Staff commitment

The statistical test showed a significant degree of association between successful implementation and staff commitment to decentralisation reform objectives. With a *p*-value = .005, it could be said that the implementation of decentralisation had a positive association with staff commitment, therefore the higher the staff commitment to reform objectives, the higher the chance for successful decentralisation implementation.

Health staff capacity

The chi-square test results (*p*-value = .170), showed that successful implementation of decentralisation was not associated with staff capacity. This suggested that

implementation of health sector decentralisation was independent of health staff capacity issues.

Communication

Communication showed a weak measure of association as shown by a *p*-value =.271. Implementation of decentralisation at the district level was therefore independent from or not associated with communication.

7.5.4 Analysis of variance (ANOVA) results

Table 7.14 gives a summary of ANOVA results and mean values and levels of responses to the four factors. It was expected that there would be variations between the districts (Dangme West, Sekyere West and Tamale) regarding their perception of factors influencing decentralisation at the district level. In this section, the analysis focuses on the following:

1) lack of capacity (e.g. staff skills and financial resources)
2) lack of leadership;
3) lack of staff commitment; and
4) lack of communication.

Table 7.14: ANOVA of health staff's views on the influence of organisation factors on implementation of decentralisation

Organisation factors influencing implementation	Mean*	Std. deviation	Df	f	Sig.
1. Lack of staff capacity	4.775	4.62199	(2, 139)	2.657	.074
2. Lack of leadership at district level	2.7113	.88791	(2, 139)	.402	.670
3. Lack of staff commitment	3.7234	.54911	(2, 139)	2.745	.068
4. Lack of communication	3.1549	.94001	(2, 139)	.283	.754

ANOVA was used here to compare differences between Dangme West, Sekyere West and Dangme West district case studies. * 1= strongly disagree; 5= strongly agree

Source: computed by author from survey data (2007).

As a first step, a one-way analysis of variance (ANOVA) was conducted on: capacity; leadership; commitment and communication in relation to decentralisation reform implementation. Table 7.15 shows no significant variation between the districts regarding the organisation factors, that is, lack of staff capacity (f (2, 139) =2.657, p=.074); lack of leadership (f (2, 139) =.402, p=.670); lack of staff commitment (f (2, 139) = 2.745, p=.068); and lack of communication (f (2, 139) = .283, p=.754). Further analysis of the mean scores (see Table 7.14) showed that respondents from the three case districts agreed that the lack of capacity (4.775); lack of staff commitment (3.723), and lack of communication (3.154) influenced decentralisation implementation in their

respective districts. However, they disagreed with the view that a lack of leadership at the district level (2.711) was influencing decentralisation reforms in the districts.

Table 7.15: Post hoc test of statistical significance of differences between case study districts**

Organisation factors	Dangme West	Sekyere West	Tamale
1. Lack of staff capacity	3.20	3.73	5.24
2. Lack of leadership	2.68	2.64	2.80
3. Lack staff commitment	3.82	3.56	3.76
4. Lack of communication and consultation	3.60	3.60	3.42

**The post-hoc test was used here to determine significant differences in mean scores of the four items across Dangme West, Sekyere West and Tamale health staff respondents. Unlike the ANOVA test, a post-hoc test reveals whether there are differences and, if so, who differs from whom.

Source: computed by author from survey data (2007).

In addition to ANOVA, a post-hoc test was conducted to help explain any possible variations across the three case districts. Results from this post-hoc test (Turkey HSD) revealed that the mean scores for the three districts were quite close on most of the issues but not necessarily significant on a number of them. Based on the design of the questionnaire, a higher mean score suggested a stronger agreement with the underlying assumption of the study that agencies' characteristics influenced decentralisation at the district level.

The results in Table 7.15 suggested that there was no significant cross-district difference among health staff (from Dangme West, Sekyere West and Tamale districts) regarding the four factors. Therefore, staff were more likely to agree with the view that staff capacity, commitment and lack of communication influence decentralisation implementation. But respondents' support for the view that staff lacked capacity appeared stronger in the Tamale district, with a very high mean score of 5. Conversely, health staff in all three districts appeared less likely to agree with the claim that leadership was affecting decentralisation implementation in their districts.

7.6 Chapter summary of interview and survey findings

This chapter has set out to report the results from the qualitative and quantitative analysis of interview transcripts and survey responses. This section gives a separate summary of findings from the interviews and the surveys as shown in Tables 7.16 and 7.17 respectively.

7.6.1 Progress in the implementation of health sector reform and decentralisation at the district level

The findings showed that some progress had been made in implementing decentralisation at the district level, but the effectiveness of implementation had been influenced by the character of the district health managers. Views on the objectives for undertaking decentralisation were mixed and one should be cautious about making generalisations about these.

Table 7.16: Summary of perceptions from public health and stakeholder respondents on the influence of organisational factors on health sector decentralisation implementation at the district level

Themes	Public health staff respondents	Non-public health or stakeholder respondents
Progress made so far with health sector reform decentralisation implementation	*1.Transfer of authority* It has largely improved stakeholder participation in decision making and planning of health activities at the district level Apathy and lack of cooperation, lack of skills and inter-agency conflict are the cause of perceived low stakeholder and community participation *2. Data and information sharing* Some information and data collection system was established at facility levels Data collection at the district level has been ineffective District health workers were unenthusiastic about data collection because there was no incentive attached to this new assignment *3. Accountability issues* Accountability mechanisms were being established, and were gradually becoming part of the daily management practice of the health service But the horizontal and top-down dimensions of accountability was uncommon; the practice of accountability was limited in several respects	*1.Transfer of authority* Degree of stakeholder engagement and participation in district health planning activities has not changed significantly The planning process is overly dominated by district health staff. *2. Data and information sharing* The implementation of data collection and processing for health decision making was lagging behind *3. Accountability issues* They were sceptical, especially about the efficacy of accountability procedures being established and operated at the district level Accountability mechanisms were in the process of being established; yet the implementation had run into many problems.
Influence of staff	DHMT lack staff capacity was	The number of staff was not

capacity on decentralisation reform	perceived as influencing decentralisation at both management and facility levels	adequate for the new task given by the district health administration
Influence of leadership on decentralisation implementation	Interviewees could not give any convincing answer to the question. Leadership was not seen as impeding health reform implementation	Leadership at district level was about the personality of the district director of health and not the team of health managers The matter was not about a lack of leadership but lack of management skills upon implementation
Themes	**Public health staff respondents**	**Non-public health or stakeholder respondents**
Influence of staff commitment on decentralisation implementation	Staff were very keen to leave the health service for better-paid jobs, either within or outside the country, provided they had the chance. Thus, level of staff commitment is low	The level of staff commitment is low due to poor working conditions in the health service
Influence of communication/ consultation on decentralisation	Interviewees often perceive information received as 'little' or inadequate. Information sharing was centralised and limited to the top hierarchy of the district health administration. Information needed for work seldom arrived on time; very little or no feedback and follow-up on information given or received from managers – very little consultation goes on between district health management and staff	Stakeholders received very little information from the district health management team on major health decisions Basic channels of communication were not used effectively, and there was little communication and consultation with stakeholders about important health reform decisions, this has created a vicious cycle of poor communication gap at district level
Influence of other factors on reform implementation	Feeling of lack of ownership Resort to survival strategies: unethical behaviours and salary-augmenting activities	

Source: prepared by author (2007).

The level of staff understanding of the objectives for health decentralisation was high among senior health officials. Most of them could explain the various objectives and, in many cases, demonstrated an understanding of the broader context in which the reforms in the health sector were taking place. Junior staff showed a superficial understanding of decentralisation and most of them explained decentralisation reform in terms of change, particularly in terms of working conditions and improvement in salary.

Table 7.17: Summary of statistical results of district health workers' perception of lack of: staff capacity, leadership, staff commitment and communication on health reform implementation

Themes	Statistical Tests Results	
	Summarised Chi-square results	**Frequency, Chi-square test, ANOVA and post-hoc results**
Lack of staff capacity	Lack of staff capacity showed a weak measure of association with implementation	There was no significant variation across the districts; but Tamale staff had a stronger view that staff capacity influenced decentralisation implementation
Lack of leadership	Lack of leadership showed a significant measure of association with implementation	There was no significant variation, leadership was perceived to have no or weak influence on decentralisation implementation
Lack of staff commitment	Lack of staff commitment showed a significant measure of association with implementation	There was no significant variation; commitment was perceived to have an influence on decentralisation implementation
Lack of communication	Lack of staff communication showed a weak measure of association with implementation	There was no significant variation; communication was perceived to have an influence on decentralisation implementation

Source: prepared by the author, based on survey results (2007).

Tables 7.16 and 7.17 provide a summary of the interview findings, which indicate that decentralisation has brought structural and operational changes about in health service management at the district level. The transfer of authority for decision making is now being undertaken through District Health Committees involving local governments, private-for-profit providers, communities and mission hospitals. For instance, structures for transferring authority to Budget Management Centres (BMC) have been established to ensure accountable and judicious use of money and resources; and information management systems for information generation and sharing for improved health service delivery are being gradually established. Staff training and redesign of administrative procedures and processes are being undertaken in pursuit of the reform

objectives. Nevertheless, interviewees reported that there were constraints to the implementation of the objectives of decentralising the health system.

7.6.2 Decentralisation within a centralised management structure

As shown in Table 7.16, despite the fact that decentralisation implementation is ongoing at the district level, the findings indicated that it was being implemented through the old centralised bureaucratic structures and management culture; what Ayee (2003) described as 'decentralised centralism'. The strategy for implementing decentralisation was strikingly top-down and followed the MOH's old hierarchical arrangements. The reform was passed down from headquarters to the regional offices and then further down to the district level, which in turn assumed responsibility for its implementation at district, sub-district and community level. The findings indicated that district health managers had little or no control over financial and personnel administration decisions. Furthermore, the findings revealed that the district health management still had vestiges of a traditional civil service process-based approach to management, instead of using new public management techniques to achieve reform (decentralisation) objectives. Thus, the health reform implementation process at the district level attached great importance to policy work and skills at the district headquarters of the organisation, but placed less emphasis on operational and behavioural dimensions of the reform at facility level.

7.6.3 General challenges for decentralisation implementation at the district level

As summarised in Tables 7.16 and 7.17, the study indicated that the implementation of decentralisation at the district level was influenced or constrained by factors internal to the DHMTs. First, the findings showed that a lack of capacity – particularly in terms of skills and staff numbers – was a challenge for decentralisation implementation. The findings suggested that this had to do more with executive members of the DHMTs. It was further revealed that, within the existing organisational paradigm, most DHMT staff lacked the experience and skills needed to perform new tasks. With particular reference to the influence of the various elements of organisational characteristics on implementation, the survey results showed that three factors were outstanding. The test of association showed that respondents perceived a lack of staff commitment and lack of staff capacity of district health managements as positively associated with decentralisation at the district level. This meant that they were important for explaining decentralisation implementation processes.

Further evidence, especially from the analysis of the survey results, indicated that there was very little or no significant difference across the districts in the influence of organisational factors upon implementation of health sector reform. With the exception of a lack of leadership, respondents were unanimous in their opinion that the characteristics of the DHMT influenced implementation. The statistical tests conducted based on survey data (see Table 7.17) showed that respondents were more likely to agree with the view that staff capacity, commitment and communication and understanding of reform goals influenced decentralisation implementation. Further cross-district analysis revealed this view to be very strong among health staff in the Tamale district. They appeared more supportive to the view that the lack of staff capacity and resources were important in explaining decentralisation implementation in their district. This was unsurprising, considering the inequity of distribution of health facilities, resources and personnel between the north and south zones of the country. Tables 7.16 and 7.17 indicated that health workers disagreed with the proposition that leadership is a constraint to the implementation of decentralisation.

Other issues that emerged from the findings were that the focus of reform was more on the structures, systems and procedures for policy formulation issues, both at district and national level, with very little on implementation. Also, the focus of reform was largely on improving policy and management capacity at the top level rather than at lower and facility levels, which had implications for implementation. In particular, findings from interviews suggested that reformers took the internal organisation and administrative capability of district health managements for granted. However, it was observed that, even though the required structural mechanisms for information gathering for decision making and accountability had been established, the practical implementation with regards to the functioning and operation of the system through, e.g. the District Health Committees and Budget Management Centres, was delayed at the district level by the lack of staff qualified to analyse data critically, identify patterns and take action (se Table 7.16). This problem was partly due to a misplaced focus of the reform as noted above, and the sequencing of the implementation which seemed to treat requirements for the implementation of reform as a secondary matter. This was coupled with staff indifference towards investing in new skills in the area of information management.

Closely related to this point is the observation that policy formulation work is given highest priority at the central Ministry of Health and is undertaken by experienced senior staff including consultants and external experts, while management of the reform implementation process (decentralisation), which is more difficult and challenging, is given to lower-level managers at the district level. Thus, more challenging tasks are transferred to the districts without a corresponding number and quality of staff required to undertaken the task. This may have created a management competence gap at district and sub-district levels which had a negative effect upon management of the implementation process.

The study also revealed that the politics and patronage involved in appointing district health directors and managers, both within and outside the service, had affected the capacity situation. Generally, it was not those medical doctors or health professionals who were competent and dedicated who were most likely to be approved for the district health directorship job. Interview findings pointed to evidence of a disregard for meritocracy in the appointment of district health directors and senior managers, and this had implications for the effective management of the health reform implementation process. The study revealed a general feeling of neglect and lack of ownership of reform at the district level and consequently a lack of commitment and low morale among junior staff, compelling them to resort to unethical and unprofessional practices for survival purposes. This had posed a challenge for reform implementation.

In addition, the findings point to the fact that decentralisation as a policy was complex and ambiguous, with several objectives; which made its comprehension difficult for both the reformers and implementers. This complexity had made implementation a difficult task for district managers who had the necessary skills for routine administration but not for new reform tasks.

7.6.4 Agency characteristics as a challenge to decentralisation implementation

As noted in Chapter 3 and the introduction to this chapter, there were several objectives of Ghana's health system decentralisation but this study sought to examine the challenges to the implementation of: transfer of authority; information flow for decision making and performance evaluation; and the establishment of accountability mechanisms to hold health workers and officials accountable.

Of the four organisational characteristics shown in Tables 7.16 and 7.17, staff capacity, staff commitment and communication issues appeared to have the most effect on the

transfer of authority, data collection and information flow and the establishment and operation of accountability mechanisms at the district level.

On the capacity issue, it was found that the problem was more serious in the Northern region where the problem was seen not in terms of lack of skills but lack of the required number of staff, logistics, equipment and financial resources. Related to this point was the finding that other factors such as loss of staff through migration, poor working conditions and general lack of motivation were among the causes of the paucity of capacity. The implication was that, in the absence of the required number of qualified staff, health data collection for decision making, and the preparation of monthly, quarterly and annual accounting reports for managerial decision making were either delayed or not submitted at all. This affected the practice of accountability and information management for decision making.

Secondly, the centralised, top-down style of communication and information sharing affected the level of staff understanding of reform, decision making and the effective participation of District Health Committee members in the district health planning process; the same finding applies to the participation of communities and stakeholders, especially private health providers (see Table 7.16). The top-down approach to communication and weak channels of sharing information on decentralised health programmes resulted in an 'information gap' between DHMTs and front line health workers and stakeholders; which has created more problems in the form of a lack of trust, lack of ownership and apathy, which in turn has affected effective decision making and, to some extent, the level of commitment to reform. As noted in Table 7.16, local government officials and stakeholders were dissatisfied with the amount of information available to them about district health programmes and activities. This caused some officials to think that district managements were siphoning off donor money meant for providing health services to the poor for themselves. The prevalence of this perception might be the reason for District Assemblies' negative response to providing financial support out of their Common Fund to DHMTs in some of the districts.

Thirdly, it was difficult to establish explicitly that leadership affected the practice of decentralisation at the district level. However, one thing emerged quite clearly; that respondents did not believe leadership was hindering decentralisation implementation at the district level.

Staff commitment was found to be low and this had a negative influence upon decentralisation implementation. But it also emerged from the findings that staff commitment was indirectly affected by factors such as working conditions, salary, promotion, motivation and staff welfare. These factors were also responsible for unethical behaviour and increased staff migration in search of better opportunities.

Lastly, it emerged from the findings that agency's character was affected by other factors in the external environment such as the social, political, economic and bureaucratic institutional environment, all of which tended to affect implementation. The method of appointing district directors had implications for reform management and performance of the district health administration; and so did the influence of the politics of implementation of decentralisation at the district level. Furthermore, the history and geography of a district had implications about which health staff would be attracted to it. It was a known fact that deprived districts in the poor north and rural areas did not attract young doctors and nurses, and this affected the regions' ability to implement health programmes effectively. These issues are taken up further in Chapter 8.

7.7 Conclusion

This chapter presented findings from interview and survey data on the perception of the influence of district health managements upon the implementation of decentralisation at the district level. There is little doubt that there had been a change in the exercise of authority, information flow and practice of accountability at the district level. But this ongoing change had been affected by staff capacity, communication and commitment of district managements at the district level. The study found that staff capacity and communication and lack of control from directors were challenges for decentralisation implementation. However, these factors on their own were insufficient for understanding the sources of challenges to decentralisation. Other factors from the far and near environment also shaped the DHMTs' performance in many ways. These issues are discussed further in Chapter 8 to help provide a depth of understanding of the factors affecting decentralisation implementation.

Chapter 8

8.0. The Challenges in Implementing Health Sector Decentralisation at District level: Discussion and Synthesis of Findings

8.1 Introduction

In Chapters 5, 6 and 7, the findings from documentary analysis, interviews and surveys were presented. The objectives of this chapter are: firstly, to discuss and synthesise these findings in light of this study's underlying propositions; secondly, to draw a linkage between the findings and the study propositions within the context of existing literature; and, thirdly, to draw out conclusions based on the discussion. The questions that the chapter examines are as follows: what do the findings tell us about the influence of staff capacity, leadership, staff commitment and communication in the implementation of decentralisation reform at the district level? And: do the empirical findings support the study's initial underlying propositions?

To facilitate the discussion, this chapter is divided into three broad sections. First, the discussion focuses on the study findings about the influence of staff capacity, leadership, commitment and communication upon the implementation of health sector reform. The next section discusses issues that emerged from the study, relating them to the existing literature and, the final section summarises the discussion and draws out conclusions from each of the variables.

8.2 Constraints on the implementation of health sector decentralisation at the district level

The constraints on implementation of health sector decentralisation at the district level, as found by this study, are summarised in Table 8.1. It indicates that three of the four propositions – capacity, commitment and communication – were generally supported by the evidence, while one – leadership – was not. Each of these factors and related propositions are discussed further in the sections that follow.

Table 8.1: Summarised key findings on the influence of staff capacity, leadership, staff commitment and communication upon health sector reform implementation

Agency characteristics	Findings from documentary analysis	Interview findings	Survey findings
Proposition 1: Effective implementation of health sector reform (decentralisation) at the district level will be associated with leadership.			
Lack of leadership	Leadership did not emerge in reports and documents reviewed as an important factor in health sector decentralisation implementation	Lack of leadership emerged as the least significant factor or challenge to reform implementation	No statistical evidence found of an association between leadership and implementation
Proposition 2: Effective implementation of health sector reform (decentralisation) at the district level will be associated with staff capacity.			
Lack of staff capacity	Lack of staff capacity in terms of numbers and skills was a constraint in reform implementation	Lack of capacity, both in terms of skills and number of staff, emerged as a constraint to reform implementation	Lack of staff showed evidence of association with implementation
Proposition 3: Effective implementation of health sector reform (decentralisation) at the district level will be associated with staff commitment.			
Lack of staff commitment	Lack of staff commitment was seen as an obstacle to health reform implementation The problem was related to other factors, e.g. poor working conditions and lack of motivation	1. There was evidence of a lack of staff commitment. This was perceived as a constraint upon effective reform implementation 2. Factors, e.g. working conditions, salary, personal career development etc.; affected commitment	Commitment was significantly associated with implementation, (p-value =.005) and 3.7 interviewees out of every 5 agreed that a lack of commitment was a challenge to reform implementation
Proposition 4: Effective implementation of health sector reform (decentralisation) at the district level will be associated with communication.			
Lack of communication	Qualitative documentary showed a lack of communication as a constraint in reform implementation It has affected MOH, GHS and civil service relations; it also affected district health management stakeholder relations at district level too.	1. Lack of communication was perceived as a constraint to effective implementation. 2. The study found that communication was weak, inadequate, not on time, with little or no feedback and follow-up 3. Mostly top-down and vertical 4. It affected relations, staff understanding of reform, staff/ stakeholders' level of trust, cooperation, ownership and commitment to reform	Lack of communication show evidence of association to reform implementation.

Source: summarised from interviews, survey and qualitative documentary analysis (2007).

8.3 Capacity constraints on decentralisation reform implementation

This study's first proposition was that effective implementation of health sector reform (decentralisation) at the district level would be associated with staff capacity. In this study, capacity is defined as the availability of a required number of staff with the appropriate skills to undertake a task and achieve goals set in a prior decision. The empirical findings provided broad support for the proposition that a lack of staff capacity is a constraint for implementing health reform at the district level (see sections 7.3.2 and Tables 7.4 and 7.12). The findings also suggested that a lack of capacity was manifested in terms of skills and numerical strength and at institutional level. The two are discussed in the sections that follow.

8.3.1 Lack of numerical strength of staff and skills in implementation

In the first place, the problem of a lack of staff with appropriate skills was reflected in the low quality of data collected. Collection and analysis of health data were supposed to be done at the district level but it was found that data collected often had to be sent to headquarters because staff lacked the technical skill needed to undertake the analysis at district level. Apart from that, the findings pointed to the shortage of staff at the district level as part of the problem. The problem of low numbers of staff varied across the case study districts. The problem was most serious in the Tamale district, where a higher number of district health staff expressed a stronger belief that the inadequate number of health workers was a major challenge for implementing health reform in their district (see Table 7.12). It also emerged that, even in areas where capacity existed, it was constrained by lack of incentive, obsolete equipment and lack of logistics. The problem encountered with the collection of health data for processing, especially at facility level was partly due to staff shortages, coupled with a general lack of interest in this new assignment because of the feeling that they would not derive any economic benefit from the exercise. Generally, health workers felt that health sector reform had brought about extra work without a corresponding incentive package; consequently they tended not to attach any seriousness to data collection assignments at the district level, and this attitude stalled reform implementation.

With regard to accountability, the findings further suggested that implementation also suffered because of a lack of staff with appropriate skills. The hope that decentralisation would improve accountability in financial and output terms was only partially fulfilled. Interview findings suggested that the establishment of Budget Management Centres (BMCs) was delayed because most districts lacked expenditure managers or spending

officers (qualified accounting staff), which was a precondition set by headquarters for granting certification to make BMCs operational. Special reference was made to the effect that the operation of BMCs in Tamale and Sekyere West districts were delayed because of a lack of staff, especially qualified accounting personnel, at the district level (see section 7.3.2 and Table 7.4). As some of the respondents observed (see Figure 7.1): 'the major problem was with the number of staff; the quantity of staff was just too low'. One cause of staff shortages at the district level was that (mostly qualified) staff refused postings to the remote districts because of a lack of basic social amenities and unattractive incentives there, and this situation was reported to be most serious in the Tamale case district. Furthermore, a lack of district health officials with the requisite skills also hampered the preparation of financial reports in accordance with required standards, resulting in poor quality reports and delays in their submission (see Tables 7.1 and 7.3). As discussed in Chapters 6 and 7, the challenge confronting decentralisation implementation was, to a large extent, more about the availability of required numbers of staff with the skills needed at a particular facility and within the district health service.

8.3.2 Institutional and managerial capacity issues in implementation

By virtue of their position, DHMTs were intended to play a supervisory role in managing the implementation of reform at the district level. The general belief, based on the findings, was that DHMT members lacked requisite management skills for implementing health reform. As the analysis showed (see Table 7.4), respondents from the Sekyere West and Dangme West districts expressed low confidence in the capacity of DHMT staff. Weak institutional and managerial capacity was reflected in: weak supervision and coordination, and an inability to manage the implementation of new information systems and respond to the needs of private sector providers and other stakeholders. DHMTs also had difficulty managing stakeholders' interests and failed to mobilise support for reform at the district level. Another manifestation of weak capacity was that DHMTs had difficulty in preparing and implementing output-based health plans and budget, which were needed to enhance the quality of service delivery at the district level. It was also realised that output accountability suffered because district health managers lacked the skills needed to develop programmes with specific output targets and monitor their implementation at facility level.

Decentralisation of health sector management aimed to open space for more stakeholders to participate in bottom-up health planning and management at district level. Bottom up planning has started in earnest in the three case districts. District health

managers have provided direction for the pursuit of this goal, but it appeared that bottom-up planning, budgeting and decision-making have not been effectively implemented. For example, the findings indicated that DHMTs were unable to enhance effective community and stakeholder participation at district level. It was found that a lack of institutional capacity needed to perform management functions was largely due to inadequate preparation given to DHMTs before they assumed responsibility of their new tasks. Because of this, DHMTs only possessed skills for routine administrative work and lacked the technical and managerial skills required for effective consultation and management of the implementation of decentralisation. This corresponds with Larbi (1998), Mills et al. (2001) and Smithson et al. (1997).

How can the finding regarding the effect of capacity on implementation be explained? In the first place, the restructuring of the health sector through decentralisation brought new roles and responsibilities. For decentralisation to be implemented effectively, a new crop of district health workers equipped with corresponding skills were required to assume responsibility for implementing reform. This was based on the belief that the new roles initiated by reform required particularly skilful agencies and staff (Jackson, 1999). However, the sequencing of health reform tended to focus more on officials at the central Ministry of Health, especially on building policy making capacity, new systems and structures for policy formulation. Implementation and its attendant challenges appeared to be taken for granted, especially at district level. Even though it was expected that health staff training and other capacity-related needs of the district health administration would be taken care of over time; this did not happen before the implementation of decentralisation commenced. In essence, there has been very little appreciation of the challenges that might confront the implementing agencies at the district level. Actually, the reformers underestimated the fact that decentralisation implementation requires more than the simple administrative, bureaucratic and closely-insulated hierarchical structure envisaged by Weber (Jackson, 1999).

In addition, the findings suggested that health sector reformers at the central level may have underestimated the administrative and managerial requirements for effective reform implementation. This was because of the erroneous assumption that the DHMTs have been in existence since 1978 and therefore were capable of managing decentralisation reform. But what was even poignant was the revelation that, where staff capacity-building programmes were initiated as part of the reform process, they were narrow and often over-concentrated on executive and senior staff training needs

(Agyepong, 1998). This made the reform focus too much on developing the capacity of staff at the centre and top hierarchy rather than on the needs of front line staff engaged directly in implementation at the district level. Therefore, health sector decentralisation started at a time when staff capacity was weak, especially for implementer agents at the district level. Apparently, the new roles and responsibilities further exposed the capacity weaknesses of DHMTs, particularly in terms of required skills and numbers of staff. Even though DHMTs have been in established since 1987, it became quite apparent that district health workers and managers were being asked to 'manage the unmanageable' (Collin, Green and Hunter, 1999).

The second and more important fact is that there were constraints to capacity even when it existed[67] It was found that, even when skills existed, they were constrained by a lack of equipment and logistical resources, poor communication, lack of feedback, weak supervision and coordination, poor working conditions, low salary, inter- and intra-organisational conflicts, weak institutions and old structures and staff behaviour at the district level (Chapters 5, 6 and section 7.4).

Of concern here was the finding from the documentary analysis in Chapters 5 and 6 that the circumstances within which public management reforms, especially health reforms, were introduced in Ghana compounded the implementation problems. Indeed, like other public management reforms, health sector reform was initiated following a deep economic crisis and in the context of already-declining public services coupled with a demoralised staff, low salaries and staff retrenchment. Indeed, the reform itself generated stress that weakened further the existing capacity (Batley, 2004). Thomas and Grindle (1990) stressed that implementation depends on competence and support within the implementing bureaucracy and that a lack of capacity within an organisation's administrative apparatus can lead to implementation failure, however inadvertent. Furthermore, if a reform does not require depth and continuity of administrative resources or highly technical skills; it is more likely to be implemented as planned (Grindle and Thomas, 1991).

The findings of the present study seemed to agree with this premise in the sense that decentralisation of health management depends on the availability of technically-skilled personnel and adequate financial and logistical resources. But, as the study revealed, district health management lacked staff capacity in terms of numbers and technical

[67] See McCourt and Bebbington, 2005.

skills so, in consequence, implementation stalled. This again underscored the works of Gow and Morss (1988 cited in Turner and Hulme, 1997); Bennett and Mills (1998) and Larbi (1998), who all found that institutional realities including a lack of staff capacity, access to resources by implementing agencies and provision of structures and processes that support information flow affect implementation – a point made earlier by Rondinelli and Cheema (1983).

Thirdly, issues of capacity conventionally tend to focus on staff skills and numerical strength, but the study findings suggested that capacity constraints were broader and extended beyond the organisational boundaries of the Ministry of Health and the district health system. This corresponds with earlier works by Larbi (1998); Mills et al. (2001); Bartley (2004); Bartley and Larbi (2004), who argue that the problem of capacity has a deeper root in the wider action environment. Capacity as a concept is ubiquitous and is difficult to define; it has several conceptualisations, connotations and operational definitions which, to a large extent, shape perception as to whether it enhances or constrains organisational performance and implementation[68]. Also, the context within which the concept of capacity is used may affect perceptions about its potential impacts on implementation (Hilderbrand, 2002). Given this study's operational definition of capacity as the lack of skills and number of staff at the district level and institutional weaknesses of the district health administration; it has been observed that the capacity problem at the district level is inextricably linked to inherent weaknesses in the MOH and to the larger Ghanaian public administration system.

Grindle (1996), Hilderbrand (2002) and Grindle and Hilderbrand (1994) argued that capacity refers to overall state capacity which entails technical, institutional and administrative, political and economic capacities; thus, the issue of staff administrative capacity is a part of state capacity. Jackson also noted in a 1999 article that organisations may have internal and external capacity; meaning that the issue of weak capacity is not limited to the health sector alone, but the problem is wider than anticipated and includes the entire public sector. Therefore, weak capacity of DHMTs as found by the study should be seen within a larger context of the problems confronting public service management in Ghana, as some respondents pointed out in Chapter 7.

[68] For different definitions of capacity see, for example, UNDP, 2003; World Bank, 1996; Bolger for CIDA, 2000; also see Wangwe and Rweyemamu, 2001; Cheema, 2003.

Thus, the study draws attention to the linkage between the district health capacity problem and the larger institutional, political and socio-economic condition of the country[69]. Jackson (1999), Grindle and Hilderbrand (1995), and Hilderbrand (2002) pointed out that external capacity is a determinant of internal organisational capacity because the former affects the ability of implementing agencies to use resources, and can compromise overall performance. This reinforces the argument in the African development management literature that capacity is tightly linked to the wider institutional, political, economic and societal context of the country (see Batley, 2004; Jackson, 1999; Brautigam, 1996; Walt, 1994; 1998). The latter view is similar to Francis Fukuyama (2004)'s position; he contends that there are no globally-valid rules for organisation design:

> Most good solutions to public administration problems, while having certain common features of institutional design, will not be clear-cut 'best practices' because they will have to incorporate a great deal of context-specific information' (Fukuyama, 2004: p.58).

The specific prevailing circumstances in a country, region or district – indeed the external environment as a whole – is a contributing factor to internal capacity problems, and may indirectly affect implementation. To sum up, lack of capacity emerged as one of the factors associated with decentralisation implementation as proposed in the working framework; but this was closely linked to the larger institutional environment of the health sector. Thus, apart from the continuing centralised bureaucratic context within which decentralisation was being implemented, the capacity of DHMTs was constrained by several factors including limited autonomy for decision-making (Jackson, 1999; Bartley, 2004), and the lack of human, logistical and financial resources needed to implement reform at the district level (Mills et al., 2004; Larbi, 1998).

8.4 Leadership and decentralisation implementation

The second fundamental underlying proposition of the study was that implementation of decentralisation will be associated with district health management leadership. That is, for decentralisation implementation to be effective, it needs good leadership. There is a vast body of literature which supports the assertion that strong or effective leadership is important both for an organisation's performance and for successful implementation[70]. For example, Mills et al. (2001) pointed out that Ghana illustrates the importance of

[69] For a discussion on the role and challenges of government capacity to support development in developing countries, see Skocpol and Finegold, 1982; Jackson, 1999; Brautingam, 1996 and Batley and Larbi 2004.
[70] For an insight into the role of leadership in implementation, see Metcalfe and Metcalfe, 2003; Schein, 1992; Viitala, 2004; Politis, 2001, Brunetto, 2000; Kiggundu, 1989; Bass, 1985; Bass and Avolio, 1994.

capacity within the MOH organisation, in the form of skills (management) and leadership; Mills et al. argued:

> Leadership is a critical factor in implementation, and decentralisation implementation is unlikely to be successful, even if managerial skills abound, if rules are changed, financial and logistical resources provided without committed and competent leadership (Mills et al., 2001).

This point was confirmed by Reilly (1990 cited in Koulipossa, 2004) who, in a study on decentralisation in Papua New Guinea, found the results of decentralisation at provincial level to have varied, depending largely on the leadership. According to him, 'where leadership has been strong and capable, programmes have improved, but where it was not good health services have actually deteriorated'. In a recent paper, McCourt and Bebbington (2005) emphasised that leadership is important for implementation success in Africa; and Leonard's (1991) earlier study on Kenyan rural development concluded that leadership played an important role in the relative success of organisations tasked with implementing rural development programmes in Kenya in the 1980s.

Contrary to the study's initial proposition, leadership turned to be the least significant of all the four agency characteristics examined. This finding was unexpected because interviewees' qualitative comments described leaders as being 'good' and 'strong' (see subsection 7.3.6). The empirical evidence did not, therefore, support the proposition that agency leadership is a challenge for decentralisation implementation at the district level. The study findings, therefore (in chapter 7), suggested that leadership has no direct linkage to health decentralisation implementation at the district level. Furthermore – and more importantly – the survey evidence also supported these interview findings; for example, in Table 7.9, most of the respondents disagreed with the assumption that a lack of leadership was a challenge to decentralisation implementation at the district level. Further documentary analysis in Chapters 5 and 6 did not show any association between leadership and decentralisation implementation at the district level either. Also, a qualitative content review and analysis of health reform policy documents and evaluation reports on national and annual district health sector performance reports do not include anything specifically on the influence of leadership in decentralisation reform implementation (see section 6.8 and Table 6.2). Thus, in light of the available empirical evidence, the findings suggested that leadership was insignificant in explaining decentralisation implementation at district level. In other words, there was not enough evidence from the qualitative and quantitative data to support the assumption that leadership was a constraint on decentralisation implementation.

While the working framework and the literature, argued, at least from an objective point of view, that leadership is especially important in implementation, the findings were at variance with the assumption. Therefore, the study findings were contrary to the assertion that leadership makes a difference and that implementation will suffer where it is lacking. Therefore, a lack of leadership is not perceived to be a challenge to health decentralisation at the district level. The stress on the importance of leadership which exists in organisational and implementation literature should be reviewed more critically in response to the present findings, since the findings seemed to suggest that a 'great man' theory of the influence of leadership on implementation would not be useful, in accordance with the study's findings.

8.5 Staff commitment to implementing decentralisation

The third proposition was that effective implementation of decentralisation would be associated levels of staff commitment to decentralisation reform[71]. In subsection 3.7.2, commitment was defined as a belief in one's organisation's goals and a desire to remain with the organisation. According to this definition, the study revealed that there was a lack of commitment among health staff, which has been a challenge for decentralisation implementation. Although a clear majority of respondents were in no doubt that the MOH was a good place to work (see Table 7.5), most were not prepared to remain with the service. The earlier discussion also indicated that this lack of staff commitment was associated to decentralisation implementation (shown in Table 7.9, statistical test in Table 7.11 a p value of .005; and Table 7.12). With a clear majority of health staff expressing reservations about remaining with the health service, it was clear that they were not committed, as reported in section 7.3.4 and Tables 7.7 and 7.8). This, therefore, was a challenge to effective reform implementation at the district level.

Viewed from a more theoretical perspective, the findings suggested a low level of normative and affective commitment because most of the staff showed very little sense of attachment to the health service. The respondents believed that most health staff do not feel obliged to remain with the health service; and are therefore ready to leave whenever they have the chance to do so (see Allen and Meyer, 1991; Meyer and Allen, 1997). Staff with more years of service have shown higher level of affective commitment and are still in post because they have personally decided to stay.

[71] In the scholarly literature, similar claims abound that, for implementation to be successful, it needs committed staff[71]. Some of the clearest evidence about the importance of commitment to organisation performance came from the works of Allen and Meyer, 1990; Meyer and Allen, 1997 cited in Swailes, 2004.

However, the study findings revealed that a majority of staff, especially young doctors, nurses and paramedic staff, were still with the public health service because they had found no better alternative to their present job. This suggested that there was a likelihood of low continuance commitment within the health service, as most personnel are waiting to find an alternative job, and the probability that they would leave the health service for something better was very high. This finding corresponds with Dovlo (2005) and Dovlo and Nyonator (1999).

Though the findings supported the initial assumption about the influence of staff commitment upon implementation, the following observations are important. First, that other factors or antecedents; i.e. internal and external circumstances, influenced the level of staff commitment. The analysis of findings (in subsections 6.9.5, 6.9.9 and 7.4, and Tables 6.2 and 7.9) suggested that, by and large, commitment was shaped by other prevailing working conditions both within the health sector and within the public service and also in the particular case study districts. Some examples of this were low salaries, poor working conditions, poor and obsolete equipment, lack of transport, and logistics and geographical location of the district.

As noted earlier in the Chapter 7 (see section 7.3.1 and Table 7.3), the level of health staff understanding about health reform goals also impacted upon their level of commitment and overall attitude to implementation management. This finding was consistent with Crosby's (1996) premise that what an organisation does and the outcome of its implementation is a product of the understanding and commitment of its staff; because, while a reform can be initiated, its implementation is neither simple nor quick.

Again, staff commitment was said to be affected by internal organisational circumstances, for example: delays in promotion, workers' uncertainty about their future, and lack of opportunity for individual professional development within the health service. Allied to this point (noted in Table 7.1), the low level of staff commitment was due to a lack of motivation and poor working conditions. This finding supported the works by Dovlo (2005); Dovlo and Nyonator (1999); Agyepong (1998); Agyepong et al. (2005); Mills et al. (2001). It also reinforced evidence in both the theoretical and empirical literature which suggested that prevailing conditions in an organisation affect staff commitment, and this, in turn, may have potential consequences for staff behaviour, for example, migration from the service, absenteeism,

or apathy towards organisational goals and job performance (see Katz and Khan, 1966; Meyer and Allen, 1991; Dovlo, 2005).

Related to this finding in respect of actions and behaviours was that poor working conditions and a lack of motivation, especially due to low salaries, have engendered adaptive, unethical and counterproductive behaviour among health workers. The theoretical literature suggested that the effect of different internal and external antecedents on staff commitment may have potential consequences for staff behaviour, for example: absenteeism, lateness, moonlighting, and apathy towards organisational goals and job performance (Meyer and Allen, 1991). Interestingly, this issue was mentioned repeatedly and strongly from the majority of respondents. Like other public sector employees, low salaries have caused health staff to resort to diverse forms of coping or what were called 'survival strategies' (see Table 7.7). These strategies ranged from undertaking salary-augmenting activities to pilfering drugs and medical supplies, deliberate lateness and absenteeism, diverting patients and prescriptions to private facilities in which officials held a personal interest, and engaging in corrupt practices. This finding was consistent with Meyer and Allen's (1990) proposition; that levels of worker commitment and behaviour are a function of other factors or antecedents, either within or outside the organisation.

Thirdly, other external factors which affected staff commitment were geographical location (e.g. rural or urban district), local politics, and the level of social and economic development of a district in question. Not only did the findings indicate that levels of staff commitment were affected by these factors, but it also added that the reason why young, qualified doctors, nurses and health mangers were often unwilling to accept postings to poor rural districts was because of some of these factors. This was typical of districts located in very poor, rural areas in the northern zone of the country.

It is probably useful to point out at this stage that two general issues emerged from the study about staff commitment and decentralisation reform implementation. The first was that staff commitment had proved to be a factor where there was evidence of an association with decentralisation implementation (see section 7.3.4 and Tables 7.7, 7.8, 7.13 and 7.15). The second issue was that there was a practical difficulty in isolating the direct effect of other (external) factors upon commitment and identifying how that influenced decentralisation implementation. Given this difficulty, it is difficult here to draw firm conclusions or make unqualified generalisations regarding the influence of

staff commitment upon implementation. The only conclusion that can be drawn is that the influence of staff commitment on decentralisation implementation at the district level was strong, but this was linked to other factors or antecedents, most of which were beyond the reach of the DHMT and the MOH.

8.6 Communication challenges in decentralisation implementation

The fourth proposition of the study was that effective implementation of decentralisation at the district level would be associated with communication of reform objectives to staff and stakeholders.

8.6.1 Communication of reform goals

According to the study findings, health sector decentralisation had been communicated by the central government Ministry of Health in a traditional 'top-down' style through the regions to the districts. Communication and consultation with staff and stakeholders about reform programme objectives at the district level was perceived to be minimal. This study's analysis of the findings indicated that information sharing at the district level was limited to the top hierarchy of the district health administration. Furthermore, the findings indicated that – with the exception of the Christian Health Association of Ghana – communities, private-for-profit service providers and local government officials had a limited understanding of health sector decentralisation and their respective roles in the process (section 7.3). In particular, district health staff at the facility level had only a superficial understanding of the objectives of health sector decentralisation.

The apparent shallow understanding of reform objectives among district health workers was attributed to the way the reform objectives were communicated to staff, but that was only one part of the problem. As noted, health workers received information on their existing jobs (section 7.3.1 and Table 7.3), but they were given very little or no information on their new roles and how job-related decisions and reform problems were being handled. District reform managers did not seem to appreciate the value of providing adequate information to front line health workers and, in consequence, they did not make a conscious effort to improve the communication system. In addition, staff did not make their voices heard, even when their work was being impeded by an inadequate flow of information from the 'top'. In fact, decentralisation was supposed to encourage worker participation in decision making but, as the study findings showed, most health workers in the three case districts had little or no information about reform objectives in terms of the aims of bottom-up planning, the role of District Health

Committees, the new system of accountability and information management, output accountability and financial audit, and the establishment of Budget Management Centres in their districts.

8.6.2 Channels of communication

Channels for communicating with staff and relevant stakeholders were regarded as weak (see subsections 7.3.7 to 7.3.7.6). Of course, the traditional channels for delivering information were the ones most used, but these were not always effective because they were not used to their full potential. Also, there was very little follow-up or feedback from the top to concerns from the bottom, and often information needed for work at district and facility level did not arrive on time. Health staff felt that it would be more helpful to receive feedback on information sent to their directors and senior staff. Stakeholders also complained that information being given to them was woefully inadequate. Therefore, both district health staff and stakeholders felt they needed more information than they had received on their new roles in the era of decentralisation.

What the findings seemed to further suggest was that general information on health decentralisation reform and programmes was not being consistently and effectively shared at the district level where the influence of the district health management team was expected to be strongest. Information from the top to bottom was inadequate but, in contrast and rather interestingly, the findings indicated that top managers had better and more effective communication and information sharing at their own level. In fact, it appeared that directors and senior health managers at the top of the district health administrative hierarchy shared information more effectively and regularly among themselves. There was freer flow of information at the top than to the bottom; but the consequence of this was low or no staff and stakeholder participation in the decision making process at the district level.

Weak communication and information sharing at the district level have implications for reform implementation in many ways. First, the findings revealed that weak communication impacted negatively on health data collection for decision making. For example, the quality of data collected was said to be poor because the process was uninformed, arbitrary and uncoordinated and therefore not always useful for health planning and decision making. Secondly, because information on output targets was either untimely or unclear, it was often difficult to conduct output audits to ensure performance accountability. Because of the weak and centralised mode of

communication and information sharing, health data collection and analysis were often delayed or sometimes not undertaken at all. Weak communication and consultation at the district level also meant that information being given to health staff, local government officials and stakeholders was either unclear or insufficient. In fact, not only was information unclear, but most stakeholders were under-informed because they received no or very little information from the district health management on district health programmes (see subsections 7.3.7.8 and 7.3.7.9). Consequently, most of them could make very little informed contribution to planning, budgeting or other health decisions at the district level.

On a more practical level, it could be argued that poor communication and weak channels for information sharing were partly responsible for some of the problems confronting implementation of decentralisation at the district level. For example, findings indicated that implementing accountability mechanisms had been constrained due to a lack of information or unclear information on output targets and procedures that officials were supposed to follow. A further analysis of the findings revealed a growing tendency towards centralisation and monopoly over information and decision making processes at the district level. Most health decisions were made by senior health officials and directors of the district health management. Because of this, many interviewees felt that consultation with staff and stakeholders was ineffective; and they also felt that the channel through which to make contributions to decision making at district level were inaccessible and ineffective. Overall, complaints were made that information sharing on decentralisation was managed within a centralised framework, instead of a decentralised one.

The DHMTs were not the direct cause of this 'centralised, top-down' style of communication, however (see subsection 6.8.1, 7.6.2 and 7.6.3), it is important to note some of the problems has a historical antecedent and is path dependent; and that the district health administration failed because it did very little to change the situation. DHMTs failed to initiate the action needed to provide more innovative mechanisms for communication and information sharing to staff and stakeholders. This point tally with McCourt's (2006) observation that, reform implementation problems should be viewed from the perspective of historical causation. One possible reason for their failure to devolve information might be due to the fact that health managers themselves were unaware of the expected changes that should be reflected in their management style as a result of decentralisation.

In fact, the tendency towards centralisation of information at the top of the DHMT hierarchy was a characteristic of the old administration system, which had been carried over to the reform era. This point corresponded to McCourt's (2005a) observation about the influence of history in initiating reform. This view was also captured aptly by one interviewee: 'They continued to do things the old way', despite a number of the members having been given training and therefore appearing attuned to the requirements of their new roles in the reform era (section 7.3.3). The paucity of information due to these centralising tendencies led to a growing dissatisfaction among stakeholders and health workers. This provided fertile ground for an avoidable suspicion that health directors and senior officials were prone to withholding or manipulating information, either about programmes of activities or over more substantive issues such as money and other material resources received from the centre. Local governments and private health providers and non-government organisations also complained about the lack of information on health programmes and reform goals and about how resources were being managed at the district level (as indicated in subsection 7.2.2).

The districts studied revealed the inadequacies of systems of communication and consultation at the district level. There was an insistence that information was inadequate (as noted in subsection 7.3.7.5) and, apart from that, information was often not delivered on time, there was very little or no follow-up, and staff were not given feedback on reports they sent to the top. Overall, it was indicated that this paucity of information and poor communication negatively affected decentralisation, because information needed by health officials for, e.g. data collection and enforcement of output accountability at district levels, was mostly unclear. In addition, accountability reporting procedures and health data collection activities were not regularised.

A number of implementation consequences arose from poor communication and ineffective information sharing at the district level. These are discussed in the section that follows. Firstly, weak communication and information sharing contributed to the limited understanding of reform and this constrained reform implementation because, instead of opening up to the challenges and opportunities brought about by the reform, health staff continued to hold onto the old value system and its style of service management in an era of change, but with a very high expectation that working

conditions would change without corresponding changes in productivity and work attitudes (see section 7.3 and Table 7.1).

Secondly, too much reliance on a traditionally centralised top-down style of information sharing created problems which constrained health reform implementation. Specifically, it caused delays in information provision and did not encourage timeliness, giving feedback or follow-up activities. Also, it did not offer policy implementers, front line staff and stakeholders the opportunity to learn from the reform processes. Other factors such as staff capacity and commitment suffered because the lack of communication created a fertile ground for distrust, lack of reform ownership, low morale, low staff commitment and intra- and inter-organisational conflict in district health management and stakeholder relations at the district level. Moreover, the paucity of information on decentralised health programmes and on the respective role of relevant stakeholders also caused apathy and uncooperative behaviour, especially from some local government officials towards district health issues. This situation often degenerated into inter-agency conflicts between local government officials and district health managements in its worst form and this, to some extent, constrained implementation. Furthermore, the lack of feedback from the DHMTs to stakeholders on district health planning and budget decisions, committee meetings and annual reviews of district health programmes, caused ill-feeling and distrust of private sector providers and some local government officials towards district health officials. This state of affairs undoubtedly stalled decentralisation implementation.

Thirdly, pluralism and participatory management of health services suffered because of the existing communication gap between district managers and relevant stakeholders. The 'Decentralised-centralised' style of communication in a traditional top-down style affected the mobilisation of support for reforms, resulting in low participation of private sector providers and communities[72]. Effectiveness of accountability also suffered in several ways: for instance, accountability became 'one-way-traffic', by which district reformers were formally accountable to both the region and to national headquarters but with very little or no feedback from the 'top' to the district. In consequence, the process of accountability had also become undertaken more at the central level (see Chapters 5, 6 and 7). In actual fact, stakeholders could not perform their partnering role in health decentralisation implementation; often their role (see Table 7.2) was limited to advising

[72] This point corresponds with Ackon, 1994; Larbi, 1998; Bossert and Beauvais, 2002;andMensah, 2002.

the district health management teams, because local government officials were not well-informed or educated about their new roles and responsibilities within the newly-decentralised health administration system. Thus, the level of participation that was envisaged for them under decentralisation was compromised. This observation corresponds with Mensah's (1997) findings on stakeholder participation in health planning at the district level.

To summarise, in this study communication proved to be one of the indicators of organisational characteristics in the working framework which showed evidence of an association with decentralisation implementation at district level. The study findings across the three case districts indicated that the lack of communication was a challenge to decentralisation implementation. Thus, lack of communication is especially important for explaining implementation of health decentralisation at district level.

8.7 Review and reflection on the findings

How can one explain these findings and what theoretical insight can be gained in light of the framework for analysis? The first point is that the framework used is principally analytic. It is an attempt to map out critical factors that influence the implementation decentralisation reform programme. Also, the findings have validated the predictive strength of the conceptual framework by demonstrating that staff capacity, staff commitment and communication are associated with effective implementation. Based on the evidence from the district health sector and decentralisation implementation case study, the study has identified and confirmed that a lack of staff capacity, lack of staff commitment and lack of communication are constraints to effective implementation and should be incorporated into a general theory of 'effective implementation', especially in developing country contexts and health reforms at the district level.

The second observation based on the study findings was the confirmation that policy formulation and implementation management issues are inextricably linked. It noted that analysis of implementation problems should therefore incorporate policy design factors as well. Furthermore, although the study's focus was on the influence of agency characteristics upon implementation, which seemed to offer a good starting point, the findings revealed that other factors in the 'far and near environment' played an equally important role in implementation and should be considered in any conceptual framework for understanding implementation challenges in developing countries (see Grindle, 1980; Grindle and Thomas, 1990; Ayee, 1994; Bossert, 1998; Larbi, 1998).

More specifically, the study findings have drawn attention to the value of combining top-down and bottom-up perspectives in the analysis of implementation problems. It showed that problems at the central Ministry of Health affected the ability of district health managements to effectively implement reform. The study therefore has drawn attention to the heuristic value of an implementation theoretical model that advocates the need for a holistic approach to analyses of factors that affect implementation; that is, an interactive political economy approach espoused by Grindle and Thomas (1990 and 1991).

Central to the interactive model was the belief that policy reform initiatives could be altered or reversed at any stage in their life cycle by the pressure and reaction from both internal and external forces that may oppose it. Contrary to the traditional linear model, the interactive model views policy reform as a process in which interested actors can exert pressure for change at many points. Whereas some actors are more effective at influencing the reformers at high levels, others are interested in affecting managers of the implementation process or those who allocate resources needed for implementation at district or lower levels (Grindle and Thomas, 1991). In connection with this, the design and implementation of reform tended to depend on the location, strength, and stakeholders involved in any of these attempts to influence the policy process. With reference to health sector reform, the influence of donors, politicians, health professionals, private providers, and non-government organisations have played into the reform process and the ensuing interactions shaped and influenced the process of implementation.

Thirdly, the study has drawn attention to the fact that the theoretical postulations of NPM are directed towards the redesign of public health management through a reconciliation of 'centralisation and decentralisation' of managerial authority. Theoretically, by focusing on the district level, the study revisited a problem that had long been the focus in academic research on policy implementation. That is: what situations would bring about an effective implementation or optimum implementation outcome in which policy makers at the centre can control local level implementers so as to ensure that the desired objectives of a policy reform are realised but not so much that implementers at the lower level would revolt and resist the policy? As noted in Chapter 3, the search for an answer to this question was the concern of 'top-down' and 'bottom-up' perspectives on implementation. Whereas top-down proponents asserted that the goal of policy implementation should remain faithful to the original policy objectives

(Pressman and Wildavsky, 1984), bottom-uppers were more sanguine about the value of the ways in which local-level implementers influenced policy to suit their particular situation (Elmore, 1980; Mclaughlin, 1987). But, as the findings of the study illustrated, a synthesis of the values of 'centralisation and decentralisation' seemed a more plausible answer to the question that both top-down and bottom-up schools of thought sought to address.

This point is rather quite interesting because essentially, as part of any reform on decentralisation, it is also important to clarify the degree of centralisation that would be required; because both these processes work together and so it is not possible to discuss decentralisation alone. Similarly, issues of policy formulation are important and should also be factored into any discussion on policy implementation because the politics of policy making affect policy implementation. In other words, the study's findings revealed that 'top-down' and 'bottom-up' approaches; politicians and administrators or policy making and implementation issues, are just two sides of the same coin and should be treated as such. Possibly, it was because of this that Cohen and Peterson (1995) accused both proponents and opponents of decentralisation of suffering from what they called 'decentralisation naïveté' and 'negative social science'. They asserted that proponents overemphasised the positive side of decentralisation without tempering their arguments with real-world lessons of experience, while the opponents concentrated solely on the failures of decentralisation without appreciating the good things that it can offer. Clearly, both arguments were open to question; but one lesson stood out from the study – that, for the past four decades, centralised administration of public services alone has not sufficiently brought about efficient, effective, equitable and sustainable development. The same was true for decentralised management of services which, on their own, had failed to achieve their policy, management and development objectives.

Wunsch and Olowu (1991) recognised this fact, noting that: 'Central leadership and resources are important to effective devolution or delegation of public sector responsibility if material and social improvement are to be promoted and political integration attained'. Joel Samoff (1990) also made the same point abundantly clear when he stated: 'There is no absolute value in either central direction or local autonomy. Both are important... at different moments. Both must coexist'. Saito (2003), in a recent study on the Ugandan experience, reminded both critics and supporters of decentralisation that the rationales were the same and meant the same thing, just being

phrased differently. Both views – top-down versus bottom-up, or centralisation versus decentralisation – have a certain validity which cannot be ignored.

It was against the background of these opposing debates that Sabatier (1986) admonished analysts that the top-down approach was useful where there was a dominant piece of legislation structuring the implementation situation and the analysts in such a situation was able to have a clearer view of the policy domain. It was also useful where a researcher wanted to do a quick assessment of responses to the policy. The bottom-up approach was useful in situations where there was no dominant piece of legislation, but rather large numbers of actors, and it was also useful when a researcher was primarily interested in the dynamics of different local situations, as in the case of health decentralisation at the district level.

During the literature review on implementation in Chapter 3 it was asserted that there was a naïve assumption that policy making and implementation were two separate spheres of activity; and that, once policies are made, implementation would be smooth. Theoretically, the findings corroborated the viewpoint that policy making and implementation were intertwined; and that problems at the central level affected implementation at district or lower levels. In other words, the findings indicated that implementation was not easy or straightforward and cannot be simplified as a technical and managerial exercise involving calculated choices, as suggested by earlier researchers (Grindle, 1980; Smith, 1997; Ayee, 1994). Grindle and Thomas (1991) pointed out that implementation was frequently a highly political process, as it was one area of the policy process where conflicting interests met, either to negotiate, build coalitions, negotiate over goals of the policy, or argue about the authoritative allocation of resources. Grindle (1980) referred to this as the 'politics of implementation'; arguing that, particularly in developing countries, policy implementation was more politicised than policy making because of the greater desire of various interests to influence its outcome since implementation outcomes would affect them vitally.

This point was presaged in the work of Pressman and Wildavsky (1973), and has been strongly reinforced by implementation studies in developing countries and Africa since then (see Rondinelli, 1983; Gow and Morss, 1988 cited in Turner and Hulme, 1997; Ayee, 1994; Akpan, 1990; Larbi, 1998; Turner and Hulme, 1997; Grindle, 1997;

Crosby, 1996; Stevens and Teggemann, 2004; McCourt and Bebbington, 2005). Although this study did not set out specifically to examine the politics of implementation of health decentralisation, the findings showed that the implementation of health sector reform cannot be seen as a managerial exercise devoid of political cause and consequence (Mills, 1990; Smith, 1999). It came to light that the influence of various interests and stakeholders at the district level generated some level of politics and its attendant inter-agency conflict; in these processes the intensity of the policy and how it was managed by the district health managers influenced decentralisation implementation.

The study has therefore contributed to the implementation literature through a case study of district health management teams, by illustrating that implementing health decentralisation is a political process, like any other public policy or programme it requires political support if it is to succeed. In addition, the study corresponds to Saito's (2003) point that results of decentralisation often needed to be negotiated and bargained to decide how political power and material benefits should be shared and contested, and these political engagements and contestations affect implementation. Thus, whether health decentralisation is driven by administrative motives or not, it is implicitly a political process requiring a shift in the contours of power and resource control (see Balogun, 2003; Ayee, 2000; Bossert, 1998; Acheampong, 1995; Mills, 1990; Mills et al., 2001)[73] As Smith (1999) argued, the most serious mistake any reformer can make – especially in developing African countries – is to assume that decentralisation is a managerial exercise devoid of political cause and consequence Therefore, mapping and managing the politics of implementation becomes a key to successful decentralisation at the district level.

Another theoretical achievement of the study is that it corroborated the assertion that the complexity of joint action affects implementation (Pressman and Wildavsky, 1973). The complexity of joint action is based on the assumption that the number of actors and veto-points involved in a policy affects implementation because of the complexity of actions and numerous clearance points needed for a decision to be taken at any point in time. A similar assertion was made by Thomas and Grindle (1990), Brinkerhoff (1996) and Corsby (1996), who found that the fewer the number of actors or organisations

[73] For example, the World Bank noted that successful implementation depends primarily on a country's institutional and political characteristics (World Bank, 1998 cited by McCourt and Bebbington, 2005: p.14). Also see Leftwich, 2004; Saito, 2003; Wunsch, 2001; Ayee, 1994; Acheampong, 1995; Wunsch and Olowu, 1990,

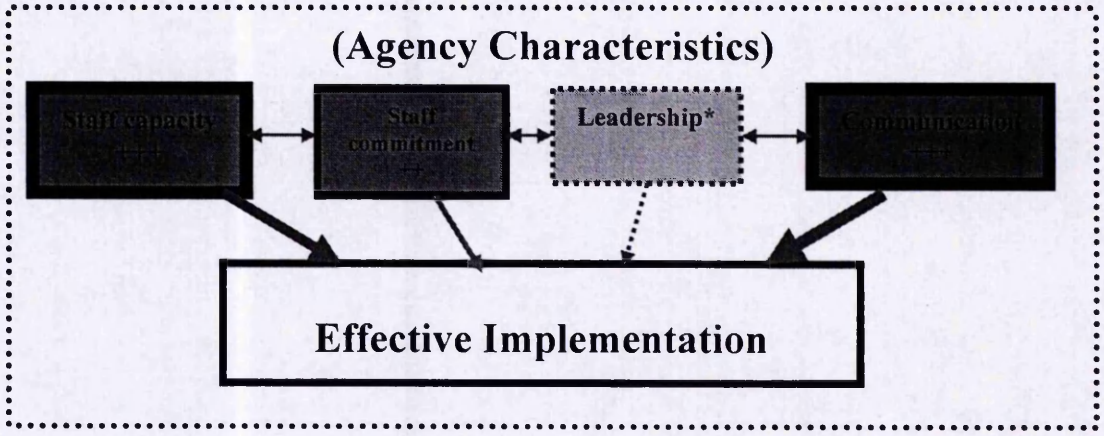
participating in implementation, the higher the chance that reform will be carried out successfully. Health sector decentralisation is a multi-actor reform programme involving several actors, and the study's findings (see sections 6.8.11 and 7.3.7.7) showed how the reaction of various stakeholders (e.g. local government, private sector providers, central agencies, donors and communities) to the reform made implementation complex and difficult for district health managers.

8.8 Putting the empirical findings in perspective

Figure 8.1summarises the issues that emerged from the study in the light of the underlying propositions of the working framework on agency characteristics and decentralisation implementation. The underlying assumption of the working framework for analysis was that lack of staff capacity, commitment, and leadership and communication constrained implementation. Out of the four elements examined, a lack of staff capacity and communication provided the most empirical evidence to support the underlying assumption of the working framework. Issues of staff commitment also supported the assumption, but this was difficult to quantify because commitment is influenced by other factors. The empirical evidence did not support the assumption that a lack of leadership is a constraint to decentralisation implementation.

In addition, the empirical evidence indicated that the four factors were interrelated and affected each other. For instance, it was observed that staff capacity and communication may influence the level of commitment and leadership performance. In a similar vein, the type of leadership might have implications for the effectiveness of communication, channels of communication and the quality of information that were given to staff and stakeholders. This revelation suggested that, even if the four elements were isolated for investigation, it would be important at some point to consider what the effect of one would be on the other and what the combined effect of all four on effective implementation would be. However, that task is beyond the scope of the present study.

Figure 8.1: Agency characteristics that have an influence upon effective implementation



+++ = very significant influence on implementation
++ = significant influence on implementation but dependent on other factors
* = no evidence of influence on implementation

Source: Prepared by author (2007)

8.9 Summary and reflection on the conceptual framework

Health sector reform is confronted with the same implementation challenges that many public sector reforms in developing countries are experiencing. Health sector decentralisation was intended to improve planning, decision making, information flow and accountability of health managers to service users. Previous studies have demonstrated the obstacles that implementers had to confront in implementing reforms (Larbi, 1998; Annan, 1998; Smithson et al., 1997; Wiskow, 1999). This research contributes to the understanding of some of these obstacles, by exploring the effect of implementing agency characteristics on implementation. More specifically, in this study, the influence of a lack of staff capacity, lack of leadership, lack of staff commitment and lack of communication upon implementation of decentralisation at the district level were all explored. It was initially expected that all four characteristics of DHMTs would show evidence of an association with decentralisation implementation.

However, of the four elements, communication and staff capacity emerged as the two elements of organisation characteristics which showed most evidence of association with decentralisation implementation at the district level. This suggested that lack of communication and lack of staff capacity are associated with implementation. The conclusion that can be drawn from the experience of the Sekyere West, Dangme West and Tamale district health management teams is that a lack of staff capacity and lack of communication are constraints to the effective implementation of decentralisation. Though the implementation of decentralisation objectives have made some progress at

the district level, the lack of staff capacity and communication have both largely affected the effective implementation of accountability requirements, regular collection of quality data and dissemination of information for decision making and effective participation of communities and stakeholders in health planning, budgeting and decision-making at the district level. In accordance with the study findings, the lack of communication created distrust, conflict, apathy, and a lack of cooperation between DHMTs and staff and stakeholders, and this tended to negatively affect implementation. Participation can only be effective when adequate information is available to people.

Similarly, stakeholders can only make informed choices and contributions to district health planning when they have access to information; but this was lacking at the district level. Staff can only give an account of their stewardship of health programmes where there is clear information on outputs, resources and the specific targets and the structural mechanism for ensuring accountability. The collection of and analysis of adequate health data will depend on available information on the exact type of data to be collected; and whether staff have the skills needed to analyse the data. Also, health officials can only be held accountable where there output accountability targets and mechanisms for measuring accountability exist. So far, the discussion has demonstrated how difficult it was to get the information needed for work and decision-making at district level. There was evidence of a paucity of information because of weak and ineffective channels of communicating. The centralised and top-down piecemeal style of information sharing stifled feedback, follow-up and timing of information dissemination at the district level.

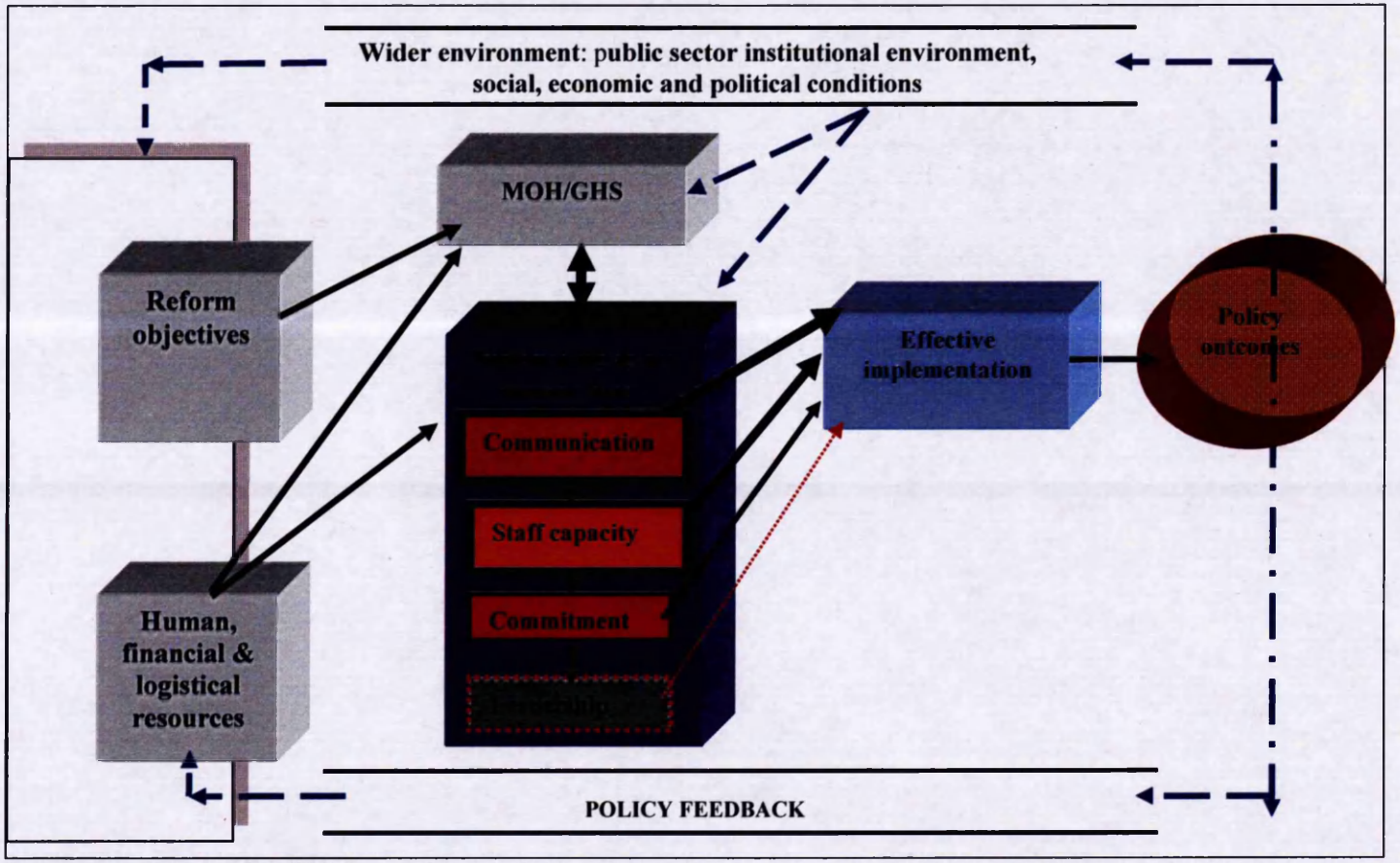
There was also considerable evidence that commitment was associated with decentralisation, but no firm conclusion could be made on this because it emerged that commitment was also influenced by other factors within the health sector and those outside. In line with Meyers and Allen's (1990) theory, the study showed that commitment might be affected by different antecedents which have potentially different consequences regarding issues concerning absenteeism, apathy towards organisational goals and job performance. As noted above, poor working conditions, low salaries and lack of incentives in the health sector were partially responsible for staff taking up salary-augmenting activities, absenteeism and several unethical and unprofessional behaviours, all of which affected reform implementation. Leadership showed no evidence of association with decentralisation implementation and therefore had no significant influence upon reform implementation.

8.10 Operational model for analysing the challenges to implementation of health sector reform

Allied to the summary in Figure 8.1, it is argued that the overall findings of this study reveal that the issues of capacity, communication and commitment comprise challenges in implementing health sector reform and decentralisation. This means that reformers have to take steps to build capacity, improve communication and information sharing and provide a working environment within the health service that would increase the level of staff commitment. The study findings suggest that implementation issues must be factored into the reform agenda right from the formulation stage, to ensure that the basic administrative preconditions for implementation are in place before launching a reform. The next finding pertains to the role of leadership in implementation, where the results indicated that respondents were unclear or uncertain about the influence of leadership on health sector reform implementation management.

Finally, the findings showed that the action environment of the implementing agency influenced the elements and, in the process, influenced implementation. Taken together, this finding can be encapsulated as a model for understanding and analysing implementation challenges as presented below in Figure 8.2. In short, lack of capacity, committed staff and communication emerged as factors within the district health management team that were constraints for the implementation of health decentralisation. Having discussed the major findings of the study and situated them within the context of the working framework, the next chapter continues from there to draw out the final conclusions.

Figure 8.2: Model for analysing challenges in decentralisation implementation at the district level



Source: prepared by author (2007).

Chapter 9

9.0 Challenges in Implementing Health Sector Reform in Ghana: Summary and Conclusions from the Study of DHMTs and Decentralisation at District level

9.1 Introduction

The principal aim of this study was to find out whether any relationship could be discerned between the characteristics of district health management teams and implementation of health system decentralisation. This logically raised a larger question: how can we explain the influence of implementing agency characteristics upon health sector reform implementation at the district level? Agency characteristics comprise of several factors, but particular focus was on:

1) staff capacity;
2) agency leadership;
3) staff commitment; and
4) communication issues.

The search for answers to the main research question was pursued through two specific questions:

1) How have issues of staff capacity; leadership; staff commitment and communication influenced the effective implementation of health sector reform at the district level?
2) What lessons can be learned from the study findings and what are the implications for health reform implementation at the district level and implementation research and public management reform in general?

This chapter summarises the key findings of the study and draws out conclusions. To facilitate the discussion, the chapter is divided into three main sections. The first section revisits the propositions in light of the study findings, to serve as a summary of the overall findings. The second section discusses the implications of the study findings for theory, policy and future research, and the third section was devoted to the concluding remarks.

9. 2 Summary of key findings and conclusions

9.2.1 Lack of staff capacity in implementation of decentralisation

The study investigated the influence of lack of capacity on implementation. In Chapter 3, capacity was defined both in terms of staff skills and numerical strength. In Chapters 6 and 7 the empirical findings provided broad support for the proposition that a lack of staff capacity is a constraint to effective implementation of health reform at the district level. The analysis further revealed that lack of capacity was most often manifested, both at individual facility and institutional levels. Also, both documentary analysis and statistical results revealed that the problem differed from one district to the other, and that it was perceived to be more serious in the Tamale case district. At the institutional level, a paucity of skills was associated with staff shortages and managerial inefficiencies involving health managers directly involved in managing the district health system. The three case study DHMTs were perceived to have particular managerial and technical problems, including management of new information and accountability systems and management of new stakeholders and communication and programme supervision.

The study draws three conclusions from the empirical evidence on the issue of staff capacity and reform implementation. Firstly, a lack of skills and inadequate number of staff is perceived as a challenge to the implementation of health sector reform and decentralisation at district level. The problem of paucity of capacity at the district level is perceived to be more serious in terms of numerical strength than skills *per se.*

Secondly, while attempts have been made to improve capacity at the centre, very little attention was given to the capacity challenge at the district level at the start of the health sector reform and often such attempts were relatively ineffective at the district level. Also, the lack of capacity has a linkage to other endogenous and exogenous factors prevailing within the health sector and in the specific districts.

Thirdly, the issue of capacity is very broad and therefore complex and, even when it existed, capacity was often constrained. Capacity is context-bound and thus its influence on implementation depended on other factors (e.g. political, economic, institutional, social and behavioural) within the country, the health sector and the specific district. Recognising the complexity of the issue of capacity is therefore important in examining its influence upon implementation, as was the case in the present study which focused solely on skills and staff numbers. To conclude, a lack of staff capacity showed

evidence of an association with health reform implementation, and was perceived as a constraint to the effective implementation of decentralisation at district level.

9.2.2 Lack of leadership in implementation of decentralisation

The second issue examined in the study was the influence of a lack of leadership upon implementation of health reform and decentralisation at district level. The findings did not support the study's proposition, but indicated that leadership had no influence upon health decentralisation at the district. Thus, leadership was not considered to be a constraint to health sector reform implementation.

9.2.3 Lack of committed staff in implementation of decentralisation

The third issue investigated was the influence of lack of staff commitment to health decentralisation at the district level. The findings supported the study proposition, revealing that a lack of commitment among health staff is a challenge in decentralisation implementation. However, the study found further that the influence of staff commitment upon decentralisation implementation is shaped, to a large extent, by other factors; especially prevailing working conditions within the health sector and within the particular district. For instance, low salaries, poor working conditions, obsolete equipment and lack of logistical support; cumbersome personnel administration procedures and lack of opportunity for individual professional development, among other things, affected levels of staff commitment and this had implications for reform implementation.

9.2.4. Lack of communication in implementation of decentralisation

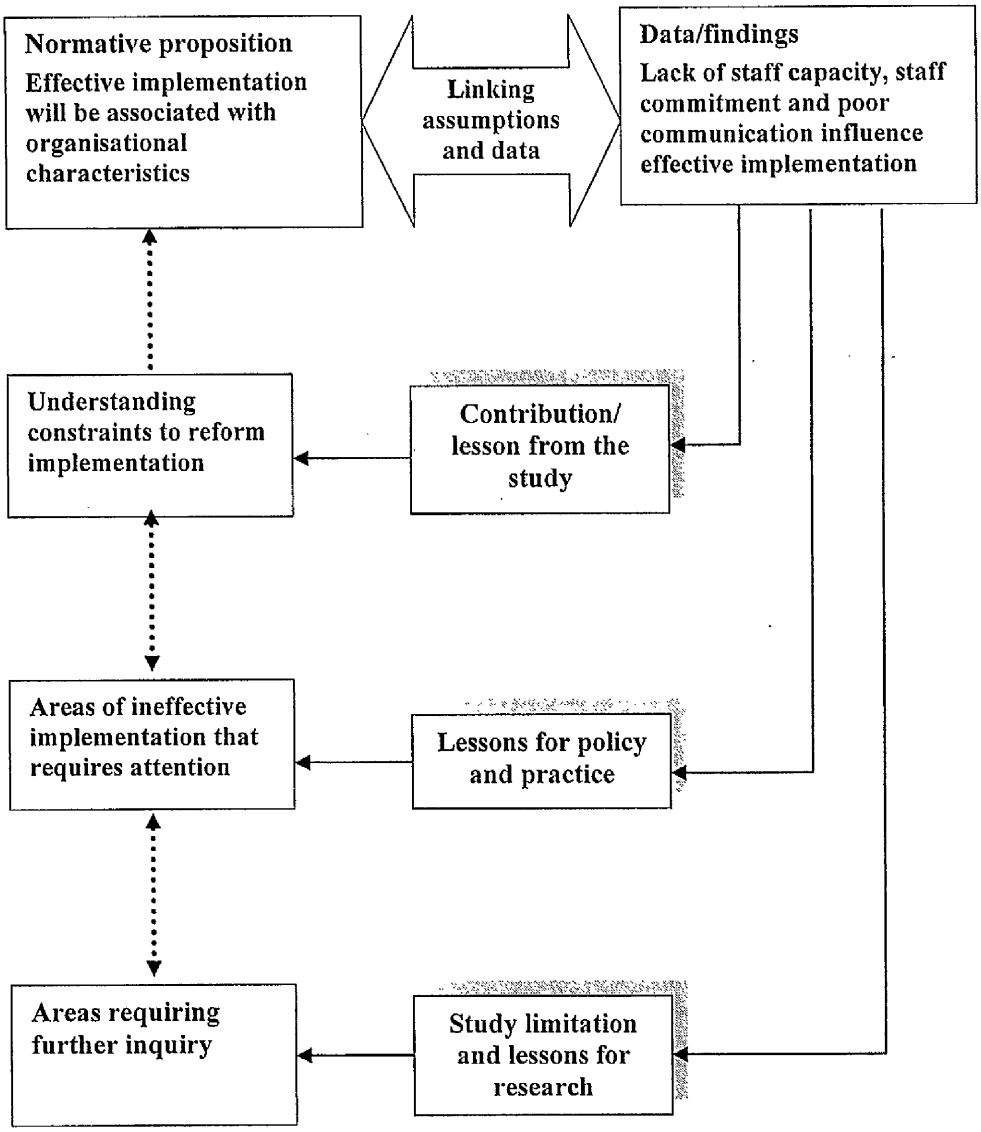
The fourth issue investigated in the study was the influence of a lack of communication upon implementation at district level. The findings supported the study's proposition, indicating that decentralisation reform has been communicated as a high national development policy priority from officials at headquarters to the district level. Yet, at district level, communication of the programmatic objectives of the reform for decentralisation was perceived to be ineffective, and information sharing with staff and stakeholders in particular was inadequate and irregular. While information sharing was frequent and effective at the top of the district health hierarchy, information being given to health personnel and stakeholders was believed to be inadequate. This affected levels of staff and stakeholder participation in district health planning. The centralised, vertical and top-down approach to information sharing made the timeliness of information, the provision of feedback to front line workers and stakeholders and follow-up activities impracticable.

The conclusions drawn from the findings are as follows: firstly, the lack of understanding of reform objectives among health staff was partially due to poor communication at the district level. Secondly, weak internal and horizontal communication, especially with local governments, private sector and relevant stakeholders was a challenge to implementation. A perceived lack of communication at the district level caused a dearth of information on new roles, functions and responsibilities at the district level, which constrained effective implementation. Thirdly, weak communication and lack of information sharing created distrust, suspicion, apathy and uncooperative behaviour, both amongst health staff and the relevant stakeholders involved in implementing decentralisation. This situation affected staff willingness to participate and to provide support for reform implementation. What are the implications of the findings and conclusions for theory, policy and research? These questions will be addressed in the sections that follow.

9.3 Lessons for policy implementation and research

The study findings and conclusions have offered important lessons for policy implementation and research; these are summarised in Figure 9.1 and discussed in the following sections.

Figure 9.1: The linkage between theoretical assumptions and empirical data



9.3.1 Contribution and lessons drawn from the study

Reform of public services in terms of structure, function and management is a common feature and ongoing process of government in both developed and developing countries. In this study, I have examined one example of such a reform programme, that is, decentralisation of health services in Ghana. Through the study, I have generated an operational framework for understanding how organisational characteristics influence reform implementation. In particular, I have attempted to show the extent to which lack of staff capacity, lack of committed staff and lack of communication and leadership act as constraints to reform implementation at the district level. By analysing these factors, I was able to map out conceptually the internal contextual factors which influence an implementing agency's ability to effectively manage the process of reform implementation. The study shows that implementing agencies and their staff play a crucial role in reform implementation – their characteristics, especially staff capacity, staff commitment and communication, deserve more systematic analytic attention than they have been given to date in implementation research, and Ghana in particular.

By focusing on the district health administration as well, the study has provided an understanding of the ways in which organisational characteristics affect health sector reform implementation rather than what is encountered or known in many studies on health reform in Ghana. The analysis of decentralisation implementation at the district level has therefore allowed this study to go a step beyond theoretical approaches which view district health management and personnel as mere tools or cogs in the wheels of the larger Ghanaian public management reform, which they have no means to influence. The study provides evidence which supports the view that implementation is primarily influenced by internal and external factors. In the specific case of decentralisation at the district level, the study pointed out that improvement in:

1) staff capacity through training, incentives and motivation;
2) freer flow of information through modernisation of communication systems; and
3) valuing people rather than structures would enhance the chance for effective implementation. This is a central lesson to be drawn from the experience of DHMTs, decentralisation and public management reform in Ghana in general.

9.3.2 Lessons for implementation management

From the public management perspective, health sector reformers in the three case study districts' DHMTs may take heed of and reflect upon the model in Figure 8.2, which summarised this study's findings, in order to appreciate the lessons for their work. Issues of a lack of capacity, committed staff and communication are evident in this study and should be taken very seriously.

Capacity issues in policy implementation

Lack of capacity emerged in this study as one of the challenges to health reform implementation and respondents identified a lack of skills and low staff numbers at the facility level as obstacles to implementation. This finding is characteristic of most contemporary studies on implementation problems associated with decentralisation in developing countries (Larbi 1998; Ayee, 1994; 2000; Rondinelli, 1983; Mills et al., 1990). Ideally, like any public bureaucracy, the district health system is intended to be an efficient instrument of policy implementation. However, evidence from the present study on the implementation of health decentralisation has been disappointing; and the main explanation for this has been weak capacity of the district health administrative staff. In order to tackle this problem, government needs to initiate programmes to build staff capacity at the district level. It is suggested that special training programmes should be designed for all decentralised health system managers, district health coordinators and support staff. Such training programmes should focus on assisting staff to understand the aims of decentralisation, roles of district health staff, sub-district health workers, stakeholders and communities in achieving those aims.

As indicated in Chapters 6, 7 and 8 above, DHMTs are not only weak in term of skills, but most of their staff have only a limited understanding of the objectives for decentralisation, and lack knowledge and the skills required for successfully undertaking new management roles. One way to address this is by introducing a special 'new management' skills training programme, including unambiguous descriptions and explanations of health reform objectives and operational activities for all staff, private sector providers, stakeholders and communities. Such training programmes should also provide a knowledge of new public management approaches to health sector management, conflict resolution, management of stakeholder interests, contract management, ability to communicate with staff, health professional associations and target health providers and consumers. In particular, it would be advisable to develop a

formal training programme for district health managers and support staff which would, over time, include skills assessment and evaluation packages that would take into account the management of integrated decentralised health systems.

Ghana, like other developing countries, has introduced a considerable amount of training programmes aimed at building staff capacity. The issue to address is not so much about training or recruiting a large cadre of health workers, but more in the mix of skills and competencies and how these are distributed and targeted to ensure attainment of health reform goals at all levels (Dovlo, 2005). For example, it is a well-known fact in Ghana that health personnel are mostly concentrated in the national capital Accra, the south and in urban centres in general (MOH, 2006; Canagarajah and Xiao, 2001). Perhaps a policy of staff rationalisation might be an option to be considered in order to make it easier for government to improve the salaries of those who remain with the service and to offer more attractive incentive packages to newly-trained doctors, nurses and health personnel who are prepared to work in poorer rural district health sectors.

The role of the 'human factor', i.e. the health workers, in implementation became apparent during the study, because health service management is a labour-intensive activity. But government appreciation of the critical importance of health workers was often more rhetorical than observed in Ghana; probably because of the country's poor economic situation (Jackson, 1999). Yet, improving the performance of district health workers is crucial to the success of the ongoing health sector reform and decentralisation. There is no doubt that improving district health staff performance through capacity-building should be taken very seriously and should not be treated as one-time administrative reform task. However, as Chapter 8 pointed out, while the building of capacity to perform is important, capacity can be constrained even when it exists, largely because of other factors, such as a lack of logistical support and poor working conditions in the service.

It was shown in Chapters 5 and 6 that health workers' performance has been influenced by a number of factors, especially following the economic crisis and the subsequent introduction of the World Bank-funded structural adjustment and economic recovery programmes in the 1980s and 1990s. Consequently, health workers in Ghana (as in other heavily indebted poor countries), experienced a catastrophic fall in their wages (Agyepong, 1998; Ayee, 1992), while a substantial number of health workers were forcefully retrenched and others migrated from the service. This resulted in widespread

demotivation, demoralisation and cynicism among health workers and made them resort to salary-augmenting activities as a means of survival. Deteriorating working conditions and lack of incentives also resulted in a decline in professional ethics and a resort to unethical and corrupt practices because of economic necessity. The level of affective and normative commitment among staff suffered in the process, leading to loss of staff through migration to other African countries and industrialised countries, where working conditions and salaries are far better (Dovlo, 2005).

Improvements in health workers' working conditions and salaries should be one of the main policy options for government to seriously consider if health reform implementation is to succeed. But improving conditions in the health sector cannot be tackled through salary increases alone; that is, it should not be based on transacted interchange only. Indeed, increasing salaries and material rewards are a good starting point but, in themselves, an insufficient condition. This suggestion is based on the study findings which showed that the problem of unattractive work conditions, demoralisation, lack of commitment and negative attitude to work are far more complex than just monetary rewards. This therefore means that the problem requires a comprehensive and multidimensional human and financial reform package involving a special programme of both incentives and punishments.

Government should assist the central Ministry of Health to initiate a sort of 'Marshal-plan' recovery programme aimed at rehabilitating health workers. As the respondents suggested during the study, that should include at least the:

1) supply of essential equipment and consumables for health work;
2) introduction of an incentive reward structure, offering both professional and financial rewards for good performance;
3) opportunity for individual career development through training and promotions;
4) supply of means of transportation to workers;
5) provision of housing for staff;
6) introduction of special allowances, e.g. responsibility allowance, deprived area allowance, risk/inconvenience and additional duty allowances;
7) establishment of regular quality improvement programmes and regular support from supervisors at regional and national headquarters; and
8) decentralisation of health service management is made truly participatory.

As the study revealed, low salary and motivation is a problem for the health sector. In order to address the problem, government should support the Ministry of Health to implement its new salary reform which seeks to acknowledge the contributions that different health workers make to health service delivery (MOH, 2006). But, as this study indicated, such reforms should avoid falling into the trap of limiting staff welfare to transacted exchanges, because this may create other serious problems for government, the health sector and public sector in general. Also, the study noted that the capacity problem extends to private health providers and other allied stakeholders. Thus, capacity-building interventions should look beyond health workers, to include private sector providers, communities and other health sector stakeholders. As the findings suggested and as some respondents emphasised, reform implementation suffered partly because private sector providers, communities, local governments and stakeholders lack the skills needed to contribute to bottom-up planning, budgeting and other elements for transferring decision-making authority to the district level. As interviewees noted, capacity-building programmes should be broadened to include district assemblies, private-for-profit and private-not-for profit providers, and all major organisations engaged in health service delivery at the district level.

Allied to this and based on the findings, it is further suggested that public service organisations, which are made up of several levels of administrative hierarchy (e.g. regional, district, sub-district, community) and which have a top-down formulation of public sector reforms, should be mindful of the processes that need to be put in place to promote implementation at the district and sub-district level. This process should be designed to facilitate, among other things, the adoption of new roles and responsibilities. As evidenced from the present study, trying to adopt a solely centralised and top-down approach to decentralisation reform implementation is likely to face serious problems because it will create a situation where the conception of reform, comprehension and staff dispositions towards reform objectives and prioritisation will be divorced from the realities and needs of district health administration units. And, as respondents suggested, the management of implementing decentralisation reform must include a consideration of key stakeholders' motivation and interest because, without this, conflict is likely and reform implementation will be stalled, as the case study districts have experienced.

The adoption of a participatory approach will enhance reform implementation and impact on wider public sector reform processes. The officials responsible for

implementing public management reform need to embrace a truly participative approach and maintain an orientation towards the development and transformation of people, rather than just structures and systems. Public sector reform managers (e.g. district health managers) should look for specific tactics that can help foster healthy and sound relationships with all the stakeholders. As the respondents reinforced, management of such relationships will require effective management of social and political conflict and that requires the use of people-centred and effective inter-personal skills. Reform managers in the public sector should, therefore, possess or develop communication, presentation, negotiation, conflict-resolution and team-working skills. Overall, implementation of public sector reform and decentralisation should involve scanning of the action environment of implementers and service users. This process should include both the near and far institutional environment and the way they may affect the needs of both implementers and targeted reform beneficiaries (Walt, 1998; Walt and Gilson, 1994).

On the whole, there is a need to rethink the roots of the capacity problem in health reform implementation. This is based on the study findings that health decentralisation has increased the managerial and administrative responsibilities of district health management teams. This, indeed, raises some important questions about capacity in general: does the Ministry of Health – that is, central and regional health administration – have the capacity to support and manage decentralised health responsibilities? Does it have the administrative capacity to identify and respond to stakeholder needs? Does it have the administrative capacity to provide technical and supervisory support where appropriate? Do regional health managements have the capacity to manage and effectively exercise supervision of the activities of district health programmes? The evidence on these issues is sparse.

As indicated in Chapters 6, 7 and 8, district staff capacity is believed to be inadequate; but this could be due to the fact that administrative and implementation requirements imposed by the central ministry are too much for district health administrators. In fact, if the appropriate administrative requirements were assigned to each district health management according to their capacity and the information required for them to perform their functions was provided, district staff capacity would probably not have become such a serious brake on decentralisation implementation. The point to note is that, even though the study found that district staff capacity was inadequate and

therefore a problem, it might be that the central and regional health administrations themselves also lack the capacity to manage district health affairs.

Observation during the fieldwork also indicated that there seemed to be no clearly designed intergovernmental relation between, e.g. the Ministry of Health and Ministry of Local Government and Rural Development and Ministry of Education. This is necessary for purposes of reform coordination but, as the situation stands, its absence does not augur well for providing the guidelines, resources, personnel and incentives that would lead to strong capacity at the district level. In fact, stakeholder informants said that there had been less debate on whether the central Ministry of Health has the wherewithal to manage health decentralisation and district health affairs or whether the implementation problems facing the health sector and district health managers was caused by the intergovernmental system in Ghana, and this point was also made by Larbi (1998).

The important policy issue here is that the influence of district health capacity on health sector reform implementation is a complicated issue, and the appropriate way to improve it may not simply be through increased training of district health officials and support staff. The suggestion is that the Ministry of Public Sector Reform, the Public Service Commission and the Office of the Head of Civil Service should incorporate capacity issues into current public sector reform policy and should impress upon the government to make capacity building part of Ghana's national development policy.

Building a constituency for health reform and decentralisation implementation

Successful implementation and sustainability of health sector reform requires commitment and support from all stakeholders. Since commitment is believed to be low in the health sector, the government should take steps to raise the level of commitment to reform; the MOH should build an adequate constituency for the reform; health sector reform must be repackaged, marketed and promoted. Although donor-driven, health sector reform and decentralisation has been internally legitimised and, therefore, government and the MOH must amplify this further by building a broader constituency of groups and organisations who not only accept the reform but consider themselves to be the new beneficiaries.

As noted in Chapter 3, commitment (affective, normative, and continuance) contributes significantly to employees' psychological state and this affects their relationship with an

organisation. Employee commitment is also affected by other antecedents which have potentially different consequences with regard to issues concerning attitude and behaviour: for example, absenteeism, apathy, laziness and indifference towards organisational goals and job performance (Meyer and Allen, 1990 cited in Swailes, 2004). Employees with a high affective commitment to an organisation will continue to stay because they deem it desirable to do so; while those with normative commitment will do so because they think they should, and those with high continuance commitment because they are obliged to.

As the findings in Chapters 5, 6 and 7 showed, levels of staff commitment are low in the health service, especially the desire and obligation to remain with the health service; in essence, affective and continuance commitment is low. Some reasons for this are: low salaries, lack of motivation, unattractive work environments, a lack of effective communication, information sharing, and lack of feedback. But, as Townley (1994) cautioned, organisations lacking formal and effective communication are likely to create conditions which encourage rumours, and this breeds low morale and lack of trust, which is detrimental to organisational effectiveness and does not encourage employees to accept change. According to the study findings, this is the situation within the Ghanaian health sector, where the centralised approach to communication structures and system has stifled effective and rapid information sharing, leading to suspicion, distrust, and erroneous understanding of health reform objectives. One way to increase the level of health staff commitment to the health service would be to improve communication within the service and between the MOH and all significant stakeholders.

The role of communication as a social process of the broadest relevance in the functioning of groups, organisations and society (Katz and Kahn, 1966) and as a 'motivator', 'educator' or 'hygiene factor' capable of increasing organisational commitment, has featured in managerial orthodoxy since the popularisation of the human relations school (Townley, 1994). Drawing on these earlier works, it is suggested here that the old centralised, rigid, one-way-traffic type of communication which concerns itself only with the narrowly-defined task at hand is no longer adequate for a decentralising, open and pluralist public health service. The MOH therefore needs a new communication system that is two-way, interactive and designed to increase levels of awareness amongst health workers and all stakeholders; this therefore should be seen as paramount for increasing organisational commitment. In this sense, communication – the exchange of information and the transmission of meaning –

should be considered essential for winning the support of both internal and external customers of health reform. Since health sector reform and decentralisation is about change, health workers and stakeholders are logically the agents of this change and their commitment is crucial for implementing the change programme. This can be achieved through information sharing and awareness programmes and should aim to create and mobilise positive constituents from within the public and private health sectors, non-government organisations, local governments, health professions, trade unions, communities and service users who would support decentralisation.

Building committed constituents for health reform requires frequent, accurate, and open communication with health staff and stakeholders so as to ensure some level of understanding of all stakeholders' perspectives and to build their trust in the service. One of the fundamental steps in increasing commitment would be for the MOH and DHMTs to consider introducing 'speak out' programmes, suggestion schemes, attitude surveys and employee appraisals as a means of enhancing two-way communication. Such schemes have been a feature in UK and US communication programmes, and function as a useful educative device and a warning to management in case of potential employee strike action (Townley, 1994).

This suggestion is premised on the basic fact that regular communication will allow for the exchange of information about each stakeholders' preferences, values and approaches to the problems at hand, thereby leading to the development of the knowledge-based trust and commitment needed to see reform implementation through (Lewicki and Bunker, 1996). For, once stakeholders have a stake in the reform programme through effective communication they will become committed and will be more likely to mobilise and work towards its successful implementation. The sector-wide approach being pursued should be revived and the MOH should extend its collaborative and partnership programmes through that experience by engaging the Ghana Health Service, Ministry of Local Government and Rural Development and Ministry of Women's Affairs in the awareness creation programme. Although support and commitment is important for decentralisation, not just any commitment will do. Health decentralisation implementation must have the support of key stakeholders within the health sector, within the ruling government and ministries, departments, agencies and civil society to assure that reform can be implemented successfully.

Role clarity in district health systems

Many of the obstacles to health sector reform implementation analysed in this study are partially due to a lack of clarity about the proper role of the district health system in Ghana's health sector development agenda. To argue that some degree of role ambiguity characterises the activities of DHMTs does not imply complete disorder in the management of public health services, but stresses the fact that unclear definitions of the new role of DHMTs in the era of decentralisation needs a clearer definition to ensure that human, logistical and financial resources are allocated accordingly. This point is crucial because ambiguity of organisational roles affects organisations' performance, effectiveness and staff satisfaction. Katz and colleagues (1964 cited in Ktaz and Kahn, 1966) have found that conditions of ambiguity in an organisation results in low job satisfaction, low sense of confidence among staff and high levels of tension and conflict. In an earlier study, Gross et al. (1958 cited in Katz and Khan, 1966) also noted that job satisfaction is affected in situations of conflict and uncertainty about issues of hiring, promotion, salary and career development, and this affects organisations' performance.

The study suggests a redefinition of the role of district health managements should be considered a critical element of the health sector reform analysis. There should be open and frank discussions, leading to a broad agreement on the new role of the district health management teams in health planning and implementation. This role needs to be unambiguous and specific and be properly resourced – if necessary through a special national funding scheme, as is the case for the District Assembly Common Fund (DACF) set aside for local governments. The donor community could be of immense help to the MOH by providing a special district health fund. But in the event that funding is unavailable to implement reform programmes, it is equally important that this is acknowledged and district health managers are not pressurised unduly to perform the impossible. In considering resource requirements, it is equally important to recognise the need for an integrated district health system, including public and private providers; and to emphasise that the development of sustainable integrated district health structures and processes which are purely reform-focused.

More important, and as the findings pointed out, the majority of district health staff appeared to be working under conditions of noticeable conflict. The effect of this is that the DHMTs reported to be under pressure from regional and central Ministry of Health at headquarters; this 'hierarchical and depersonalised' (Katz and Kahn, 1966) pressure

from reformers has a consequence for effective implementation. It is important that this conflict is minimised by clearly-defined roles, chains of command and systems of reporting, which may reduce role and inter-organisational conflict in the health system.

Provide an institutional medium for communication, consultation and dialogue

Inadequate communication and weak channels of information sharing emerged in this study as one of the challenges to implementation of health sector reform. It was noted in Chapters 6, 7 and 8 that the health sector reforms and decentralisation that have been launched since the mid-1980s in Ghana, have failed to incorporate, to a large extent, adequate communication, consultation, public education and awareness creation as part of the grand design process. There was some recognition of the need to engage stakeholders, the private sector, communities and health professional associations in health decentralisation in the First and Second Five-Year Health Sector Programmes of Work, but little or no particular attention has been paid to the critical role of communication and consultation and a national dialogue involving stakeholders and private sector health providers in the successful implementation of health reforms.

The point to note is that communication is important because, in a sense, it is a way of giving 'ownership' to employees, as Townley (1994) noted. Employees comprise one important group of stakeholders in the health sector, alongside service providers, users and communities. It is argued that employees are the 'internal customers' of the health service (Agyepong et al., 2004), so the customer satisfaction regime must be extended to cover their interests, needs and welfare. Health managers and supervisors should pass along everything district health workers need to know in order to enhance the chances of reform success.

While health staff do not need to know everything about the health reform, they need to know all about the ways health decentralisation will have an impact on their work, roles and responsibilities. They also need to know how reform will affect their performance and relationship with relevant others. As such, it is suggested that health policy makers should build regular consultations, accurate and open communication and dialogue into the implementation management, and consciously develop a broader institutional forum for consultation and deliberation on health reform and decentralisation. That is, the system of communicating reform ideas and channels of information sharing should be overhauled; in particular, fora should be created at district and sub-district levels to engage the interest of all relevant people in health reform matters. Health sector reform

at headquarters and, especially, the district level, should therefore consider using new communication channels and a two-way form of communication. For example, suggestion schemes, employee attitude surveys, health fora to give feedback, regular consultations and follow-up activities on major health programmes should be introduced, as some respondents suggested. At the district level, this could be achieved through further 'de-decentralisation' of the structures for information sharing through the sub-district health managers and also through the district health committees system.

As the findings indicated in Chapters 6 and 7, collaboration and inter-organisational coordination is not very effective due to limited communication and information sharing. Therefore, inter-sector and inter-organisation collaboration through increased public-private partnership should be encouraged, to build greater interest and trust in the district health administrative system. This would help reduce apathy, distrust and inter-agency conflicts and improve information management and information sharing through multiple channels. The effect of communication on trust and organisational commitment was found in a study by Butler and Cantrell (1994), who discovered that job-related communication through repeated interaction improves trust, and that commitment also increases where there is regular contact and dialogue. Health managers would, therefore, need to increase internal communication, for example, through brochures, special reports, newspapers, magazines, newsletters, community durbar, circulars, district retreats, district health conferences and workshops, rallies, surveys, suggestion schemes, seminars and symposiums.

A one-stop-shop information desk could be established where individuals and groups could access vital information regarding health matters. Regular dialogue should be encouraged at all levels of the service; and the educative role of communication and other awareness programmes of activities need to be increased. They should not focus on executives and managers alone but should embrace all front line workers, stakeholders and service users as well. Regular dialogue between the central Ministry of Health and district health managers, staff, local government officials and stakeholders should be institutionalised to ensure mutual understanding of the stakeholders requirements and to promote commonality, mutual trust and organisational learning (see Phillips, 1997; Powell, 1996). Implementation mistakes of the past should be factored into future reform for purposes of learning; this is important because reform mistakes which cannot be remembered are more likely to be repeated.

Promotion and maintenance of a high standard of professional ethic

Continuous anti-corruption efforts had been made since 1983 by the Rawlings PNDC military government, followed by the ruling NPP government's declaration of a 'zero tolerance' policy on corruption and the subsequent establishment of the Office of Accountability under the auspices of the Presidency. However, corruption and unethical behaviour is still rife in Ghanaian public life. As noted in subsection 7.4, issues of corruption and unethical behaviour, particularly moonlighting, undertaking salary-augmenting activities, absenteeism, lateness, pilfering and diversion of drugs and equipment meant for the public to private clinics was found to be rampant among health officials at the district level. But the issue of unethical behaviour is beyond the scope of this study because it did not specifically set out to investigate ethical and unprofessional behaviour and its effect on implementation. Thus, what we seek to do here is to record that corruption and unprofessional behaviour came up during the study as a potential threat to reform implementation and therefore must be incorporated into future reform initiatives. This is because the findings seemed to suggest a damaging erosion of a public health ethos, where unethical behaviour has become considered virtues instead of vices.

The study therefore suggested that, in reforming the health sector, particular attention should be devoted to the ethical conduct of public health officials. It is further proposed that special strategies should be designed to strengthen professional ethics and standards and disciplinary mechanisms for curbing unprofessional behaviour. However, it is not easy to develop ethical standards for public service managers. As Wanna et al. argued (1992), ethical standards are difficult to define, and ethical frameworks have developed as a result of government policy, legislative requirements and financial and administrative codes, guidelines and conventions:

> Ethical standards in the public sector emanate from the practical operation of a political system of administration. Ethics are not god-given, invariable creeds which are imposed on the system from without. Rather, ethical behaviour is a constantly refreshed conventional code of practice which largely originates from within. In this sense, political conventions, value expectations, bureaucratic norms, legislative requirements and formal and informal codes of conduct all combine to produce a somewhat ambiguous mix of ethical practices (Wanna et al., 1992: p.209).

This viewpoint is consistent with MacItyre's (1981) suggestion that ethical values should be located within the context of a practice; that is a professional code of conduct of the health profession and the public service as a whole. Thus, the health profession should reinvigorate its internal virtues and redefine the moral foundation of medical

practice so as to provide a stronger basis for adherence to professional ethics. This would inevitably require that central government should be committed to implementing its anti-corruption policy, and resources should be devoted to showing that the public health system, and the district health system in particular, is important and valued. This should be backed with action through appropriate remuneration of health staff, and the Ministry of Health (MOH) should also provide more resources for increasing training opportunities for health managers and career development for the long-neglected health sector staff.

Every action directed at health professionals should be placed in the larger public service context, and the complexities and diversities of the public sector need to be recognised (Lawton, 1998); since the NPM reforms have to work with the diversities in the public sector rather than introduce a new public service ethos for particular professions in the public bureaucracy. However, as Denis Ives (1994 cited in Lawton, 1998) put it, a 'new professionalism' is required which recognises the virtues of a traditional public service ethos and includes values associated with new ways of working and new tasks. This aspect of the issue is crucial, since public health officials engage in a range of relationships by virtue of their work – both with customers and stakeholders, especially the weak and the vulnerable in society, inside and outside the service, and so a concern with ethics is critical – that is, responsiveness, morality and justice and fairness.

Last but not least, disciplinary institutions and mechanisms should be made operational and more effective in the public sector as a whole and health in particular, and those who engage in unethical behaviour should be disciplined and, if necessary, have their names published in public newspapers as a form of punishment. But the authorities should not put too much faith in institutional arrangements and processes for controlling unethical and corrupt behaviour. This is because this might lead to them losing sight of the real purpose of the institutional checks and balances and focusing instead too much on perfecting disciplinary rules, controls, regulations and mechanisms for promoting ethical and responsible behaviour (Lawton, 1998). Regardless of the fact that promoting professional ethics is important, on its own it is insufficient, and should be backed by the necessary motivation and associated logistical support.

9.3.3 Limitations of the study

As noted in subsection 4.8.1, the study had some practical limitations that should be acknowledged. Some of them are revisited here along with ways to mitigate them in future research endeavour. First, the study collected information mainly from health staff. Although the use of single-sector key informants is common in social science research, the use of informants from non-health related organisations like education, trade unions, Ministry of Local Government and Rural Development and domestic households would have improved the quality of data.

Also, the study used a qualitative self-styled interview guide to solicit data at a single point in time and requested health staff to answer questions on the effect of agency characteristics upon implementation. While this was undertaken with vigour to minimise any interview bias, the approach was, to some extent, narrow, and it therefore limited the opportunity to investigate and understand other equally critical issues involved in analysing the influence of district health administration in decentralisation programmes at the district level. It is, therefore, suggested that future research should increase the survey component and focus on a cross-district comparative study of the issues raised with regard to agency characteristics and implementation. More importantly, future research should consider the use of longitudinal studies, which would provide an interesting account of the process and effect of reform itself on implementing organisations, and might provide additional insights into how health managers and systems operate after having been exposed to decentralisation.

As shown in Chapter 4, the interview data was processed through a qualitative content analysis. This has its own weaknesses which might have affected the output from data, and even the final results. Perhaps more survey data could be collected to enable a more in-depth, statistically-based analysis of the impact of agency characteristics upon implementation. By using more quantitative methods, advanced and rigorous statistical tests could be conducted to examine the degree of influence or effect of each variables included in the working framework on implementation.

Another limitation of the study, as noted in section 4.8.1, is the fact that this was a single case study of the health sector, not a comparative case study, even though data was obtained from three districts. The fact that the study focused on the health ministry makes it a unique case study, however, this uniqueness might limit the ability to generalise the findings to other organisations and countries. Because the study findings were based on evidence from three geographical zones of the country, the chances are

higher that the results could usefully be generalised to other districts and public sector organisations at the district level in Ghana.

9.3.4 Suggestions for further research

Based on the findings, it is suggested that future studies of health sector reform in Ghana should not focus only on DHMTs' organisational factors, but should integrate such a perspective with political, institutional, behavioural, and geopolitical and economic framework conditions. Health sector decentralisation at the district level is a good illustration of the importance of including institutional, attitudinal and behavioural and organisational factors in the analysis of decentralisation reform implementation at the district level in Ghana. Although health sector reform has brought about significant changes in the structure and systems of health service management, the attitudinal and behavioural change that was expected to occur has not been prominent. Nor have health staff understood the goals of decentralisation reform, and the combination of the fact that there has been low stakeholder participation and a feeling of lack of reform ownership meant that the partnership and participation that the reform was expected to promote has not been realised. Thus, research into obstacles to behavioural and attitudinal changes would be helpful.

Most of the interviewees emphasised the importance of staff capacity for effective reform implementation, possibly because of its wider implications. As the empirical evidence shows, capacity as a problem is very broad, including skills, number of staff, logistics and equipment, transport and communication. It also includes the public sector's wider institutional capacity. The issue of capacity therefore has deep roots in the wider action environment. In particular, the influence of a lack of capacity needs to be examined in greater depth in relation to other factors within the health service, which are beyond the reach of district health managements. This is because, even in situations where capacity existed, it was constrained by other factors, such as the centralised governance structure which continued to affect implementation at the district level.

Commitment from local government authorities and private sector health providers is essential for health decentralisation reform to succeed in Ghana. The problem, however, is that it is precisely at the district level that conflict between local government and private service providers and district health managers has become evident. The challenge is to understand the cause of this conflict between district health managers and their counterparts in private sector and local government officials, and to find a way

to build a stronger partnership between them for effective reform implementation management.

The study has indicated that there is a need to democratise the politics of implementation by creating space for stakeholder participation in district health planning. This can be achieved through education and awareness creation about Ghana's new health paradigm (MOH, 2006: p.50) and its place within the broader reform goals to all stakeholders.

The study could not satisfactorily establish any relationship between leadership and the implementation of decentralisation. This might be due to weaknesses in the research instrument or wrongful presentation of the research question to respondents and lack of understanding of the research question on leadership. Other studies, such as Leonard (1994) and (McCourt and Bebbington, 2005) have found that leadership is important for African implementation success. In view of this, it is suggested that a rigorous follow-up research be undertaken into the issues of leadership and leadership style and how this is shaping health sector reform and decentralisation implementation at the district level. Such research should isolate specific issues on transactional leadership from transformational leadership and should explore the ways each influence workers' behaviour, performance and attitudes to work within the health service. This could first be pursued through elite interviews and focus group discussion sessions, which would provide some initial clues about the concept before a follow-up in-depth semi-structured interviews and survey on the matter.

Overall, since the study has, at least, provided an insight into implementation problems and generated new ideas on the area, it is suggested that a cross-country study be undertaken using the same factors and conceptual model, which could provide an opportunity for new and more insightful findings that would add a new dimension and insight to the implementation literature on Africa, especially on public sector decentralisation implementation challenges. Similar studies could also be conducted in other districts of Ghana, other countries within the West African sub-region, or other African countries using similar variables and a conceptual framework.

9.4 Concluding remarks

The year 2007 is an auspicious one for the government and people of Ghana, as the country will celebrate its 50th anniversary of independence from British colonial rule on 6 March 2007. Poverty reduction, through the transformation of Ghana's economy, has

been an important agenda item since independence, was so for the National Democratic Congress government; and is still the same for the ruling New Patriotic Party government under the leadership of President John Agyekum Kufour. Central to the development agenda of both the NDC and NPP governments was the promise to transform Ghana into a middle-income country (i.e. for the NDC by 2020 and NPP by 2015), through poverty reduction and wealth creation. Two key strategic development policy documents were designed to that effect: the NDC's *Ghana Vision 2020* and the NPP's *Agenda for Accelerated Growth and Development*. In addition, the government accepted the World Bank's Poverty Reduction Strategy as an integral part of its development policy; and since the Millennium Declaration, the NPP government has also added the Millennium Development Goals to its development policy package to provide direction to the country's long-term accelerated development objectives which are to be pursued through the broad framework of poverty reduction strategies (Azeem and Adamtey, 2006).

The health sector was given priority in all these development programmes, based on the firm belief that health is a *sine qua non* for economic growth and that improvements in the nation's health will improve human capital, productivity and wealth creation and reduce poverty. The Ministry of Health launched a major reform in 1997 as a rapid response measure; the reform objectives were captured in the first and second Five-Year Programmes of Work as noted in subsection 6.5.2. However, this study found that, despite the progress made, the health ministry is beset with problems which are impeding the sector to contribute effectively to the government's developmental agenda.

Against the backdrop of this study's findings, the question should be asked: what lessons should the Ministry of Health and the NPP government learn from health sector reform and decentralisation under the POW of 1997 to 2006? Perhaps one important lesson from this study is that the status and role of district health management teams in the overall scheme of health sector restructuring needs to be looked at more critically. That is, in designing future programmes of work for the health sector, the administrative and implementation needs of the district health administration should be factored into the reform agenda. This is crucial because strengthening district health management teams through decentralisation has been relatively successful, but has been achieved despite fierce constraints. Issues of lack of capacity, communication and commitment

are among these constraints, but these challenges need to be viewed in the broader context and must be addressed holistically.

The second point is that management of the implementation of health reform at all levels needs to be reviewed and equal attention must be given to structural, behavioural and attitudinal dimensions of reform. This is because systems and structures have shifted but have not been fully transformed. Professional and managerial cultures have also shifted, but corresponding changes in behaviour and attitude have not taken place.

The third point is that the challenge for the government, Ministry of Health and district health managers is how to improve upon their systems and channels of communication and to share information with communities, stakeholders, private-for-profit and local governments and service users about what decentralisation means in the scheme of the government's development agenda and the role of stakeholders in the programme. Under the first and second programme of work district health management teams and teaching hospitals gained relative autonomy, leading to a new politics of health sector policy making and implementation, with efforts aimed at increasing stakeholder participation and pluralism. Under the POW-2 it was affirmed that the district and sub-district levels are critical channels for the effective implementation of health decentralisation and allied strategies and designs in health care delivery (MOH, Programme of Work 2002-2006).

Also, the Ghana Poverty Reduction Strategy emphasises district/sub-district/community-based quality care as an essential instrument for reaching the majority of the poor. Furthermore, the district health management system is seen as an important convergence point for planning, implementation and supervision, regarding many of the key principles being emphasised by the government and Ministry of Health. But, as the evidence from the study shows, human, financial and logistical resources, mobilisation, recruitment, motivation and retention of staff are major unresolved issues for the health sector. In fact, personnel at district levels are inadequate and many of them lack the incentives and logistics necessary to carry out effective service delivery.

The question now is whether, there will be any further strengthening of DMHTs with increased resources, enhanced capacity, improved communication and commitment to service delivery, under the new or forthcoming Programme of Work. If that happens, it

will be interesting to see how district health managements will perform and the ways in which they will influence the implementation of health decentralisation. But all this will depend on the way that the central Ministry of Health addresses the implementation problems facing the district health management teams.

The central ministry should also be mindful of its new role following reform, as it is expected that the MOH will provide effective supervision to the Ghana Health Service and to DHMTs and ensure that they are given the support required to help them do their work. But overall, the lesson that the government and Ministry of Health should carry over to the future is that, no matter what amount of resources is devoted to health sector reform programmes, and no matter how well the reform is designed, the way it is executed by the agency put in charge is crucial to its success. Thus, for the MOH to contribute to the achievement of government development goals, it should pay special attention to the agencies tasked with implementing health reform policies and programmes – the DHMTs and their staff included.

References

ABRAHAMSON, M. (1983), Social Research Methods, Englewood Cliffs, NJ: Prentice Hall

ACHEAMPONG, E. (1995), 'Tug of war in Ghana: The centralising features of decentralisation', *Africa Insight*, Vol. 25, No. 3, pp 186-194

ACKON, E. K. (1994), *The Management of Health Services in Developing countries: The Case of Ghana*, Accra-North: Bel-Team Publications Ltd.

ADJEI, E. (2003), 'Health Sector Reform and Health Information in Ghana', *Information Development*, Vol. 19 (4) pp. 256-264

AGYEPONG, I. (1998), 'Reforming Health Service Delivery at District level in Ghana: The Perspective of a District Medical Officer', *Health Policy and Planning*, Vol.14 (1) p.59-69

AGYEPONG, I.A. ANAFI PATRICIA, ASIAMAH, E., EVELYN ANSAH, DANIEL ASHTON AND CHRISTIANA NARH-DOMETEY (2004), 'Health Worker (internal customer) satisfaction and motivation in the public sector in Ghana', *International Journal of Health Planning and Management*, Vol. 19, pp. 319-336

AGYEMAN-DUAH, B. (1987), 'Ghana, 1982-86: The Politics of the PNDC', *Journal of Modern African Studies*, December

AKOSA, A.B. (2002) *Ghana Health Service: Staffing Situation in the Ghana Health Service*, November.

AKPAN, P. (1990) 'Local government structures as a political framework for rural development in Nigeria', *Public Administration and Development*, Vol. 10, No.3 pp. 292-306

ALLEN, N.J. AND MEYER, J. P. (1990), 'The Measurement and Antecedents of affective, continuance and normative commitment to the organisation', *Journal of Occupational Psychology*, vol. 63, pp. 1-18

ALIMO-METCALFE, B. & ALBAN-METCALFE, J. (2003), Leadership in public sector organisations, In J. Storey (Ed.) *Current Issues in Leadership & Management Development*. London: Routledge (publication date December 2003).

ALLISON, G. (1971), *The Essence of Decision*, Little: Brown

ANNAN, J. (1999), *Ghana Health Sector-Wide Programme: A Case Study*, A Report Prepared for DACI/CD Network and Policy Branch of Canadian International Development Agency, Accra: J.S.A. Consultants Ltd

ANNAN, J. (1995), *Health Sector Review: Ghana*, Report Prepared for the Royal Danish Embassy, Accra: J.S.A. Consultants Ltd

ARYEETEY, G. AND HARRIGAN, J. (2000), *Economic Reforms in Ghana: the Miracle and the Mirage*, Oxford: James Currey Ltd., pp.

AUCOIN, P. (1990), 'Administrative Reform in Public Management: Paradigms, Principles, Paradoxes, and Pendulums'. *Governance*, Vol. 3, No. 2 pp. 115–37

AUCOIN, P. AND BAKVIS, H. (1988), *The Centralisation-Decentralisation Conundrum: Organisation and Management in the Canadian Government*, Halifax: Institute for Research on Policy

AUSTIN, D. (1964), *Politics in Ghana: 1946-60*, London

AVOLIO, B.J. (1999), *Full Leadership development: Building the vital forces in organisations*, Thousand Oaks, CA: Sage

AYEE, J. (2003), 'Local Government, Decentralisation and State Capacity in Ghana', in: Tettey, W.J., Korblah, P. Puplampu, Bruce, J. Berman Eds.), *Critical Perspectives on Socio-Economic Development in Ghana*, Leiden: Brill, chapter 2, pp 45-81

AYEE, J.R.A. (2000), 'The Global Context of Decentralisation' in Thomi, W. Yankson, P.W.K. and Azanu S.Y. (eds) *A Decade of Decentralisation in Ghana: Retrospect and Prospects*, Accra: Gold-Type Ltd. (EPAD Research Project and Ministry of Local Government and rural Development)

AYEE, J. (1998), 'Decentralization and Civil Society in Ghana', in Thomas Scheidtweller (ed.) *Human and Economic Development: The Importance of Civil Society and Subsidiarity* (Bonn: KAAD)

AYEE, J. (1997), 'The Adjustment of Central Bodies to Decentralisation: The Case of the Ghanaian Bureaucracy', *African Studies Review*, Vol. 40, No 2, pp.37-57

AYEE, J. (1997a), 'Civil Service Reform in Ghana: A Case Study of Contemporary Problems of Reform in Africa', Paper presented to Development Policy Management Forum, Addis Ababa, Ethiopia. December 4-5

AYEE, J. (1994), *An Anatomy of Public Policy Implementation*, Aldershot: Averbury
AYEE, J. (1993), 'Decentralisation and Local Government under the PNDC', in: Gyimah-Boafi, E. (ed.), Ghana under PNDC Rule, London: CODESRIA, pp. 114-134
AYEE, J.R.A. (1992), 'Decentralisation and effective government: the case of Ghana's District Assemblies', *Africa Insight*, Vol.22, pp. 49-56
AYEE, J. (1991), 'Civil Service Reform under the Provisional National Defence Council of Ghana', *Journal of Management Studies*, Vol. 7, No 3, pp.1-12
AZEEM, V. AND ADAMTEY, N. (2006), *Budget ceiling and health in Ghana*, Accra: Centre for Budget Advocacy, ISODEC
BABBIE, E. (1995), *The Practice Of Social Research* (7th ed.). Belmont, CA: Wadsworth
BANA, B. A. AND S.S.A. NGWARE (2006), 'Reforming the Public Service: The Tanzanian Experience', in Kithinji Kiragu and Mutahaba Gelase (eds.), *Public Service Reform in Eastern and Southern Africa: Issues and Challenges*, Dar e Salaam: Tanzania, Mkuki na Nyota Publishers, pp. 199-224
BALOGUN, J. (2003), 'The Scope for Popular Participation in Decentralisation, Community Governance, and Development: Towards a New Paradigm of Centre-Periphery Relations', *Regional Development Dialogue*, Vol.21, No. 1, pp.153-172
BARNEIJI, D. (2003), 'Reflections on the Twenty-Fifth Anniversary of the Alma-Ata Declaration', *International Journal of Health Services*, Vol. 23 No. 4, pp 813-818
BARRETT, S. M. AND FUDGE, C. (1981) *Policy and Action: Essays on the Implementation of Public Policy,* London: Methuen
BARRETT, S. AND FUDGE, C. (1981), Examining the policy-Action relationship, in: Susan Barrette and Colin Fudge (eds.), Policy and Action: Essays on the implementation of public policy, London: Methuem & Co.Ltd.
BASS, B. (1985), *Leadership and performance beyond expectations*, New York: Free Press
BASS, B. AND B. AVIOLO (1994), *Improving Organisational Effectiveness through Transformational,* New York: Free Press
BATLEY, R. (2004), 'The Politics of Service Delivery', *Development and Change*, Vol.
BATLEY, R. AND G. LARBI (2004) 'Changing Views of the Role of the Government', Richard Bartley and George Larbi (eds) *The Changing role of Government: The Reform of Public Services in Developing Countries*, Houndsmill, Basingstoke, Hampshire: Palgrave Macmillan, pp.15-17
BAYNHAM, S. (1986), *The Military in Nkrumah's Ghana, Colorado*: Boulder
BENNETT, S. AND A. MILLS (1998), Government capacity to contract: health sector experience and lessons', *Public Administration and Development*, vol. 18. No 4, pp. 307-326
BENNETT, S., RUSSEL, S. & MILLS, A. (1995) *Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: A Review of Experience*, Paper No. 4, London School of Hygiene and Tropical Medicine
BERG, B.L. (2004), Qualitative Research Methods (5th ed.)London: Pearson Education, Inc.
BIRD, R.M. (1999), 'Fiscal Federalism', In: Cordes, J.J. Ebel, R.D. and Gravelle, J.G. (eds), The *Encyclopaedia of Taxation and Tax Policy*, Urban Institute, Washington D.C.
BLAS, E. (2004), 'The Proof of the reform is in the implementation', *International Journal of Health Planning and Management,* Vol. 19; S3—S23
BOLGER, J. (2000), 'Capacity Development: why, what and how', *CIDA Occasional Series,* 1 (1) Canadian International Agency (CIDA), Ottawa
BORINS, S. (1997) 'What the new public management is achieving: A survey of Commonwealth experiences', in Jones Schedler, K. and Wade, S. (eds.) *Advances in International Comparative Management, International Perspectives on the New Public Management.* Greenwich, CT: JAI Press, pp. 49-70
BORINS, S. (1997) 'What the new public management is achieving: A survey of Commonwealth experiences', in Jones Schedler, K. and Wade, S. (eds.) *Advances in International Comparative Management, International Perspectives on the New Public Management.* Greenwich, CT: JAI Press, pp. 49-70
BORIN, S. (1995) 'The New Public Management is Here to Stay', *Canadian Public Administration*, Vol. 38, No. 1, pp122–32.
BORINS, S. AND WARRINGTON, E. (1996), *The New Public Administration: Global Challenges: A Report on the Second Biennial Conference of CAPAM*, London: Commonwealth Secretariat

BOSSERT, T. (1998), 'Analysing the decentralisation of health systems in developing countries: decision space, innovation and performance', *Social Science and Medicine*, Vol.47, No. 10, pp.1513-27
BOSSERT, T. AND BEAUVAIS, C.J. (2002), 'Decentralisation of Health Systems in Ghana, Zambia and Uganda, *Health Policy and Planning*, Vol. 17 (1), pp. 14-31
BOSSERT, T. (1998), 'Analysing the decentralisation of health systems in developing countries: decision space, innovation and performance', *Social Science and Medicine*, Vol.47, No. 10, pp.1513-27
BRATTON, M. AND VAN DE WALLE, N. (1992), 'Towards Governance in Africa: Popular Demand and State Responses', G. Hyden and M. Bratton (eds.), Governance and Politics in Africa, Lynne Rienner, Boulder.
BRATTON, M. LEWIS, P. AND GYIMAH-BAODI, E. (2001), 'Constituencies for Reform in Ghana', Journal *of Modern African Studies*, Vol. 39, no. 2, pp. 231-259
BRAUTIGAM, D. (1996), 'State Capacity and effective Governance', in: B. Ndulu and N. van de Walle (eds.) Agenda for Africa's Economic Renewal, New Brunswick: NJ and Oxford, UK, Transaction Publishers, pp. 81-108
BRESSERS, T. and VALENTINA DINICA (2003), The Implementation of Renewable Energy Policies: Theoretical Considerations and Experiences from Spain, Netherlands and United Kingdom Paper Presented at RIO 3 - World Climate & Energy Event, 1-5 December 2003, Rio de Janeiro, Brazil 39
BRENNAN, G. AND BUCHANAN, J.M. (1980), *The Power to Tax: Analysis Foundations of fiscal Constitution*. Cambridge: Cambridge University Press
BRINKERHOFF, W.D. AND CROSBY, B. L. (2002), *Managing Policy Reform: Concepts and Tools for decision-Makers in Developing and Transitioning Countries*, Bloomfiled: Kumarian Press
BRINKERHOFF, D.W. (1996), 'Process Perspective on Policy Change: Highlighting Implementation, *World Development*, Vol. 14, No. 9, pp. 1395-1401
BRUNETTO, Y. (2000), 'Management of Policy Implementation within Australian Universities', *Asia Pacific Journal of Human Resources*, Vol. 38, No. 1, pp. 51-67
BRUTLER, J.K. AND CANTELL, R.S. (1994), 'Communication Factor and Trust: An Exploratory Study', *Psychological Reports*, Vol. 74, pp. 33-34
CAIDEN, G.E. (2006), 'Public Service Reform', in: Huque Shafiqul Ahmed and Zafarulah Habib (eds.), *International Development Governance*, London: Taylor and Francis Group, pp. 561-686
CANAGARAJAH, S. AND XIAO, Y. (2001), 'Public Health and Education Spending in Ghana in 1992-98: Issues of Equity and Efficiency', World Bank *Policy Research Working Paper* 2579, April (2001); Accra, Ghana: The World Bank Country Department
CASSELS, A. AND JANOVSKY, K. (1992), "A time of change: health policy, planning and organisation in Ghana, *Health Policy and Planning*, vol. 7(2), p. 144-154
CASSELS, A. AND JANOVSKY, K. (1996), Reform *of the Health Sector in Ghana and Zambia*; Current Concerns SHS Paper No. 11 (Geneva: WHO)
CAVANAGH, S. (1997), 'Content Analysis: concepts, methods and applications', *Nurse Researcher* , Vol. 4, No. 3, pp. 5-16
CHAMBERS, R. (1983), *Rural Development: Putting the First Last*, London: Longman.
CDD-Ghana/DIFID (2004) Public Sector Management Reform Programme, (PSMRP) Phase 1 Civil Service Performance Improvement Program, (CSPIP): *Assessing the Impact of Public Sector Reform Programmes in Ghana,* Final Evaluation Report submitted to DFID, Ghana; by the Ghana Centre for Democratic Development Accra: CDD-Ghana, January 2004
CHAZAN, N. (1991), 'The Political transformation of Ghana under the PNDC', in: Donald Rothchild, (ed.), *Ghana: the political economy of recovery*: Boulder CO: Lynne Rienner, pp. 21-48
CHAZAN, N. (1983), *An Anatomy of Ghanaian Politics: Managing Political Recession, 1969-82*, Colorado: Boulder
CHEEMA, G.S. (2003), *Capacity development at the country level: a ten-point agenda for action,* Paper Prepared for Presentation to the Workshop on Capacity Building: Lessons and Future Directions, Bellagio Study and Conference Centre, Italy, December
CHEUNG, A.B.L. (2002), 'The Politics of New Public Management: Some Experience from Reform in East Asia, in: McLaughlin, K. Stephen CHEUNG, A. B. L. (1997) 'Understanding

Public Sector Reforms: Global Trends and Diverse Agendas', *International Review of Administrative Sciences*, Vol.63, No.4, pp. 435–57
P. OSBORNE AND E. FERLIE (ed.), *New Public Management: Current Trends and Future Prospects*, London: Routledge, pp. 243-273
CLARKE, J. AND NEWMAN, J. (1997), *The Managerial State*, London: Sage Publications
COHEN, J. M. AND PETERSON, S. B. (1995), *Administrative Decentralisation Strategies for the 1990s and Beyond* (Research study prepared for the Governance and Public Administration Branch, Division for Public Administration and Management Development, Department for Development Support and Management services, United Nations Secretariat, November).
COLLIN, C. GREEN A. HUNTER, D. (1999), 'Health Sector Reform and the interpretation of policy context, *Health Policy*, vol. 47, pp. 69-83
COLLINS, C. (1989), 'Decentralisation and the need for political and critical analysis', *Health Policy and Planning*, Vol. 4, No. 2 pp.168-171
COLLINS, C. AND GREEN, A. (1994), 'Decentralisation and primary health care: some negative implications in developing countries', *International Journal of Health Services*, Vol. 24, No. 3, pp459-75
COMMON, R. (1998), 'The New Public Management and Policy transfer: the role of international Organisations', in: M. Minogue, C.Polidano and D. Hulme (eds.), *Beyond the New Public Management: Changing Ideas and Practices in Governance,* Cheltenham: Edward Elgar, pp.59-75
CONYERS, D. (2006), 'Managing Development in Africa: How many more false starts? In: Huque Shafiqul Ahmed and Zafarulah Habib (eds.), *International Development Governance*, London: Taylor and Francis Group, pp. 611-623
CONYERS, D. (1990), 'Centralisation and development Planning: a comparative perspective', in P. de Valk and K.H. Wekwete (eds.), *Decentralisation for Participatory Planning*, Aldershot, Gower Publishing Co.
CONYERS, D. (1989), 'The Management and Implementation of Decentralised Administration', in Commonwealth Secretariat, *Decentralised Administration in Africa: Policies and Training*, London, Commonwealth Secretariat.
CONYERS, D. (1984), 'Decentralisation and Development: a critical Review of the literature', *Public Administration and Development*, IV, No. 2, pp 187-97
CONYERS, D. (1983), 'Decentralisation: the latest fashion in development?' *Public Administration and Development*, Vol. 3, pp.97-107
CONYERS, D. (1981), 'Decentralisation for regional Development: a comparative Study of Tanzania, Zambia and Papua New Guinea', *Public Administration and Development*, Vol. 1, No. 2, pp. 107-120
COOPEY, J. AND HARTLEY, J. (1991), 'Reconsidering the Case for Organisational Commitment', *Human Resource Journal*, Vol. No. 3, pp. 18-32
CRESWELL, J. W. (1998), *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage.
CRESWELL, J. W. (2003), *Research Design: Qualitative, Quantitative and Mixed Method Approaches*. Thousand Oaks, CA: Sage.
CRESWELL, J. W. (1994), *Research Design: Qualitative and Quantitative Approaches*. Thousand Oaks, CA: Sage.
CROOK, R. AND MANOR, (1998), *Democracy and Decentralisation in South Asia and West Africa: Participation, Accountability and Performance*, Cambridge: Cambridge University Press.
CROOK, R. (2003), 'Decentralisation and Poverty Reduction in Africa: The Politics of Local-Central Relations', *Public administration and Development*, Vol. 23, pp. 77-88
CROOK, R. C. (1994), 'Four Years of the Ghana District Assembly in Operation: Decentralisation, Democratisation and administrative Performance', *Public Administration and Development* Vol.3, pp. 339-64
CROZIER, M. (1964), *The Bureaucratic Phenomenon*, Chicago: Chicago University Press
DEZIN, N.K. (1989), *Interpretive Interactionism*, Newbury Park, CA: Sage
DENZIN, N. K. AND LINCOLN, Y. S. (Eds.) (2000), *Handbook of qualitative research* (2nd ed.) Thousand Oaks, CA: Sage.

DIELEMAN, M. TOONEN, J. TOURE, M. AND MARTINEAU, T. (2006), 'The match between motivation and Performance management of health sector workers in Mali', *Human Resource Journal*, Vol. 4, No. 2, vol: 10.1186/1478-449-4-2.
DILLINGER, W. (1994), Decentralisation and its implication to urban service delivery, *Urban Management Programme Paper* 16, World Bank, Washington, D.C,

DOANLDSON, D. (1993), *Health Sector Reform in Africa: Lessons Learned*, Data for Decision Making Publication, No. 3, Harvard School of Public Health, Boston
DOVLO, D. (2005), 'Wastage in the health workforce: some perspectives from African countries', *Human Resource for Health*, vol. 3(6), doi:10.1186/1478-4491-3-6; http://www.human-resources-health.com/content/3/1/6, last accessed 11th September 2006
DOVLO, D, (2005) 'Taking More than a Fair Share: The Migration of Health Professionals from Poor to rich Countries', PLoSMed Vol. 2 (5), e109: http://medicine.plos.org/perlserv?request-document&doi=10.137journa... Last accessed 11 September 2006
DOVLO, D., AND NYONATOR, F. (2004), 'Migration by Graduates of the University of Ghana Medical School: A Preliminary Appraisal', *Human Resources Development Journal*, Vol. 3 (1); http://www.who.int/hrh/en/HRDJ_3_1_04.pdf, last accessed 11th September 2006
DOVLO, D. (1999) 'Issues affecting the mobility and retention of health workers in Commonwealth African states'. *Report Prepared for the Commonwealth Secretariat*, London.
DOVLO, D, (2003), 'Health Sector Reform and Deployment, Training and Motivation of Resources Toward equity in Health Care: Issues and Concerns in Ghana', *Human Resources Development Journal*, Vol. 2 (1); http://www.who.int/hrh/en/HRDJ_2_1_03.pdf; last accessed 11th September 2006
DOVLO, D., NYONATOR, F. & KANLISI, N. (1992), *Decentralization and Health Systems Performance in Eastern Region, Ghana*; Phase One Report
DUNLEAVY, P. AND HOOD, C. (1994), 'From old Public Administration to New Public Management', *Public Money and Management*, July-September, pp.9-16
DUNSIRE, A. (1978) *Implementation in Bureaucracy*, Oxford: Martin Robertson
ECONOMIC COMMISSION FOR AFRICA (2003) *Public Sector Management Reform in Africa: Lessons Learned*, Ethiopia: *Development Policy Management Division* (DPMD), Addis Ababa, Ethiopia
EBEL, R. (1998),"Logic of Decentralisation and Worldwide Overview," Talking Points, September 4, 1998: http://www.undp.org/governance/docs/DLGUD_Pub_overview-decentralisation-worldwide-paper.pdf#search=%22Robert%20Ebel%20on%20Decentralisation%22 accessed 14 September 2006
ELCOCK, H. AND MINOGUE, M. (2001), 'Local Government: management or politics' in Willy McCourt and Martin Minogue (eds) *The Internationationalisation of Public Management: Reinventing the Third World,* Cheltenham, UK: Edward Elgar, pp. 90-106
ELMORE, R. (1985), 'Forward and backward mapping', in: *Policy implementation in Federal and Unitary systems,* in: K. Hanf and T. Tooten (eds.) Dordrecht: Martinus Nijhoff, pp 33-70
ELMORE, R.F. (1980), 'Backward mapping: Implementation research and policy decision', Political Science Quarterly, 94 (4) pp. 601-616
FARAZMAND, A. (2006), 'Public Sector Reforms and Transformation: Implications for Development Administration', in Huque, Shafiqul A. and Zafarullah, Habib, *International Development Governance*, Sound Parkway, NW: Taylor and Francis Group, pp. 545-586
FARMER, T. K. ROBBINSON, S.J. ELLIOT AND J. EYLES (2006), 'Developing and Implementing a Triangulation Protocol for Qualitative Health Research', *Qualitative Health Research*, Vol. 16, No. 3, pp. 377-394
FARHAM, D. AND HORTON, S. (1993), *Managing the New Public Services* (2nd edn.), Chippenham: Mcmillan Press Ltd.
FIELDER, E. (167) *A Theory of leadership Effectiveness*, McGrawhill
FIGUERAS, J. SALTMAN, R. AND MOSSIALOS, E. (1997), *Challenges in Health sector Reform: An Overview*, LSE Health Discussion Paper No. 8
FLYNN, N. (2002), 'Explaining the New Public Management: the importance of Context', in: McLaughlin, K. Stephen P. Osborne and Ewan Ferlie (ed.), *New Public Management: Current Trends and Future Prospects*, London: Routledge, pp. 57-76

FRITZEN, S. (2003), 'The misery of Implementation : Governance, institutions and anti-corruption in Vietnam', Paper presented at a Conference on *Governance, institutions and anti-corruption in Asia*, New Zealand Asia Institute, University of Auckland, New Zealand Election Study centre, National Chengchi University, Taiwan, 28-30 April, Auckland, New Zealand
FOSTER, P. AND ZOLBERG, A. (1971), *Ghana and the Ivory Coast: Perspectives on Decentralisation*, Chicago, Ill.
FUKUYAMA, F. (2004), *State Building*, London: Cornell University Press: Profile Books
GASTER, L. AND O'TOOLE, M. (1995), 'Local Government Decentralisation: An Idea Whose Time have Come?, School for Advanced Urban Studies, Working Paper 125, Bristol: University of Bristol.
GOGGIN, M.L., BOWMAN, A.O.M., LESTER, J.P., AND O'TOOLE, L.J., Jr (1990) *Implementation Theory and Practice: Towards a Third Generation*, Glenview, Ill.: Scott Foreman/Little Brown and Company
GLESNE, C. & PESHKIN, A. (1992), *Becoming Qualitative Researcher: An Introduction*, White Plains, NY: Longman
GILSON, L. (1995), 'Implementing Health Care Reform in Sub-Saharan Africa', *Social Science and Medicine*, vol. 40, No. 5 pp. 695-710
GRINDLE, M. (1997),'Divergent Cultures? When Public Organisations Perform Well in Developing Countries', *World Development*, Vol.25, No.4, pp. 481-495
GRINDLE, M. (1996), Challenging the state: Crisis and Innovation in Latin America and Africa, Cambridge: Cambridge University Press
GRINDLE, M.S. (ed) (1980), *Politics and Policy Implementation in the Third World*, New Jersey: Princeton University Press
GRINDLE, M.S. AND THOMAS, J.W. (1991), *Public choices and policy change: The Political Economy of reform in Developing Countries*, Baltimore: The John Hopkins University Press
GRINDLE, M.S. (1980), 'Policy Content and Context in implementation, in: Grindle, M.S. (ed) (1980), *Politics and Policy Implementation in the Third World*, New Jersey: Princeton University Press, pp 3-34
GULHATI, R. (1989), 'Impasse in Zambia: Economics and Politics of Reform', *EBRD*, Washington
GYIMAH-BOADI, E. (1990), 'Economic recovery and politics in PNDC's Ghana', *Journal of Commonwealth and Comparative Studies*, Vol. 28, pp. 328-343
GYIMAH-BOADI, E. AND JFFRIES, R. (2000), Ghana: The Political Economy of Reform, in: G. Aryeetey, Harrigan, J. and N. Machiko (eds.); *Economic Reforms in Ghana: the Miracle and the Mirage*, Oxford: James Currey Ltd., pp. 51-67
HADING, A. AND PREKER, A. (eds) (2003) 'Conceptual Framework', in *Innovations in Health Service Delivery: the corporatisation of hospitals*, Washington, DC.
HAGGARD, S. (1995), 'The reform of the state in Latin Americas' Unpublished draft manuscript (San Diego: University of California Graduate School of International Relations and Pacific Studies)
HAM, C. (2003), 'Betwixt and Between: Autonomisation and Centralisation of U.K. Hospital', in: Hading, A. and Preker, A. (eds) Innovations *in Health Service Delivery: the corporatisation of hospitals*, Washington, DC
HAM, C. HAWKINS, L. (2002) 'Implementing Organisation Reforms to Hospitals in the Public Health Sector', in, Hading, A. and Preker, A.(eds) *Innovations in Health Service Delivery: the corporatisation of hospitals*, Washington, D.C.
HAMEL, J. DUFOUR, S. AND FORTIN, D. (1993), *Case Study Method*, Thousand Oaks, CA: Sage
HARRISON, M. I. (2003), *Implementing Change in Health Systems: market Reforms in the UK, Sweden and the Netherlands*, London: Sage Publications
HARUNA, F.P. (2003) 'Reforming Ghana's Public Service: Issues and Experiences in Comparative Perspective', *Public Administration Review*, Vol. 63, No.3 pp. 343-354 May/June
HARUNA, P.F. (2004), 'Rethinking Administrative Globalisation: Promises, Dilemmas, and Lessons in Ghana', *Public Administration theory and Praxis*, Vol. 26, No 2, pp. 185-212
HEEKS, R. AND MUNDY, D. (2001) 'Information Systems and Public Sector Reforms in the Third World, in Willy McCourt and Martin Minogue (eds) *The Internationationalisation of Public Management: Reinventing the Third Wor*ld, Cheltenham, UK: Edward Elgar, pp 175-196

HILL, M. (1997) *The Policy Process in a modern State*, Hemel Hempstead: Prentice Hall/Harvester Wheatsheaf
HILL, M. (1981), 'The policy-implementation distinction: a quest for rational control? in S.M. Barrette and Fudge Colin (eds), Policy and Action: Essays on the implementation of public policy, London: Methuem & Co.Ltd. pp. 207-224
HILL, H. C. (2003), Understanding Implementation: street-level Bureaucrats' resources for reform, *Journal of Public Administration Research and Theory*, Vol. 13, No. 3, pp. 265-282
HILL, M AND HUPE, P. (2003), 'The Multi-Year Problem in Implementation Research', *Public management Review*, Vol. 5, no 4, pp. 471-490
HILL, M. AND HUPE, P. (2002), Implementing Public Policy, London: Sage Publications
HILDERBRAND, M.E. (2002), 'Capacity Building', in C. Kirkpatrick, Clarke, R. and Charles Polidano (eds.) *Handbook on Development Policy and Management*; Cheltenham, UK: Edward Elgar, pp.315-324
HILDERBRAND, M.E. AND M. GRINDLE (1995), 'Building Sustainable Capacity in the Public Sector: what can be done?, *Public Administration and Development*, vol. 15 (5), pp. 441-463
HJERN, B AND PORTER, D.O. (1981), 'Implementation structures: A new unit of administrative analysis', *Organisation Studies*, vol. (3) pp. 211-227
HJERN, B. AND HULL, C. (1982), 'Implementation Research as Empirical Constitutionalism', in: B. Hjern and C. Hull (eds) Implementation Beyond Hierarchy, Amsterdam: Elsevier (Special Issue of European Journal of Political Research) pp. 105-115
HOOD, C. (1991), 'A new public Management for all seasons?' *Public Administration*, Vol. 69, No 1, pp. 3-19
HOPE SR. K.R. (2006), 'Capacity Development and governance', in: Huque Shafiqul Ahmed and Zafarulah Habib (eds.), *International Development Governance*, London: Taylor and Francis Group, pp. 587-598
HOPE, K. R. (2002), 'The New Public Management—a Perspective from Africa', in: McLaughlin, K. Stephen P. Osborne and Ewan Ferlie (ed.), *New Public Management: Current Trends and Future Prospects*, London: Routledge,
HOPE, K.R. CHIKULO, B. C. (2000), Decentralization, the New Public Management, and the Changing Role of the Public Sector in Africa, Vol. 2, (1), pp. 25-42
HORTON, S. AND FARHAM, D. (1993), *Public Management in Britain,* Basingstoke: Palgrave
HOWE, K. (1988), 'Against the Quantitative-Qualitative Incompatibly Thesis, or Dogmas Die Hard', *Educational Researcher*, Vol. 17, No. pp. 10-16
HSIEH, H. AND SHANNON, S. (2005), 'Three Approaches to content analysis', *Qualitative Health Research*, Vol.15, No. 5, pp.1277-1288
HUGHES, O. (1997), *Public Management and Public Administration*, Basingstoke: Macmillan
HULME, D. AND WOODHOUSE, P. (1994), 'Decentralisation by Default: Local governance and the view from the village in The Gambia,' *Public Administration and Development*, Vol. 14, pp253-269.
HUTCHFUL, E. (1996), 'Ghana: 1983-94'. In: P. Engberg-Pederson, P. Gibbon, P. Raikes, and L. Udsholt (eds.), *Limits of Adjustment in Africa: The Effects of liberalisation, 1986-1994* (pp.144-214), Copenhagen: Centre for Development research.
HUTTINGTON, S. (1991), *The Third Wave: Democratisation in the late Twentieth Century*, Norman: University of Oklahoma Press.
HYCNER, R. H. (1999), 'Some Guidelines for the Phenomenological Analysis of Interview Data', In: A. Bryman & R.G. Burgess (Eds.), *Qualitative research* (Vol. 3, pp. 143-164). London: Sage.
HYDEN, G. (2006), African Politics in Comparative Perspective, New York: Cambridge University Press
INGRAHAM, P. W. (1996), 'The reform agenda for national civil service systems: external stress and internal strains', in: Bekke, H. A.G.M. Perry, J.L. and Toonene, T.A.J. (eds) *Civil Service Systems in Comparative Perspective*. Bloomington Indianapolis: Indiana University Press.
INTERNATIONAL MONETARY FUND (IMF), (1991), *Ghana: Adjustment and Growth, 1983-1991*, Washington D.C. IMF Occasional Papers No. 86

JACKSON, P. (1999), 'New roles of government in supporting manufacturing: the capabilities of support agencies in Ghana and Zimbabwe, *Public administration and Development*, Vol. 19, pp. 281-298
JEPPSON, A., A. OSTERGREN, AND B. HAGSTROM (2003),'Restructuring a Ministry of Health – an Issue of Structure and Process: A Case Study from Uganda', *Health Policy and Planning*, vol.18 (1), pp. 68-73
JENKINS, W.I. (1978), *Policy Analysis: A political and organisational perspective*, London: Martin Robertson and Company Ltd.
JICK, T.D. (1979), 'Mixing Qualitative and qualitative methods: Triangulation in Action', *Administrative Science Quarterly*, Vol. 24, pp. 602-611
JUMA, C. AND CLARKE, N. (1995), 'Policy Research in Africa: An Imploration', *Public Administration and Development*, vol. 15, pp. 121-137
KATZ, D. AND KAHN, R.L. (1966), *The Social Psychology of Organisations*, London: John Wiley and Sons, inc.
KIGGUNDU, M. (2002), 'Bureaucracy and Administrative Reform in Developing countries', in C. Kirkpatrick, Clarke, R. and Charles Polidano (eds.) *Handbook on Development Policy and Management*; Cheltenham, UK: Edward Elgar, pp.291-302
KIGGUNDU, M. (1996), 'Integrating Strategic Management Tasks into Implementing Agencies: From Fire-fighting to Prevention', *World Development*, vol. 24, No. 9, pp. 1417-1430
KIGGUNDU, M. (1998), 'Civil service reforms: limping into the twenty-first century', in Minogue, M. Charles Polidano and Hulme, D. (eds.), *Beyond the New Public Management: changing ideas and practices in governance,* Chetlenham: Edward Elgar Ltd pp.155-171
KIGGUNDU, M. (1989), *Managing Organisations in Developing countries: An operational and strategic Approach*, Oakwood, West Hartford: Connecticut, Kumarian Press, Inc.
KILLICK, T. (1995),
KILLICK, T. (1978), *Development Economics in Action*: *a study of economic policies in Ghana* London: Heinemann
KING, D.N. (1984), *Fiscal Tiers: the economics of multi-level government*, London: George Allen & Unwin Publishers Ltd
KIRAGU, K AND MUTAHABA, G. (2006) 'Introduction', in: Kithinji Kiragu and Mutahaba Gelase (eds.), *Public Service Reform in Eastern and Southern Africa: Issues and Challenges*, Dar e Salaam: Tanzania, Mkuki na Nyota Publishers, pp.1-16
KOTTER, J. P. (1990), *A Force for Change*, London: The Free Press.
Integration-Leadership Competencies Profile (Integration-LCP). Leeds: Leadership Research & Development. *The Transformational Leadership Questionnaire (TLQ)* Leeds: Leadership Research & Development Ltd.
KRIPPENDORF, K. (1980), *Content Analysis: An Introduction to Its Methodology*, Newsbury Park, CA: Sage
KUADA, J. (1994) Managerial Behaviour in Ghana and Kenya: A Cultural Perspective, Aalborg: Aalborg University Press
KULIPOSSA, F.P. (2004), 'Decentralisation and Democratisation in developing countries: An Overview', *Development in Practice*, Vol. 14, No. 6 (November), pp.768-779
KUHNERT, K.W. (1994), 'Transforming Leadership: Developing People through Delegation', in B.M. Bass & B.J. Avolio (eds.) *Improving Organisational Effectiveness through Transformational Leadership*, (pp. 10-25). Thousand Oaks, CA: Sage
KRAUS, J. (1991), 'The Political Economy of stabilisation and Structural Adjustment in Ghana', in: Donald Rothchild, (ed.), *Ghana: the political economy of recovery*: Boulder CO: Lynne, Rienner pp. 119-56
LANE, JAN-ERIK (1996), 'Introduction: Public Sector Reform: Only Deregulation, Privatisation and Marketisation?' Jan-Erik Lane (ed.) *Public Sector Reform: Rationale, Trends and Problems*, London: Sage
LANE, J.K. (2000), *The Public Sector: Concepts, Models and Approaches,* 3rd Edition, London, Newsbury Park and New Delhi, Sage Publications
LARBI, G. (1998), *Implementing New Public Management Reforms in Ghana: Institutional Constraints and Capacity Issues*—cases from public health and water services, PhD thesis (unpublished), University of Birmingham

LARBI, G. (1998a) 'Management Decentralisation in Practice: A Comparison of Public Health and Water Services in Ghana', in Minogue, M C. Polidano and D. Hulme (eds) *Beyond the new Public Management: Changing Idea and Practices in Governance,* Edward Elgar, pp. 188-206
LARBI, G. (1998c), 'Institutional Constraints and Capacity Issues in Decentralising Management in Public Services: the Case of Health in Ghana', *Journal of International Development*, Vol. 11, Nos. 2/3, pp. 154-163
LAWTON, A. (1998), *Ethical Management for the Public Services*, Buckingham: Open University Press
LEE, T.W. (1999), Using Qualitative Methods in Organisational Research, London: Sage
LEFTWICH, A. (2004) 'Theorising the state', in Burnell Peter and Vicky Randall (eds.) *Politics in the Developing* World, Oxford: Oxford University Press, pp.139-154
LITVACK, J., JUNAID AHMAD AND RICHARD BIRD (1998), *Rethinking Decentralization in Developing Countries*, Washington, D.C. World Bank
LEFTWICH, A, (1993), 'Governance, Democracy and Development in the Third World', *Third World Quarterly*, Vol. 14, No. 3 pp. 603-624
LEONARD, D. K. (1982), 'Analysing the Organisational Requirements for Serving the Poor', in: Leonard, D. and Marshall, D.R. (eds.), *Institutions of Rural Development for the poor: Decentralisation and Organisational Linkages*, Berkeley: University of California Press
LEONARD, D. K. (1991), African Successes: Four Public Managers of Kenyan Rural Development', Berkeley, CA: University of California Press
LEVIN, M. (1980), 'Conditions contributing to effective implementation and their limits,' unpublished manuscript, Brandeis University
LEVITT, R. (1980), Implementing Public policy, London: Croom Helm
LEVY, B. (2004), 'Governance and Economic Development in Africa: Meeting the Challenges of Capacity Building', in: Levy, B. Sahr Kpunde (eds), *Building state Capacity in Africa: New approaches and Emerging Lessons,* Washington, D.C. USA, World Bank; pp 1-42
LEWICKI, R.J. AND B.B. (1996), 'Developing and Maintaining Trust in Work Relationships', in R.M. Kramer (eds.), 'Trust in Organisations: Frontiers of Theory and Research, CA: Thousand Oaks, Sage Publication
LINCOLN, Y.S. AND GUBA, E.G. (1985), *Naturalistic inquiry*, Beverly Hill, CA: Sage
LIPSKY, M. (1971), 'Street-Level Bureaucracy and the Analysis of Urban reform', *Urban Affairs Quarterly*, vol. 6, pp. 391-409
LIPSKY, M. (1980), *Street-level bureaucracy: Dilemmas of the individual in public services.* Russell, New York: Sage Foundation,
LOWI, T. J. (1972), 'Four Systems of policy, politics and choice', *Public Administration Review*, vol. 32(4), pp 298-310
LYNN, L. (1998), 'The New Public Management as an International Phenomenon: A sceptical viewpoint', in: L. Jones and K. Schedler (ed.) *International Perspective on the New Public Management*, Greenwich, CT: JAI Press
MAcINTYRE, A. (1981), *After Virtue: A Study in Moral Theory*, London: Duckworth
MADDICK, H. (1963), *Democracy, Decentralisation and Development*, Bombay: Asia Publishing House.
MADDICK, H. (1981), 'Major approaches and strategies in decentralisation for development', Paper to UN interregional Seminar, Khartoum, September.
MAETZ, M. AND QUIETI, M.G. (1987), *Training for Decentralised Planning: Lessons from Experience*, Vol.2, Rome, FAO.
MALAMA, A. (2003), *A Proposal for the Process of Implementation of the Decentralisation policy in Zambia*, Unpublished Summary Report, IDD, University of Birmingham
MAJONE, G. AND WILDAVSKY, A. (1978), 'Implementation as evolution', in *Policy Studies Review Annual-1978*, ed. by Howard Freeman, Beverly Hill: Sage
MANOR, J. (1995), *The Political Economy of Democratic Decentralisation*, Direction in Development Series, Washington: D.C: World Bank
MANNING, N. (2002), The New Public Management in Developing countries, in C. Kirkpatrick, Clark, R. and Charles Polidano (ed.s) *Handbook on Development Policy and Management*; Cheltenham, UK: Edward Elgar, pp.303-314
MANNING, N. (2001), 'The legacy of the New Public management in Developing countries', *International Review of Administrative Sciences*, Vol. 67, pp.297-312

MARSHALL, H. (1990), 'Civil Service Reform in Ghana', RIPA Report, Vol. 11, No. 1 (spring)
MAWHOOD, P. (1983), *Local Government in the Third World: The Experience of Tropical Africa,* Chichester: John Wiley & Sons.
MAWHOOD, P. (1987), 'Decentralisation and the Third World in the 1980s', *Planning and Administration*, Vol. 14, No. 1, pp. 10-22.
MAZMANIAN, D. AND SABATIER, P. (1981), *Effective Policy Implementation*, Davis, California: University of California Press
MAZMANIAN, D. AND SABATIER, P. (1983), *Implementation and Public policy*, Chicago: Scott Foresman and Co.
MAZMANIAN, D. AND SABATIER, P. (1989), *Implementation and Public Policy*, London, Maryland: Univeristy Press of America, Inc.
McCOURT, W. (2006), *The Human Factor in Governance: Managing Public Employees in Africa and Asia*, Houndmills, Basingstoke: Palgrave Macmillan
McCOURT, W. (2005a), *Path Dependence and History in Malaysian Civil Service*, University of Manchester, Governance and Development Morking Paper No. 13
McCOURT, W. AND BEBBINGTON, A. (2005), 'Statecraft in the South: A Framework for understanding public policy success in developing Countries', Paper presented at a Seminar on *'Policy Success in Developing Countries'*, Institute for development Policy and Management, Manchester University, Manchester, May 20, 2005
McCOURT, W. (2003), 'Political Commitment to Reform: Civil Service Reform in Swaziland', *World Development,* vol. 31, pp. 1015-1031
McCOURT, W. (2002), 'New Public Management in Developing Countries', in McLaughlin, K. Stephen P. Osborne and Ewan Ferlie (ed.), *New Public Management: Current Trends and Future Prospects*, London: Routledge, pp. 227-242
McCOURT, W. (2001), 'The NPM Agenda for Service Delivery: A Suitable Model for Developing Countries', in Willy McCourt and Martin Minogue (eds) *The Internationationalisation of Public Management: Reinventing the Third World,* Cheltenham, UK: Edward Elgar, pp 107-128
McCOURT, W. (1998), 'Civil Service Reform Equals Retrenchment: The Experience of Rightsizing and retrenchment in Ghana', Uganda and UK, in Minogue, M. Charles Polidano and Hulme, D. (eds.), *Beyond the New Public Management: changing ideas and practices in governance,* Chetlenham: Edward Elgar Ltd pp.172-187
McCOURT, W. and Nazar Sola (1999), 'Using training to promote civil service reform: a Tanzanian local government case study', *Public Administration and Development*, Vol. 19, pp. 63-75
McLURE, C.E. (1995), 'Comment on Prud'homme', *World Bank Research Observer*, Vol.10, No.2, pp.220-26
MORROW, R.H. (1983), 'A Primary Health Care Strategy for Ghana', in: *Practicing Health For All*, (ed.) D. Moreley, J. Rhode and G. Williams, pp. 272-299; Toronto: Oxford University Press
MELLON, E. (1993), 'Executive agencies: leading change from the outside', *Public Money and management*, Vol. 13(2), pp. 25-31
MENSAH, K. (2002), Attracting and Retaining Health Staff: A Critical Analysis of the factors influencing the retention of health workers in deprived/hardship area, A report submitted to Ministry of Health, February 2002, Accra
MENSAH, E.N. (1997), 'The Ghanaian decentralisation process and health care reforms', A paper presented to East/South Africa Regional Conference Workshop in *Health Financing: Lessons Learned*, Harare, Zimbabwe, May 26-29
MERRIAM, S.B. (2001), *Qualitative Research and Case study Application*, San Francisco: Jossey-Bass
MERRIAM, S.B. (1998), *Qualitative Research and Case Study Application in Education*, San Francisco, CA: Jossey-Bass
MEYER, J.P. AND ALLEN, J.N. (1997) *Commitment in the workplace: Theory, Research and Application,* California: Sage Publication
MILES, M. B. AND HUBERMAN, A. M. (1994), Qualitative data analysis, a sourcebook of new methods, Beverly Hills: Sage

MILLS, A. (1999), 'Reforming Health sectors: fashions, passions and common sense'. In: Mills Anne (ed.) *Reforming Health Sectors*. London: Kegan Paul
MILLS, A. (1994), 'Decentralisation and Accountability in the health from an international perspective: what are choices', *Public Administration and Development,* vol. 14, pp. 281-292
MILLS, A. (1990), 'Decentralisation concepts and issues: a review', in Mills, A. Vaughan, D.L. Smith, and I. Tabibzadeh, (eds) *Health System Decentralisation: Concepts, Issues and Country Experiences*, Geneva: World Health Organisation
MINOGUE, M. POLIDANO, C. AND HULME, D. (1995) *Beyond the New Public Management: Changing Ideas and Practices in Governance*, Edward Elgar Publishing
MINTZBERG, H. (1983), *Structure in Fives: Designing Effective Organisations*. Engle-wood Cliffs, NJ: Prentice Hall

MORSE, J.M. (2003), 'Principles of Mixed Methods and Multimethod Research Design', in: Abbas Tahsakkori and Charles Teddlies (eds.), *Handbook of Mixed Methods in Social and Behavioural Research*, Thousand Oaks, California: Sage Publication Inc. pp. 189-208

MORSE, J.M. (1994), Qualitative Research: Fact or Fantasy? In J.M. Morse (ed), *Critical Issues in Qualitative Research Methods*, pp. 1-9, Thousand Oaks, CA: Sage
MUSGRAVE, R.A. (1959), *The Theory of Public Finance*, New York: McGraw Hill
NAKAMURA, R. AND SMALLWOOD, F. (1980), *The politics of policy implementation,*
NDIAYE, J.M. (1990), 'Decentralisation of Health Services in Senegal', in Mills, et al (eds.), *Health System Decentralisation: Concepts, Issues and Country experience*, Geneva: WHO
NDEGWA, S. N. AND LEVY, B. (2004),'The Politics of decentralisation in Africa: A comparative analysis', in: Brain Levy and Sahr Kpundeh (eds.) *Building State Capacity in Africa: New Approaches, Emerging Lessons*, Washington, D.D. World Bank, pp 283-322
NEUMAN, W. L. (2000), *Social research methods: Qualitative and quantitative approaches* (4th ed.). Boston: Allyn and Bacon.
NEWMAN, J. (2002), 'The New Public Management, modernisation and institutional disruptions, disjunctures and dilemmas', in: McLaughlin, K. Stephen P. Osborne and E. Ferlie (ed.), *New Public Management: Current Trends and Future Prospects*, London: Routledge, pp. 77-92
NEWELL, K.W. (1995), *Health by the people*, WHO: Geneva
NINSIN, K. (1991), 'The PNDC and the Problem of legitimacy', in: Donald Rothchild, (ed.), *Ghana: the political economy of recovery*: Boulder CO: Lynne Rienner, pp. 49-68
NORTHOUSE, P.G. (2004), *Leadership: Theory and Practice*, Thousand Oaks: California, Sage Publication
OLOWU, D. AND SAKO, (2002), (eds.) *Better Governance and Public Policy: Capacity Building for Democratic Renewal*, Bloomfield: Kumarian Press.
OLOWU, D. (1999), 'Redesigning African civil Service Reform', *Journal of Modern African Studies*, Vol. 37, No. 1, pp. 1-23
OQUAYE, M. (1995), 'Decentralisation and Development: The Ghanaian Case under the PNDC, *Journal of Commonwealth and Comparative Politics*, vol. 33, (2), pp.209-39
OCED (2005), *Modernising Government: The Way Forward*, Paris: OCED
ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (1994) Public Management Development, Paris: OECD
ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (1995) *Governance in Transition: Public Management Reforms in OECD Countries*, Paris: OECD
OSBORNE, D. AND GAEBLER, T. (1992) *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*, Reading, MA: Addison-Wesley
ONYACH-OLAA, N. (2003), The Challenges of Implementing Decentralisation: Recent Experiences in Uganda', *Public Administration and Development*, Vol. 23, pp. 105-113
PATTON, Q. (1990), *Qualitative evaluation and research method*, Newbury Park CA: Sage
PHILLIPS, R.A. (1997), 'A Stakeholder Theory and A Principle of Fairness', *Business Ethics Journal, Volume*, 7, No. 1, pp. 51-66
POLITIS, J.D. (2001), 'The Relationship of Various Leadership Styles to Knowledge Management', *Leadership and Organisation Development Journal*, Vol. 22, No. 8, pp.354-364
POLLITT, C. BIRCHALL, J. AND PUTMAN, K. (1998), *Decentralising Public Service Management*, London: Macmillan.

POLLITT, C. AND BOUCKAERT (2000), *Public Management Reform: A Comparative Analysis*, Oxford: Oxford University Press
POLLITT, C. (2000), 'Is the Emperor in his underwear? An Analysis of the impacts of public management reforms, *International Journal of Public Management*, Vol. 2, No. 2, pp. 181-199
POLLITT, C. (1990), *Managerialism and Public Service: The Anglo-American Experience*, Cambridge, M.A.: Blackwell
POWELL, W.W. (1996), 'Trust-based forms of Governance', in R.M. Kramer (eds.), 'Trust in Organisations: Frontiers of Theory and Research, CA: Thousand Oaks, Sage Publication
PRICE, R. (1984), 'Neo-colonialism and Ghana's Economic Decline', *Canadian Journal of African Studies*, vol. (1)
PRICE, R. M. (1975), *Society and Bureaucracy in Contemporary Ghana*, Los Angeles: University of California Press
PRUD'HOMME, R. D. (1995), 'The Dangers of Decentralisation', *World Bank Research Observer*, Vol.10, No.2, pp.201-220
QUICK, S.A. (1980), 'The Paradox of Popularity: 'Ideological' Programme Implementation in Zambia', in: Grindle, M.S. (ed) (1980), *Politics and Policy Implementation in the Third World*, New Jersey: Princeton University Press, pp 3-34
pp. 40-63

RAY, D. (1986), *Ghana: Politics, Economics and Society*, London: Macmillan.
Reilly (1990),
RICCUCCI, N.M. (2001), 'The "Old" Public Management Versus "New" Public Management: where does the public administration fit in?' *Public Administration Review*, Vol. 61, No. 12, pp. 172-175
RIPLEY, R. B. AND FRANKLIN, G.A. (1982), *Bureaucracy and Policy Implementation*, Homewood, Ill.: Dorsey Press
RONDINELLI, D.A. AND CHEEMA, G.S. (1983), 'Implementing decentralisation policies: an introduction:' in G.S. Cheema and D.A. Rondinelli (eds.), *Decentralisation and Development: Policy Implementation in Developing Countries*, Beverly Hill: Sage Publications.
RONDINELLI, D.A. AND NELLIS, J.R. AND CHEEMA, S.G. (1984), 'Decentralisation in Developing Countries: A review of Recent Experience', *World Bank Staff working Paper* No. 581.
RONDINELLI, AND NELLIS (1986), 'Assessing Decentralisation Policies in Developing Countries: The Case of Cautious Optimism', *Development Policy Review*, Vol. 4, pp. 3-23
RONDINELLI, D.A. (1981), 'Government Decentralization in Comparative Theory and Practice in Developing Countries', *International Review of Administrative Sciences*, Vol. 47, No. 2: 133-145
RONDINELLI, D. A. (1981), 'Government Decentralisation in Comparative perspective: Theory and Practice in Developing Countries', *International Review of Administrative Sciences*, Vol. 47, No. 2, pp. 133-145.
ROTHCHILD, D. (1991) (ed.), *Ghana: The Political Economy of Recovery*, Boulder, Co: Lynne Rienner
ROTHENBERG, I. F. (1980), 'Administrative Decentralisation and the Implementation of Housing Policy in Colombia', in: Grindle, M.S. (ed) (1980), *Politics and Policy Implementation in the Third World*, New Jersey: Princeton University Press, pp.145-169
Russell, S. Bennett, S. Anne Mills (1999), 'Reforming the Health Sector: Towards a Healthy New Public Management, *Journal of International Development*, Vol. 11, pp. 767-775
SABATIER, P. A. (1986) "Top-down and bottom-up approaches to implementation research: a critical analysis and suggested synthesis", Journal of Public policy, vol. 6(1) pp 21-48
SABATIER, P. AND JENKINS-SMITH, H. (199) (eds.) *Policy Change and Advocacy Coalition Approach*, Boulder Colorado: Westview Press
SABATIER, P AND MAZMANIA, D. (1979), 'The conditions of Effective implementation', *Policy Analysis*, vol. 5, (Fall), pp 481-504
SABATIER, P AND KLOSTERMAN, B. (1981), A comparative analysis of policy implementation under different statutory regimes', in Daniel mazmania and Paul Sabatier (eds) *Effective Policy implementation*, Lexington, M.A. D.C. Heath, pp. 169-206
SABATIER, P. (1999), 'The Need for Better Theories', in Paul Sabatier (ed.) *Theories of the Policy process*, Boulder Colorado: Westview Press, pp 3-18

SAITO, F. (2003) *Decentralisation and Development Partnerships: Lessons from Uganda,* Springer-Verlag, Japan: Tokyo
SALTMAN, R.B. BANKAUSKAITE, V. (2004), *Implementing Decentralisation in European Health Care Systems: Searching for Policy Lessons*, Paper Presented at the 5th European Conference of Health Economists, London School of Economics, 8-11 September 2004
SAKYI, E.K., (2004). 'Promoting Accountability through State Audit: An appraisal of the Auditor-General's Reports on the Consolidated Fund (CF) in Ghana, 1993-1999', *African Administrative Studies*, Vol. 62, pp.1-18
SAMOFF, J. (1990), 'Decentralisation: the politics of interventionism', *Development and Change*, Vol.21, pp.513-530
SANBROOK, R. AND OELBAUM, J. (1997), 'Reforming Dysfunctional Institutions through Democratisation? Reflections on Ghana', *The Journal of Modern African Studies*, Vol. 35, No. 4, pp. 603-646
SANDBROOK, R. (2000), *Closing the Circle: Democratisation and Development in Africa*, London & New York: Zed Books Ltd
SANBROOK, R. (1993), The Politics of Africa's Recovery, Cambridge: Cambridge University Press
SAWYER, O.O. (1993), 'Environmental Uncertainty and Environment Scanning Activities of Nigeria Manufacturing Executives: A Comparative Analysis', *Strategic Management Journal*, Vol. 14, pp. 287-299
SCHARPF, F.W. (1978) inter-organizational policy studies: Issues, concepts and perspectives, in: H.I Hanf and F.W. Scharpf (eds.) *Inter-organizational Policy making: Limits to Coordination and Control,* London: Sage Publication
SCHARPF, F.W. (1986) 'Policy failure and Institutional reform: why should form follow function?, *International Social Science Journal*, vol. 38 (2) pp. 171-191
SCHARPF, F. W. (1988), 'The Joint Decision trap, *Public Administration*, vol. 66, pp 239-278
SCHEIN, E.H. (1992), *Organisational Culture and Leadership*, (2nd edition) Jossey-Bass, San Francisco
SEDDOH, A.T., ADJEI, S. AND ADDAI, E. ET. AL. (2000) *Health/Local Government Linkages: A Synthesis of Key Issues* (Accra: MOH/GHS).
SELVIN, D.P. AND PINTO, J.K. (1987) 'Balancing strategy and tactics in Project implementation', *Sloan Management Review*, Fall, pp. 33-44
SELZNICK, P. (1975) *Leadership in Administration*, New York: Harper and Row
SIDDIQUEE, N.A. (1997), *Decentralisation and Development in Bangladesh: Theory and Practice*, Dhaka: University of Dhaka Press
SILVERMAN, D. (2000), *Doing Qualitative Research: A Practical Handbook*, Thousand Oaks, California, Sage
SKOCPOL, T. AND FINEGOLD, K. (1982) 'State Capacity and economic intervention in the Early New Deal', *Political Science Quarterly*, Vol. 97 (2), pp.255-278
SLATER, R. AND WATSON, J. (1989), 'Democratic decentralisation or political consolidation: the case of local government reform in Karnataka', *Public Administration and Development,* Vol. 9, No. 2, pp.147-157.
SLATER, D. (1989), 'Territorial Power and the Peripheral State: The Issue of Decentralisation', *Development and Change*, Vol. 20, pp.501-531
SMITH, B.C. (1997), 'The Decentralisation of Health Care in Developing Countries: Organisational Options', *Public Administration and Development* Vol. 17, pp 399-412
SMITH, B.C. (1996), 'Sustainable Local Democracy', *Public Administration and Development*, Vol. 16, No.2 pp. 163-78
SMITH, B.C. (2002) 'Decentralisation', in: Colin Kirkpatrick, Ron Clark, and Charles Polidano (eds.) *Handbook on Development Policy and Management*, Cheltenham: Edward Elgar.
SMITH, B.C. (1990), *Choices in the Design of Decentralisation*, London: Commonwealth Secretariat
SMITH, B. C. (1985), *Decentralisation: The Territorial Dimension of the State*, London: Allen & Unwin
SMITHSON, P., ASAMOAH-BAAH & MILLS, A. (1997) *The Role of Government in Adjusting Economies: The Case of Health Sector in Ghana* (Birmingham: University of Birmingham).

SMITHSON, P. (1993) *Sustainability in the Health Sector*. Part 2: *Financial Constraints to Health Service Operation and Development in Ghana*. Save the Children Fund, London, UK.
SMOKE, P. (2001), *Fiscal Decentralisation in Developing Countries: A Review of Current Concepts and Practice*, Geneva: United nations Research Institute for Social Development.
SMOKE, P. AND OLOWU, D. (1993), 'Successful Local Government: Methodological and Conceptual Issues Reconsidered,' *Public Administration and Development*, Vol. 13, pp.507-514.
STEPHEN, N. NDEGWA, AND LEVY B. (2004), 'The Politics of decentralisation in Africa: a comparative analysis', in: Levy, B. Sahr Kpunde (eds), *Building state Capacity in Africa: New approaches and Emerging Lessons,* Washington, D.C. USA, World Bank; pp 283-321
STEVENS, M. TEGGEMANN, S (2004), 'Comparative Experience with Public Service Reform in Ghana, Tanzania, and Zambia' in: Levy, B. Sahr Kpunde (eds), *Building state Capacity in Africa: New approaches and Emerging Lessons,* Washington, D.C. USA, World Bank; pp 43-86
STIGLITZ, J. (2002), *Globalisation and its discontents*, London: Pengium Books
STRAUSS, A. AND CORBIN J. (1998), *Basics of Qualitative Research: Techniques and Procedure for Developing Grounded Theory,* London: Sage
SUSSMAN, G.E. (1980), 'The Pilot Project and the Choice of an Implementing Strategy: Community Development in India', in: Grindle, M.S. (ed) (1980), *Politics and Policy Implementation in the Third World*, New Jersey: Princeton University Press, pp103-122
SWAILES, S. (2000), 'Goals, creativity and achievement: commitment in contemporary organisations', *Creativity and Innovation Management*, Vol. 9, No. 3, pp. 228-59
TASHAKKORI, A. AND TEDDLIE, C. (2003), Preface, in: Abbas Tahsakkori and Charles Teddlies (eds.), *Handbook of Mixed Methods in Social and Behavioural Research*, Thousand Oaks, California: Sage Publication Inc.
THOMAS, J. AND GRINDLE, M. (1990), 'After the decision: Implementing policy reform in developing countries,' *World Development*, vol. 18, No. 8 pp. 1163-1183
THOMAS, A. (1998), Challenging Cases, in: Alan Thomas, Joana Chattaway and Marc Wuyts (eds.), *Finding Out Fast: Investigative Skills for Policy and Development*, Bonhill Street, London: Sage Publication
TOURISH, D. OWEN, D. AND HARGIE, W. (1998), 'Communication between Managers and Staff in the NHS: Trends and Prospects' *British Journal of Management*, Vol. 9, pp. 53-71
TURNER, M. AND PODGER, O. (2003), *Decentralisation in Indonesia: Redesigning the State*, Canberra; Asia Pacific Press.
TURNER, M. (1999), 'Central-local relations: themes and issues', in M. Turner, (ed.), *Central-local Relation in Asia-Pacific: convergence or divergence?*, London: Macmillan
TURNER, M. HULME, D. (1997), *Governance, Administration and Development: making the state work*, London: Macmillan
TOYE, J. (1991), 'Ghana', in P. Mosley and Jane Harrigan and J. Toye, Aid and Power: The World Bank and Policy-based Lending, London: Routeledge
TOURISH, D. OWEN, D. AND HARGIE, W. (1998), 'Communication between Managers and Staff in the NHS: Trends and Prospects' *British Journal of Management*, Vol. 9, pp. 53-71
TOWNLEY, B. (1994), 'Communicating with employees', in Keith Sisson (ed) *Personnel Management: A Comprehensive Guide to Theory and Practice in Britain*, Oxford: Blackwell Publishers, pp. 59632
TSIKATA,. G.K AND AMUZU, G.K (1993), 'Fiscal Development Policies and Options', in: V.K. Yanteng (ed.), *Policies and Options for Ghanaian Development*, University of Ghana, ISSER
UPHOFF, N. ESMAN, M.J. AND KRISHNA, A. (1998), *Reasons for Success: Learning from Instructive Experience in Rural Development*, West Hartford, Conn.: Kumarian Press
UNITED NATIONS DEVELOPMENT PROGRAMME (2003), Capacity Development: http://www.undp.org/capacity, accessed September 7, 2006
UNITED NATIONS (1961), *A Handbook of Public Administration*, New YORK
UNITED NATIONS (1962), 'Decentralisation for National and Local Development', UN Technical assistance Programme, New York: The United Nations.
UNITED NATION DEVELOPMENT PROGRAMME (1998), *Factors to consider in designing Decentralised Governance Policies and Programmes to Achieve Sustainable People-Centred*, paper prepared by the Management Development and Governance Division, UNDP, New York.

Van de WALLE, N. (1994), 'Political Liberalisation and Economic policy reform in Africa,' *World Development*, vol. 22, No. 4, pp. 483-500
VAN METER, D. AND VAN HORN, C. (1975) The Policy implementation process: a conceptual framework, *Administration and Society* VIITALA, R. (2004), 'Towards Organisational Leadership', *Leadership and Organisation Development Journal*, Vol. 25, No. 26, pp. 528-544
VRANGBAEK, K. (2004), *Decentralisation and Centralisation in Scandinavian Health*, Paper Presented at EHPG Conference, London September 8-11
WALT, G. (1998), 'Implementing Health Care Reform: A Framework for Discussion', in: R. Saltman, J. Figueras & C. Sakellarides, (eds.) Critical Challenges for Health Care Reform in Europe, Buckingham: UK Open University Press
WALT, G. (1994), *Health Policy: an introduction to process and power*, Johannesburg: Witwaterand University Press, Zed Books
WALT, G. AND GILSON, LUCY ((1994), 'Reforming the Health Sector in Developing Countries: the central role of policy analysis, *Health Policy and Planning*, Vol. 9, no. 4, pp. 353-370
WANNA, J. O'FCHEALLAIGH, C. AND WELER, P. (1992), *Public Sector Management in Australia*, Melbourne: Macmillan
WANGWE, S.M. AND RWEYEMAMU, D.C. (2001), *Human Resource and Institutional Development in Africa: an overview*, Paper Presented at the First Pan African Capacity Building Forum, Bamako, Mali, October
WEBB, E. CAMPBEL, D. SCHWARTZ, R. SECHRIST, L. (1981), *Non-reactive measures in the Social Science*, Boston: Houghton Mifflin
WEBER, R.P. (1990), Basic *Content Analysis*, (2nd ed.), Newbury CA
WELMAN, J. C., AND KRUGER, S. J. (1999), *Research methodology for the business and administrative sciences*, Johannesburg, South Africa: International Thompson
WHITMORE, R. (1984), 'Modelling the Policy/Implementation Distinction: The Case of Child Abuse', *Policy and Politics*, vol. 12 (3), pp 241-267
WISKOW, C. (1999). Human Resource Management and Development in the District Health Service in African Countries: Summary of findings from Country studies on Ghana and Cameroon, Research Report Prepared for GTZ (Ghana), December
WITTROCK, B. ET AL., (1982), 'Implementation beyond hierarchy: Swedish energy research policy', *European Journal of Political Research*, vol. 10 (June), pp 131-143
WOLFERS, E.P.(1982), Decentralisation: Options and Issues: A Manual for Policy Makers, London, Commonwealth Secretariat).
WORKS, R. (2002), 'Overview of Decentralisation Worldwide: A Stepping Stone to Improved Governance and Human Development', Paper Presented at "2nd International Conference on *Decentralisation Federalism: The Future of decentralising states*, 25th – 27th July 2002, Manila, Philippines:http://www.undp.org/governance/docs/DLGUD_Pub_overview-decentralisation-worldwide-paper.pdf; last accessed 23rd October, 2006
WORLD BANK, (1993), *World Development Report 1993: Investing in Health*, Washington, D.C.
WORLD BANK (1993b), *Project Completion Report: Republic of Ghana, Structural Adjustment Institutional Support Project*, Washington, DC: Country Operations Division, Western Africa Department, World Bank, 15 November
WORLD BANK, (1993) *Investing in Health: World Development Report, 1993:* (Oxford: Oxford University Press).
WORLD BANK (1996) World Development Report, *Towards Better and Slimmer Government*, New York: Oxford University Press.
WORLD BANK, (1989), *Strengthening Local Government in Sub-Saharan Africa*, EDI Policy Seminar Report No.21, Washington, D.C.: World Bank
WORLD BANK, (1997), *World Development Report: The State in a Changing World.* New York: Oxford University Press.
WORLD BANK, (1993), *Governance: the World Bank experience*, World Bank: Washington, D.C.
WORLD BANK, (2003), *World Development Report 2004 Making Service Work for the Poor*, Washington, D.C.: World Bank and Oxford University Press

WORLD BANK, (2002), *World Development Report 2002: Building Institutions for Markets*, Washington, D.C.: World Bank
WORLD BANK, (2001a), Decentralisation and Governance: does decentralisation improve public service delivery, PREM notes No. 55, Poverty Reduction and Economic Management Network, World Bank, Washington, D.C.
WORLD BANK (2001b), *Education and Health in Sub-Saharan Africa: A Review of Sector-Wide Approaches*, Washington, D.C.: World Bank
WORLD BANK, (2000), *World Development Report 1999/2000*, New York: Oxford University Press
WORLD BANK, (2000), 'Decentralisation and Health Care', Decentralisation Thematic Group: Washington, D.C.
WORLD BANK, (2000), 'New Paths to Social Development: Community and Global Networks in Action', Social Development Department, Environmentally and Socially Sustainable Network, Washington, D.C.
WORLD BANK, (2000), *World Development Report 2000/2001*, Oxford: Oxford University Press.
WORLD BANK, (1997), *World Development Report: The State in a Changing World.* New York: Oxford University Press.
WORLD BANK (1996), World Development Report 1996: *From Plan to market*, New York: Oxford University Press.
WORLD HEALTH ORGANISATION (2001), *World Health Report: Health Systems, Improving Performance*'. Geneva
WORLD HEALTH ORGANISATION (1978), *Primary Health Care: Report of the International Conference on Primary Health Care*, Alma-Ata, USSR, September 6-12, Geneva
WORLD HEALTH ORGANIZATION (1995) *Decentralization and Health Systems Change: A Framework for Analysis* (Geneva: WHO).
WORLD HEALTH ORGANIZATION/MINISTRY OF HEALTH, Ghana (1992-1994) *Restructuring the Ministry of Health: Review of Progress* (Geneva: WHO).
WORLD HEALTH ORGANISATION (2001), *World Health Report: Health Systems, Improving Performance*
WUNSCH, J.S. (2001), 'Decentralisation, Local Governance and Recentralisation' in Africa, *Public Administration and Development*, Vol. 21, No. 4, pp. 277-288
WUNSCH, J. S. AND OLOWU, D. (1996), 'Regime transformation from below: decentralisation, local government and democratic reform in Nigeria', *Studies in Comparative International Development*, Vol.31, No. 4, pp. 66-82
WUNSCH, J.S. AND OLOWU, D. (1990), *The Failure of the Centralised State: Institutions and Self-governance in Africa*, Boulder: Westview
YIN, R. (1994), *Case Study Research: Design and Methods*, (2nd ed.), Thousand Oaks, CA: Sage Publication
ZAFARULLAH, H. AND HUQUE, A. S. (2006), 'Understanding Development Governance: Concepts, Institutions, and Process', in: Zafarullah Habib and Ahmed Shafiqul Huque (eds.) International Development Governance, NY: Taylor and Francis, pp. 13-50

Government of Ghana Selected Documents

Ghana, Republic of (1988), Health Administration Law, 1988 (PNDC Law 209), Tema: Ghana Publishing Corporation
Ghana, Republic of (1992) *Constitution of the Republic of Ghana, 1992*, Tema: Ghana Publishing Corporation.
Ghana, Republic of (1997), *Ghana-Vision 2020: the first medium tem development plan, (1997-2000),* Accra; Ghana Publishing corporation
Ghana, Republic of (1998), *Ghana-Vision 2020: programme for action for the first medium-term development plan, (1997-2000)*, Accra: Ghana Publishing corporation
Ghana, Republic of (2000c), *Interim Poverty Reduction strategy, Paper 2000-2002*
Ghana, Republic of (2003), *Ghana Poverty Reduction strategy, 2003-2005*
Ghana, Republic of (1993) *Local Government Act (Act 462)*, Accra: Ghana Publishing Corporation.
Ghana, Republic of (1996), Ghana Health Service and Teaching Hospitals Act, Act 525, 1996

Ghana, Republic of (1999) *Comprehensive Development Framework: Health Sector*;
Ghana, Republic of (2003), *Public Sector Reform: Towards a Future strategic Framework*, Draft Report Prepared and submitted to GOG by Price-Water House Coopers: Accra
Ghana, Republic of (1991), 'Broadcast to the Nation on New Year's Day' by Rawlings, J.J,. *A Year of Bold Actions*, Accra: Information Service Department
A First Draft Comprehensive Development Framework towards Ghana's Vision 2020, 10th Consultative Group Meeting, November 1999.
Ghana, Republic of (2002) *Ghana Poverty Reduction Strategy, 2002-2004*. (Accra).
Ghana, Republic of (2002), *Ghana Poverty Reduction Strategy, 2002-2004*, February 2002;
Ghana Republic of (2002) *Decentralization in Ghana: Implementation Status and Proposed Future Directions, March 2002*; Accra: MLGRD
Ghana Statistical Service (2000), *2000 Population and Housing Census: Provisional results*, Accra: GSS

Ministry of Health & Ghana Health Service Selected Reports

Ministry of Health (1994) *The Health Sector in Ghana: Facts and Figures*, Accra: MOH.
Ministry of Health (1994) *Policies and Priorities for the Health Sector, 1994-1995* Accra: MOH.
Ministry of Health (1995) *Medium Term Health Strategy: Towards Vision 2020* Accra: MOH.
Ministry of Health (1996a) *Institutional Reform in the Health Sector*, Accra: MOH
Ministry of Health (1996b) *Management Arrangements for Implementation of the Medium Term Programme of Work (1997-2001);* Accra: MOH
Ministry of Health, (1996c), *Health Sector Five year Programme of Work*, Accra: MOH
Ministry of Health (1998) *Financial Report December* 31, 1998
Ministry of Health (1999) The Health Sector in Ghana: Facts and Figures, Accra: MOH
Ministry of Health (2000), *Health Policies in Ghana – Implications for Equity: A Policy and Literature Review*, July, Accra: MOH
Ministry of Health (2001) *The Health of the Nation: Reflections on the Five Year Health Sector Programme of Work, 1997-2001*, Accra: MOH
Ministry of Health (2002a) *Common Management Arrangements (CMA II) For the Implementation of the Second Health Sector Five Year Programme of Work, 2002-6*. A Component of SWAP II (Accra: MOH).
Ministry of Health (2002b) *Ghana Health Sector Programme of Work, 2002: From Policy to Strategy: Consolidating the Programme of Work for Action* (Accra: MOH).
Ministry of Health (2002c), *The Second Health Sector 5 Year Programme of Work, 2002-2006: Partnerships for Health: Bridging the Inequalities Gap*, Accra: MOH
Ministry of Health, (1982), *The Health Policy of Ghana*, Accra: MOH
Ministry of Health (2006), *The Ghana Health Sector 2006 Programme of Work*, Accra: MOH
Ghana Health Service – *Dangme West District, 2000 to 2003 Annual Reports and Reviews of Sector Performance*
Ghana Health Service – *Sekyere West District, 2000 to 2003 Annual Reports and Reviews of Sector Performance*
Ghana Health Service – *Tamale District, 2000 to 2003 Annual Reports and Reviews of Sector Performance*
Ghana Health Service Programme of Work 2003, MOH: Accra
http://www.ghanahealthservice.org/includes/upload/publications/HRU%20Report%202003.pdf, last accessed February 2006
Ghana Health service (2005), Annual Report and Programme of Work: *Building the Inequality Gap: Addressing Emerging Challenges with child Survival*, MOH: Accra
http://www.ghanahealthservice.org/includes/upload/publications/GHS_2005_Report.pdf, last accessed February 2006
MOH/GHS (2004) Programme of work and Budget
http://www.ghanahealthservice.org/includes/upload/publications/2004%20PROGRAMME%20OF%20WORK.pdf, last accessed February 2006
Ghana Health Service (2001), Annual Report: *Building Partnership for Health: Building the Inequality Gap*, MOH: Accra
http://www.ghanahealthservice.org/includes/upload/publications/2002%20REPORT.pdf, last accessed June 2006

Ghana Health Service 5-Year Programme of Work- 2002-2006, The Second Health Sector Programmes of Work. http://www.ghanahealthservice.org/includes/upload/publications/GHANAPLAN.pdf, MOH: Accra, last accessed May 2006

MOH/DANIDA (2001), *Review of Financial Management Systems in the Ministry of Health,* A Review Report submitted to the MOH by Danish International Development Agency: http://www.danida-health-ghana.org/publications/pdf/review-financial.pdf, last accessed November 2006

Appendix 1: List of Names Interviewees and Organisations

Dangme West District

	Interview Date	Names of Interviewees	Organisation	Position	Transcript Codes
1	11/08/05	Yao Brobbey-Mpiani	Administrative Support Service MOH	Head, Administrative Support Service	**DWS01**
2	11/08/05	Mr. Ebow	Ministry of Health, HQ	Director, Transport Management Unit	**DWS02**
3	16/08/05	George Dakpallah	Ministry of Health, HQ	Head, Planning & Budget	**DWS03**
4	09/08/05	Dr. S.K.	Pantang Hospital	Medical Officer I/C	**DWS04**
5	09/11/05	Kwasi Asabri	MOH	Deputy Director Human Resource	**DWS05**
6	17/11/05	Hellen Dzikunu	Danish Development Agency (DANIDA)	Health Programme Officer	**DWS06**
7	17/08/05	Albert Vanderpuije	Ebenezer Clinic Prampram	Medical Officer	**DWS07**
8.	17/08/05	Osman Abdul Rishid	Dodowa Health Centre	Senior Dispensary Technician	**DWS08**
9.	17/08/05	Nancy Akrong	Dodowa Health Centre	Senior Nursing Officer	**DWS 09**
10	14/11/05	Barbara Bentum	District Health Admin. Dodowa	District Pharmacist	**DWS10**
11	11/11/05	Ishmael Offei Beckoe	Dodowa Health Centre	Laboratory Technician	**DWS11**
12	11/11/05	Abdul Safo	District Health Admin. Dodowa	District Accountant	**DWS12**
13	11/11/05	Leticia Adetor	District Health Admin. Dodowa	District Health Administration	**DWS13**
14	09/11/05	Christiana Fiati	Ningo Health Centre	Senior Mid-Wife	**DWS14**
15	09/10/05	Samuel Tetteh	Ningo Health Centre	Dispensary Technologist	**DWS15**
16	14/10/05	Boison Ayi-Trosi	Ningo Health Centre	Biostatistician Record Officer	**DWS16**
17	14/11/05	Felicia Kabutey	Ningo Health Centre	Community Health Nurse	**DWS17**
18	21/11/05	Madam Susana	Ningo Health Centre	Health Nutritionist	**DWS18**
19	18/11/05	Stephen Swanzy	Osu Doku Health Centre, Asutware	Biostatistician	**DWS19**
20	18/11/05	Vida Setse	Osu Doku Health Centre, Asutware	Medical Assistant	**DWS20**

Sekyere West District: List of Interviews conducted with Health service Staff (Regional/District Health Service)

	Interview dates	Participants/Officials	Organization	Transcript Codes
1.	5/10/05	Regional Personnel Officer	Ghana Health Service	**SWS01**
2.	5/10/05	Regional Deputy Director	(GHS)	**SWS02**
3.	7/10/05	Medical Superintendent	Ghana Health Service	**SWS03**
4.	10/10/05	Supply Officer	District Hospital (DHS),	**SWS04**
5.	04/10/05	Secretary	Mampong	**SWS05**
6.	04/10/05	Disease Control Officer	District Health Service	**SWS06**
7.	06/10/05	Surveillance Officer	District Health Service	**SWS07**
8.	06/10/05	Accountant	District Health Service	**SWS08**
9.	21/10/05	District Director	District Health Service	**SWS09**
10.	7/10/05	I E & C	District Health Service	**SWS10**
11.	11/10/05	Pharmacist	DHS, Chairman (DHMT)	**SWS11**
12.	18/10/05	Personnel office	DHS, Mampong	**SWS12**
13.	11/10/05	Lab Technician	DHS, Mampong	**SWS13**
Stakeholder Interviewees				
14.	12/10/05	Gyamfi Mensah, Medical	Nadaworoma Clinic	**SWS14**
15.	13/10/05	Officer Nursing Officer	Mampong Quality Health Clinic	**SWS15**
16.	13/10/05	Programme Officer	Adventist Development Agency (ADRA)	**SWS16**
17.	05/10/05	Deputy Coordinating Director	Sekyere West District Assembly	**SWS17**
18.	18/10/05	District Focal Person on AIDS	Ghana AIDS Commission	**SWS18**

Informal Conversations with Academics/Researchers				
	Names	**Position**	**Institutions**	**Codes**
1.	Dr. Collins Ahorlu	Medical Sociologist Research Fellow	Nogouchi Memorial Institute for Medical Research	**IC01**
2.	Dr. C.K. Dunyo	Medical Doctor, Principal Research Fellow (Malaria Research Unit)	Nogouchi Memorial Institute for Medical Research	**IC02**
3.	Dr. Kwabena Poku	Senior Lecturer & Consultant for WHO and Ghana AIDS Commission	School of Public Health, University of Ghana	**IC03**
4.	Mr. K. Obuobi	Senior Lecturer of Health Sector Reforms	School of Public Health, University of Ghana	**IC04**
5.	Dr. S.K. Asibuo	Senior Lecturer and Consultant Local Chairman, Governance and Public Sector Reforms	Department of Public Administration and Health Services Management	**IC05**
6.	Mr. Yao Boachie-Danquah	Senior Lecturer/Consultant Globalisation and Local Government Reform; Chairman of Ghana's Local Government Council	Department of Public Administration and Health Services Management	**IC06**

List of Interviewees, Tamale District				
Interview	**Interview Dates**	**Names of Interviewees**	**Organisations**	**Transcript Codes**
1	22/08/05	Moses Laar	DHMT	**TMS01**
2	22/09/05	Mutaka Sulley	DHMT	**TMS02**
3	28/09/05	Iddrisu Mariam	DHMT	**TMS03**
4	23/09/05	Margaret Mwini	DHMT	**TMS04**
5	14/09/05	Asong Cynthia	West Hospital	**TMS05**
6	14/09/05	Ken Gbeve	Ghana Health Service	**TMS06**
7	15/9/05	Anthony Amalbah	Pharmacy Council	**TMS07**
8	13/9/05	Moses Tibila	GHS	**TMS08**
9	19/9/05	Twum-Manu John	SDA Hospital	**TMS09**
10	27/09/05	Tenii Mahama	PPAG	**TMS10**
11	25/09/05	Alhaji Fuseini Seidu	West Hospital	**TMS11**
12.	24/09/05	Manteaw Abenago	GHS	**TMS12**
13	26/09/05	Charity Azantilow	GHS	**TMS13**
14	20/09/05	Marshall Ziema	Tamale Municipal Assembly	**TMS14**
15	27/09/05	Dr. Clutes Kuubiere	Tamale Regional Hospital	**TMS15**

Appendix 2: Qualitative Interview Guide

IMPLEMENTING HEALTH SERVICE DECENTRALISATION IN GHANA
DISTRICT HEALTH MANAGEMENT TEAMS (DHMTs)
KEY INFORMANT INTERVIEW GUIDE

Key Issue Areas

SECTION A: Policy Objectives of decentralisation

Q1. Has decentralisation of health service started in your district?
Probe for details on delays and timing of the programme

Q2. What were the aims/objectives for decentralisation?
Probe for the extent to which staff of DHMTs understands these objectives
Example:

a) Changes in authority and responsibility among stakeholders in health (e.g. MOH, GHS, DHMTs, private providers etc);
b) Transfer of resources/function to DHMTs;
c) Establishing accountability mechanisms;
d) Improvement in information flow (downward and upwards)

Q3. How widely were these aims shared? *(Probe if some groups had different goals or disagreed with the aims)*

SECTION B: Transfer of Authority and Responsibility

Q4. Do you have district health forum? *Probe who was involved and why*? E.g.
a) Central Government, MOH, GHS
b) District assemblies, community leaders, private providers, mission hospitals, and traditional providers
c) Donors and NGOs

Q5. Can you describe how decisions are made in setting district health priorities?
Probe: Does it differ at different levels e.g. regional, district, Sub-district level, Unit Committee and Community levels?

Q6. What do you see as having been the main changes in the budget and planning process at the district level since decentralisation? *Probe for specific examples*

Q7. Does your district engage in bottom-up planning? Yes/No
If No please why, probe for details on the process, ask who the participants were

Q8. How would you describe the bottom-up planning? *Probe instances of success or failure*

Q9. At what level(s) does bottom-up planning occur? *Probe for differences*

Q10. What were the major obstacles to bottom-planning in your district? *Probe especially for political and administrative factors*

Q11. Thinking about accountability how would you describe the accountability of district health system/health officials? *Probe for:*

a) *Vertical/Horizontal;*
b) *Upward and downward accountability*

SECTION C: Human and Financial Resources

Q12. How would you describe the availability of resources (quantity and quality) for the decentralisation programme? *Probe on the following*:

a) Resource availability (equipment, e.g. computers, printers, vehicles);
b) Funding;
c) Number and quality of personnel tasked with implementation

Q13.How much confidence do you have in the knowledge, skills and abilities of the leaders of DHMT in your district? (a) Not much (b) Moderate amount (c) Great deal

SECTION D: Perceived Impact of Decentralisation on Health Administration

Q14. Mention the general changes that have taken place in the management of the health system since the start of decentralisation reform. *Probe for specific changes in the following areas:*

a) Functions, roles/responsibilities of DHMTs
b) Control over personnel decisions (recruitment/firing staff/transfer)
c) Sharing of information
d) Stakeholder participation and support (District Assemblies, NGOs, Mission hospitals, private health providers)

SECTION E: Perceived Obstacles to Implementation

Q15. What are the major obstacles to implementing the objectives of decentralisation reform at the district level? *Probe for obstacles with particular reference to the following objectives:*

a) Accountability requirements (performance and financial accountability)
b) Information gathering and processing
c) Regularity of reporting
d) Stakeholder participation in district health programmes

Q16. Has decentralisation made any difference to the DHMTs relationship with important stakeholder? *Can you give examples of change?*
Probe for details regarding the following organisations:

a) District Assemblies
b) Private hospitals
c) Mission Hospitals
d) Health related NGOs (e.g. DANIDA)
e) Community or service users

Q17. (a) Would you say the health service a good place to work? Yes/No
(b) Would you leave the health service for another job if the chance comes? Yes/No
Q18. Do you think there are some important issues that have not been covered but are relevant to the study?

IMPLEMENTING HEALTH SERVICE DECENTRALISATION IN GHANA STAKEHOLDER INTERVIEW GUIDE

Implementation of Decentralisation
Q1. How well are DHMTs implementing decentralisation objectives? *Probe for specific objective of decentralisation that have been well implemented, ask for explanation on:*

a) Accountability
b) Stakeholder participation in decision making
c) Transfer of resources/function to DHMTs
d) Improvement in information flow (downward and upwards)

Q2. What are the major obstacles to implementing the objectives of decentralisation reform? *Probe for specific problems in regard to the following:*

a) Capacity

b) Leadership
c) Communication/coordination
d) Staff commitment
e) Agency relationship with Ghana Health Service (at regional and national levels)

Q3. How would describe the technical and management capacity of DHMTs?
(e. g. Weak, Very weak; Probe for detailed explanation)

Q4.To what do you attribute the slow or quick implementation of decentralisation to? *(Probe for specific examples of aspects of the reform implemented slowly or quickly and why?)*

Q5. How would you describe the relationship between DHMTs and stakeholders involved in health service delivery activities? *(Very Close, Close, Fairly close, rarely close, No relationship) Probe with particular reference to:*

a) District Assemblies
b) Private Health Providers
c) Mission Hospitals
d) Health-related NGOs
e) Donors
f) Community and service users (*Probe the effect of the relationship on implementation)*

Q6. Do you think there are some other important issues that have not been covered in this interview but are relevant to the study?

IMPLEMENTING HEALTH SERVICE DECENTRALISATION IN GHANA
POLCY MAKERS' INTERVIEW GUIDE
Implementation of Decentralisation

Q1. How well are DHMTs implementing decentralisation objectives?
(Very well or poorly, Probe for reasons for answer)

Q2. What are the major obstacles to implementing the decentralisation reform? *Probe with reference to the following programme of activities at the district level?*

a) Accountability requirements (performance and financial accountability)
b) Information gathering and processing
c) Regularity of reporting
d) Stakeholder participation in district health programmes

Q3. How would describe the technical and management capacity of DHMTs
(Very strong, strong, weak or very weak) *Probe for reasons for answer*

Q4. In your view are DHMTs given full autonomy and control? Ask for specific examples.
Probe for details on:

a) Annual work plans;
b) Expenditure
c) Recruitment and firing of personnel

Q5. What would you attribute the slow implementation of decentralisation to?
(Probe for reasons)

Q6. Has decentralisation made any difference to the DHMTs relationship with important stakeholders? *Probe for examples of the nature of relationship with the following stakeholders:*
a) District Assemblies
b) Ministry of Health
c) Health related NGOs
d) Private health providers
e) Mission hospitals
f) Communities and service users

Q7. How would describe the DHMTs staff understanding of health decentralisation? *(Probe for implications of answer)*

Q8. Do you think there are some important issues that have not been covered but are relevant to the study?

Appendix 3: Survey Questionnaire

A STUDY OF THE EXPERIENCES OF DISTRICT HEALTH MANAGEMENT TEAMS (DHMTs) IN IMPLEMENTING HEALTH SERVICE DECENTRALISATION IN GHANA

Introduction

Sir/Madam,
I am currently conducting an academic research on implementation of decentralisation in the Ghana health sector. This research is a major part of my postgraduate research work which focuses on the influence of internal characteristics of implementing agency on the implementation of health system decentralisation.

The questions concern your opinion and personal experience(s) with implementation of decentralisation in the Health Sector in Ghana with particular reference to the District Health Management Teams. I would be very grateful if you would complete the attached survey questionnaire.

My humble request is that you be as frank as you can in your responses. The information being solicited will be used for academic purposes only and will be treated with the utmost confidentiality that it deserves. It is my hope that you will answer the questions without looking over your shoulder.

How to complete this questionnaire
The questions require you to tick in an appropriate space or circle a number to show your view. Please tick or circle only the answer that represents or is close to your view.

Thank you for your co-operation.

Emmanuel K. Sakyi
University of Manchester
Institute for Development Policy and Management
Harold Hankins Building
Oxford Road,
Manchester, M13 9QH
UK
Email: emmanuel.k.sakyi-2@postgrad.man.ac.uk or eksakyi@ug.edu.gh

SURVEY QUESTIONNAIRE

Introduction

The following questions are designed to obtain your views about the experiences of district health management teams in implementing decentralisation reform in Ghana. ***Please tick or circle the answer or number that is closest to your view.*** ☺

Please give your views on the following statements on transfer of authority and responsibility to District Health Management Teams. Please state whether you agree or disagree.					
Please tick only one answer or number	**Disagree strongly**	**Disagree**	**Neither agree or disagree**	**Agree**	**Agree strongly**
1a. The transfer of authority or control over management of personnel and financial resources is one of the objectives for decentralisation. *Please give reason for your answer*.....	1	2	3	4	5
1b. Decentralisation has provided mechanisms that encouraged transfer of authority to district managers to make decisions on all heath issues *Please give reason for your answer*.....	1	2	3	4	5
2. Decentralisation has given DHMTs full control over financial/budget decisions *Please give reason for your answer*.....	1	2	3	4	5
3. Decentralisation has given DHMTs full control over personnel decisions at the district level *Reason(s) for your answer*	1	2	3	4	5
4. Decentralisation has improved training and capacity building for staff at the district level *Please give reason for your answer*.....	1	2	3	4	5
5. Decentralisation has increased stakeholder participation in health administration at the district level *Please give reason for your answer*.....	1	2	3	4	5
6. Decentralisation has changed DHMTs relationship with important stakeholder in organisation in the health sector. *Please give reasons for your answer*	1	2	3	4	5

Say whether you agree or disagree	**Disagree strongly**	**Disagree**	**Neither**	**Agree**	**Agree strongly**

7. DHMTs Reporting and Coordinating mechanisms are effective *Please give reason for your answer*…… ……	1	2	3	4	5
8. Inter-organisational coordination is a major problem to DHMTs in implementing decentralisation *Please give reason for your answer*…… ……	1	2	3	4	5
9. Ministry of Health/Ghana Health Service is a good place to work. *Please give reason for your answer*…… ……	1	2	3	4	5
10. Given the chance all workers would leave the service for other jobs *Please give reason for your answer*…… ……	1	2	3	4	5
11. DHMTs staff are committed to the success of health decentralisation *Please give reason for your answer*…… ……	1	2	3	4	5
12a. Majority of DHMTs staff have clear understanding of the objectives of health decentralisation *Please give reason for your answer*…… ……	1	2	3	4	5
12b. Staff fully support decentralisation *Please give reason for your answer*…… ……	1	2	3	4	5
13. DHMTs always consult and involve district assemblies, private providers; local community, NGOs in setting district health plans and priorities *Please give reason for your answer*…… ……	1	2	3	4	5

Say whether you Agree or Disagree to ff. statements Please tick/circle only one answer or number and give reasons for your answer.	**Disagree strongly**	**Disagree**	**Neither agree or disagree**	**Agree**	**Agree strongly**
14. District Health Directors (DHDs) provide good leadership. *Reason(s) for your answer* …… ……	1	2	3	4	5
15. DHDs provide adequate supervision.	1	2	3	4	5

Reason(s) for your answer …… ……					
16. Directors at all levels delegate authority and responsibility to middle/junior staff. *Reason(s) for your answer* …… ……	1	2	3	4	5
17. Director show full understanding of the objectives of decentralisation. *Reason(s) for your answer* …… ……	1	2	3	4	5
18. DHD are fully committed to the success of health decentralisation. *Reason(s) for your answer* …… ……	1	2	3	4	5
19. Regional Directors of GHS supports and cooperates with DHMTs. *Reason(s) for your answer* …… ……	1	2	3	4	5
The following are said to be major obstacles to Implementation of decentralisation at the district level. Say whether you agree or disagree. Please give reasons for your answer.					
20. Lack of communication of the objectives of decentralisation to staff. *Reason(s) for your answer* …… ……	1	2	3	4	5
21. Poor leadership and failure to involve staff in daily administration of DHMTs. *Reason(s) for your answer* …… ……	1	2	3	4	5
22. Lack of Resources: financial/logistical and staff. *Reason(s) for your answer* …… ……	1	2	3	4	5
23. Lack of trust and infighting amongst senior staff of DHMTs. *Reason(s) for your answer* …… ……	1	2	3	4	5
24. Unattractive conditions of service and lack of motivation. *Reason(s) for your answer* …… ……	1	2	3	4	5
25. Poor supervision and coordination by directors and senior staff at the	1	2	3	4	5

district level. *Reason(s) for your answer* …… ……					
26. Lack of staff cooperation with Directors/senior managers. *Reason(s) for your answer* …… ……	1	2	3	4	5
27. Directors' lack of authority to make decisions regarding finance, staff and equipment. *Reason(s) for your answer* …… ……	1	2	3	4	5
28. Lack of support from District Assemblies and communities. *Reason(s) for your answer* …… ……	1	2	3	4	5
29. Lack of support from private/mission hospitals and NGOs in the district. *Reason(s) for your answer* …… ……	1	2	3	4	5
30. Lack of stakeholder participation especially donors agencies *Reason(s) for your answer* …… ……	1	2	3	4	5
31. Implementation of Ghana's Health sector decentralisation has been successful *Reason(s) for your answer* …… ……					

SECTION B:
RESPONDENTS BACKROUND DATA
Staff Positions:

Management staff Directors	Senior staff	Middle-level staff	Junior staff
4	3	2	1

Years of Service:

~~Years~~	~~code~~
~~26-30~~ ~~31-35+~~	~~6~~ ~~7~~
1-5	1
6-10	2
11-15	3
16-20	4
21-25	5

Professional Classification

Doctor	1
Nurse	2
Midwife	3
Ward Asst.	4
Paramedics	5

Other	6

Regional/District Codes

Regions	Code	District	Code
Northern	1	Tamale	101
Ashanti	2	Bekwai East	201
		Mampong	202
Greater Accra	3	Dangbe East	301
Volta Region		Ho District	302

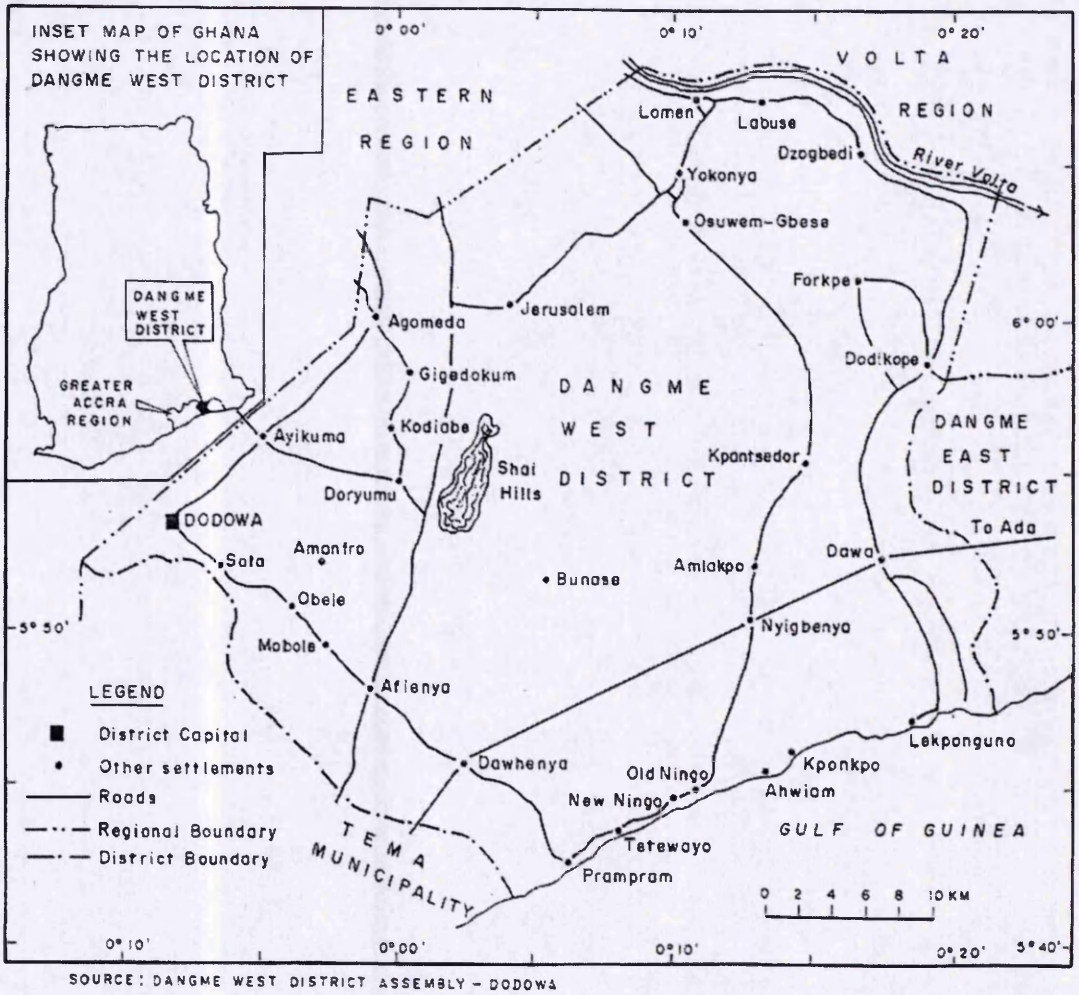
Appendix 4: Background Information and Maps of Case Study Districts

Case Study 1: Dangme West District

Dangme West District is one of the five districts in the Greater Accra region. It is located in the South-Western side of the region, sharing boundaries with the North Tongu district to the North East, Yilo-Krobo district to the North West, North Akwapim district to the West, Tema district to the South-West and Dangme-East District to the east. The district is predominantly rural and has not yet fully caught up in the spate of rapid urbanization that has gripped the other surrounding areas of the city of Accra. The Dangme West district is the largest in terms of land surface in the Greater Accra region: Covering 1,442 square kilometres of land area; it forms part of the Accra plains and has a gently undulating relief with few isolated hills and knolls scattered erratically over the area. The district had an estimated population of approximately 96,809, and accounted for 3.3% of the total population of the Greater Accra region (Ghana Statistical Service 2002; Ghana Health Service 2002). The Dangme West district has about 124 settlements and majority of the population, 73, 959, reside in the major towns of Dodowa, Old Ningo, Afienya, Prampram, Asutsuare and Dawhenya; only 22,850 are rural dwellers (GSS 2002). Of the total population, women accounted for 51% (50, 259), and men 49% (46,550). The ratio of males to females was 93:100. Majority of the working population engage in agriculture – crop farming, fishing, livestock and agro-forestry – major crops cultivated included cassava, maize, rice, pepper, fruits and vegetables (MOH, Dangme West District 2002).

Administratively, the district was formally re-demarcated following the PNDC's nationwide decentralisation programme in 1988. Currently, the district has four sub-district administrations: Dodowa; Prampram; Great Ningo and Osudoku. There are also seven Area/Town councils corresponding to the traditional areas of the district, and these are related to the local government council division of the district into town/area councils. They are Dodowa Town Council, Ayikuma Area Council, Osuwem Area Council, Prampram Area Council; Ningo Area Council, Dawa Area Councils and Asutuare Area Councils.

Figure 2: A Map of the Dangme West District

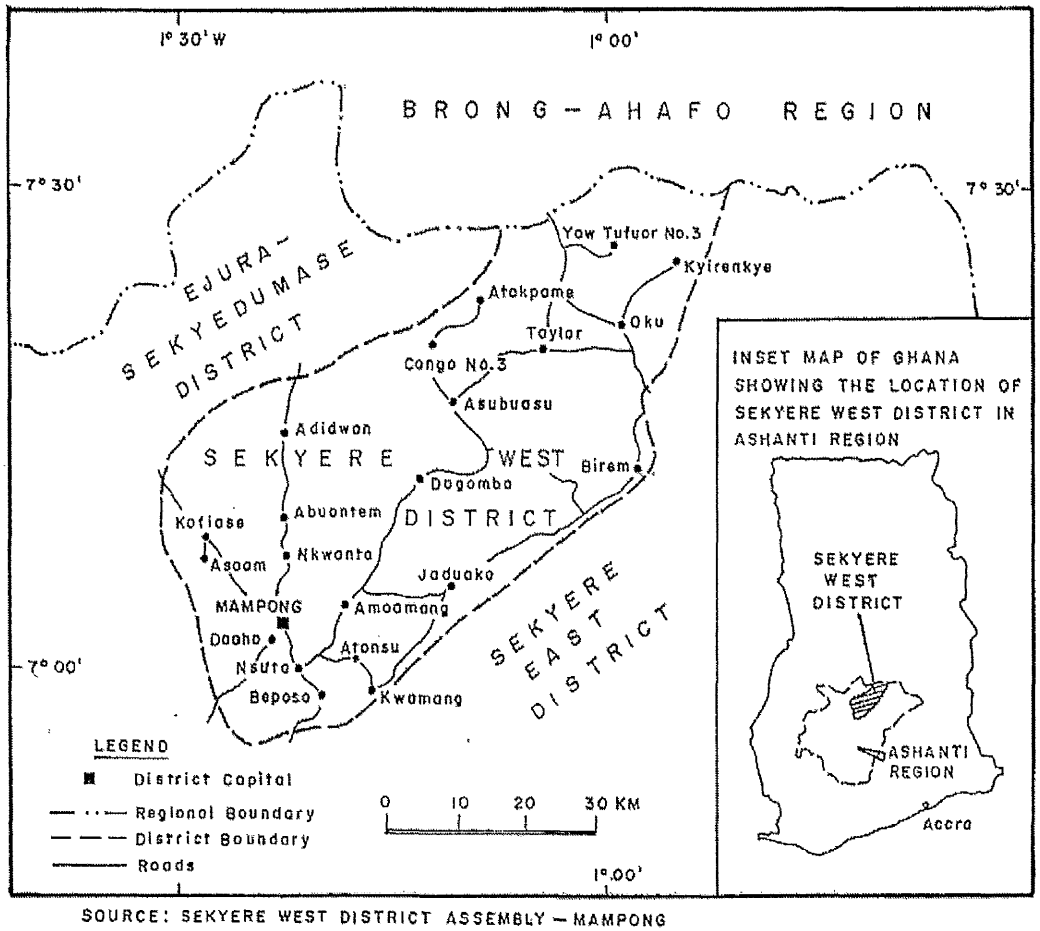


SOURCE: DANGME WEST DISTRICT ASSEMBLY – DODOWA

The district health administration is confronted with several challenges because there are no hospitals in the district. Doctor and nurse population ration is 1:48,298 and 1: 1756 respectively; this situation has had serious implications and impacted on the quality of and access to health services in the district for a long time now. Generally, delivery of health services in the district is through health posts and community clinics; the health post at Dodowa is being upgraded to a district hospital. Also there are three health posts at Prampram, Old Ningo and Osudoku, and nine community clinics. As noted earlier health services are delivered through the above-mentioned health facilities as well as through 103 outreach sites run by staff of the Ghana Health Service. Private health provision is not common; there is only one private midwifery in Dodowa town, and one private clinic each in Prampram and Afienya. There are no pharmacy shops in the district; however, the district has 42 chemical sellers. The inadequacy of health facilities in the district compelled most residents who require hospital care to visit nearby hospitals namely Atua Government Hospital, Agomanya Catholic Hospital, and Battor Catholic Hospital, Akuse Government Hospital, Tema Central Hospital or Ridge Hospital. It is important to add that there are private clinics and private chemical sellers located in the district. Major diseases suffered by the population are malaria, diarrhoea, upper respiratory infections, schistosomiasis and HIV/AIDS. Utilisation of formal health services in the district is at best described as low despite a slow but steady rise in out-patience attendance. For instance, according to the district's 2002 Annual Performance Report, only 10 – 20% of households use the formal sector health services as their first response to morbidity whatever the diagnosis made at the household level (Ghana Health Service, Dangme West Annual Report 2002). Apart from factors such as geographic access and perceived quality of care, the cause for low public health service use in the district is due to inability to pay for the cost given the widespread poverty.

Case Study 2: Sekyere West District

The Sekyere West District is one of the eighteen administrative districts in the Ashanti region. The district is generally low lying rising through the rolling hills, which stretch southwards of Mampong. Geographically, the district is situated on the Mampong scarp, which runs from east to west covering a total land surface area of 2, 346.02 kilometres square, and made up of about two hundred and twenty settlements. The district shares boundaries with Sekyere East to the east, Ejura-Sekyeredumasi to the west, Afigya-Sekyere to the South and Atebubu in the Brong-Ahafo region to the north. The Sekyere West District has an estimated population of approximately 165, 379 in .....2000. The district is located in the rainforest zone of the country, making majority of the working population (50%) to engage in agriculture, and about 57% of those engaged in non-agricultural activities still take up farming as a part-time employment. Petty trading is another employment activity in the district; this largely takes the form of buy and sell. The district is largely rural with high concentration of the bulk of the population in the big cities and the district capital, with Mampong alone accounting for about 18% of the total urban population and Kwaman, Beposo, Atonsu, Nsuta and Kofiase sharing the rest. The remaining 63.7% of the population live in the rural areas (Sekyere West District Assembly, 1996).



SOURCE: SEKYERE WEST DISTRICT ASSEMBLY – MAMPONG

Figure 3: A Map of Sekyere West District

The Sekyere West District is served by fifteen government and non-government health facilities. The district government hospital is located in Mampong, the district capital. There are approximately 331 health workers in the district – 17 doctors, 123 nurses and 115 paramedical staff (MOH, Mampong Ashanti 2000). Just like other rural settings in Ghana, the condition of roads in the district is poor. This has affected access to health facilities in the district. For example communities residing in the Afram Plains of the district find it difficult accessing level C facility at the Mampong district hospital. According to the district's 1996-2000 Development Plan, inadequate outreach programmes, lack of staff accommodation, lack of staff especially in the rural areas and inadequate logistics/funds are among the problems hampering effective delivery of health services in the district. Since the launching of the health sector decentralisation reform in the early 1990s, the Ghana Health Service in collaboration with the

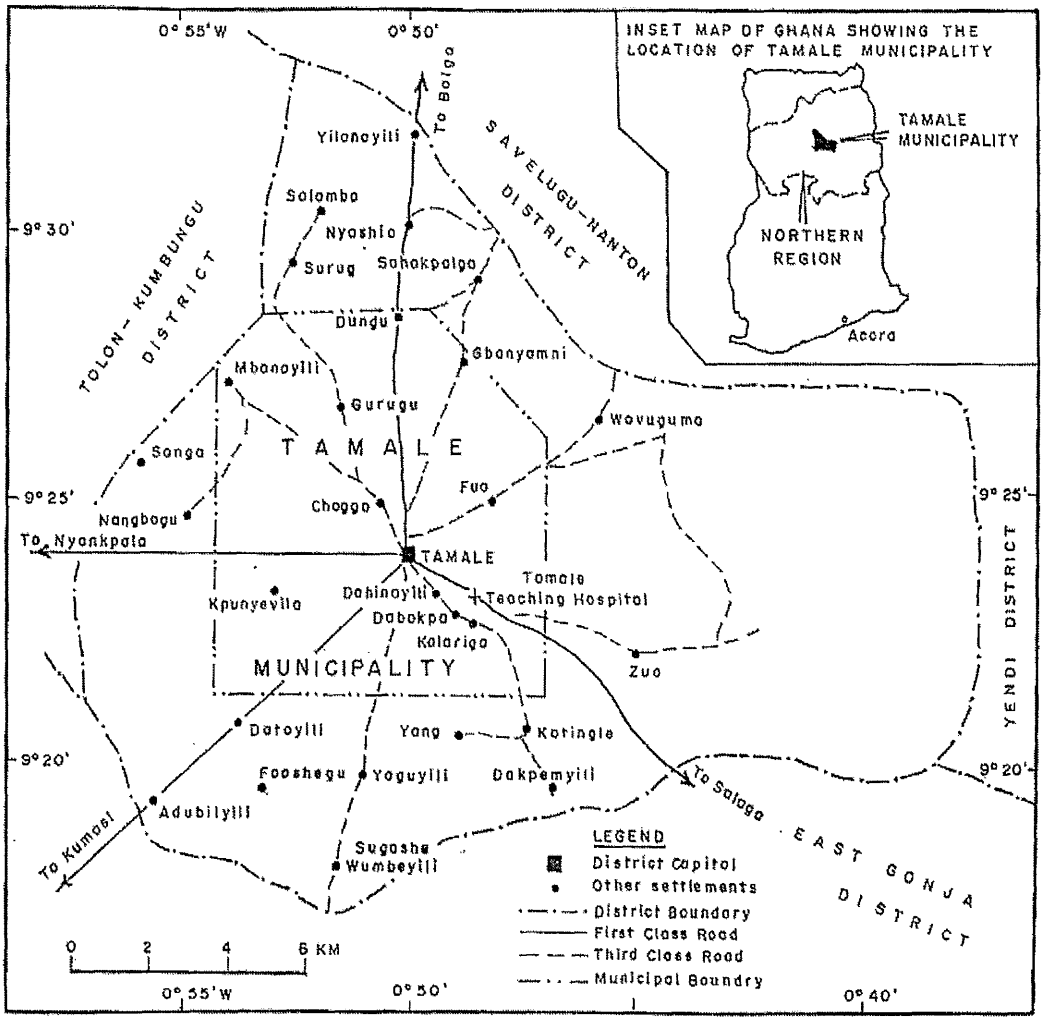
people and stakeholders has taken steps aimed at improving access, quality and equity in the delivery of health service in the district.

Case Study 3: Tamale Municipality/District

The Tamale district forms part of the thirteen (13) districts in the Northern region. The district is located centrally in the northern region not only extending to the borders of the Upper East and Upper West regions but also to neighbouring countries of Burkina Faso and Mali. Being the smallest district in the region the Tamale district shares boundaries with Savelugu/Nantong, Tolon/Kumbugu and Goja East and Gonja West districts: It has a population of about 293,881. Of this 146, 979 are males and 146, 902 females; the male ratio to females is 100.1(see Ghana Statistical Service 2002). The district is located 180 metres above sea level, with a generally rolling land surface with shallow valleys that serve as waterways. Climatic conditions in the district are such that it experiences only one rainy season starting from April to May. The mean annual rainfall is approximately 1100mm with only 95 days of heavy rainfall which allows for the growth of Guineas savannah type vegetation showing tall giant-grasses interspersed with drought resistant trees such as neem, sheanuts, dawadawa and mahogany. Majority of the population engage in agriculture. This is combined with other income generating activities which include petty-trading and other informal sector productive ventures. In the rural areas most farmers engage in small landholder subsistence food production, combining this activity with animal rearing. Tamale, the district capital is centrally located, and hence serves as a nodal point for all administrative and commercial activities for the region. Tamale district has over the years experienced rapid urbanisation leading to population explosion but without corresponding increase in social services and basic infrastructure. Coupled with this situation is the limited managerial capacity of the district authorities to confront the challenges of the urbanisation, thus leading to an urban sprawl.

Health services in the district are provided through public and private health institutions. The Tamale district has a hospital located in Tamale, which serves as the regional as well as the district hospital. The hospital serves as a referral institution for the northern region. Other health facilities in the district included clinics (7) and maternity homes (2), all located within the Tamale municipality. Common among the health problems in the district are malaria, diarrhoea and upper respiratory diseases just to mention a few. Utilisation of health facilities in the district is low, partly because of the spatial location of the existing health facilities in Tamale to the neglect of the rural areas of the district where even lower level health facilities are non-existent. A Ministry of Health report showed that the district has low staff capacity than the number required; the district has one doctor, two medical assistants, 49 preventive nurses and curative nurses, no laboratory staff and eight auxiliary staff (MOH 1997).

Figure 4: A Map Showing Tamale Municipality



SOURCE : Tamale Municipal Assembly – TAMALE