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# 1. Introduction

Decentralization – the transfer of power and resources away from the central government and towards a lower tier of subnational government, has and continues to be pushed by various international bodies as a reform response to a variety of state conditions (OECD, 2018; Sajjad Ali Khan, 2021; Jesse Ribot, 2001; Daron Acemoglu, Tristan Reed, James A. Robinson, 2014; Paul Jackson, 2017). Weak institutional arrangements, debilitating basic service provisions, and illiberal state settings are a few examples of these. Most remarkably, decentralization as a reform response is one that has been utilized in conditions emergent from violent intrastate warfare (Paul Jackson, 2017). Able to be utilized as an approach to development, decentralization acts promotive and redistributive of power to local governments and allows these, on the account of their spatial relations to local citizens, to develop and strengthen local institutions and implement strategies enabling local citizens access to various public services and reintegration into the political structure (Daron Acemoglu et al, 2014; Jackson, 2017; Gareth J. Wall, 2016). Which is critical in conditions where development should act conducive to peace and stability. Because of decentralization's applicability in intrastate warfare, and general development, the reform process has emerged as an important field of study in the social sciences. Especially within ethnically heterogenous states, such as in Africa, where decentralization has been utilized as a prominent tool of conflict management (Jackson, 2017). Is it because of this and more that decentralization thusly has thusly been dubbed the "fashion of our time" (Manor, 1991:1) and the "quiet revolution" (Tim Campbell, 2003). But how conducive is decentralization to post-conflict states? According to once group of scholars, decentralization is theoretically beneficial (Omar Azfar, Satu Kähkönen, Patrick Meagher, 2001; Jesse Ribbot, 2001; Paul Smoke, 2003; Jean-Paul Faguet, 2014). While another group argues against it on the basis of a lack of empirical evidence (Christopher Dick-Sagoe et al, 2020; Lars Erik Cederman et al, 2015). Despite the importance of decentralization as a field of research, literature remains divisive on whether to support or reject the reform approach altogether. But we argue that despite the critical stance of the literature and the empirical evidence arguing against it, decentralization's promise, and the benefits such might provide to PC conditions, requires a thorough examination for its potential viability. In lieu of this, the thesis aims to discover how decentralization can succeed in post-conflict (PC) contexts, and we pursue such an inquiry by examining a PC decentralization of health. The principal purpose with this topical selection lay within an intent on ameliorating pre-existing research literature on decentralization and bridging the gap between the theoretical and empirical aspects of the reform process. The thesis argues that a theoretical study into the decentralization process is imperative on account of these last few decades' failed state/commandist development approaches which invariably have turned decentralization into the linchpin of institutional governance reform and (re-)construction across Latin America, Asia, and Africa (Khan, 2021).

## 1.1 Problem statement

Remarkably little research has gone into deriving explanations into why decentralization processes in so many countries have failed to provide the expected results in e.g., service delivery. And this gap appears notably more prevalent within the PC context. Reticent on the basis of state idiosyncrasies, research on decentralization appear as largely removed from a theoretically informed cross-state comparative study that explores or attempting to formulate an explanation into why applied decentralization might fail within a specific policy field. On account of the theoretical benefits of decentralization and the potential negatives that failure might manifest, the thesis establishes a line of enquiry into understanding and explaining how success/failure within decentralization is reached. In an endeavour to understand such, the thesis by way of comparing Sierra Leone and Rwanda's decentralized healthcare systems' process and therein ascertain how and why one failed and the other largely succeeded.

As such, the thesis directly establishes this line of enquiry:

*Why is one country able to successfully decentralize its provisions of health, while another fails?*

# 2. Literature review

This section of the thesis provides a review of the literature on generic decentralization, PC decentralization, the noted theoretical benefits, and the empirical suggesting a beneficial or detrimental effect of such on health.

## 2.1 Post-conflict decentralization

In a 2000's lessons paper from the UN, the Department of Economic and Social Affairs noted and argued for decentralization as a central governance component around the world. Within the paper, the department details the various conditional factors required to successful implement the reforms like e.g., fiscal decentralization, institutional interdependence, the legislative framework, and much more. According to this document, decentralization appears principally supported by non-governmental organisations (NGOs) and by international organizations like the World Bank (Ahmad J., et al, 2005) and the OECD (2019). These organisations continue not only to support decentralization as a preferred method of enacting institutional reform strategy, but the OECD in 2019 published a handbook detailing their support for decentralization on two key points: firstly on the systemic failures of centralized governments in sufficiently providing for services

that aligns with the needs of the poor; and secondly, that service provisions occur within the periphery, not within centralized structures (Ahmad et al., 2005). Meaning on account of the spatial relations to local citizens, local governments (LGs) appear the closest and most apt administrative entities to identify their needs and thus allocatively steer resources to meet such (Mehrotra Kaufmann, 2005). Proponents of decentralization likewise argue for those local citizens would be more willing to pay for these amenities when their particularly involved as critical stakeholders (ibid). Decentralization literature have largely argued for the myriad of benefits that include, but not limited to; the enhancement of representation of local regions and minorities (Woodward, 2002); allows for the infusion of good governance principles into the state's various governance systems (Ribbot, 2001; Paul Smoke, 2003; Jean-Paul Faguet, 2014); improve upon the efficiency of sub-national governments response to local needs (Omar Azfar, Satu Kähkönen, Patrick Meagher, 2001; Ribbot, 2001; Smoke, 2003); introduce accountability mechanisms into the sub-national government (Lago, 2021); aids in poverty reduction (Von Braun & Grote, 2000; Katsiaouni, O, 2003; Khan, 2013; Steiner, 2007;); improve upon the domestic equity situation (Thomas J. Bossert, et al, 2003); and enable a more effective service delivery of public goods (Kaufmann et al, 2002; Regmi et al, 2010). And specifically to healthcare, decentralization was noted as providing superior implementation of health policies – with access to more streamlined targeted programs on local conditions; greater public private integration; less duplications in the health services offered; better community involvement and financing – locals become key stakeholder and such allows for local preferences to be factored in; lessens inequality between urban and rural areas; a more unified health system (Faguet, Sanches, 2009; Christopher Dick-Sagoe, 2020). It is upon these argued benefits that the literature has asserted that fragile, developing, and developed healthcare systems require decentralization; however, as noted previously, decentralization as a reform strategy does not often provide the quality increases describe in notably the developing world (Christopher Dick-Sagoe, 2020; Be-ere, 2021). For instance, in a comprehensive paper on decentralization within post-conflict and conflict situations, Arild Schou and Marit Haug (2005) reviewed extant literature on decentralization within multi-ethnic post-conflict states in order to ascertain the literature gap within the scholarship. In examining these the authors emerged with findings that indicated PC has having engendered mixed results. Not only that, Schou and Haug argued "consistent evidence to document that decentralization has improved efficiency, equity or service delivery as promised in the development discourse on decentralization" (2005:4). Likewise, Seregious Be-ere in a recent paper argued that evidence for decentralization within specifically the Global South has been found to be both "weak and uninspiring" (Be-ere, 2021: 1). And these authors are not alone in that assessment. Particularly in regard to post-conflict decentralization. Kent Eaton (2010) in a paper on armed clientelism in Colombia, notes the downsides of PC decentralization as rooted in the potential capture of political and economic resources by former combatants. He argues that the potential theoretical

risks associated with the possibility of these utilizing those resources to finance armed struggle is a real. And he proves such by identifying decentralization as the core financial mechanism which facilitated an armed clientelist expansion and these co-opted the reform process to further destabilize the state (Eaton, 2010). Further noting the harm of decentralization in PC conditions, Lars Erik Cederman et al (2015) in a comprehensive paper assessing post-WW2 intrastate conflicts, discovered decentralization may be more conflict-inducing than mitigating. The study found that in PC contexts the provision of regional autonomy is linked to greater incidences of renewed conflict contra autonomy combined with national power sharing (Cederman et al, 2015). Yet, despite these authors arguing for the lack of evidence to support decentralization and the dangers of pursing such in PC contexts; overviews, case studies, and large comparative analyses do exist that attest to a positive correlation between decentralization and PC conditions. Gareth J. Wall (2017) in a paper on decentralization as a post-conflict state building strategy note that within Rwanda, the reform process has provided greater community cohesion and reconciliation following the genocide of 1994. Not only that, but the author notes evidence is indicative of Rwanda's PC decentralization has enabled better basic local service provisions and governance (Wall, 2017). Despite the litany of extant literature on PC decentralization, little exists that focuses on PC decentralization and health. In light of this imbalance, the thesis instead endeavours to provide a review of literature that notes or assesses decentralized healthcare within PC and non-PC conditions. For as argued by William T. Fox, PC contexts are "confronted with the same public service delivery and financing issues as other countries" and as such, the only tangible difference lay in the environment upon which these structural changes made (2007: iv).

## 2.2 Evidence for decentralization of health and their contributing causes

Noting the positive impact decentralization has had on health outcomes, Santosh Mehrotra (2006) reported that in Mali, Benin, Guinea, and Mozambique, decentralization had been the major cause for the increase in immunisation rates, lower infant mortality, and access to affordable health services. On how decentralization was enabled such, they identified the enhancement of community financing, management, and local participation as the reason for such improvements (Mehrotra, 2006). Likewise in a study on Rwanda's PC health governance and decentralization, Derick W. Brinkerhoff and Sara Stratton (2009) identified a positive correlation between decentralization and its impact on the countries health governance. Arguing specifically that success was derived through Rwanda's decentralization programme improving the healthcare systems accountability, responsiveness, efficacy, and effectiveness; fragments of one whole that collectively impacted overall health outcomes by ensuring more women sought hospital treatment during birth rather than doing so at home (Brinkerhoff et al, 2009).

Sylvie Boyer et al (2010) in a paper on the treatment of HIV infections noted and identified the positive impact of decentralization within the delivery and access of antiretroviral treatment (ART) in Cameroon. They argued that though the reform strategy acted faciliatory to the success, recent evidence suggests that despite this achievement recentralization of the delivery and access of ART as emerged. Specifically, the authors note that the qualitative literature on Cameroonian ART has observed a "spontaneous tendency to de facto establish a separate chain for antiretroviral drug procurement with tighter direct control of national authorities" (Sylvie Boyer et al, 2010: 13) which overall weakens and threatens the decentralized healthcare systems delivery of ART. The paper does not trace any direct causal explanation other than recentralization and top-down management to this. Likewise, Olowu Dele and James S. Wunsch (2004) in their study on Nigeria's decentralized healthcare system arrived at the conclusion that such did have a positive impact; but did not formulate any explanation as to the underlying process mechanisms which enabled such. Extant literature focused on assessing the decentralization's effect on healthcare rarely appears to provide a clear line of inquiry into the causal mechanisms or trace explanations for what enables (un)successful healthcare decentralization. And this lack of evidence is not distinct to single within-case studies. It moreover emerges in larger cross-case studies. In a departure from what Paul Jackson noted as a scholarship "dominated by the outcomes of a very varied set of case studies" (Jackson, 2017: 750), Youngju Kang et al (2014) conducted a cross-national empirical analysis on decentralization's impact on health outcomes within OECD nations between 1995-2005. The conducted study emerged with results indicative of a positive correlation, though only in a nonlinear fashion. They discovered that decentralization can provide a positive health impact on e.g., the reduction of infant mortality rates (Yongju Kang et al, 2012). Despite the breath of data, the paper by Kang et al (2012) similarly lacks a cohesive and/or contribution analysis oof the underlying causal mechanisms. These argued primarily that causation lay in the market incentivise provided to local authorities and within a decentralization public contract model. And like these authors, a myriad more exist with literature attesting to the benefits of decentralization (Daniel Cobos Muños et al, 2016; Mathew Andrews, Larry Schroeder, 2003).

But, as noted within Boyer et al (2010) and more, research has observed operational variances in the decentralized healthcare systems within their performance (Andres, Schroeder, 2003; Olowu, Wunsch, 2004; Mehrotra, 2006; Boyer et al, 2010). Meaning, the impact of decentralization on healthcare is not equal across the board. In fact, extant literature on ensuring successful decentralization exists, and these note that certain conditions are required to be met at the local levels and within the bodies or systems being decentralized (Dick-Sagoe, 2020). Some of these factors, outside of the ones noted above, are the LGs not being provided with the capacity to match the devolved functions i.e., the absence of LG support. Which if not provided is something that could potentially lead to damaging outcomes like; elite capture; broken planning and

cooperation; insufficient and/or inadequate funding for persistent expenditures; and a lack of supply for key public services (Mills, Vaughan et al. 1990; Collins & Green 1994; Remy Prud'Homme 1995; Schwartz, Racelis et al. 2000; Jeppsson 2001; Akin, Hutchinson et al. 2005). Though some scholars argue that no frameworks exist to generalize or isolate factors behind (un)successful decentralization on health outcome, evidence so far indicates two key explanations: firstly, that success can be derived from a supportive legal and institutional framework that ensures decentralization and the inability of central governments (CGs) to interfere with LGs. Secondly, elite capture and the tendency for CGs to resist decentralization and inhibit LGs devolved functions (Dolores Jiménez, Peter C. Smith, 2005). Likewise, capture of regulatory institutions and the decentralization process by elites/special interest groups emerge as a critical component that disallows the reforms to succeed (Collins & Green 1994; Prud'Homme 1995; Bardhan & Mookherjee 2005). Within a study on Sierra Leone's dysfunctional post-conflict decentralized healthcare system, Felix Marco Conteh (2016) identifies corruption and a lack of a supportive legal framework as some core impediments for the decentralization process. More specifically, the case of Sierra Leone's failure is argued by Conteh as derived from a culture of strong resistance towards the devolution of power and finances which developed to curtail the decentralization process and its legislative framework for the intergovernmental fiscal transfers due to fears of losing central government influence on the periphery (Conteh, 2016). Yet, though these appear as factors impeding and irrevocably damaging the noted decentralization processes of healthcare, they are causative elements, not core causative factor(s).

Seregious Be-ere (2021) in a paper on decentralization designs noted the inconsistent and minimal impact of the reform strategy in the Global South. In fact, he attaches causation of (un)successful decentralization to the overall design of the decentralization process. Arguing that the legal and institutional frameworks/structures as central factors in shaping the decentralization process, identified these and their contradictory arrangements as core contributing causes to the emergence of impediments like e.g., elite capture and more (Be-ere, 2021). On why faulty designs and failure emerge, Be-ere identified the political interests as central determinants for "the goals of decentralization in many countries" and that these interests "are mostly aimed at achieving political ends first and, probably, technical goals second" (Be-ere, 2021; 6-8). Other authors likewise argue the paramount nature of decentralization design in contexts on (un)successful decentralization (Nicholas Awortwi, 2011; Falleti, 2005; Sharma, 2005; Singh, 2006). In fact, the OECD in a 2019 handbook for policy makers on decentralization argued the reform processes "outcomes depend very much on the way the process is designed and implemented" (OECD, 2019: 1). For healthcare to be successfully decentralized thus requires sound overall design of the decentralization process (Be-ere, 2021; OECD, 2019; Singh, 2006; Sharma, 2005; Falleti, 2004). Furthermore, in a paper noting the importance of FD, Chanchal Kumar Sharma (2005) likewise argued the success of these as dependent on their design.

Noting the different emerging dilemmas on constructing a sound decentralization design, Sharma argued that the processes requires a mixture of administrative, fiscal and political reform to effectively generate any positive outcome (Sharma, 2005). In a paper for the WB, Roy Bahl and Jorge Martinez-Vasquez (2005) noted the lack of research on decentralization designs, sequencing, and reform implementation. Though focused primarily on the mechanics of generating successful outcomes through FD, the authors do, in concordance with Sharma, echo sentiments of design and/or their sequencing as core determinants for the success of the processes. In fact, the Bahl and Martinez-Vasquez (2005) argue that specific sequence patterns enable greater benefits than others (Bahl, Martinez-Vasquez, 2005). An argument which Tulia G. Falleti (2004; 2005) formulated a theory on decentralization around. In her paper on the Latin American decentralization process, Falleti (2005) posited not only that the sequencing of different reforms as key determinants of (un)successful decentralization, but that in conjunction with their design sets a path dependent trajectory towards specific outcomes. By forming a theory of sequential decentralization (TSD) that borrows from historical institutional (HI), Falleti posited and confirmed via empirical tests that sequences and their design affect decentralization outcomes.

One major weakness of the literature on decentralization has been the lack of robust empirical analysis on the determinants of decentralization outcomes. Not only that, extant sources on service-related outcomes fail to systematically measure the degree to which decentralization reforms have affected e.g., access, utility, quality and more. Yet studies on democratic participation, conflict-mitigation, and governance appear more common, but are methodologically inadequate since these rarely construe casualty from correlation. And neither do the analyses on service-related outcomes typically pursue a theoretical examination of causation. In lieu of this, the thesis ameliorates upon the literature gap by testing theoretical explanation on why one group of states are enabled to reach specific service-related outcomes by way of their decentralization programmes while others are not.

# 3. Theory

This section of the thesis presents this thesis' theoretical framework. Rooted in a HI theoretical perspective, the thesis appropriates path dependency and Falleti's TSD to craft a framework able to explain (un)successful decentralization. From this we craft tentative hypothesises that respond to the research question.

## 3.1 Historical Institutional: Change and path dependency

When this thesis discusses decentralization and refers to such as a reform strategy, as a process, and as a method of institutional (re)construction, it jointly regards these rudimentary designations as inherently

occupying an avenue of addressing change. Specifically change within government institutions. For as noted by the OECD (2019), Kwamie et al (2015) and Dolores Jiménez and Peter C. Smith (2005), decentralization in general entails the intergovernmental transfer and/or (re)construction of subnational units inherent administrative and fiscal responsibilities. Within the literature, research has noted that the myriad of potential impediments and overall (un)successful decentralization hinges on the design. i.e., the design of the institutional (re)constructive process (see Nicholas Awortwi, 2011). In lieu of this, the thesis constructs a framework enabling the examination of institutional change by theoretically expounding on how initial design choices affect the temporal development of institutional reforms. We accomplish such by assembling a framework within HI - an approach arguing historical events sequences and their timing affect institutions, and inform such via path dependency and Falleti's TSD to structure a theoretically led comparative inquiry into the decentralization reform process. The paper reasons that by tracing causation on (un)successful decentralization of healthcare to those temporal context/event(s) that formed and affected the condition, persistence, and possible structural alignments/design of institutions, an answer suitable to the research question appears (Hall & Taylor 1996, Sven Steinmo 2008; Kathleen Thelen, 1999).

HI, as a branch of New Institutionalism – a broad theoretical framework developed to explore the constraining and enabling effect of institutions, derives its roots from Political Science by way of its principal intent on the utilization of "temporal phenomena, including the role of timing and sequence" to explain contemporary for phenomena (Orfeo Fioretos, Tulia G. Falleti, Adam Sheingate, 2016: 3; Paul DiMaggio, 1998). Institutions within this theoretical framework are defined as rules of the game – i.e. that the formal and/or informal "rules (…) in a society (…) are the humanly devised constraints that shape human interaction" (Douglas North, 1990: 3). Emplacing the analytical foci on temporal phenomena, and arguing these as central for insight into institutional outcomes and/or process, HI thus allows for examination into how "processes and events influence the origin and transformation of institutions that govern political and economic relations" (Fioretos et al, 2016: 2). One vital component within this temporal-focused theoretical inquiry lay in path dependency - a key notion of HI that argues prior choices and particular events and/or their sequences matters because the patterns of the past persist because of resistance to change. I.e., path dependency provides this theory with the argument of 'inertia', a critical theoretical variable in understanding institutional reform and trajectory (Mahoney, 2000). For HI and path dependency scholars, inertia as a concept that initial and/or preliminary events within a sequence provides the greatest overall influence on the trajectory of the path dependent process (Adrian Kay, 2012). In other words, the first choice and/or early policy decisions – policy legacy - function as constraints upon which institutions are limited on the overall choices available for policy makers to make. Similar to the 'design' argument of Be-ere (2021). Onto this Mahoney argues that path dependent process "are marked by relatively deterministic causal patterns" and as such have "relatively

deterministic properties" (Mahoney, 2000: 511). This idea of path dependence as deterministic, not relatively deterministic, is defined as strong path dependence by Bengtsson and Ruonavaara who presupposes change within strong path dependent process as solely occurring "through exogenous factors, that is, external shocks and changes in the environment" (2016:7). Though Bengtsson and Ruonavaara (2016), Colin Crouch and Henry Farrel (2004) argue for weak path dependence – defined here as stochastic and nondeterministic, this thesis formulates a theoretical framework as rooted in Mahoney's strong path dependence (Bengtsson, Ruonavaara, 2016). And as such, notes that traditional HI analysis on institutional change is problematic because there lies a deep underlying assumption of contemporaneous policy and institutional systems/structures as tending "to be conservative and find ways of defending existing patterns of policy, as well as the organizations that make and deliver those policies" (Guy Peters, Jon Pierre, Desmond S. King, 2005: 1276). In lieu of this, and the noted theoretical arguments, the thesis expounds and argues on the basis of 'policy legacy' as the core clarifying component for this thesis. As such, the theoretical framework thus expounds on how the 'policy legacy' can lead to faulty institutional arrangements like e.g., weak subnational organizations, and which causative mechanisms emerge to defend and or strengthen these.

### 3.1.1 Causative mechanisms: origin and subsistence of the path-dependent process

Central to path dependency and HI is the identification and elucidations of the causal mechanisms by which institutional structures/designs or 'policy legacies' are entrenched, repeated, and safeguarded. Chief, and most important to this thesis is the mechanism of self-reinforcement – repeat replication of a given institutional pattern (Mahoney, 2000; Falleti, 2004). In exploring why self-reinforcement mechanisms materialize to defend faulty and/or weak subnational structures, we identify and argue such on the basis of 'increasing returns'. For as noted by Mahoney, with:

> *increasing returns, an institutional pattern - once adopted - delivers increasing benefits with its continued adoption, and thus over time it becomes more and more difficult to transform the pattern or select previously available options, even if these alternative options would have been more "efficient"* (Mahoney, 2000: 508).

Meaning, when political actors or other entities emerge from the adoption of new institutional pattern with benefits, such becomes entrenched because the positive feedback loop i.e. public policies, enables their continued existence and makes deviation or departure from these less likely to occur over time (Kay, 2012; Fioretos, 2016). What these benefits and the positive feedback loop might materialize as are largely idiosyncratic in nature and based on the state context of decentralization (Falleti, 2004). Regardless, one explanation for institutional persistence, be they good or bad, is derivable from this explanation. Hall

and Talor in ameliorating upon HI's notion of positive feedback loops emphasised power asymmetry within institutional development. A feature that Peter Bachrach and Baratz (1962) and Steven Lukes (1974) collectively contended for as an accentuating feature of institutional development. For as noted by Paul Pierson, "power asymmetries are often hidden from view; where power is most unequal, it often does not need to be employed openly" (2000: 259). Tying power asymmetry to positive feedback loops, John Gaventa (1970) argued that the unevenness of power often appears reflective of the process of a feedback loop. Meaning, increasing returns:

> *can transform a situation of relatively balanced conflict, in which one set of actors must openly impose its preferences on another set ("the first face of power"), into one in which power relations become so uneven that anticipated reactions ("the second face of power") and ideological manipulation ("the third face") make open political conflict unnecessary (Paul Pierson, 2000: 259).*

As such over an extended period of time power asymmetry arises between actors on account of persisting positive feedback loops and the increasing returns tied to such. These are, in HI, imbued or baked into the institutional structure through its development, thus rendering the power relations, to an extent, non-noticeable (Pierson, 2000). Decentralization or allocation of authority towards one or more actors is noted herein as a key source of this specific type of positive feedback loops. For as Mahoney (1999) noted, when particular actors possess authority to impose rules on others, the utilization of such may be self-reinforcing. Meaning, actors might be able to use their political authority to change the rules of the game and design such to increase their own power. Thus, small initial disparities on the political resources inherent to these actors might deepen as those with power and authority change the rules of the game in their favour and thus allow this type of positive feedback loops to dramatically increase the resource and power asymmetry between these (Pierson, 2000; Mahoney, 1999; Mahoney, 2000). We would in this regard theorise that positive feedback loops intended to increase power asymmetry in favour of specific one group, and weaken another within the context of decentralization as contextualised via 'power reproduction', i.e., repeat replication of institutional and/or regulatory patterns that preserve or entrench asymmetrically designed institutional arrangements. Likewise, we identify per Pierson and Mahoney self-reinforcement as an overarching casual mechanism to explain power reproduction and policy feedback loops/effects i.e. that existing policies affect the policymaking process.

Though the mechanism of self-reinforcement appears heavily in the HI literature, Mahoney (2000) notes another causative mechanism within path dependency. Instead of observing the policy legacy creating an institutional reproductive process pushed by increased returns and strengthen by self-reinforcement, he and other theorize argue for 'reactive sequences' i.e. "chains of temporally ordered and causally connected

events" as a method of explanation (Mahoney, 2000: 509). In this case, we observe that the initial embedded changes or events to a sequence invariable function as antecedent events which temporally sets of that sequence.

In both frameworks, understanding when sequences initiate is critical. For as noted by scholars within HI and path dependency, the inertia of the initial policy legacy i.e. the early events/institutional structure "carry more causal weight in shaping end results" (Fioretos: 10). Meaning, inheritance is significantly more important than choice. In lieu of this, understanding what the initial policy legacy consists of is important because such invariably affects the event or reform/policy sequences to follow. And thusly set the trajectory towards a bad or positive outcome. And that is because when those initial sequences or changes are embedded, thus turning into policy legacies, self-reinforcement will emerge to strengthen these and their entrenchment within the polities institutional structure.

But how do changes or new policy legacies form? For HI to examine such and the underlying process through which new institutional configurations emerge requires an analysis or focus which Kathleen Thelen and James Conran (2016) notes does not come easy to the HI and path dependency. In fact, they note that institutions within HI are primarily stable entities on account that such " is more or less built into the very definition of the term institution" (Kathleen Thelen, James Conran, 2016:10). Likewise, a myriad of authors have stated that once a change is embedded, whether that be in policy or within the design of institutions and such offers "increasing returns" (C.A. Carter, 2008:), political actors or relevant organizations become dependent on these. How then are change introduced? Pierre et al noted that historical:

> *institutionalism conceives of public policymaking and political change as a discrete process, characterized by extended time periods of considerable stability—referred to as "path-dependency"—interrupted by turbulent, "formative moments." During those formative periods public policy is assigned new objectives, new priorities are established, and new political and administrative coalitions evolve to sustain those new policies (Pierre et al, 2005: 1276).*

In line with what Bertone et al described as a "window of opportunity" (Bertone et al, 2014: 2), 'formative moments' or critical junctures as Collier and Collier (1991) describes these, are essential components for path dependency. Critical junctures are largely defined as periods of " significant change, which typically occurs in distinct ways in different countries (or in other units of analysis) and which is hypothesized to produce distinct legacies" (1991:29). Arguing on the basis of HI and the approach's utilization of exogenous shocks as a descriptive vehicle for status quo disruption, we define these periods within the context of decentralization as intermittent windows where reform and/or institutional change is introduced and embedded (Daniel J. Galvin, 2016: 8; Bertone et al, 2014). And it is within these moments of disruption,

critical junctures, and/or windows of opportunity where path dependent process initiate because they inject new policy legacies into extant structures (Fioretos, 2016; Giovanni Capoccia, Daniel Kelemen, 2007; Pierre et al, 2005). Following these junctures, alterations subsequently embedded into structures becomes hard to change due to lock-in – denoting situations where political actors and the polity reorientates around the policy changes and derive increasing returns from such (Pierson 1996). As such, "not following the rules and standards established by previous choices (exit option) generates 'costs' in terms of investment, learning, coordination and anticipation" (Trouvé et al, 2010: 4).

## 3.2 Falleti's theory of sequential decentralization

With intrastate warfare being one example of an exogenous shock to extant political and institutional systems, and decentralization the reform response and/or method of (re)constructing that the state forms institutional structure around, there emerges a question; how would the initial design form a 'policy legacy'?

One key argument provided in the literature review was that decentralization process hinge on effective power allocation and support. But, as this theoretical framework perceives actors – architects of institutional structures as rational and self-serving, how can we then explain (un)successful decentralization in a comparative fashion? Falleti's (2004) TSD, as rooted in HI enables such. Based on the path dependencies central concept of self-reinforcement and institutional mechanisms of reproduction and change, Falleti argued on the basis of an examination of three Latin American case studies that timing, sequence, and the initial contextual conditions under which reforms are implemented emerges as the core determinants of its later condition (Falleti, 2005). On the basis of an ordered sequential argument – meaning that the "temporal order of the events in a sequence is casually consequential for the outcome of interest", noted that the sequence of reform implementations determines the power subnational or central governments end up with, and that such affects the emergence of "positive or negative outcomes" within the overall process (Falleti, 2004: 328). Note, though Falleti's theory primarily examines subnational power increases and not (un)successful healthcare decentralization, we can appropriate core elements of her theory in conjunction with HI to formulate an explanatory framework suitable for this thesis. Because Falleti's theory focuses Noting path dependencies and HI's proclivity to argue on the basis of inertia, the thesis contends by way of Falleti's theory that initial design choices i.e. the initial policy legacy formed around the early shape of decentralization process, is a casually consequential determinant of (un)successful decentralisation. For as Falleti and this paper contends, the initial decentralization types: administrative, fiscal, and/or political and their designs acts as the underlying sequence pattern or policy legacy that affects the degree unto which changes are permitting to occur. In her endeavour to determine why specific types of decentralization

reforms could lead to less power afforded to subnational entities, and in general favour the emergence of negative outcomes, conceptualized the reform sequences within a framework of a political and power asymmetry. This section of the theory thus appropriates her framework and the basis of HI to argue that the casual sequential order of decentralized reforms and most importantly the policy/reform legacy derived from the initial designs of these sequences affect the trajectory of decentralization processes by forming a path dependent process.

### *3.2.1 Decentralization reforms*

We note prior to expounding upon Falleti's theory that the author's approach to fusing path dependence and decentralization occurs over four important restrictions. (1) Decentralization is defined and conceived as a process of "public policy reforms and not as a description of the state of being of the political or fiscal systems" (Falleti, 2005: 328). At its most abridged, decentralization would in the context of HI and path dependency be described as the policy and/or institutional reform structure that interjects or (re)constructs jointly, or singularly, the devolution or delegating of responsibilities, resources, and/or authority towards a lower governmental tier (OECD, 2017; Tulia G. Faguet, 2004; Falleti, 2004). Decentralization is a reform process and as such should in a path dependent process repeatedly manifest by way of policies, regulatory, and legal processes. (2) Decentralization is, on paper, a set of governance reforms which initiates the process of authority transfer in "planning, decision making and the collection of public revenues" and public functions with their corresponding responsibilities in a centre to periphery allocative procedure (Alper Ozmen, 2014: 416). Meaning, it is the lower levels of government with become recipients of authority and/or power. (3):

> *because decentralization is a process of state reform, a transition to a different type of state necessarily implies the commencement of a new decentralization sequence. The contents of decentralization policies and their interaction with the broader political and economic systems are highly determined by the type of state they seek to reform* (Falleti, 2005: 329).

Meaning, if the intent is to compare states' decentralization process as analytically equivalent processes, the paper must assess the policies taking place within the same type of state. Furthermore, as Falleti argues: "the origin of the process of decentralization are important both theoretically and methodologically" and as such defined "the origin of the (…) process by the state context in which it takes place" (Falleti, 2005: 330). As such, in contexts of post-conflict (a new state context or period of critical juncture), decentralization sequences emerging in such are herein argued as points of initiation for path dependency. As such, to understand how (un)successful decentral occurs, attention needs to be put on the

decentralization sequence i.e. the inherent sequence reform types within a macro-context of the countries reform projects "overarching political and economic objectives" (Falleti, 2005: 330).

Lastly, Falleti's (4) remaining restriction argues that in attempting to study "downward reallocation of authority requires a clear taxonomy" on the processes and how the types and methods of devolving authority affects the decentralization process – healthcare in this instance. We herein look to how "the transfer of political, fiscal, and administrative powers to subnational units of government" (2000: 108) affects such power, authority, and/or the ability for subnational governments to act upon their decentralized functions (Schneider, 2003; Falleti, 2004; Falleti, 2005; J.P Faguet, 2014; Lago, 2020; Isaac Khambule, 2021).

### *3.2.2 Administrative decentralization*

Each reform type of decentralization functionally imbues LGs with different core functions or roles. And these affect the overall reform process in diverse ways. Administrative decentralization (AD) denotes the "hierarchical and functional distribution of powers and functions between central and non-central units" (John M. Cohen, Stephen B. Peterson, 1999:2). AD hence functionally provides a redistribution of public functions and authority in administration, i.e. the delivery of services – health, education, social welfare, and the financial resources to support such (Faguet, 2004; Ozmen, 2014). Likewise, though AD would contain the devolution of decision-making authority, such is not a required condition (Dennis Rondinelli, 1999). The AD process and its subtypes are perceived singularly as an intragovernmental process.

The leading argument for AD is oft carried by priori notions of benefits like allowing LGs to match service provisions to local preferences and needs, thus reducing spill-over and increasing efficiency (Isaac Khambule, 2021; Hart and Welham, 2016; Dick-sagoe, 2021). But that is only if these endeavours are funded, for we herein distinguish between funded and unfunded AD (Falleti, 2004). Related to fiscal decentralization (FD), we note that if AD occurs in a context where funding is allocated on a centre-periphery basis to meet the cost of delivering social services, such is termed funded AD. If the subnational government is made to bear the cost of these services on the basis of their own pre-existing revenue sources, then such is termed unfunded AD (Falleti, 2004). As such, if early decentralization reforms are designed to be unfunded, that would invariably affect and inject a specific 'policy legacy' affecting the overall trajectory. For instance, if early administrative decentralization is theoretically assumed to empower the local and national state bureaucracies foster training for subnational officials, allows for education by way of exercising the newly delivery functional responsibilities, and better the capacity of subnational government institutions, such would require fiscal support (Falleti, 2004; Ribot, 2002). As such, if the AD is unfunded, these measures are unable to occur, and the LG would be dependent on the central government (CG) to support such via fiscal transfers or these would have to accrue private or public debt towards the delivery of public services like

e.g., health. I.e., the design and implementation of a decentralization reform would generate increasing returns in the form of CG control via the LGs dependency on their fiscal transfers. If the AD were funded the opposite could occur. We note 'could' because the design of how the AD is funded would demonstrate which state actor gains increasing returns (Falleti, 2004).

In addition to AD encompassing these, research have also noted the central AD concept as labelled into three smaller sub-categories; which explains the different types of applied administrative decentralization, namely: deconcentration; delegation; devolution (Ozmen, 2014).

On deconcentration, the sub-category refers to how responsibility and staffing, managed by the central government, is dispersed towards regional or local administrative branches. Meaning, though some form of decentralization does occur, the majority of power and authority lay still with the central government. As a form of decentralization, deconcentration is viewed by a plethora of scholars as not limiting the reform scope but weakening overall decentralization as it does not functionally contain any transfer of legitimate power to local authorities (Tri Widodo Utomo, 2009). By contrast, delegation refers to the allocation of authority and responsibility of governmental functions to subnational governments, but upon which continues to stay under the purview of the central government. Meaning, the central governments acts as the agent of accountability, thus the main difference between Deconcentration and delegation in the method of state control. Within delegation, states derive control by way of "contractual relation that enforces accountability of local government" (Schneider, 2003: 38). Of the last sub-categories, devolution emerges as the most extreme method of administrative decentralization. Administrative devolution denotes the allowance of the central government for local government to emerge as quasi-autonomous units with "legally recognized geographical boundaries over which they exercise authority" on the devolved policy field (Rondinelli, 1999: 3). By the transfer of responsibilities for handling services, devolution usually allows subnational governments and the elected officials therein e.g., mayors, regional or local councils to raise revenue, and organize independent decisions on investment choices (Rondinelli, 1999). Compared to both concentration and delegation, devolution offers the largest degree of autonomy for subnational governments. For the subnational government is only accountable in the sense that control might be derived by a "threatening to withhold resources or responsibility" and not by way of direct or legal control (Schneider, 2003: 38; Khambule, 2021; Lago, 2021).

### *3.2.3 Fiscal decentralization*

As the foci of administrative decentralization lay on the degree onto which local governments were granted autonomy on matters related to services and secretarial functions, fiscal decentralization refers in contrast to the economic autonomy of subnational governments (Falleti, 2005). Defined largely as the "series of

policies designed to increase the financial autonomy of sub-national governments" (Rondinelli, 2003: 3), fiscal decentralization is the shift of revenue responsibilities to subnational governments. For in the pursuit of devolved functions, local governments require funds to support their programmes and endeavours as noted in the AD section. As such, fiscal decentralization denotes these the ability to raise expenditures through local means, extract money from the states' reserves, create new subnational taxes, and delegate authority on taxes via a centre-periphery allocative context. As such, fiscal decentralization could manifest in local governments utilizing user charges or self-financing; involving the users as co-producers or co-financiers in the construction of infrastructure, service delivery, or by way of contributing through labour; local sales or property taxes; intergovernmental transfer of money from the central state to LGs for specific use cases (Rondinelli, 1999). Note, the paper does not include within this definition of FD the expenditure responsibilities and the ability for subnational governments to utilize provided funds. Expenditure responsibilities lay in the realm of devolved AD functions and tasks. The reason for this distinguishment lay in clearly distinguishing between revenue and expenditure, and likewise in easier to evaluate consequences and observe the trajectory of their impact (Falleti, 2005).

Likewise, fiscal decentralization also holds positive or negative implications based squarely on its design (Falleti, 2005). If the design accommodates for higher levels of automatic transfers towards subnational institutions, these institutions and subnational officials would "benefit from higher levels of resources without being responsible for the costs (political and bureaucratic) of collecting those revenues" (Falleti, 2004: 4). Likewise for healthcare specifically, Tiangboho Sanogo (2019) noted that a larger degree of autonomy and spending strengthen healthcare systems and increased access for citizens. In contrast, if the design delegates authority to collect taxes to local governments, and these are unable to collect such due to administrative capacities, which would hinder the operations and pose serious constraints on their budget. Likewise, it would increase their dependency towards central government transfer. Subnational units that are prosperous would rather collect their own taxes, while the fragile, or poor states and subnational units would be negatively affected "every time the collection of taxes is decentralized and, as a consequence, the horizontal redistribution of transfers from rich to poor subnational units is affected" (Falleti, 2004: 4).

### *3.2.4 Political decentralization*

Denoting specifically the process of enabling subnational government offices to be sought and acquired through elections and more broadly constitutional amendments or electoral reforms on political systems that then enable the emergence of subnational representation in politics (Falleti, 2005). This type of decentralization aims to provide citizens and their elected representative the authority and influence in the decisions taken by the local governments (.). Oft correlative to democratization, PD acts only in a mutually

reinforcing manner to democratization and ought not be expressed as correlative of such. PD exists to enable greater participation of locals in the in the political realm. PD reform policies thus devolve electoral authority and/or political authority to LGs.

Thus, political decentralization enables the local to share government with the state government, but the most significant electoral reward would remain still within the national offices (Falleti, 2005; Awortwi, 2011). In addition, the degree of political decentralization can be measure by the importance of the decentralized subnational office, for i.e., the higher the office, the less the state can exert control over the local area (.). Though Falleti (2004) and Awortwi (2011) would contend that political decentralization within a HI causal sequential framework would always have a positive effect, research on post-conflict states have noted the dangers of a re-emergence of conflict in conditions where the central government appears weak (Paul Jackson, 2017; Cederman, 2015).

### *3.2.5 Decentralization sequencing*

Central to the theoretical frameworks arguments on (un)successful decentralization lay a notion of power asymmetry inherent to the reform process. Entrenched reforms or locked-in changes emerge herein as possible policy or reform legacies. It is within this framework and how these are guided and further solidified via causal mechanisms of institutional/policy and power reproduction that we apply such within Falleti's sequence patterns.

Falleti's TSD argues that the level of government who initially prevails in the design negotiations in the beginning "will likely dictate the first type of decentralization that is pursued" (Falleti, 2004: 7). Note, we argue that CGs should appear to predominantly dominate as the party to dictate the first decentralization type and its design because PC conditions require a strong centre to keep the country together and push reform decision forward in resource constrained environments (Jackson, 2007). The consequence from this is that the CG would direct the trajectory of the decentralization because of inertia and increasing returns (Falleti, 2004). On the actors relevant to this discussion of this power asymmetry, Falleti recognized two actor groups, the executive represented by the president – which this thesis generalizes by denoting as the central government, and the subnational executive represented by governors and mayors, which the thesis denotes as LGs (2005). It should be noted that each actor grouping intends to impose their preferences on the other by designing the initial policy legacy to favour them or their interests, and as such would derive increased returns (Pierson, 2000).

We, on the basis of Falleti's TSD argue that the main preference of CGs lay in a design that ensures a minimal amount of state expenditure is transferred towards subnational governments. As such, CGs would prefer sequences that initiate with AD – because the state is enabled herein to divest itself of fiscal

expenditure responsivities first. Meaning, by providing LGs with administrative responsibility of e.g., healthcare and sanitation, these subnational institutions must contend with securing enough fiscal backing to support those endeavours. For as noted by Garman et al, they " would expect the president to be more inclined to transfer responsibilities than the resources to meet them." (Christopher Garman et al. 2001: 209). As such, following this choice, the CG would rather provide fiscal authority than political. We note that these examples appear as extremes, and that this specific sequence should only appear if the CG had no intention of devolving much of any authority to LGs. Much of the same line of reasoning would apply to LGs. For they would want to initiate with political decentralization as such allows these to appoint or remove LG officials, and permits them to pursue legislative initiatives and push forward issues relating to the government without fear of retaliation. Fiscal decentralization is the second preferred option after political as fiscal authority would allow these acts independent on matters related to taxation and revenue collection rather than dependent on the CG and adhere to the requirements following their resource allocations. The last reform the LGs would lock in would be AD, for as Falleti puts it, the LGs prefer "political autonomy, money, and responsibilities, in that order" (Falleti, 2005:330). The following table lists the litany of available options, and note that on the last row lay the degree of change i.e., the expected amount of autonomy the sequences should provide to LGs.

Table 1: Sequences of decentralization and their effects on institutional subnational development

| Prevailing interest in first move | 1st type of decentralization | Casual Feedback Mechanism | 2nd type of decentralization | 3rd type of decentralization | Degree of change in the inter-governmental balance of power towards LGs |
|---|---|---|---|---|---|
| LG | P | Self-reinforcing | F | A | High |
| CG | A | Self-reinforcing | F | P | Low |
| LG | P | Reactive | A | F | Medium/low |
| CG | A | Reactive | P | F | Medium |
| Tie | F | Reactive | A | P | Medium/low |
| Tie | F | Self-reinforcing | P | A | High |

A - administrative decentralization; P - political decentralization; F - fiscal decentralization. Adapted from: Awortwi, 2011.

Falleti identified these six sequences of decentralization policy trajectories on the basis of the first reform implementation. Table 1 illustrates what and how these fit together and the degree unto which LGs are empowered. Sequences that generate low to medium decentralization changes do not, in the case of Uganda, Ghana (see Awortwi, 2015) engender positive results, but changes initiating with PD and following that up with FD i.e., which is expected to produce high changes in power, does in the case of Kenya (see

Duncan M. Wagana, 2017). On why such a difference in changes exist, Falleti utilized self-reinforcement and policy feedback as causal mechanisms for answering such. According to her, if the subnational government prevails in choosing the first type of decentralization what would emerge is a policy ratchet effect i.e., policy feedback mechanisms/self-reinforcement of extant institutional patterns. In her own words, it would mean that a " group of supporters (…) will continue to push in the direction of further decentralization" (Falleti, 2004: 7). Echoing this paper sentiments that the initial policy legacy would propel forward casual mechanisms of institutional rigidity.

If the final outcome of this decentralization process favours the LGs in that these are enabled to lock in the first and second reform types, they would receive a 'high' shift of power and autonomy. In contrast, if the process does not conform to the LGs interests, and the CG wins the first round and introduces AD and such is unfunded, a self-reinforcement mechanism emerging on the basis of lock-in and returns would allow the CG to reproduce their power/control over the trajectory and thus set the timing, pace, and content of the decentralization reforms (Falleti, 2004). But if the LG won in the first round, and a reactive mechanism emerges "such as a fiscal crisis that undermines the subnational demands for fiscal decentralization", the CG would win the second round and design AD (Falleti, 2005: 332).

Note, though Falleti and the theory presumes that one party would prevail in the first round, what could happen likewise is that both CG and LG parties could strike a compromise. Meaning, the second most preferred option of both parties would emerge in the first round, and subsequently either the LG and/or CG would impose their preference on the second type.

## 3.3 Hypothesises

Why do decentralization processes fail? The thesis on account of Falleti's TSD and path dependency argue that the primary reason for (un)successful decentralization lay not only in the design and implementation of the reforms but likewise in the inability of CGs to properly allocate fiscal and political authority to subnational governments, and that the sequences which emerge from these affect the entirety of the processes trajectory. Due to this, the thesis proposes two hypotheses on which the analysis contends with.

H1: the thesis posits that (un)successful decentralization is determined by the initial design of the sequence of reforms i.e., the first and second type. And that these invariably set the trajectory for whether the (re)constructed LG systems is and was able to manage and/or enabled the decentralization of a functional healthcare system. We herein contend that in cases of success we should see from the initial policy/reform legacy i.e., the first and second reform types, designed to entrench the decentralization process to which consequently causes a policy feedback loop to that effect. In cases of failure, we should see a policy legacy which is unsupportive of decentralization and consequently causes power reproduction within policies

and/or reform design types to emerge.

H2: the thesis posits that (un) decentralization is contingent on a sequence of reforms that affords the subnational government with medium/high power. We contend that in cases of success that we should see a path dependent reform sequence of P – F – A; F – P – A; or A – P – F. In cases of failure, we should see a sequence following an A – F – P; P – A – F; or F – A – P structure.

# 4. Method

This section of the thesis presents and clarifies the rationale behind the paper's methodological choices. There is herein made illustrated the research design, methods, choice and analysis of data and the operationalization of core concept

## 4.1 Research strategy

This thesis takes its outset from a comparative process tracing methodology, as described by Bo Bengtsson and Hannu Ruonavaara (2016). In social science research, researchers often engage in the detection of how and why condition A reaches outcome B. One method conducting this type of research is via a process tracing method – a within-case analytical approach, which we expound upon in the case study section.

Unique to Bengtsson and Ruonavaara's (2016) process-tracing method is the combination and amelioration of how to utilize process-tracing in a comparative approach. We note that though this study utilizes their approach, it deviates slightly, as these contend with weak path dependency, while this thesis works within the frames of strong path dependency. Their approach is of special interest to this thesis because it enables the examination of how PC decentralization as an initial condition can reach an (un)successful outcome. On why the thesis focuses on examining PC decentralized healthcare, such is rooted in the preliminary literature review that demonstrated the specific policy fields utility in answering the research question. Likewise, accordingly the thesis noted the absence of extant research on the topic and as such, endeavoured to apply a theoretically informed comparative process-tracing research method to answer the research question. How the thesis proceeded in that route was by, (1) creating the theoretical framework and therein establish the analytical approach – identification of the policy legacy and tracing such via causal mechanisms; (2) establish hypothetical explanations on why (un)successful decentralization occurs; (3) testing these explanations within the analysis and comparatively assessing why one state succeeded and the other failed. Though Derek Beach and Rasmus Brun Pederson argue that "evidence from

individual process-tracing studies cannot be meaningfully compared with evidence in another case, making cross-case comparisons more or less impossible", we and Ruonavaara and Bengtsson outline that a comparison via process-tracing is possible if such occurs on the basis of ideal-types and portable social mechanisms (causal mechanism) like e.g., positive feedback loops, sunk costs, increasing returns and self-reinforcement ( Derek Beach, Rasmus Brun Pederson, 2013: 28).

As such, the thesis works deductively, and predominantly in a qualitatively fashion, though with some little quantitative components. We root our inquiry in the theoretical framework because, as Bryman notes; theories "attempts to understand and explain a limited aspect of social life" (Bryman, 2016:21).

### 4.1.2 Comparative approach

This thesis utilizes a case study design intertwined with process tracing and a comparative method. Primarily derived from Bengtsson and Ruonavaara's CPT (2016), the rationale behind the comparative case study approach lay in that such enables a thorough and focused examination for the purpose of answering the research question. In fact, an in-depth within-case examination should endow the paper with the requisite substance enabling us to answer the research question and ameliorate upon a limited research area.

On this approach, Bryman notes "case study research is concerned with the complexity and particular nature of the case in question" (Bryman, 2016: 66). Though Bryman herein describes the analysis of a particular case, comparative analysis would therein suggest a similar concern with complexity and reorient such towards an assessment and synthesis of two cases' similarities, differences, and patterns via the same methods (Bryman, 2016). We are herein interested by this approach to examine and explain our outcome of interest by identifying key events, processes, and/or decisions that led to such. For this particular comparative case study, as noted previously, process-tracing lay at its heart. For process tracing is according David Waldner, a:

> *longitudinal research design whose data consist of a sequence of events (individual or collective acts or changes of a state) represented by nonstandardized observations drawn from a single unit of analysis* (Waldner, 2012: 58)

Though Waldner herein argues for "single units of analysis", multiple units can be compared and contrasted against each other (see Moore, 1966). How such occurs is argued via theory and guided by Bengtsson and Ruonavaara's CPT. We note herein that the nonstandardized method of observations are within this paper guided additionally by the theoretical framework. As such, how this thesis enacts its comparative study lay manifested in a comparison guided via a theoretically informed analytical method. Before the paper fully expounds upon this, it notes and argues for the chosen cases and on which parameters these were elected

upon.

How this thesis chose its cases lay rooted in the intent of the research question. As this paper sought to examine PC decentralization, and to do so in a comparative sense, it naturally veered towards embracing cases that were similar on a number of features relevant to this inquiry. The requirements for these were: similar rationale for enacting decentralization reforms (state building strategy); state context upon implementation (post-conflict); state structure (unitary); healthcare status (maternal/infant mortality rate – see fig. 1); demography (see fig. 3). We note these conditions were not required to be completely exact, but that these have to be similar-enough to warrant a contrasting examination. For as argued by Arend Lijphart (1971), though the comparative approach emerges as a promising approach by its allowance on greater examination of a given study, these should be comparable i.e., they must appear similar on a number of features.

## 4.2 Case selection

As this paper intends to explore success and failure of applied decentralization in a comparative perspective, imperative becomes the amelioration of what constitutes failure and success. As such, this section of the thesis explores the case of Sierra Leone and Rwanda and argues that (un)success in the decentralization of health is derived from the decrease in mortality rate; maternal mortality rate; and degree of decentralization (devolved functions). As such, (un)successful decentralization is operationalized via these measures.

### *4.2.1 Rwanda: A case of successful decentralization*

As a case, Rwanda emerges within the wider academic literature and discussion on PC reconstruction as largely a success story (see Morag Goodwin, 2021). Notably, the decentralization of healthcare within the state appears to have addresses major immediate post-war concerns and starkly reduced both infant, and child mortality rate (Shalini Navale et al, 2017). Likewise, positive strides have been taken towards ensuring widespread access to health facilities within the country (Ministry of Health, 2010). Collectively, the data on mortality rates, the persistent focus on healthcare delivery, quality, and access (Benjamin Chemouni, 2018) indicates that a persistent focus on health long after the adoption of the National Decentralization Policy (NDP) in 2000 (Ministry of Government and Social Affairs, 2001; Malin Hasselskog, Isabell Schierenbeck, 2015). Following the decentralization process, healthcare deconcentration and devolution, and the subsequent programme that followed have enabled the state in decreasing a high maternal and infant mortality rate. The following figure illustrates such:

| Rwanda | Maternal: P. 100,000 | Infant: P. 1,000 |
|---|---|---|
| **2000** | 1,100 | 109,5 |
| **2008** | 540 | 50,2 |
| **2017** | 260 | 32 |

Fig. 1. Source: UNICEF, WHO World Bank, UN DESA Population Division, 2022.

On whether these change in numbers can be tied to decentralization, a 2009 study on good governance and health within Rwanda noted the positive effect decentralization had on the overall governance of health, herein also the responsiveness, accountability, and effectiveness (Brinkerhoff et al, 2009). As noted in the literature review, the paper noted that decentralization enabled better health outcomes because a larger amount of live births were occurring at health facilities as opposed to at their homes (Maurice Bucagu et al, 2012). As such, not only does the data indicate higher maternal births within hospitals, but likewise a decline on infant and maternal deaths; a result which has and can be tied to the decentralization of the provision of health (Bucagu et al, 2012; Brinkerhoff et al, 2009). In addition, another indicator for success is argued by this paper as derived by the decentralization of functions and services – initiated in 2000, and which continues still (Simon Pierre Niyonsenga et al, 2021). Lastly, the myriad of policies (MINALOC, 2021), restructuring(MINALOC, 2001; MINALOC, 2011), programmes(Brinkerhoff, 2009; Hélène Delisle, 2019), and initiatives (Benjamin Chemouni, 2014) that emerged illustrates the intent of the central government of Rwanda (CGoR) on improving and supporting a decentralized healthcare system (Government of Rwanda, 2020). Another indicator of success is identified by Tina Rosenberg from the New York Times (202) as the community-based health insurance (CBHI) or *Mutuelles De Sante*, which enabled 96% of the country to have health insurance – though we note the CBHI is a mandatory insurance (Tina Rosenberg, New York Times, 2012). Likewise, in 2006, the provision of health was completely decentralized to LGs (Chemouni, 2014).

In lieu of this, the thesis regards Rwanda's decentralized healthcare as a successful outcome on account that it emerged from its civil war and genocide in 1994 with a lacking physical and social infrastructure, a non-existent service delivery capacity, highly discredited and damaged domestic institutions, and a collapsed healthcare system (Goodwin, 2021; Derick W. Brinkerhoff, Sara Stratton, 2009). For Rwanda, a unitary state, was in it's the immediate PC context, for all intents and purposes, in a severely fragile state.

### *4.2.2. Sierra Leone: A case of failed decentralization*

The case of Sierra Leone's decentralization of health lay in stark contrast to Rwanda's. Where we argued for Rwanda as a successful case, we herein argue Sierra Leone as representing the opposite. For while Rwanda's decentralization process enabled a healthcare decentralization and in decreasing the states maternal and infant mortality rates, Sierra Leone appears unable to paint a similar picture of its process. Sierra Leone – a unitary state emerged from its civil war in 2002, and like Rwanda lacked much of its infrastructure. And like Rwanda, the state embarked on an ambitious decentralization programme to reform and (re)construct its governance system (Wall, 2016). Though Sierra Leone by 2005 had devolved its designated health functions, the Ministry of Health and Sanitation (MoHS) resisted changes to devolve certain functions like payroll, and healthcare staff (Felix Marco Conteh, 2016). And this is notably interesting because the MoHS was the only institutional body that devolved its functions on time. But despite this limited decentralization or deconcentration, the data Is not indicative of such having a large effect. Fig. 2 illustrates such:

| **Sierra Leone** | **Maternal: P. 1,000** | **Infant: P. 1,000** |
|---|---|---|
| **2004** | 1,845 | 126 |
| **2010** | 1,360 | 107,2 |
| **2017** | 1,120 | 84,4 |

Fig. 2. Source: UNICEF, WHO World Bank, UN DESA Population Division, 2022.

Not only that, in contrast to Rwanda where academic and grey literature appears suggestive of decentralization positive effects on health, but evidence for such on Sierra Leone's healthcare system appears bereft. Likewise, evidence appears to suggest Sierra Leone's healthcare system suffers from a myriad of issues. For one, it is heavily fragmented due to international staff implementing parallel structures in ensuring essential services were provided; which of these parallel structures exists still (OECD, 2010). Secondly, parallel medical supply chains on e.g., HIV, Malaria, NTD's and more (Arwen Barr et al, 2019). In addition to possessing a fragmented health system, Sierra Leone's primary health care suffers from an exceptionally prominent level of corruption (Barr et al, 2019; Josephine Appiah-Nyamekye Sanny, 2020). In 2018 the Afro barometer index published a survey noting that 50% of all respondents who sought treatment at a public health facility had to pay a bribe to obtain medical care (Josephine Appiah-Nyamekye Sanny, 2020). In addition, the thesis notes Sierra Leone's failure as additionally derived in the recentralization of devolved functions. For in 2014 the MoHS in resistance to the devolution of functions ordered the Director of Hospital Services to take control of the running of hospitals from the local council (Felix Marco Conteh, 2016). In lieu of these facts, the thesis argues for Sierra Leone as a case that failed in its healthcare

decentralization, or at least appears highly suggestive of such. This thus allows the thesis to permit for a comparative case study between this and Rwanda on the factor(s) permitting this variance in results.

### *4.2.3 Comparative justification*

Because this thesis attempts to assess the hypothesises generated within the theoretical framework via a comparative analysis, we herein justify the selection and approach. The cases of Rwanda and Sierra in this endeavour were chosen primarily on the causal similarities between these. Several similar conditional features exist between these states; they are both unitary states; are PC states; initiated their respective decentralization sequence via PD; similar demographic conditions; and own comparable figures on infant/maternal mortality rates on the year where decentralization was implemented. See Fig 3 and 4 for the data on infant/mortality rates.

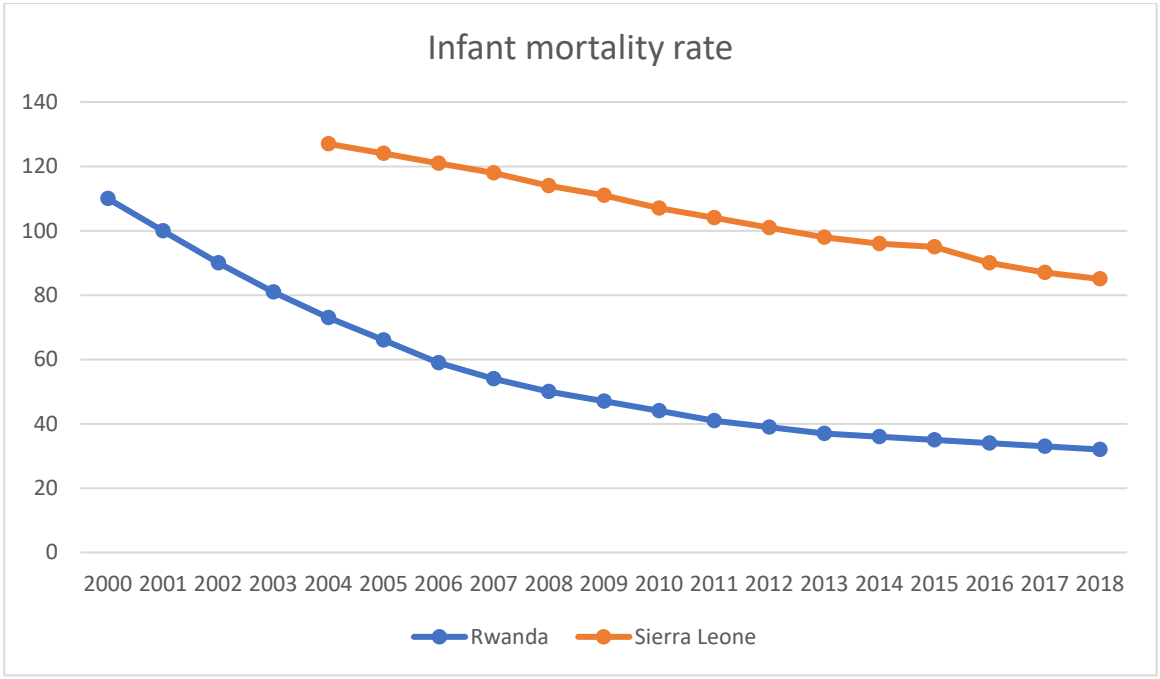


Fig 1. Source: UNICEF, WHO, World Bank, UN DESA Population Division at https://childmortality.org/

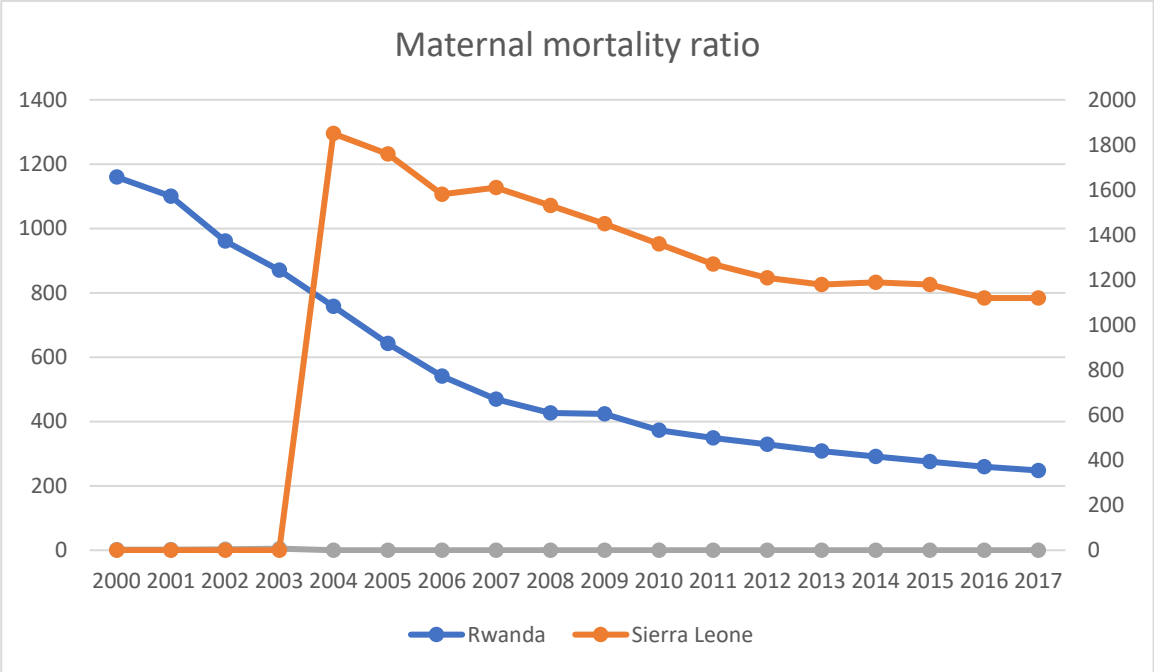


Fig. 2. Source: WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 2000 to 2017. Geneva, World Health Organization, 2019

We note additionally that Rwanda by the end of its civil war and genocide in 1994 had 5,836,495 citizens, while Sierra Leone in 2000 had 4,965,770 citizens (WB, 2022).

We on these points contend that a comparative assessment is possible due to the similarities. Especially considering that on decentralization these were more similar on their respective decentralization implementation years. The outcome of interest within these are Sierra Leones recentralization and Rwanda's enhancement of the reform process. An intriguing variance considering these started at the same place. The thesis herein examines how each reached their outcome.

## 4.3 Analytical approach

We note that this thesis' analytical approach to the research question was proposed in order to explain how Rwanda and Sierra Leone's initial reform design and implementation moved towards specific conditions. The thesis has herein on the basis of path-dependency and Falleti's theory argued, and formulated two hypothesises centred on explaining how condition A reached condition B. In lieu of the identified causal mechanisms, the thesis sections the analysis into two; the primary within-case analysis intended to examine and draw trace the chronology of the policy legacies of Rwanda and Sierra Leone's decentralization designs towards their respective outcomes of interest and therein observe if the noted causal mechanisms within the hypothesises were at play (Bengtsson, Ruonavaara, 2016). Before this section continues to elaborate on

this process, we expound herein on process-tracing, the thesis' analytical method.

As noted by Alexander George and Andrew Bennet, the process-tracing method is an approach that assesses causal processes by identifying "the intervening causal process - the causal chain and causal mechanism - between an independent variable (or variables) and the outcome of the dependent variable" (2005:206). Tying this to the theoretical framework, the paper has identified two key mechanisms i.e., the intervening variables on which the decentralizations policy legacy advances from: institutional reproduction by way of (1) a policy feedback loop, and (2) power reproduction. Though other causal mechanisms like lock in and critical juncture could explain the emergence and entrenchment of certain processes as offered by Mahoney (2001), they remain unable to encapsulate how initial policy legacies are reproduced. On why these causal mechanisms can be utilized as intervening variables, Mahoney (2001) reduced these as causally productive in that they generate outcome. We note that the casual mechanisms refer thus to portable conceptual process' that can be applied to different empirical contexts, and thus enable some form of limited comparison and generalizability (Bengtsson, Ruonavaara, 2016). The intent herein with utilizing process-tracing as the underlying analytical methodological framework lay as such in enabling the identification of causal mechanisms between causes and effect via temporal analysis; a sequential evaluation designed and framed through theory (Bengtsson, Ruonavaara, 2016).

How this manifest in the thesis is through a theoretically guided two step approach. Via theory, the thesis generates two tentative hypothesises which is then assessed by gathering empirical evidence. Following this, the within-case analysis – i.e., the first step of the two-step analytical approach, orients such around the two noted causal mechanisms by empirically examining the initial design of the decentralization reforms and how these reached the noted outcome of interest. The following table illustrates this approach.

Table 2. Casual mechanism linking post-conflict decentralization to an (un)successful provision of health

| | Condition | Casual Mechanism | Outcome |
|---|---|---|---|
| Causal Chain | Sierra Leone and Rwanda separately pursues decentralization as a PC institutional (re)construction reform strategy to improve and ensure stable provisions of public services. | From their initial designs of their respective decentralization We should an underlying policy/reform pattern emerge upon which subsequent reforms and/or policies emerge to entrench such and replicate its patterns. For Rwanda, the policy legacy enables a policy feedback loop that builds focuses attention on ensuring healthcare is | The trajectory of their respective decentralization reforms and policies makes emergent a condition of healthcare that is either successful or fails in architecting an effective service delivery system. |

| | | | |
|---|---|---|---|
| | | decentralized, functional, and improving.<br>For Sierra Leone, the policy feedback mechanism emergent from the states initial policy legacy would favour a pattern of power reproduction to the detriment of the healthcare system. | |
| Observable implication | Both states initiates their decentralization processes by enacting one type of decentralization reform, i.e., either political, administrative, or fiscal decentralization with the explicit purpose of improving service delivery. | We should be able to observe from their initial and/or second decentralization reform type an underlying design pattern e.g., an aim to ensure smooth intergovernmental cooperation. As such, in the case of Rwanda we observe a policy legacy that acts beneficial to public services and from such emerges supportive policies and reforms to that effect. Sierra Leone's in contrast will have reforms and policies that negatively affect the healthcare system due to its policy legacy. | The outcome emergent from Rwanda's decentralized healthcare system manifest in the beneficial health outcomes, and in Sierra Leone such manifests in recentralization |
| Empirical evidence | N.A | N.A | N.A |

As such, the within-case analysis traces the reform sequences on the basis of Falleti's identified ideal-type periodization - the temporal order which can be sliced up into different periods; namely, AD, FD, PD. We identify their design and assess how these affected the trajectory of the decentralization of healthcare. The paper should from this examination have empirical evidence enabling a between-case comparison – i.e., the second step of the analytical approach, to assess the hypothesises (Bengtsson, Ruonavaara, 2016).

## 4.4 Data

Though Bengtsson and Ruonavaara note papers utilizing path dependency and process tracing would require "direct access to primary actor material in the form of documents and interviews", we note this paper limitation in interviewing actors and document retrieval on the basis of two core reasons (2016:13-14). (1) some of the documents are barred from the researcher due to a language barrier. Rwanda's official languages are French, Kinyarwanda and English, and though a myriad of documents are written in English, some do not exist electronically, and others have not been translated into English; (2) because this paper has a limited

time to pen the thesis, and due to the geographical differences, interviews with government officials was not possible. In light of these limitations, the thesis utilized documentary research method to distinguish between two types of materials that could be used. Namely, primary, and secondary sources (Monageng Mogalakwe, 2006). The former of these denotes eyewitness accounts, and the latter testimonials obtained or compiled by way of relevant documents. And as this thesis attempts to reconstruct the decentralization process – a state-reform procedure, the thesis strove to utilize both when able. Note, speeches and diaries were unavailable likewise due to the language barrier. The application of documentary sources herein offers indirect mediate access rather than proximate. Meaning, the paper is herein provided access to the decentralization process via the material sources, rather than being contemporaneous with primary sources (Mogalakwe, 2006).

Distinguished between private, public and personal documents, this method retains a myriad of definitions on the litany of available documents, but we recognize and distinguish such solely through the private/public/personnel dichotomy (Mogalakwe, 2006). Private denotes source material derived from the private sector i.e., invoices, personnel records, meeting transcription, tax information and more. Public would signify materials like census data, ministerial documents, reports, INGO and NGO reports, government publications, news reports and more. Lastly, personal would primarily denote individual records like memoirs, letters, comments, direct interviews, and more (Mogalakwe, 2006).

Vital for this section is the distinguishment because the cataloguing enables the accumulation of specific types of data enabling for a good examination. As this paper intends to construct trace the decentralization healthcare from the design legacies emergent from the reform types, it will utilizes extant public research which utilizes interviews with government officials, state government white papers, grey literature, INGO and NGO reports, state laws and government policy guidelines. In light of this, the data selection is reasoned as rooted and guided by three criteria's: (1) authenticity, meaning that the evidence and/or data sought is dependable; (2) credibility, that the data/material recovered provides a true account; (3) and lastly, meaning - denoting that the evidence sought is clear and coherent within a collaborative context-defined fashion (Mogalakwe, 2006).

In light of these criteria, to find material enabling the answer to the proposed research question and constructing our chronology, this paper consulted with extant research literature i.e., secondary documents, specifically those formed around interviews and analysis on both states' healthcare systems and initiatives within the decentralization process. Likewise, the extant research was additionally consulted to portray and inquire into the intent of the actors (government officials) within those periods. There was chosen specifically to engage with both academic papers and grey literature. The latter specifically more because of the litany

of INGO and NGOs that review and assess the operations and development of both states' healthcare systems within their respective decentralization processes.

# 5 Rwanda's and Sierra Leone's decentralization trajectory

This section of the thesis traces the decentralization process of Rwanda and Sierra Leone within the context of their healthcare systems and wider state reform process.

## 5.1 Rwanda

Though an understanding of prior events might be pertinent to a study of Rwanda's decentralization, we contend on the basis the civil war that emerged in 1994 and the state reforms emergent in 2000, that this period critical juncture enabled the adoption or application of decentralization. We identify in the case of Rwanda the path dependent process initiated with the adoption of the NDP in May of 2000.

In 2000 when the NDP released and Rwanda engaged with decentralization, the process was explicably designed to be approached through in phases (MoH, 2001). What do we mean by such? As the NDP of 2001 clarifies, because the government of Rwanda (GoR) made decentralization a key policy of the government, the state strategically split its programme aimed at the "promotion of good governance; poverty reduction; efficient, effective and accountable delivery of services" (MINALOC, 2007: 7) into three phases:

- Phase 1, 2000-2006: the GoR deconcentrates key administrative functions and responsibilities towards the district level. The district and relevant subnational units are thereafter strengthened via capacity-building initiatives so these can be fully devolved the service functions in phase 2. Likewise, phase-1 will ensure grassroots elections, and ensure the deconcentration and decentralization of fiscal functions and supporting legislation and policy reforms while sorting the intergovernmental fiscal transfers (Brinkerhoff et al, 2009; Pierre, 2003).
- Phase 2, 2006 – 2011: the GoR continues to strengthen the LGs in primarily resource management, grassroot mobilization, designing accountability mechanisms, and devolving administrative functions towards the and initiating a deconcentration towards the sector-level (Brinkerhoff, 2009; GoR, 2001).
- Phase 3, 2011-currently: the GoR concentrates on the fiscal decentralization of LGs to ensure sustainable resource mobilisation, equitable development, and increasing the planning and management capacity of these. Likewise, the GoR intends for the capacity of the districts and sector level to be sufficiently high enough to remove the provincial subnational tier and incorporate the responsibilities of these into the LGs (GoH, 2011; Brinkerhoff et al, 2009; MINALOC, 2001).

In a departure from a number of developing states (see Awortwi 2011; Falleti, 2004), Rwanda's decentralization process is split into separate phases aimed at covering different objectives. We note herein that according to NDP (2001), the Government of Rwanda (GoR) initiated decentralization via PD first, and followed that up with a funded AD that initially deconcentrated healthcare functions so to firstly enhance the LGs institutional capacity for a later devolution – a feature which was repeated on all subnational tiers so these could be delegated service functions in the future (MINALOC, 2011). Fiscal decentralization would follow AD, but do so in a limited format.

At its core with this phased approach lay a focus on institutional (re)construction i.e., strengthening the LGs via state and NGO funded capacity building projects (Brinkerhoff et al, 2009). From a survey of Rwanda's phased approach, it is already apparent that the states PC decentralization programme is different. For according to the NDP (2001) all three reform types emerge within phase 1 and they do so in close proximity of one another. On the effects of such we herein examine.

### 5.1.2 Phase 1: Subnational governmental (re)construction

In May of 2000, the Rwandan government approved of the NDP of 2000 and initiated a decentralization process by firstly consolidating the administrative structures around the country via the laws N° 43/2000 of 29th December 2000; N°04/2000 of 13th January 2001; N°05/2000 of 18th January 2001; N°07/2001 of the 19th January 2001; and N°18/2001 of 01st March 2001 (Pierre, 2003; GoR, 2017; Brinkerhoff, 2009; Malin Hasselskog, Isabel Schierenbeck; 2015; Conteh, 2016). The intent with this institutional re-design lay in that the CGoR strove to form an LG system which would manage decentralized service responsibilities and to establish chief administrators via popular elections (MINALOC, 2012). As such, the process would initiate by ensuring grassroots elections and the consolidation of the LGs administrative structures (Benjamin Chemouni, 2014; GoR, 2012). As a result, though the laws and the NDP of 2001 functionally clarified the deconcentration of service functions, it was popular elections and hence political decentralization that emerged as the first observable application of this new reform process. Following pilot programmes in 2000, the GoR established the grassroots elections of electoral leaders through a law in December of 2000, and manifested such in March of 2001. Following these elections and redistricting process, the initial LG structure would evolve thereon to this:

Rwanda's institutional framework: pre-2001

| Entities | Chief Administrator | Number |
|---|---|---|
| Prefectures | Prefect | 12 |
| Sous-prefectures | Mayor | 22 |
| Communes | Mayor | 154 |
| Sector | Coordinator | 1,531 |
| Cell | Coordinator | 8,987 |

Rwanda's institutional framework: 2001-2006

| Entities | | Chief Administrator | Number |
|---|---|---|---|
| Province | | Prefect | 11 |
| Kigali City | | Mayor | 1 |
| Town | Provincial | Mayor | 11 |
| | Town | Mayor | 3 |
| District | | Mayor | 84 |
| Sector | | Coordinator | 1,550 |
| Cell | | Coordinator | 9,119 |

*Fig. 5. Rwanda's institutional structure 2001-2006. Source: Benjamin Chemouni, 2014; Pierre Munya, 2003.*

Note, the Rwandan government is comprised of two layers, the central and local government, and in period between 2001-2006 the latter would be divided into six subnational units. The eleven provinces functioned and continue to function as a delegated arm of the CGoR and it was expected these would be phased out when the districts in phase 3 attain fiscal and administrative autonomy ( Pierre, 2003; GoR, 2017; Brinkerhoff, 2009; Malin Hasselskog, Isabel Schierenbeck; 2015). The Ministry of Local Government likewise noted the provinces as delegated governmental body, which would be utilized as "a coordinating organ (…) in the planning, execution, and supervision of the deconcentrated services" (MINALOC, 2001a: 19-20; Munya, 2002). Following the provinces, the district level i.e., the "basic politico-administrative unit of the country" (MINALOC, 2001a: 11) was and remains the Rwandan LGs seat of administrative and political power; below these are the sector and cell tiers of government, where the LG deconcentrates specific service delivery functions (MINALOC, 2001a). At all three tiers of subnational administration i.e., the district, sector, and cell levels, decision making authority lay at the elected representatives within each of these administrative bodies' councils and executive committees (MINALOC, 2001a).

#### *5.1.2.1 Political decentralization*

The first decentralization measure enacted and implemented as noted previously was a 'limited' and phased form of political decentralization in March of 2001. We distinguish between phased and limited because the PD was designed in a particularly unique fashion. For one, we note phased because Rwanda's PD would not be supremely entrenched into law before June of 2003 through a constitutional referendum and because some electoral offices were not devolved fully (Brinkerhoff et al, 2009). Despite authors arguing the local elections between 2001-2003 can only be categorized as pilot programmes, we note that such was not the case (see Chemouni, 2014). For through the law N° 42/2000 of 15 December 2000 and the elections that followed, PD was established at almost " every tier of local government, except the provincial level" – which represents the delegated power of the CG, and the district mayoral level (Chemouni, 2014: 252). And this paper notes the initial PD as designed to be 'limited' on two reasons. The first reason lay in that the election of LG offices above the cell-level followed an indirect electoral process. A measure adopted in the initial 2001-2002 elections which continued thereafter (Pierre, 2003). For as Chemouni notes:

> *[members] of sector and district councils are elected indirectly from the level below, with reserved seats (…), the district is composed of a councillor elected at the level of each sector of the district, (…) [crucially], no candidate at local elections can claim partisan affiliation: parties are not officially allowed to campaign or play any role in local elections* (Chemouni, 2014: 252)

Meaning, at the cell-level, residents able to vote directly elect elect cell-level council members, and from these elected cell council members emerges representatives, also indirectly elected, and it is one of these representatives that thusly get indirectly elected to the district council (Pierre, 2002; Chemouni, 2014). In addition, the district mayor was not directly elected at the cell-level; in fact, they were not elected at all between 2000-2006 (Pierre, 2002; Scher, MacAulay, 2010). The second reason lay in that the CG reasoned on the basis of the countries (re)constructive phase and the lack of capacity at the local level, that they should be the ones to elect mayors until a later point in time (Scher, MacAulay, 2010). The purpose with this indirect electoral design lay in the CGoRs intent to dissuade clientelist opportunities and/or capture of local political institutions. Another design measure baked into the decentralized electoral system is the prevention of local political elites capturing electoral systems by mobilizing citizens around competing development projects via the prohibition partisan affiliations for candidates (Pierre, 2003; Chemouni, 2013). In fact, no parties are officially permitted to campaign nor play an active role in local elections (Pierre, 2003). The overall design intent with the PD is noted by Chemouni who argues such as meant to foster a benign local political competition for:

*[elections] are hardly decisive either in the running of the sectors and cells because of the consultative role of elected individuals or the running of the district since the mayor is a very indirect emanation of voter's preference* (Chemouni, 2013: 253).

Having a PD designed to sanitize the local political climate and align voter preferences to technocratic representatives is and remains the core intent. Likewise, the PD also functionally displays the CGoRs intent in designing systems that overall provide autonomy, but an autonomy that still allows for centralised control. One example of this lay in that district mayors were elected not by local citizens, but by the CG. And though the CG noted that measure as temporary, it continued into 2006 when they gave up the seat and exchanged local political control via an accountability mechanism (Scher, MacAulay, 2010). As such, the RPF designed the initial political decentralization to ensure grassroots elections, enable top-down control.

#### *5.1.2.2 Administrative decentralization: Deconcentrating Healthcare*

In tandem with the initial phased delivery of 'limited' political decentralization, Rwanda having emerged from its grassroots elections in 2001 and the initial(re)constructive institutional process as noted in fig. 5, with five tiers of LGs (MINALOC, 2001a: 11). On paper (MINALOC 2001a), the LGs were politically and administratively independent – to an extent (MINALOC, 2003; Pierre, 2001; Chemouni, 2014). We again note the initial limitations put on the AD process, and more specifically, the restrictions put on the decentralized healthcare system. For as the five tiers emerged in 2001, so did the overall restructuring of Rwanda's healthcare. Divided into three levels; mirroring the overall tiers of administration power, the following notes these as:

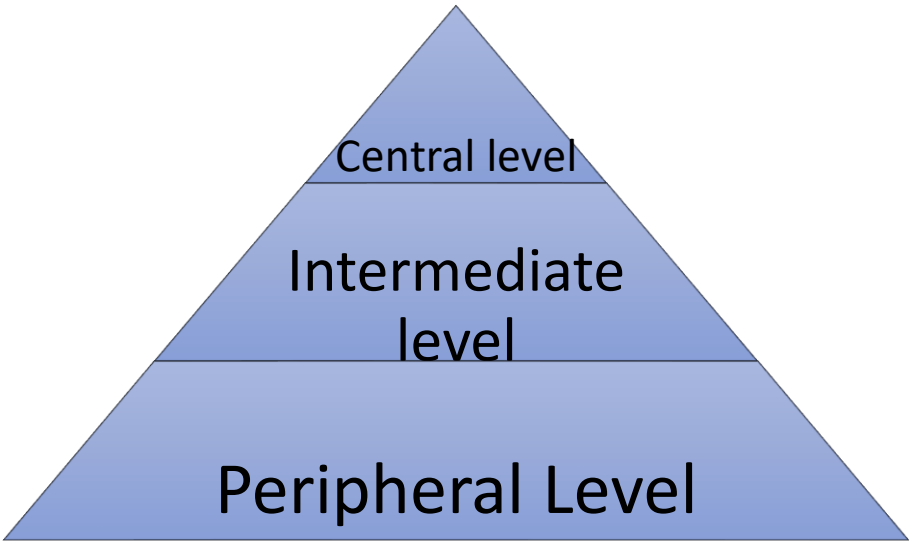


Fig. 6. Rwanda's public health sector. Source: MINALOC, 2003.

Each of these administrative levels within Rwanda's decentralized public healthcare system were provided upon with their own minimum activities package detailing their technical and administrative platforms i.e. their functions (MINISANTE, 2003). Based in the capital (Kigali City), the central level stood directly for the development of national health policies via the ministries who framed the overall strategic and technical health agenda. Likewise, the central level was in charge of supervision, evaluation of programmes, and in managing the national referral hospitals i.e. the teaching hospitals in Butare and Kigali (MINISANTE, 2003). Note, the central level i.e., the CG, is the only entity which can elect mayors, train/hire medical staff, employ public officials, and likewise is the only one able to fire these – except for the mayor which is likewise an ability of the district LGs (Scher, 2010; Brinkerhoff et al, 2009; Pierre, 2002). The rationale for this top-down approach on specifically officials and medical professionals were argued on the basis of LGs lacking the capacity to handle these (Scher, 2010). In addition, the teaching hospitals would provide specialized services which, in contrast to district hospitals, would make them the highest tier medical service provider within Rwanda (MINISANTE, 2003). And though the national teaching hospitals (NTH) could take on referred cases like the district hospital (DH), they do and would not as that would intersect with the DHOs delineation of responsibilities. And yet, delineation would still occur (MINISANTE, 2003; MINALOC, 2007). At the intermediate level emerges the provincial health offices (PHO) primarily offer supervisory and/or technical support to both the districts and their health departments. And lastly, the peripheral level. On paper, the 2001 NDP notes that at the district level, administrative functions would be devolved; however, in practice decentralized healthcare functionally manifested in the peripheral level via newly formed, separate, and decentralized administrative units; health district offices (DHOs) (Sher, MacAulay, 2010; Brinkerhoff et al, 2009). For as noted by the MINISANTE, the DHOs are "autonomous entities, providing services to well-defined populations in either urban or rural zones" (MoH, 2003: 9). And within their allocated districts, these DHOs would at the peripheral level of Rwanda's healthcare system have at each district "an administrative office, a district hospital, and primary health care facilities (health centers) (MoH, 2003: 10)"- meaning, primary care facilities placed at the sector level. Note, though Rwanda's government system had and has in place a top-down supervisory system, meaning each LG tier supervises the one below it; the DHOs in contrast have only had the MoH, the Mayor, and the PHOs as their supervisory units (ibid). As such, and as noted by the MoH, the DHOs were functionally independent and did not fall under the direct purview of the districts (MINISANTE, 2003). But they were still part of the district administration. For one, the DHOs had their own district administrative office – a group comprised of healthcare professionals, elected and non-elected local community members (MINISANTE, 2003), was housed together with the district administration . These were responsible for the day to day coordination, planning, emulation, and management of health districts activities (Brinkerhoff, 2009; Scher, 2010). The design of the management team illustrates also the

CG intent in collaborating and making sure that local communities perceived these and other health-related administrative organizations as local-owned. This they did, as noted, by comprising the managerial health administrative units of local community members (Pierre, 2002; Brinkerhoff, 2009). As such, the overall design of the healthcare AD in conjunction with the PD appears to suggest a pattern of intent by the CGoR to institute, despite promises of a bottom-up planning process within the 2001 NDP, a top-down planning process. We argue this on the basis of absent legislation and policies accompanying the noted bottom-up process/mechanisms. What we see instead is the noted enhancement of CGoR control and local community participation as a cost-sharing feature, for healthcare volunteers are unsalaried and so was the health district administration office (MINISANTE, 2003).

The design intent with the DHOs followed the rational that local capacity was not up to par to manage it. As such, the (re)construction of the healthcare system could not fall on the shoulder of the LGs. For as noted by MINISANTE (2003), in 2001 the Rwandan healthcare system functionally lacked district hospitals, staff, had severe capacity-issues, and there was absent functional cross-LG cooperative and communicative systems. And chief amongst these issues was the overlap of activities between districts and referral hospitals due to unclear delineation of responsibilities. In an assessment of the Rwandan decentralization process, Pierre (2001) critically noted this issue of delineation which needed "be overcome if the resources are to reach the grassroots levels where services are needed" (Pierre, 2002; 35) and the lack of access. As such, the design of the healthcare tiered healthcare system, and the separate DHOs was done to allow the CGs to build up the capacity of LGs and empower by clarifying and building legal and procedural instruments for later administrative devolution. On the latter, Rwanda between November of 2000 to May of 2002 alone implemented sixteen different laws meant to clarify and assert decentralization, and districts and provincial functions (Pierre, 2002). Many of those laws were directly aimed designing a supportive legislative framework for LGs, demonstrating not the political willingness of the CG in enhancing and developing a strong healthcare system, but the 2003 constitutional referendum enshrined within Rwanda the right to good health without discrimination as a fundamental constitutional right, further stressing and entrenching the CGs disposition (Katia Savchuk, 2014).

In the NDP of 2001, the GoR argued that the decentralized political and administrative structure should ensure that ensure that inadequate "participation of the majority of the population in the making of decisions that concern their livelihood" does not happen and likewise deal with the inadequacy on "capacity (human, systems, structures, institutions, networks, attitudes, etc) at both central government and local levels" (MINALOC, 2001: 4). We again note the lack of both legislative and policy support to ensure this bottom-up measure, because the CGoR policy-wise replicated and entrenched participation as a cost-sharing feature by integrating unsalaried Community Health Workers (CHW) as a reform response to deal with the

shortage of medical workers (Savchuk, 2014; Abott et al, 2017). These CHWs are not only trained by the MINISANTE in the administering of preventative, diagnostic, and medical services, they likewise function as local referrers that ensure individuals go to district hospitals to get treated if necessary. These CHWs are local citizens who are elected by the local communities - at all the lowest tiers of the LGs (Savchuk, 2014; Abott et al, 2017). Because these live and work within the communities, they are argued as functionally representing a local-level ownership of the healthcare system in that the CHW functionally aid in the policy and programme implementation (Julia Robson et al, 2020; Médard Nyandekwe et al, 2014; Abott et al, 2016). In combination with the adoption of CHWs into the decentralized healthcare system, Rwanda likewise adopted a Community-based Health Insurance (CBHI) scheme and a performance-based financing system (PBF) in 2004 and 2005 respectively. On the latter, such follows the same pattern within the design of the PD in that the CG shaped a policy feature that clearly shows their intent in fostering a results-based and elaborate technocratic base of officials. This move policy wise emerged as a reactive due to Rwanda's healthcare system between 2001-2005 lacking in healthcare results. As such, the GoR utilized the PBF in incentivizing officials to ensure more beneficial outcomes within healthcare (MoH, 2005). Not only did the PBF benefit CHWs, but was likewise universally implemented in 2005 for all the LG and CG employees (MINALOC, 2010). Likewise, the CBHI itself is also a reactive measure to the CGs disappointment with the results of the healthcare systems. As such, the GoR incorporated the CBHI into the healthcare system to improve access and utilization of primary healthcare services(Louis Rusa et al, 2008).

In lieu of this, the thesis identifies a reform legacy rooted in a results-based, top-down led, and community integrating decentralization process with a governmental centre willing enact policy reforms to entrench and secure positive decentralization results. And we these underlying patterns emerge overtly entrench themselves within the healthcare system through the 2005 Health Sector Policy (HSP) plan – a document which elaborates on Rwanda's overall health sector visions (GoR, 2005). The GoR notes the policy plan is the:

> *basis of national health planning and the first point of reference for all actors working in the health sector. It sets the health policy objectives, identifies the priority health interventions for meeting these objectives, outlines the role of each level in the health system, and provides guidelines for improved planning and evaluation of activities in the health sector* (GoR, 2005: 4).

In essence, the HSP is overall policy vision for the health sector and its development. And not only that, the HSP is operationalized by policies like the Health Sector Strategic Plan (HSSP) which defines priorities health objectives, and acts as an instrument to guide the entire health sector between 2005-2009 (GoR, 2005). Though the HSSP (GoR, 2005) makes no mention of decentralization, it notes itself as an

operationalization of the HSP. We note such as important because it is within the HSP that the underlying reform patterns that emerged in the PD and AD are overtly formalized via policy. For within the HSP, Rwanda's Minister of Health, Dr. Jean Damascène Ntawukulirayoyo distinctly notes they via the HSP will strategically innovate the health system by "introducing notions of adding value by using concepts of results orientation, quality and performance based techniques" (GoR, 2005: ii).

#### *5.1.2.3 Fiscal decentralization*

Amongst the myriad of laws and regulatory instruments meant to succeed and enhance the Rwandan states decentralization process, the AD for LGs and DHOs were funded and another 'limited' fiscal decentralization emerged hitherto these. In fact, according to the myriad of laws, and the MoH, the LGs and in specifically the DHOs were provided with a complete decentralization of "financial and logistic resource management" (MoH, 2003: 9) which in combination with LGs which housed the DHOs within their administrative structures, could via the several mechanisms and laws pursue funding. For one, the LGs could pursue conditional grants and loans – meaning that the LGs could accrue debt and finance their services through borrowing from private and public institutions (MINALOC, 2001). Secondly, the districts have been legally empowered to collect and levy head and property taxes and collect revenue from certain licenses and rents (Pierre, 2003). Those have been the two main methods of the operationalization of the fiscal decentralization. As such, 'partial' fiscal decentralization was initiated early on so the district could feel enabled to "raise their own resources and to be able to finance their current activities" by having tax sharing arrangements (Pierre, 2001: 11). Despite this, the majority of health facilities relied still on user fees to finance their activities due the country being resource poor (Louis Rusa et al, 2009; Pierre, 2003). Likewise, the Government of Rwanda (GoR) established developments funds for LGs, enhanced and bolstered their accounting and auding systems, and designed programmes around the budgets of districts so not to hamper these and their activities (MINALOC, 2001; Pierre, 2003). Yet, though fiscal decentralization had been locked in at the time, the capacity of LGs and the minimal amount of funds these accrued via their revenue collection mechanisms, hampered several projects, and caused a "slow progress of actualizing fiscal decentralization" (Pierre, 2003: 23). It is due to this that fiscal decentralization of healthcare within phase 1 relied predominantly on user pay and government funding to subsist, as districts own revenue was limited. Like with the AD design, Rwanda thus focused on increasing the LG government budget and enhancing these and their fiscal decentralization.

### 5.2.3 Phase 2 and 3: Policy feedback loop and self-reinforcement of CG control

In the 2004-05 interim, the GoR evaluated the overall decentralization programme and therein made remarks on the myriad of noted capacity, communicative, fiscal, and service delivery issues (MINALOC, 2007). Thus, the GoH moved into phase 2 of decentralization via a nation-wide redistricting and by initiating full AD new obligations of all LG administrative tiers (Brinkerhoff et al, 2009). Via the ORGANIC LAW Nº 29/2005 OF 31/12/2005, the Rwandan government this evolution:

Rwanda's institutional framework: 2001-2006

| Entities | | Chief Administrator | Number |
|---|---|---|---|
| Province | | Prefect | 11 |
| Kigali City | | Mayor | 1 |
| Town | Provincial | Mayor | 11 |
| | Town | Mayor | 3 |
| District | | Mayor | 84 |
| Districts of Kigali City | | Mayor | 8 |
| Sector | | Coordinator | 1,550 |
| Cell | | Coordinator | 9,119 |

Rwanda's institutional framework: 2001-2006

| Entities | Chief Administrator | Number |
|---|---|---|
| Province | Prefect | 4 |
| Kigali City | Mayor | 1 |
| District | Mayor | 30 |
| Sector | Coordinator | 450 |
| Cell | Coordinator | 2,148 |
| Village | CHW | 14,744 |

*Fig. 7, Rwanda's evolving institutional structure 2001-2006. Source: Benjamin Chemouni, 2014; Pierre Munya, 2003.*

With this new institutional framework, the cells, sectors, districts, and provinces were consolidated and decreased in number, and a new non-administrative tier was added; the village/umudugudu level (ORGANIC LAW Nº 29/2005 OF 31/12/2005). This new restructuring occurred not only occurred for the noted reasons, but likewise to integrate and increase collaboration between the central and local levels (Brinkerhoff et al, 2009).

The GoRs redistricting reform affected not only the administrative units, but likewise the health districts (Brinkerhoff et al, 2009). Not only were the district governments functions enlarged, but the DHO were formally melded into the district's administrative structure, thus making these their departments of health and services and thus under their purview (Brinkerhoff, 2009). Likewise, MINISANTE reduced the number of central-level appointed staff as personnel were transferred onto lower levels. As such, the DHOs were devolved away from the MoH and towards the changed administrative districts, now run by the locally elected leaders and locally elected mayors who collectively assumed control of the healthcare sector (Derick W. Brinkerhoff, Catherine Fort, Sara Stratton, 2009). As such, reporting relationships were altered so that

health managers/officials who were responsible for the service delivery no longer reported to central-elected staff, but instead now to locally elected officials (Brinkerhoff et al, 2009). The new district health and administrative officials would thus oversee, plan, and administer their oversight upon their respective districts health related activities. Because as noted by Charles Munyaneza - former director general of Rwanda's Territorial Administration in the Ministry of Local Administration, to Sher and MacAulay, by 2006 the LGs had become "viable administrative entities that can easily deliver services to the people" (Charles Munyaneza quoted within Scher, 2010).

There were now at least one district hospital at each district level, but health posts were missing. And as such, the LGs in conjunction with the CG collectively worked towards building these – of which would be introduced in phases (MINALOC, 2012; Pamela Abott et al, 2017; Brinkerhoff et al, 2009). The following figure details the new healthcare system:

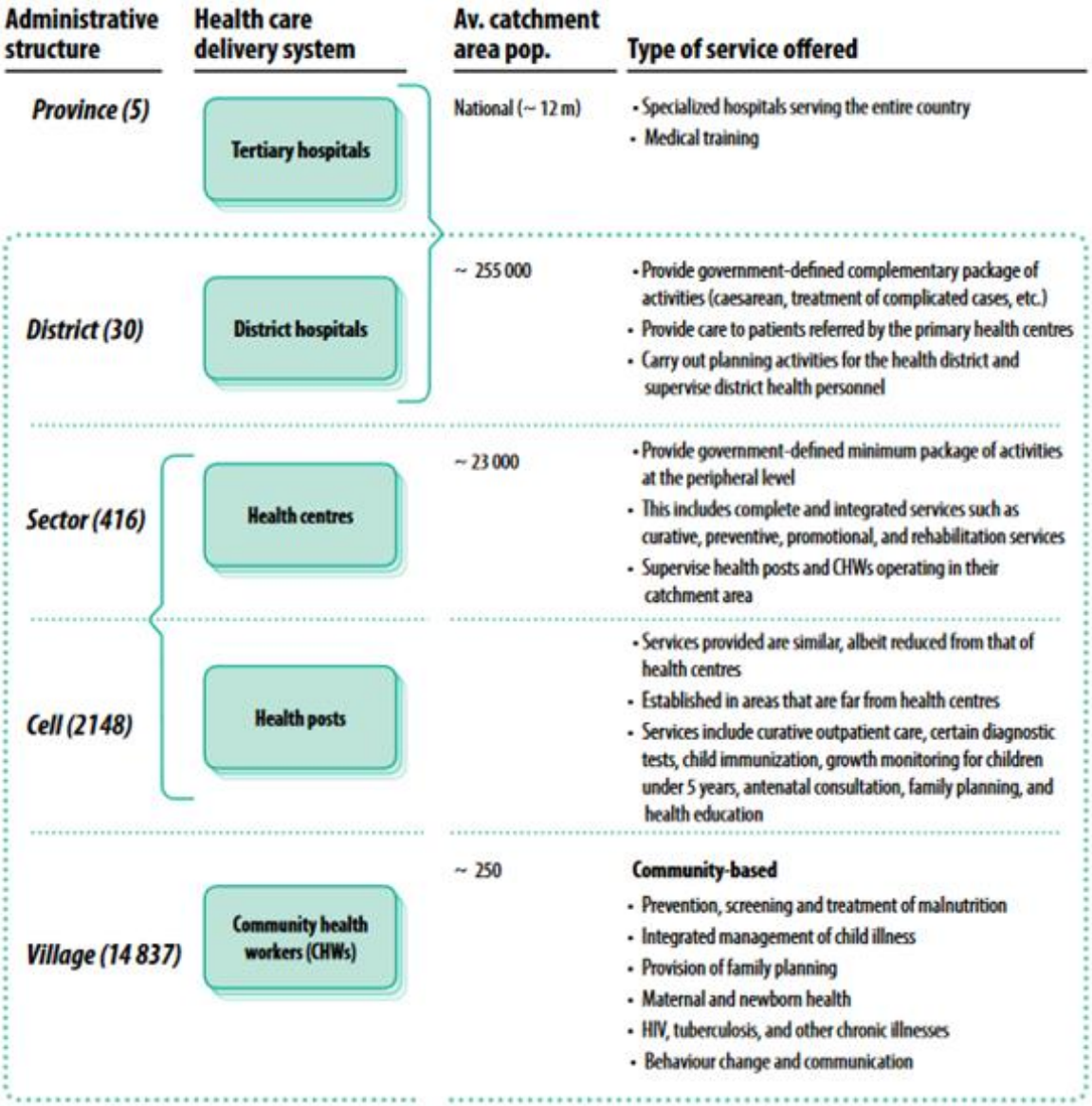


Fig. 8, Rwanda's healthcare system. Source: MoH, 2015; WHO, 2018: 13.

It should be noted that despite Charles Munyaneza comment, the districts still required capacity development. Especially when it came to the salaried officials (Chemouni, 2016). In fact, Rwanda's HSP distinctly notes such (GoR, 2005). So, why this sudden overt change in decentralization? And does this redistricting deviate from the initial policy legacy? It does not. For these changes emerged primarily because of the decentralization processes lack of results and the financially unviable disposition of the districts i.e., their small own-revenue accumulations (MINALOC, 2006; Chemouni, 2014). It was for these reasons Rwanda chose to administratively consolidate and shift the phased decentralization approach towards a more overt fast-tracked within phased development rooted in a top-down, results-based framework. We argue this on the basis of the post-2005 policies, initiatives, and laws that (1) instituted this fast-track development route on decentralization and (2) put a large emphasis on results over process (MINALOC, 2013). The HSP, HSSP I, AD, PD, and the administrative consolidation are all derived from this result-based focus. Further emphasizing the redistrict emerged because of this, Fred Mufulukye – former director general of Territorial Administration and Good Governance in 2010, explains that in 2006 and prior, the MINALOC had become concerned with whether the districts could ensure that the government delivered on their development goals (Scher, 2010). Because as Chemouni (2014) notes, the CGoR was dependent on the LG if they wanted to reach the targets they set within their own national documents. As such, in dealing with this, the CGoR approach such in three ways. Firstly, they consolidated the administrations of the LGs. Secondly, they strengthened the technocratic base of LG officials in 2005. For just prior to the administrative consolidation, Rwanda evaluated all of its civil servants at the subnational levels. The intent with these tests were to assess the skills of each employee and from such evaluate whether they should be kept on or fired (Chemouni, 2014; 2018). Likewise, the provincial governors were tasked with identifying potential mayoral talents. And from all of this, "technocratic profiles, knowledgeable about the functioning of local government, have been promoted" (Chemouni, 2014: 254). And thirdly, the CGoR in 2006 just after the redistricting, devised and implemented imihigo contracts – a pre-colonial practice of publicly vowing to undertake certain tasks (Sher, MacAulay, 2010). In the modern day, the GoR operationalized the tradition by utilizing these as binding agreements for district mayors, district officials, healthcare workers and many more in accomplishing specific and measured tasks (WHO, 2018; Chemouni, 2014). Note, these contracts are signed by officials at all LG levels, and in 2012 the imihigo contracts were pushed into the private household (Malin Hasselskog, 2016). The imihigo are thusly meant to function as a top-down results-based management system, i.e., a massive expansion of a reform pattern that only appeared implicitly in 2001, strengthened in 2004 via PBF, and entrenched itself within healthcare in 2005 (ibid). How the CG utilizes and have repeated their control over the LG via these are by having imihigo contracts comprised of:

> *a list of the most important activities drawn from the annual district action plan. It is signed between the district mayor and the President of the Republic, and is evaluated by a team composed of high officials from different sectorial ministries, the Prime Minister's Office and the President's Office* (Chemouni, 2014: 249).

As such, the imihigo management system functions like so; directed by the national priorities within the annual action plans, districts, sectors, cells, and the village level administrative bodies take these and draw up imihigo contracts translating the national priorities into tangible local-level targets which officials at all levels sign up on to reach. It is herein noted that the line ministries i.e. MINISANTE and/or MINALOC often bargain over these drafts, and though the process should be informed via a bottom-up approach, such rarely occurs in reality (Niamh Gaynor, 2013). In essence, the imihigo contract thus acts as a subset of the action plan by displaying the districts defined performance measure of national-set priority activities. These imihigo contracts are by extension a measure by the centre to retain control and ensure results. For if an official do not score over 70% in their imihigo performance review, which transpire monthly at the cell and sector level, but only annually at the district level, they are fired (WHO, 2020). Why the imihigo was to function like so was noted by a district vice-mayor who noted to Chemouni that decisions for important sectors, "such as health and agriculture, […] all comes from the top" (Chemouni, 2014: 250). I.e., again, though there appears a promise of ensuring a bottom-up approach, accompanying legalisation scantly references such. And since the GoR is the only entity able to generate and draft national development plans, which the annual district plans are derived on, they can tailor what the LGs pursue policy and initiative wise on the local level, despite these being functionally independent (MINALOC, 2001; 2013). One example of an operationalized imihigo lay in the HSSP I (MINISANTE, 2005: 1). For one of the national targets therein was a 100% enrolment of the populace into the CBHI scheme (MINISANTE, 2005; Chemouni, 2014). And because the mayors and public officials signed imihigo contracts pledging to reach these targets, were forced to utilize methods of detaining non-CBHI bearers, do livestock confiscation, and even denial of aid to those who did not partake in the CBHI scheme (Benjamin Chemouni, 2018). And these imihigo contracts on health typically house out of 100, "*15 health-related indicators"* (Brinkerhoff, 2009: 5). The reason for these drastic actions are because for district Mayors, their annual imihigo contracts are publicly tracked and distributed quarterly within Rwanda. And if these mayors fail in reaching their targets, they are either let go by the district council or directly removed by the CGoR (Daniel Sher, Christine MaCAulay, 2014). This as such feeds into the PD, enhancing the technocratic unpartisan aspect, and allows for the imihigo contracts to be deeply embedded into the administrative structure and the decentralization process. For it is the main method upon which the CG enacts its top-down control on the administrative functions and ensures that success follow its development programmes. And as noted by Desire Nyandwi - former secretary-general of the RPF, to Scher and MacAulay,

"If you work, there's got to be a target (…) [Imihigo] creates an incentive for bureaucrats to get things done and not just sit in their offices with their arms crossed" (Scher, MacAulay, 2010: 3). As the political and administrative decentralization of Rwanda then reoriented itself around the imihigo contracts, results determined the career and/or status of public officials.

Following this overt adoption and repeat replication of those policy patterns, the post-2006 period saw several amendments and revisions to existing policy plans. For one, the key laws that underpinned the AD process were changed via Presidential orders, and the functions and organisations of the districts, sectors, vells, and villages were changed (GoR, 2006). And two key decentralization policies were reformulated; the NDP in 2013, and the Community Development Policy (GoR, 2001; 2008). Likewise, a number of five year plans (MINALOC, 2004; 2010) and strategies emerged (MINALOC, 2007; 2012) which incorporated the result-based approach noted in the HSP (2005) like the five year health plans that were operationalized via the imihigo contracts (MINISANTE, 2009; MINISANTE; 2013; MINISANTE, 2018).

One notable 'revision' was the explicit mentioning that phase aimed to:

> *fast-track and sustain equitable local economic development as a basis for enhancing local fiscal autonomy, employment and poverty reduction, by empowering local communities and local governments to explore and utilize local potentials, prioritise and proactively engage in economic transformation activities at local, national and regional levels, and ensure fiscal discipline* (GoR, 2013).

This objective of ensuring LG self-reliance for phase 3 lay rooted in that Rwanda's districts were not functionally able to become financially independent from the state. For the LGs remained unable to extract large fiscal gains from their territories following. And as such, the health budgets for districts remained and remains centralized. For example, in 2008 77% of the health budget was controlled by the CG through a block grants "using a distribution formula that is still based on historical disbursement rates rather than on the actual needs of districts" (WoH, 2008: 41). Though the CGoR fiscal support for the LGs have been growing year on year since 2000, and the LGs have theoretical freedom to utilize the allocated budget, the "centre does not hesitate to intervene in the choice of investment projects and can override district choice" (Chemouni, 2014: 252). In general, the fiscal transfers between the LG and CG function on four types; (1) The Local Authority Budget Support (LABSF) fund provides a recurrent block grant, (2) earmarked grants; (3) capital block grants; (4) cross-organizational fiscal transfers (MINALOC, 2013). These fiscal transfers are herein likewise supported by the district's ability and capacity to collect local taxes and other relevant own revenue methods. But, as noted before, much of it remains in the control of the CG. Earmarked transfers like

those typically found in Rwanda's public health sector (see WHO, 2008) are by definition controlled by the government. On the other hand, the districts do enjoy freedom in the utilization of their collected fiscal resources, and that is because these have been provided with full fiscal decentralization – even though they might remain fiscally independent on the GoR (MINALOC, 2013).

As such, phase 2 of Rwanda's decentralization process focused predominantly on an administrative decentralization and implementing a top-down designed results-based management system and incorporate result based tenets into the policy process.

## 5.2 Sierra Leone

Formally, the decentralization process commenced in Sierra Leone after the GoSL passed the Local Government Act in April of 2004. Thus re-establishing the local councils, a subnational government tier which had been abolished in 1972; the act likewise attempted to "re-create and re-legitimize the institutions of the chieftaincy, which had suffered greatly during the period of one-party rule and the civil war" (Vivek Srivastava, Marco Larizza, 2011: 143). At least that was what had been stated publicly. For as noted by Andrew Jackson and Joel Cutting (2016) – two faculty members of the University of Birmingham who provided support to Sierra Leone's Local Government Task Force between 2002-04, noted that Sierra Leone's Ministry of Local Government and Rural Development (MLGRD) was chiefly focused on restoring the Traditional Authorities (TAs) i.e., the chieftains for one reason primarily; to institutionalize a method of indirect rule. In lieu of this intent, these authors note that the MLGRD designed a decentralization programme centred on a fast-track political decentralization that, (1) did not clearly mention the devolved functions for the subnational units, and (2) did not specify the function nor mechanism for their intergovernmental fiscal transfer system. On the former, the MLGRD was successfully pressured by the WB, European Union (EU), and the DFID in clearly defining the scope, authority, and role of the local councils (Jackson, Cutting, 2011). And on the latter, the discussions around the fiscal propositions of the decentralization reform brought the finance ministry into the design process, and from these discussions emerged "a small group of senior and mid-level civil servants committed to change" (2011:801) – so committed in fact that these became the de-facto cluster of civil servants fronting the reform. As a result, the CG approved and enacted in April of 2004 LGA; thus institutionalising into law and forming 19 local councils; 12 District council; 5 Municipal Councils; 1 Town Council; 1 Rural district council.

### 5.2.1 Political decentralization

The first decentralization measure enacted upon was the election of officials into the newly reconstructed local government tier, the local councils. On this, the 2004 World Bank loan appraisal report noted that the:

> *Kabbah government has chosen a route of political decentralization to open up the political space and improve inclusiveness. (…) By establishing democratically elected local councils to replace the existing Management Committees appointed by the President, the Government hopes to create a participatory local governance structure where people (including previously marginalized groups) can actively participate in the decision-making process at the local level* (World Bank, 2004: 17)

In essence, the political decentralization was noted by these as a reform act that elects public officials and utilizes these via their political seats to replace the Management Committees – centrally appointed government and UN representatives who managed the councils for the Government of Sierra Leone (GoS) (Phakiso Mochochoko, Giorgia Tortora, 2004). After this, the local council emerged per the LGA as the " the highest political authority in the locality and shall have legislative and executive powers to be exercised in accordance with this Act" (Supplement to the Sierra Leone Gazette Extraordinary Vol. CXXXV, No. 14: 16). Likewise, the LGA established for Sierra Leone a multi-party system and a political framework encompassing electoral process; local and city council compositions; criteria for councillors; electoral procedures for urban mayors and rural chairpersons – the highest administrative seat of the Local and Rural councils respectively; the; and provisions for accountability, institutional transparency, and citizens participation (Srivastava, Larizza, 2011). And as noted before, the Chiefdom councils were legally recognized. But, the LGA put these as the lowest unit of Sierra Leone's administrative structure. As such, the paramount chiefs – the leaders of the chiefdom councils, were enabled to be represented within the various councils. A choice which citizens overwhelmingly voiced their protest against during district level consultations, but was incorporated still in the LGS due to "intense lobbying by the MLGRD and with the support of UNDP" (Nickson, Cutting, 2016: 803) – the United Nations Development Programme. As such, the LGA reconfirmed the chiefdoms position by its institutionalization and the ability of local council to delegate functions to such. In lieu of this, the LGA provided traditional chiefs with 1-3 reserved seats within the 12-member district and councils (Paul Jackson, 2005).

The design of Sierra Leone's political decentralization is, despite the success of the local elections in 2004 and 2008 – with these being described as democratic by international standards, one preferentially shaped towards the CG. We note such this because in 2012 and onwards the local elections would be held alongside national and parliamentary elections (Melissa T. Labonte, 2011). The national system of Sierra Leone followed a proportional representation design, while the local elections would occur via popular votes and competitive elections (Labonte, 2011). However, despite these measures the actual extent to which

Sierra Leone's decentralized political strategy has impacted the democratic local governance and the electoral process remains not only questionable, but we argue to some degree that it was a detriment to such. We argue this on the basis of two issues. (1) the LGA neither specifies the degree of autonomy the LG can receive, and (2) neither does it describe the legal safeguards LGs have against CG interference. In fact, a strong and/or clear legal and regulatory framework for political decentralization appears wholly absent in the case of Sierra Leone (Labonte, 2011; Nickson, Cutting, 2016). And an absence of critical legal precision has and continues in many instances to enable the CG widespread discretion in the extent to which autonomy is granted to councils (Paul Jackson, 2005). And such appears to be a deliberate design choice by the CG. For additionally, in the drafting of the LGA, several radical design recommendations for the political decentralization were proposed like; choosing not to reserve seats on councils for paramount chiefs; disallow partisan candidacy for local elections; and have special seats on councils for youth, women and disabled war veterans (Paul Jackson, 2005). And not only were all of these rejected, but the CG incorporated into the LGA a new rural district council as a "*a proviso […] at the last minute […] giving strong supervisory powers over local government to the three resident ministers who head the provincial administration* (2005: 529). As such, the design of the PD appears hence to be firmly rooted in the CG attempting to shape a loose regulatory framework for decentralization that in theory initiates the process, but in practice enables for the maintenance of centralized authority. Following this, the 2004 election voted in around 456 councillors who almost unanimously were member of the two largest political parties (Labonte, 2011).

And this is the overall reform legacy manifested in the political decentralization, and we see this policy pattern of CG authority once again in 2010 when the GoSL reintroduced the District Officer – a centrally appointed position that had been abolished in 2004 with the adoption of the LGA (Nickson, Cutting, 2016; Srivastava, Larizza, 2011) . The official explanation for the return of DOs was noted by Srivastava and Larizza as the CG arguing that they needed a "stronger channel of communication between the national government and the chiefs" (2011: 150). As such, the Dos would serve as a hub for government policies by their dissemination and facilitation of such (Public Sector reform Unit, 2010). And as noted by Srivastava and Larizza, DOs were:

> *perceived to usurp functions played by district councils and chiefs. Many feel the Local Government Act (…) obviate DOs and that their reintroduction cast doubts over the government's commitment to the decentralisation of power* (2011: 144).

Not only this, but the CG likewise repeated and strengthened a strong LG-CG power asymmetry by the approval of the National Decentralization Policy in September of 2010. For according to the policy, "Local councils shall continue to exist as the highest development and service delivery authority" (Government of

Sierra Leone, 2010). Not only does this reformulation clash with the LGAs enunciation of Local Councils being the highest local political authority, but it was also this which reintroduced the DOs. It has been noted that the parties in opposition to the SLPP and Sierra Leonian civil society groups all expressed concerns with the DOs, and the reformulation via the 2010 NDP (Srivastava, Larizza, 2011). In addition, up to the 2010 formulation of the NDP, the GoSL in 2007 replaced the national elections from a composition based on proportional representations without geographical constituencies, to single-member constituencies for MPs. Thus making the local councils and MPs competitors (Srivastava, Larizza, 2011).

### 5.2.2 Administrative decentralization and Healthcare system

Much of the same policy patterns within the renewed local electoral and political system remerge in the (re)construction of Sierra Leone's subnational government structures. According to the legal framework (LGA 04), Sierra Leone's administrative arrangements are therein detailed and is complemented by a number of key regulatory and supervisory bodies for the explicit purpose of realizing the intended functional and effective decentralized administration (Emmanuel Gaima, 2009). One elemental component of the local councils decentralized administrative structure is that these are headed by a political leadership comprised of a council mayor with an assistant deputy. And on the side of the administration, such is headed by a chief administrator who likewise has an advisor and principal assistant who handles administrative and technical matters related to the management and running of local councils. The council administration ensures that the council "mandatory and discretionary mandates in accordance with LGA 2004 and all other policy and regulatory frameworks in existence and operation" (Gaima, 2009: 7). In conjunction with the local councils, the LG structure is likewise comprised of chiefdom counsels, which includes paramount chiefs, chiefdom speakers, section chefs, and village headmen (Paul Koroma, 2012). Note, the elected chiefdom council rule chiefdoms, and the political leadership of such is comprised of a paramount chief, the speaker, and a treasure (Jackson, 2005).The LGA in addition to crafting these LG tiers and institutionalizing informal ones like the chiefdom councils, also functionally devolved ministerial, department and agencies towards the local councils. We note, the LGA frames the local council as the primary service delivery entity, and noted that certain functions were:

> *evolved between 2005 and 2008 included primary and mid-secondary education, primary and secondary health facilities, feeder roads, agriculture, rural water, solid waste management, youth and sport activities, and some fire and social welfare functions* (Srivastava, Larizza, 2011: 145).

Most critical to this thesis is the AD of Sierra Leones healthcare system. And as noted by Conteh, one of the official rationales for the decentralization programme was to "make the delivery of social services more efficient and reduce the waste and graft that undermined service delivery, including that of primary health care (Conteh, 2016: 2). As a result, we should have seen a concentrated focus on strengthening the healthcare system. But such was not the case. Before the thesis argued why such is the case, we present he structure of the Sierra Leonean healthcare delivery system within an administrative decentralized context. The public health (PBH), in terms of coverage, delivers through hospitals and peripheral health units (PHUs) an estimated 50% of all health services, while the rest is supplied via the private sector and NGOs (Conteh, 2016). The PBH system is divided into four levels; the peripheral level; district level; regional level; and national level. Sierra Leone's frontline health service lay at the peripheral level, which are managed by the District Health Management Teams (DHMTs) – separate decentralized administrative units (MoHS, 2017). The peripheral level itself is likewise comprised of three sub-components. (1) Maternal and child health posts (MCHPs) comprised of trained community health workers and volunteers; (2) Community health posts – which serves between 5000-10,000 people and is staffed by professional nurses and maternal/child heart (MCH) aides; And lastly, (3) community health centres (CHCs) – of which are "situated at the chiefdom level, cover 10 000 to 20 000 people and are staffed by a community health officer (CHO), SECHNs, MCH aides" (Joses M. Kiriga et al, 2011: 5; Government of Sierra Leone, 2009a; Conteh, 2016). At the district level, these are comprised largely of hospitals – which offer secondary care, and which provide referral support to PHUs. Within these, the district health management team acts as the overall body which oversees planning, policy executions, cross-institutional collaborations, district health supervisions, and assesses the district level health services (Kiriga et al, 2011). Via the LGA of 2004, the local councils were devolved the responsibility to manage "the delivery of both the primary and secondary health care levels" (Kiriga et al, 2011: 1). Likewise, the health sector reforms following the LGA provided the local councils with "tied grants amounting to a quarter of the national health budget (…), introduction of user fees in public health facilities (…), and experimentation with autonomy for hospitals" (Kiriga et al, 2011: 1). At the regional level, the hospitals therein provide tertiary care, and at the national level resides the Ministry of Health and Sanitation (MoHS) who drafts the overall health policies, offer capacity development, technical assistance, organizes health services, training, supervision, and evaluations (Conteh, 2016).

As noted previously, there appears absent between 2004-10 a focus on designing a clear regulatory framework for healthcare and policies within a decentralized context. Mirroring the PD policy situation, Sierra Leone's legal and regulatory framework for its decentralization process is not only inconsistent, but the persistence of such has established within the healthcare system a culture of resistance towards the devolution of functions (Conteh, 2016). As noted by Conteh, the lack of a regulatory and legal clarity implies

for an ”unfounded assumption of a culture of collaboration between government ministries” as the reason for a lack of absence in “the process of repealing or amending obsolete and sometimes conflicting laws” (Conteh, 2016: 6). Though Conteh argues such, this paper contends such a proposition and argues instead that the unclear clarity of law was and remains a feature of the decentralization programme because it provides the CG with increasing returns and allows these to interfere with the LGs. And such is apparent with the litany of established departments, agencies, and ministries within the health sector that compete for functions and powers (Gaima, 2009). Though it has been noted that the MoHS has accomplished well in a centre-periphery allocative devolution of functions compared to other ministries, even this semi-effective process appears dogged by a litany of issues rooted in the regulatory framework (Conteh, 2016). The legacy of the unclear and conflicting policy and legal context has undermined the GoSL provision and decentralization of health. For instance, the 2003 Hospital Boards Act (HBA) (2003) and the LGA, though simultaneously drafted, heavily contradicts each other. One of these contradictions manifest in that the HBA provides the Minister of Health the capacity to appoint both hospital board members and the chairperson, which contradicts the LGAs devolution of management of district hospitals to local councils. And though amendments followed to the HBA (2007), these only altered board financing rather than attempt to re-enforce district council control. The uncertain policy context derived from these have caused a litany of issues within the administration of PHC and other public service sectors (Gaima, 2009). In addition, in 2012 the local council and district hospital staff not only contested the Hospital Boards attempts to supervise health centres, but likewise questioned their legitimacy on the grounds that their term had since been expired (Conteh, 2016). Seats which the CG neither sought to replace or remove. We argue this contestation as rooted in the reform legacy and that such has enabled an unstable policy contest that the CG derives increased returns from. We identify these in the hospital boards which appeared as having become avenues for the CG to allocate patronage to loyal members (Conteh, 2014; Conteh 2016).

As such, this policy context has caused the local council to be functionally denied the administration independence of such healthcare provision. Likewise, AD of healthcare was designed in such a way that the healthcare staff were and are not recruited by the councils nor that these provide for their salaries. All of these responsibilities remained with the CG, and the councils were likewise not devolved the authority or capacity to fire these. For as Richard Fanthorpe, Andrew Lavali and Mohamed Gibril Sesay notes: “[resisting] payroll devolution ensures that line ministries can treat local councils as little more than disbursement agencies” (2011:23). And such is why the MoHS still has not devolved health care staff to the councils.

Likewise, another health area affected by the uncertain policy context was the human resources within health (HRH) (Maria Paola Bertone et al, 2013). As recognized within the 2004-2009 period, suggestions of reforms to deal with the ambiguous nature of the health and decentralization policy area were

rarely implemented nor did there emerge a collective response to deal with these (Bertone et al, 2013). Key political actors noted their lack of strategic decision control and the HRH Development plan of 2004-2008 likewise sourced, by arguing that "the current level of uncertainty regarding the exact nature of the reforms" (Bertone et al, 2013:39) formed the uncertain policy context. In 2008 as the SLDPP lost to the opposition, the GoSL published their second *Sierra Leone Poverty Reduction Strategy Paper* (GoSL, 2018). Within this document, maternal and child health were identified as core health issues requiring attention, and such influences the draft of the *National Health Sector Strategic Plan* (HSSP I) (MoHS, 2009). For within the HSSP I, the GoSL launched the *Basic Package of Essential Health Services,* and in 2010, the *Free Health Care Initiative* (FHCI) for children under give and pregnant and lactating women (Bertone et al, 2013). And only 1 year after that, the GoSL introduced a PBF scheme to tackle "the issue of user fees in accessing services" (GoSL, 2017: 54) as the FHCI recipients continued to be fraudulently charged. The GoSL argued that this was because of the "high numbers of unsalaried staff that populate Sierra Leone's health facilities" (GoSl, 2017: 31), and as such was compelled to introduce the PBF scheme to alleviate the issues these brought. Likewise, in 2017, the GoSL officially launches the compulsory Social Health Insurance (SLeSHI) to the wider population; but, the SLeSHI was drafted to function as an autonomous administrative body with a separate autonomy on fiscal and administrative matters (GoSL, 2017). All of the noted policies between 2004-2011 emerged in response and because of the initial policy context, and though Bertone et al noted that it appeared after "the momentum created by the launch of the FHCI, it seems that the reforms are slowing down and the implementation of many has been delayed" (2013:39). Not only that, in early 2014 when the Minister of Local Government attempted to pressure the MoHS in further devolving promise functions towards local councils the Minster of Health responded by ordering the states Director Hospitals to recentralize management of hospitals. And as an interviewee from the decentralization secretariat noted to Conteh that the GoSL rationale for such lay in an argument that local councils were not responsible enough (Conteh, 2016). And despite declarations of condemnations, the MoHS continued with the re-centralization. As such, walking back on the NDPs promise of "full devolution (…) to local councils by the end of 2016" (Edwards et al, 2015:76).

And it would appear that Bertone et al had been right; had the Ebola crises not struck. For between 2014-16 the health system was not only tested, but it was disrupted by the exogenous shock of the rampant Ebola virus. And following the outbreak, the healthcare system - with broad international donor support, began to set a new (re)constructive trajectory for Sierra Leone's healthcare system (MoHS, 2017; Barr et al, 2019). Launched in 2015, three critical policy plans emerged; *The Basic Package of Essential Health Services* (2015-2020); *National Health Sector Recovery Plan* (2015-2020); And the *President's Recovery Priorities* (2015-2017). Though these policy documents have been a "mixed blessing for Sierra Leone's health sector"

(MoHS, 2017: 17) the exogenic shock of the Ebola crises propelled forward the implementation and draft of more policy strategies to tackle the endemic health sector issues. In 2017, the GoSL would publish the *National Health Sector Strategic Plan 2017-2019 (HSSP II)* and like the three policy plans drafted in 2015, it sets out the future policy plans and clarifies on where the health sector is, and where it ought to go still. The following table illustrates the latter:

Table 3: Overview of Sierra Leone's Health plans and policies 2015-2021. Adapted from: MoSL, 2017:17-18

| Description | | Timeline | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Type | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| *HIV/AIDS* | Strategy | | < | | | | > | |
| *TB & Leprosy* | Strategy | | < | | | | > | |
| *Malaria* | Strategy | | < | | | | > | |
| *Insecticide Resistance* | Strategy | | | < | | | > | |
| *RMNCAH* | Strategy | | | < | | | | > |
| *Family Planning <-- **under development*** | CIP | | | | | | | |
| *Vaccines* | Strategy | | | < | | | | > |
| *Nutrition* | Strategy | | | > | | | | |
| *Anemia <-- **under development*** | Strategy | | | | | | | |
| *Mental Health* | Policy | | | | | | | |
| *NTDs* | Strategy | | < | | | | > | |
| *HRH* | Strategy | | | < | | | | > |
| *HRH* | Policy | | | | | | | |
| *CHWs <-- **under development*** | Strategy | | | | | | | |
| *CHWs* | Policy | | < | | | | > | |
| *Supply Chain* | Strategy | | | < | > | | | |
| *Labs* | Strategy | | < | | | | > | |
| *HIS* | Strategy | | | < | | | | > |
| *Health Financing <-- **under development*** | Strategy | | | < | | | | > |
| *Public Health Agency<-- **under dev.*** | Strategy | | | | | | | |
| *Health Promotion* | Strategy | | | | | | | |
| *AMR<-- **under development*** | Strategy | | | | | | | |
| *IPC* | Plan | | < | | | > | | |
| *IPC* | Policy | - | | | | | | |
| *Environmental Health* | Strategy | < | | | | | > | |
| *Waste Management* | Strategy | | > | | | | | |
| *Pest Management* | Strategy | | < | | | | | > |
| *Pesticides Management* | Policy | | - | | | | | |

Yet, despite the exogenic shock of the Ebola crises, the institutional patterns largely remained the same due to the initial unstable policy legacy created in 2004. As such, the reform legacy of Sierra Leone's decentralization programme has invariably affected the quality of the state's provision of health. For one, because the state has resisted significant devolution of financial and decision-making power – as noted by HSSP II. And secondly, the countries regulatory and legislative framework does not, according to the MoHS

provide “answers regarding how the health sector should best be managed from an operational perspective to deliver the best possible health outcomes to the people of Sierra Leone” (MoHS, 2017:22). In practice, this had led to widespread corruption both at the ministry level (see Anna Workman, 2011; Labonte, 2011) and at the local peripheral level both within the free healthcare initiative and at the health centre level (Pieternella Pieterse, Tom Lodge, 2015; Hanna Mitchell, 2017). Not only that, the institutional design of the health system itself is affected to such a degree that it has been argued as heavily fragmented (Conteh, 2016; Barr et al, 2019). Due primarily to the strong NGO presence, with these providing the majority of the funds to the health system. As such, policy legacy has within the AD of healthcare enabled a “distortion, dilution, and diversion of health sector funding into numerous avenues of often overlapping or inadequately integrated vertical programmes” (Barr et al, 2019: 3).

### 5.2.3 Fiscal Decentralization and Health Financing

The LGA supplied not only the local councils with a framework for fiscal decentralization, but likewise the chiefdom councils. Though by law the chiefdom councils remain politically and administratively subordinates to local councils, the LGA specified a revenue domain which emphasized the relations of these (Srivastava, Larizza, 2011). Frequently noted within the literature, this administrative setup and the chiefdom councils subordination to local councils have causes strife, and the chiefs have not accepted this structure, which is something that the “ambiguity on the part of the national government” enables to persist (Srivastava, Larizza, 2011: 143). But why are the relations between these important? For one, the LGA specified that a FD framework that granted the chiefdom councils the function of collecting tax funds via local property taxes, a head tax, user fees, and from business licences and allocating a portion to the local (Nickson, Cutting, 2017; Srivastava, Larizza, 2011; Bob Searle, 2008). In 2010 this FD design enabled the councils to accumulate an own-revenue figure at around 3% of the GoSL total revenue that year, and the councils’ figure has, according to Rachel Beach and Vanessa van den Boogaard (2022), been stagnant for some years. This issue is one that can be traced back to the LGA’s provision of tax collection to chiefdom councils, which detailed a “requirement to forward a 40% precept to district councils” (Nickson, Cutting, 2017: 804) and likewise to the inefficient tax collection methods of these (Beach, Boogard, 2022). On the former, the fiscal decentralization of tax collection to these have caused the local councils to receive less than these were both projected and owed according to law. For according to Sidi Bara not only were the transfer between local and chiefdom councils “subject to extremely weak oversight” (2010:32), but the dysfunctional of that system allowed the chiefdom councils to provide only 10% of the estimated own-revenue returns to the local councils. One of the main reasons this fiscal decentralization design has caused this issue lay in that the local councils and chiefdom councils due to the LGA and the PD, contend against each other on the basis of a limited revenue

scope and more importantly, governing power at the local level (Barr et al, 2019; Nickson, Cutting, 2017; Sidi Bara, 2010). Not only did the fiscal decentralizations design flaws manifest there, but likewise emerged within the transfer of funds to local councils (Sidi Bara, 2010). For as the CG are theoretically meant to fund the health programmes quarterly via transfer to local councils, these have at times appeared not when they were supposed to (Conteh, 2016). And the noted cause for this allocative unpredictability lay in the GoSLs "practice of allocating resources to ministries, departments, and agencies, including local councils" which consequently means that "the DHMTs have had to rely on funds provided by other donors" because of the red tape (Conteh, 2016: 8).

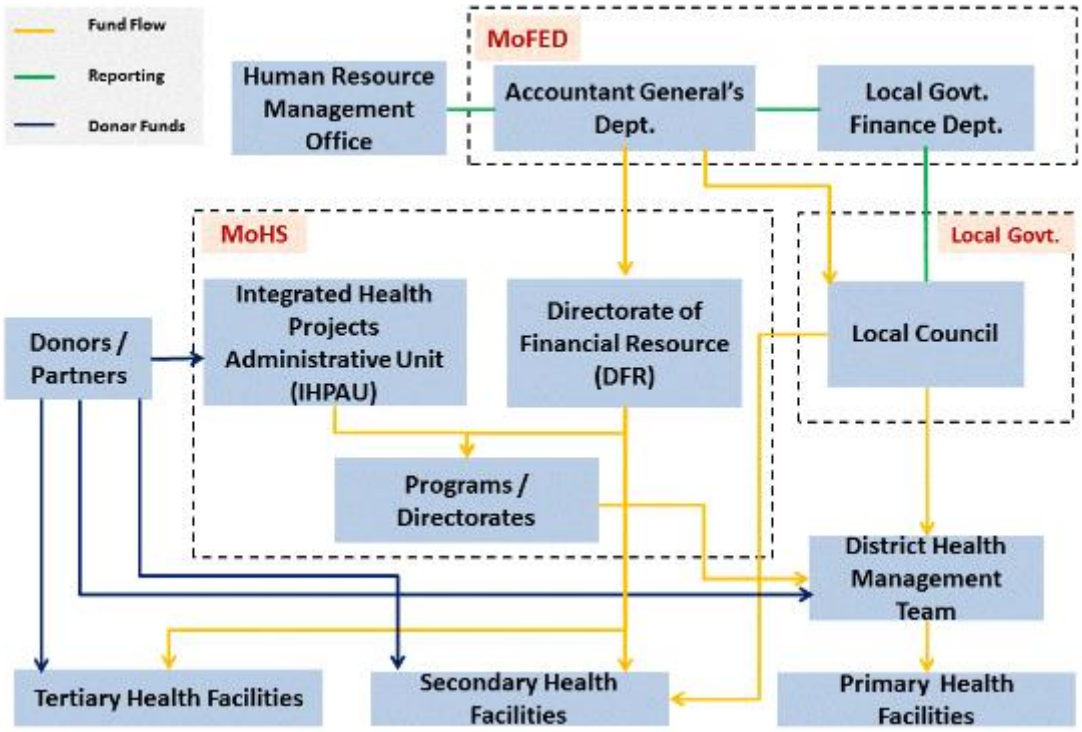


Fig. 9. Source: MoSL, 2017: 54.

And though in theory the local councils are in charge of PHC as noted in the LGA, in practice it is the DHMTs that largely design and implement programmes as the councils are not devolved health staff and lack fiscal and structural capacity for such (Conteh, 2016). In parts due to the erratic fiscal transfers towards local councils and DHMTs, there has occurred periods where the councils were not allocated any. Between July of 2012 to January of 2013, exactly such occurred. And because the DMHTs as such had to rely on NGOs to fund their PHC activities, tensions emerged between these and the local council due to the DHMTs not reporting the expenditure of such funds (Conteh, 2016). As a result, this furthermore incumbers the decentralized healthcare service as the NGOs emerge to be the accountability organ that the DHMTs respond to. On why

the NGOs perceive the councils as corrupt is noted within the transparency issues relating to subnational taxation and own-revenue accumulation.

We note likewise that the issues between DHMTs and the local councils are compounded by the fact that these have been unable to strike any workable deal in regard to how decentralized resources are distributed. In 2012, a District Medical Officer was described by the DHMT as refused a suggestion that the council could retain 30% of the allocated health budget for its own use. This refusal caused, as Conteh described, "a near breakdown of services as the local councils refuse to release funds for the implementation of programmes" for six months (Conteh, 2016: 8). Episodes like these are not uncommon for the councils' provision of healthcare. The overall design of the decentralized health financing suffers from these issues because of a lack of accountability and contestation between DHMTs, local councils and chiefdom councils. Even patronage by way of absent transparency in the programme intervention phase has enabled political and governmental elites to derive sponsorship by allocating contracts, projects, and funding. As such, it appears that health financing is driven by local political elites, and is these that decide where funds go and how these are utilized; not the medical needs of local populations (Conteh, 2016).

All of these and the "inefficient implementation of health sector decentralization, along with poor health financing practices stretching across […] MOHS" (MoHS, 2017: 16) are noted and have been identified within the HSSP II. In lieu of these, the HSSP II noted that the MoHS had begun drafting a new Health Financing Strategy to target a myriad of these as the GoSL attempts to achieve Universal Health Coverage (MoHS, 2017).

## 5.3 Case comparisons: deriving an explanation for (un)successful decentralization

Both countries appear to have followed similar reform sequences (Conteh, 2016; Gaima, 2009; Srivastava, Larizza, 2011). As noted in the analysis, both states initiated their decentralization programmes with a PD that allowed for electoral seats fill in the new (re)constructed subnational administrative unit. Not only that, but both of these states similarly had policy plans and/or laws provide for the foundation and clarification on decentralized health service functions. Not only that, but both cases had AD accompanies by a 'limited' fiscal decentralization to support self-revenue collection and to fund subnational activities ( Kiriga et al, 2011; MoH, 2003). As such, in many instances both of these cases appear familiar on their utilization of decentralization to reform and (re)construct subnational institutions. Yet, again, they differ vastly on the outcome of interest. The analysis of these had identified a similar application of the P – A – F sequence, something which Falleti's TSD suggested would provide a low-medium amount of autonomy to LGs. But only Sierra Leone failed despite this. Why? Where exactly do they differ? The most obvious answer to these questions are derived in the

designs of the reform types themselves and how the causal mechanisms therein emerged.

Rwanda's decentralization programme appears on paper designed around supplying LGs with much fiscal, political, and administrative autonomy, in practice however the provided autonomy is masked by a centralised imihigo management system (Chemouni, 2014). The central pattern which appears to underscore most of the policy choices within Rwanda's decentralized healthcare is that top-down, result-based approach. Not only does it guide programme operations, but likewise the construction of policy papers (GoR, 2005). We see this manifest as noted in the technocratic base public officials and political elites. Though no data exists that points to whether the healthcare system enjoys benefits from these, the entrenchment of the imihigo contracts on every level down to the household is nonetheless an astonishing idiosyncratic feature of Rwanda's decentralized system and it underscores the how entrenched the results-based approach has become (Hasselskog, 2016). Accompanying these we identify a strong political will from the GoR – a one party dominant authoritarian state, that provided "significant public works and services while exerting control over nearly every facet of society" (Hilary Matfess, 2015: 181; Chemouni, 2014; Scher, MacAulay, 2010). As such, though Rwanda provides administrative and political autonomy, the decentralization process is nominally however a centralized endeavour – a fact which is noticeably by how the imihigo contracts are constructed. And yet despite this, the healthcare system is decentralized and the results within maternal/infant mortality rates, and CBHI members speak for the decentralization programmes success.

In contrast, though Sierra Leone likewise followed a path dependent process, such was a detriment to its healthcare (Conteh, 2016; Gaima, 2009; Srivastava, Larizza, 2011). Identified through the analysis on the LGA and HBA I-II, an unstably policy context emerged that not only formed a culture decentralization resistance, but likewise the litany of policies that emerged afterwards and attempted to rectify the inconsistent institutional environment. The result from these attempts were severe institutional resistance and recentralization (Conteh, 2016; Gaima, 2009; Srivastava, Larizza, 2011). The central policy pattern which underline Sierra Leone's decentralization programme is the inherent power asymmetry developed and entrenched through the LGAs enabling of resistance to decentralization. And this has had consequences on the design and reform implications of decentralisation. While Rwanda's PD was designed and emerged to counter local capture, Sierra Leone's was notably designed to devise elections to fill the new administrative seats (Conteh, 2016; Gaima, 2009; Srivastava, Larizza, 2011). Though the PD of Sierra Leone is the most successful component of its decentralization process, it has not curbed corruption – despite the GoSL being presented with a design that followed the same PD pattern of Rwanda (Workman, 2011; Labonte, 2011). As such, we would contend that the absence of a critical legal and regulatory precision was the policy legacy for Sierra Leone. A choice that effectively orchestrated a trajectory for a path dependent healthcare system to

become an arena of political and administrative contestation between the LG, CGoSL, chiefdom council, and DHMTs. And likewise between MPs, local councils, and chiefdom councils. All of whom are critical components of the decentralization process. As such, the lack of any clear regulatory and legal framework thus enabled the not only local capture, but likewise enabled the "inefficient implementation of health sector decentralization" (MoHS, 2017: 16). As such, the policies which emerged between 2004-2015 was as such was unable from the start to address the underlying issues policy context because a number of these only disregarded the underlying policy context as seen in the analysis of the HBA II and the NDP of 2010. In 2014 following the recentralization of key devolved LGA functions on healthcare, the Ebola outbreak occurred and the exogenous shock from this enabled a critical juncture to emerge and a litany of policy documents in human resources within health, health financing, strategic health plans, and more emerged to deal with the underlying frailty of the health system. In contrast, Rwanda continued on with strengthening its healthcare system through policies that rooted in the same policy legacy.

In contrast to Rwanda, Sierra Leone's PHC system is controlled by the DHMTs, and a policy feedback mechanism never emerged to conjure a redistricting, devolution of separate administrative healthcare units, nor an HSP, or HSSP I-II-III. Instead, power reproduction within Sierra Leone's PHC system (Conteh, 2016). For we see not only a resistance to decentralization, but likewise the MoHS and the ministry of local governments bouts in 2014 and the repeated resistance of the MoHS in devolving staff and payroll to local councils. We note that because Rwanda's initial policy legacy had none of the contradictory policy, legal, or regulatory markings like Sierra Leone, it was enabled to enshrine decentralization and end phase 1 with the initiation of full devolution.

Though the PD of Sierra Leone is the most successful component of its decentralization process, it has not curbed corruption. In fact, corruption, and capture of service delivery, particularly of healthcare is large issue for Sierra Leone. We note as such that Siera Leone's design choice for its electoral PD system is interesting because the GoSL was presented in 2003 presented with a remarkably similar proposal Rwandan PD design. But the GoSL decided against adopting it. Focusing instead on adopting the noted LGA. As such, we would contend that the absence of a critical legal and regulatory precision for the PD of Sierra Leone was a deliberate design choice. A choice that has effectively arranged a path dependent healthcare system to emerge as an arena of political and administrative contestation.

# 6 Conclusion

In lieu of the within-case analysis and between-case discussion, we conclude that the hypotheses were successful in their composition. Hypothesis one correctly identified that in the cases of success, i.e., Rwanda, positive feedback mechanisms would emerge on the basis of initial reforms and entrench a decentralized healthcare process. For overwhelming evidence appears suggestive of Rwanda largely succeeded in parts due because the initial reform designs entrenched a technocratic and top-down policy pattern within the PD and AD. Because Rwanda's decentralization reform oriented itself around the states weakened PC conditions, we saw emerge the initial limited PD and funded AD that deconcentrated the healthcare system because of the limited capacity of LGs. The phased approach was to ensure that LGs could be decentralized and expected to develop and maintain the healthcare system. As such, between 2000-2006, Rwanda's decentralization process focused on ensuring grassroots elections and capacity development. It was only between 2005-2013 that the policy patterns fully emerged, and the policy feedback effect took hold. The various health policies, strategic plans, laws, and revised national decentralization plans exhibit and reinforce a specific top-down, result-based management policy pattern. As such, we contend that the initial design of decentralization reform do, in cases of success, determine, to some degree, whether decentralization can be effective in the provision of healthcare. Likewise in cases of failure, the power reproduction mechanism were identifiable in the deliberate disregard for the unstable policy context enabled by the LGA of 2004. The decentralization pattern that emerged within Sierra Leone's PD and AD was and remains the core reason for the unsuccessful decentralization of its healthcare. The thesis has traced the unstable policy context generated to the LGA and the contradictory laws and policy papers as the root cause for its failure. The lack of a cohesive political centre that endeavoured to reformulate and adopt new laws refining the unstable policy context created from the LGA appeared and appears absent due to increasing returns provided to the political elites. So why did Sierra Leone fail? That reason lay in that the initial decentralization design did not emerge accommodative of the state PC context and entrenched a preference for a CG favoured power asymmetry.

We note that the second hypothesis largely failed to largely failed to identify the sequence patterns and that the analysis and corresponding discussion emerged with a generalized answer that (un)successful decentralization is largely dependent on the design and not sequence patterns. Not only that, the Falleti's ideal-types appear non-applicable in the case of Rwanda and Sierra Leone. For not only did the reforms within these emerge swiftly after one another, and Falleti's theory did not appear to take such an occurrence into account.

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