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Decentralising urban health activities in developing countries

Trudy Harpham and Jane Pepperall

While there is considerable documented experience of decentralising health services in rural areas of developing countries, the decentralisation of health services in the urban context is rarely analysed. Urban development literature usually fails to address health issues, while the literature on the decentralisation of health services tends to ignore the urban sector. This article addresses the relationship between a Ministry of Health and a City Council, and identifies key issues to consider in the decentralisation of urban health activities: roles and responsibilities; legislation; co-ordination and communication; and resource constraints. The case-study from Maseru, Lesotho, highlights aspects of planning which need to be considered by national and local governments which are trying to strengthen urban health activities by decentralisation.

INTRODUCTION: DECENTRALISATION IN THE URBAN CONTEXT

Decentralisation can be defined as 'the transfer of authority, or dispersal of power, in public planning, management and decision making from the national level to subnational levels, or, more generally, from higher to lower levels of government' (Mills 1990).

Decentralisation has become one of the central tenets of primary health care in developing countries, bringing the potential for greater democracy, improved inter-sectoral collaboration, and enhanced local participation in the delivery of health services. However, the possible drawbacks of decentralisation include increased inequity between geographical areas, and lack of managerial skills at peripheral levels, leading to mediocre performance and the danger of strengthening the hand of local elites.

There is now considerable documented experience of decentralisation of health services in rural areas of developing countries which looks at the respective roles of the district and the region (for example Cassels 1992, Collins 1989, and Conyers 1981). In contrast, decentralisation of urban health services to municipalities and city councils is seldom documented. Work on the financial and organisational aspects of strengthening municipalities usually fails to address health-service delivery (for example, Blore 1989, Watts 1991). Literature on the decentralisation of health services tends to ignore the urban sector, and urban development literature tends to ignore health. In addition, relatively little attention has been paid to 'local government', even within the growing literature on public administration. This neglect reflects the persistence of extremely centralised public

administration in developing countries. For example, while in industrial countries 57 per cent of all government jobs were accounted for by 'local' rather than 'central' government, the figure was only 15 per cent for developing countries: 6 per cent in Africa, 21 per cent in Latin America and the Caribbean, and 37 per cent in Asia (World Bank 1983, quoted in Stren 1989). Some countries adopt the so-called 'pendulum model', in which periods of high centralisation and ineffective local government are followed by attempts to redress the balance through decentralisation, as in Nigeria in the 1970s (for example, Mawhood 1983).

However, the importance of the role of the municipality in urban health development is increasingly recognised. For example, the technical discussions of the 44th World Health Assembly in 1991 were devoted to 'Strategies for health for all in the face of rapid urbanisation'. A series of broad resolutions was made, including the imperative 'to decentralise and put the emphasis for action at the municipal level' (Rossi-Espagnet *et al.* 1991). The weakness of urban local government is also being highlighted. Hardoy and Satterthwaite (1992) suggest that the failure of 'governance' is one of the most important factors leading to health problems in cities of developing countries.

> Good governance is critical for cities, both to ensure that the potential environmental health advantages of concentration are fully exploited and that potential disadvantages are avoided. The extent to which good environmental quality is achieved in cities may be one of the most revealing indicators of the competence and capacity of city and municipal governments and of the extent to which their policies respond to the needs and priorities of their population. (Hardoy and Satterthwaite 1992:iii).

However, effective governance is almost impossible without a stable and reasonably prosperous economy. The influence of international, external, or 'exogenous' factors must also be recognised in any analysis of urban decentralisation. White (1989) examines some of these factors and suggests that they result in limited public cash flow, high urban unemployment, and stagnant rural productivity, to such an extent that reforms like administrative decentralisation and improved policy coordination 'have been stillborn' (p. 307).

This article analyses the relationship between a Ministry of Health and a City Council in one particular case and, through the example of their respective roles in environmental health activities, highlights some of the planning considerations for decentralisation for municipalities more generally.

THE STUDY[1]

The study was conducted in Maseru, the capital of Lesotho, which has an estimated population of 130,000. The city is rapidly growing, with an overall growth rate of 7.8 per cent in the period 1976-1986, rising to 16 per cent in the peri-urban areas.

Maseru City Council was inaugurated in April 1989 within the legal framework of the 1983 Urban Government Act, with funds from a World Bank Urban Reorientation Project. It was established as a para-statal structure and, as such, is autonomous but operates under the Ministry of Interior. The Health and Environment Department, one of four departments in the Council, is headed by a Chief Health Inspector. Since inauguration there has been tension between the Health and Environment Department and the

Environmental Health Division of the Ministry of Health over the implementation of environmental health activities in urban Maseru.

This study was intended to help to clarify the roles and responsibilities of the Ministry of Health and the City Council in the delivery of environmental health services in Maseru, and to analyse progress made in strengthening the City Council Health and Environment Department since a previous consultancy (Zawide 1990).

It addressed the relationship between the two organisations by using the activities of their respective environmental health officers as a case-study. It drew on existing documentation and interviewed key members of Maseru City Council and the Ministry of Health. Interviews, which were open and guided, covered the following topics: responsibilities and actual activities of environmental health officers; constraints faced by each organisation; and relationships with officers in the other organisation.

THE FINDINGS

The findings were presented in the form of a discussion document which was the basis of informal meetings between the two organisations and a round-table meeting between key officers. It provided a framework for discussion and agreed action within the identified problem areas. As such, the study highlighted four areas within which potential problems might arise in decentralising public health activities to a municipality.

Roles and responsibilities

This study was undertaken in Maseru precisely because of problems over agreed roles and responsibilities of environmental health officers working for the Ministry of Health and Maseru City Council. Some responsibilities were being duplicated by the Ministry of Health and the City Council, for example the certification of premises, while others were being neglected by both, for example environmental health coverage of some of the peri-urban areas. This diminished the effectiveness of environmental health service delivery in the city, as well as leading to tension and animosity. Duplication and omission are likely to be particular problems of decentralisation in a capital city, where national ministries and a municipality are usually both situated. In practice, defining roles is a highly political issue, particularly when funds are expected from international donors, who may in turn interfere with, or otherwise distort, new decentralised structures (Sollis 1992).

In the process of urban decentralisation, clarification of the new roles and responsibilities of the municipality and Ministry of Health is closely linked to the new legislation to support them. Changes are unlikely to be recognised until legislation is enacted, and legislation depends on basic agreement about respective responsibilities. It is, therefore, vital that an appropriate and acceptable division of responsibilities is formally agreed as early as possible between a municipality and a Ministry of Health.

Experience in Maseru highlighted that the following factors need careful consideration:

The phasing of decentralisation from a Ministry of Health to a municipality: In considering phasing it may, for example, be appropriate for services such as environmental health to be decentralised and suitably strengthened before curative health

services are also decentralised. In Maseru, the City Council was insistent about its right to take over all health clinics, despite being clearly under-resourced to do so. Indeed, the Council had previously built one health clinic in South Maseru which had never been opened and which at the time of this study was being converted into environmental health offices. In turn, the Ministry of Health was tenacious in its desire to retain control of health clinics, perhaps fearing that, until the City Council was stronger, handing over to them would lead to a deterioration in services.

Whether decentralisation will be done on a functional or geographical basis: If the latter, it is vital that all areas of the city, including peri-urban areas which may fall between a Ministry's responsibility for rural areas and a municipality's responsibility for urban areas, are clearly the responsibility of one or other of the organisations. This is a particular problem in developing countries, where decisions over the siting of the urban-rural boundary have to be made. In Maseru there was clearly neglect of some peri-urban areas by both organisations. Examples included areas where sewage from bucket latrines was not collected, and areas where the quality of water sources was not controlled. The most recent outbreak of typhoid in the city had been in one such neglected peri-urban area.

The role of the Ministry of Health in health service delivery in the city, following decentralisation: It is normal for a Ministry of Health to retain overall responsibility for the health of a country, including urban areas. However, the extent to which it is involved in implementation, supervision, and control varies among countries and needs to be clearly defined. This issue was still being deliberated in Maseru. Following this study, it was agreed that, while the Ministry of Health had national responsibility for the health of the whole country, the City Council had responsibility for implementing environmental health activities in urban Maseru. It was further agreed that the Ministry of Health had a role in collaborating with the City Council in relation to specific areas of environmental health concerned with epidemics of infectious disease.

How the agreed division of responsibilities will be disseminated to staff of the two organisations, the public, and the international donor community: In Maseru, members of the City Council feel that the issues of municipal and local government are poorly understood at present by most of these groups. Our discussions within the Ministry of Health suggested that officers there were not clear about the legitimacy of the City Council. In addition, despite their advocacy of decentralisation, donors' support for the health sector is almost exclusively channelled through the Ministry of Health, with whom donors are accustomed to dealing. There may indeed be a fear that, where there is conflict between the two organisations, support for a municipality may undermine more conventional bilateral relationships with the national government.

Agreement on standards: Where both organisations are implementing environmental health activities within the same city, it is important that they work to agreed standards, for example in the certification of food-retail outlets, or building construction standards. In an example of duplication and variable standards, the City Council cited instances where they had gone to certify food premises only to find that the Ministry of Health had already done so, though standards were not in fact acceptable. Certification entails payment of a fee, so personal benefits may arise from being the first on the scene.

To take the agreed division of responsibilities between the organisations down to operational level, the organisations' respective 'mission statements' need to be clear, and individual officers within them require formal job descriptions.

Legislation

In order to avoid ambiguity and consequent conflict, the agreed roles of a Ministry of Health and a municipality within a city should be reflected in legislation. If a municipality is being created, appropriate local government legislation should be put in place first; if an existing municipality's role is being expanded, necessary legislative amendments should be made. There should be sufficient flexibility to allow for responsibilities to be reallocated, as resources and capabilities of the municipality change. The relevant legislation should be disseminated to all organisations which it will affect. Ideally, legislation to define the balance of responsibilities between a Ministry of Health and a municipality should be formulated with the full co-operation of both.

In Maseru, the City Council derives its authority from the 1983 Urban Government Act which, among other things, allows for the Council to 'generally promote the public health, welfare and convenience and the development, sanitation and amenities of the municipality' (Government of Lesotho, 1983). This is brought about by authorising them to undertake a number of sections of orders and regulations that were previously the responsibility of the Ministry of Health, for example sections from the 1970 Public Health Order. However, at the time of this study, many senior officers in the Ministry of Health were unaware of the existence of the 1983 Act, and hence unaware of the basis of the City Council's claims to areas of responsibility.

In the 1970 Public Health Order's interpretation, a 'health officer means and includes any medical officer, any health inspector, and any public health nurse employed by or so designated by the Permanent Secretary for Health' (Government of Lesotho, 1970). This is to be expected, as the Order came into being before Maseru City Council was conceived. It does, however, lead to a situation whereby City Council environmental health officers are taking up roles and responsibilities authorised to them by the 1983 Act, while not statutorily existing as a cadre under the 1970 Order. Although they may continue to function in this ambiguous position, they are occasionally prohibited from carrying out functions which are rightly their responsibility under the 1983 Act, because they do not have statutory rights under the 1970 Order.

An example of this was that the City Council had recently ceased to carry out inspections of business premises because, although authorised to do so by the 1983 Act, they were removed from the Local Licensing Board by central government officials after it was pointed out that they did not have a statutory right to sit on the Board under the 1970 Order. This example was cited by the City Council as a major cause of recent tension between the two organisations, and emphasises the importance of legislation being clarified and rationalised to reflect the decentralised responsibilities. It seems that the 1983 Act had been expected to supersede previous legislation, but that, in practice, the 1970 Order has remained authoritative.

At the conclusion of this study, it was agreed that the two organisations would discuss together the 1970 Public Health Order and the 1983 Urban Government Act, with a view to clarifying the planning and management implications that these raise. It was further

agreed that when the Ministry of Health updates the 1970 Public Health Order, this will be in consultation with all relevant parties, including the City Council, and will take into account the 1983 Act.

Co-ordination and communication

Defining roles and responsibilities and formalising them in legislation establish an essential framework for the effective delivery of health services between organisations in a city. Sustaining effective delivery, however, also requires continued co-ordination and communication. This might be arranged formally and informally at both senior officer level and operational staff level. In Maseru, it was reported that a one-off and particularly successful co-ordination meeting between the City Council and Ministry of Health had contributed to a coordinated response to a typhoid outbreak in the city.

The round-table meeting itself led to a decision to establish a Ministry–Municipality Liaison Committee which would meet quarterly to take policy matters forward. It was also decided that an operational staff member of each organisation would attend the monthly meetings of the other, to improve co-ordination and communication between the two.

At senior levels it is important to establish *appropriate* channels of communication. In Maseru, the expected liaison between chief health inspectors of the two organisations was hampered by bureaucratic delays experienced by the officer in the Ministry of Health within his own organisation, itself a reflection of lack of delegation of authority within the Ministry. The Chief Health Inspector in the City Council had greater delegated authority to make decisions, and was able to be more responsive and flexible as a result. It had, therefore, become customary for him to consult with senior levels of the Ministry of Health, consequently undermining the status of his direct counterpart.

Constraints on resources

A major problem area was the resource constraints that the City Council faced in taking on the responsibilities decentralised to it. This is always likely where a shift of responsibilities is not matched by a shift in budgetary allocations or authority to raise revenue. The problem of financial dependence of local government on central government is not of course specific to the health sector — indeed, it may permeate all activities of municipalities. Ultimately, it is a shift in budget that leads to a true transfer of power, with the political consequences that that brings. In Maseru it is not clear that any shift of budget from the Ministry of Health to the City Council accompanied the legal transfer of responsibilities in 1989.

Maseru City Council Health and Environment Department has suffered staff shortages from the outset, compounded by transport and equipment constraints. This has put it in the position of wanting to take on full responsibility for environmental health but being unable to do so, and, at times, obliging the Ministry of Health to intervene.

The City Council's position at the time of this study was particularly constrained because funds from the World Bank Urban Reorientation Project were frozen, with particular implications for the City Council's human-resource development programme. Training inputs to both organisations help to strengthen the City Council's capabilities and simultaneously strengthen the Ministry of Health in its support role. As mentioned

earlier, however, the City Council tends to be overlooked by most donors concerned with the health sector, and it is the norm for the Ministry of Health to screen most nominations for donor-funded international training. Until appropriate divisions of responsibilities are allocated, backed by legislation, and recognised by donor agencies, the resource deficit in the City Council is unlikely to change.

CONCLUSION

The experience of decentralising environmental health activities in one particular city suggests that, for successful decentralisation of activities from a Ministry of Health to a municipality, it is important to establish that:

- agreed roles and responsibilities of the two organisations are reflected in legislation, and disseminated throughout both organisations, to the general public and to international donor agencies;
- roles and responsibilities of individual officers in both organisations are clearly delineated and properly reflected in their job descriptions;
- responsibility is allocated for peri-urban areas which stand the risk of being neglected by both organisations;
- appropriate channels of communication are established between the two organisations;
- formal and regular co-ordination meetings are held between relevant departments of both organisations.

From this particular study, it is clear that decentralisation from a Ministry of Health to a City Council depends on the political commitment to accept and formalise a municipal approach to health service delivery; and that this commitment is particularly important on the part of senior officers within the Ministry of Health.

NOTES

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