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UNFPA AND GOVERNMENT DECENTRALIZATION: A STUDY OF COUNTRY EXPERIENCES

What is Decentralization?

Many countries are decentralizing their government structures to better respond to local needs. The result of government decentralization can take a number of forms that can in turn have very different impact on programme development and programme delivery. In 1999 the Office of Oversight and Evaluation (OOE) undertook a study to identify issues in UNFPA collaboration with governments at sub-national levels particularly with respect to health/reproductive health (RH) programmes. The purpose of this study was to make recommendations on the basis of lessons learned to improve UNFPA's response to the demands of decentralization while ensuring programme quality as well as accountability.

The study focused on a sample of seven countries (Bolivia, Ghana, India, Mexico, Nigeria, the Philippines and Viet Nam) and responses to a questionnaire sent to UNFPA Representatives in an additional twenty countries that have had some experience with government decentralization. Data was collected in country by study teams of two or three national and international experts, including specialists from UNFPA's Country Technical ServicesTeams (CSTs). The responses to the questionnaire were used to situate the findings of the country case studies and provide a broader base of knowledge on the impact of decentralization.

The study teams examined the challenges decentralization presents for effective programme delivery; reviewed the many implications it has for UNFPA programme development and implementation; and the implications it has for the role and workload of UNFPA country offices. The study also contained an outline of considerations and suggested steps for programming at sub-national levels.

This issue of Evaluation Findings provides a brief review of what decentralization is and examines the challenges decentralization presents for effective programme delivery. Subsequent issues present the other main issues covered by the study.

Motivating forces for decentralization

Over the last two decades an increasing number of countries have made efforts to decentralize government services, often with emphasis on health and population programmes. Decentralization has emerged as a result of a global trend to local autonomy and self determination, and as a result of a trend to reduce reliance on centralized planning of economies and be more responsive to market forces as well as local needs and characteristics. Countries receiving international assistance have also been pressured by donors to improve the delivery of public services in terms of responsiveness, effectiveness and efficiency through decentralization.

The fact that the 1994 International Conference on Population and Development (ICPD) emphasized community and population empowerment and a grassroots approach to RH has also been a motivating factor for decentralization. The need to ensure beneficiary involvement in the planning, formulation, and monitoring of RH activities was highlighted. Drawing from the ICPD recommendations, some governments have decided to work towards a planning system sited at the sub-national level, which includes more participatory features.

Thus, factors behind decentralization appear to be related to:

- Trends worldwide towards a realization that development should not be a top down process but rather that it requires community involvement and motivation. This has spilled over into demands by local governments and local populations for a greater share of resources and decision making power to affect their own development;

- The realization in many countries that centralization of the planning and allocation of resources has led to only limited flows of resources to the peripheral levels with much of the funds being drained off centrally. In some cases – at least on paper – governments are decentralizing with the aim of improving public-sector/local government administration and performance and in an attempt to be less bureaucratic; and,

- A realization that centrally administered programmes do not always provide for effective programme delivery at the local level, as they do not take into account local needs and characteristics.

Forms of decentralization

There are different forms of decentralization that are often recognized in the literature. These include deconcentration, delegation, devolution, and privatization. Each of these represents a progressively greater degree of decentralization (see Box 1).

Box 1: Forms of decentralization

- ***Deconcentration***, often referred to as administrative decentralization, describes the transfer of specific functions to the peripheral agencies of the same central government institutions, without the transfer of the faculty of inter-institutional or inter-sectoral coordination or integration. In this type of decentralization, the decentralized agencies remain dependent on the central government.
- ***Delegation*** is the attribution of certain specific functions to semi-autonomous autarchic or para-statal organizations, which execute them independently, without owing direct responsibility to either local or sectoral central government institutions.
- ***Devolution*** refers to the transfer of specific functions to local authorities together with the legal basis, capacity for the generation of material and human resources and discretionary decision power. The decentralized agencies in this context have little reliance on the central government, unless prescribed in the legal basis for the devolution.
- Finally, ***privatization*** refers to a complete and final transfer of a package of government services to private for-profit or not-for-profit organizations.

Source: Decentralizing Health and Family Planning Services, The Family Planning Manager, March/April 1995, Volume IV, # 2

Although the seven case study countries and the twenty countries surveyed by questionnaire represent different forms of decentralization, they can be generally grouped into two classifications – *devolution* and *deconcentration*. The **Philippines** and **Nigeria** represent two cases of devolution. Each country is characterized by devolution of all health facilities, personnel and health delivery responsibilities to a lower level of government. The remaining five countries studied (**Bolivia, Ghana, India, Mexico and Viet Nam**) are examples of countries that have deconcentrated greater authority and resources to a lower level, while maintaining a strong element of central control. This is also the case with several of the twenty countries polled by the questionnaire. In many countries, the decentralized structure is not yet mature, but rather is in a state of evolution.

Decentralization is a process

Decentralization is an evolving political and administrative process rather than a particular form of organizational structure or institutional arrangement. As such, the characteristics of decentralization in any particular country are dynamic and are subject to rapid change depending on the current government in power and popular trends. Because decentralization is such a new concept in many countries, it becomes a learning process and hence, structures may be tried and discarded as unworkable.

In the cases of **India, Nigeria, the Philippines** and **Mexico**, decentralization is based on the political/legal structures (e.g. the Constitution, specific laws or government bills covering decentralization) of each country. In these countries, the states or provinces form a federation, which generally has its own elected government with a wide range of fiscal and programming powers and responsibilities. In contrast, countries such as **Viet Nam, Bolivia**, and **Ghana** are unitary states, with political sub-divisions generally at the departmental level or at the provincial level. In these countries, decentralization often takes a more administrative and operational character, regulated through decrees or directives from the central government. In the countries studied, decentralization is also defined by the extent to which fiscal powers have been decentralized. In most countries the federal/central authority represents the highest level of governance with first priority over fiscal resources. It is only when the federal or central authorities agree to share their resources that true decentralization can proceed (see Box 2).

Box 2: Decentralization in practice - a closer look reveals some interesting details

- **Bolivia** is a unitary state divided into departments headed by prefects who are nominated by the central government. The departments are further divided into provinces, which incorporate municipalities. Decentralization has been driven by regional demands for greater control over fiscal resources, adoption of decentralization reforms in neighboring countries, and impetus from international cooperation agencies. The municipalities are responsible for the physical health infrastructure, whereas personnel management corresponds to the health districts, which respond to the prefectures. Some programmes run by the central ministry, such as immunization campaigns, remain centralized. Despite some notable successes, problems have arisen in the implementation of the process, due to the fragmentation of the decision making process and some lack of mechanisms to ensure accountability. The latter has resulted in confusion and a lack of definition of roles. In addition, many municipalities are simply too small to sustain a locally managed health system.

- Although **Ghana's** stated objective is to devolve health delivery responsibilities to local governments, there does not appear to be universal agreement on this approach. In the meantime, the federal ministry responsible for health has begun to deconcentrate its resources in the context of a sector-wide approach. Even though planning and budgeting have been delegated to the regions and districts under this arrangement, the central level maintains control over the overall allocation of resources, standard setting, employment of health workers and procurement of essential drugs and supplies. From this perspective, the health system is deconcentrated.

- At the federal level **India's** Ministry of Health and Family Welfare coordinates the health system. The states have a similar structure in place and are the primary administrators of the health system and the districts represent the level at which services are delivered. The districts have sub-centres, primary health centres, and community health centres, depending on the population served. At the same time, The Panchayat Raj Institutions (PRIs) or village assemblies have been allocated political powers for the administration of local governments. The PRIs are meant to be the political structures that develop and implement local development plans which set local priorities including areas such as health, RH, etc. Because the PRIs are new to these responsibilities, much of the planning and operation of the health system remains under the vertical line ministries at the federal and state level. Thus, the primary trend in India is that of administrative decentralization, involving changing to a bottom-up planning process and greater latitude to execute activities at the district level.

- The **Mexican** health system is composed of three segments, each serving different parts of the population. The two public systems are the Health Services Secretariat (SSA), covering a predominantly rural population, and the social security system. The latter is made up of the Mexican Institute of Social Security (IMSS), covering the predominantly urban insured population, the Social Security System for Government Employees (ISSSTE), and IMSS-Solidaridad, a special programme funded by IMSS contributions to attend the rural population. In addition, there is a significant privately operated system, whereas about ten million persons are not covered by any system. Despite the federal nature of the country and a desire to decentralize to the local level, what has been achieved is fiscal deconcentration, including institutional reform and revision of the legal framework. The purpose is to delegate responsibilities to the lower tier of government, particularly the state level, although the municipalities have also gained more access to resources and taken on some additional attributions in the area of health. The process has met with resistance from the labor unions and even from some state governments, which fear having to assume many new responsibilities without adequate funding.

- In **Nigeria**, the health system is split among the three levels of government. The federal level is responsible for norms and standards, the development of training approaches, the tertiary care hospital system, and the procurement of essential drugs and contraceptives. The state government is nominally responsible for the health system within the state and must ensure that appropriate personnel are hired, that adequate training is provided, and that standards of care are maintained. The local governments have front line responsibility for providing services, maintaining primary health care facilities, paying health staff, and ensuring availability of equipment and supplies. Separate funds are allocated to federal, state and local governments. One notable twist in the system is that the state hires and controls the health workers, while the local government manages and pays them.

- The decentralization process in **Viet Nam** has not modified the complex structure of the population and health sectors made up of vertically organized hierarchies, but has merely meant a shift – a deconcentration – in planning and implementation functions from the center to the provinces. Every element of this multi-agency structure reports horizontally to the coordinating People's Committee and vertically within their own structure. Thus, decentralization proceeds in a tightly run fashion where interaction between sectors and agencies of the government are maintained and strengthened within existing party mechanisms. Although there are plans to shift further to the district and commune levels, roles and responsibilities have not been deconcentrated because of the lack of skills at the lower levels to successfully carry out the RH programme. The purpose of decentralization is seen as bringing services closer to the people and tailoring them better to their needs.

Almost all of the twenty UNFPA country offices polled by the questionnaire for this study reported that the national government had decentralized its administration. However, there is broad variation from one country to another in the degree of decentralization and the commitment of those responsible for decentralization. In some of the countries the local administrative entities have real authority to plan, implement and evaluate their activities. In others, the decentralization effort is either in its nascent stages or is being implemented unevenly. In such cases, decentralization seems to be adopted purely as an administrative measure without any impact on the way things are managed at the local level. As a result, although there might be a range of legal, political or administrative regulatory instruments to sanction decentralization, there is sometimes strong resistance from central authorities to let go of their power or there is no enabling environment to exercise the decentralized authority.

The challenges of decentralization

In the seven case study countries, as well as in the twenty countries in which UNFPA country offices responded to the questionnaire, decentralization of the health system seems to be more advanced than that of the other sectors. To-date, experience has been mixed and has brought to light some advantages but also a number of risks and barriers to effective programme delivery. For instance:

Decentralization can occur too quickly: If decentralization occurs too quickly, the organizational structures, roles and responsibilities for the management of population and RH programmes may be inadequately defined, creating structural imbalances in the health system as a whole. And health managers at both the central and sub-national levels may not always be prepared for their new roles. These problems were evident in virtually all of the case studies. In some cases, decentralization has been unsettling and confusing for the dislocated personnel involved, and caused a certain amount of demoralization and a decrease in productivity at least initially. It was also clear from the countries studied that there are problems associated with managing the cultural changes to a decentralized system. Central governments are often reluctant to share power or relinquish power and authority. And sub-national governments tend to resent the fact that they are made responsible for service delivery without the necessary resources.

Insufficient capacity and/or resource: In some countries, decentralization of responsibilities has been overzealous and decentralized units are either too small or too under-resourced to take on their obligations, especially at the secondary level of the health system. This is often characterized by insufficient staff, inadequate training, and poor management as well as insufficient management systems and procedures. This situation was particularly noted in **Bolivia** and in **Nigeria.** To exacerbate this situation, the decentralized jurisdictions are often totally dependent on the fiscal allocation received from the central government. The study shows that there has been a tendency to provide funding allocations to lower level jurisdictions based on percentages and formulas, which may not be related to actual need or past expenditure levels. If the allocations are not carefully formulated, the decentralized levels of the health system may find that they have insufficient funds to pay salaries or purchase drugs. This problem was particularly striking in **Nigeria**, where block allocations (i.e. whereby one amount is transferred to the states and Local Government Areas to cover all their requirements) had to

cover health worker salaries. Since the health workers are actually hired and fired by the state governments, the local government authorities found themselves not only unable to pay the health workers but also unable to lay them off. Since the local government rarely has other sources of income, the situation quickly becomes untenable. Also, as was noted in the **Philippines,** maintaining health services, especially tertiary health care can involve heavy costs, which may be beyond the financial capacity of local government entities. In this sense, decentralization can exacerbate the shortages of funding at lower levels by adding on costly new responsibilities and requirements without the commensurate funding required.

Instability in the political framework: It was also noted that there has been considerable instability in the political and legal framework for decentralization among the countries studied. This has been particularly problematic in **Bolivia** and **Ghana**, where successive governments with different political philosophies have destabilized the decentralization process by passing contradictory laws. That the contradictions are never reconciled only further confuses the underlying basis for decentralization.

This issue of *Evaluation FINDINGS* is based on findings, conclusions and recommendations drawn from a study entitled " UNFPA and Government Decentralization: A Study of Country Experiences", published by the Office of Oversight and Evaluation.

For a copy of the study please contact:

United Nations Population Fund
Office of Oversight and Evaluation
Daily News Building
220 East 42nd Street
New York, NY 10017

Telephone: (212) 297-5213
Fax: (212) 297-4938
e-mail: mompoint@unfpa.org

Or visit our web site:
www.unfpa.org