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Special Paper No. 06.20

Service Delivery in Tanzania: Findings from Six Councils 2000-2003

Einar Braathen

Geoffrey Mwambe

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Abbreviations

ABC	Abstain, Be faithful, Condomise
AFREDA	African Relief and Development Consultancy
AIDS	Acquired Immune Deficiency Syndrome
ALAT	Association of Local Authorities of Tanzania
AMREF	African Medical Research Foundation
BAKWATA	The Muslims' Council of Tanzania (*Baraza Kuu la Waislamu Tanzania*)
CBO	Community-Based Organization
CC	City Council
CCBRT	Comprehensive Community-Based Rehabilitation in Tanzania
COM	Community/Citizens/Users
DC	District Council
DMO	District Medical Officer
FARAJA	NGO. Trust fund for women's development
FASCO	CBO in Bagamoyo working on sexually transmitted diseases
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
JUHUDI	CBO/youth group in Iringa
KIWAKKUKI	Kilimanjaro Women Group in the Fight against HIV/AIDS (*Kikundi cha Wanawake cha Kupambana na Ukimwi Kilimanjaro)*
KIWOHEDE	Kiota Women's Health and Development Organization
LG	Local Government
LGAs	Local Government Authorities
LGR	Local Government Reform
LGRP	Local Government Reform Programme
MACDA	Marangu Community Development Association
MC	Municipal Council
MKUKI	The AIDS control programme in Moshi (*Mradi wa Kudhibiti Ukimwi Moshi)*
NGO	Non-Governmental Organization
NORAD	The Norwegian Agency for Development Cooperation
OC	Other Charges
O&OD	Opportunities and Obstacles to Development
PE	Personal Emoluments

PEDP	Primary Education Development Plan
PO-RALG	President's Office - Regional Administration and Local Government
PRSP	Poverty Reduction Strategy Paper
PSSS	Policy and Service Satisfaction Survey (REPOA) 2003
SAKUVI	Help to Control HIV/AIDS in Rural Areas (*Saidia Kudhibiti Ukimwi Vijijini*)
SHA	Self-Help Activities
SOCAC	CBO in Bagamoyo
SP	Service Provider
TAHEA	Tanzania Home Economics Association
TANESA	Tanzanian Essential Strategies Against HIV/AIDS
TASAF	Tanzania Social Action Fund
TUSHIKAMANE	CBO in Kilosa dealing with HIV/AIDS control matters
UMATI	Reproductive and Family Care Association in Tanzania (*Uzazi na Malezi Bora Tanzania)*
WDC	Ward Development Committee

PREFACE AND ACKNOWLEDGEMENTS

As a part of its support to the Local Government Reform Programme (LGRP) in Tanzania, NORAD is financing a Formative Process Research Project to closely follow the development of the LGRP. The aim of formative process research is to provide stakeholders with useful data and analysis of a change process (e.g. the LGRP) while in operation. In consultation with the President's Office Regional Administration and Local Government (PO-RALG), the project has been organised on the basis of institutional collaboration between Research on Poverty Alleviation (REPOA), Dar es Salaam, Chr. Michelsen Institute (CMI), Bergen, and the Norwegian Institute for Urban and Regional Studies (NIBR), Oslo. The project has been conducted over the four-year period of 2002-2005.

This report provides the baseline for the main theme on 'Service delivery and poverty alleviation'.

Special thanks to Siri Lange (CMI), Ambrose Kessy, (UDSM/REPOA), Florida Henjewele (REPOA) for inputs and excellent cooperation during data collection, and to an anonymous reviewer for constructive comments on an earlier draft. Finally, I am grateful to Berit Aasen (NIBR) for editorial and other support.

Points of view and any remaining errors can be attributed to the author.

Einar Braathen

Oslo, August 2006

EXECUTIVE SUMMARY

An overarching objective of the Local Government Reform Programme (LGRP) in Tanzania is to restructure Local Government Authorities (LGAs) so that they can "*respond more effectively and efficiently to identified local priorities of service delivery in a sustainable manner*". This includes more specific objectives, such as to "*improve quality, access and equitable delivery of public services, particularly to the poor*" and to "*increase civil society participation in service provision*". This report analyses data on service delivery with regard to performance and change processes from 2000 to 2003.

The data was collected from six councils that have been selected as 'case councils' for the formative process research on the Local Government Reform Programme: Ilala Municipal Council, Mwanza City Council, Iringa District Council, Moshi District Council, Kilosa District Council, and Bagamoyo District Council. No pretension is made that the six are fully 'representative' of the 114 local councils in Tanzania.[1] However, the six councils should depict some of the vast differences between the councils across the country. When this report claims to identify certain common features across the six councils, or across the four rural district councils, it is assumed that these features are shared by a large majority of Tanzania's local councils.

Chapter 2 provides an **overview of service delivery** in selected councils. Over half (54 %) of all respondents in the 2003 Citizens' Survey Citizens' Survey, (1,260 respondents in total; being 210 respondents in each case council), had seen general improvement in local government service delivery over the last two years. The variations between the six councils were quite large. Mwanza and Iringa stood out with more than 60 % of citizens seeing improvement, and less than 10 % thinking service delivery was 'worse than before'. In Ilala and Bagamoyo, 44-48 % of respondents saw improvements, while about 25 % thought service delivery was worse than before.

Primary education stood out as the only service rated as satisfactory by a majority of the respondents. **Primary health** (dispensaries) received the second highest rating. This was the picture in all six councils. For all other services, the satisfaction rating was much more mixed, with significant variations between councils. The respondents in all six case councils were definitely least satisfied with agricultural extension services and garbage collection. **Water supply** is the service that most citizens wanted to see improved in all six councils. However, the councils' own priorities with respect to service delivery diverted in general substantially from the citizen's priorities. For example, none of the case councils spent more than 2 % of their total expenditures on water supply. This indicates that a functioning participatory, bottom-up, and cross-sector planning system for service delivery had not yet been realised.

Chapter 3 presents official data, the results of the Citizens' Survey, and the authors' own judgments of **performance in key service areas.** In **primary education** there was an immense growth in school enrolment from year 2000 to 2003. Enrolment was close to 100 % in all six case councils. This success can be attributed to the abolition of school fees in 2001, and the introduction of the Primary Education Development Plan (PEDP). The pass-rate also increased in all the case councils, although a majority of the grade/standard 7 pupils were still (in 2003), failing to pass. There were some clear signs of progress in the quality of education – measured by indicators, such as pupils per classroom, pupils per desk, and pupils per textbook. However, the main quality indicators, such as pupils per teacher and share of qualified teachers, did not show progress for many of the councils.

[1] There were 114 councils in 2002 when the six case councils were selected. The number of councils is expected to increase to 117, with three urban councils (Kibaha TC, Korogwe TC and Babati Council) recognised ahead of the general and local elections on October 30, 2005.

The lack of (qualified) teachers threatens the sustainability of education reform, and tends to widen the gap between 'advanced' councils and those lagging behind.

In **basic health services**, significant progress was reported from all six councils regarding the public health situation. The infant mortality rate decreased, and the immunisation rate rose to well above 80 % in all councils. Problems existed, however, linked to the health facilities (dispensaries and health centres). Although there was progress in accessibility from year 2000, around one-third of the population in Iringa, Kilosa and Bagamoyo was still without access to health facilities in 2003. Although there were improvements in the number of health workers (nurses) and average waiting times for patients at dispensaries, the problem of affordability made the majority of the population dissatisfied, more so with the health centres than with the dispensaries. People saw that drugs and medicines were more available in the private and non-government facilities, but only for those who could afford them. People had to pay user fees or Community Health Fund contributions to government health facilities – where the quality of services still left a lot to be desired.

Regarding **domestic water supply**, no significant progress was reported on accessibility with the exception of Mwanza CC. In three of the six councils, around half of the population was not covered by adequate water supply services. It is likely that these were overestimates. Data on the quality of services was also in short supply. Thus, it is not surprising that citizens' gave top priority to improved water supply, as reflected in the citizen survey presented in chapter 2.

In attempting to make an overall account of the performance in the three key service sectors, we used two criteria: first, the (self-) reported improvements from 2000 to 2003 and, second, the prior level of accessibility or quality of the service. There were substantive differences between the case councils. In the 'rural council' category, Iringa was ranked number one, followed closely by Moshi DC. However, Kilosa DC and Bagamoyo DC were the low performers of our sample. As to the urban councils, there were too many contradictions in the data sets – for example, between citizens' perceptions and official representations – to rank their performance. Since comparable data from Ilala MC were missing, it was equally difficult to assess the improvements and 'average ranking' of each urban council.

Chapter 4 discusses **technical and political factors in local service delivery**. To change and improve the current service delivery systems, certain resources need to be mobilised to build new and cooperative capacities. To facilitate the analysis, we examined:

- the service providers and mobilisation of their professional resources and capacities in processes of capacity-building, i.e., the technical factors in service delivery; and
- the citizens (users) and mobilisation of their popular resources and capacities in processes of empowerment, i.e., the political factors of service delivery.

The **Government** – through the Local Government Reform Programme – has a role in promoting both technical and political factors in local service delivery. In regard to the increased primary school enrolment, the citizens perceived the government (and thus political factors) to be most important. The government abolished school fees, and sensitised and mobilised people. As to the citizens themselves, the Citizens' Survey indicates good participation in user committees (28 % in school committees and other local bodies (17 % in village/ward/council leadership). These figures suggest a more people-driven and decentralised system for service delivery should be a key to the future LGRP agenda.

The planning documents and interviews from the case councils did not reflect any consistent or clear definitions of poverty. There were only vague definitions of 'the poorest-of-the-poor', and there were no coherent anti-poverty strategies. Moreover, the emphasis was on '*equitable delivery of public services*' (emphasis added, Ed.) rather than 'services particularly to the poor'. There was an emphasis

on social-reproductive services rather than on economic-productive services, such as support for the reorganisation and revitalisation of the agricultural sector, which surveyed citizens found in a dismal state. Another dimension of anti-poverty work is to make the whole planning system a participatory-democratic one.

Three challenges in the set-up of this planning system could be mentioned:

i) to make it really participatory,
ii) to make it bottom-up & relevant, and
iii) to make the reformed service delivery system truly pro-poor.

The way these challenges are met depend much on the influence and vested interests of non-governmental organisations (NGOs) and community-based organisations (CBOs), as well as the role of self-help activities (SHA) in poverty reduction.

As to anti-HIV/AIDS work, the surveyed citizens reported that they were well informed by multiple national and local sources. In 2003, guidelines for forming AIDS Committees were circulated to all local councils from the President's Office for Regional Administration and Local Government (PO-RALG). Within a few months these committees had been established at the council level, and even at the ward level in Moshi DC and Mwanza CC. These two councils were identified as 'the high prioritisers' of anti-HIV/AIDS work. Ilala MC and Bagamoyo DC were 'medium prioritisers'. Iringa DC and Kilosa DC were 'low prioritisers'. The latter two district councils were also singled out as 'low performers' in the researcher's judgment of technical, or operational, characteristics of anti-HIV/AIDS intervention. The other four councils were classified as 'medium performers'. Much remains to be done even in the local councils with proven dedication to the struggle against HIV/AIDS.

In chapter 5, it is concluded that local service delivery in Tanzania has improved, but the citizens are still dissatisfied with the accessibility, quality and affordability of public services. The exception is primary education, where progress, comprehensive community involvement, and citizen satisfaction seem to coincide. Future research should examine more closely the relationships between public policies, governance, the state of finances and financial management, and the performance of local service delivery.

1. INTRODUCTION

1.1 Research on Local Government Reform in Tanzania

An overarching objective of the Local Government Reform Programme in Tanzania is to restructure Local Government Authorities so that they can "respond more effectively and efficiently to identified local priorities of service delivery in a sustainable manner". This includes more specific objectives, such as to "improve quality, access and equitable delivery of public services, particularly to the poor" and to "increase civil society participation in service provision".[2]

The aim of the Formative Process Research Project is to closely follow the development of the LGRP, and to provide its stakeholders with useful data and analysis while the LGRP is in progress. The major focuses of the research project are to observe changes in local authorities' provision of basic services to the public, and to analyse changes in local authorities' capacity for financial management and revenue enhancement. Both sets of changes relate to governance. The project is based on the assumption that the following three broad dimensions of the local government reform are interdependent:

i) Governance: local autonomy, citizen participation, council planning, and principles of good governance like democracy, bottom-up participatory planning, transparency, responsiveness of local government, and respect for human rights.
ii) Finances and financial management: accountability, efficiency, and local resource mobilisation.
iii) Service delivery and poverty alleviation: criteria of success and operational constraints.

This report analyses data on service delivery and poverty alleviation from 2000 to 2003. The emphasis is on describing the situation at a certain point of time, in line with the baseline approach. However, much of the description is based on citizens' perceptions of performance and changes in service delivery, thus leading to a more evaluative analysis.

Therefore, the overview of service delivery in the six councils in **Chapter 2** is constructed on the basis of a Citizens' Survey. This is complemented by, and compared with, official statistics on the education, health and water sectors in **Chapter 3**. The three sectors are selected because of their size (in the local service delivery machinery), their centrality in poverty reduction, and their importance to the citizens' life (as confirmed in the survey). Moreover, the data collected from the education sector, and to some extent from the health sector, seem to be more reliable than data from other sectors. This is partly due to the assignment of these sectors to specialised staff in every council. Data from the water sector are more difficult to examine, as will be discussed. However, we build on a special study carried out in Kilosa DC and Moshi DC to validate data for the water sector.

Moreover, given the aim of establishing 'criteria of success and operational constraints' in service delivery, certain aspects of governance and resource mobilisation are brought into the analysis. These political and technical factors provide key inputs, as well as constraints to service delivery performance. Transcending the sector-specific services, **Chapter 4** addresses some extraordinary types of 'service' or 'welfare delivery': anti-poverty and anti-HIV/AIDS work respectively. They demand urgent, cross-sector and public/civic co-operation. Deemed as critical cases, they provide indicators of councils' capacity for innovative and socially inclusive action. In addition, to reflecting the situation and changes during the period 2000-2003 in local government action, they also reveal some of the technical and political factors determining the performance of local service delivery.

[2] URT, 2002. The Local Government Reform Programme Mid-Term Plan and Budget

Although this report does not aim to explore causalities, it is hoped that it generates ideas for further analysis of processes of change in local service delivery. **Chapter 5** provides some conclusions.

1.2 The Six Case Councils

The data was collected from six local councils. Half of the case councils – Ilala Municipal Council, Mwanza City Council and Iringa District Council – have formally taken part in 'Phase 1' of the LGRP. The other three councils are Bagamoyo District Council, Kilosa District Council and Moshi District Council (see Figure 1.1 for locations of councils in Tanzania). No pretension is made that the six are fully 'representative' of the 114 local councils in Tanzania. However, the six councils should depict some of the vast differences between the councils across the country.

The case councils were selected on the basis of the following criteria (see Formative Process Research on The Local Government Reform in Tanzania (2002). *Inception Report*):

- variations in resource bases,
- rural-urban variations,
- degree of inclusion in the LGRP,
- degree of donor presence or support, and
- composition of political parties.

The rationale for including councils that were not part of phase 1 of the LGRP (i.e., Bagamoyo DC, Kilosa DC and Moshi DC), was to establish the extent to which changes occurred even without the incentives of the reform. In other words, the research sought to identify, through the method of individualising or contrasting comparison, reform or change agents that are located at the local level or in other sectors than those driving local government reform (LGR).

Bagamoyo District Council

Bagamoyo is one of Tanzania's oldest towns situated 80 km north of Dar es Salaam in the Coast Region, along the Zanzibar Channel. The total area of the district is 9,842 square kms. Its population in 2002 was 230,000, comprising predominantly agriculturalists.

Ilala Municipal Council

Ilala is one of the three municipal councils within Dar es Salaam City Council. Main economic activities include manufacturing industries, services, trade and agriculture. The total area of the municipality is 210 square kms, of which 20 % is rural area supporting agriculture. Its population according to the 2002 census (URT, 2003a) was 638,000.

Mwanza City Council

Mwanza is Tanzania's second largest city, 1,100 m above sea level, on the southern side of Lake Victoria in the northwest of Tanzania. It has fishing and other industries, but agriculture remains the most important economic activity. The total area of the city is 1,342 square kms, of which 900 square kms is water. Its population in 2002 was 266,000.

Iringa District Council

Iringa lies 1,600 m above sea level in the Southern Highlands, along the main highway between Morogoro and Mbeya. It has experienced a substantial growth in agricultural production in recent

years. The majority of the population (95 %) have livelihoods based on agriculture. Iringa Town has a separate municipal council, while the surrounding area is organised in Iringa District Council. The total area of the district (before it was split into two districts in 2004) was 28,457 square kms, and its population in 2002 was 246,000.

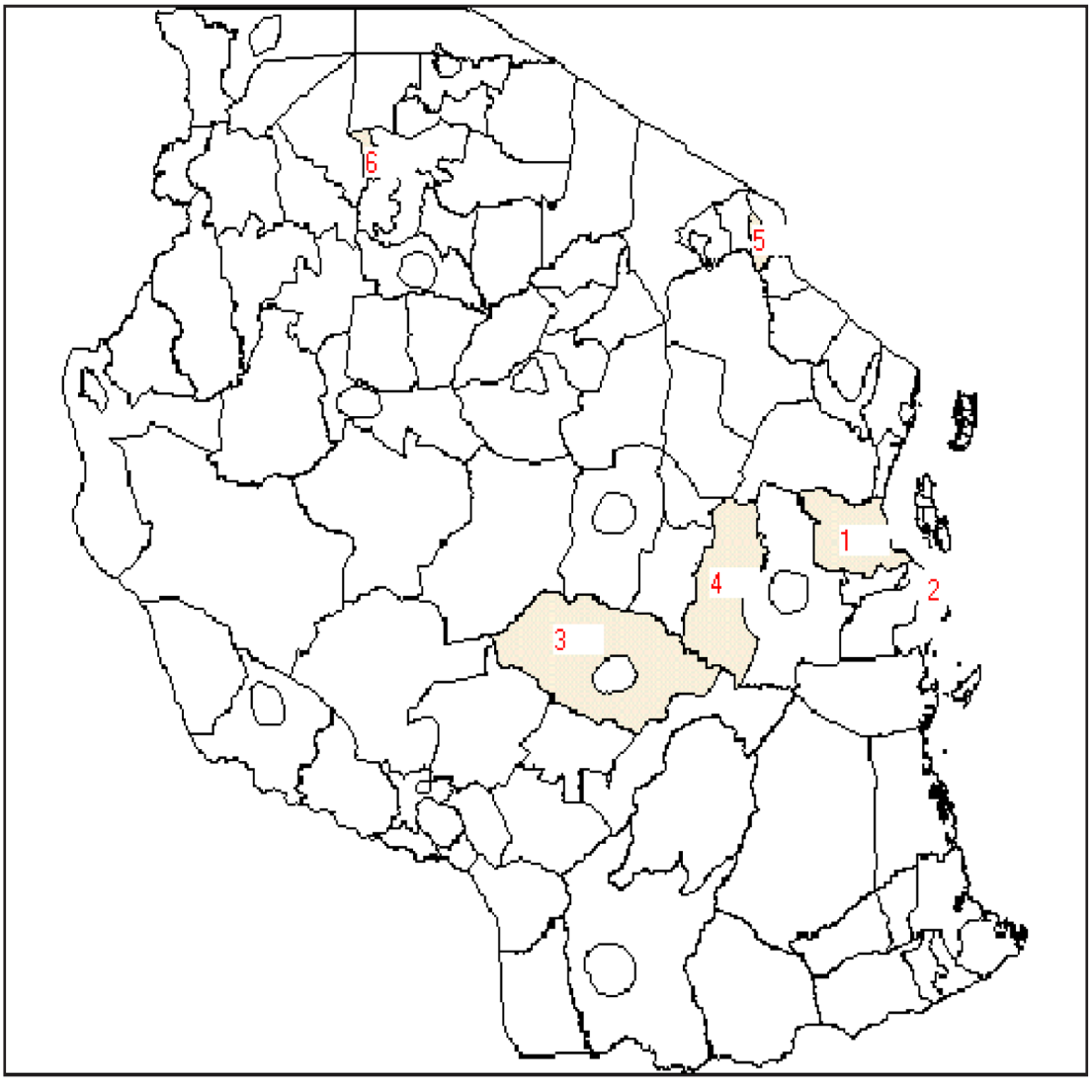
Kilosa District Council

Kilosa lies in the Morogoro Region, 220 km west of Dar es Salaam. It was a centre for Tanzania's sisal industry until this industry collapsed in the 1970s. Central parts of Kilosa DC are economically depressed due to collapses in the sisal industry, and more recently, in the sugar industry, while areas located near the main roads to Dodoma and Iringa have experienced increasing economic activity. Total land area is 14,245 square kms. In 2002, its population was 490,000.

Moshi District Council.

Moshi is located about 800 m above sea level at the foot of Mt. Kilimanjaro in the north of the country. Moshi Town has a busy tourist industry and is the centre of one of Tanzania's major coffee growing areas. However, there has been a sharp decline in the revenues from coffee exports in recent years due to falling prices. Moshi Town has a separate municipal council, while the surrounding area is organised in Moshi District Council. The area of the district council is 1,713 square kms, and its population in 2002 was 402,000.

Figure 1. Map of Tanzania Showing the Six Case Councils



Key:

1. Bagamoyo DC
2. Ilala MC
3. Iringa DC
4. Kilosa DC
5. Moshi DC
6. Mwanza CC

1.3 Methodology

To establish the baseline for this study, data collection is linked closely to indicators of change induced by the LGR. These indicators are based on a set of common data (at council, ward and village level) that is easily accessible, easily compiled, and easily maintained for all case districts over time. Priority is given to data needed for comparison of impacts and effects across districts and over time. In essence, a small, common database is developed for all case councils.

The baseline provides a reference point for the situation in the case councils with respect to the three main themes until the end of 2003. A new comparative study of changes will take place in November 2006 to cover subsequent years.

The baseline data are derived on the basis of a combination of quantitative and qualitative methodologies:

- Citizens' Survey comprising 1,260 respondents in total; 210 respondents in each case council (conducted in October 2003).
- Quantitative secondary data, or administrative data, collected in the case councils and from PO-RALG (URT, 2003b, and URT 2003c).
- Quantitative (secondary) data submitted by contact persons in the case councils.
- Qualitative research in each council, ward and village designed especially to examine events of change due to the LGR (see the Formative Process Research on the Local Government Reform in Tanzania (2003). *Fieldwork Manuals* for details on key informers interviewed).

Collecting data on service delivery confronts a key structural weakness that the Local Government Reform Programme in Tanzania is supposed to address: basic capacity in record keeping, compilation of data, and mechanisms of feedback on performance in service delivery. The six case councils, or their service delivery sub-sectors, have different capacities in this regard. Thus, there are weaknesses in the quality of the quantitative secondary data (or administrative routine data) presented. The validity of data needs to be continuously questioned.

The Citizens' Survey conducted in October 2003 (Nygaard and Fjeldstad, 2003) stands out as the most coherent source of comparative analysis of service delivery. It benefited from the questionnaire developed by the Policy and Service Satisfaction Survey – PSSS (REPOA 2003). The rationale for using some common questions in different surveys is precisely to compare findings between surveys. The PSSS is a national survey with results disaggregated by DSM/other urban/rural and by the gender of the head of household. The aggregate results are weighted to give an approximate 'national' picture. As such, it provides a good basis for comparing findings from the Formative Process Research Project.

The Poverty and Human Development Report 2005 (URT, 2005) provides a comprehensive overall picture of the changes in income and non-income poverty since 2000, combining data from the Household Budget Survey 2000/01, the national population census 2002 and more recent routine data from the government on the annual economic growth and on key social sectors like health and education. It also delivers a spatial analysis of poverty and depicts the geographic disparities across Tanzania. Its main findings are indeed relevant and will be discussed in our concluding remarks.

Our study report presents certain common features across the six councils, as well as differences among them. It is assumed that these features are shared by a large majority of Tanzania's local councils, although we do not claim that the small sample of six councils is representative. The findings from the case councils illustrate some of the differences between the councils across the country, and particularly the differences between urban and rural councils. Comparisons are made to identify policy implications for the Local Government Reform. Different councils might require different types of central support to face different types or scopes of problems.

2. SERVICE DELIVERY IN SELECTED LOCAL GOVERNMENT AUTHORITIES - THE VIEW OF THE CITIZENS

2.1 The Citizens' Assessment

The survey carried out by the formative process research project in 2003,[3] addressed the respondents more as citizens than as users. They were not asked directly about their own access to, and benefits of, various services. Instead they were asked to assess the delivery system.

Table 2.1 shows that 54 % of all respondents had seen an improvement in local government (LG) service delivery in general over the last two years.

Table 2.1 Local Government Service Delivery Over the Last Two Years (% of all respondents)

LG Service Delivery	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Better than before	44	48	49	61	55	66	**54**
About the same	19	25	24	24	29	20	**23**
Worse than before	26	25	11	5	14	10	**15**
Don't know	11	2	16	10	1	5	**8**

Source: Citizens' Survey (2003)

Q50: "*What do you in general think of the quality of local government services today compared to two years ago?*"

Options: 1. Worse than before 2. About the same as before
3. Better than before 4. Don't know

The variations between the six case councils were quite large. Mwanza and Iringa stood out with more than 60 % of respondents citing improvement, and less than 10 % thinking service delivery was 'worse than before'. In Ilala and Bagamoyo, 44-48 % saw improvements while about 25 % thought service delivery was worse than before.

The view becomes much more mixed when citizens were asked to consider service by service. Table 2.2 presents the percentage of respondents that thought the service was 'better than before' (i.e. better than two years ago).

[3] Nygaard, K. and Fjeldstad O.H., (2003), "Citizens' Survey, October 2003". Formative Process Research on Local Government Reform in Tanzania. Hereafter referred to as the Citizens' Survey (2003).

Table 2.2 Citizens' Perceptions of Service Improvement (% of all respondents choosing 'Improved')

Description	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Primary School	84	90	88	85	81	84	**85**
Dispensary	55	33	32	41	26	37	**37**
Secondary School	25	33	10	46	10	31	**26**
Water Supply	20	11	17	36	17	21	**20**
Road Maintenance	13	11	25	30	10	16	**18**
Sanitation	21	6	21	14	24	12	**16**
Electricity	13	13	34	30	4	4	**16**
Law and Order	27	11	18	28	2	5	**15**
Health Centre	26	14	3	8	4	7	**10**
Market Place	13	7	6	3	12	2	**7**
Garbage Collection	19	7	1	-	1	1	**5**
Agriculture Extension Services	-	2	7	5	3	3	**4**

Source: Citizens' Survey (2003)

Q48: "*In your opinion, which of the following services have improved the most, the last two years?*"

Options: Improved - Not improved

Primary education stands out as the one and only service that a large majority thought had improved. As will be outlined in Chapter 3, this is due to visible effects of abolition of school fees and introduction of the Primary Education Development Plan (PEDP). 85 % of all respondents thought that primary school services had improved over the last two years.

Primary health (dispensaries) came second with 37 % of citizens seeing improvement.

Garbage collection and agriculture extension were ranked at the bottom – only 4.6 and 3.5 % respectively, thought these services had improved. However, these should be disaggregated to urban and rural areas.[4] As to garbage collection, 19 % of the respondents in Ilala MC had seen improvements, in contrast to only 1 % in Mwanza CC.

Regarding agricultural extension services, Kilosa DC had the highest score with only 7 % having seen improvements, and Bagamoyo DC recorded the lowest (2 %).

Comparing tables 2.1 and 2.2, there is evidence to suggest that most respondents had primary education in mind when they thought service delivery was better than before. These assessments reflect the importance that the citizens attribute to primary education. In other words, we witnessed a particular 'PEDP effect' among local communities.

[4] Source: Table Q48 in Citizens' Survey (2003)

Table 2.3 below gives the percentage of all respondents, by council and for the whole sample, that were satisfied with twelve selected services. There is reason to believe that the respondents here let their own and/or family members' access or lack of access to services, and other personal experiences as users influence their opinions.[5]

Table 2.3 Citizens' Satisfaction Rating of Key Services (% of all respondents, by council, saying they are satisfied with the particular service)

Description	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Primary School	69	61	83	73	67	67	**70**
Dispensary	46	37	35	37	35	38	**38**
Secondary School	19	21	29	34	16	21	**24**
Water Supply	18	10	21	35	19	30	**22**
Road Maintenance	26	27	13	28	14	25	**22**
Sanitation	24	17	21	26	21	19	**21**
Electricity	24	10	20	15	28	19	**19**
Law and Order	22	12	25	28	10	15	**19**
Health Centre	25	24	5	16	10	13	**16**
Market Place	19	12	3	5	25	15	**13**
Agricultural extension Services	2	8	12	6	10	9	**8**
Garbage Collection	20	6	1	-	7	10	**7**

Source: Citizens' Survey (2003)

Q47: "*Some people are satisfied with the quality and capacity of public services in this district/town. Others are dissatisfied with the public services. What is your opinion about the following services in this area?*"

Options: Satisfied - 50/50 - Dissatisfied - Don't know - None

Again, primary education stood out. It was the only service rated as satisfactory by a majority of respondents. Primary health (dispensaries) recorded the second highest rating. This was the picture for all six councils.

[5] Unfortunately, our data does not allow us to identify the specific reasons for (dis-) satisfaction with the various services – e.g. reasons such as availability, quality or costs, The exceptions are for primary education and health, with data on perceived improvements/deteriorations within these services presented later in Chapter 3. However, primary education and dispensaries are usually not associated with unavailability - the citizens of Tanzania nowadays are more concerned with the quality of these services. Whereas for water supply, sanitation, electricity, etc the issue is availability.

For all the remaining services, dissatisfaction prevailed. However, the dissatisfaction rate varied somewhat between the services. In total, the respondents were definitely least satisfied with agricultural extension services (7.9 % satisfied) and garbage collection (7.1 % satisfied).[6] The remaining services received a total satisfaction rating from 13 to 24 %.

We see the same overall pattern of assessments across the councils. Some exceptions are worth noting: the respondents in Iringa DC were much less dissatisfied with road maintenance and water supply than were other respondents, and respondents in Ilala MC were less dissatisfied with market places and garbage collection. However, findings for urban Mwanza CC were more like other rural councils than Ilala MC. One cannot identify any systematic divide between urban and rural areas as to citizens' assessments of service delivery.

2.1.2 Citizens' Demand

In the citizen survey, respondents were asked which service was most important to improve. Table 2.4 shows that water supply was the single public service that respondents were most concerned about.

Table 2.4 Citizens' Priority for Service to be Improved (% of all respondents, by council, choosing the particular public service)

Service That Should Be Improved	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Water Supply	32	39	52	22	30	33	**35**
Dispensary	11	22	17	21	9	13	**16**
Health Centre	18	9	5	6	17	17	**12**
Second School	9	7	3	7	14	6	**8**
Primary School	5	8	5	7	9	8	**7**
Road Maintenance	9	3	5	6	10	8	**7**
Agriculture Extension Services	1	6	5	16	3	1	**5**
Electricity Supply	6	5	2	6	7	3	**5**
Market Place	1	1	3	6	1	2	**2**
Law and Order	4	1	2	2	1	1	**2**
Garbage Collection	1	-	-	-		7	**1**
Sanitation	2	-	-	-	1	1	**1**

Source: Citizens' Survey (2003)

Q49:*"In your opinion, which of the below public services is most important to improve?"*
Response: Circle only one based on respondent priority

[6] E.g. the ratings of agricultural extension services and garbage collection vary across the councils. This might reflect the different degrees of urbanisation and emphasise on agriculture. For example, there is a relatively high satisfaction with garbage collection in Ilala MC, while only 1.9 % were satisfied with agricultural extension.

When dispensary and health centres are grouped together, the results show that health was the other sector that the citizens perceived as urgent to improve.

The quite low score for primary education probably reflects the high degree of satisfaction with this service.

2.2 Council Responses To The Citizens' Demand

2.2.1 Allocations

Data on the allocation of total council expenditures may explain why primary education stood out as the one perceived as satisfactory and improved by the citizens. In 2002, Moshi DC allocated 66 % of its recurrent expenditures to education, and Iringa DC allocated about 60 % of total expenditures to education. For the remaining councils (Bagamoyo, Ilala and Mwanza), the education sector received around 35 % of total expenditures. With the exception for Kilosa DC, the case councils' annual allocations to education remained relatively stable during the period 2000-2002 (i.e. as a share of total expenditures). Kilosa allocated about 22 % of total expenditures to education in 2002, but this must be seen in connection with a relatively high allocation to education in 2001 (i.e., more than 60 % of total expenditures) (Fjeldstad et al, 2004)[7].

The allocation to the health sector has been much less than to primary education. This might indicate why the citizens were much less satisfied with health services. In 2002, the allocation was, on average, approximately 10 % of total expenditures. While Ilala MC allocated almost 12 % of total expenditures to the health sector in fiscal year 2002, the corresponding figure for Kilosa was only 4.9 %. However, in Kilosa's case the low allocation to health in that year may have been due to the relatively high allocation (19.4 %) in the previous fiscal year. (Fjeldstad et al, 2004)

Allocations to the remaining service sectors were much smaller than to education and health. Considering that water supply was the sector most prioritised by the citizens, i.e. viewed as most important to improve, the low allocations to the water sector were quite stunning. Bagamoyo DC was the biggest spender on water supply but with only 2.0 % of total expenditures. Ilala had the lowest allocation with 0.3 %. (Fjeldstad et al, 2004).

Table 2.5 Priority of Service Sectors: A Comparison

Dimension	Primary Education	Health Services	Water Supply
% of Citizens Satisfied with Sector [8]	70	27	22
% of Citizens Prioritising Sector	7	28	35
% of Total Expenditure Allocated to Sector	66.0 (Moshi) – 22.3 (Kilosa	11.8 (Ilala) – 4.9 (Kilosa)	2.0 (Bagamoyo) – 0.3 (Ilala)

Source: Citizens' Survey (2003). On expenditures: compiled by Fjeldstad et al (2004) based on the local councils' 'Abstracts of Final Accounts' for 2002.

[7] Recurrent and capital expenditures are not separately identified

[8] The figures of 'citizens satisfied' taken from table 2.3; they do not refer to satisfaction with the particular figures spent on the particular sector..

The surprisingly low allocation to the water sector may be explained by a combination of several factors:[9]

i) lack of grants to the councils from the central government to this sector;[10]
ii) lack of own revenues – there are simply not enough resources in the councils to satisfy the basic water needs of its population;
iii) lack of knowledge among the local government representatives of the stated needs and priorities of its population;
iv) lack of will among the local government representatives to meet the priorities of its population, or, in other words, lack of responsiveness of the LGAs.

To what extent can the perceptions of council representatives shed more light on these factors? This is examined next.

2.2.2 The Council Representatives' Assessments

Table 2.6 Service Sector Priorities Identified by the Local Councils

Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC
- Health: expansion of dispensaries - Water supply: wells and taps - Agricultural: inputs and extension officers - Education in its broader context	- Health: Public dispensary - Public secondary school	- Health in terms of availability and affordability - Roads - Water supply - House construction Comment: - Agriculture: introduction of new food cash crops, - Modernisation of pastoralists	- Water supply - Health: improved dispensaries - Agriculture: sunflower-pressing machines - Micro-credits to women's groups	- Health: more dispensaries - Water: safe, clean and reliable) to all villagers	-Health: expansion of dispensary to offer in-patient services - Secondary schools
Comment: In line with the citizens	Comment: Little in line with the citizens	Comment: Only to some extent in line with the citizens	Comment: Substantially in line with the citizens	Comment: in line with the citizens	Comment: Only to some extent in line with the citizens

Source: City or district plans; written statements from the respective LGAs (2003).

Table 2.6 presents the service sector priorities of local councils as contained in written statements from the respective LGAs. Comparing table 2.6 with table 2.4 ('Citizens' perceptions of which service that must be improved'), the following can be noted:

[9] The figure for Ilala's spending on water, 0.3%, should be handled with caution as 80 % of the areas is covered by an autonomous institution "Dar es Salaam Water Supply Company-DAWASCO" which is somehow private. The council provides water to rural areas, the remaining 20% of the area. (Ilala City Council, 2001, Status of Current Service Delivery)

[10] The water sector is supposed to be fully paid by central government especially through Personal Emolument (PE), and, to some extent, Other Charges (OC). However, over time OC has been steadily declining.

Only one case council, Iringa DC, is substantially in line with their citizens. There is nearly perfect agreement that water supply, dispensaries and agricultural extension should be prioritised.

Two case councils, Ilala MC and Moshi DC, are in line with their citizens. The exception in Ilala MC is the emphasis on agriculture cited by the council planners. In Moshi DC, the council and the citizens agreed that water supply and health services should be priorities. However, with regard to health, the DC emphasised expansion of dispensaries while the surveyed citizens preferred improvement of the health centre.

Two case councils, Kilosa DC and Mwanza CC, are only to some extent in line with their citizens. In Kilosa, the DC and the surveyed people put water and health at the top of the list. However, the DC's priorities of roads, agriculture and pastoralist modernisation had no strong backing from the Citizens' Survey. In Mwanza CC, there was agreement that the quality of the health services should be improved (more patient services in the dispensaries and better health centres respectively). The CC, however, was less concerned with water supply and more concerned with secondary education than the surveyed citizens.

One council, Bagamoyo DC, was little in line with their citizens. Although all agreed that health services needed to be improved, the priorities of the DC did not reflect the citizens' priority number one for improved water supply. The planners emphasised the need for secondary schools more than the citizens.

2.3 Summary and Remarks

Of all the respondents in the 2003 Citizens' Survey, 54 % had, in general, seen an improvement in LG service delivery over the last two years. The variations between the six councils were quite large. Mwanza and Iringa stood out with more than 60 % seeing improvement, and less than 10 % thinking service delivery was 'worse than before'. In Ilala and Bagamoyo, 44-48 % saw improvements while about 25 % thought service delivery was worse than before.

Primary education stood out as the only service rated as satisfactory by a majority of respondents. Primary health (dispensaries) received the second highest rating. This was the picture for all six councils. For all the remaining services the satisfaction rating was much more mixed, with significant variations between the councils. The respondents in all six case councils were definitely least satisfied with agricultural extension services and garbage collection. Water supply was the single service that most citizens wanted to see improved in all six councils. However, of their total expenditures, no council spent more than 2 % on water supply. In assessing further incongruence between stated plans and priorities for service delivery of the councils on the one hand, and the preferences of their citizens on the other, we found that half of the case councils were to some degree out of step with their citizens. This shows that a truly participatory, bottom-up, and cross-sector planning system for service delivery had not yet been realised.

3. PERFORMANCE IN KEY SERVICE AREAS

3.1 Primary Education

3.1.1 Accessibility

Table 3.1 Expansion of Primary Education: (1) Enrolment

	Urban Councils		Rural Councils			
	Ilala MC	Mwanza CC	Kilosa DC	Iringa DC	Moshi DC	Bagamoyo DC
Gross Enrolment Rate						
2000	94 %	90%	N/A	75 %	99 %	87 %
2003	137 %	N/A	N/A	99 %	116 %	99 %
Net Enrolment Rate						
2000	57 %	69 %	64 %	114.2%	N/A	85%
2003	94%	90 %	94.6 %	117.2%	N/A	93%

Source: Council profiles and data delivered by the council management teams[11]

As seen in table 3.1 above, there has been immense growth in school enrolment in all six case councils from year 2000 to 2003, whether measured by gross or net enrolment rate[12]. This can be attributed to specific national policies:

- the abolition of school fees in 2001
- the Primary Education Development Plan (PEDP), 2002-2006.

Affordability was improved when school fees were abolished in 2001, in the start-up of the PEDO programme. Thus, accessibility improved immediately. On average, 84 % of respondents in all six case councils were of the opinion that improved accessibility to primary schools was due to abolished school fees.[13] PEDP had helped to sustain improved accessibility. It channelled resources from the donor community into a 'basket fund', and it helped to distribute resources to every village in terms of new classrooms, more desks and more textbooks. Particularly in the construction of new classrooms, the PEDP had mobilised communities to contribute with money and labour.

Nevertheless, there were considerable differences between the councils. In relative terms, the biggest increases in enrolment were in Ilala MC and Kilosa DC. Bagamoyo DC had a lower increase than the others. Are there similar differences in other indicators of primary school expansion? Table 3.2 below shows the differences as to physical facilities:

[11] Not confirmed whether the council management teams have used the census 2002 (URT 2003a) for their accessibility/population estimates.

[12] The gross enrolment rate (GER) counts for the total enrolment in primary education regardless of age, expressed as a percentage of the age group that is officially supposed to be enrolled in grade 1 (e.g. those who are 6 years old that year). The net enrolment rate (NER) counts for the enrolment only of the particular age group.

[13] Citizens' Survey (2003) Q52: Reasons for increased primary school enrolment. See table 4.1.

i) construction of new classrooms measured by improvement in pupil/classroom ratio, and relative to the growth in enrolment;
ii) construction of new schools, measured by 'average distance to nearby school' and 'portion of population living more than 5 km away from nearby school'.

Table 3.2 Expansion of Primary Education: (2) Facilities

	Urban Councils		Rural Councils			
	Ilala MC	Mwanza CC	Kilosa DC	Iringa DC	Moshi DC	Bagamoyo DC
Pupils Per Classroom						
2000	104	45	73	66	57	69
2003	70	60	74	54	49	69
Average Distance to Nearby School						
2000	8 km	5 km	<5 km	6 km	5 km	3 km
2003	2 km	3 km	<5 km	5 km	4 km	2 km
Portion of Population Living More Than 5 km Away From Nearby School						
2000	N/A	20 %	0 %	18%	11 %	25 %
2003	N/A	15 %	0 %	12%	8 %	20 %

Source: Council profiles and data delivered by the council management teams

In Ilala MC, the impressive increase in enrolment was accompanied by an equally outstanding growth in classrooms (as indicated by pupils per classroom) and reduction of average distance to nearby school. Also in Moshi DC and Iringa DC the construction of classrooms was ahead of the growth of students, and that the distance to a nearby school was shortened. Their classroom/pupil ratio also improved. Kilosa DC achieved a balance between the growth of pupils and class rooms and reported that already in 2000 the entire population lived less than 5 km away from a school. Also Bagamoyo DC achieved a balance between the growth of pupils and classrooms from 2000 to 2003, but this balance was less impressive given the modest increase in gross enrolment rate. In Mwanza CC, classroom construction lagged behind enrolment.[14]

3.2 Quality of Services

In general, the case councils appeared to do well in supplying more physical inputs for primary education, such as classrooms, desks and textbooks. While the supply of classrooms and desks, to a large extent, depends on self-help and community mobilisation, the supply of textbooks is more determined by administrative delivery. Hence, the supply of textbooks is the only one of the four selected indicators for input quality where improvement and convergence occurred across all case councils. In community dependent supplies like classroom and desk construction, Mwanza CC, Bagamoyo DC and, to some extent Kilosa DC, showed negative trends compared with the other three case councils, where self-help seemed to work better. For example, in Bagamoyo DC there were 4 pupils per desk in 2000 and 6 pupils per desk in 2003. Likewise, the input of human resources (teachers) into the primary education varied considerably between councils.

[14] It was thus puzzling that both Mwanza CC and Bagamoyo DC report a considerable construction of new schools (measured both by portion of population living more than 5 km away from nearby school and average distance to nearby school).

Table 3.3 Quality of Primary Education: (1): Inputs (Human & Educational Resources)

	Urban Councils		Rural Councils			
	Ilala MC	**Mwanza CC**	**Kilosa DC**	**Iringa DC**	**Moshi DC**	**Bagamoyo DC**
Pupils Per Desk						
2000	7	3	3	4	4	4
2003	5	4	4	4	2	6
Pupil Per Textbook						
2000	9	12	3	5	6	8
2003	5	7	4	4	3	5
Pupils Per Teacher						
2000	43	48	39	63	50	40
2003	51	60	54	56	43	53
[Teacher A : Teacher B+C] ratio [15]						
2000	2:1	2:1	1:1.5	1:1	N/A 1:4	1:4
2003	3:1	3:1	1:1	2.6:1	N/A 1:2	1:5

Source: Council profiles and data delivered by the council management teams.

Moshi DC, Iringa DC and Ilala MC stood out with improvements in their 'inputs' to primary education from 2000 to 2003. Moshi DC was the only council that had managed to come within reach of the national targets relative to pupils per desk, pupils per textbook, and pupils per teacher. It showed improvement in four of the input quality indicators listed, while Ilala MC and Iringa DC reported improvements in three of the four indicators. The slight deterioration of the pupils/teacher ratio in Ilala MC was compensated by improvement in the formal qualifications of its teaching staff – Ilala, like Mwanza, the other city in the sample, had three times more 'IIIA' teachers than 'IIIB' and 'IIIC' teachers. Iringa DC's trebling of the share of 'A' teachers was impressive, given its rural status, and in comparison with the other district councils.

The remaining three case councils presented rather mixed or negative developments in input quality. Mwanza CC showed deterioration in two of the four indicators. Kilosa DC and Bagamoyo DC deteriorated on three of the four dimensions. However, whereas Kilosa showed a significant improvement in the formal qualifications of its teachers, Bagamoyo lagged even further behind the other case councils on this aspect.

It will probably take some years before improvements in inputs to primary education will produce improved results. Table 3.4 presents three indicators of quality outcomes: completion rate (i.e., percentage of a cohort enrolled in grade 1 to complete grade 7), which reflects extent of drop out mainly among girls before reaching grade 5, 6 or 7); pass rate (i.e., percentage of grade 7 pupils passing their finals exams); and transition rate (i.e., the percentage of primary school leavers starting secondary school the subsequent school year). Available data was compared for years 2000 and 2003. Since those completing grade 7 in 2003 had seen PEDP introduced for their two last school years

[15] Grade IIIA+ includes those with qualifications IIIA or higher (e.g. diplomas), in contrast to the less qualified grades III B/C.

– the two most critical years as to completion – the changes in the completion rates are considered a valid measure of the PEDP effect. The pass rate should also be affected by PEDP. The transition rate, however, depends not only on good grade 7 exams results, but also on external constraints: the availability of secondary schooling, and the financial capacity of households to pay school fees and/or boarding expenses.

As to completion rates, Moshi DC and Bagamoyo DC reported big improvements. The changes in the four other councils were insignificant. As to primary school 7 pass rates, immediate improvements had been produced in all case councils (except in Bagamoyo,). Kilosa DC reported a four-fold increase in its pass rate, and Moshi DC and Iringa DC nearly doubled theirs. The positive development of the pass-rate was accompanied by a similar positive development in the transition rate in the same three DCs, most likely reflecting a simultaneous community mobilisation for secondary schooling. Surprisingly, the two city councils Ilala MC and Mwanza DC showed deteriorating transition rates; here, the secondary schooling capacity of households and state/society might lag behind.

Table 3.4 Quality of Primary Education: (2) Results

	Urban Councils		Rural Councils			
	Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC	Bagamoyo DC
Completion Rate [16]						
2000	85 %	94 %	64.1 %	85 %	98 %	75 %
2003	85 %	97 %	64.2 %	96 %	96 %	85 %
Pass Rate						
2000	38 %	47.6 %	11.0 %	11 %	23 %	36 %
2003	41 %	54.2 %	14.6 % [17]	22 %	42 %	32 %
Transition Rate [18]						
2000	10 %	23 %	12 %	4 %	N/A	30 %
2003	8 %	14 %	30 %	11 %	31 % [19]	50 % [20]

Source: Council profiles and data delivered by the council management teams

[16] Percentage within each cohort starting grade 1 that completes grade 7

[17] We received contradictory figures from Iringa DC, e.g. 24 % pass rate in 2002, and 40 % 'expected' for 2003, but these were not confirmed.

[18] The percentage of primary school leavers starting secondary school. It is likely that most councils have operated with a 'NET transition rate', i.e., counting only the students that passed grade 7 and that started in a secondary school the following school year. Other councils might keep record of 'GROSS transition rate', i.e., counting the youngsters starting in grade 8 the particular year, regardless of when they passed grade 7. At least Bagamoyo DC belongs to the latter category, since its reported transition rate was larger than the pass rate.

[19] Year 2002

[20] Bagamoyo DC reported a jump in transition rate from 24 % in 2002 to 50 % in 2003.

3.3 Primary Education

Table 3.5 Citizens' Perceptions of Changes in Primary Education (% of all respondents)

Description		Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC	Bagamoyo DC	Total
Buildings	**Improvement**	86	81	85	84	88	81	86
	No change	6	15	13	10	9	15	10
	Deterioration	5	4	1	5	1	4	3
Number of Classrooms	**Improvement**	81	78	80	82	78	78	80
	No change	1	11	18	8	16	11	10
	Deterioration	12	9	2	7	3	9	6
Teachers' Performance	**Improvement**	40	40	53	51	54	40	47
	No change	16	27	32	13	21	27	22
	Deterioration	20	16	9	5	13	16	12
Number of Teachers	**Improvement**	31	36	52	36	55	36	42
	No change	10	28	30	16	21	28	22
	Deterioration	28	19	15	10	14	19	16
Availability of Books	**Improvement**	19	22	38	22	31	22	27
	No change	11	30	29	11	31	30	24
	Deterioration	28	24	20	17	24	24	21
Availability of Desks	**Improvement**	58	44	51	63	52	44	54
	No change	8	21	28	11	23	21	20
	Deterioration	15	24	18	10	21	24	16
Cost of School	**Improvement**	75	72	92	75	89	72	80
	No change	6	16	4	7	4	16	8
	Deterioration	5	7	1	11	4	7	6

Source: Citizen Survey (2003)

Q51 *"In the last two years, have you noticed any significant changes in the quality of primary education?"*

Options: as shown

The table gives the percentage of all respondents, by council and in total, that had seen improvements or deteriorations in the given aspects of primary school quality over the last two years; other respondents did not know. It should be noted that the availability of books was the aspect that least respondents (27 %) had seen an improvement in. However, the citizens' perceptions were supported by the PEDP expenditure tracking study in 2004, which showed a systematic disappearance (or 'leakage') of resources in the PEDP supply of textbooks (REPOA, 2004).

The table also shows that twice as many citizens saw improvements in the 'cost of school' and in the construction of new buildings and classrooms, than in teacher numbers and teachers' performance.

3.4 Basic Health Services

3.4.1 The Public Health Situation

When discussing health services, a starting point – as well as the ultimate goal for interventions – is the actual health situation of the population. The infant mortality rate is one of the most reliable health indicators. The table below shows steady and encouraging progress in all case councils in reducing the infant mortality rate. In addition, two councils stand out with a much lower infant mortality rate than the others: Mwanza CC and Moshi DC.

As to prevalence of waterborne diseases, the data provided by the district councils must be used with some caution. First, many people with waterborne diseases do not consult the dispensaries or health centres; consultations depend on the proximity and access to these facilities. Secondly, the quality of the reports provided to district medical officers (DMOs) on these diseases leaves a lot to be desired. Staff in the dispensaries and health centres have a lot of paper work, and they tend to give priority to other types of reporting.[21]

Table 3.6 The Public Health Situation in the Six Case Councils

	Urban Councils		Rural Councils			
	Ilala MC	**Mwanza CC**	**Iringa DC**	**Moshi DC**	**Kilosa DC**	**Bagamoyo DC**
Population (2002)	638,000	266,000	246,000	402,000	490,000	230,000
Infant Mortality Rate						
2000	12%	3 %	16 %	3 %	11 %	12 %
2003	10 %	2 %	16 % [22]	2 %	9 %	11
Cases of Waterborne Diseases[23]						
2000	67	162,825	26,211	145,206 [24]	19,444	15,441
2003	2, 558	100,003	16,299	23,600 [25]	20,200 [26]	N/A
Immunisation Rate						
2000	86 %	84 %	71 %	85 %	81 %	77 %
2003	88 %	94 %	96 %	89 %	82 %	82 %

Source: Council profiles and data delivered by the council management teams including the district medical officers.

[21] District Medical Officer, Moshi DC, interview 03-09-2004. The DMO claims that the quality of reporting had particularly deteriorated lasting recent years – it was more accurate in 2000 than in 2003.

[22] There might be an error in the figures from Iringa DC: 15.7 % infant mortality rate reported for all years 2000-2003

[23] Usually reported as diarrhoea; only a very few isolated cases of cholera reported.

[24] From 2001. Females above the age of 5 provided 120 212 of the cases. (District Medical Officer, Moshi DC, interview 03-09-2004).

[25] The DMO did have confidence in these figures and thought the real number was much higher (District Medical Officer, Moshi DC, interview 03-09-2004).

[26] From 2002.

Figures for waterborne diseases are discussed later in section 3.3 on water supply. As to public health interventions measured by the immunisation rate,[27] progress was recorded in all six case councils. Iringa DC shows the biggest improvement, from the lowest rate in 2000 (71 %) to the highest rate in 2003 (96 %). Mwanza CC and Moshi DC achieved the second and third highest rates respectively.

3.4.2 Accessibility

Table 3.7 Access to Health Facilities: (1) Official Data[28]

	Urban Councils		Rural Councils			
	Ilala MC	**Mwanza CC**	**Iringa DC**	**Moshi DC**	**Kilosa DC**	**Bagamoyo DC**
Percentage of Households with Access to Health Services [29]						
2000	72 %	98 %	50 %	85 %	68 %	50 %
2003	72 %	99 %	68 %	87 %	64 %	60 %
People Per Dispensary						
2000	7,589	6,357	6,664	5,040	7,462	6,800
2003	7,589	5,980	6,147	5,094	8,060	6,800
Number of Dispensaries (2003)	99	75	44	88	62	32
Number of Health Centres [30]						
-2000	12	8	5	4	7	5
-2003	14	10	8	6	7	5

Source: Council profiles and data delivered by the council management teams.

The case councils also made progress relative to people's access to health service facilities, with Mwanza CC and Moshi DC better off than the other councils. Again, Iringa DC produced the biggest gains from 2000 to 2003, particularly in the expansion of its network of health centres. Here Mwanza CC and Moshi DC again ranked second and third.

[27] Usually tuberculosis (Bacille Calmette Guérin or BCG) immunisation, although not confirmed in Kilosa DC and Mwanza CC

[28] We have also collected data on access to centre/hospital beds. However, there were too many missing or inconsistent data to present the patients/bed ratio.

[29] 'Access' defined as "living less than 5 km away from nearby dispensary/health facility".

[30] Includes centres, excludes dispensaries and hospitals.

Table 3.8 Access to Health Facilities: (2) Citizens' Data (% of all respondents, by council and three sub-sectors, saying they have access)

	Urban Councils		Rural Councils				
	Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC	Bagamoyo DC	Total
Government	186	85	83	67	90	81	82
Mission/BAKWATA/ NGO	10	16	31	28	49	31	28
Private	91	52	21	50	11	29	42

Source: Citizen Survey (2003)

Q53: "*Do you have access to a health facility in this area?*"

Options: As shown. Yes - No

Citizens surveyed reported much better access in 2003 than what our council-aggregated data suggested. This might be due to biased sampling in the survey[31]. Of interest, almost all surveyed citizens in Ilala MC, and about 50 % of the citizens in the other case councils (except Iringa DC and Bagamoyo DC), had access to at least one other facility (mission/Bakwata/NGO or private), in addition to the government facility.

Table 3.9 Access to Health Workers

	Urban Councils		Rural Councils			
	Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC	Bagamoyo DC
People Per Doctor						
2000	19,000	23,000	150,243	201,000	228,000	N/A
2003	22,000	43,000	150,205	201,000	167,000	118,000
Number of Doctors (2003)	29	6	2	2	3	2
Number of Hospitals (2003)	1 [32]	4	2 [33]	4 [34]	2	1
Number of Health Workers						
2000	562	315	135	338	261	268
2003	700	334	186	340	290	301
People Per Health Worker (2003)[35]	900	800	1,300	1,200	1,700	760

Source: Council profiles and data delivered by the council management teams

[31] The survey may have been conducted, to a large extent, in clusters around sub-district centres where access to health facilities were much better/above the council average.

[32] Ilala MC has only one government hospital. There are 9 purely private hospitals which, however, do not receive any kind of support from the government.

[33] Ipamba Hospital and Iringa District Hospital

[34] The Marangu, Kibosho, Kilema and TPC hospitals.

[35] Approximate figures.

As far as access to health workers and medical doctors was concerned, it is not surprising that the cities (Ilala MC and Mwanza CC) were better off and managed to attract the major share of essential personnel. All rural district councils, including Bagamoyo, suffer from a lack of doctors and very high population per doctor ratios. However, relative to the employment of health workers in general (nurses, etc.), all case councils made progress, particularly Iringa DC once again, but also Kilosa DC and Bagamoyo DC who had both lagged behind on the health service indicators listed earlier. The excellent availability of health workers in Bagamoyo is perhaps due to its close proximity to the labour market of Dar es Salaam.

3.4.3 Quality of Services

Table 3.10 Quality of Health Services): (1) Patient's Waiting Time

	Urban Councils		Rural Councils			
	Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC	Bagamoyo DC
People Per Health Worker (2003)[36]	900	800	1,300	1,200	1,700	760
Time Spent Queuing At Dispensaries						
2000	60 min	90 min	60 min	30 min	60 min	180 min
2003	60 min	35 min	45 min	30 min	40 min	180 min

Source: Council profiles and data delivered by the council management teams

The reliability of data on time spent queuing up for attention at a nearby dispensary may vary from one council to another. The official data on access to health workers in table 3.10 are not comprehensive enough to indicate changes from 2000 to 2003 in this area. However, the data on citizens' perceptions in table 3.12 below clearly points out that for two indicators of access – 'politeness of health staff' and 'speed of treatment' – there were clear improvements in Ilala MC, Iringa DC, Moshi DC and Kilosa DC. In Mwanza CC and Bagamoyo DC, however, nearly as many respondents cited deterioration as cited improvement. As to council staff reporting on average time spent in dispensary queuing (see table 3.10 above), there were big variations; from 30 minutes waiting in Moshi DC to 3 hours in Bagamoyo DC. These data seem to be in line with the citizens' perceptions of change in speed of treatment, except for Mwanza CC which appears to overestimate its progress (waiting time cut from 90 minutes in 2000 to 35 minutes in 2003).

[36] Approximate figures.

Table 3.11 Quality of Health Services: (3) Improved Availability of Drugs/Medicines (% of All, by Sub-sector and By Council)

Sub-sector		Bagamoyo DC	Ilala MC	Iringa MC	Kilosa DC	Moshi DC	Mwanza CC	Average
Public/ Gov't	Improved	22	37	48	42	49	30	*38*
	Deteriorated	29	23	16	28	15	32	*24*
Mission/ BAKWATA	Improved	61	85	81	52	77	85	*72*
	Deteriorated	8	-	11	2	-	-	*4*
Private (for profit)	Improved	75	66	54	55	76	80	70
	Deteriorated	2	2	7	5	1	2	*2*

Source: Citizen Survey (2003)

Q54: "*If Yes on Q53; in the last two years, have you noticed any significant changes in the quality of health care?*"

Options: Improved - Not changed - Deteriorated

On average, 38 % of the citizens across all six councils thought that public (government-owned) dispensaries had improved the availability of drugs and medicines. Again, results indicated that Iringa DC and Moshi DC improved more than the other case councils, and Bagamoyo improved less. However, it is a serious challenge to the government that nearly twice as many citizens in all the case councils thought that there had been improvements in the NGO owned non-profit and private for-profit dispensaries in this regard. The government-owned dispensaries may not be doing enough to meet people's rising expectations of affordable medicines.

3.4.4 Citizens' Account of Performance in the Health Sector Services

When analysing the citizens' perceptions (Table 3.12 below), they confirm that the 'speed of treatment' had improved considerably,[37] first and foremost in Moshi DC, but also in Kilosa DC, Iringa DC and Ilala MC. What had improved the most in all of the councils was 'cleanliness'.

[37] I.e. significantly more citizens saw improvements than deterioration.

Table 3.12 Citizens' Account of Performance in Health Services (% of All Respondents, By Council)

Government Health Facility		Urban Councils		Rural Councils				
		Ilala MC	Mwanza CC	Iringa DC	Moshi DC	Kilosa DC*	Bagamoyo DC	Total
Cleanliness	**Improvement**	82	69	74	59	69	65	**70**
	No change	12	2	20	26	26	25	**21**
	Deterioration	4	6	7	3	4	10	**6**
Politeness of Health Staff	**Improvement**	49	38	56	58	48	37	**47**
	No change	28	30	29	22	29	42	**30**
	Deterioration	20	26	14	5	21	20	**18**
Availability of Drugs	**Improvement**	37	30	48	49	42	22	**38**
	No change	37	31	35	23	27	49	**34**
	Deterioration	23	32	16	15	28	29	**24**
Speed of Treatment	**Improvement**	42	28	39	49	46	24	**38**
	No change	34	39	40	25	32	46	**36**
	Deterioration	21	25	20	13	20	29	**21**
Cost of Treatment	**Improvement**	35	35	51	49	51	25	**41**
	No change	32	33	22	26	19	34	**28**
	Deterioration	30	24	27	11	28	40	**27**
Number of Observations		182	178	174	142	188	171	**1,035**

Source: Citizens' Survey (2003)

Q54: "*If Yes on Q53; in the last two years, have you noticed any significant changes in the quality of health care?*"

Options: as shown

* Kilosa DC has 189 observations under the issue of cleanliness

3.5 Domestic Water Supply

The council management interviewed in all six case councils agreed that water supply was inadequate. However, there were serious flaws in the official data on domestic water supply. Therefore, the indicators of accessibility used below may not be based on consistent definitions and statistics.

3.5.1 Accessibility

There are methodological difficulties to be addressed when assessing accessibility of water. First, one has to differ between 'installed' water schemes and 'functioning' water schemes.[38] Secondly, it is necessary to differ between water schemes that function the whole year, and those that are

[38] Kilosa DC has installed water schemes that might have served 357,658 people, or 73 % of its population. However, only 238,721 (about 49 % of the population) in 2003 were served by water schemes found to be 'functioning'. Source: the district water engineer, Kilosa DC, interview 10-09-2004.

vulnerable to seasonal variations. Here, some DCs like Moshi operate with a 'rigid' definition, while other DCs like Kilosa operate with a 'lean' definition. Thus, 'adequate water supply service' in Moshi DC is defined as the supply of satisfactory amounts of water the whole year, without seasonal interruptions (due to dry seasons, or contamination of wells in the rainy season).[39] In Kilosa DC, the water sources vulnerable to dry seasons are included.[40] The definition of "adequate water supply service" tends to equate to the more formal definition of access to water, namely "living less than 5 kilometres away from nearby drinking water collection point". Shallow wells represent the critical issue in this context. Ideally, only access to deep wells (with pumps) and/or piped water should count as 'adequate water supply service'. Thus, comparisons across the case councils, particularly within the same year, should be avoided. Instead we should focus on the development within the same council over time. Once the longitudinal data is established, however, one could make comparisons between locations.

Nonetheless, if the available official data on accessibility is compared (see Table 3.13), the share of population covered by adequate water supply service ranges from 69 % in Mwanza (highest of the five with available data) to 49 % in Kilosa (lowest).

Table 3.13 Access to Water (official data)

	City		District Councils			
	Mwanza	Ilala	Iringa	Kilosa	Moshi	Bagamoyo
Population covered by adequate water supply service						
2000	12%	N/A	N/A	52%	50%	64%
2003	69%	52 % [41]	N/A	49% [42]	52%	64%
Portion of population living more than 5 kms away from nearby drinking water collection point						
2000	28%	8%	28%	43%	10%	23%
2003	20%	0%	19%	49%	9%	23%
Number of wells/bore holes						
2000	195	N/A	103	554 [43]	33	119
2003	198	N/A	170	554	36	122
Average distance to water (metres)						
2000	200m	N/A	1,800m	2,230m	2,000m	1,500m
2003	70m	N/A	1,340m	1,800m	1,500m	1,500m

Source: Perception and statistical data from the Local Government Authorities (planning officer and water engineer).

When looking into other indicators of water accessibility, still constrained by the quality of official data, variations become more significant. If measuring the portion of population living more than 5 kilometres away from nearby source of drinking water, Moshi DC stood out with only 9 %

[39] The census 2002 (URT, 2003a). used a 'leaner' definition of water access: the portion of population served by water collection points. With this definition Moshi DC sees a rise in its coverage, from 52 % based on a rigid definition, to 63 % based on the lean definition. (Source: The district water engineer, Moshi DC, interview 03-09-2004.)

[40] Between 20 % and 35 % of the 'functioning' water schemes, mainly shallow wells with hand pumps, are from one year to another affected by drought. (District water engineer, Kilosa DC, interview 10-09-2004.) Thus, in Kilosa DC the real portion of the population covered by 'adequate water supply services' is only about 30-35 %.

[41] Figure for 2002.

[42] The figures from Kilosa DC are probably grossly over-estimated. See footnote above.

[43] The number of wells and boreholes has been constant in Kilosa DC, but there has been upgrading – 83 in 2000 and 221 in 2003 were of improved quality.

experiencing this type of social exclusion, while Kilosa DC reported the worst situation. Mwanza is definitely excelling also in average distance to water source – only 70 m, but has the advantage of being a densely populated urban area. As to construction of new wells/boreholes, Iringa DC is the only council to report significant progress.[44] The differences might to some degree be explained by population density.

A district medical officer suggested that the number of skin infections is a good indicator of extreme lack of access to water.[45] However, we managed to collect data on this from only one case council.[46]

3.5.2 Quality of Services

As already noted, the indicators above do not say anything about the quality of the service provided. Is water supply adequate, sustainable (without interruptions and break downs), clean and safe? Unfortunately, the case councils do not deliver reliable information on this issue. A proxy indicator used to measure the quality of water – i.e., the access to clean and safe water – is the number of cases of waterborne diseases.[47]

Table 3.14 Quality of Water Supply: Number of Waterborne Diseases (official data)

Year	City Councils		District Councils			
	Mwanza CC	Ilala MC	Iringa DC	Kilosa DC	Moshi DC	Bagamoyo DC
2000	162,825	67	26,211	19,444	145,206 [48]	15,441
2003	100,003	2,558	16,299	20,200 [49]	23,600[50]	N/A

Source: Statistical data from the Local Government Authorities (planning officer and water engineer).

The data provided by the district councils on waterborne diseases have already been presented and discussed above (see section 3.2.1. on the public health situation). Notwithstanding the reliability of these data, the quality of water supply seemed to be under acceptable control only in Ilala MC. The situation was alarming in Mwanza CC: 162,825 cases of waterborne diseases were recorded in 2000, although this decreased to 100,003 three years later. Moshi DC presented dramatic figures for 2000/2001, but recorded big improvements by 2003. The situation was a little more stable in Iringa and Kilosa, although Iringa DC showed some improvements lasting recent years – down from 26,211 cases of waterborne diseases in 2000 to 16,299 in 2003.

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[44] Kilosa DC reports a systematic upgrading of its water collection points. This has however, not influenced the figures for the population's access to water.

[45] District Medical Officer, Moshi DC, interview 03-09-2004. Skin infections is a result of lack of washing.

[46] Moshi DC registered 16,001 cases of skin infections in 2001.

[47] Predominantly registered as 'diarrhoea'. Now and then cases of cholera are registered, but cholera has not been reported as epidemic lasting recent years in the case councils. For instance, Moshi DC registered only 15 cases in 2001, 2 in 2002 and 2 in 2003 (District Medical Officer, Moshi DC, interview 03-09-2004).

[48] From 2001. Females above the age of 5 provided 120,212 of the cases. (District Medical Officer, Moshi DC, interview 03-09-2004).

[49] From 2002.

[50] The DMO did not put confidence into these figures – he thought the real number was much higher. (District Medical Officer, Moshi DC, interview 03-09-2004).

Kilosa DC reported 19,444 cases in 2000 and 20,200 in 2002.[51] Bagamoyo DC reported 15,441 cases in 2000 but no figures for 2003.

3.6 Summary and Remarks

In primary education there was immense growth in school enrolment from 2000 to 2003. Enrolment was close to 100 % in all six case councils. This success can be attributed to the abolition of school fees in 2001, and to the Primary Education Development Programme. The pass-rate also increased in all case councils, although a majority of grade 7 students were still failing to pass in 2003. There were some clear signs of progress in the quality of education, measured by indicators such as pupils per classroom, pupils per desk, and pupils per textbook.

However, the main quality indicators, like pupils per teacher and share of qualified teachers, did not show progress for many of the councils. The lack of (qualified) teachers threatens the sustainability of the education reform and tends to widen the gap between 'advanced' and 'backlogging' councils.

These findings are supported by the Poverty and Human Development Report 2005 (URT 2005). In the country as a whole, primary school net enrolment increased from 59 % in 2000 to 91 % in 2004 (URT 2005: 11). Interestingly, the completion rate as well as the pass rate for the primary school leavers have been improved particularly since 2003 (ibid.:16). However, key quality of education indicators such as the pupil /qualified teacher ratio and text books/students ratio have not improved. This may have impacted on the transition rate from primary to secondary school. The transition rate is still low – the secondary net enrolment has increased from 6 percent to 8 percent (ibid.:11).

In basic health services there was significant progress reported from all six councils regarding the public health situation. The infant mortality rate decreased, and the immunisation rate rose to well above 80 % in all councils. However, problems existed, linked to the health facilities (dispensaries and centres). Although there was progress in accessibility from 2000, around one-third of the population in Iringa, Kilosa and Bagamoyo were still without access to health centres in 2003. And despite an improvement in the number of health workers (nurses) and average waiting times for patients at dispensaries, the problem of affordability made the majority of population dissatisfied (more so with health centres than with dispensaries). People felt that drugs and medicines were more available in the private and non-government facilities, but only for those who could afford it. People have to pay user fees (or Community Health Fund contributions) to government health facilities – where the quality of services still left a lot to be desired.

The Poverty and Human Development Report 2005 (URT 2005) provides a similar picture for Tanzania as a whole. There has been a positive reduction of infant mortality from 99 to 68 and of under-five mortality from 147 to 112 per 1000 live births (URT 2005:21). Much of this decline is likely to be the result of improved malaria control (ibid:23). Also the child immunisation is at a higher level than in other sub-Saharan countries (ibid.:25). However, child nutrition and maternal health have not improved, reflecting the high income poverty (ibid.: 27-30, 35-38).

In domestic water supply there was no significant progress reported on accessibility, with the particular exception of Mwanza CC. In three of the six councils, around half of the population was *not* covered by adequate water supply services. To make the picture gloomier, it was likely that these data were based on overestimates. Data on the quality of services was also in short supply. This was noted by the Poverty and Human Development Report 2005 (URT 2005) as well, calling into question "the validity of relying on government routine data for monitoring progress towards targets" in water supply (URT 2005:48). It states that "[t]he census estimate of 42 per cent of rural households with access

[51] Unfortunately, no data was available from Kilosa DC for 2003 on this issue.

to improved water supply is notably less than the 2003 routine data figure of 53 per cent" (ibid.:47). Thus, citizens' top priority of water supply, as found in the survey presented in chapter 2, appears to be based on sound logic and common sense. The 2003 Afrobarometer survey "found that for 52 per cent of respondents the Government was doing 'very badly' or 'fairly badly' in delivering water to households, and preliminary 2005 results suggest that the situation has not improved: close to 54 per cent of the respondents remain dissatisfied" (URT 2005:48).

4. TECHNICAL AND POLITICAL FACTORS IN LOCAL SERVICE PROVISION

4.1 The Relationship Between the Main Stakeholders

There is a triangular relationship between the main stakeholders in service delivery: the government (GOV), the service provider (SP) and the community of citizens/users (COM). There is a division of labour: each actor performs a different role and provides different inputs in the service delivery system. Each controls different factors that need to interact effectively with the others to produce satisfactory services. The government controls laws, policies and financial flows necessary to produce services in a modernising society (political and economic capital). The service providers control the technical skills and equipment (human and physical capital). The citizens have the duty to contribute as active users of services, i.e. community user groups, but also the right to influence policy and the actual delivery of services (e.g. the right to complain). The obligations may include cost sharing or the responsibility to send children to school and to have regular health checks.

To change and improve the current service delivery systems, certain resources need to be mobilised to build new and cooperative capacities. We will look at:

- on the one hand, the service providers and mobilisation of their professional resources and capacities in processes of capacity-building; i.e., the technical factors in service delivery; and,
- on the other hand, the citizens *(*users) and mobilisation of their resources and capacities in processes of empowerment; i.e., the political factors in service delivery.

The Government – through the Local Government Reform Programme – has a task in promoting both technical and political factors in local service delivery. Let us see how the citizens perceive the role of the government in service delivery improvements. The increased primary school enrolment is probably the best example of current improvements.

Table 4.1 Reasons for Increased Primary School Enrolment
(% of all respondents, by council, saying the particular reason is important)

Reasons for Increased Enrolment in Primary School	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
School Fees Have Been Abolished	81	83	84	89	83	83	**84**
People Have Recognised the Importance of Schooling	78	79	78	74	81	77	**78**
Government has Mobilised People	53	54	57	49	76	74	**60**
Quality has Improved	36	31	35	31	51	49	**39**
People Have More Money Than Before	12	8	19	15	5	3	**10**

Source: Citizens' Survey (2003)

Q52: "*More people send their children to primary school than before. Why do you think this is the case?*"

Options: "Important reason - Not an Important reason - Don't know"

Here only the percentage of respondents choosing the option 'Important reason'

As shown in table 4.1, each respondent was given scope to choose several reasons, because service delivery improvement is a combination of different factors. The most important reason cited was the government decision to abolish school fees; 84 % viewed this as the most important reason. The two next two most cited reasons were linked to empowerment of the people – popular sensitisation ('people have recognised the importance of schooling') and the 'government has mobilised people'. The latter perception was particularly widespread in Moshi DC and Mwanza CC. The purely technical supply factor – 'quality has improved' – was perceived to be important only by a minority of respondents. When asked more generally about the reasons for service improvement (see table 4.2 below), people's empowerment was unfortunately not among the listed response alternatives. As one can see, 'citizen contributions' was an option applied only in Kilosa DC, where 18 % regarded it an important factor.

Table 4.2 Reasons for General Service Improvement (% of respondents, by council, who see general improvement in service delivery and attributes improvement to the particular factor [52])

Description		Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
LGRP	**Yes**	24	24	16	22	23	26	**22**
	No	43	38	58	49	10	19	**38**
	Don't know	33	38	27	28	68	55	**40**
Central Government	**Yes**	45	42	57	57	33	29	**45**
	No	26	20	21	18	6	15	**18**
	Don't know	29	38	22	25	61	56	**37**
Donors	**Yes**	33	16	17	24	4	19	**20**
	No	37	36	54	52	28	19	**39**
	Don't know	30	48	30	24	68	62	**41**
TASAF	**Yes**	1	33	-	10	-	1	**7**
	No	57	24	70	61	30	33	**48**
	Don't know	42	43	30	28	70	67	**45**
Other	**Citizens' Contribution**	-	-	18	-	-	-	**3**
	Not Applicable	100	100	82	100	100	100	**97**
Number of Respondents		177	128	151	176	102	156	**890**

Source: Citizens' Survey (2003)

Q56: "*If there has been any improvement in the service delivery in this area in recent years, to which factors can it be attributed to?*"

Options: as shown

On average, 'central government' was attributed to be the most important factor. However, there were

[52] A sub-sample where those who have not seen any improvements (29.4 % of the whole sample) were excluded.

big variations between the case councils. Lower popularity of the central government as reflected in stronger support for the opposition parties (as in Moshi DC) and the strong presence of donors[53] (as in Ilala MC, Mwanza CC and Bagamoyo DC) may have reduced the share of respondents that selected 'central government' as the main reason for improvements. Only 22 % of the respondents attributed service improvements to LGRP, with only small variations between councils, which puts it nearly on par with the percentage (20 % on average) attributing improvements to 'donors'. This low perceived importance of the LGRP might indicate, again, that technical factors and professional capacities of the service providers are still seen to play a major role.

When specifically asked about the role – or commitment – of 'central government' in service delivery, a large majority of respondents (60-65 %) in general believed that the government was doing its best. There is reason to conclude that the positive key role attributed to the central government by citizens was informed by the Primary Education Development Plan – the 'PEDP effect'.

The exceptions were Moshi DC and Ilala DC, where the population was more divided. A majority in Moshi DC thought that the government was *not* doing its best to fight poverty and that the LGRP was *not* helping to improve service delivery.

Table 4.3 Government's Role in Service Delivery (% of all respondents, by council)

Description		Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Government Is Doing Its Best To Improve Service Delivery?	**Yes**	60	71	68	67	58	70	**65**
	No	40	30	32	33	42	30	**35**
Government Is Doing Its Best To Fight Poverty?	**Yes**	51	60	68	64	49	59	**58**
	No	49	41	32	36	51	41	**42**
LGR Is Helping To Improve Service Delivery?	**Yes**	53	64	62	64	44	61	**58**
	No	47	36	38	36	56	40	**42**
Government Cares For Its People In Provision Of Services?	**Yes**	56	64	65	67	57	61	**62**
	No	44	36	35	33	43	40	**38**

Source: Citizens' Survey (2003)

*Q*14: "*Which statement in each pair corresponds more closely to your own views?*"

Options: as shown: "Yes, government - " vs. "No, government is not …"

What about the role of the role of the citizens? How important is popular participation in service delivery? In which sectors? Table 4.4 maps out the participation of respondents in particular committees.

[53] We include TASAF among 'donors' – a World Bank designed and funded programme, although marketed as part of the central government's poverty reduction strategy.

Table 4.4 Popular Participation in User Committees (% of all respondents involved in the particular committee)

Description	Number	% of Respondents
School Committees	355	28.2
Water Management Committees	168	13.3
Public Works Project Committees	111	8.8
Agricultural/Livestock Extension Contact Groups	37	2.9
TASAF-Project Committees	24	1.9

Source: Citizens' Survey (2003)

Q12: "*Have you or another person in your household been involved in any of the following?*"

Options: as shown

Primary education is by far the most community-based service delivery. A good proportion of respondents (29 %) have taken part in school committees. Water supply and public works represented an intermediate category: 13 % had participated in water management committees, and 9 % in public works project committees. Only 3 % had taken part in agricultural/livestock extension contact groups. The PSSS survey reported the same tendency, although with lower figures: 16 % had participated in school committees and 6 % in water committees (REPOA, 2003).

The school and water committees distinguish themselves with a high number of responsibilities: planning, budgeting, mobilisation of community to self-help, contribution in construction and maintenance work, and management in general. This is supposed to create a sense of community ownership of the school and water scheme. Community ownership is more formally developed in the water sector, however, with injection of community funds. The health sector does not enjoy a similar system of wide popular participation in its management committees. However, the health centres have community representatives on their boards. There are also health sub-committees within most of the village councils, which are sometimes involved in the running of the nearby government dispensary.

Table 4.5 Popular Participation in Other Local Bodies (% of all respondents involved in the particular body)

Description	Number	% of Respondents
Participation In Full Council Meetings	305	24.2
Preparation Of The Village/Ward Plan	248	19.7
Village/Ward/Council Leadership	218	17.3
Primary Co-Operative Society/Farmers Association	109	8.7
Local Government Reform Training Workshop	69	5.5
Civic Education Programme	63	5.0

Source: Citizens' Survey (2003

Q12: *"Have you or another person in your household been involved in any of the following?"*

Options: as shown

A very high portion (20 %) of respondents had taken part in preparing the village/ward plan (compared to 23 % in the PSSS-survey), and 17 % had taken part in the village/ward/council leadership (24 % in the PSSS survey). 5.5 % reported they had attended a local government reform training workshop, and 5 % a civic education programme. These figures need to be scrutinised and checked with other surveys. If the high level of popular participation can be confirmed as suggested by the citizen survey, then a more people-driven and decentralised system for service delivery should be a key to the future LGRP agenda.

The interaction between technical and political factors, and professional and community capacities, produces the mobilisation-for-change capacity in service delivery. This capacity may vary from one case council to another. Some councils have better access to well-educated and experienced professionals than others, and some councils have stronger self-help capacities within their communities than others. May this varying capacity explain the differences in service delivery performance, as described in chapter 3? It is beyond the scope of this report to carry out a systematic analysis of this question. However, two cases will be briefly investigated: anti-poverty work and anti-AIDS work.

Anti-poverty work as well as anti-HIV/AIDS work can be interpreted as extraordinary types of 'service delivery' in their demands for urgent, cross-sector and public/civic cooperation. They demand close cooperation between technical and political, and professional and popular forces. They provide indicators on the councils' capacity for innovative and socially inclusive action, as well as the capacity to implement key national policies for social development.

4.2 Case 1: Anti-Poverty Work

One objective of the Local Government Reform Programme (LGRP) is to restructure the LGAs so that they "improve quality, access and equitable delivery of public services, particularly to the poor". (emphasis added, Ed.)

Steps two to five of the 17 steps comprising the first phase of the LGRP sought to mobilise professional and popular resources with the aim of setting up a plan for improved pro-poor service delivery/ poverty alleviation.

- Step Two: holding of the first stakeholders' awareness workshop.
- Step Three: data collection (e.g. council base data collected from heads of departments; NGOs, CBOs and other Service Providers Survey; Stakeholders Survey.
- Step Four: data analysis (leading to reports – Iringa DC: "Analysed Report of District Council Service Delivery Performance", and Ilala MC: "Status of the current services delivery by the Council").
- Step Five: holding of new stakeholders meeting to discuss the report, leading to a strategic plan for service delivery.

Based on the reports, and interviews with planning officers and other key actors in these activities, the councils' poverty orientation was analysed focusing upon:

- definitions of 'poverty' (e.g., includes everyone or 'underdevelopment'),
- definitions of 'the poorest-of-the-poor', and
- council strategy: long-term address of poverty in general and short-term target groups.

Definitions of poverty differed substantially from a general presentation of 'everybody' as poor in Bagamoyo DC to a picture of individual vulnerability in urban Ilala MC; from a market induced impoverishment in Kilosa DC and Moshi DC to an ecologically produced underdevelopment in

Iringa (lack of water in sub-districts). Since poverty usually takes different forms and is perceived differently in different parts of a country, elements of a national poverty reduction strategy need to be formulated by local councils. However, we found no coherent anti-poverty strategies in any of the case councils, not even in those with relatively well-functioning participatory planning systems. For instance, there were only vague definitions of 'the-poorest-of-the-poor', and hence no groups were targeted for short-term poverty alleviation or social safety nets.

Moreover, three general features in the plans for improved service delivery were identified.

i) The emphasis was on "equitable delivery of public services" (emphasis added Ed.) rather than "services particularly to the poor". A typical example was water: the plans suggested supply-driven rollout of standard services to non-served parts of the district, or rehabilitation of water schemes not functioning. The poverty focus was implicit, but not openly informing the plan, e.g., by prioritising certain sub-districts. The plans did not explicitly address needs targeting the poor. Nor were needs identified by representatives of the poor. Poverty targeting activities were often left to foreign NGOs or donor-funded national social sector infrastructure investment programmes like TASAF to formulate.

ii) If vulnerable groups or 'the poorest of the poor' were identified, the emphasis was on reactive alleviation of an unspecified number of 'lucky few' rather than pro-active safety nets for everybody within the category. The vulnerable groups identified in the six councils were many and broad: 'the old people', 'old people who have no children to take care of them', 'street children', 'orphans', 'handicapped', 'the youth and the unemployed', 'divorced women', 'unmarried women', 'the farmers in general', 'retired officers', 'young pregnant girls who have been chased from home', 'prostitutes'. Usually there was no analysis and no estimate of how many persons comprised each group. Moreover, the measures directed towards these groups were not developed in consultation with the identified groups themselves.

iii) There was an emphasis on social-reproductive services rather than on economic-productive services, such as agricultural extension. Despite a justifiable gender bias (pro-women), this approach does not address a long-term vision of production and employment related poverty eradication. The Citizens' Survey quoted above showed that agriculture extension was the public service with the lowest rates of satisfaction (next to garbage collection) and with a low level of perceived improvement. While 9 % of respondents had taken part in public works project committees, only 3 % had participated in agricultural/livestock extension contact groups. Only 9 % of respondents, of whom 55 % were farmers, were members of primary co-operative society/farmers associations. Although the latter figure reflects the collapse of farmers' co-operatives for subsidised inputs and marketing, it highlights the critical lack of support to reorganisation and revitalisation of the agricultural sector. Possible exceptions are Kilosa DC and Moshi DC. Both councils had traditionally been relatively well off due to cash crop production (sisal and coffee respectively) concentrated in certain sub-districts. However, due to a decline in production and prices (and failure of state policies for sisal restructuring), those sub-districts are now impoverished. The councils try to stimulate new cash crop cultivation. However, these bold plans suffer from lack of funding.[54]

Another dimension of anti-poverty work in councils, where the majority of the citizens are very poor, is to make the whole planning system a participatory-democratic one. The LGRP aims to restructure the LGAs so that they "respond more effectively and efficiently to identified local priorities of service delivery in a sustainable manner". (emphasis added Ed.) In support of the LGRP, PO-RALG designed

[54] In Kilosa DC, the agriculture - and livestock-oriented district development program suffered a lot when its donor, Irish Aid, phased out and withdrew in 2003.

a tool to 'identify local priorities': the participatory planning tool, 'Opportunities & Obstacles to Development' (O & OD). It was introduced in 2002 in several pilot districts. Kilosa DC was one district.

The planning was village-based. In each village, 10 persons were (s)elected for the O&OD committee. They received 7 days' training from district council facilitators, prior to preparing a village plan over a period of 11 days. The plan was supposed to be discussed by the Village Council, before it was sent to the Ward Development Committee. From there it was sent to the Village Assembly for final adoption. All the village plans were sent to a computing unit under the District Planning Officer at the council headquarters. At the district level, the council organised stakeholders' meetings to consult with civil society organisations (including NGOs and CBOs) about the district plan.[55]

Three challenges in the set-up of this planning system are discussed below: (i) how to make it really participatory, (ii) how to make it bottom-up and relevant, and (iii) how to make it truly pro-poor.

i) Making the planning system really participatory. The O & OD model seems to be too costly for the councils to apply it regularly and to all villages and groups of the district. Besides, the critical aspect is to link the 'chosen few' in the village planning committees to the Village Councils and to all villagers through the Village Assembly.

ii) Making the planning system bottom-up and relevant. In this context, relevance means to feed the planning at the village and *mtaa* (street) level into a ward-based plan, and from there, to link the ward plan with resource allocation processes at the council level. Urban-based councils (Ilala MC, Mwanza CC) seem to have some financial advantage and are a bit ahead of the rural-based councils, although Moshi DC reported that the main priorities in every ward development plan had been funded and implemented. The challenge is to routinely link up and fund village/*mtaa* based planning. Certain types of predictability (budget ceilings, rolling three-year plan etc) were yet to be seen in the case councils.

iii) Making the reformed service delivery system truly pro-poor. Apart from the overarching issues of designing pro-poor systems of public information, transparency and accountability, certain political issues need to be addressed: the influence and vested interests of NGOs and CBOs, as well as the role of self-help activities (SHA) in poverty reduction. We found a high NGO presence in service provision in all the councils visited, particularly in Moshi and Mwanza where the politico-administrative and cultural environment have been conducive to private participation. However, there are conflicts and problems of coordination. Sources cited a variety of obstacles to improved service provision.

SHA and micro-credit schemes are often seen as poverty reduction by definition. However, it is important to determine whether, and to what extent, SHA reach the disadvantaged parts of the population. Communities, districts and regions possessing high social capital tend to be much better off economically than others, but they are also more capable of encouraging SHA than others. But do they mainly reach those who already have a fair amount of assets?

4.3 Case 2: Anti-HIV/AIDS Work

4.3.1 Government Policy and Local HIV/AIDS Committees

After formulating a policy, the starting point for any government in anti-HIV/AIDS work is to make citizens aware of the policy and to start a popular mobilisation for its implementation. According to data collected (see table 4.6 below), awareness is low on many issues, but high concerning HIV/AIDS.

[55] This information is based on fieldwork interviews and observations in Iringa District Council in February 2003 and in Kilosa District Council in August 2003.

Only 6 % of surveyed citizens had not heard about the government's HIV/AIDS control policy. In contrast, 53 % had not heard about the LGRP.

Table 4.6 Awareness of Government Policies (% of respondents, by policy)

Government Policy	Have Not Heard Of Policy	Have Heard About Policy Through The Following Media/Institution						
		Radio	Newspapers	TV	Word Of Mouth	Service Delivery Point	NGO/ CBO	Others
Law And Order Policy	60	29	2	2	5	3	-	-
Local Government Reform	53	27	2	1	16	1	-	0.6
Rural Roads Policy	47	34	1	1	9	7	0.1	0.2
Water Policy	32	40	2	2	15	10	0.2	-
Taxation Policy	30	53	3	2	11	0.8	-	-
Privatisation Policy	28	57	5	5	5	0/3	-	0.1
Poverty Reduction Strategy	28	53	4	3	11	2	0,2	0.3
Health Policy	22	47	2	3	10	16	0.2	0.4
Education Policy	21	51	3	3	11	11	0.1	0.2
Anti-Corruption Policy	12	71	4	3	10	0.6	0.2	0.5
HIV/AIDS Control Policy	6	64	3	6	13	4	4	0.4

Source: Citizens' Survey (2003)

Q13: "*You may have heard about different government policies. Which of the following policies have you heard about? And where do you generally hear about these policies?*"

Options: as shown.

The patterns in these figures are similar to those found in the PSSS survey. Popular awareness of government policies was highest on HIV/AIDS, followed by anti-corruption, education and health. Local government reform, and law and order policies ranked lowest in popular awareness (REPOA, 2003).[56]

[56] However, the PSSS survey shows in average a much higher popular awareness of all the public policies. See REPOA 2003:9 (table 5.1.1.).

Table 4.7 below shows that respondents had received information about HIV/AIDS from multiple information sources. By far the most common source of information was the radio (96 % on average, but also printed media like advertising board and newspaper or magazines were common sources). Health centres (80 %) were ranked next. Health workers were not surprisingly the most important face-to-face source of information, but also village/*mtaa* leaders played an important role. In third place came churches or mosques (77 %), while other NGO/CBOs helped inform only 47 % of respondents. People in all the councils were equally well informed. However, there were two indicators of more intensive civic campaigning – church or mosque leaders, and dance/theatre troupe as sources of information. Moshi DC and Mwanza CC had a higher score than the other councils on these indicators.

Table 4.7 Source Of HIV/AIDS Information (% of respondents, by council, having received information from the particular source)

Description	Ilala MC	Bagamoyo DC	Kilosa DC	Iringa DC	Moshi DC	Mwanza CC	Total
Radio	97	92	96	94	99.5	99.5	**96**
Health Centre /Dispensary	78	71	90	73	83	87	**80**
Church or Mosque	68	62	78	74	94	87	**77**
Advertising Board	77	60	72	58	87	82	**73**
Newspaper or Magazine	77	61	67	55	89	85	**73**
Village/Mtaa Leader	60	65	87	82	69	71	**72**
Wall Poster	73	53	71	61	82	79	**70**
Government Official	57	56	75	56	69	77	**65**
Dance/Theatre Troupe	54	62	34	61	73	72	**60**
Politician	53	48	61	51	62	65	**56**
NGO/CBO	52	46	21	56	52	56	**47**
Television	69	42	23	17	59	66	**46**
Others	13	8	3	2	12	13	**9**

Source: Citizens' Survey (2003)

Q55: "*In the last twelve months, have you received information about HIV/AIDS from the following sources?*"

Options: As shown: Yes - No

The "Guidelines for forming AIDS Committees at local government level" was circulated to all local councils from the PO-RALG on January 8, 2003. The extent to which the six different councils adhered to PO-RALG's requirements after few months is now examined.

Table 4.8 State of 'Council Multi-sector HIV/AIDS Committees' in 2003

	Observed	Council Level	Ward and Village Level
Ilala MC (Dar-es-Salaam)	February 03	Established	Wards: 1) WDC sub-committee on environment works on HIV/AIDS Village: 2) A HIV/AIDS school committee
Mwanza CC	February 03	Established	Wards: Established. Ward special committees for HIV
Bagamoyo DC	February 03	Established	N/A
Iringa DC	February 03	Not established	Village: A committee set up by an NGO
Kilosa DC	August 03	Established	Wards: The health committee works on HIV/AIDS
Moshi DC	August 03	Established	Wards: "Committees established in every ward"

Source: Research team observations.

Data from city/district council level, and from two wards/villages in each council.

(In Ilala, the first is an urban poor ward: Buguruni. The second is a peri-rural ward: Chanika.)

The Ward Development Committee (WDC) reports to the LGA.

As shown in table 4.8, the PO-RALG circular was quickly followed up. HIV/AIDS committees had been established at the district and city levels in five of the six case councils. However, apart from a first meeting to constitute themselves, the committees did not seem to undertake frequent meetings. In other words, it was yet to be seen whether the committees were going to be dormant or active.

Taking into consideration that research observations were made very soon after the circular was issued – at two months then at eight months – it was not surprising that committees were not yet established at the sub-district ward level. The exceptions were Mwanza CC and Moshi DC. In Moshi DC, each Ward Development Committees had already initiated cooperation with NGOs/CBOs dedicated to anti-HIV/AIDS work.

4.3.2 'Political' Characteristics of The Anti-HIV/AIDS Work

The responsibilities of the AIDS Committees defined by the PO-RALG circular included the following:

- to bring together stakeholders;
- to oversee the forming of AIDS committees [below their level];
- to recommend and to analyse the state of HIV/AIDS plans and their implementation;
- to evaluate the state of AIDS in the committees' areas;
- to evaluate stakeholder activities on the issue of AIDS;
- to develop, together with citizens and other stakeholders, plans concerning the fight against AIDS/HIV infection, to increase the people's understanding of AIDS, to obtain and keep statistics of the state of AIDS, including the economic status of those affected.

The circular adds that *"Councils will need to have enhanced capacity and knowledge on AIDS control in their areas".*

To some extent, the HIV/AIDS awareness campaigns, especially in the rural districts, had been outsourced to certain NGOs/CBOs. At the ward-level and below, we did not observe a single case of a specialised local government committee on HIV/AIDS. Of course, this may be attributed to the expected slowness of implementing such instructions. On the other hand, the situation on the ground might reflect the lack of capacity in the sub-district government structures. Hence, the existing ways of combating HIV/AIDS might, in some places, represent the best way of utilising scarce (public and private) resources.

What characterises the councils with a high (and real) priority to fight HIV/AIDS? A point of departure is the emphasis on HIV/AIDS – the declared or stated priority – given in interviews by the local political authority at district and village government level.[57] However, those statements should be checked against observed action, as revealed by action plans, action reports, and current activities executed by government and non-government agencies.

We have identified a pattern of variation between councils, as indicated by table 4.9 below. In regard to 'political' characteristics of HIV/AIDS interventions, we refer to the priority stated by the local authorities, the level of actions and involvement by the government locally, and the level of actions and involvement by 'civil society' locally. Using this method, high, medium and low 'prioritisers' of HIV/AIDS were identified among the districts and cities.

Table 4.9 'Political' Characteristics of HIV/AIDS Intervention

Council	Emphasis on HIV/ AIDS	Government Involvement	Civic Involvement	Sum: Real Priority
Mwanza CC	High	High	High	High
Moshi DC	High	High	High	High
Ilala MC	High/medium	Medium	Medium	Medium
Bagamoyo DC	Medium/low	Medium	Medium	Medium
Iringa DC	Low	Medium	Medium	Medium/low
Kilosa DC	Medium/low	Low	Medium	Low

Source: Research team observations

Note: Data from city/district council level, and from two wards/villages in each council.

Operational definitions:

"Emphasis on HIV/AIDS": High/ low priority stated by local political authority.

"Government involvement": High/low; which departments most active; mode (own action, with NGOs).

"Civic involvement": High/low; which NGOs/CBOs most active, in which activities.

"Real priority": assessed priority of HIV/AIDS based on stated emphasis and observed action.

Table 4.9 indicates that Mwanza CC and Moshi DC attributed high priority, Ilala MC and Bagamoyo

[57] The council executive director, the mayor/council chairperson, council committee chairpersons etc., and village executive officer, village council chairman etc.

DC medium priority, and Iringa DC and Kilosa DC low or medium/low priority to HIV/AIDS work.

The councils which placed high priority on HIV/AIDS work, Mwanza CC and Moshi DC, saw the council taking a lead role in the struggle, and a high number of NGOs and CBOs were co-operating closely with local authorities at all levels. Two NGOs were recognised by other actors as the head of the 'movement' – TANESA and KIWAKKUKI/SAKUVI. They had close relations to CBOs and the villages respectively. At the ward-level, workshops that trained 50 educators to work in the villages were conducted, with access to the Village Meetings organised every three months by the Village Council.

The 'medium prioritisers', Ilala MC and Bagamoyo DC, saw active engagement by the government, but more by the sector ministries (health and education) than by the council. In Ilala, anti-HIV/AIDS was the first priority of the Health Action Plan, but only Tshs 8 million of the Tshs 1,405 million health budget was earmarked for activities linked to HIV/AIDS. Every school was supposed to have a HIV/AIDS committee, but most education on the subject seemed to be made by the NGO, CCBRT, which spends two days at every school. The public sector was a 'junior partner' to the non-government sector. Still, among the NGOs there was no 'locomotive' or driving force for the campaigns (see table below). The situation appeared the same in Bagamoyo DC, except that one NGO, TANESA, was reported to be a driving force.

The 'low or medium/low' prioritisers, Kilosa DC and Iringa DC, showed low engagement by council leadership. In the Kilosa District Plan, HIV/AIDS was mentioned late in the report, as one of three 'cross cutting issues' along with women and environment. The health and education administrations kept no high profile on the issue, particularly in Kilosa. The schools were reported not to raise the issue seriously. However, a few villages were very concerned with HIV/AIDS, particularly those along the main national roads in Iringa. A handful of very active CBOs were also identified, but there was no major anti-HIV/AIDS force among the NGOs to penetrate all villages in these districts.

Table 4.10 NGOs/CBOs Identified To Work On HIV/AIDS In The Six Case Councils

NGO/CBO Acronym	Type Of Organisation + Main Activity	Mwanza	Moshi	Ilala	Baga	Iringa	Kilosa
AMREF	NGO for health development		X			X	
AFREDA	CBO, Works in Gairo, a sub-district in Kilosa						X
BAKWATA	NGO; Moslem social work organisation	X					
CARE	NGO, international multi-sector agency. Works with AIDS patients.				X	X	
CCRBT	NGO, big in Ilala; awareness in schools			X			
CONCERN	NGO, international multi-sector agency; HIV awareness 'streamlined'					X	
FARAJA	NGO. Trust fund for women's development. In a sub-district in Kilosa						X
FASCO	CBO. Works on sexually transmitted diseases				X		
JUHUDI	CBO. Youth group					X	
KIWAKKUKI	NGO, 'Women against AIDS in Kilimanjaro'[58]		XX				
KIWOHEDE	NGO/CBO, against sex and child labour in Buguruni ward, Ilala			X			
MACDA	CBO		X				
MKUKI	CBO		X				
PLAN	NGO, international multi-sector agency	X		X			
Rainbow	CBO		X				
Red Cross	NGO		X				
SAKUVI	NGO/CBO[59]		XX				
SOCAC	CBO -				X		
TAHEA	NGO, Tanzania Home Economics Association		X		X	X	
TANESA	NGO, an association for research and treatment of HIV and venereal diseases.[60]	XX			XX		
TUSHIKAMANE	"CBO dealing with HIV/AIDS control matters"						X
UMATI	CBO		X				

Source: Research team observations

Key: Mwanz=Mwanza CC Moshi=Moshi DC Ilala= Ilala MC

Baga=Bagamoyo DC Iringa=Iringa DC Kilosa=Kilosa DC.

Note: The NGO/CBO regarded to be a prime mover in the local work against HIV/AIDS is marked with a double cross ('XX')

[58] "Kikundi cha Wanawake cha Kupambana na Ukimwi Kilimanjaro"

[59] "Saidia Kudhibiti Ukimwi Vijijini". Carries out education on how to deal with the HIV problem; in Moshi since 1997.

[60] TANESA helps the society in implementation of HIV policies. Works in villages with youth or age groups ("Waeleimishaji lika")

Three of the six councils – Mwanza CC, Moshi DC and Bagamoyo DC – have a 'locomotive' among the NGOs/CBOs for their anti-HIV/AIDS work. These organisations are identified with a double 'cross' in table 4.10.

4.3.3 'Technical' Characteristics of Anti-HIV/AIDS Work

The more technical, or operational, characteristics of anti-HIV-AIDS intervention are typically the responsibility of the health authorities, and it is possible to identify 'high', 'medium' and 'low' performers on anti-HIV-AIDS interventions. Table 4.11 presents four indicators of performance. As one can see, the capital city council of Ilala was doing well, probably because of its relatively good access to human and financial resources. Also the high prioritisers, Mwanza CC and Moshi DC, were performing reasonably well, and so was the medium prioritiser, Bagamoyo DC. In sum, these four councils were classified as 'medium performers'.

Table 4.11 "Technical" Characteristics of HIV/AIDS Intervention

	Operational Priorities	Testing Facilities	Socio-Medical Knowledge	Scope of Intervention
Mwanza CC	Clear	Yes, only in hospital	Medium	Broad
Moshi DC	Clear	Yes, even at one health centre	Medium/high	Broad
Ilala MC	Clear	Yes, even at health centres	Medium/high	Semi-broad
Bagamoyo DC	Semi-clear	Yes, only in hospital	Medium/low	Broad
Iringa DC	Unclear	No	Low	Narrow
Kilosa DC	Unclear	No	Low	Narrow

Source: Research team observations

Note: Data from city/district council level, and from two wards/villages in each council.

Operational definitions:

"Operational priorities": extent of prioritisation and 'concreteness' of plans and activities.

"Testing facilities": hospitals (city/district level), health centres (sub-district) and dispensaries with facilities to test people for HIV.

"Socio-medical knowledge": knowledge of the prevalence of the pandemic (infected, dead) and of its main social causes (carriers and circumstances of infection).

"Scope of intervention": Limited to 'awareness' only (narrow), or extended to prevention (E.g. condom campaigns), care or even treatment (broad).

Iringa DC and Kilosa DC should be classified as low performers in this regard. They offered no testing facilities, and no knowledge about the prevalence and social causes of the pandemic. Their scope of intervention was also less ambitious. The usual references to behavioural change campaigns in Tanzania are 'ABC': 'Abstain, Be faithful, Condomise'. The two low performers presented a narrow scope of work. The only issue was 'awareness', linked to the religious teachings of 'Abstain', or 'Be Faithful'. The 'C '– 'Condomise' – was rarely emphasised. Furthermore, active prevention, care for the victims, and treatment for the infected were not on the agenda.

The four 'medium performer' councils offered a wider scope of intervention, although awareness raising was the major issue in these councils as well. However, they also provided prevention campaigns, not to youth in general, but rather to sex workers in urban areas. Additionally, there was some support for home-based care, provided by community nurses. Similarly, medium performers showed some concern for orphans, although we saw no public orphanages or special programmes. Treatment was offered to HIV-positive women giving birth and to their newborn in some places, e.g. Bagamoyo DC and Mwanza CC. In some rural areas there was cooperation between health authorities and traditional healers relative to treatment, and some social categories were emerging as more or less clearly identified target groups.

Two important weaknesses were prevalent in all six councils. First, testing facilities were limited. The dispensaries and other primary health units had no testing facilities, and only a few health centres or the main hospital offered this service. The majority but not all pregnant women were tested. Further testing was conducted on those who happened to come for consultation, and whom the doctors suspected were infected. Very often the results of the tests were not being conveyed to the patient.

Secondly, socio-medical knowledge about the disease, its prevalence and its social causes was limited. Ilala MC claimed to know that AIDS caused 36 % of all premature deaths in that city. A Moshi DC representative claimed to know that 10 of its staff had died from AIDS, and health officers in Bagamoyo DC knew that 7% of pregnant woman were infected. However, a comprehensive and exact picture of the pandemic had not been drawn in any city or district.

Hence, a lot remains to be done, even in the local councils with proven dedication to the struggle against HIV/AIDS.

4.4 Summary and Remarks

Through the Local Government Reform Programme, the government has a role in promoting both technical and political factors in local service delivery. As to the increased primary school enrolment, the citizens perceived the governments (and thus political factors) to be most important. The government abolished school fees, and it sensitised and mobilised people. As to the citizens themselves, the Citizens' Survey indicated a very high participation in user committees (28 % in school committees) and other local bodies (17 % in village/ward/council leadership%). These figures need to be scrutinised and checked with other surveys. If confirmed, a more people-driven and decentralised system for service delivery should be a key to the future LGRP agenda.

Anti-poverty work as well as anti-HIV/AIDS work were interpreted as extraordinary types of 'service delivery' in their demands for urgent, cross-sector and public/civic cooperation. Both demand a close cooperation between technical and political, and professional and popular forces. They also provide indicators on the councils' capacity for innovative and socially inclusive action, as well as the capacity to implement key national policies for social development.

As to anti-poverty work, the planning documents and interviews from the case councils did not reflect any consistent or clear definitions of poverty. There were only vague definitions of 'the poorest-of-the-poor', and there were no coherent anti-poverty strategies. Moreover, the emphasis was on "equitable delivery of public services" (emphasis added, Ed.) rather than "services particularly to the poor". If vulnerable groups or 'the poorest of the poor' were identified, the emphasis was on reactive alleviation of an unspecified number of 'lucky few' rather than pro-active safety nets for everybody within the category. There was also an emphasis on social-reproductive services rather than on economic-productive services, such as support to the reorganisation and revitalisation of the agricultural sector, which surveyed citizens found in a dismal state.

Another dimension of anti-poverty work, in councils where the majority of the citizens are very poor, is to make the whole planning system a participatory-democratic one. Three challenges in the set-up of this planning system were discussed:

i) how to make it really participatory,
ii) how to make it bottom-up and relevant, and
iii) how to make the reformed service delivery system truly pro-poor.

The way these challenges is met depends on the influence and vested interests of NGOs and CBOs, as well as the role of self-help activities in poverty reduction. The government – and local council staff – is required to regulate and oversee the NGOs and CBOs and to enforce the law and contracts. Central and local governments also need to support the active empowerment of the poor and disadvantaged groups.

As to anti-HIV/AIDS work, surveyed citizens reported that they were well informed by multiple national and local sources. That was a good starting point. The "Guidelines for forming AIDS Committees at local government level" was circulated to all local councils from the President's Office (PO-RALG) on January 8, 2003. Within a few months these committees had been established at the council level, and in Moshi DC and Mwanza CC, even at the ward level. These two councils were identified as 'the high prioritisers' of anti-HIV/AIDS work. Ilala MC and Bagamoyo DC were 'medium prioritisers'. Iringa DC and Kilosa DC were 'low prioritisers'. The latter two district councils were also singled out as 'low performers' when it came to the researcher's judgment of technical, or operational, characteristics of anti-HIV/AIDS intervention. The other four councils were classified as 'medium performers'. A lot remains to be done even in the local councils with proven dedication to the struggle against HIV/AIDS.

5. CONCLUDING REMARKS

The findings in this report can be summarised as follows: local service delivery in Tanzania has improved, but the citizens are still dissatisfied with the accessibility, quality and affordability of almost all public services. The exception is primary education, where donor and government led progress (through the PEDP), comprehensive community involvement, and high citizen satisfaction coincide.

The findings from the Citizens' Survey underlying this report are supported by the Policy and Service Satisfaction Survey (REPOA 2003). Major improvements, comparable to those in primary education, have not taken place in health care, despite enhanced spending in this sector. Only a quarter of the respondents have seen improvement in domestic water supply, and agricultural services were in even worse shape, according to the citizens surveyed (REPOA, 2003).

The Poverty Reduction Strategy Paper for 2000-2005 defined education and health as the main priorities. The Poverty and Human Development Report 2005 (URT 2005) confirms that there have been progress not only in education, but even in the health sector, particularly in services that benefit the youngest part of the population. As to the water and sanitation sector, progress is more difficult to ascertain due to unexplained discrepancies between various data sources, "which call into question the validity of relying on routine data for monitoring progress towards the targets" (URT 2005:48).

A common denominator in all local services was a scarcity of professional human resources. Funding for investments had improved in recent years due to increased conditional grants for health and education (as a result of the HIPC arrangement) and schemes to support self-help initiatives (like TASAF). However, there was insufficient funding to re-employ the required personnel, nurses and teachers. Financial austerity programmes and retrenchments in the public sector in the 1990s led to substantial loss of jobs in public service provision. There has been a cautious drive towards re-employment in recent years. Still, community driven development, as in the education sector, appears to create a 'demand' for skilled labour not adequately supplied due to bottlenecks in the national supply of financial and human resources. Moreover, the human resource policy and management in the health and education sectors appear to provide disincentives for increased productivity in these sectors. Inadequate staff housing, uncertainties about pension rights for personnel transferred from government to local council pay rolls, and cuts in remuneration of officers due to abolition of certain allowance schemes, etc., are not yet addressed.

As concluded by the Poverty and Human Development Report 2005, the equitable provision of essential services has to be enhanced, and the deployment of staff is a key – the rural districts need a higher number of qualified professionals. The remedy is to provide improved financing and staffing to the poorest districts through formula-based central government allocations to address the spatial inequalities (URT 2005:77, 94).

The interaction between technical and political factors, and professional and community capacities, produces the mobilisation-for-change capacity in service delivery. This capacity may vary from one case council to another. Some councils have better access to well-educated and experienced professionals than others, and some councils have stronger self-help capacities among its communities than others.
To sum up, there are sector-specific as well as general governance characteristics at play:

1 Sector-specific policy characteristics;

i) The policy itself (incoherence, ambiguities, lack of realism, etc.).
ii) Policy implementation and financial arrangements, including the relationships between LGAs on the one hand, and other agents – NGOs, donors, central government, specialised bodies, etc. – on the other.
iii) Policy implementators (council financial and professional capacity, staff qualifications, participation of councillors at district and village levels etc.).

These policy characteristics are interlinked and shaped by governance characteristics.

2. General governance characteristics providing organisational inputs to local social development:

i) The central-local relationship (vertical) – the extent of local autonomy in cross-sector development planning, resource allocation, and management.
ii) The relationship (horizontal) between sector planning and management and cross-sector planning and management.
iii) The relationship between professional and popular capacities – e.g. the extent of professional domination.
iv) Gender relations. Since the 'users' in social service delivery are usually women/mothers, one should emphasise the gender perspective particularly in the assessment of popular capacities.

For all four sub-dimensions the extent of optimal/productive cooperation in development activities should be a main aspect.

Future research should examine more closely the relationships between public policies, governance, financial situation and management, and the performance of local service delivery.

APPENDIX

Indicators of Change For Service Delivery

Inputs	**Changes In Service Delivery**	**The Main Objective Of The LGRP**	
	Objectives	**Indicators of Change**	**Methodology/Data Sources**
LGRP **-Focus on training and capacity building** **-New administrative procedures**	1. Improved service delivery (quality)	- Citizens' perceptions on improved quality of the key services - Council staff perceptions on citizens' involvement in planning - Elected leaders'/councillors' perceptions on citizens' involvement	- Citizens' survey/focus group discussions - Interviews with staff at service points - Interviews with council HQ staff - Interviews with councillors - Interviews with elected political leaders at hamlet and village levels - Interviews with stakeholders at the central level (ALAT, LGRP)
	1.1 Improved quality of primary schools	- Increased average satisfaction rating with primary schools (responsiveness indicator) - Improved teachers' grade - Increased average primary school pass rate (data from the LGAs) - Teacher-pupil ratio - Pupil-desk ratio - Pupil-textbook ratio - The national ranking of primary schools in the LGA	- Citizens' survey - Interviews with School committee members - Interviews with council staff (Education officer) - Interviews with head teachers - Interviews with councillors and elected leaders from village and hamlet levels - Data from the LGAs - Data from the LGRP - Data from ALAT - Data from the Ministry of Education

Inputs	**Changes In Service Delivery**	**The Main Objective Of The LGRP**	
	Objectives	**Indicators of Change**	**Methodology/Data Sources**
Other Reforms/ Programmes	1.2 Improved quality of health services	- Increased average satisfaction rating with health care (responsiveness indicator) - Perceptions on the availability of drugs - Infant mortality rate - Immunisation rate - Morbidity rate - Prevalence of stunting	- Citizens' survey - Interviews with dispensary committee members - Interviews with council staff (health officers) - Interviews with health staff/nurses/dispensary staff - Interviews with councillors and elected leaders at village and hamlet levels - Data from the LGAs - Data from the LGRP - Data from ALAT - Data from the Ministry of Health
Other Factors	1.3 Improved quality of water supply	- Number of cases of water born diseases reported - Perceptions of changes	- Interviews with council staff (Health officer) - Interviews with health staff/nurses/dispensary staff - Interviews with councillors/elected leaders - Data from the LGAs - Data from the LGRP - Data from ALAT

Inputs	Changes In Service Delivery	The Main Objective Of The LGRP	
	Objectives	**Indicators of Change**	**Methodology/Data Sources**
	2. Improved accessibility to key services for poor people (quantity)	- A larger share of council total expenditures going to key social services - Perceptions on access to services	- Data from the LGAs (Financial statements) - Data from the LGRP - Citizens' survey
	2.1 Improved access to primary schools	- Perceptions on accessibility - Number of classrooms (schools) per village/ward - Pupil-classroom ratio - Number of teachers per pupil - Enrolment rate - Average distance to nearby school - Secondary school enrolment rate (share of pupils who completes primary school and proceeds to secondary school)	- Citizens' survey - Interviews with school committee members - Interviews with council staff (education officers) - Interviews with head teachers - Interviews with councillors and elected leaders from village and hamlet levels - Data from the LGAs - Data from the LGRP - Data from ALAT - Data from the Ministry of Education
	2.2 Improved accessibility of health services	- Perceptions on accessibility - Percentage of households/people with access to health services (effectiveness indicator) - Number of health centres in the LGA (changes over time) - Number of health personnel (changes over time) - Doctor-population ratio - Patient-hospital bed ratio - People-dispensary ratio - People-per doctor ratio - Time spent at the dispensary - Average distance to dispensary/health facility - Availability of drugs	- Citizens' survey - Interviews with dispensary committee members - Interviews with council staff (health officers) - Interviews with health staff/nurses/dispensary staff - Interviews with councillors and elected leaders at village and hamlet levels - Data from the LGAs - Data from the LGRP - Data from ALAT - Data from the Ministry of Health

Inputs	**Changes In Service Delivery**	**The Main Objective Of The LGRP**	
	Objectives	**Indicators of Change**	**Methodology/Data Sources**
	2.3 Improved access to clean water	- Number of people with access to clean water - Average distance to drinking/clean water source - Number of wells/bore holes	- Interviews with council staff (Health officer) - Interviews with health staff/nurses/dispensary staff - Interviews with councillors/elected leaders - Data from the LGAs - Data from the LGRP - Data from ALAT
	3. Increased non-public/ private service providers	- Number/share of non-public service providers (PPP)/non-government service outlets (e.g., share of pupils in private school; and number of patients in private health facilities compared to number of patients in public health facilities) - Public control/regulations of non-public service providers	- Data from the Education & Health departments - Data

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