



Institutional Characteristics and Its Effect on Public Health Service Delivery under Decentralization in Local Government Authorities in Tanzania

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Abstract: This article examines the effects of institutional characteristics on public health service delivery under decentralisation in rural Tanzania. It adopted a cross sectional design to examine institutional characteristics and its effects on health service delivery at Pangani and Urambo Local Government Authorities (LGAs). Both qualitative and quantitative approaches were employed; primary data were collected by using interviews, questionnaires, FGDs and observation. The study established that, the instructional characteristics impaired significantly the decentralisation initiatives for improved health service delivery in the rural areas in Tanzania. Institutional characteristics, legal frame work, systems and administrative structures were the main hindrance in the implementation of decentralisation for improved health services and its delivery. The institutional effects resulted to poor health service delivery infrastructures in terms of equipments availability, drugs and medicines, health workers, distance, delayed service, time management, lack of accountability and transparency. The study recommends a review of the existing framework, administrative systems, structures and processes and human resource capacity building.

Keywords: Decentralisation, Institutional Characteristics, Health Services, Local Government Authorities.

1. Introduction

The study examined the institutional characteristics and its effects on decentralization for improved public health service delivery in rural Tanzania drawing experiences from Pangani district in Tanga and Urambo district in Tabora. The study reviewed reforms in public service with a focus on public service delivery. The review indicated that many countries have implemented the reforms at the central government and local levels. It was also imperative that the objective of reforms whether broad or for sector specific were centred on improving effectiveness and efficiency in service delivery (Hope, 2001; Hussein, 2013; World Bank, 2005;2006). However, the level of reform implementation, forms of decentralisation and their impacts varied from one country to another (Hope, 2001). The factors for variations were anchored and imbedded on institutional set up within a given country and choice (Blair, 2000;2001; Larbi, 2005). The design and impetus for decentralisation indicated more influences from external pressure that affected the ownership, impacts and the expected outcomes (Hussein, 2013;2014;2015; Masanyiwa *et al.*, 2013). Theoretically, there is a consensus that decentralisation brings the government closer to the people and address people's needs and expectations in an effective and efficient manner. Moreover, decentralisation initiatives have attracted both theoretical and empirical debate regarding its impact on public health service delivery.

Health sector reforms and decentralisation are part of the most critical agenda of many nations intending to meet the challenge of the 21st Century and Millennium Development Goals (MDGs). Herrera and Post (2014) opined that decentralisation was adopted and implemented by many nations as a solution to address the challenge of improved public service delivery in rural areas. In 1990's Tanzania made attempts to reform its public service as a response to deteriorated public services and consequent lost confidence by the public on competence and integrity of public institutions to serve the nation (URT, 2000; Venugopal and Yilmaz, 2010). Among the factors attributed to that anomaly included an expansion

of public service structures, pervasive political interference and patronage influence, complicated institutional set up and characteristics, lowly paid bureaucracy, red tape, nepotism and non-responsive bureaucracy, violation of laws and human rights and dignity (Boon, 2007; Mollel, 2010; Mushi, 2002; Ringo *et al.*, 2013; Venugopal and Yilmaz, 2010). The Tanzanian government redefined her role, scope of functions, reviewed structures, reviewed institutional set up and redefined the size of the public sector to address the needs and expectations of the society. In order to achieve these objectives the government undertook public service reforms. The overall objective of these reforms was to have a smaller, affordable, well-compensated, efficient, responsive and effectively performing public service, which could foster development and sustained economy through improved service delivery and hence improve social welfare in the country (Hope, 2001; Mutahaba and Kiragu, 2002; Pallotti, 2008; URT, 2000).

Given the limited impact on the quality of public service delivery under previous reforms, the Government launched an ambitious programs which included Public Service Reform Program (PSRP), Legal Sector Reform Program (LSRP), Financial Sector Reform Program (FSRP), Local Government Reform Program (LGRP), Health Sector Reform Program (HSRP) and other sector reforms (URT, 2000;2007). The Local Government Reforms program (LGRP) under decentralisation was comprehensive with intent to enhance governance and devolve powers to the grass root governments in order to improve service delivery (REPOA, 2008). This article revisits the LGRP by examining the institutional characteristics and its effect on decentralisation for improved public health service delivery in rural Tanzania.

2. Local Government Reform Program and Decentralisation

The 19th Century witnessed a wave of reforms under the auspices of New Public Management (NPM) with emphasis on Decentralisation for improved public service delivery (Doherty and Horne, 2002). The World Bank and International Monetary Fund supported institutional changes with an intention to transform the old public administration, which was condemned as rule bound, hierarchical, unresponsive and inefficient. Decentralized form of administration was assumed to be more responsive to citizen needs and effective in terms of access and quality of public services (Hope, 2001).

The emergence of these reforms were deliberate initiatives to transform the government in terms of its functions and organizational structure, policies and providing institutional support for government decentralisation and managing the process hence bring change on service delivery (Pollitt and Bouckaert, 2004). Decentralisation and public health service delivery in developed and developing nations have been implemented using new public management approach and institutional approach as a guiding frame work (Batley, 2004; Hope, 2001; Larbi, 2005). Andrews and Vries (2007) noted that, many countries made strides on reforming Local Government Authorities (LGAs) under decentralisation of the fiscal, political and administrative responsibilities from central government to grass roots. The reforms intended to improve service delivery including public health services. Principally, decentralized system in the public services were expected to be more accessible and responsive to local needs as citizens could directly or indirectly influence decisions about resource allocation and service delivery. World Bank (2008) pointed out that, “everyone is doing it” with a focus to enhance institutions and improve service delivery to the citizen.

However, Azfar *et al.* (2004); Batley (2004); Palencia and Pérez-Foguet (2011) in Masanyiwa *et al.* (2013) noted that decentralisation for service delivery including health, entailed restructuring institutions and/or creating new ones because its expected outcomes partly depend on institutional arrangements and their power relations. World Bank (2010) pointed out that availability and access to infrastructure serves as pre-conditions for quality health services to the population. Further, noted that decentralisation efforts still leave some odds as distance to access health service delivery denies access and availability of health care especially to the poor. The World Health Organization (WHO) Alliance for Health Policy and Systems Research defines six building blocks of health care systems, the infrastructure constituting one component of the building block “service delivery”. The term ‘infrastructure’ is used in manifold ways to describe the structural elements of systems and administrative institutions. In the context of a health care system management and delivery in reference to health care facilities, was defined as the total of all physical, technical and organizational components or assets that are prerequisites for the delivery of health care services.

3. Local Government Reforms in Africa

During the period of three past decades, African countries have embarked on comprehensive public service reform programs including reforming sub national governments. However, despite the tremendous

efforts and resources allocated to this endeavour, progress remains scant and less impressive (Willis-Shattuck *et al.*, 2008). The World Bank and other donors in Africa have been concerned with finding alternative ways of organizing and managing public services and redefining the role of the State to give more prominence to markets and competition, and to the private and voluntary sectors (OECD, 2005). The alternative vision, based on issues of efficiency, representation, participation and accountability, has sought to create a market-friendly, liberalized, lean, decentralized, customer-oriented, managerial and democratic state (*ibid*). Rob and Richard (2007) using case studies from Sub-Saharan Africa arrived on similar conclusion that civil services were described as oversized, unresponsive, rule-bound or with no effective rules, low incentive, driven by corruption, patronage and red tape (*ibid*).

The public service (ministries, local authorities and departments) always have been the tool available for African governments for the implementation of developmental goals and objectives. It is seen as pivotal for growth of African economies and poverty reduction and improving citizen welfare (World Bank, 2004). It is responsible for the creation of an appropriate and conducive environment in which all sectors of the economy can perform optimally, and it is this catalytic role of the public service that propelled governments all over Africa to search continuously for better institutional approach that could foster quality of public service delivery and sustained economy (*ibid*).

4. Forms and Typologies of Decentralization

Rondinelli D. A. and Nellis (1986) opined that there are definitions which distinguish between types and forms of decentralisation. Typologies refer to what is being decentralized and therefore encapsulate three areas: political, administrative and fiscal. The form refers to the transfer of authority for making decisions to local units by central agencies (deconcentration), lower levels of government (devolution), or semi-autonomous authorities (delegation). While de concentration and delegation imply a reorganization of central government, devolution means relinquishing political power. In addition, devolution as a type of decentralisation refers to transfer of governance responsibility for specified functions to sub national levels, either publicly or privately owned, that are largely outside the direct control of the central government.

Rondinelli D. *et al.* (1984), further defined decentralisation as the transfer of responsibility for planning, management, and resources raising and allocation from the central government and its agencies to: (i) field units of central government ministries or agencies; (ii) subordinate units or levels of government; (iii) semi-autonomous public authorities or corporations; (iv) area wide, regions, or functional authorities; or non-governmental, private or voluntarily organizations. There are a variety of different arrangements, which are often included in the discussions on decentralisation. Rondinelli D. *et al.* (1984) identified four major forms of decentralisation, namely; devolution, delegation, decentralisation and divestment. According to Rondinelli D. *et al.* (1984) devolution is the transfer of responsibility for governing, understood more broadly as the creation or strengthening financially or legally of sub national units of government, whose activities are substantially outside the direct control of central government. Rondinelli D. *et al.* (1984) further argued that, while devolution transfer responsibility of governance, delegation is simply the transfer of managerial responsibility for specifically defined functions to public organizations (this can be local governments or parastatals) outside the normal bureaucratic structure of central government.

Deconcentration on the other hand, is the spatial relocation of decision-making, or the transfer of some administrative responsibility or authority to lower levels within central government ministries or agencies. While de concentration transfer some administrative responsibility to public organizations, divestment as another form of decentralisation, takes place when planning and administrative responsibility or other public functions are transferred from government to voluntary, private, or non-governmental institutions which clear benefits to and involvement of the public. Ribbot and Larson (2001) highlighted two forms of decentralisation, Similarly, Rondinelli D. *et al.* (1984) on the other hand, identified four major forms of decentralisation (a) devolution; (b) delegation; (c) decentralisation, and (d) divestment. It is therefore clear that the types of decentralisation were specifically referring to political, administrative and fiscal.

One may conclude that, decentralisation is the transfer of power from the centre to the periphery where by the local citizens participates in decision-making. The quest for decentralisation in Africa was a result of the inefficiency of the state especially the central government doing everything hence failing to deliver. Consequently, the need to decentralize was considered critical for improved service delivery in terms of reliability, access, quantity, quality, affordability, economy and timely service delivery.

5. Local Government Reform Program in Tanzania

Local Government reform program in Tanzania was established following the deterioration of public services and consequent fall of public confidence in the competence and integrity of the civil service (URT, 2000). Among the factors attributed to that anomaly included; over expansion of public service structures; pervasive political interference and patronage influence; state controlled economy, over staffing and lowly paid bureaucracy. Other factors included; corruption, red tape, nepotism; non-responsive bureaucracy; non-compliance to financial and administrative regulations and violation of laws and human rights (Mushi, 2002). The government in the 1990's had to rethink and redefine her role, scope of functions, review its structure. The government redefined the size of the public sector to address the needs and expectations of the society. In order to achieve these objectives the government adopted massive public service reforms. Overall, the reforms intended to achieve a smaller, affordable, well-compensated, efficient, responsive and effectively performing public service with proper institutions which could foster development and sustained economy through improved service delivery (Mutahaba and Kiragu, 2002; URT, 2000).

Generally, the reforms were comprehensive with intent to combat corruption, strengthen the legal sector and judicial systems, enhance financial accountability and devolve powers to the grass root governments in order to improve service delivery, participation and accountability. In 1998 as part of the reforms tool (URT, 1998). The main objective of local government reform program was to strengthen local government authorities as institutions and enable them to execute their role more effectively and efficiently. Also to enable them deliver sufficient, reliable, predictable, affordable and quality services (URT, 2000;2002). The guiding principle in the LGRP was Decentralisation by Devolution (D by D) with thrust on improving performance of the public sector particularly local institutions, to increase the accountability and to minimize mismanagement and waste of resources. In order to achieve this, it was considered imperative to give more powers, functions and resources to the people in the communities through empowering LGAs (Shivji, 2003).

According to LGRP, the decentralized LGAs were expected to be autonomous institutions and were anticipated to be free to make operational decisions consistent with central government policies. The LGAs were also expected to be cost effective in service delivery. The LGAs were to be strong and effective by possessing resources and authority necessary to effectively perform roles and functions mandated to them. The LGAs were expected to be noble democratic institutions. The leadership of the LGAs was expected to be chosen through a fully free and fair democratic process, extending to village councils and grassroots level. The LGRP was expected to facilitate community participation in deciding on matters affecting their lives, planning and executing their development programmes. The LGAs were considered as subsidiary institutions and were expected to have roles and functions that correspond to the demands for its services by the local people and the socioeconomic conditions prevailing in the area. The structure of each LGA was designed to reflect the nature of its roles and functions. The LGAs were expected to be transparent and accountable institutions to the people. This was presumed to be achieved based on their autonomy justified by being free from undue central government interference. Besides, local government leaders (Councillors) and staff were to adhere to a strict code of ethics and integrity (URT, 1998).

In this context, LGAs in Tanzania are institutions with multi sector units with legal status operating on the basis of discretionary. Moreover, their general powers are under the legal framework constituted by the national legislation. The LGAs are expected to deal with most aspects of the society and be directly responsible for a wider range of sectors including public health service (URT, 2003). The authorities are considered having responsibility for social development and the provision of public services in their jurisdiction, facilitation of maintenance of laws and orders and issues of national importance such as education, health, water, roads and agriculture.

In line with the LGRP, the role of central government was confined in facilitation and enabling of LGAs in service provision, development and management of a policy and regulatory framework, monitoring accountability, financial, performance audit and provision of adequate grants. The studies by other scholars indicated that Tanzania like any other developing nations has long and interesting history of implementing decentralisation reforms since independence (Kessy and McCourt, 2010; Pallangyo, 2011). The country has continuously implemented local government reforms aimed at enhancing the quality, accessibility and equitable delivery of public services rendered by LGAs (Hussein, 2014).

6. Local Government Laws in Tanzania

Local government issues in Tanzania are non-union matter. In mainland Tanzania, the Constitution of the United Republic of 1977, Articles 145 and 146 state that the National Assembly or the House of Representatives must provide for local government through legislation. Article 146 states that one of the objectives of LGA is ‘to enhance the democracies process within its area of jurisdiction and to apply the democracy for facilitating the expeditious and faster development of the people’ (URT, 1977). It is further explained that local government has a constitutional protection. Article 145(1) of the constitution, as amended in 1984, states that, “There shall be established local government authorities in each region, district, urban area and village in the United Republic, which shall be of the type and designation prescribed by law to be enacted by the Parliament or by the House of Representatives” (URT, 1977). Section 2 of the same Article categorically states that: “Parliament or the House of Representatives, as the case may be, shall enact a law providing for the establishment of local government authorities, their structure and composition, sources of revenue and procedure for the conduct of their business” (URT, 1977).

The purpose and functions are stipulated in Article 146(1 and 2) of the constitution. Thus, it states; “The purpose of having local government authorities is to transfer power, responsibilities and authority to the people. LGAs shall have the right and power to participate, and involve people, in planning and implementation of development programmes within their respective areas and generally throughout the country” (URT, 1977). Besides the constitution, the legal framework of the local government comprises a number of laws enacted by Parliament, and these are:

- The District Authorities Act, No. 7/1982, as amended by Act Number13 of 2006.
- The Urban Authorities Act, No. 8/1982, as amended by Act Number13 of 2006.
- The Local Government Finances Act, No. 9/ 1982, as amended by Act Number13 of 2006.
- The Public Service Act Number 8 of 2002 as amended in 2008.
- The Local Government Negotiating Machinery Act of 1982, as amended by Act Number13 of 2006.
- The Regional Administration Act 19/ 1997.
- The Urban Authorities (Rating) Act, 1983, as amended by Act Number13 of 2006.

Noiset and Rider (2011) argued that dependence of LGAs to central government is manifested within legal framework that defines the existing relationship. The central government controls resources, hence affecting fruition of decentralisation for service delivery improvements. Kessy and McCourt (2010) pointed out the sceptics on decentralisation and ironically calling it as recentralisation from the analysis of central local relation on LGAs financing. They also noted that LGAs in Tanzania had no clearly defined functions. The Functions described were rather broad and vague with no limits of powers among various levels of central government and LGAs. Kimaro and Sahay (2007) also observed and emphasised on the importance attached to institutional arrangement and relationship for decentralisation to be more meaningful and foster service delivery.

7. Administrative Structure of Local Authorities and Service Delivery in Tanzania

Decentralisation received a major push in 1996 when the government of Tanzania published a local government reform agenda. The subsequent policy paper in 1998 defined far-reaching decentralisation aims by promoting the famous principle: decentralisation by devolution. This approach aimed at the devolution of real power and authority to elected sub-national governments and not only at a deconcentration of central agencies. This far-reaching reform aimed to fundamentally change the role of the state and local authorities. The central government ministries were expected to switch from direct implementation to a role of support and monitoring of local authorities under the slogan “hands off, eyes on”.

The program was implemented in phases with the main aims of devolution of power to locally elected councils and committees (political decentralisation); Collection of taxes and budgeting based on local priorities (financial decentralisation); De-linking local authority staff from the respective line ministries making them accountable to the local government (administrative decentralisation); and changing the role of line ministries from control to that of policy making, regulating, support and monitoring to ensure quality of services and national standards (Egli and Zuicker, 2002). The local

government levels in Tanzania involve district authorities and urban areas. The district authorities include district councils, village councils, and township authorities. The urban authorities are divided into city, municipal and town councils that all have their own functions. District councils coordinate the activities of the township authorities and village councils, which are accountable to the district for all affairs as defined by law for day-to-day administration. The village and township councils have the responsibility for formulating plans for their areas (URT, 2002). The local authorities also have a number of democratic bodies to debate local development needs. In the rural system, the 'Vitongoji', the smallest unit of a village, is composed of an elected chairperson assisted by three members all of whom serve on an advisory committee. In the Urban areas the Mtaa (a small urban area or geographical division of a ward) is the smallest unit within the ward of an urban authority. Unlike the Vitongoji, the Mtaa Committees have a fully elected membership comprising of a chairperson, six members and an executive officer."

The committees discuss priorities for local services delivery and development project, before being forwarded to the ward development committee (WDC). In the rural system proposal reach the ward development committee (WDC) via the village council (VC). The ward development committee members includes the elected ward councillor as chairperson, the ward executive officers, a salaried official, women councillors special seat, representative from Non-Governmental Organization and all village chairpersons within the ward. The ward development committee coordinates development plans and social service plans, supervises project implementation and service delivery activities, and is an intermediary for discussing initiatives from the sub-ward levels and the plans from the principal local authorities.

The village and township councils also have responsibility for formulating plans for their areas, and in most cases for securing district approval. Plans are developed in association with formally established bodies. District councils and township authorities must have three standing committees, namely; finance, administration and planning; education, health and water; and economic affairs, works and environment. Village councils have three standing committees: finance and planning; social services; and Defence and security (URT, 2006). Statutory committees for both district and village councils include an HIV/AIDS committee and a council ethics committee. Local authorities have discretion to establish further committees, although there is a maximum for each type of authority. The role of the committees is to develop policy, set budgets and oversee the works of specified departments.

For urban councils, there are three types of urban authorities, that is, town, municipal and city council. The chairperson of the town councils and mayors of the municipal councils and their deputies are indirectly elected by the councillors. Urban councils have all the same standing committees as the district councils, and the discretion to establish further ones. Non-elected members may be co-opted onto committees. Phase one of the local government reform programme (LGRP) was implemented between 2000 and 2008. These reforms were implemented concurrently with health sector reforms whereby the health service at the District level was devolved to LGAs to increase their mandate in health service provision (URT, 2003). Under this arrangement, the expectation was that the health units including the District Hospitals (DH) would provide services under the supervision of the Council Health Service Boards (CHSBs) and Health Facility Committees (HFC).

It was also expected that the duty of LGAs as democratic organs shall be to ensure that, health facilities and services provided are of acceptable quality, managed by qualified personnel according to staffing level in line with the Ministry of Health (MoH) Policy Guidelines, Regulations and Standards (URT, 2003). Phases two of the reforms (LGRP II 2009-2014) were implemented from 2009 to 2014.

The second phase of the local government reform programme was implemented amidst other progressive policies and strategies, such as the Development Vision 2025 (URT, 2000) and the National Strategy for Growth and Reduction of Poverty (URT, 2010). The overall goal of LGRP II was to achieve "accelerated and equitable socio-economic development, public service delivery and poverty reduction across the country to a middle economy." In relation to this goal, the overall purpose of LGRP II aimed to achieve devolution of government roles and functions hence transform Local government authorities (LGAs) to a competent strategic leaders and coordinators of socioeconomic development, accountable and transparent service delivery and poverty reduction interventions in their areas of jurisdiction (URT, 2009).

Phase one and two (LGRP I and LGRP II) understand the process of 'decentralisation' as the main strategy to achieve the goals and objectives of the reforms and aim at enhancing citizens' participation and improving service delivery, (URT, 1998;2009). The overall objective of such initiative focused towards improving service delivery to the public. Thus, made it through transferring power of the decision making, functional responsibilities, and resource from central government to local government authority (ibid). Katera and Ngalewa (2008) however, points out that there have been cases including lack of involvement of stakeholders in planning process, on the side of the human resources involved in the process. Despite

those dimensions the questions of interest includes: what powers are transferred and to which local institutions are they transferred to. The answers to these questions determine the extent to which local institutions as recipients of decentralized powers, can effectively plan and implement development activities including public health service provision (Conyers, 2007).

Underlying these arguments is the assumption that decentralisation of service delivery occurs within an institutional environment that provides the political, administrative and financial authority to local institutions (Azfar *et al.*, 2004; World Bank, 2001). According to Conyers (2007), the outcomes of decentralisation depend on the type the institutional design, the way is implemented, the capacity of institutions involved, and the wider economic, social and political environment. Hence, decentralized service delivery requires a mix of relations between central and local institutions, referred to as 'institutional pluralism' by Blair (2001). However, many studies indicate that the necessary institutional characteristics for the desired outcomes are rarely observed. Most decentralisation reforms are either flawed in their institutional design or central governments do not decentralise sufficient power and resources to local level governments to enable them to have significant effectiveness on local service delivery (Conyers, 2007; Devas and Grant, 2003; Ribot *et al.*, 2006).

8. The Findings

8.1. Institutional Effects on Decentralisation and Public Health Service Delivery

This section focuses and seeks to account on the effect of institutional characteristics on decentralisation for improved public health service delivery in rural Tanzania. In addressing this theme, the study had one fundamental question which intended to ascertain on how the institutional characteristics affected decentralisation for improved public health service delivery in rural Tanzania. The study used both quantitative and qualitative approaches to ascertain the nature and character of existing institutions and structures as well as their effect on decentralisation for improved public health service delivery in rural Tanzania. The analysis triangulated primary and secondary information to establish the linked effect of those policies, laws, administrative structures and practices as institutions on public health service delivery in rural areas of the selected Local Government Authorities (LGAs).

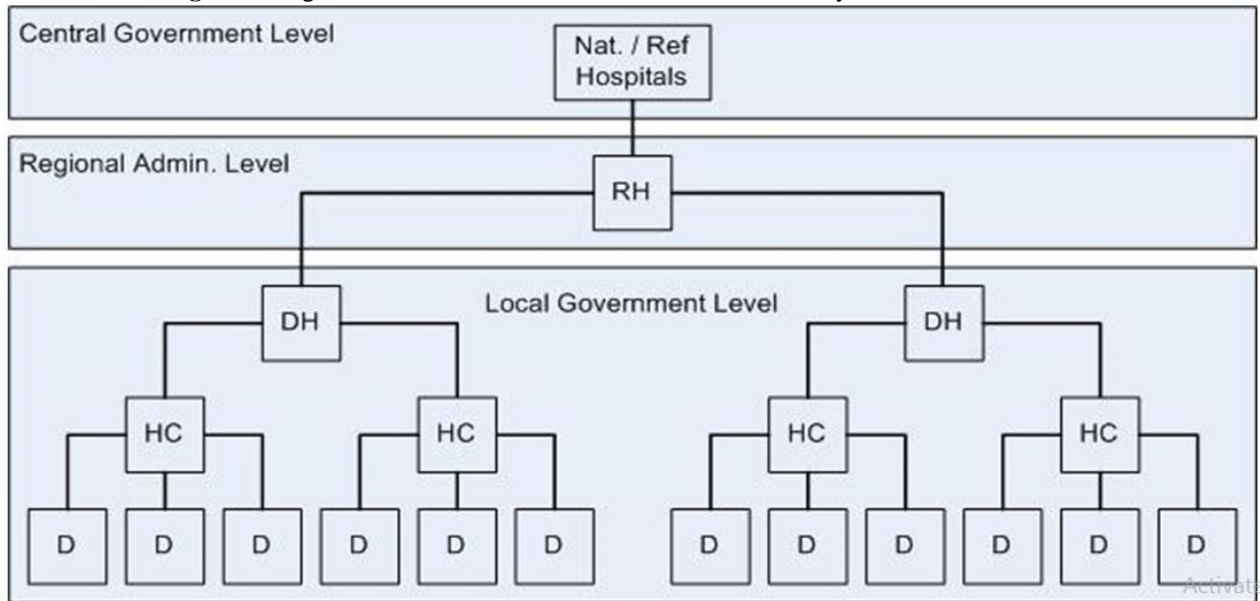
8.2. Effects of Policies and Laws on Public Health Service Delivery (Demand Side)

The study thought it imperative to know from both demand and supply side whether decentralisation policies and laws contributed towards improving public health service delivery in rural Tanzania.

A triangulation of information from interviewees, focused group discussion and observation revealed that, after almost fifteen years of implementing decentralisation reforms distance has not been reduced much and number of health facilities not increased much in number to improve availability and access. The analysis through documentary review established that at Urambo during the study there were fifteen (15) Wards but there was only one ward with Health Centre (HC) instead of fifteen Health centres. There were fifty nine (59) villages but only 20 Dispensaries (D) in twenty villages were available.

Pangani District Council had 14 Wards and 33 villages but there was only one (1) Health Centre (HC) and sixteen (16) Dispensaries. This situation defeats the objectives stated in the decentralisation policy and The National Health Policy, which categorically states that every village shall have a Dispensary (D) and every ward shall have a Health Centre (HC) to ensure that services are closer to citizens. Figure 1 Summarizes the health structure as per National Health Policy of 2003 and 2007 in line with Decentralisation thrust agenda.

Figure 1. Organizational Structures for Health Service Delivery in Tanzania Mainland



Source: Boex (2015)

O'Donnell *et al.* (2007) defined access to health care in a variety of ways. In its most narrow sense, it refers to geographic availability. A far broader understanding identifies four dimensions of access: availability, accessibility, affordability, and acceptability. In the context of this study, it is a fact that access in the selected LGAs is still at remote to materialize, especially in terms of number of health facilities in wards and villages. The World Health Organization (2007) emphasized access in terms of population coverage and extent of health services provided. Similarly Shinde *et al.* (2013) found that, geographical coverage of health services in the society is a key parameter in defining access of health service delivery in Tanzania. The study found that understanding of access in terms of facility availability in geographical coverage to ensure services are closer to citizens is important (Campbell and Graham, 2006; Ringo *et al.*, 2013).

The national health policy and decentralisation policy understands access using similar parameters hence creating a health system as an operational tool to cascade and decentralize health service management and delivery in Tanzania. The issue of whether decentralisation laws and policies help citizens to access public health services in the selected LGAs, 90.2% of respondents who participated in the study at the time of the study indicated that access was still a problem in their areas and structurally denied. Also the study intended to establish if citizens were satisfied with the institutional set up between the central government and local government in improving public health service delivery. The study established that 57.1% of the respondents were not satisfied. Finally the study asked respondents if the existing policy on decentralisation and laws empowered them to make autonomous plan and budget related to public health without interference by central government. The findings indicated that 78.3% of the respondents didn't agree that LGAs were autonomous in terms of plans for health and execution of the same. (Table 1) below provides a detailed summary of results.

Table 1. Effects of policies and laws on public health service delivery in rural Tanzania (N=203)

Items	Number	Percentage
Do the decentralisation laws and policies help to improve public health service delivery		
Yes	43	21.2
No	160	78.8
Do decentralisation laws and policies help citizens to access public health services		
Yes	20	9.8
No	183	90.2
As a citizen are you satisfied with the institutional set up between the central government and local government in improving public health service delivery		

Satisfied	76	37.4
Not satisfied	116	57.1
Don't know	11	5.4
Does the existing policy on decentralisation and laws empower to make autonomous plan and budget related to public health without interference with central government		
Yes	44	21.7
No	159	78.3

Source: Field Survey, 2015

Apart from those descriptive results, the study analysis through triangulation of information from in-depth interview, documentary analysis established that, decentralisation infrastructure in terms of laws there were issues that needed to be addressed for the same to bear fruition of results. The information from key informants highlighted the issue of ‘...*hierarchy in ordering of drugs, medicines and other medical supplies. Number of Health centres and dispensaries not implemented as per National Health Policy...*’ Blair (2000) in his study on decentralisation in the state of Karnataka in India found that democratic local government does increase participation and representation but does not necessarily enhance empowerment of non-elite groups nor does this form of government make the distribution of benefits more equitable. Therefore it was concluded that, decentralisation does improve access to service delivery in local governance but other factors should be taken into consideration.

Mubyazi *et al.* (2004) in a study at Babati, Lushoto, Muheza and Mkuranga districts reported that ward and village leaders commonly complained about the failure of district authorities to respond to local priorities. The village leaders cited some diseases, which were perceived by community members as major health problems in their respective areas but were not reflected or were given low priority in district plans. Tidermand *et al.* (2008) had more or less similar conclusion, observing that community involvement in health planning and delivery were very minimal because many district health plans did not beam identified community needs through the bottom-up O&OD planning process that is supposed to be the basis for district plans. This suggests that LGAs are largely still “implementers of national and sector wide development programmes” with little reference to local priorities (URT, 2009).

Crook (2003) demonstrates with evidence from Ghana, Code d’Ivoire, Kenya, Tanzania and Zimbabwe that even where democratic representation mechanisms exist, local governments have not been responsive to local needs and community aspirations mostly were ignored in drawing up district plans. This compels district council officials to harmonize village plans to include other national priorities for which funds are available. Tidermand *et al.* (2008) conducted a study on decentralisation and had similar conclusion that LGAs in Tanzania have no clearly defined functions. Descriptions of functions are rather broad and vague in scope.

Also the study established that levels of responsibilities were unclear below district levels. While there is consensus on the fact that decentralisation has a significant potential for enhancing accountability and local participation in public sector service delivery, there is less consensus in the degree to which it necessarily per se will contribute significantly to improved service delivery for that matter (Sikika, 2013; Tidermand *et al.*, 2008).

World Bank (2001) noted that decentralisation holds great promise for improving the delivery of public services including health services at sub national levels, but outcomes depend on its design and on the institutional arrangements governing its implementation. Jutting (2004) pointed out that, that if decentralisation takes place in an environment of weak institutions and political conflict, it may actually make matters worse. The study also made follow-up on parliamentary sessions (Hansard reports) and observed that the members of Parliaments from rural councils have been asking focusing on deficit in terms of number of Health Centres and Dispensaries in wards and Villages (URT, 2014;2015;2016).

8.3. Effects of Policies and Laws on Health Service Delivery in Rural Tanzania (Supply Side)

The analysis from the supply side (service provider) established that 75% agreed the decentralisation policy had significantly contributed towards improvement of public health services in some aspects. On the issue of decentralisation laws and policies whether show commitment by the central government to decentralize 60% agreed and 40% disagreed. This indicates that there were issues that needed to be worked upon as 40% of respondents cannot be ignored.

The study also established that 65% of respondents from the supply side agreed that existing policy and laws on decentralisation empower them to execute their plan and budget related to public health. However 35% were sceptical on the issue of autonomy. The study also intended to assess if respondents do think that there any relationship between decentralisation and improving public health services delivery in local government in rural Tanzania. Where 60% agreed that there was a relationship, while 40% said there was no relationship. [Table 2](#) summarizes the results.

Table 2. Effects of policies and laws on public health service delivery in rural Tanzania –Supply side (N=20)

Items	Number	Percentage
Do the decentralisation laws and policies help to improve public health service delivery		
Yes	15	75.0%
No	5	25.0%
Do decentralisation laws and policies show commitment by the central government to decentralize		
Yes	12	60.0%
No	8	40.0%
Do existing policy on decentralisation and laws empower you to execute your plan and budget related to public health		
Yes	13	65.0%
No	7	35.0%
Do you think there any relationship between decentralisation and improving public health services delivery in local government in rural Tanzania		
Yes	12	60.0%
No	8	40.0%

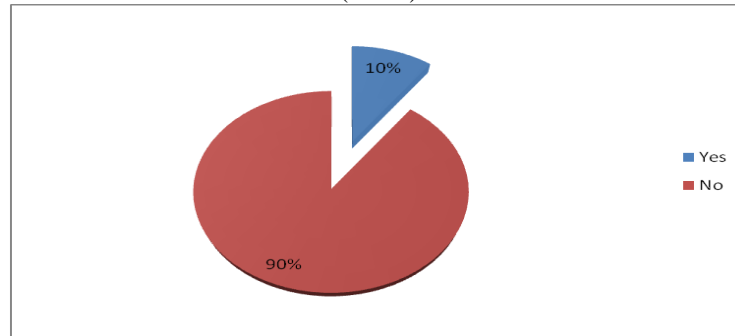
Source: Field Survey, 2015

The analysis through triangulation of data obtained from the interviewees, Councillors, Village chairperson, District Medical Officers and District Health Secretaries, it was established that the improvement were not comprehensive to draw robust conclusions that access, quality, quantity and responsiveness had been achieved. The analysis noted from key informants and secondary information that there were critical shortages of medical staff, facilities and medical supplies. [Sikika \(2013\)](#) observed similar bottlenecks and established that 48% of health facilities had no sufficient essential medicines and medical supplies to support smooth service delivery in the country. Similarly results from the focused group discussions indicated that citizens were not satisfied with the issue of availability of drugs and other medical supplies in public health facilities.

Another observation from interviewed key informants was the issue of coordination problem. ‘.....Policy issues about health care were under The Ministry of Health while implementation was under Local Government Ministry.....’. To this regard the discussion and analysis established that there was a problem in ensuring effective implementation of decentralisation and hence have significant results on improved health sector. In order to counter check if the responses on contribution of decentralisation had contributed on improving rural health services, the respondents were asked if the same has contributed towards availability of medical equipment and related supplies.

[Sikika \(2013\)](#) emphasized on this by pointing out that in Tanzania essential medicines, medical supplies and equipment were poorly available in most of the public health facilities, leading to unnecessary suffering and even deaths of innocent citizens. [Figure 2](#) paints the reality from the supply side.

Figure 2: Availability of sufficient medical supplies and equipments to support smooth health service delivery (N=20)



Source: Field Survey, 2015

8.4. Government Structure and Its Implication on Decentralisation and Health Service Delivery

This section provides an exploration on the Government Structure, nature of LGAs in Tanzania, their legal framework hence analyze their influence and implication on decentralisation and health service delivery in rural Tanzania. Therefore the section points out and discusses critically the issues that it considers to affect decentralisation for improved public health service delivery in rural Tanzania. The study found that the government of United Republic of Tanzania has two tiers of Government that is to say, Central Government and Local Government Authorities. The Constitution of the United Republic of Tanzania under Chapter one Article 1-3 and their subsequent sub articles provides for the proclamation and formation of Central Government while Articles 145(1-2) and 156(1-2) they are about establishment of Local Government Authorities (LGAs) in the country and their respective functions (URT, 1977).

The study discussion and analysis established that the legal framework and the administrative structure of central government in Tanzania is complicated and conflicting with the decentralisation policy and theories of decentralisation. According to in depth interviews and questionnaires filled by selected respondents, the study found that the level of autonomy to LGAs is questionable due to overlapping of power and authority among the two tiers of government. There were also conflicting of functions and responsibilities between Districts and LGAs hence causing redundancy. Pallangyo (2011) also found the same to be true in his study on the impact of Local Government Reforms and Human Resource Capacity in Tanzania.

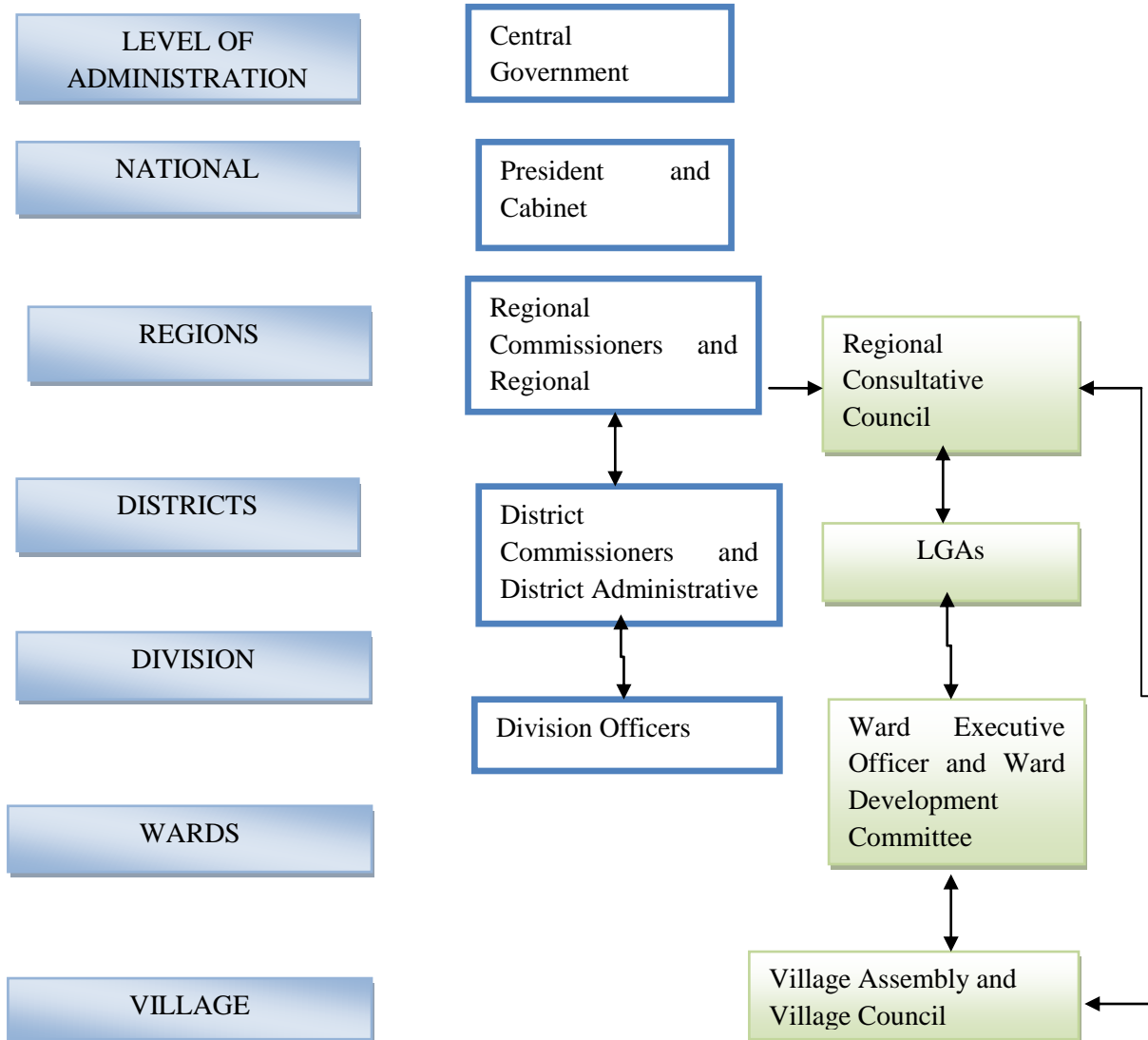
The study established that, the policy, legal and structural framework are the main cause of conflicting of roles and responsibilities among those levels implicating decentralisation initiatives. The study also realized that Tanzania Constitution and other laws do conflict hence indicating elements of a unitary state system which emphasizes on centralization of power, authority and responsibilities. Boyne (2007) argued that a unitary state system allows all the three organs to be governed as one single government. The political powers have been devolved to LGAs but the central government has powers to recall them and retain the same at the centre. The study in the analysis of legal instruments including the Constitution and Local Government Act Number, 7 of 1982 as amended by Act Number 13 of 2006, established that LGAs apart from being legal entities in their existence, constitutionally The President has discretion on their existence. The President as per constitution has powers to establish or abolish any office including LGAs. The study further found that The Minister responsible for Local Government Administration has powers over LGAs as he has been vested powers to accept or not to accept any proposal for establishment of new LGAs in Tanzania (URT, 1977;1982;2002).

This observation entails that initiatives to decentralize are farfetched and inherently affected by the institutional arrangements in the country. Most decentralisation reforms are either flawed in their institutional design or central governments do not decentralise sufficient power and resources to local level governments to enable them to have significant effectiveness on local service delivery (Conyers, 2007; Devas and Grant, 2003; Ribot *et al.*, 2006). Hope (2001) pointed out that in the context of the New Public Management, decentralisation should be seen as the means through which governments are able to provide high quality services that citizens value; increasing managerial autonomy, particularly by reducing central administrative controls. The study was able to establish that, The National Health Policy (NHP) on addressing decentralisation states that, '...at the Regional level, the Region will supervise health services at that level and below, including health care at the Regional Hospital, will also support the District on technical aspects and provide supervision being an extended arm of the Central

Government...'(URT, 2003). LGAs are under the Ministry of Local Government Administration but policies on health guidelines, standards and regulations are prepared by Ministry of Health, interpreted by the region level while implementation and their adherence is done at the level of LGAs.

The study also observed that Article 61(5) of the Constitution of United Republic of Tanzania and the Regional Administration Act Number 19 of 1997 give some overriding powers to Regional Commissioners to intervene the autonomy of LGAs in Tanzania (URT, 1977). The study considers this to cripple the efforts for effective and efficient decentralisation for improved health service delivery in rural Tanzania. (Figure 3) illustrates the structure of Government of Tanzania.

Figure 3: Structure of Government of Tanzania



Source: URT (2014)

8.5. Administration of LGAs and Its Implication on Health Service Delivery Rural Tanzania

Local government in Tanzania is a non-union matter; however it is enshrined in the Union constitution. The 1977 Constitution of the United Republic of Tanzania, Article 145(1) states that, '... There shall be established local government authorities in each region, district, urban area and village in the United Republic, which shall be of the type and designation prescribed by law to be enacted by Parliament...'. Article 145(2) states that, '...Parliament or the House of Representatives, as the case may be, shall enact a law providing for the establishment of local government authorities, their structure and composition, sources of revenue and procedure for the conduct of their business...' (URT, 1977).

Article 146.(1) points out that, '...the purpose of having local government authorities is to transfer authority to the people. Local government authorities shall have the right and power to participate, and involve the people, in the planning and implementation of development programmes within their respective areas and generally throughout the country..' (URT, 1977). In the spirit of the above, each local government authority has the following broad functions to perform:

- To perform the functions of local government within its area as defined.
- To ensure the enforcement of law and public safety of the people.
- To consolidate democracy within its area and apply it to accelerate the development of the people.

Besides the constitution, the legal framework of the local government comprises of eight sets of law enacted by Parliament and these are:

- The Local Government (District Authorities) Act, Number 7 of 1982, as amended by Act Number 13 of 2006.
- The Local Government (Urban Authorities) Act Number 8 of 1982, as amended by Act Number 13 of 2006.
- The Local Government Finances Act Number 9 of 1982, as amended by Act Number 13 of 2006.
- The Public Service Act Number 8 of 2002 as amended in 2008.
- The Regional Administration Act Number 19 of 1997.
- The Urban Authorities (Rating) Act, 1983, as amended by Act Number 13 of 2006.

Apart from the Constitution and parliamentary legislations mentioned above as the legal framework, the decentralisation process was guided by a government policy framework, which articulated the government vision 2025. The Millennium Development Goals on health. The National Health Policy also was one of the key frameworks which guided decentralisation. The National Health Policy and Tanzania Development Vision 2025 also identified Health as one of the priority sectors. Among its main objectives is achievement of high quality livelihood for all Tanzanians. This was expected to be attained through strategies, which will ensure realization of the following health service goals: which included access to quality primary health care for all and access to quality reproductive health service for all individuals of appropriate ages (URT, 2003).

The decentralisation policy, which was formulated and endorsed in 1996, had the overall objective of improving the delivery of services to the public. The main strategy to do so was to implement decentralisation. Similarly, the vision of the local government system in Tanzania is articulated in Local Government Reform Agenda 1996-2000 (URT, 1998;2007). The objectives to be achieved included;

The *raison d'être* for the devolution of roles and authority by the central government, and the existence of the local government, will be the latter's capacity and efficiency in delivering services to the people. Local government councils will be free to make policy and operational decisions consistent with the laws of the land and government policies without interference by the central government institutions.

The strengths and effectiveness of local government institutions will be underpinned by: The leadership of the local government authorities that will be chosen through a fully democratic process, which should also extend to village councils and grassroots organizations. Each local government will have roles and functions that correspond to the demands for its services by the local people, and the socio-economic conditions prevailing in the area. The structures of each local government will reflect the nature of its roles and functions.

The local government authorities will be transparent and accountable to the people. This will be the basis for justifying their autonomy from undue central government interference. Local Government leaders (councillors) and staff will adhere to strict code of ethics and integrity. In particular, leaders with incontestable ethical standards will be elected to champion the cause of people's development (URT, 1996). The Rural Local Government Authorities (RLGAs) in Tanzania as legal entities formed vide The Local Government (District Authorities) Act, Number 7 of 1982, as amended in 2006. These are the lowest or grass root governments where decentralisation effects are felt directly when assessing health service delivery.

The lowest level is the Hamlet (Kitongoji), which comprises of about 50 families. It is headed by an elected chairperson. The second level is the Village which is formed by four (4) to five (5) Hamlets (Vitongoji) with residents ranging from 250-500 households. The leader is an elected chairperson assisted by Village Executive Officer (VEO) who is an employee of the Council. The village Council (VC) is the

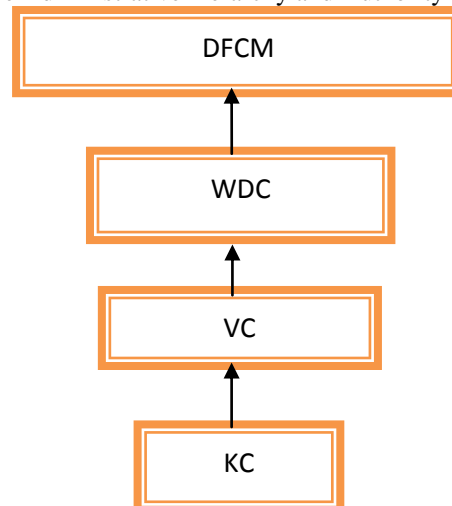
highest decision making body. This is the general meeting whereby all citizens aged 18 years and above with sound mind are allowed to attend and participate in decision-making. This structural framework is in line with the Constitution that recognizes the same age for one to participate in election and other decisions (URT, 1977;2007). During the study the selected LGAs had 59 villages for Urambo and 33 villages for Pangani.

The Ward level is the third of LGAs administrative structural system in Tanzania. During the study the sampled LGAs Urambo and Pangani had 15 and 14 wards respectively (URT, 2014). The Councillor as their representative represents the wards to the council. The councillor is also the chairperson of the Ward Development Committee (WDC) that makes critical decisions on development issues and administrative ones on behalf of citizens of the respective ward. The membership in the WDC is the Village Chairpersons, Ward special seats councillor(s), NGO representatives Ward Executive Secretary (WEO) as secretary (URT, 2007).

The study analysis through interview and documentary analysis established that WDC is a very critical and important unit in managing LGAs especially with regard to decision making related to public health concerns in rural areas. Pallangyo (2011) also observed that WDC have mandated functions to identify needs and priority for service needs and delivery in rural areas. Supervision of projects undertaken in their areas is another important function for WDC and monitoring of service delivery in their respective areas. The study through analysis of information obtained during the study established crystal clear that, health service plans and priorities to the Council are channelled through the WDC, hence competence and ability to articulate issues at this level relatively very crucial for meaning decentralisation. URT (2003) and Sikika (2013) also observed and noted that, health services delivery is among the priority services provided at district level and other levels (Villages and Wards) these include health centre and dispensary (the first entry point for a patient).

The fourth level of LGAs legal and administrative structure is the District Level which is formed as combination of all wards within the defined jurisdiction. A Council Chairperson elected among Councillors within the council heads this Level in rural authorities. Vice Chairperson and standing committees assist him/her. The District Executive Director (DED) is the Accounting Officer and secretary in the Full Council Meeting (DFCM). The study noted that the DFCM is the highest decision making body for LGAs as per Act number 7 of 1982 (URT, 1982). However, some key informants were sceptical and pessimistic that, the Central Government has in most cases changed the decisions made by the DFCM since there is low level of honouring priorities and plans from the LGAs. Analysis through secondary sources established that this issue is a fact due to unharmonized central local relations between the two tiers of Governments hence create autonomous LGAs (Hussein, 2013). The Administrative hierarchy and Authority flow in LGAs is clearly illustrated (Figure 4) below.

Figure 4. The Administrative hierarchy and Authority for Rural LGAs in Tanzania



Source: URT (2006)

Further analysis indicated that LGAs decisions on health service delivery theoretically are presumed to be made by the citizens in their respective localities. However the study analysis found that the plans and priorities in its originality seem to be inclusive and participatory but the implementation on the ground keeps on changing even without prior consultation with the citizens hence impairing meaningful

role of decentralisation for improved health service delivery. REPOA (2008) arrived on similar conclusions that the objective of decentralisation to create autonomous LGAs has not been achieved as the central government had powers to instruct LGAs functions administratively, financially and politically. Interviewees at village ward and district levels of the respective LGAs affirmed this. The Local Government Authority Act Number 7 of 1982 as amended in 2006 provides for the formation or establishment of Service Boards (SBs) at village and Ward levels, which include health issues (URT, 2007) and (URT, 1982). These Boards are open to the public whereas the principle is to empower citizens as members of the community to influence and hold officials accountable on service delivery.

The study through documentary analysis and interview found that most of the citizens do not attend such meetings and are not even aware on the roles and functions of such boards hence leaving the political leaders and technical staff to decide for them. The study further realized that such dilemma has negative consequences on access, quality, quantity and availability of health services in respective LGAs. The study also established from both councils of Urambo and Pangani that citizens sometimes do attend meeting but their level of participation is minimal. This explanation was also made clear above in the analysis of respondents' level of awareness and level of education, where majority had primary education of which affect their capacity to know, articulate issues and integrate the same in decisions affecting their lives including health services.

Citing an example of the Council Health Service Boards (CHSBs), COWI and EPOS (2007) found that despite their well elaborate roles and functions, most of them were not functioning properly and meet infrequently. This implies that CHMT members (agents) with little or no involvement of CHSBs, prepare council comprehensive health plans (CCHPs), the main planning framework for health interventions in LGAs with or without inputs from Community health boards. Boon (2007) Indicated that the government dominates selection of CHSB members and that community representative have no forum for consultation with their constituencies and have weak decision-making powers. Conyers (2007), on the other hand observed that, the effectiveness of management and user committees depends on their structure, composition, motivation and capacity of their members; and how they are linked to the local and national structures. In this case, the presence of committees and service boards does not appear to have any meaningful contribution towards improving public health service delivery in respective LGAs under decentralisation. Pablo (2010), in his analysis of the effectiveness of decentralisation and access to primary health observed that: if indeed a decentralisation process can produce larger positive effects on access to basic health services in developing countries of which Tanzania is of no exclusion, designing adequate decentralisation frameworks. This could help significantly in increasing the quality of life of their citizens through better access to services, which would together with other aspects, contribute to improve health outcomes of the population.

9. Conclusion and Recommendation

The study established that, the instructional characteristics impaired significantly the decentralisation initiatives for improved health service delivery in the rural areas in Tanzania. Institutional characteristics, legal frame work, systems and administrative structures were the main hindrance in the implementation of decentralisation for improved health services and its delivery. The institutional effects resulted to poor health service delivery infrastructures in terms of equipments availability, drugs and medicines, health workers, distance, delayed service, time management, lack of accountability and transparency. The study recommends a review of the existing legal frame, administrative systems, structures and processes. Efforts on resourcing, human resource capacity building and review the modals for decentralisation are also recommended.

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