More than a decade of decentralization in Tanzania: Its implications on Pro-poor service delivery. The case of primary education and health services

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Abstract- The paper investigated on an assessment of decentralization and its implication on pro-poor service delivery for primary education and basic health services for more than a decade ago. The services are delivered by the local government authorities, institutions that are closets to service beneficiaries.
The study relied on secondary data to assess decentralization and its impacts on pro-poor service delivery. Decentralization related documents were reviewed and documented to synthesize the implication of decentralization in service delivery.

It was noted that government of Tanzania has taken various notable steps to improve service delivery to beneficiaries. The steps included inter-aria:- amendment of the laws to incorporate decentralization aspects; establishment of opportunities and obstacles to development; a participatory planning methodology used by local government, abolishing school fees in primary education in order to enhance accessibility and affordability for all even the poor segment of the society and the exemption in health service provision for old people, expectant mothers and children aimed at pro-poor service delivery.

The study found that despite of the government's efforts to enhance pro-poor education and health services, yet achievements are far behind the expectations since there are no mechanisms to incorporate multitude community priorities into council plans. With limited own sources of revenue, primary education has quantitatively expanded although there is inability of taking care of physically challenged pupils, thus this increase illiteracy rate to pupils. Also exemption in health facilities has little impacts for poor people since medical supplies in government facilities are out of stock something which forces them to seek the service from private health facilities at market price.

On the basis of the above, the study concluded that although the government amended laws, established tools for community participation and made efforts such as abolishing school fees and exemption, yet education and health services are not much pro-poor service. In order to combat the situation the study recommended that the government should establish mechanism to ensure community plans are incorporated into council plans; enhance the availability of adequate local government own sources of revenue for provision of community felt needs; ensure both quantitative and qualitative improvement in service delivery and adequate availability of medical supplies in public health facilities.

Index Terms- Decentralization, implications and pro-poor service.

I. INTRODUCTION

Decentralization in its various forms is now a common feature of reform in both developed and developing countries. It is taken as a political strategy for improving service delivery. Factors triggering the introduction of decentralization differ from one country to another (World Bank, 1990). In some countries for example Pacific countries, decentralization resulted from demand of regional or local groups for increased local autonomy. In most of developing countries, it has been introduced as a result of pressure from the centre (Sohag, Wajidi and Miankhel, 2013, Kolehmainen-Aitken, 2004, Devas, 2005 and World Bank 1990).

Decentralization is highly linked with establishment of local government authorities which in most of the developing countries for example Tanzania, Kenya, Uganda and Zambia were for the first time introduced during the colonial time particularly in preparation for independence. The established local government based either in British or French local government model. It meant to facilitate the provision of certain services to respective communities.

In Tanzania, decentralization can be traced back during the British rule in which various efforts to establish local government were undertaken starting with introduction of self rule, Native authorities, municipal council and establishment of local government training school for training native authority workers and the councilors (Marx, 1991). The effort meant to provide room for indigenous participation in managing their fellow citizens and minimizing people's resistance to British rule.

The independent Tanganyika inherited the British colonial local government and made some changes from time to time. The changes included abolishing native authorities in 1963 and establishment of council and uniform election system for both rural and urban local governments (Warioba, 1999). Local Governments were officially abolished in 1972 as a result of its inability to provide services to the community. Decentralization by deconcetration was established in its place. In this context, planning and implementation of the development plans were executed by employees of central government allocated in regional and district level.

The current decentralization by devolution was introduced in 1990s after the re-introduction of local government authorities in 1983 and became operational in 1984 after the election of the councilors. It is a vehicle of reforming local government with the

focus to transfer some of political, financial and administrative powers to local government. It also, focused on changing central-local relation from that of command into negotiation between the two (United Republic of Tanzania [URT], 1998). Decentralization is meant to realize article 146 of the Constitution of United Republic of Tanzania of 1977. The article provides for the purpose of establishing local governments in the country, that is to transfer powers to the people and local governments are required to establish conducive environment for people's participation in planning and implementation of development plans (URT, 2008).

Decentralization by devolution focuses on service delivery improvement through addressing community felt needs reflected by affording them opportunities to participate in planning and implementation of development plans. It aimed at enhancing poor and vulnerable group needs to be addressed.

In order to realize the objective, the government amended laws to incorporate decentralization, established Opportunities and Obstacles to Development (O&OD); a community participatory planning methodology launched in 2006 and increased central government transfers. However, little is known on what are the implications of decentralization in pro-poor service delivery in the country. Therefore, the study intended to bridge this knowledge gap by reviewing and incorporating literature into the document.

1.1 Statement of the problem and Justification of the study

In order to assess implications of decentralization on pro-poor service delivery in Tanzania for a decade or so, a desk study was carried out focusing on primary education and basic health services in local government Authorities. There are five national policy priority areas in the country comprising of primary education, basic health care, water, road maintenance and agricultural extension services. Under decentralization system, actual delivery of these services is made by local government authorities. Out of the total budget of local governments, 70% is allocated for primary education and 18% allocated to basic health care and 7% allocated jointly to local road maintenance, water and agricultural extension services (Boex, 2003).

Primary education (70%) and basic health care (18%) are comparatively highly prioritized services on the ground that healthy and aware population is the basis for social and economic development (Tibaijuka, 1991). On the basis of the importance attached to primary education and basic health services in terms of their perceived impacts and significant allocation of the resources, the study dwell to examine implications of decentralization of these services to poor segment of the Tanzanian society.

For realization of the focus of the study, the following aspects were included: - community participation, accountability mechanisms to ensure service delivery reach beneficiaries and conclusion and recommendations.

II. Materials and Methods

The study relied on secondary data to assess decentralization and its impacts on pro-poor service delivery. Decentralization related documents were reviewed from various literatures and documented to synthesize the implication of decentralization in service delivery.

The study on implications on Pro-poor service delivery was limited to some *Mitaa* in Dodoma Urban where primary education and health centers were found. In order to supplement the secondary sources of data the study interviewed 5 MEO'S and Mitaa residents ranging between 567 and 574 to suit the purpose. The study area was selected because of data access, availability of data to meet objectives specified since primary education and health centers are scattered in almost all Dodoma Urban district.

III. Results and Discussions

Decentralization by devolution is a pro-poor strategy to improve service delivery in the country through improved community participation and enhanced accountability to ensure resources are efficiently and effectively spent to deliver public services. Local government authorities being the institution which are closest to service beneficiaries are expected to capture people felt needs in the respective plans and in turn people would demand quality service delivery from supply side. Therefore, in this part the emphasize is to analyze literature on both community participation and accountability mechanisms in local government authorities in the country and the implications of each of these in pro-poor service delivery for primary education and basic health services.

3.1 Community participation

Decentralization focuses on service delivery improvement particularly for the poor through community participation. It is expected to result from increased allocate efficiency by better matching public service provision to felt needs of the respective community (World Bank, 2001 and Antwi, Analoui and Cusworth, 2008).

The government of Tanzania came up with mechanisms and tools to enhance community participation. Legal frameworks were established to enhance decentralization and community participation in planning and implementation of development plans. It started with the amendment of the constitution of United Republic of Tanzania of 1977 to incorporate local government and decentralization. It provides peoples participation as a sine quo non condition for existence of local governments in the country; amendment of local government laws to incorporate Decentralization by devolution; preparation of local government bylaws which among others provide statutory meeting at grassroots levels and the use of Opportunities and Obstacles to Development (O&OD), an authorized community participatory planning methodology used by local governments in Tanzania (URT, 2003; URT, 2004 and URT, 2008). The statutory meeting and use of O&OD are important means through which community participation is made possible in the country. Therefore, in the next part of the paper analysis is made on how each of these contributes to community participation.

3.1.1 Opportunities and Obstacles to Development

O&OD methodology is an intensive consultative planning process that uses participatory tools to come up village/mtaa plan (URT, 2004). It is a participatory bottom-up planning in which community plans of either village or mtaa are compiled at ward level and later each ward submits its plan to form a part of the respective local government headquarter plan. It applies participatory tools including village maps; institutional analysis,

gender resource map, wealth ranking in a village and seasonal calendar to collect data for planning purposes. With jointly collected data, it enables the community to identify opportunities at disposal and obstacles for utilization of available opportunities. It enhances the community to forge mechanism of utilizing the available opportunities in overcoming the obstacles. Ideally, community Plans are to be incorporated into the LGA Plan, but no practical system to do so has been established. Since a typical rural LGA is composed of 60 to 100 villages, it is not difficult to understand the difficulty faced by the LGA officers to incorporate such plans (PMO-RALG, 2008).

Moreover, community participation is very minimal in both planning and implementation of development plans. For example table 1 show a summary of Mitaa Executive Officers' (MEOs) responses on the study conducted in 2008 regarding community involvement in preparing mitaa plans.

Table 1: MEOs' views on community involvement in planning process by percent

Response by MEOs	**Frequencies**	**Percent**
Non involvement in Economic, Planning and Finance Committee	4	80
Adequate involvement in Economic, Planning and Finance Committee	1	20
Total	**5**	**100**

Source: Field data, 2008

According to the study, 80% of *mitaa* executive officers argued that there was no involvement of people in the Economic, Planning and Finance process since there were no detailed *mitaa* plans and 20% of them had views that there were adequate involvement of people in the Economic, Planning and Finance process. Generally, findings correspond with the study conducted by Chaligha and colleagues (REPOA, 2005). They revealed that the depth of implementation of bottom-up planning in the studied council differed from one council to another. Also in most cases, it was undertaken by few experts who did not reach people (Ibid). They considered it to be top-down rather than bottom-up. Findings confirm that community involvement in preparing the *mitaa* plans was still minimal.

This can also be reflected by examining community identified priorities in planning process through the use of O&OD and the actual plan approved plan details. Table 2 summarizes the findings on community identified priorities in planning process through the use of O&OD.

Table 2: Residents' Priorities by percent

Response by *Mitaa* residents	**Frequencies**	**Percent**
Roads, trenches, nearby Health Centre and Markets	188	33.2
Reliable source of water	136	24.0
Building teamwork spirit in solving *mitaa* problem	18	3.2
Environmental cleanliness along the streets	9	1.6
Police Station and reduce price of commodities	33	5.8
Increase on the number of classrooms of Primary School	40	7.1
Employment and loan with soft conditions	74	13.1
Establishment of industries and centers for conducting business	33	5.8
mitaa leaders should apply participatory planning	15	2.6
Protection of women and children against thieves and rapists	21	3.7
Total	**567**	**100.0**

Source: Field data, 2008

According to findings on Table 2**,** 33.2% of respondents listed *mitaa* roads, trenches, nearby health centers and market to be priorities of their respective *mitaa*. But 24% of respondents pointed reliable sources of clean and safe water as their priority. Also, about 13.1% of respondents indicated the need for provision of employment opportunities and loan with soft conditions to *mitaa* residents to be among the *mitaa* priorities while 7% of respondent's added increase in the number of classrooms for primary school is priorities of their respective *mitaa*.

Basing in the findings on Table 2, it shows that construction of classrooms for secondary school was one of the major projects that were implemented at the ward level. Such findings reflect that council was not responding positively to residents' priorities. The findings concur with findings by Braathen and colleagues (REPOA, 2007). Moreover, the findings to some extent tally with grassroots views at the Zone workshop about poverty reduction that mentioned, among others, poor roads and lack of market to contribute to income poverty reduction in agricultural sector. Findings revealed that priority projects in *mitaa* were roads, trenches, nearby health centers, water sources and markets.

Table 3: Projects implemented as per *mitaa* Strategic Plans by percent

Table 3 presents summary of responses on the projects or activities implemented since 2006 to date as per *mitaa* plans.

Response by *Mitaa* residents	Frequencies	Percent
Not known	38	6.6
No project	258	44.9
Road, and trenches Maintenance	1	0.2
Construction of classrooms for Secondary School	202	35.2
Fish keeping	1	0.2
Refugee collection	44	7.7
Connection and payment of water bills for Primary Schools.	30	5.2
Total	**574**	**100.0**

Source: Field data, 2008

Findings on table 3 above shows that, 44.9% of the total respondents explained that there were no projects implemented as per *mitaa* plan. On the other hand 35.2% of them mentioned construction of classrooms for secondary schools as *mitaa* projects implemented for that time. Also, 0.2% of them confirmed that roads and trenches maintenance were the main projects implemented at that time. In addition, 0.2% of respondents added to the list fish keeping among the *mitaa* projects that were implemented during that period.

Furthermore, findings from documentary reviews provided that under the Local Government Capital Development Plan Indicative planning Figure, 50% of the Capital Development grant could be planned at the District/Urban council level and 50% of the remaining sums at the sub-district level, ward and village/*mitaa* (URT, 2004). However, additional findings through interviews with MEOs and WEO revealed that such plans were not implemented at the area. Respondents pointed further that formerly *mitaa* had no bank account, but in February 2008, municipal director directed *mitaa* to open bank accounts. Moreover, respondents argued that if such funds had been directed to meet residents' priorities as per guidelines, *mitaa* roads, trenches and nearby health centers would have been constructed and rehabilitated because they were residents' priorities.

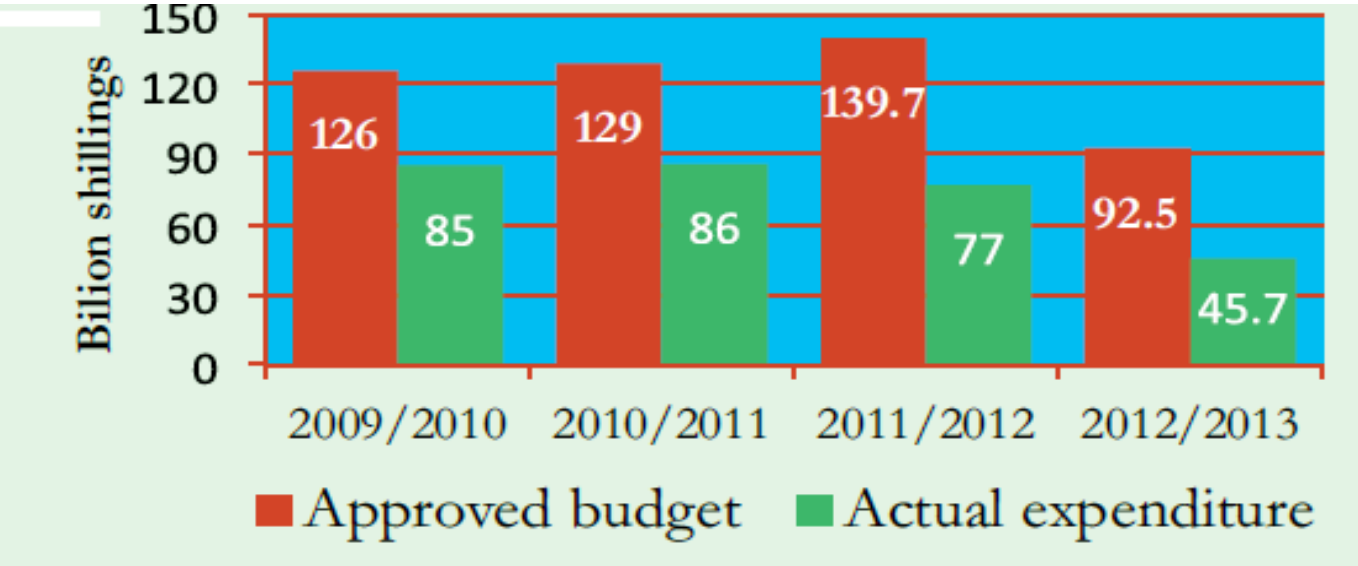
Study findings relates to those from the study conducted by Fisher (2007) who argued that key forest management objectives in the study area were always set by Government or bureaucracy. Thus, local community participation tended to be limited (Ibid).
On the basis of the findings, the study substantiates that there are insignificant number of projects implemented at *mitaa* level and most of them result from the council's plan. The council was not positively responding to the residents' needs.

IV. Education Service

Since 2001, Tanzania relying on the National Education policy of 1995 has been taking major strides to revamp its primary and secondary education sectors. The Primary Education Development Plan (PEDP, 2002-2006) and the Secondary Education Development Plan (SEDP) implemented starting in 2004 led into significant improvements in provision of basic education in the country. The plan focuses to realizing goal 2 of Millennium Development Goal which aims at Universal primary education by 2015 (UN, 2013). In attempt to realize it and make primary education pro-poor, the government abolished both primary school fees and contributions.

As a result, quantitative improvement of primary education is reflected by increased Net Enrolment Rate (NER) from 66% in 2001 to a peak of 97% in 2007 and 2008. Overall, gender parity in access to primary education has been achieved. However, since 2008, the NER has steadily declined to 94% in 2011 (URT, 2011). Moreover, budget allocation for the service increased from year to year. However, the challenges rest on the under spending of the allocated funds. The red bars in figure 1 shows the allocated budget and the green ones show the spent budget (Policy Forum, 2013). The under spending is a common phenomenon in all four years implying failure to achieve the set targets and it is a reflection of lack of accountability mechanisms.

Figure 1: Allocations versus expenditure development budget of education from 2009/2010-2012/2013



Source: Policy Forum, 2013

However, quantitative expansions do not match with qualitative improvements. For example, a large-scale national survey conducted in 2011 revealed alarmingly poor numeric and literacy skills among primary-aged children. The findings indicated an urgent need to improve the quality of tuition, which in turn, will depend on the increased and equitable deployment of qualified teachers and resources to all areas of the country (URT, 2012). The other problems associated with the quality of primary education were identified by Uwezo Tanzania including: - inability to read in both Kiswahili and English language; inability to solve basic mathematics and frequent absence of teachers from work. For example the findings highlighted that only 3 in 10 standard three pupils can read basic story in English and Kiswahili and only 3 in 10 standard 3 pupils can solve basic mathematics. Laddunuri (2012), although his conclusion of the study highlighted factors hindering improved performance in secondary education, some of them also affect primary education. Such factors include:- inadequate facilities and inadequate of qualified teachers.

In 1994 the Tanzanian Government ratified the Salamanca Statement. The statement emphasizes the need to provide children with special needs basic education, and sees this as an indispensable step to reach the goals set at the first Education for all (Krohn-Nydal, 2008) .However, there are immense challenges remained un tackled to make education inclusive to physically challenged pupils. Tanzania disability survey as quoted by URT (2012) found that 41.7% of people with disabilities had no formal education compared with 23.5% of individuals without disabilities. The rate of illiteracy among disabled Tanzanians was 7.6%, almost double the proportion among non-disabled Tanzanians. The disparity in primary-level education was less marked; 49.4% of people with disabilities had attended primary school compared with 59.2% of people without disabilities.

Tanzania Disability Survey (2008) highlighted inhibiting factors for pupils with disability to enroll and sustain ably continue with education in the country. The factors included: - household chores facing children; inability to meet expenses related with schooling and negative attitude towards education. Moreover, Krohn-Nydal (2008) noted some challenges facing inclusive primary education in Tanzania include: - Inadequate training provided to teachers on inclusive education; inadequate support from government for acquisition of important facilities; lack of transport to disabled children (some of them due to the type of disability need assistance to reach both school and home); lack of food for pupils and unfriendly infrastructures like classrooms and toilets.

V. Health Service Delivery

Health services delivery is among the priority service next to primary education in terms of budget allocation. URT (2003) and Sikika (2013) provide that district health services and other levels of it are provided by district council. The other levels of district hospital include health centre (first referral level) and dispensary (the first entry point for a patient). Health service provision is emphasized on the ground that good health is a major resource essential for poverty eradication and economic development. Health services refer to both curative and preventive services.

The provision of health services in the country is guided by the National Development Vision 2025 which in this area focus is directed to accessibility of primary health care; access to quality reproductive health care and reduction of infant and maternal mortality rate (URT, 1995). Moreover, Tanzania has adopted Millennium Development Goals to improve health service delivery. Goal 4 focuses on reducing child mortality; goal 5 concerns the improvement of maternal health and goal 6 focuses on combating HIV/AIDS, malaria and other diseases (MDGs, 2013). The government incorporated these three goals into the targets of the National Strategy for Growth and Reduction of poverty for operationalizing purposes. More

specifically, the targets focused on:- reduced child (under five) mortality from 154 in 2008 to 79 in 2010 per 1000 live births; reduced infant mortality from 95 in 2002 to 50 in 2010 per 1,000 live births and reduced maternal mortality from 529 in 2008 to 265 in 2010 per 100,000 live births (URT, 2010).

The country provides exceptions to the vulnerable groups to ensure accessibility of health services to the poor people. This includes children, expectant mothers and old people (URT, 2013). However, this might not mean accessibility of the services to vulnerable groups because in most cases essential drugs are out of the stock and then they are bought from private hospitals and pharmacy. Sikika (2013) emphasizes on this by pointing out that in Tanzania essential medicines, medical supplies and equipment are poorly available in most of the public health facilities, leading to unnecessary suffering and even deaths of innocent citizens.

The results of evaluation of implementation of MKUKUTA targets show among other things that:- infant and under five year mortality rate have dropped by 45%, from 147 deaths per 1,000 births in 1999 to 81 deaths per 1,000 births in 2010 (MKUKUTA target for 2010 was 79); infant mortality rate decreased from 99 to 51 deaths per 1,000 births over the same period (only marginally missing the MKUKUTA target of 50); and marginally reduction in maternal mortality rate from 578 per 100,000 live births in 2008 to 454 deaths per 100,000 in 2010 (missing MKUKUTA target of 193 deaths per 100,000 live births).

From the evaluation of implementation of MKUKUTA targets, the government has a long way to go to achieve reduced maternal mortality rate, the section of the society that is conceived as marginalized ones. There are immense factors inhibiting reduction of maternal mortality rate in the country. One of these factors is inability to attend health facilities for birth service. **Figure 2** provides a summary of births attended in Health facilities by region.

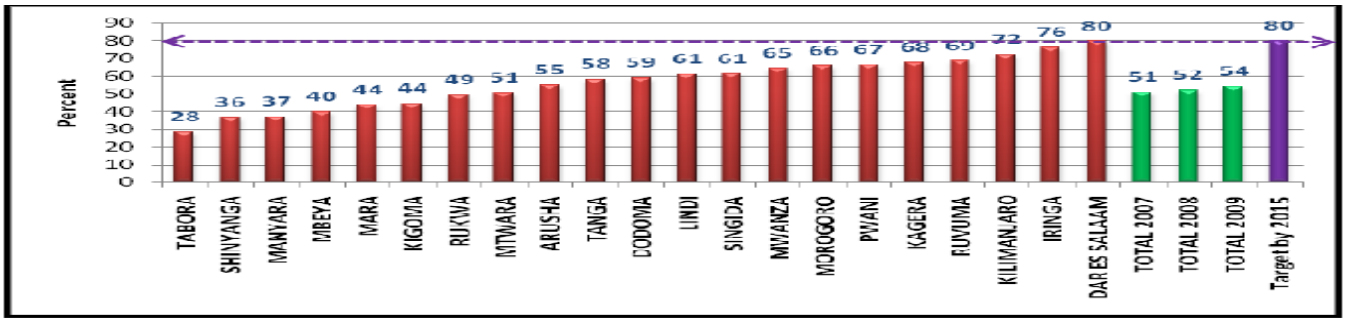


Figure 2: Births Attended in Health facilities by region
Source: URT, 2010:16

From figure 2 above, Tabora region has the lowest level of births attended by health facilities (28%) followed by Shinyanga region (36%). It implies that 72% of births in Tabora and 64% of births in Shinyanga are attended by traditional midwives or through self help initiatives. This is highly associated with high maternal and infant mortality rates as it is difficult to deal with complicated cases of pregnancy in general and delivery in particular. This in turn results into higher maternal mortality rate. Dogba and Fournier (2009) confirms this by estimating that there are 529, 000 annual maternal deaths worldwide, 99% of them occur in developing countries, making maternal mortality a major health and development challenge. Moreover, among women who avoid maternal death, approximately 10 million suffer from complications related to pregnancy and childbirth. The risk of dying during pregnancy is 1/6 in the poorest countries compared with 1/30 000 in Northern Europe.

There are statistically correlations between low births attendance in health facilities and high maternal mortality rate. Figure 3 below shows some of these correlations.

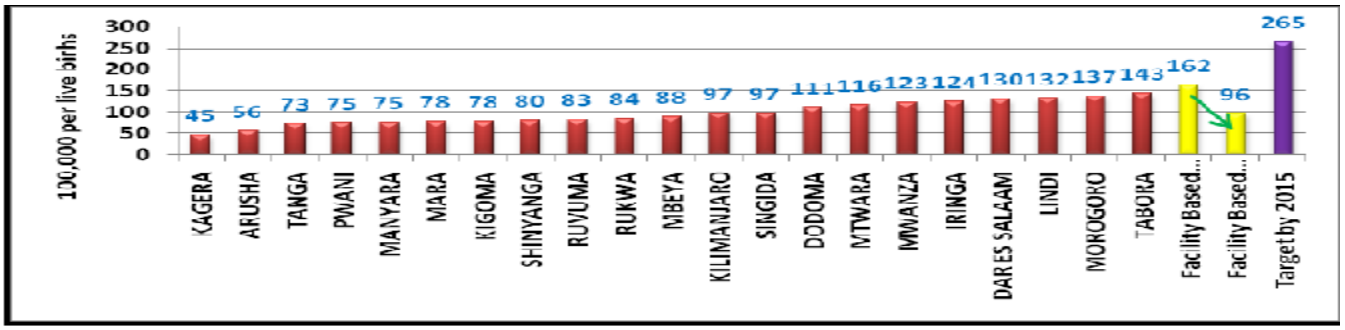


Figure 3: Maternal mortality ratio by Region
Source: URT, 2010:10

In figure 3 Tabora region register highest mortality rate followed by Morogoro and Lindi regions. However, no explanations are provided on why Shinyanga region does not register higher mortality rate because it has low births attended in health facilities. Implied it might mean that there is a problem of poor records regarding maternal death. That means many maternal deaths go unrecorded.

According to Human resources for health (HRH), a crisis which has grown into common phenomenon in the sector is highly associated with maternal deaths. URT (2013) points out that HRH crisis is recognized as a major impediment to achieving Millennium Development Goals (MDGs), particularly those related to maternal and child health (URT, 2013).

Other associated problems regarding low birth attendance at health facilities include: - distance from home place to health facilities; taboos or traditional practices related to pregnancy and childbirths; unsatisfactory health services (abusive language by Health workers) habits and inability to afford transport cost (Semfukwe, 2008). Moreover, unfriendly services due to bad behavior of healthcare provider, presence of traditional birth attendants, and only one had no anybody to escort her to health facility were identified as inhibiting factors for births attendance at health facilities (Samson, 2012).

VI. Conclusion and Recommendations

On it's side Tanzanian government has made notable efforts to provide improved social service delivery to the poor by amending laws, transferring powers to local government authorities, establishing opportunities and obstacles to development, abolishing school fees in primary education and exempting old people, expectant mothers and children from health cost sharing. However, there are numerous challenges which hampered pro-poor service delivery. The challenges includes, inability of councils to incorporate community based plans with multitude felt needs; inadequate councils' own sources of revenue; quantitative expansion of primary education accompanied by dropping down literacy rate, inability of education sector to establish adequate friendly infrastructures for physically challenged children; inadequate medical supplies in public heath facilities and exemptions for cost sharing in health services become meaningless as the poor people get the same in private health facilities at market price.

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