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Institutional arrangements for decentralized water and health services delivery in rural Tanzania: differences and constraints

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In recent years, decentralization has been upheld by governments, donors and policy makers in many developing countries as a means of improving public services although opinion is divided on the link between decentralization and service delivery. This article reviews recent literature and research on decentralized service delivery in Tanzania. It uses the principal-agent theory and broader decentralization frameworks to describe and compare decentralization in two sectors: water and health. The analysis shows that decentralization between the two sectors differs, with the water sector displaying a mixture of bottom-up and top-down models while the health sector is more centralized with an orientation towards the top-down model. It is concluded that decentralized service delivery in Tanzania takes on different forms where the nature of sector is an important factor in the kind of institutional arrangements, in which gender plays a role as well.

Keywords: Decentralization, institutions, principal-agent theory, public services, Tanzania.

INTRODUCTION

Tanzania has undergone major decentralization reforms over the past one decade through local government reforms (LGRs) with an overall objective of improving the quality, access and equitable delivery of public services provided through or facilitated by local government authorities (LGAs). Although decentralization has been an important part of the development agenda for much of the post-independence period, there are major variations in the forms that decentralization has taken place. Earlier attempts from the 1960s to mid-1990s were often implemented by 'deconcentrating' and 'delegating' responsibilities to regional and local governments (Tordoff, 1994; Hirschmann, 2003; Shivji and Peter, 2003; Kessy and McCourt, 2010). Recent reforms which started in 1998 have been described as more 'holistic' and 'far-reaching' (URT, 2008a). LGRs are being implemented under the policy of 'decentralization by devolution' with a goal of restructuring LGAs[1] so that they can respond more effectively and efficiently to identified local priorities of service delivery (URT, 1996, 1998, 2008a, 2009).

Since then, many studies focusing on different dimensions of the reforms have been carried out including those looking at the fiscal aspects (Boex, 2003; Fjeldstad, 2004; Fjeldstad et al., 2004; Lund, 2007), political devolution and local democracy (Lange, 2008; Kessy and McCourt, 2010), and local government discretion and accountability (Venugopal and Yilmaz, 2010). Few researchers have examined the relationship between the process of decentralization and its outcomes on service delivery. Examples include those looking at the water sector (Jiménez and Pérez-Foguet, 2010a,b; de Palencia and Pérez-Foguet, 2011) and the health sector (Mubyazi et al., 2004; Boon, 2007; COWI and EPOS, 2007; Maluka et al., 2010). Although some of these studies highlight the types of institutions created by the reforms to facilitate delivery and management of

[1] *LGAs in Tanzania are divided into rural and urban authorities. Rural authorities are district councils and township authorities while urban authorities include city, municipal and town councils.*

public services, little attention has been paid to the interplay between the local level institutional arrangements and the broader governance structures based on an analytical framework. Similarly, the differences and constraints in institutional arrangements between different sectors have not been fully explored.

To bridge this gap and contribute to the decentralization literature in Tanzania, this article examines decentralized service delivery in the sectors of water and health employing the principal-agent theory to explain the relations between actors in the institutional arrangements. The main question is: what are the main institutional characteristics of the current decentralization processes with regard to water and health services delivery, and what are the factors that constrain the realization of decentralization? The specific questions are: which institutions are responsible for delivery of water and health services at the sub-district level; how are the power relations between and within these institutions structured; and what are the constraints and differences between the two sectors?

We define institutions as the "structures of rules, procedures and organisations whether state provided or otherwise" (Kimenyi and Meagher, 2004). Decentralization for service delivery entails restructuring institutions and/or creating new ones because its expected outcomes partly depend on institutional arrangements and their power relations (Azfar et al., 2004; Batley, 2004; Eaton and Schroeder, 2010; de Palencia and Pérez-Foguet, 2011). The assumption is that having the right local institutional framework will result into better use of resources leading to improved service delivery (Mubyazi et al., 2004; Cleaver and Toner, 2006; Ribot et al., 2006). Although decentralization has mostly been approached as a sector-neutral process, effective institutional arrangements for public services delivery could be sector specific. Hence, it is important to analyse decentralization not by focusing on one sector only or on local public services in general. Furthermore, it can be hypothesized that decentralization processses are gendered, meaning that they will not equally address men's and women's needs, while this will also differ per sectors. We see gender as a cross cutting perspective using Moser's (1993) distinction between practical and strategic gender needs. The next section presents the methodology used in this study.

METHODOLOGY

The present article forms part of a research project on the 'gender perspectives on the implications of decentralization reforms on service delivery in rural Tanzania' currently being carried out by the first author in the districts of Kondoa and Kongwa. The article is based on the information obtained through a desk review of the scientific literature, research reports and policy documents on decentralized service delivery in general, and Tanzania in particular; semi-structured and unstructured interviews with district council officials and village leaders; and analysis of secondary data from district councils and village leaders. While a major part of the analysis and discussion relies on the literature review, some relevant preliminary empirical findings from the field are also integrated. In the next section, we discuss the theoretical perspectives on decentralization focusing on its meaning, potential benefits and limitations for service delivery, and the principal-agent theory which is the main analytical framework in this article.

Decentralized service delivery: meaning, rationale and limitations

Although decentralization has been defined variedly, it is generally accepted that in the broad sense, it denotes "the transfer of power and responsibility to plan, make decisions and manage public functions from higher level of government to a lower one" (Conyers, 1990:19). Decentralization deals with the territorial distribution of power, authority and responsibility for the political, fiscal and administrative systems between the centre and the periphery (Brinkerhoff and Azfar, 2010). Crucial questions are therefore, what powers are transferred and to which local institutions are they transferred to. The answers to these questions determine the extent to which local institutions as recipients of decentralized powers, can effectively plan and implement development activities including service provision (Conyers, 1990).

Decentralization is frequently advocated as a means of improving public services delivery based on the assumption that in a decentralized system services are more responsive to local needs and demands of service users because citizens can directly or indirectly influence decisions about resource allocation and service delivery (Rakodi, 2002; Conyers, 2007). Decentralized institutions are viewed to improve matching of public services to local needs and preferences and increase accountability of local governments to their constituencies (World Bank, 2001), resulting in better targeted policies and lower transaction costs (Ribot et al., 2006). The World Bank (2004) stresses that decentralization is an institutional mechanism that has the potential of enhancing the service users' voice in a way that leads to improved services.

Underlying these arguments is the assumption that decentralization of service delivery occurs within an institutional environment that provides the political, administrative and financial authority to local institutions, along with effective channels for local accountability and central oversight (World Bank, 2001; Azfar et al., 2004). According to Conyers (2007), the outcomes of decentralization depend on the type of public services

involved, the institutional design, the way it is implemented, the capacity of institutions involved, and the wider economic, social and political environment.

Hence, decentralized service delivery requires a mix of relations between central and local institutions, referred to as 'institutional pluralism' by Blair (2001). However, many studies indicate that the necessary institutional arrangements for the desired outcomes are rarely observed. Most decentralization reforms are either flawed in their institutional design or central governments do not decentralise sufficient power and resources to local level governments to enable them to have significant impact on local service delivery (Devas and Grant, 2003; Ribot et al., 2006; Conyers, 2007). The principal-agent theory discussed in the next section is therefore a valuable analytical perspective to explain the relations between the actors within the institutional arrangements.

Decentralization and the principal-agent theory

The principal-agent theory (in the literature also referred to as agency theory) is one of the dominant theoretical perspectives for analysing and describing public governance reforms. Initially used mostly by economists (e.g. de Groot, 1988; Dixit et al., 1997; Besley and Coate, 2003), it is now widely applied by sociologists, political scientists and others (Shapiro, 2005; Papenfuß and Schaefer, 2010). The theory proposes a 'principal' with specific objectives and 'agents' who are required to implement activities to achieve those objectives. The core of the principal-agent theory is the 'agency relationship', which depends on power positions and information flows between principals and agents. The question, then, is how principals can manage the interests of agents so that they are in line with the goals they (principals) wish to achieve (Bossert, 1998; Bossert and Beauvais, 2002; Batley, 2004; Brinkerhoff and Azfar, 2010; Calabrò and Torchia, 2011).

Hiskey (2010:30) views decentralization, especially when it takes the form of devolution, as "an alteration of principal-agent relationships, where principals theoretically gain more leverage over agents directly responsible for service provision". He emphasizes that analysing decentralization reforms using the principal-agent perspective helps to explain the trade-offs between different actors and the changes that decentralization may bring with them given the new responsibilities of the actors involved. Mewes (2011) links the theory to top-down and bottom-up models. In the first, local governments are agents, exercising responsibilities on behalf of the central government (principal). In the bottom-up model, the ultimate principals are the citizens or service users, while politicians as representatives in decision-making organs are agents. In turn, local government administrators responsible for executing service delivery functions are agents of local political leaders and service users.

The theory has been criticized for focusing on the vertical relationship between the centre and periphery in a 'one-dimensional' way, which makes it difficult to analyse multiple principals and agents, especially if they are at different administrative levels (Bossert, 1998; Batley, 2004). However, available evidence shows that the theory can accommodate multiple agency relationships (see for example Batley, 2004; Tommasi and Weinschelbaum, 2007; Calabrò and Torchia, 2011) or can be modified to address different contexts (Bossert, 1998; Bossert and Mitchell, 2011). For example, Bossert (1998) introduces the concept of 'decision space' to include various functions and activities over which local governments have control and the degree of choice they are allowed by the central government, as well as the powers actually exercised in practice. The following part introduces the context of LGRs in Tanzania before examining the institutional arrangements for water and health sectors using the principal-agent theory and the wider decentralization frameworks as analytical tools.

The history of decentralized service delivery in Tanzania

During the first decade of independence (1961-71), the local government system inherited from the British colonial government that was based on a combination of chiefdoms and locally elected representatives, was amended into a more inclusive system of representative local authorities. However, local governments did not meet the expectations due to limited financial and human resources, and perception of local governments as implementing agencies of the central government rather than representative bodies answering to local needs. In 1972, local governments were abolished and replaced by a system of deconcentration for a period of ten years. In 1982, local governments were revived and charged with substantial authority over roads, health, primary education and water services. But again, they did not deliver as anticipated because of the tendency to centralize and concentrate powers in central government agencies (World Bank, 1999; Hirschmann, 2003; Shivji and Peter, 2003; URT, 2009; Kessy and McCourt, 2010; Venugopal and Yilmaz, 2010).

As a result of this centralized mode of governance, delivery of social services to the largely rural population was mainly the responsibility of central government with support from donors. The economic crisis of the late 1970s and early 1980s caused deterioration of almost all social services up to the early 1990s. According to a World Bank (1999) review, the health sector experienced critical shortages of basic pharmaceutical and other medical supplies, inadequate and dissatisfied workers, and decreased supervision to district and sub-district health facilities. In the water sector, implementation of the

regional water master plans faltered, leaving communities with partially constructed wells and pumping systems and no improved access to water services.

In 1996, a decisive step was taken to reform LGAs[2] through a Local Government Reform Program (LGRP) following the publication of the Local Government Reform Agenda (URT, 1996) and later the Policy Paper on Local Government Reform (URT, 1998). LGRP was seen as a vehicle through which government would promote and drive the decentralization process. It was envisaged that through the principle of subsidiarity, service provision would be brought closer to the users and political powers devolved to lower levels as far as possible and feasible (URT, 2008b). In order to create an enabling institutional and legal framework, LGRs have since then been incorporated into the Tanzanian Law through the Local Government Laws (Miscellaneous Amendments) Act, No.6 of 1999 which amended the Local Government (District Authorities) Act No.7 of 1982; the Local Government Finances Act, No.9 of 1982; the Local Government Services Act, No.10 of 1982; and the Local Government Negotiating Machinery Act, No.11 of 1982 (Shivji and Peter, 2003).

LGRs involved four main areas. First, political devolution of powers by setting up of local democratic institutions and enhancing public participation in decision-making processes. Second, fiscal decentralization of local government finances by introducing equitable and transparent discretionary and sector-specific grants from the central government to LGAs, and giving powers to LGAs to pass their own budgets based on local priorities. Third, administrative decentralization entailing de-linking LGA staff from central government line ministries and integrating them into LGA administration, LGAs recruiting their own personnel, and local government staff being accountable to local councils. Fourth, changing of central-local relations, with the central government having over-riding powers within the constitutional and legal framework, and with local governments having devolved powers and responsibilities in law. The main agency for coordinating the implementation of service delivery functions in rural areas is the district council (URT, 1996, 1998, 2008a, 2009). In the next section, we address the implications of these reforms and institutional arrangements on water and health services delivery at the local level.

Rural water supply: A mix of top-down and bottom-up models

Delivery of rural water services in Tanzania has followed different approaches from the 1960s, reflecting the development philosophy and governance approaches adopted. Currently, the national water policy adopted in 2002 is the guiding framework for water services delivery.

This policy is partly framed by LGRs and aims at Creating a comprehensive institutional and legal framework with a view of promoting effective institutional linkages among actors including central government, LGAs, private sector, NGOs, CBOs and communities (URT, 2002). As opposed to its 1991 predecessor, which was based on a 'supply-driven approach', the 2002 policy adopts a 'demand-responsive approach' stating that service users should be responsible for establishing, owning and managing their water schemes, and ensuring full cost recovery for operation and maintenance (O and M). The policy also emphasizes fair representation of women in village water entities and effective participation of men and women in rural water supply programs.

The main policy instrument for domestic rural water supply is the Water Sector Development Program (WSDP) (formerly called Rural Water Supply and Sanitation Project), which was launched in 2006. The main actors in this sector are at three levels: the central government through the Ministry of Water (MoW) and Prime Minister's Office –Regional Administration and Local Government (PMO-RALG), district councils and communities (wards and villages). The main responsibilities of MoW include: design of WSDP according to national priorities aiming at increasing equity in water services delivery, funds allocation to LGAs in collaboration with PMO-RALG and preparation of guidelines for implementation (de Palencia and Pérez-Foguet, 2011). In line with the principles of LGRs, the district council through its water department has the overall responsibility for the management and coordination of rural water supply activities including domestic water, water for livestock, irrigation and sanitation. It is the focal point for decentralized implementation responsible for promoting demand at village level, planning, providing support and monitoring the implementation of community projects.

However, interviews with district council officials revealed that district councils have weak financial and technical capacity to undertake their decentralized mandates. Budget allocations for WSDP are not proportional with demand for services and approved budgets are not timely disbursed to LGAs. In 2010/11 for example, Kondoa district planned to drill 27 boreholes but only 19 were approved by MoW. Further, funds and permits to engage contractors were released by MoW in June, the last month of the financial year compelling the district to implement these interventions in the next financial year. Information obtained from district water departments shows that both districts face shortages of staff with Kongwa having only 22% of the required staff in the water department and Kondoa 50%. Weak technical, administrative and financial capacities in LGAs have been cited as major obstacles to efficient and effective service delivery and in some cases used as justifications

[2] *Initially, the government focused on one third of LGAs and subsequently all 133 LGAs were incorporated in the reforms (URT, 2008a).*

for recentralization (Devas and Grant, 2003; Rondinelli, 2006).

The district council is also responsible for the selection of beneficiary villages based on lack of access to water services, the amount of cash contributed by villagers, presence of village water committee, and vulnerability to diseases. These criteria have to be discussed with ward councillors and decided on full council meetings. Our interviews with district council officials and village leaders revealed that to qualify for WSDP projects, villages have to raise five percent of the total initial costs for drilling, pump and engine installation, and water distribution, and that the actual amount differs between villages depending on the depth of the borehole and the length of the distribution network. Jiménez and Pérez-Foguet (2010b) are concerned that the demand-driven approach advocated in policy has been narrowly interpreted to imply cash and labour contribution with no consideration of other indicators. Vulnerability to diseases and lack of access to water supply services are not rigorously applied as selection criteria for WSDP projects. This puts women with their practical gender needs for access to sufficient and safe water at a disadvantage.

At village level, communities are expected to initiate demand for improvement of facilities by using the opportunities and obstacles to development (O and OD) planning process (Jiménez and Pérez-Foguet, 2010b; de Palencia and Pérez-Foguet, 2011). Although village planning is a well-established and inclusive process that allows villagers to identify their needs and priorities (Cooksey and Kikula, 2005), it appears that the process is limited in scope and quality. Village plans are influenced by national priorities and directives, and local priorities sometimes change if budgets exceed available funds. Moreover, the current funding mechanisms do not feed into village priorities because village plans are rarely used as sources of information for selection of villages to benefit from WSDP. Thus, the link between inputs from village participatory planning processes and district plans and bugdets is generally blurred (Venugopal and Yilmaz, 2010; de Palencia and Pérez-Foguet, 2011).

Seeing this from the principal-agent perspective, delivery of rural water services is compounded with multiple agency relationships exhibiting both top-down and bottom-up models. In the top-down model, the central government is the ‘principal’ with the objective of improving water services delivery and LGAs are the ‘agents’ charged with responsibilities for delivering the services. LGAs have some degree of autonomy and ‘decision space’ where they can plan and implement a range of water supply interventions, but the centre shapes most LGAs’ decisions through conditions for intergovernmental transfers, guidelines and directives. Although policy documents stipulate that Tanzania is implementing “decentralization by devolution” (URT, 1996, 1998, 2008a, 2009), actual implementation on the ground is more inclined towards deconcentration and delegation, and less towards devolution (cf. Brinkerhoff and Azfar, 2010).

In the bottom-up model, villagers (the service users) and councillors are the principals, and district council administrators are the agents. It was learnt from interviews with village leaders that villagers exercise their agency as principals during survey and final selection of sites to drill boreholes using their indigenous knowledge in addition to the technical expertise of surveyors, in electing village water committees and in setting water user fees and payment modalities for O and M, which is an indication of decentralization moving towards the devolutionary end. However, the agency of councillors as principals does not appear to work effectively because technical staff often have more power and influence than councillors in planning, budgeting and personell management (Venugopal and Yilmaz, 2010). This reflects power inequality between lower level principals and higher level agents who in practice deny the agency of their principals. Batley (2004) refers to this as the ‘agency problem’ where agents have limited incentives to serve the goals of their principals.

Adopting the principles of managing water resources at the ‘lowest appropriate level’ as stipulated by the water policy has also meant the creation and/or strengthening of village water committees, water user groups and water user associations to own, manage, operate and maintain water supply systems on behalf of communities (URT, 2002, 2008c; Cleaver and Toner, 2006). Preliminary observations from the field show most of the villages manage their water sources through village water committees and few use private operators. It was observed that the proportion of women in village water committees ranges from 20% to 56% indicating some variations on how national policies like decentralization are interpreted and implemented in different local settings. Whether their members represent service users’ interests is questionable. While equal representation of women in water committees could be expected to contribute to gender equity and address strategic gender needs if the bottom-up model were working, the current situation suggests that women representation does not help much, since these committees are in fact agents, and hence, representation is at the agent level rather than at the principal level.

Health services delivery: The limits to decentralization

The health sector was one of the pioneers of decentralized service delivery through health sector reforms (HSRs) starting from the early 1990s aiming at improving the quality of health services provided to communities (URT, 2003; Maluka et al., 2010). Delivery of public health care services is organised at three administrative levels. At the centre is the Ministry of

Health and Social Welfare (MoHSW) responsible for development of sectoral policy and the regulatory framework, monitoring and evaluation in collaboration with PMO-RALG. At the regional level, the Regional Medical Officer forms part of the Regional Secretariat and is responsible for providing supervisory and technical support to LGAs (Tidermand et al., 2008). In accordance with HSRs and LGRs, district councils are responsible for running district hospitals, health centres and dispensaries using subventions from central government and locally generated resources. Voluntary agencies, faith based organisations (FBOs) and the private sector provide health services through contractual agreements with district councils (URT, 2003). A number of studies show that, there is significant progress in decentralizing planning, budgeting and management of health services to LGAs. District councils have some autonomy over a wide range of health related matters and institutional bodies are in place in almost all districts (Mubyazi et al., 2004; COWI and EPOS, 2007; Yoshida, 2008; Tidermand et al., 2008; Maluka et al., 2010).

There has been an increase in resource allocation to district councils through central government transfers with around 29% of their total expenditures going to the health sector (COWI and EPOS, 2007; Maluka et al., 2010). Although central government oversight is necessary in ensuring that LGAs use financial and other resources in an efficient, effective and transparent way (World Bank, 2001; Azfar et al., 2004), LGAs' authority to plan and allocate funds according to their needs is constrained. Most financial transfers are controlled by the centre through budget ceilings, guidelines and approvals. In addition, services have to comply with national priorities, and the centre can withhold funds if it is not satisfied with LGA's performance (COWI and EPOS, 2007; Tidermand et al., 2008). This shows a principal-agent problem where the central government (principal) exercises more power on LGAs (the agents). As others have argued, this problem is characteristic of many developing countries where in most cases local institutions are given power to make decisions but not the control over resources needed to implement those decisions (Ribot, 2002; Conyers, 2007). This suggests that decentralization in the health sector is more dominated by the top-down model, and takes the forms of deconcentration and delegation (cf. Rondinelli and Nellis, 1986; Litvack et al., 1998).

Before the current reforms, management and administration of health services was the exclusive responsibility of the central government. At the district level, the district medical officer (DMO), the overall in-charge of medical services in the district was directly accountable to MoHSW. In the current set up, DMOs and other health personnel are employees of the district council, administratively reporting to the DED and to MoHSW on technical matters. But because of persistent recruitment problems at the district and lower levels especially in the remote and poorer areas, human resource recruitment has been recentralized. URT (2009:7) identifies "the apparent reluctance by central government to devolve autonomy for human resource management to LGAs" as one of the bottlenecks in implementing decentralization by devolution, which can be viewed as a principal-agent problem. Shortage of skilled staff, inequitable distribution of the existing workforce with a tendency for more health workers per population in urban than in rural and less advantaged areas, and bureaucratic recruitment processes stand as major challenges in human resources for health (COWI and EPOS, 2007; Tidermand et al., 2008). Information obtained from DMOs in both districts shows that health centres and dispensaries which are rural based are seriously understaffed as reflected by deficits of 70% and 60% of required health personnel in Kondoa and 60% and 49% in Kongwa in their health centres and dispensaries, respectively. Certainly, difficulties of recruiting and retaining skilled staff at district level and below is a widely recognised constraint (Francis and James, 2003).

Another important initiative in the reform process has been the establishment of institutional bodies for governance, planning, budgeting, implementation and monitoring of local services. As shown in Table 1, various committees and service boards as centrally determined by MoHSW and PMO-RALG have been established at all levels. With the exception of the Council Health Management Teams (CHMTs), which are composed of health staff only (agents), all others have mixed membership, involving both principals and agents. In theory, service boards and committees have the potential to strengthen the voice of users and responsiveness of service providers and make politicians and policy-makers more accountable to service users (Ribot, 2002; Boon, 2007) i.e. the devolutionary end on the "decentralization continuum" (cf. Brinkerhoff and Azfar, 2010). However, the state of affairs on the ground may differ. Citing an example of the Council Health Service Boards (CHSBs), COWI and EPOS (2007) explain that despite their well elaborate roles and functions, most of them are not functioning properly and meet infrequently. This implies that council comprehensive health plans (CCHPs), the main planning framework for health interventions in LGAs, are mostly prepared by CHMT members (agents) with little or no involvement of CHSBs. Boon (2007) shows that selection of CHSB members is dominated by the government and that community representatives have no forum for consultation with their constituencies and have weak decision making powers. According to Conyers (2007), the effectiveness of management and user committees depends on their structure, composition, motivation and capacity of their members; and how they are linked to the local and national structures. In this case, the presence of committees and service boards does not appear to alter the existing power relations between lower level principals (service users and

Table 1. Composition and roles of health committees and service boards

Name of committee/board and level	Composition	Functions
Council Health Service Board (district)	Four community service users of whom at least two are women One representative from a voluntary agency providing services in the area One representative from private sector providing services in the area The chairman of the council social services committee District planning officer District medical officer (secretary) One representative of the regional health management team	Ensure that the population receives appropriate and affordable health care services Discuss and approve health plans, budgets and reports from CHMT and submit to the Full Council for approval Support CHMT in managing and administering health resources Promote community involvement through sensitization
Council Health Management Team (district)	District medical officer District health secretary District health officer District nursing officer District pharmacist District medical laboratory technologist District dental surgeon	Prepare district comprehensive health plans Ensure that health services are implemented as per comprehensive health plans Carry out supportive supervision to health staff at all levels in the district Ensure data collection, analysis, utilization and feedback mechanisms by health workers Monitor and evaluate implementation of health activities
Hospital Governing Committee (district hospital)	Three community representatives appointed from service users Two members appointed from the health centre committee and dispensary committee One person appointed from voluntary agencies providing health services in the district One person appointed from private sector providing health services in the district One member of the CHSB District medical officer One representative of the MoHSW	Oversee management of resources at the hospital Discuss and pass proposals and budgets for the hospital and submit to the council through CHSB Identify, mobilize and solicit financial resources for the financing of the hospital services Receive and discuss implementation reports from hospital management team Provide feedback to the community about hospital development plans and their implementation
Health Centre Committee (health centre)	One person appointed from private sector providing health services in the area The officer in-charge of the health centre (secretary) Three persons appointed from community members receiving services from the health centre One member from dispensary committees One member from ward development committees (WDC)	Receive and discuss implementation reports prepared by the Health Centre Management Team Identify and solicit financial resources for the running of health centre services Advise and recommend to the CHSB on matters related to human resources development Overseer the availability of essential supplies of drugs and medical equipment
Ward Health Committee (ward)	Ward councillor Ward executive officer One head teacher of a primary school within the ward Two community members of whom one is a female Clinical officer in charge of a health care facility within the ward One representative from community based organisations One representative from the WDC	Initiate and coordinate comprehensive community health plans Monitor level of contributions and user-fee revenues Mobilize community members to join the community health fund (CHF) Organise general meetings of members of CHF

Table 1. Continue

Name of committee/board and level	Composition	Functions
Dispensary Committee (dispensary)	Three members from dispensary users One representative from a private health facility One representative from a voluntary health facility One representative of WDC One representative of village council In-charge of dispensary (secretary)	Discuss and pass dispensary plans and budgets Identify and solicit funds Assist Dispensary Management team in planning and managing community based initiatives Ensure the delivery of appropriate services

Source: Adapted from URT (2001); Maluka et al. (2010).

representatives in the committees) and higher level agents (technical district staff).

At sub-district level, studies show that establishment of health facility committees (HFCs) did had a positive impact on participation of communities in managing health facilities, even though planning of health delivery targets and priorities, still largely remains under the control of the centre (Mubyazi et al., 2004; Tidermand et al., 2008; Maluka et al., 2010). The multiplicity of committees (multiple agents) is however, a challenge at the ward and village level. COWI and EPOS (2007) question the necessity of creating special governing committees for each health facility when village and ward health committees which are linked to local government structures are in place and functioning. This arrangement is seen as diluting the relationship between health facilities and local government authorities. In principal-agent terms, this shows 'multiple agents' at the same administrative level with each trying to exercise power and control over the other, resulting in tensions and conflicts.

The current situation also raises the question of LGAs responsiveness to local needs. The health policy emphasizes community involvement and ownership through active participation in identification of problem areas, planning, implementation, monitoring and evaluation of health care services (URT, 2003). However, a study by Mubyazi et al. (2004) in Babati, Lushoto, Muheza and Mkuranga districts reports that, ward and village leaders commonly complained about the failure of district authorities to respond to local priorities citing some diseases which were perceived by community members as major health problems in their respective areas but were not reflected or were given low priority in district plans. Tidermand et al., (2008) arrived at almost a similar conclusion, observing that community involvement in health planning and delivery is very minimal because many district health plans do not reflect identified community needs through the bottom-up O and OD planning process that is supposed to be the basis for district plans.

This suggests that, LGAs are to a large extent still "implementers of national and sectoral development programmes" with little reference to local priorities (URT, 2009:7). Crook (2003) demonstrates with evidence from Ghana, Code d'Ivoire, Kenya, Tanzania and Zimbabwe that even where democratic representation mechanisms exist, local governments have not been responsive to local needs and community aspirations are mostly ignored in drawing up district plans. This conclusion should however be taken with caution, considering the nature of the health sector. For example, discussions with district council officials revealed that, village plans mostly focus on curative and not preventive health services, and do not reflect gender issues. This compels district council officials to harmonize village plans to include other national priorities for which funds are available.

Water and health services: Does sector make a difference?

It is apparent from the above analysis that there have been significant efforts to decentralize the institutional arrangements in both sectors, although the effectiveness of the decentralised structures leaves much to be done. Decentralization theory argues that services should be decentralized if demand and supply conditions are highly localised (Andrews and Schroeder, 2003). While both sectors are prime candidates for decentralization, they differ in a number of ways. Rural water supply requires substantial infrastructure investments along with operating and maintenance inputs, its users are defined territorially and can organize themselves on that basis. This localised nature of the service provides a justification for decentralizing organisation, implementation and O and M. Under the on-going reforms the central government has changed its role from an implementer and manager to facilitator and regulator, and encouraged community participation in rural water supply schemes, displaying both bottom-up and top-down models. By contrast, primary health care is provided through a vertically integrated chain of service delivery units which is produced by combining skilled health staff, non-recurrent resources and infrastructure, and involves benefits and risks that extend beyond local jurisdictions.

Clients also use the service while in a state of crisis and vulnerability, and information asymmetry limits their choice (Batley, 2004). Therefore, decentralization of primary health care services requires more central government involvement especially with regard to financing, allocation of expertise and coordination. The current situation in Tanzania shows that the health sector has a more hierarchical institutional set-up from the lowest village level up the ladder to the centre with more orientation towards the top-down model, which could also be viewed as decentralization in the forms of deconcentration or delegation.

Decentralization in the two sectors also shows some similar constraints. Fiscal decentralization as a supporting strategy to service delivery functions has evolved in both sectors. Intergovernmental transfers from central government to LGAs have been institutionalised and are the major sources of local government financial resources. Despite the increased proportion of resources spent at the local level, LGAs are highly dependent on central government grants with limited capacity to raise their own local revenue. Experience from other African countries shows that central governments use their fiscal strength to influence provision and production decisions at the local level (Andrews and Schroeder, 2003). In both sectors, poor community involvement in planning and integration of local needs into district plans contests the widely held notion that 'decentralization brings government and services closer to people'. Generally, there are discrepancies between the decentralized structures as they appear in policy and what is actually happening in practice. The changes in institutional arrangements have not matched with changes in the processes, rules and attitudes of technical and administrative staff that would enable the newly created structures to operate with greater autonomy to achieve 'decentralization by devolution'. Whereas the role of central government is in principle supposed to be limited to policy making, regulation, monitoring and quality assurance, or 'eyes on' and 'hands off' (URT, 1998; 2008a; 2009), in practice there is a high degree of central government involvement in LGAs' affairs (Kessy and McCourt, 2010; Venugopal and Yilmaz, 2010). This reflects what Blair (2001:120) refers to as 'distributed institutional monopoly' where the central government decentralizes authority and responsibility for certain functions, but maintains a hierarchical state control in the form of deconcentration or delegation.

CONCLUSION

The main impression gained from this review is that water and health sectors present different institutional arrangements and spaces for the exercise of control between multiple principals and agents. The nature of sector plays an important role in the institutional arrangements for decentralized service delivery because it determines which functions to decentralize and which ones to centralize. Different forms of decentralization are being used simultaneously though with varying degrees depending on the nature of sector. This has also created some principal-agent problems, thus limiting LGAs' autonomy to exercise their decentralised service delivery functions. The evidence from this review therefore raises a number of issues for further investigation. For example, using a gender lens is crucial to assess from the users' perspectives the extent to which the delivery of appropriate water and health services to rural households has improved after the reforms. The lens is also important to assess how gender roles and needs are reflected in the decision-making processes regarding service delivery, and how different community groups participate in decision-making and whether decentralization reforms have enlarged their opportunities for participation.

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APPENDIX 1:

LIST OF ABBREVIATIONS

CBOs	-	Community Based Organisations
CCHP	-	Comprehensive Council Health Plan
CHMT	-	Council Health Management Team
CHSB	-	Council Health Service Boards
DED	-	District Executive Director
DED	-	District Executive Director
DMO	-	District Medical Officer
FBO	-	Faith Based Organisation
HFCs	-	Health Facility Committees
HSRs	-	Health Sector Reforms
LGAs	-	Local Government Authorities
LGRP	-	Local Government Reform Program
LGRs	-	Local Government Reforms
MoHSW	-	Ministry of Health and Social Welfare
MoW	-	Ministry of Water
NGOs	-	Non-Governmental Organisations
O&M	-	Operations and Maintenance
O&OD	-	Opportunities and Obstacles to Development
PMO-RALG	-	Prime Ministers' Office – Regional Administration and Local Government
URT	-	United Republic of Tanzania
WDC	-	Ward Development Committee
WSDP	-	Water Sector Development Program