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The promise and reality of decentralization: a critical appraisal of Sierra Leone's primary health care system

Abstract

Post-war reconstruction in Sierra Leone was accompanied by an ambitious donor-promoted decentralization programme aimed at making delivery of the country's failing social services more efficient. A decade after the 'decentralization' of health services, this article examines systemic failures that have resulted in de-concentration rather than devolution of the health system. It identifies four factors that have contributed to a dysfunctional decentralized provision of primary health care. First, is an inconsistent political and legal framework that blurs and distorts delineations of authority between central and subnational government institutions. This leads to three further challenges that interact to create an ineffective public health sector: the central government is resistant to devolution, partly due to a culture of accumulation; local-level interventions are uncoordinated; and there is limited accountability for frontline health workers. As a result, citizens' health needs are unmet. Sierra Leone is plagued by some of the worst maternal and child mortality rates in the world, and faced the most intractable outbreak of the 2014-2015 Ebola epidemic. Drawing on participant observation and interview data, this article suggests that building a resilient decentralised primary healthcare system will largely depend on the willingness of the centre to meaningfully devolve power and resources to subnational governments, and establish a mutual accountability mechanism in which 'actors' at all levels are held accountable.

Key words: Sierra Leone, decentralization, primary health care, local councils, district health management teams, NGOs.

Introduction

In 2004, the Government of Sierra Leone (GoSL), with support from development partners, embarked on an ambitious programme of decentralization as a response to governance failures that were blamed in part for the country's 11-year civil war. Part of the official rationale for the 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 (PHC). A 2004 public expenditure tracking survey, for example, discovered that although the country's central medical stores reported supplying essential drugs worth 40.9 million Leones to secondary and tertiary hospitals, medical officers only acknowledged receipt of drugs estimated at 28 million Leones (Government of Sierra Leone 2006). The country's post-war decentralization policy notes that, 'the goal of Sierra Leone's decentralization is to ensure that the local people and their communities are empowered and fully involved in political and socio-economic development processes' (Government of Sierra Leone, 2010a:4). However, after a decade of decentralization, the country continues to register some of the highest maternal and child mortality rates in the world. The free health care initiative launched in 2010 to address the challenges relating to the healthcare needs of vulnerable citizens, such as under-fives, pregnant women and lactating mothers, has not made a significant impact in reducing maternal and child mortality rates, partly due to the lack of a coherent law or policy guiding its implementation. Moreover, the recent Ebola epidemic has exposed the systemic failings of the delivery of healthcare, prompting a debate as to why the virus completely crippled the health system.

The central question this research addresses is why, after extensive post-war developmental interventions, Sierra Leone's decentralization efforts have failed to transform a dysfunctional primary healthcare system. It analyses a political economy in which the interaction between law and policy, central and subnational authority, and frontline health staff and service users remains contested and blurred. The research highlights the extent to which the resulting failings in primary healthcare manifest themselves within the context of a decentralized health system, and the implications for reforms in the sector. The article argues that, whereas the devolution of powers to subnational institutions for the provision of services was initially seen as a panacea for the country's failing health services by the government and donors, the failure to address long standing systemic weaknesses in the pre-existing structure, on top of which post-war decentralization reforms were built, made the resulting dysfunction inevitable.

The Ministry of Health and Sanitation (MoHS) has performed relatively well in 'devolving' its functions to the local councils compared to other ministries (Whiteside 2007), yet even this semi-'successful' process continues to be plagued by a number of challenges that undermine the delivery of health services. Both national and subnational politicians have paid a great deal of attention to the rebuilding and expansion of the sector's battered physical infrastructure: tangible improvements that arguably garner them political capital. However, the less visible system itself remains largely inefficient due to a number of factors that have undermined the stated goal of decentralization. To identify and understand these sub-institutional political processes, the research draws on interviews with a range of informants, including central government officials, local council staff, service users, NGOs staff and donors. Fieldwork was carried out in Sierra Leone between August 2011 and July 2015, with a review of secondary data used to illuminate the Ebola-related context.

The article has five sections. Following the introduction is a survey of literature on decentralization in Africa, and the challenges of implementation in Sierra Leone. The second section gives an overview of the country's health delivery system, examining and analyzing the different layers of the delivery architecture, the legal and policy framework underpinning the delivery of health services, as well as the systemic and political economic factors driving the health ministry's resistance to devolution. The third section examines the fragile process of coordinating the activities of local actors delivering health services, looking at their conflicting spending preferences, erratic intergovernmental transfers, and the uncoordinated operations of health NGOs. The fourth section discusses the primary healthcare infrastructure, including staffing and the management of health facilities; and the fifth concludes.

The context

Decentralization is arguably one of the most popular governance policies of the post-cold war era. Even where there has not been a full-scale or national programme of decentralization, many countries have decentralized some aspects of governance or service provision. Its appeal rests on the normative benefits attributed to the policy. Decentralization is designed to better guarantee fairness through the equitable allocation of resources to marginalised groups and communities (Bossert et al 2000:1). It is also expected to improve the transparency, quality, legitimacy, and accountability of service provision due to the participation and oversight of end users in the planning and delivery of services (Rondinelli and Cheema 1983; Manor 1999; Crook 2003; Crawford and Hartmann 2008). Accordingly, it is seen as potentially able to improve allocation of 'services and expenditures' by tying them more directly to the preferences of local users, and

to improve efficiency in service provision through greater cost awareness at the community level (Rondinelli 1981; Rondinelli and Cheema 1983; World Bank 1988; Manor 1999; Brinkerhoff and Azfar 2010).

Poor and marginalized communities often perceive large governance institutions as unaccountable, remote, and corrupt (Gaventa 2004). Decentralization offers an adapted approach designed to increase participation in political and development processes within local communities, whereby citizens can make demands on government and hold them accountable (Crawford and Hartmann 2008; Crook 2003; Manor 1999; Rondinelli and Cheema 1983). Also, because people participate in political and development processes, they are able to make inputs into development plans, while at the same time increasing their self-efficacy and confidence (Wagle 2006; Ribot, 2006; Osmani 2008). Further, as states decentralize, the space for local constituents to express their voice and concerns with local politicians widens (Hiskey 2010; Brinkerhoff and Azfar 2010). Commenting on the potential of decentralization, Blair suggests that, 'the hope is that as government comes closer to the people, more people will participate in politics'; a fact 'that will give them representation, a voice in public policy decisions which will affect their futures' (2000:23).

In the health sector in Africa, decentralization has been driven by the Bamako Initiative, launched at the 1987 World Health Organization Regional Meeting of the African Ministers of Health (Paganini 2004; Bossert et al 2000; Obioha and Molale 2011). The main thrust of the Bamako Initiative was for governments to continue to pay health workers' salaries, incur some of the recurrent cost of delivering health services, and enable service users to take a 'leading role' in the management of health facilities (Paganini 2004:12). Given the fact that primary health care is 'the first level of contact for individuals, the family and the community within the national health system' (Obioha and Molale 2011:73), its decentralization through the use of District Health Management Teams (DHMTs) was seen as a major step in making quality healthcare accessible and affordable. Paganini described the role of communities as 'not expected to contribute more resources out of their pocket, but on the contrary to receive better quality services, curative as well as preventive, from a fraction of what they were already spending in the informal system' (2004:12). This cost reduction would be achieved through improved infrastructure, staff training, and supply of drugs and consumables, all under the oversight of community representatives (Paganini 2004).

Despite the lofty aims of the Bamako declaration and initiatives to improve health services for the poor, there has been a mismatch between such aims and the reality (Bossert et al 2000). As Gaventa observes, there is evidence that 'democratic decentralization simply opens up space for the empowerment of local elites, not for consideration of the voices and interests of the more marginalized' (2004: 32). In some instances, there are infrequent elections and they are often contested on the platform of ethnicity and personalities rather than on any coherent programme of positive change. In Uganda, where decentralization was introduced primarily to increase civic participation in politics and development, empirical studies show that the process has not led to any significant increase in citizens' participation, especially in health care provision. In a study of the impact of decentralization on health delivery in Uganda, the findings revealed that the state of primary health care in 1996 was the same as in 1986, as pervasive administrative and operational problems remained unchanged (Golooba-Mutebi 2005).

Many attempts to decentralize the provision of services have produced considerable disparities between citizens' health needs and the services provided by subnational governments. A study of decentralization in Ghana found a lack of congruence between District Assembly-funded outputs and popular preferences for health services (Crook, 2003:80). In Nigeria, Crook and Sverrisson have argued that after years of decentralization, there was a lack of meaningful community decision-making, 'whether direct or indirect, in primary health care, even though responsibility was devolved to elected officials at the local level' (2001: 35). The programme had adverse effects, including, 'declining confidence in local health committees, as there were doubts that their deliberations and recommendations were being taken seriously':

Overall, local residents saw [primary healthcare] as unreliable, ineffective and unresponsive to their needs. In addition, councillors were unaware of the health needs of constituents, had little contact with communities, and had little knowledge of health plans and activities (Crook and Sverrisson 2001: 35).

Commenting on the failure of decentralization to improve primary health care provision in Nigeria, Wunsch and Olowu (1996-7) have also noted that community consciousness of the primary health care system and administration was negligible, intermittently absent, to the point that by 1993 there was little or no indication of an active debate around the issue. Similar findings have been reported for other countries in Africa with the result of undermining the normative case for decentralization (Crook and Manor, 1998; Smoke, 1993).

Sierra Leone's ongoing decentralization programme has produced mixed results in a number of sectors, with central government ministries continuing to resist the devolution of functions to councils. The country's programme has been lauded by some as a successful example of post-conflict decentralization reforms, with local council elections that have opened up space for increased local political participation (Zhou 2009; Zhou and Zhang 2009; World Bank 2014). However, others have questioned such optimism. In the education sector, Whiteside (2007:15) has argued that the Ministry has had to 'grapple with issues of loss of control and power' and 'greater challenges in mobilizing the necessary political will at all levels to push decentralization forward'. Meanwhile, the procurement figures for teaching and learning materials quoted in the individual budgets of local councils (Searle, 2008) may not match what is eventually delivered to them by the ministry of education, or be of the same monetary value, given that councils are not involved in procurement (Kargbo 2009).

A similar situation exists in agriculture, one of the government's priority sectors, which has retained the bulk of the budget centrally for the procurement of equipment and seed rice. It has been estimated that between 60 to 70 per cent of the Ministry of Agriculture's non-recurrent budget is still held in the capital, with the 19 local councils sharing the remainder (Conteh 2014a). The practice of central government ministries carrying out procurement and other functions and responsibilities that should have been transferred to the councils under decentralization undermines their capacities and leaves room for misappropriation and under-procurement. The next section analyses how these efforts and challenges play out in Sierra Leone's health care delivery system.

Sierra Leone's health care delivery system

The structure of Sierra Leone's health delivery system is multifaceted, with players ranging from the biggest provider – the government – to smaller actors, including local and international NGOs, faith based organizations, and private health service providers (Government of Sierra Leone 2009a; Audit Service Sierra Leone 2012). In terms of coverage, MoHS through its hospitals and peripheral health units delivers an estimated 50 per cent of health care services, with the remainder being provided by the private or non-profit sector (Renner et al 2005; World Health Organization, 2005). As in other countries in West Africa, the private sector, like the public sector, is underdeveloped, uncoordinated, and focuses mostly on curative rather than preventive medicine. It is made up of a chain of pharmacies and clinics located mainly in urban centres and accessed primarily by the economically secure, who can afford to pay high medical fees (Institutional Reform and Capacity Building Project 2008; Government of Sierra Leone 2009a).

Given the high levels of poverty in the country, and in rural areas in particular, the majority of the health facilities are in the public sector. Based on the primary health care programme developed in the 1980s, these facilities and the system that depends upon them originated in the structural adjustment programme era, when Bretton Woods institutions forced governments to cut spending on health care, and encouraged community financing of health services in its place (Paganini 2004). The public health delivery system has three interrelated and complementary components. Peripheral Health Units (PHUs) are the first and most basic level of care, found primarily in rural communities where the majority of Sierra Leoneans live. PHUs consist of three sub-components, of which the Community Health Centre (CHC) is the biggest, followed by the Community Health Post (CHP), and Maternal and Child Health Post (MCHP). Together, they constitute the frontline of the healthcare system (Government of Sierra Leone 2009a; Audit Service Sierra Leone 2012). The second component comprises district hospitals for secondary care, scattered across the country's district headquarter towns and cities. The third level of care consists of the regional or national hospitals utilised for tertiary care, found only in the regional headquarters (Kirigia et al 2012; Government of Sierra Leone 2009a, 2010b; 2011). The total number of PHUs in Sierra Leone remains in flux, as new ones spring up regularly, and sometimes without central coordination. However, at the time of writing, the country had 'about 1,390 PHUs registered with the Ministry of Health' (Interview with Monitoring and Evaluation Officer, Directorate of Primary Health Care, 7 August 2013, Freetown).

The lack of effective central coordination in construction of new physical infrastructure for health service delivery is indicative of the functionality of the current legal and policy framework for decentralization. The current challenges besetting service delivery are rooted in the weak, conflicting and inconsistent regulatory mechanisms. The country's current health delivery system is predicated on a number of legal and policy documents – including the Local Government Act (LGA) 2004, Hospital Boards Act (HBA) of 2003, Hospital Board Amendment Act of 2007, National Health Policy of 2002, and the National Health Sector Strategic plan 2010. Despite the fact that some of them were simultaneously drafted, they often contradict each other and other legislations. The lack of clarity in law and policy suggests that the implementation of the decentralization programme has been based on an unfounded assumption of a culture of collaboration between government ministries and agencies, which have not always worked

together. As a result, not much attention has been given to the process of repealing or amending obsolete and sometimes conflicting laws that established Ministries, Departments, and Agencies (MDA) working in health and other sectors with competing functions and powers (Gaima 2009).

Inconsistent and obsolete laws regulating the health sector have become ‘excuses of convenience’ that underpin the ministries’, departments’, and agencies’ justifications for failing to devolve powers and resources to the local councils. MDA representatives constantly argue – rightly or wrongly – that the laws do not allow them to do so. Even though the Local Government Act post-dates the Hospital Boards Act, the two are in conflict with each other on a number of key issues (Interview with Legal and Policy Officer, Decentralization Secretariat, Freetown, 2 November 2011, Freetown). For example, whereas the LGA devolves the management of secondary hospitals to the local councils, the HBA gives a controlling function to the Minister of Health, who appoints board members, including the chairman, with only a tokenistic provision made for inclusion of ‘a representative of the appropriate District Council’.¹

Amendments were made to the HBA in 2007, but the changes only affected financing of the boards, further solidifying their position and, in turn, weakening the capacity of district councils to effectively supervise hospital operations. Their composition reflects Sierra Leone’s patrimonial politics (Conteh and Harris 2014). Despite attempts by the MoHS to solidify their legal basis, the boards have become avenues for the exercise and distribution of patronage, as loyal ruling party supporters are rewarded with membership (Conteh 2014a). By early 2012, the board members’ terms had expired; yet, no move was made to renew or replace them, causing some of the councils and medical staff to challenge their legitimacy when they attempted to supervise health centres (Interview with Director of Hospital Services, Ministry of Health and Sanitation, 9 February 2012, Freetown). One of the reasons for the ineffective exercise of supervisory and administrative control of councils over ‘devolved’ health staff stems from the fact that the recruitment and payment of staff salaries remain centrally controlled. Local councils do not have the power to hire and fire them, apart from their own core staff. In fact for many officials, ‘resisting payroll devolution ensures that line ministries can treat local councils as little more than disbursement agencies’ (Fanthorpe et al. 2011: 23).

In the health sector, it is the hospital boards and DHMTs – not local councils – that retain power over recruiting and disciplining health staff. Thus, health workers tend to show greater accountability to the DHMTs, which are responsible for their recruitment and promotion, rather than to local politicians and administrators. The 2010 decentralization policy envisaged that in addition to councils’ core staff, they will be able to hire and fire devolved sector employees by 2016 (Government of Sierra Leone, 2010a; Srivastava and Larizza, 2011), and their payroll will be transferred to them as well. However, given the recent lacklustre political will, the absence of a decentralization champion in government (Fanthorpe et al. 2011; World Bank, 2011), and politicians’ shifting focus towards the general elections in 2017, it is unlikely that the target date will be met. In addition, the unimpressive response of local councils to the Ebola epidemic is likely to undermine their case for increased powers and responsibility.

Underpinning the inconsistent policy and legal framework, is the culture of resistance of the administrative and political officials in the MoHS that reinforces a political economy in which the distribution of power and resources is skewed against local councils. On paper, the MoHS is

the only ministry to have ‘systematically’ followed the ‘devolution’ schedule of the LGA and statutory instrument of November 2004 (Whiteside 2007; Institutional Reform and Capacity Building Project, 2007; 2008a; 2008b; 2009). However, in practice, the ministry has resisted meaningful devolution by retaining functions that carry with them financial power and significant resource allocations (Republic of Sierra Leone 2007; Kargbo 2009). Whereas the MoHS agreed to devolve the procurement of equipment and medicines to local councils (Government of Sierra Leone 2004), it has retained 40 per cent of the total amount for the provision of primary health care services at the centre (Republic of Sierra Leone 2007). Officially, the Ministry’s reason for retaining the most significant budget lines is to reduce wastage, which has been inherent in the procurement and delivery of medical supplies to health facilities across the country (Government of Sierra Leone 2006). Nevertheless, the political economy of procurement contracts in Sierra Leone (Workman 2011) has also served as an incentive for doing so. In one case, some of the most senior officials of the ministry, including a minister, were involved in illegitimate activities that influenced outcomes of tendering processes (Standard Times, 4 November 2009).

MoHS officials have been involved in one corruption scandal after another in the post-war era, although they are not always found guilty (Kargbo 2014). A real-time audit of the management of funds intended for the response against the Ebola epidemic in 2014, documented systematic violations of procurement procedures and laws by some Ministry of Health officials, who were unable to properly account for billions of Leones, purportedly paid out to district health management teams to tackle the disease in their districts (Audit Service Sierra Leone 2015). It is this institutional culture that has shaped the behaviour of many officials in the MoHS. Oyono has argued that because decentralization is often a process that involves transferring political power and resources, it invariably causes jealousy, apprehension, and overt opposition (Oyono 2004). Therefore the resistance of MoHS officials to devolution is perhaps unsurprising, even if it has proved inimical to service delivery. As Blair (1998:20) puts it:

In most developing countries, most politicians and civil servants operating in the national political arena perceive that power will be devolved to the local level at their expense. This is especially true in the unitary states characteristic of most of the developing world.

Fanthorpe et al. describe devolved sector staff as ‘generally enthusiastic about decentralization...on the grounds that it channels unprecedented volumes of resources to their sectors and gives them greater autonomy in administrative decision-making’ (2011:23). However, local politicians have cited the retention of budget lines relating to procurement as an issue that undermines their capacity to determine the type, quantity and quality of drugs and medical supplies that are needed in a particular district’s health facilities (Institutional Reform and Capacity Building Project 2007). The practice of public officials resisting reforms and expanding their sphere of influence in terms of their expropriation capacity, albeit illegally, is not new in Sierra Leone (Reno 1995). Like many African countries where the dualistic existence of the ‘moral’ and ‘civic’ publics survived colonialism (Ekeh 1975), many public officials have tended to view the state as an exploitable resource for furthering their personal interests, and not an entity to protect.

As Oyono (2004) argues, the instinct to preserve the ‘consumable’ profits of the central elite is the basis for resistance, which in Sierra Leone, sometimes takes place between officials of

central government ministries, as they clash over the control of powers and resources that should have been devolved (Conteh 2014a). The Minister of Local Government continues to push for devolution without success, and in some cases comes into conflict with her colleagues. For example, in early 2014, the ministers of Health and Local Government were embroiled in a contest over the control of secondary and tertiary hospitals, which had been ‘devolved’ to the local councils since 2005. In a move that illustrated the resistance of MoHS officials to devolution, and the extent to which they can go to recentralize devolved functions, the Minister of Health directed the Director of Hospital Services to take over the running of the hospitals. The official rationale for doing so was ‘because the local councils are not responsible’ enough to manage them (Interview, Legal and Policy Officer, Decentralization Secretariat, 1 April 2014, Freetown). The move by the Minister of Health is unsurprising given that, of the 80 functions to be devolved by central government ministries, slightly more than half have been devolved since 2004, with some recentralizing what had already been devolved (Conteh 2014a). Despite protestations from the Minister of Local Government and Rural Development, the decision was not rescinded, deepening tensions between officials of the two ministries (Interview, Legal and Policy Officer, Decentralization Secretariat, 1 April 2014, Freetown).

Coordinating and implementing primary health care: Government and non-governmental actors

The resistance to decentralization and the recentralization of functions, is further compounded by the erratic transfer of funds to local councils. This has not only affected the timely delivery of services by the local councils and DHMTs, it has also undermined their capacity to regulate other local actors, including NGOs operating in the health sector. In theory, the local councils are in charge of PHC services. However, in practice the DMHTs design and implement health programmes, given the lack of capacity within the councils and the central government’s unwillingness to devolve health staff to them. Given the multiplicity of actors operating in the health sector and their disparate interests, coordinating their work has proved extremely difficult, if not impossible for the councils and DMHTs to do.

The funds transferred from the central government for the implementation of health programmes have been erratic and unpredictable, coming long after they are really needed. By January 2013, for example, the allocations of funds for the third and fourth quarters of 2012 to local councils were still outstanding (Interview with Finance Officer, DHMT Bombali, 18 September, 2013, Makeni). This late and unpredictable pattern of receiving funds is caused in part by the Government’s practice of allocating resources to ministries, departments and agencies, including local councils, as revenue is collected by the National Revenue Authority. This means that the DHMTs have had to rely on funds provided by other donors, which are in many ways more predictable than those from government coffers. This exacerbates tensions with the councils, as the DHMTs do not report to them on the receipt and expenditure of such funds (Interview with Local Government Finance Officer, Bombali District Council, 3 April 2012, Makeni). For instance, according to their internal accounting mechanisms, only 77.5 percent of the total funding received by the Bombali DHMT in 2011 was accounted for through the district council. Ideally, local councils formulate policies relating to health care on the ground, while the DHMTs implement them. Many donor agencies and international NGOs prefer transferring funds directly to DHMTs, because of the councils’ chequered history with corruption and because it means they can avoid an extra layer of red tape in programme implementation.

The result, however, is that some aspects of health programme implementation becomes accountable not to the district council, but to the donors and NGOs (Interview with District Medical Officer, Bombali, 17 October 2011, Makeni). This is partly due to the fact that transparency remains a problem, and opportunities to misappropriate decentralized resources are more prevalent in the programme implementation stages than at the policy formulation levels (Interview with Area Base Manager, Western NGO, 11 December 2012, Port Loko). In many instances, it is the interests and incentives of the local elite – local political and administrative officials and DHMT staff – that determine where and how funds are spent, rather than the objectively assessed medical needs of the poor. Allocation of funding and projects functions as a form of political patronage, either through the provision of services, contracts, or in the worst cases, graft and misused funds. The sides that emerge victorious in discussions over expenditure are those who are not only savvy negotiators, but who are also politically connected and powerful (Interview with Area Base Manager, Western NGO, 11 December 2012, Port Loko). Generally, in the development of health plans and budgets, local councils favour capital intensive projects, while DHMTs prefer increased spending on administration and capacity building programmes.

Local councils often award procurement contracts for capital projects, which sometimes come with ‘kickbacks’ (Workman, 2011), adding to the incentive for having such programmes dominate health budgets. In addition, local politicians can derive immense credit from capital projects during elections, since many of them are tangible for voters to see. For instance, although the establishment of PHUs is supposed to be based on the health needs of the population, in a context of resource scarcity, the decision to construct PHUs – or not – has often been influenced by political considerations and the interests of politicians. Politicians use such projects to demonstrate their commitment to ‘take development to their people’, in what can be an effective vote-buying strategy, sometimes even if it means depriving other communities, where such facilities are potentially in even shorter supply (Interview with Deputy Chief Administrator, Bombali District Council, 5 September 2011, Makeni). The drive to build new facilities also appears to outpace the need for renovations and repairs.

Although it is difficult to measure and document the scale of graft and mismanagement of funds given the variations in their occurrence and officials’ tolerance for them across local councils, where it occurs, less is spent on the actual delivery of services, such as drugs and equipment, particularly in the face of shortages requiring quick mobilization of resources. For example, in one case in the Kambia District, the local council awarded a contract for the renovation of two PHUs, and paid the contractor 100 per cent of the project’s cost, deviating from the usual practice of paying them in tranches depending on work completed (Interview with Western donor Operations Officer, 15 February 2013, Freetown). Donors eventually visited the project sites after persistent media coverage over delays and uncompleted works, finding that the contractor had paid a substantial kickback to the local council officials that made it difficult for him to finance the project’s completion (Interview with Station Manager, Radio MAWOPNET, 5 August 2013, Kambia).

Whereas local councils prefer having capital projects dominate health budgets, given the personal and political advantages derived from them by their officials, the DHMTs, on the other hand, prefer inserting into health budgets programmes relating to administration costs and

capacity building, areas which also involve procurements contracts, but with leverage for the teams to solely undertake, without going through the rent-seeking procurement procedures of the councils – an arrangement which nonetheless, can accrue DHMTs significant kickbacks (Interview with Senior Economist, Local Government Finance Department, 18 April 2012, Freetown). The consistent and persistent manner in which DHMTs increased the costs of administration and capacity building programmes across the country forced the Local Government Finance Department to place a ceiling on the extent to which the teams can allocate funds to such programmes (Interview with the Director of Local Government Finance Department, 18 April 2012, Freetown). Although one can argue that spending on capital expenditure can benefit the poor, this is only indirectly, since health services can be delivered even in makeshift structures, as is often the case in some rural communities; and for capacity building programmes, the frequent and haphazard manner in which they are conducted, sometimes leaving PHUs without nurses for weeks, undermines the very basis for which they are conducted.

Where the local councils and DHMTs have not been able to strike a workable compromise regarding the “redistribution” of decentralized resources, there has been a near breakdown of services as the local councils refuse to release funds for the implementation of programmes. This was the case in Port Loko in 2012, where the District Medical Officer was reported to have refused to agree to a deal in which the DHMT would allow the council to retain 30 per cent of the district’s health budget as its “share” of the funds transferred from Freetown (Interview with Area Base Manager, Western NGO, 11 December 2012, Port Loko). The stalemate continued for six months, during which most health programmes in the district were not implemented, save for those supported by NGOs (Interview with District Births and Deaths Registrar, 11 December 2012, Port Loko). Cooperation between the local council and DHMT was only re-established when the DMO was controversially transferred to another district, a posting that was believed to have been engineered by the chairman of the local council (Interview with Area Base Manager, Western NGO, 11 December 2012, Port Loko). Whilst the Port Loko case represents an extreme example of services grinding to a halt due to the irreconcilable interests of the local council and DHMT, it is not uncommon for the provision of services across the country to suffer due to a combination of factors, including personality clashes between district council officials and DMOs, and challenges relating to transparency and accountability, underpinned by a ubiquitous sense of moral hazard, given that officials can always shift the risks and consequences of their (in) actions to others.

In addition to the strained relationship between local councils and DHMTs, their individual attempts to regulate and coordinate the operations of NGOs, have been largely unsuccessful. Decades of systemic neglect and the civil war of the 1990s left the country’s service delivery infrastructure severely weakened; and the state’s abdication of responsibility for the provision of certain services in the interior of the country was accompanied by the growth and expansion of the NGO industry, which filled the resulting gap (Conteh 2014b; Nishimuko 2009; Zack-Williams 1999). By the end of the War, NGOs became entrenched and wielded immense influence in the provision of services for communities. Therefore, the provision of health services by the local councils in the post-war period requires the coordination of activities among local actors, including local councils, DHMTs, NGOs and PHU staff, whose interests and incentives are varied and often conflicting.

The number of health related NGOs operating in Sierra Leone is uncertain, but in mid 2015 the NGO desk of the MoHS had on its register 89 (59 international and 30 local), all of them implementing programmes across the country, whose interventions often duplicate and overlap with each other (Interview with NGO Desk Officer, Ministry of Health and Sanitation, 31 July 2015, Freetown). The fact that NGOs often bypass the local councils and deal directly with DHMTs in the implementation of health programmes does not mean that the relationship between NGOs and DHMTs has not been characterized by tensions and suspicions. Few regulatory safeguards exist in Sierra Leone's NGO sector to prevent misappropriation of funds and other resources, and it is not uncommon for actors to become suspicious of one another, especially if their activities appear uncoordinated and obscure.

Given the goodwill enjoyed by most international NGOs, their increased access to resources relative to their overall mandate, and their minimal oversight, they have by and large operated outside the control or regulatory framework of District Councils. Although they have contributed to the rebuilding of the country's primary healthcare infrastructure, some aspects of their work have been uncoordinated, thus creating governance and systems problems, while attempting to solve individual and household-level health problems. For instance in Bonthe District, one Western NGO is reported to have constructed PHUs without the knowledge and authorization of the local council and the DHMT, the relevant institutions that would have advised on the communities where such facilities are needed, as well as the specifications of the buildings. As the DMO noted:

A major problem we have here is the uncoordinated operations of the NGOs. They will construct PHUs, without informing us, and at the end of the day, they expect us to provide staff and equipment for them (Interview with District Medical Officer, Bonthe, 3 August 2013, Mattru Jong).

The uncoordinated construction of health facilities by NGOs, and the contestation of the DHMT is not only a symbol of centralized planning pre-empting local knowledge and decision-making power, it also illustrates the failure of regulation, and NGOs' disregard for even the minimum established protocols, given the weak regulatory framework under which they operate. Generally, getting NGOs to effectively coordinate their activities with the local authorities has not been easy. Attempts by local council officials, many of whom have worked for NGOs, to get NGOs to be more transparent in their operations have largely proved ineffective. In Bo District, the council established an NGO forum for sharing their activities with council staff, and preventing duplications and overlapping of health and other programmes (Awareness Times, 12 March, 2013). Yet, the initiative was undermined by the poor level of their reporting and the non-attendance of the 'big' ones.² When asked why the NGOs were not taking the forum seriously, the council's Monitoring and Evaluation Officer replied that, 'they just don't want to be accountable, because they think we will know how they are expending their budgets', implying that international NGOs are misappropriating funds meant for development in the district (Interview with Monitoring and Evaluation officer, Bo District Council, 13 August 2013, Bo).

The challenge of local and international NGOs not accounting to either local councils or central government for funds they receive for the implementation of projects in rural Sierra Leone has been a topical issue. In early 2014, parliament set up a special select committee to investigate

them. Some NGOs did not present the documents the committee wanted to examine, which led the chairman to warn that they will be charged with contempt (Awareness Times, 7 March, 2014; Concord Times, 10 March, 2014). In some ways, the action of parliament is unusual, even if it has the mandate to do so, and raises suspicions of attempts to frighten vociferous NGOs into submission, especially when some of them were very critical of the activities of both the ruling and opposition parties during the 2012 elections. Nonetheless, it is a very popular action, as many people hold the view that NGOs need to account for funds they receive ‘on behalf of the people of Sierra Leone’ (Radio Democracy FM 98.1, Good morning Salone, 7 March 2014, Freetown). The tensions between local councils, central government, and NGOs has resulted in those actors responsible for the delivery of health services trying to outmanoeuvre each other to acquire power and influence, with the health needs of the poor merely a secondary priority to the political business of contested oversight and authority.

Primary health care infrastructure, staffing, and management of health facilities

This article has thus far examined the myriad ways in which local councils, DHMTs, and NGOs compete to control resources and to determine which areas receive intervention at the district level. However, the infrastructure, staffing, and management of PHUs, around which the interaction between service users and health workers revolves, are equally, if not more, fraught with challenges. As described above, the construction of PHUs by NGOs, community associations, and private individuals is so uncoordinated that the Directorate of Primary Healthcare in the Ministry of Health does not know the exact number of facilities in the country (Interview with Measurement and Evaluation Officer, Directorate of Primary Health Care, 7 August, 2013, Freetown). In 2009, Sierra Leone had about 870 PHUs. By August 2013, the figure was over 1390 – an increase of roughly 520 PHUs in five years (Interview with Monitoring and Evaluation Officer, Directorate of Primary Health Care, 7 August 2013, Freetown). This dramatic increase may be partly a reflection of the need for rebuilding the country’s health infrastructure in the wake of the civil war. However, while the reconstruction of the country’s war-torn health infrastructure could be indicative of an effective and fast-moving recovery effort, much of the NGO and donor driven development has not been properly incorporated into the government-operated health system (Local Government Finance Department, n/a; Bombali DHMT, 2008; 2011; Moyamba DHMT, 2012; Kambia DHMT, 2013). A survey conducted by UNICEF in early 2015, for example, noted that the country had 1185 government-owned PHUs. The disparities between the numbers of the government and its partners point to the general challenge of the availability of reliable data to inform planning in the sector.

Moreover, where health facilities are present, they are often marginally functional. In Bombali District, over 43 per cent of PHUs were either in need of major rehabilitation or replacement in 2008 (Bombali DHMT, 2008). In Bo District in 2011, 30 per cent of the PHUs were ‘...found to be in a very bad shape and needed urgent rehabilitation...’ (Bo DHMT, 2011a:2). In addition, throughout the country, many PHUs are operated from private-owned houses that are not designed to undertake the delivery of health services in the first place, and which are further dilapidated (Bombali DHMT, 2011; Bo DHMT, 2011b; Kambia DHMT, 2013). In many rural communities, where purpose-built health facilities do not exist, health workers operate out of makeshift structures, capitalising on spaces designed for other services. In some Tonkolili

District villages, for example, health workers used rooms in the staff quarters of community schools.³

Further to the infrastructural problems and partly as a result of the above-described mismanagement, there is a dire shortage of health professionals. Primary health units are designed to have at least three health staff – a nurse, vaccinator and midwife. However, it is not uncommon to have just one nurse serving a catchment area of 15 or more villages. In Bonthe District, for example, 15 out of 55 PHUs were functioning with just one nurse at the time of fieldwork, a year before the Ebola outbreak (Interview with District Medical Officer, Bonthe, 3 August 2013, Matru Jong). Sierra Leone, with one of the highest maternal mortality rates in the world, had just 95 midwives across the country in 2010 – 205 short of what was needed to serve all health facilities (King 2010). The ratio of nurses and midwives was 0.36 per 1000 people in 2009, and just 0.03 physicians (Kinfu et al. 2009). Overall density of physicians, nurses, and midwives per 1000 of the population was thus 0.39, with an annual growth rate of 1.7, compared to a population growth rate of 2.6 per cent (Kinfu et al. 2009). The workforce growth rate required to adequately serve the country was an impossible 16.1 per cent. There are a variety of factors that have led to such paltry numbers of health workers. First, many health professionals left the country during or as a result of the civil war. Second, the poor conditions of service in the health sector mutually reinforce the undesirability of working in such a medical environment. Further, the remoteness of rural outposts are places where highly-skilled health workers, many of whom are from and trained in urban areas, would prefer not to work (Interview with District Medical Officer, Bonthe, 3 August 2013, Matru Jong). The result is that the most marginalised communities stay underserved for the same reasons that drive marginality in the first place.

The Health Service Commission (HSC) which is expected to ‘raise staff numbers, and improve retention rates and the conditions of service for health workers’ (Ministry of Health and Sanitation, 2010b:15) is yet to become effectively functional, due to its capacity and resource constraints. As it grapples with its challenges, the MoHS and Human Resources Management Office (HRMO) continue to directly recruit health workers at the national level ‘because the human resources needed to deliver health services are highly technical’ (Interview, Director of Hospital Services, MoHS, 9 February 2012, Freetown). This marks yet another way in which power is not devolved to the local level, as the MoHS fears ‘losing control’ over local health personnel if recruitment were devolved to the councils.

Compounding the challenges posed by the general shortage of health workers, the distribution of personnel - like other health resources – by MoHS has not always reflected the individual needs of PHUs and their catchment communities. Powerful local and national elites often lobby the MoHS for their chiefdoms to be assigned more health workers than required, relative to the needs of other areas (Interview, District Operations Officer, Bombali DHMT, 24 March 2012, Makeni). Nurses have also learned to influence postings by compromising staff, seeking to be assigned to areas they feel more comfortable working. These areas are generally more developed, nearer to big towns and cities, and where the nurses can make additional money by running private clinics in their homes (Interview, District Operations Officer, Bombali DHMT, 24 March 2012, Makeni). The MoHS is considering the introduction of remote allowances to motivate nurses to live and work in deep rural areas. It is unclear whether that alone will compensate for the challenges of working in those areas, if other enablers, such as staff quarters

and social amenities, are excluded from the planned incentive package (Interview, District Operations Officer, Bombali DHMT, 24 March 2012, Makeni).

The final level of challenges that result from the myriad capacity and governance challenges in the Sierra Leone health system is the micro-level management of PHU funds and services. Even where PHUs are staffed, their professionalism and treatment of service users can be problematic. The management arrangements of health facilities have undergone numerous rapid changes since the launch of the decentralization programme in 2004, with a myriad of foreign policies and initiatives being borrowed and tested, turning the country and its health system into a laboratory for donor experiments. Prior to 2011, each PHU was allocated LE 1 million Leones (US\$ 227) in operating costs per quarter (Interview with DMOs and CHOs and Health Workers in Bo, Bombali and Bonthe – 2011, 2012, 2013). The funds were meant to undertake minor renovations to the PHUs, payment for toiletries, and the payment of Traditional Birth Attendants (TBAs), who assist Maternal and Child Health Aides (MCHAs) in child delivery, but are not on the official payroll (Interview with Finance Officer, DHMT Bombali, 18 September 2011, Makeni).

The cash-to-facility mechanism had a number of challenges. First, payments were irregular and, when paid, often saw only a fraction going to PHUs, as senior DHMT staff deducted an unspecified amount for administrative fees or bank charges (Interviews with CHOs and Health Workers, 2011-2012, Bombali and Bo Districts). The fraction that would be paid was not properly accounted for, as Community Health Officers (CHOs) and other staff rarely kept detailed records on how the funds were spent (Interview, Northern Region Coordinator with Health for All Coalition, 23 October 2011, Makeni). In Bombali District, none of the in-charges of PHUs liquidated their accounts with the DHMT finance office in 2011, making it impossible for the team to account to external auditors for how over LE 200 million was spent by the district PHUs, partly due to the fact that, the transfer of financial responsibility was not accompanied by the necessary capacity building required to manage the funds (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni). The lack of accountability at the PHU level echoes inconsistent and weak accountability from the DHMTs themselves. In Pujehun District, for example, the Parliamentary Oversight Committee on Finance and Economic Development discovered that the DHMT could not account for LE 27 million worth of drugs supplied by the district council in July 2013 (Awareness Times, 23 July, 2013). More importantly, on top of these accountability problems, the cash-to-facility system did not adequately incentivise increased utilization of facilities by service users as funds were paid regardless of whether patients accessed the facilities.

The challenges associated with the cash-to-facility finance mechanisms were identified in an MoHS and donor-led review of PHU financing that led to the introduction of a new performance-based financing (PBF) scheme in 2011 (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni). Supported by the World Bank, the PBF system was borrowed from Rwanda, where it was deemed to have been highly successful in increasing access to health services and making health workers accountable (Interview with Western donor Communications Specialist, 1 February 2013, Freetown). According to the government document, the system ‘distributes funding to health service providers according to the outputs (health service provision) or outcomes (health status of the target population) that they provide’ (Government of Sierra Leone, 2011:9). Specifically, performance-based funds are designed to

increase uptake of services through a battery of health-supporting incentives. These include rewards and compensation for TBAs, light food, like soup, for pregnant women during antenatal visits, small ‘baby packs’ for women delivering at health facilities, gifts to husbands who accompany their wives during deliveries, and bathing soap for mothers after delivery (Ministry of Health and Sanitation 2011).

Given that performance-based finance is made according to health facilities’ outputs, not inputs, funding is based on scores in six areas for which PHUs are monitored on a quarterly basis. These include: women accessing contraception through the facility; women receiving a fourth antenatal consultation with a health professional; pregnant women in labour being attended by a health professional; postpartum women receiving three consultations with a health professional; children aged less than 12 months completing the Expanded Programme on Immunization (EPI); and children under-five receiving outpatient consultation at the facility (Government of Sierra Leone, 2011; Ministry of Health and Sanitation, n.d.). These reflect the country’s overall emphasis on improving maternal and under-five health, a push that has been particularly strong since the 2010 introduction of free healthcare for pregnant women and children under five, as the country struggles to improve its Millennium Development Goal indicators, albeit without a coherent policy to drive the process. Facilities are also required to meet a number of cross-cutting and quality standards including: maintaining accurate facility attendance registers; reports on facility management; minutes of the Village Development Committee (VDC) signed by the chairman; a wall-chart displaying facility performance, registers, tally sheets and drugs records; and ensuring that the PHU and its environment is clean (Ministry of Health and Sanitation, n/a; Government of Sierra Leone, 2011).

Of the total performance-based funding allocated to a health facility, ‘a maximum of 60 per cent...may be used as incentives to PHU staff and the remaining 40 per cent or more, spent on operational costs and minor investments at the facility’ (Ministry of Health and Sanitation, n/a: 2-3). In the vast majority of health facilities, in-charges continue to use the maximum 60 per cent on staff incentives (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni). Although the performance-based finance operational manual details strategies to ensure compliance and to prevent health workers from falsifying data in order to increase their quarterly funding, they frequently do manipulate the data, and obtain fraudulent receipts and invoices to justify their expenditures (Interviews with Finance Officer, Bombali DHMT, 29 January, 2013, Makeni; District Medical Officer, Bonthe, 3 July 2013, Matru Jong). In a well known case at Sanda Tendaren Chiefdom, Bombali District, health workers from a PHU collected the names of all the children in the local school, and reconciled them with those on the facility’s attendance register, even when they did not attend the facility in that quarter, so that supervisors would not detect inconsistencies and falsifications in the records (Interview with Community Development Coordinator, Local NGO, 25 January 2013, Makeni). In addition to fraudulent records, the PBF system is being undermined by the continued levying of additional and illicit fees for patient services. Despite the fact that the PBF is intended to increase clinic attendance by providing incentives to individual service users, health workers often demand that women pay for their children’s record-keeping books and purchase toiletries when they deliver their children; and light food and other incentives are often not being provided for women during antenatal visits, despite being covered by the PBF (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni).

In their study of the different manifestations of corruption in Francophone West Africa, Blundo, et al (2006:74) found that the charging of unwarranted fees often ‘exploits the diligence or zeal of users and generally takes advantage of their ignorance of the fees officially charged.’ In Sierra Leone, part of the problem underpinning the charging of unwarranted fees by health workers stems from a serious lack of information on the existence of PBF funds among Village Development Committees and community members. Health workers deliberately guard such information from service users. No case illustrates this situation better than that of the Safroko Limba Chiefdom headquarter town of Binkolo, where it took a community sensitization meeting organized by the Anti-Corruption Commission (ACC) to inform community members of the quarterly payments to PHUs, a revelation that was greeted with great surprise by the audience.⁴ Although the charging of unwarranted fees increases the financial burden of service users, there is a somewhat ambivalent tolerance for it, as both service providers and users justify it on the basis of low salaries (Blundo et al. 2006:74). At the community level, the fear of having no nurse increases tolerance for unwarranted fees, as a bad one is seen as better than no nurse at all.

Apart from the charging of unwarranted fees by health workers and their concealing of vital information from service users, the decision of the MoHS to bypass the DHMTs and directly transfer quarterly instalments of performance-based funds into the bank accounts of PHUs has further complicated the accountability cycle. This increases suspicions and tensions among the DHMTs and health workers, as the latter frequently conceal information regarding the time of payment and the amount from the DHMTs (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni). As a result, DHMTs have been reduced to merely receiving financial returns from PHUs, documents whose authenticity is all the more difficult to verify when DHMT Monitoring and Evaluation Officers are suspected of colluding with health staff in the utilization of PBF funds (Interview with Finance Officer, Bombali DHMT, 29 January 2013, Makeni).

The weak oversight of PHU staff by the DHMTs means that service users remain at the mercy of health workers and, given their lack of knowledge of what is due them, they can hardly hold them accountable even if they want to do so. As Booth (2010:4) notes, one of the key factors underpinning differences in the outcome of public goods provision across different countries is the extent to which service providers ‘are subject to effective top-down performance disciplines, even if in other respects the organizational context is severely lacking in the attributes of a well-resourced and well-regulated bureaucracy’. Further, the project has dubious sustainability implications for a country whose health sector is largely donor-dependent. As Booth describes, where ‘the superimposition of successive waves of public sector reform, often under donor influence [occur] without sufficient efforts to resolve the inconsistencies thereby created’, such reform measures are almost always bound to fail (2010:8-9). In practice, performance-based financing amounts to the World Bank doubling the salaries of health workers for performing the jobs for which they are recruited and paid to do by the government, while creating a culture of reporting that is detached from meaningful monitoring and evaluation standards.

Conclusion

This article has analysed the decentralization of primary health services in Sierra Leone through a multi-level analysis of the delivery system, its legal and policy framework, and the political

economy at the local, district, and national level. It identifies a culture of resistance at the centre to any meaningful devolution of power and finances, as well as fraught coordination relationships among local actors responsible for the delivery of health services. Finally, these dysfunctional patterns continue at the community level in the tenuous relationship between service providers and users.

The challenges besetting the country's decentralization of primary health care illustrate the difficulties involved in bridging the gap between the lofty goals espoused in policy documents and the reality of fixing long broken social services and the infrastructure needed for delivery. Reform programmes, such as decentralization, promoted by donors and designed to dislodge embedded structures and interests, are as much political as they are technical. Therefore, both political economy and technical factors responsible for implementation failures have to be adequately understood and addressed. The purposes and uses of the legal and policy framework have not only been regulatory, they have also been politically instrumental, as they have been selectively and conveniently interpreted and applied to suit, primarily, central government interests.

Whereas decentralization is often seen as a process that aligns user preferences with government policies, reforming social services in states such as Sierra Leone, long immersed in destructive forms of patrimonial politics, requires a more careful mapping of actors and their interests and an incentive system that ensures that reform does not become a zero-sum game that triggers insurmountable resistance by the elites benefiting from the status quo. The launch of the Sierra Leone decentralization programme in 2004 created a crisis of legitimacy for central government officials, who had long used state resources to support patronage networks that enabled them to maintain influence, if not control, over the periphery. Although on paper the biggest winners of decentralization have been local actors in the form of councillors, local administrators, NGO staff, and nurses, in reality, the central elites' influence over the periphery in the delivery of health services remains largely intact.

As with central government officials, understanding the imperatives and actions of local actors requires an understanding of the societal and other pressures to which they constantly have to respond. They, too, need to reciprocate the favour of their superiors at the centre. They need to maintain political support and win re-election. They need to provide social services, often while appropriating or diverting public resources to demonstrate success in a political economy that rewards wealth and patronage. These and other social and political constraints are essential for understanding the failures and weaknesses of the Sierra Leone health system and decentralization's intended panacea.

The policy implications for designing and implementing decentralization programmes are a much more robust understanding of local contexts and contested interests. The histories, politics, economics and cultural dynamics of societies should help shape the nature of decentralized institutions, rather than notions or models borrowed from outside. Indeed the unregulated operations of NGOs, which implement programmes "borrowed" from contextually different countries, outside the framework of the development plans of the central and local governments, often in uncoordinated fashion, adds to the challenges. Attempts to improve the delivery of primary health services will require effective coordination and oversight of donors and NGOs,

which have generally disregarded efforts by the state to regulate their operations. As the country's Ebola crisis showed, NGO and donor inputs are essential to gaining adequate infrastructural and health worker capacity in a resource-strapped health system. However, what the Ebola epidemic also revealed and what this paper has demonstrated, is that NGO activity without coordination at the council and ministerial level can create as many problems as it solves. Donors need to work not only with the MoHS, but also across the health service delivery chain, reinforcing management and oversight mechanisms, strengthening governance relationships, and abiding by – rather than undermining – the very transparency and reporting mechanisms they demand.

In some ways the decentralization of primary health care, and indeed the decentralization programme generally, fits into the patterns of continuity and change that have characterised the country's attempt to break away from the illiberal governance practices of the past, whilst often getting firmly stuck in them. Despite the many post-war reform programmes supported by donors, Sierra Leone has still not been able to extricate itself from the negative control exerted on its governance and services structures by competing powerful political and economic interests. This situation is reminiscent of the creation of the “Shadow State”, when powerful foreign business interests gained and maintained control of the functioning of the state machinery in the 1980s and early 1990s (Reno 1995; 1996), a phenomenon that continues to replicate itself in different guises. It also reflects the long term impacts that decades of institutional weakness and decay, a dysfunctional political and governance culture, and the civil war have had on the state's ability to deliver efficient health services to its citizens.

Finally, the challenges of Sierra Leone's decentralization of primary health services points to the fact that, while devolved power might be desirable, it does not necessarily provide sufficient guarantees that the poor will get a fair deal. The successful delivery of health services, whether under a decentralised or centralised system, will require genuine political commitment from politicians who do not just implement reforms for the political capital they can gain, but are willing to take a long term perspective, complemented by a robust system of top-to-bottom and mutual accountability.

Notes

¹ See section 9 of the Hospital Boards Act of 2003.

² Minutes of Bo District Council monthly coordination meeting, 5 October 2011; 2 November 2011; 7 December 2011.

³ Observations and discussions with health workers in Tonkolili District, during field visits, 18 - 22 February 2013.

⁴ Focus group discussion, 7 February 2012, Binkolo.

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