

**Decision Making Under the Tree:
Gender Perspectives on Decentralization
Reforms in Service Delivery in Rural Tanzania**

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**Decision Making Under the Tree:
Gender Perspectives on Decentralization
Reforms in Service Delivery in Rural Tanzania**

Zacharia S. Masanyiwa

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CHSB	Council Health Service Boards
DED	District Executive Director
DMO	District Medical Officer
DPs	Distribution Points
FAO	Food and Agriculture Organisation of the United Nations
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HSRs	Health Sector Reforms
IOB	Policy and Operations Evaluation Department of the Netherlands Ministry of Foreign Affairs
lpcd	litres per capita per day
LGAs	Local Government Authorities
LGRP	Local Government Reform Program
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
MoW	Ministry of Water
MoWLD	Ministry of Water and Livestock Development
MSD	Medical Stores Department
NGOs	Non-Governmental Organisations
NICHE	Netherlands Initiative for Capacity Development in Higher Education
O&M	Operations and Maintenance
O&OD	Opportunities and Obstacles to Development
PMO-RALG	Prime Ministers' Office-Regional Administration and Local Government
SACCOS	Savings and Credit Cooperative Society
SPSS	Statistical Program for Social Sciences
TBA	Traditional Birth Attendants
Tsh.	Tanzanian Shillings
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
VICOBA	Village Community Bank
VWCs	Village water committees
WDP	Women Dignity Project
WHO	World Health Organisation
WSDP	Water Sector Development Program

Chapter 1

General introduction

This chapter introduces the study by presenting a general overview of what it is all about. The first section discusses the background of the study, followed by a description of the motivation for undertaking this study in the second section. In the third section, the research problem and the objective are presented. This is followed by discussion of the theoretical perspectives and the research questions in the fourth and fifth sections, respectively. Next, I define and discuss the main theoretical concepts used in this study and present the conceptual model that connects the theoretical perspectives and the key concepts. The chapter ends with an outline of the remainder of the thesis.

1.1 Background to the study

This study is about the impact of decentralization reforms on service delivery in rural villages in Tanzania from a gender perspective. Decentralization has emerged as an important trend in development policy and discourse in recent years. Most countries worldwide have attempted decentralization of the fiscal, political and administrative responsibilities from central governments to lower level governments. As a World Bank (2008:5) report asserts: “Everyone is doing it.” Although not completely a new phenomenon, the current wave of decentralization focuses on enhancing service users’ participation and improving service delivery. The World Bank (2004:187) emphasizes that “decentralization must reach the clinic, the classroom and local water utilities in ways that create opportunities for strengthening accountability between citizens, politicians and policy makers.” The theory is that in a decentralized system, public services should be more responsive to local needs because citizens can directly or indirectly influence decisions about resource allocation and service delivery. It is argued that decentralizing responsibilities to local governments will result in better use of resources and deliver more appropriate services since decisions will reflect local needs and priorities (Jeppsson and Okuonzi, 2000; Ribot, 2002; Devas and Grant, 2003; World Bank, 2004, 2008; Ahmad *et al.*, 2005; Ribot *et al.*, 2006; Andrews and de Vries, 2007). Decentralization is also often regarded as an important vehicle for enhancing women’s participation in local decision-making processes and for addressing gender inequality (Beall, 2007). In reality, however, the evidence about these expectations is mixed.

In terms of development thinking and practice, decentralization reforms have coincided with a paradigm shift in governance theory from monocentric governance, an approach where the state is the centre of political power and authority, towards polycentric governance, the idea of multiple centres of power within a state (Termeer *et al.*, 2010). In this view, decentralization is viewed as an appropriate response to the problems of state failure that were characteristic of many developing countries in the 1970s and 1980s and lead into the decline of most state provided public services (Batley, 2004; World Bank, 2004; Ahmad *et al.*, 2005; Mehrotra, 2006). Thus, the recent decentralization reforms have been implemented in the context of new approaches to public management (Hope, 2001; Batley, 2004; Larbi, 2005). In the context of new public management, decentralization is aimed at replacing the “highly centralized and hierarchical government structures by decentralized management environments where decisions on resource allocation and service delivery are made closer to the point of service delivery” (Hope, 2001:120). The emphasis is on ‘bringing the state in’ as opposed to earlier reforms which focused on ‘rolling back the state’ (Beall, 2007). Consequently, local government reforms have been used as a supporting strategy for decentralization because reforms are needed to improve governance and service delivery capacity of local governments required to fulfil their new responsibilities (Andrews and de Vries, 2007; Dubois and Fattore, 2009).

Tanzania fits well into this global picture because of its long and ‘troubled’ history of implementing decentralization reforms. More recently, the country has pursued local government reforms aimed at improving the quality, access and equitable delivery of public services provided through or facilitated by local government authorities (LGAs). The recent reforms

were initiated in 1996 following the publication of the Local Government Reform Agenda 1996-2000 which set the vision for the reforms. The vision states that the *raison d'être* for the devolution of roles and authority will be the capacity and efficiency of the local government in delivering services to the people (URT, 1996). In 1998, the government endorsed the policy of 'decentralization by devolution' through the Policy Paper on Local Government Reform as a guiding framework for local government reforms in the country. The paper spells out that public service provision must be brought as closely as possible to the user. It explains that the principle of subsidiarity involves decentralization of public service provision linked to devolution of political powers to lower levels as far as possible and feasible (URT, 1998).

The first phase of the local government reform programme (LGRP) was implemented between 2000 and 2008. Currently, the government of Tanzania is implementing the second phase of the local government reform programme (LGRP II 2009-2014) amidst other progressive and gendered policies and strategies, such as the Development Vision 2025 (URT, 2000) and the National Strategy for Growth and Reduction of Poverty (URT, 2010a) that aim at attaining gender equity, democracy and sustainable development (URT, 2009a). The overall goal of LGRP II is to achieve "accelerated and equitable socio-economic development, public service delivery and poverty reduction across the country." In relation to this goal, the overall purpose of LGRP II is "to achieve devolution of government roles and functions, and to that end transform LGAs to competent strategic leaders and coordinators of socio-economic development, accountable and transparent service delivery and poverty reduction interventions in their areas of jurisdiction" (URT, 2009a:28). Both the LGRP and LGRP II define the process of 'decentralization by devolution' as the main strategy to achieve the goals and objectives of the reforms and aim at enhancing citizens' participation and improving service delivery, the 'twin' objectives of decentralization reforms (URT, 1998, 2009a).

While policy documents on decentralization in Tanzania and elsewhere claim that decentralization leads to improved service users' participation and service delivery, this link is contested in the academic literature. The empirical evidence shows mixed results on the expected positive impacts of decentralization on both participation and service delivery. Hope (2001), for example, concludes that decentralization in Africa has resulted in better governance, increased popular participation, allowed better mobilization and use of resources, and increased reliability and delivery of public services. In Uganda, a country that has been described as having the 'most far-reaching' local government reforms in the developing world (Francis and James, 2003; Robinson, 2007), Onyach-Olaa (2003) shows that decentralization has increased opportunities for citizens to make choices on the type and quality of public services they want. Meyer-Emerick *et al.* (2004:232) report "vast improvements" in service delivery at the sub-district levels in Botswana. At the same time, in the literature it is argued that there is no automatic assurance that increased participation will lead to improvements in public services (Conyers, 2007; Robinson, 2007). For example, a study in six Latin American countries indicates that transfer of resources and staff to local governments neither improved the provision nor reduced costs of healthcare services (Burki *et al.*, 1999). Studies on decentralised public health services in Uganda show that if not well designed, decentralization may lead to outcomes that are potentially worse than in centralized systems (Akin *et al.*, 2005;

Hutchinson *et al.*, 2006). This observation is corroborated by the findings of a World Bank (2008:4) review in 20 developing countries which found “weaker connections between decentralization and service delivery in health but stronger connections in education.”

A major problem with the empirical literature on decentralization in sub-Saharan Africa, and Tanzania in particular, is that most studies do not address the gender dimensions of the process and outcomes of decentralization. Little is written about decentralization and gender, especially at the sub-district levels. The tendency has been to focus on women’s political engagement at the national and district levels (Beall, 2007). There is an on-going discourse on gender in development processes, ranging from theory linked to a modernization perspective to Marxist-oriented theory, and from women in development to gender and development paradigms (Parpart *et al.*, 2000). The question that comes up every time is whether women should be supported to strengthen their autonomy or whether their participation in male-dominated structures should increase. This study contributes to this debate by examining the empirical data to test the validity of the theoretical arguments. Furthermore, there is limited systematic evidence across different public service sectors on whether increased women’s participation in decentralised local institutions generates better service delivery outcomes which are accessible, affordable and appropriate to different community groups in equal quantity and quality. This study intends to fill this gap by investigating the impacts of decentralization reforms on two sectors: rural water supply and primary healthcare services.

1.2 Motivation for the study

The motivation to pursue this study stems from the author’s observations and experience with community development work for over twelve years in rural settings in the region of Dodoma and other parts in Tanzania. One of the main development challenges in these areas is the inadequate access to the basic social services of rural water supply and primary healthcare, which has serious consequences for people’s welfare, particularly that of women and girls. Due to the gendered division of labour, women and girls are the primary actors in domestic water provision and in care for children, the sick and elderly, which suggests that their needs for water and health services are more urgent than those of men. Various interventions have been implemented by the government, donors and communities to address these challenges, with varying degrees of success. The current local government reforms which are part of the wider public sector reforms are examples of such initiatives. However, the extent to which these succeeded in improving the interactions and relationships between service users and providers and in securing access to gender-sensitive public services, has not been clearly documented.

Working in an institution¹ that is responsible for providing training, research and advisory services in the field of rural development planning, and is an anchor institution for providing capacity building to LGAs in Tanzania, the author has frequent contacts with LGAs in the country. While the local government reforms envisage LGAs as autonomous

¹Institute of Rural Development Planning, Dodoma-Tanzania

entities that reflect local demands and conditions and deriving legitimacy from services to the people (URT, 1996), I could observe that mostly they are still seen as mere implementers of national and sectoral development plans. There is inadequate involvement of the public in LGAs' affairs and lack of gender integration in most LGAs plans (URT, 2009a). As a member of the team that was involved in developing a proposal for the Netherlands Initiative for Capacity Development in Higher Education (NICHE/TZA/002), submitted to the Netherlands University Foundation for International Cooperation (NUFFIC) in 2009, my interest to explore some of these issues became evident. In line with the overall objective of the NICHE/TZA/002 project which is "to enhance the capacity of the Institute of Rural Development Planning for strengthening Local Government Authorities to implement decentralization by devolution in the light of LGRP II", it was possible to undertake this study. Thus, this thesis is one of the outputs of the NICHE/TZA/002 project.

1.3 Research problem and objective

Over a decade now since Tanzania started implementing the local government reforms, subsequent reviews have noted that the reform was too ambitious given the complex policy and reform environment (URT, 2008a, 2009a). While the logic behind it was that LGAs would be able to manage service delivery more efficiently than the central government (Hirschmann, 2003), coverage and distribution of health services remains inadequate (UNICEF, 2007) and over half of rural households travel more than a kilometre to their nearest drinking water sources in the dry season (URT, 2007a, 2009b). Many service users are still dissatisfied with the accessibility, quality and affordability of almost all public services (URT, 2009b). People's participation in planning is minimal. The Opportunities and Obstacles to Development (O&OD), the official planning methodology for LGAs, appears to be disregarded at higher levels of decision making. Hence, the voice of the people, the clients and users of services is insufficiently heard (URT, 2009a).

Decentralization reforms in Tanzania are also expected to address gender inequalities with regard to women's participation in decision-making processes and in improving their access to public services. Recent reviews, however, show that women are marginalized and their interests and needs filtered out when village plans are integrated into district plans (URT, 2009a). While the law stipulates that women must constitute at least 30 percent of elected councillors and 25 percent in village councils (though mainly through special seats), women's representation in local decision-making structures is still low (Braathen *et al.*, 2005; PMO-RALG, 2006). These are critical observations, because the government acknowledges that men and women have different perspectives and affirms that gender diversity must be consistently addressed in the on-going reforms (URT, 2009a). It is argued that "it is impossible to meet the overall goal of local government reforms of poverty alleviation without integration of women and gender issues" (PMO-RALG, 2006:5). While the reforms aim at enhancing cooperation and trust between citizens and local leadership, it is not clear how cooperation and trust affect the user-provider interactions and delivery of gender-sensitive services, and whether decentralization reforms have indeed increased cooperation and trust

at the local level. Similarly, it has not been established whether there are gendered variations in the level of trust between leaders and citizens, and among fellow citizens.

The main objective of this study is to examine the impact of decentralization reforms on service delivery in rural areas in Tanzania through a gender lens. The main research question is: how does decentralization affect the user-provider interactions and gender-sensitivity of public services at the local level in rural areas in Tanzania? As said, the research focused on water and health services delivery.

1.4 Theoretical framework

To answer the research questions, this study used a combination of theoretical perspectives, drawing on both governance and sociological theories. Parpart *et al.* (2000) describe a theoretical framework in the social sciences as a system of ideas or conceptual structures that help to 'see' the social world, understand it and explain it. It consists of basic assumptions about the nature of the social world and how it works, providing a systematic way of examining social issues. Lassa and Enoh (2000) view it as a set of theories put together to provide a basis or support for explaining, viewing and conceptualising a phenomenon. The functions of a theoretical framework include delimitation of scope, providing a context of meaning and interpretation, prediction of outcome(s), and integration of research findings. A theoretical framework also provides a set of concepts to be used to clarify a problem or issue, which fundamentally shape research approaches (Parpart *et al.*, 2000). The research approach comprises the formulation of the research problem and research questions, the definition and operationalization of concepts and the identification of relationships that are postulated in the form of research questions or hypotheses (cf. Niehof, 1999).

The theoretical framework for this study is based on the following theoretical perspectives: an institutional perspective, principal-agent theory, an actor perspective and gender theory. In what follows, I briefly discuss each of these perspectives. The subsequent empirical chapters apply one or a combination of them because these perspectives are inter-related in a number of ways and, therefore, connect at some point. In Chapters 3 and 4, I use principal-agent theory to elaborate the institutional perspective. The actor perspective is used as an analytical framework in Chapters 5 and 6, while the gender perspective is the central theme throughout Chapters 4, 5, 6 and 7.

1.4.1 An institutional perspective

Institutions are defined by North (1989:1321) as the "rules, enforcement characteristics of rules, and norms of behaviour that structure repeated interactions." The purpose of institutions is to "provide certainty in human interactions which is accomplished by the inherent features of rules and norms" (North, 1989:1324). Mitchell and Pigram (1989:198) expand this definition using the concept of 'institutional arrangements' which refers to a "combination of legislation and regulations, policies and guidelines, administrative structures, economic and financial arrangements, political structures and processes, historical and traditional customs and values, and key participants and actors." This study uses the concept of institutions because decentralization is an institutional reform which involves the transfer

of roles and functions from one central institution to multiple institutions and actors at the lower level (Ribot, 2002; Kimaro and Sahay, 2007). The design of institutions and the participation of various actors in these institutions influence both the process and outcomes of decentralization. In the case of public services like rural water supply and primary healthcare that directly impact on people's lives, the design of these institutions has a critical bearing on service users' access to such services.

1.4.2 Principal-agent theory

Because institutions shape behaviours of individuals and their interactions, which in turn shape institutions, an institutional perspective is an important framework for examining how interactions between actors take place including what is allowed or prohibited, and under what conditions (Kimaro and Sahay, 2007). In investigating this, this study uses the principal-agent theory which is considered critical in revealing the roles of different actors in decision-making processes, in mediating access to public services among different users and, and in enhancing cooperation and trust between citizens and leaders. This theory is important in analysing decentralization reforms because it focuses on the trade-offs between different actors and the changes that decentralization may bring with them (Bossert, 1998; Batley, 2004; Hiskey, 2010). The theory allows us to view the central government as the 'principal' with the objective of improving the access, quality and equity of public services, and local governments as 'agents' charged with responsibilities and resources to implement decentralization policy to achieve these objectives (cf. Bossert, 1998). At the lower level, the citizens or service users and local politicians are principals with mandates to make decisions on local service delivery needs and priorities (cf. Batley, 2004). The interest of the study is on both the broader institutional framework at the centre as well as the local institutional arrangements and their interfaces, and how these arrangements affect service users' participation in village-level decision-making processes, service delivery outcomes, and cooperation and trust relations between citizens and leaders.

1.4.3 An actor perspective

The actor perspective entails "identifying the actors relevant to the specific arenas of action and contestation, bearing in mind that neither actor categories nor relevance are uniformly defined" (Long, 2001:240). The actor perspective focuses on delineating everyday organising and symbolizing practices, and aims at elucidating the sets of interlocking relationships and social practices that interpenetrate various social, symbolic and geographical spaces. I use this perspective in this study because decentralization processes involve actors at different levels including elected bodies, administrative appointees, community groups and central government ministries (Ribot, 2002). These actors are not passive recipients of this 'externally designed and planned intervention' (Long, 2001), but are active agents who participate strategically for meaningful outcomes. Therefore, decentralization processes are likely to be incorporated and substantially transformed by local organisational and social structures. This requires identifying the linkages between the local and other political and administrative levels in order to understand the range of actors, structures, practices and processes operating

at different levels (Beall, 2007). The use of the actor perspective in this study contributes to this understanding, particularly the linkages between village-level actors and processes, and district and national levels, which also links to the principal-agent theory discussed earlier.

The actor perspective also includes the users' perspective which assumes that people shape and reshape their situation and interact with their environment using their skills, knowledge and experience (Niehof and Price, 2001). Campilan (1996:196) describes users as "actors, who far from being receivers of services are dynamic individuals and groups with ability to perform a range of activities along the service delivery chain, and demonstrate informed decision making." In the context of decentralization, participation of users in the design, operation and maintenance of service infrastructure is regarded as key to performance (World Bank, 1994, 2004, 2008). Thus, this perspective is essential in assessing whether indeed decentralization is contributing to service users' access to improved gender-sensitive water and health services, and whether it is enabling women to meet their needs. In Chapters 5 and 6, I adopt the users' perspective with special attention on women users to examine the impact of decentralization reforms on improving water and health services, respectively. The users' perspective also overlaps with the gender perspective, as discussed below.

1.4.4 A gender perspective

A gender perspective brings in the gender dimensions of both the process and outcomes of decentralization. In practice, this means that various questions are analysed and discussed from the perspectives of both men and women. This is useful in explaining the role of men and women in decision-making processes, whether service delivery outcomes are gender-sensitive, and the gendered dimensions of cooperation and trust. It is hypothesized that decentralization processes are gendered, meaning that they will not equally address men's and women's needs, while this will also differ per sector. Moser's (1993) distinction between practical and strategic gender needs is used in this study because it is "the basis for much of gender and development analysis" (Allen and Sachs, 2007:5). Practical gender needs relate to women's daily needs in caring for themselves and their households, whereas strategic gender needs are concerned with changing gender relations and challenging women's subordinate position (Moser, 1993; Parpart *et al.*, 2000). Decentralization reforms more or less explicitly aim at addressing the practical gender needs by improving access to the immediate perceived service needs such as rural water supply and primary healthcare, and are strategically oriented towards changing the structures that subordinate women by enhancing their participation and bargaining ability in local decision-making structures. However, these concepts are rarely applied in decentralization studies.

In addition to the general gender perspective, this study also uses the concept of intersectionality to reflect on the intersections between gender and other socio-cultural variables such as age, marital status, ethnicity and religion. Crenshaw (2000:8) defines intersectionality as a "conceptualization of the problem that attempts to capture both the structural and dynamic consequences of the interaction between two or more axes of subordination." It addresses the manner in which patriarchy, class and other discriminatory systems create background inequalities that structure the relative positions of women, races,

ethnicities and classes. Intersectionality also looks at the way specific acts and policies create effects at these intersections that would aggravate the dynamics of disempowerment. Rather than viewing women as a unified category, awareness of this intersectionality provides an understanding of women's lives and experiences (Allen and Sachs, 2007). In this study, I use this concept to show how gender intersects with other socio-cultural variables such as age, ethnicity and religion, that promote or hinder women's participation and their access to public services or mediate cooperation and trust relations. The gender debate also relates to the actor versus the institutional perspective, which is why gender is in the centre of the conceptual model (Figure 1.1).

1.5 Research questions

The main research question of how decentralization affects the user-provider interactions and gender-sensitivity of public services at the local level in rural areas in Tanzania, is further elaborated into four sub-questions. The first of these questions is a preliminary question of which the answers provide the contextual frame within which the answers to the following three research questions can be placed.

- i). What are the main institutional characteristics of the current decentralization processes with regard to water and health services delivery in rural districts in Tanzania, and what are the factors that constrain the realization of decentralization?
- ii). To what extent have decentralization reforms increased women's opportunities for participation in local decision-making processes with regard to water and health services delivery, and how are women's gender roles and needs reflected in these processes?
- iii). To what extent has the delivery of gender-sensitive water and health services to rural households been improved after the decentralization reforms?
- iv). How does trust between local leaders and citizens affect decision-making processes and provision of water and health services, and to what extent have the decentralization reforms increased cooperation and trust?

1.6 Definitions and discussion of key concepts

In this section, I briefly discuss the main concepts used in this study. As the title of the thesis suggests, decentralization and gender are the central organising concepts in this study. These concepts feature throughout the thesis and are central in the theoretical perspectives discussed in the previous section. Participation is analysed in detail in Chapter 4. Chapters 5 and 6 use the concepts of decentralization and gender linking them to water and health services delivery, respectively, while cooperation and trust are the main themes of Chapter 7.

1.6.1 Decentralization

Decentralization is an ambiguous concept to which different authors writing from different disciplines have attributed different meanings. This study follows the definition proposed by Conyers (1990:19) which refers to decentralization as "the transfer of power and responsi-

lity to plan, make decisions and manage public functions from a higher level of government to a lower one.” This definition is useful in analysing the decentralization processes in Tanzania because it signifies both the processes and the results of decentralization or what Dubois and Fattore (2009:707) refer to as the “process of becoming” and “the state of being decentralized.” The definition also encompasses the various dimensions that can be distinguished in decentralization: the political, administrative and fiscal dimensions.

The literature on decentralization identifies three major forms: deconcentration, delegation and devolution (Litvack *et al.*, 1998; Manor, 1999; Hope, 2001; Ribot, 2002; World Bank, 2004, 2008). Deconcentration is the least extensive form where responsibilities are transferred to an administrative unit of central government that is spatially close to the population where service is to be provided. The allocation of responsibilities occurs “within the hierarchy of central government” (de Visser, 2005:14) whereby ‘allocative decisions’ remain at the centre while only control over ‘implementation decisions’ is decentralized (Conyers, 2006). Delegation involves the transfer of authority and responsibilities for specifically defined functions to lower level governments outside of central government. The ultimate responsibility remains with the central government since power can be ‘circumscribed’ and ‘withdrawn’, which creates a degree of accountability to the centre (Rondinelli and Nellis, 1986; Litvack *et al.*, 1998; de Visser, 2005). In devolution, the central government transfers authority, responsibilities and accountability to subnational governments with some degree of political autonomy (World Bank, 2008). Devolution differs from delegation in that it is often institutionalised through provisions in the constitution or other legislation, and therefore, meant to be a ‘permanent’ placement of power at that level (de Visser, 2005), hence, providing a greater scope for strengthening local voice, and the relationship between service users and local service providers (World Bank, 2004). According to Hope (2001), devolution provides a mechanism that enables citizens to participate in local governance processes and allows community interests to be represented in government decision-making structures.

While this distinction is important in theory, some commentators show that some countries have used all three types simultaneously or began with one and later shifted to another approach (Rondinelli and Nellis, 1986; Manor, 1999). The World Bank (2004) maintains that in practice decentralization involves a mix of deconcentration, delegation and devolution. Brinkerhoff and Azfar (2010:82) consider these forms as variants along the same “continuum where at one end, the centre maintains control with limited power and discretion (deconcentration) to progressively decreasing control and increasing local discretion at the other end (devolution).” However, since the outcomes of decentralization on service delivery depend on the extent and form of decentralization (World Bank, 2001; Conyers, 2007), the typology provides a useful framework for analysing decentralization of service delivery.

When viewed along these dimensions, the current decentralization processes in Tanzania fall, at least in policy, into the ‘devolution’ category. The central government envisages creating local governments that are largely autonomous, democratically governed, fostering participatory development, reflecting local demands and conditions, and conducting activities with transparency and accountability (URT, 1996, 1998, 2009a). However,

this assertion needs to be taken with caution, since even earlier decentralization initiatives from the 1960s to the mid-1990s used similar terminology but the reality turned out to be quite the opposite. Using Mawhood's (1983) analogy of a 'pendulum', the question is whether the current reforms should be interpreted as just another temporary phase which is likely to be followed sooner or later by a 'swing' in the other direction towards increasing centralization. Or, as Conyers (2006) posits, should it be taken as a more fundamental change, stimulated by different factors and involving different forms of decentralization and, therefore, not likely to be followed by a reversion to relative centralization?

1.6.2 Participation

Even more than decentralization, participation is also a multi-layered concept. As Agarwal (2001:1624) writes: there are different views "on how participation is defined, whom it is expected to involve, what is expected to achieve, and how it is to be brought about." Definitions of participation range from the narrow perspective where it is defined in terms of nominal membership in a group, to a broad perspective where participation is seen as a dynamic interactive process in which different groups have voice and influence in decision making (Agarwal, 2010). The World Bank (1996) offers a more general definition stating that participation is about the ways in which citizens exercise influence and share control over development initiatives and decisions and resources that affect them. Drawing on earlier typologies of participation, Agarwal (2001) offers a useful typology on the levels of participation including: nominal participation, consultation, activity-specific participation, active and interactive participation. She also identifies the "striking neglect of a gender perspective on who participates, what effects this has, and what factors constrain participation" (Agarwal, 2001:1624). This study offers such a gendered analysis.

In the literature, the emphasis on decentralization is closely linked to an orientation towards democratization. Decentralization is theorized as an important element to strengthen participatory democracy because it enlarges opportunities for citizens to participate in decisions affecting their lives (Litvack *et al.*, 1998; Manor, 1999; Bryld, 2001; Bardhan and Mookherjee, 2006; Ribot *et al.*, 2006). Conyers (1990) summarizes the participatory benefits of decentralization as bringing power and government closer to the people and strengthening democracy. Bergh (2004) sees participation and decentralization as having a 'symbiotic relationship' arguing that decentralization requires some degree of local participation to ensure responsiveness of local government to local needs, while at the same time the process of decentralization itself can enhance the opportunities for participation by placing more power and resources at a level of government closer to the people.

In principle, it is difficult to draw a clear boundary between participation as a democratic right of citizens and service users' participation. The World Bank (2010:10) refers to citizens as "people who participate individually or in groups or organisations in political processes to shape and attain collective goals" and service users as "people who use a particular service." The focus of this study is on service users' participation because in most settings, all service users are citizens, but depending on the service not all citizens are service users. In this case, participation is seen as a means of enhancing the quality and relevance of develop-

ment plans (Conyers, 2007), which in turn can improve service providers' responsiveness to local needs leading to improved service delivery outcomes. In Chapter 4, I use Agarwal's (2001) typology of participation to examine how men and women participate in decision-making processes and whether their participation contributes to meeting both the practical and strategic gender needs.

1.6.3 Gender

Although the term 'gender' might seem to be common in the development discourse, more often than not, it is confused with the term 'sex' or used as a synonym for 'women' or 'female'. It is, therefore, important to clarify what I mean by 'gender' in this study. Gender refers to the socio-cultural construct of roles and relationships between men and women (van Wijk *et al.*, 1996; Vlassoff and Moreno, 2002) and to the economic, social, political and cultural attributes and opportunities associated with being male or female. Parpart *et al.* (2000) describe gender as the differentiation between masculinity and femininity as constructed through socialization. Gender relations are social relations found in all spheres of society, and are produced (and reproduced) on a daily basis by the actions, ideas and discourses of individuals and groups. In most societies, men and women differ in the activities they undertake, in access to and control of resources, and in participation in decision-making processes. Gender is, therefore, a socio-economic and political variable which can be used to analyse the roles, responsibilities, constraints and opportunities of people (Vlassoff and Moreno, 2002).

In the literature, decentralization is often represented as a neutral arena in which men and women are assumed to benefit equally. The assumption is that decentralization can be an effective means to address gender inequality and close gender gaps (Beall, 2004, 2007; Goetz, 2007; Lakwo, 2009). The UNDP (2009) argues that without gender-sensitive decision making, services may be inappropriately designed and fail to address women's and girls' needs. This is consistent with Moser's (1993) observation that basic services delivery has fundamental implications in meeting practical and strategic gender needs. She shows that most planning interventions meet the practical but not the strategic gender needs, because they do not change existing power relations and women's subordinate position in the society. The World Bank (2010) considers service provision to be gender-sensitive if it meets one or more of following conditions: sensitive to gender differentials, taking into account that men and women have different service needs; addressing the gender-specific service needs of men and women; and being transformative and empowering to men and women. The impacts of the processes and outcomes associated with decentralization on women, however, need to be studied more systematically. This is why this study puts the gender perspective at the centre.

1.6.4 Cooperation and trust

Decentralization demands a re-assessment of the role of government and its relationship with its citizens, and with the formal and informal organisations of civil society. This connects with the concept of trust, defined by Breeman (2006:20) as "a mental status of favourable expectations." As a form of social capital, trust is described as people's perceptions of the

trustworthiness of other people and key institutions that shape their lives, thus encompassing attempts to work and solve problems together (Evans, 1996; Grootaert *et al.*, 2004). Trust as cognitive social capital is an important factor in people's motivations that underlie actual processes and interactions. It is an important facilitator of democratic governance and the legitimacy of democratic systems partly depends on the extent to which the electorate trusts the government (Blind, 2006; Kuenzi, 2008). Hence, this concept is relevant in analysing the relations between citizens, and their leaders and service providers at the village level because it implies "a situation with imperfect information, and a belief that another actor is willing to act and capable of acting on another's behalf" (Jacobsen, 1999:841). Cooperation and trust are interrelated in that trust is needed for ensuring cooperation between groups, which in turn enhances participation in collective activities (Mendoza-Botelho, 2013).

While cooperation and trust have been quite extensively researched in developed countries, this is not the case for developing countries. It is known, however, that also in developing countries initiatives to improve public services may depend on cooperative efforts at the community level (Evans, 1996; Kuenzi, 2008). Such cooperation is based on trust as an important factor in people's motivations to engage in interactions and provide mutual support. A study about the synergy between poverty and impacts of HIV and AIDS in Tanzania (Nombo, 2007) demonstrates how important trust is for social cohesion and for people's participation and belief in community-based structures. Because of this, trust will shape decentralization outcomes. Since social capital is not gender-neutral (Molyneux, 2002), it can be expected that cooperation and trust are also gendered.

1.7 Conceptual model

The four concepts discussed in the preceding section and their interconnections to the theoretical perspectives described earlier in this chapter, form the basis for the conceptual model which is graphically presented in Figure 1.1. The model departs from an understanding that decentralization is a multi-dimensional institutional process involving different actors at different levels. The design and implementation of decentralization reforms is influenced by many factors at the international, national and local levels. Thus, I see the decentralization reforms in Tanzania to be taking place within a broader institutional context underpinned by the international and national policy frameworks including the changing global development discourses and priorities, the need to achieve the Millennium Development Goals (MDGs), the national Development Vision 2025 and National Strategy for Growth and Reduction of Poverty, and other wider public sector and sectoral reforms. All these policies and strategies have a bearing on the design, processes and outcomes of decentralization reforms.

The framework is also cognisant of the fact that the actors at the LGA and lower levels (administrators, politicians and service providers), the main recipients of decentralised powers and resources operate within an institutional context (both formal and informal) including national guidelines, procedures and priorities. This determines the range of powers these actors can exercise and, therefore, is likely to influence the process and outcomes of decentralization. Furthermore, decision-making processes and service provision at the local

level take place within the socio-cultural context which may influence service users' participation in these processes, their level of cooperation and trust, their access to basic services, and their perceptions on whether the reforms are contributing to improving the services. In this, I see gender as a cross-cutting concept that can influence people's participation, access to public services, and cooperation and trust relations. Similarly, I see trust as an important mediator in decision-making processes and service delivery arrangements.

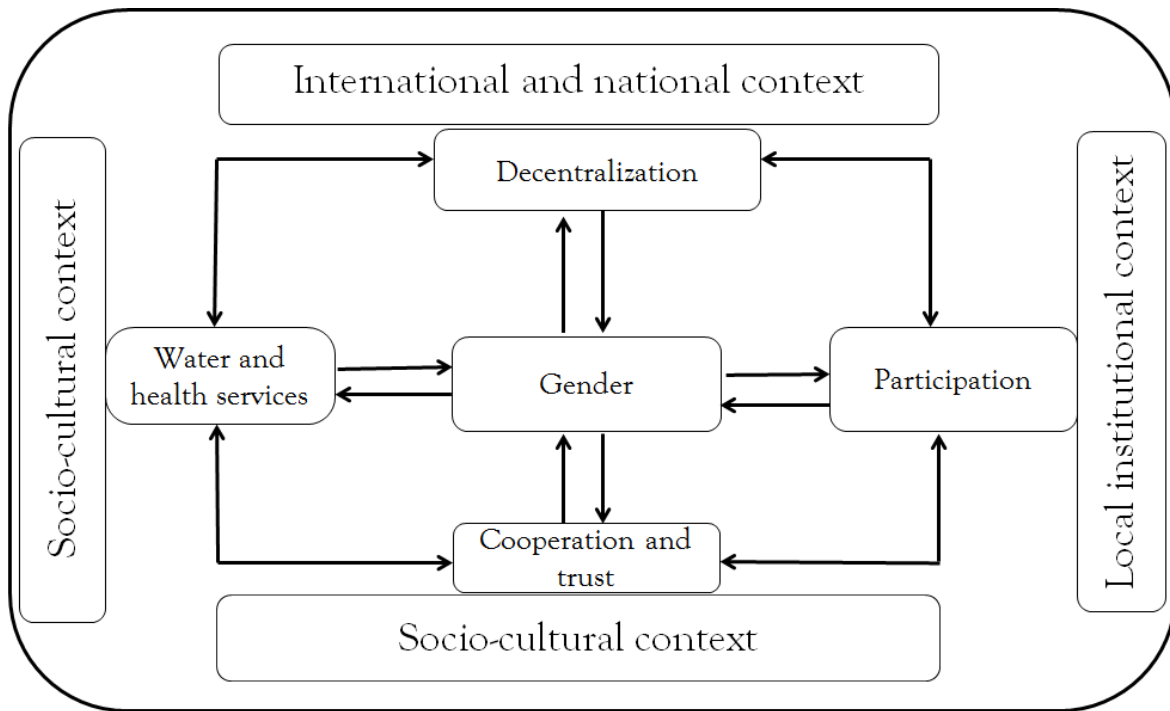


Figure 1.1: Conceptual model for the study

1.8 Relevance of the study

The design and implementation of decentralization reforms aimed at enhancing service users' participation and improving service delivery requires a thorough understanding of the gender dimensions of both the process and impact of these policy changes. This study contributes to the theoretical and policy debates on the linkages between decentralization and participation, decentralization and cooperation and trust, and decentralization and improved service delivery outcomes. From a theoretical stand point, the insights from this study are useful in validating and challenging the theoretical underpinnings that inform studies on gender and decentralization. An important and innovative theoretical contribution of this study is that it puts the gender perspective at the centre, combining it with the institutional and users' perspectives.

Although decentralization reforms in Tanzania have entailed fundamental changes in the entire governance system of the country, this study focuses on the impact of these macro processes at the village and household levels. Most studies on decentralization tend to focus on macro level units of analyses (district, regional and national levels), but fail to capture the

micro-processes at the village and household levels which are likely to be underpinned by both the formal and informal institutions. Decentralization is not only about the formal powers, but also has implications for the informal power relations between the actors involved (Dubois and Fattore, 2009). A gendered analysis at these lower levels, therefore, aims to improve our understanding of this relationship because it recognizes the fact that political processes such as decentralization operate across wide and deep terrains, which traverse and connect the social and political spheres (Beall, 2007).

In terms of policy, the study identifies the factors that facilitate or impede people's participation in decision-making processes and delivery of improved public services at the local level. This is important for policy makers and implementers because the study shows the gaps between theory and practice, and identifies possible areas of intervention. Thus, the findings will help to inform actors at different levels on the appropriate design and implementation of decentralization processes so as to enhance equitable service delivery and use women's potential in decision-making and planning.

1.9 Structure of the thesis

This thesis is organised into eight chapters. After this introductory chapter, Chapter 2 presents the research context and methodological design of the study. Although the empirical chapters of this thesis are based on papers published or in the process of being published in international peer reviewed journals and, therefore, contain brief methodological sections, this chapter provides a more comprehensive picture. It first introduces the research context in terms of the country and the study districts, discusses the study design used, reflects on the fieldwork processes, and broadly describes the data collection methods that were used to answer the research questions. The chapter also explains how ethical issues were considered in this study.

Chapter 3 analyses the main institutional characteristics of the current decentralization processes with regard to water and health services delivery, and the factors that constrain the realization of decentralization. Drawing on the empirical and policy literature, and on preliminary study findings, the chapter seeks to answer the first research question regarding the institutional arrangements for decentralized water and health services delivery, using principal-agent theory and broader decentralization frameworks. The chapter shows 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.

Chapter 4 discusses the impact of decentralization reforms on service users' participation in decision-making processes using the gender perspective and principal-agent theory. The chapter addresses the second research question. It investigates whether decentralization reforms increased opportunities for service users' participation in decision-making processes for delivery of public services at the local level, how men and women participate in these processes, and how this contributes to meeting women's practical and strategic gender needs. The chapter reveals that decentralization reforms have created spaces for service users' participation at the local level. Women's participation contributes to meeting practical

gender needs, but to a lesser extent addresses their strategic gender needs because existing power relations have been untouched by the reforms.

Chapters 5 and 6 focus on the third research question: whether the delivery of gender-sensitive water and health services to rural households has improved after the decentralization reforms. Chapter 5 looks at rural water supply and Chapter 6 at primary healthcare services. Both chapters combine a users' and a gender perspective with a particular focus on women users. A common finding of both chapters is that the reforms have produced mixed results. They have improved access to these services for some users while, at the same time, they have created or reinforced inter- and intra-village inequalities, including gender inequalities.

Chapter 7 examines the impact of decentralization reforms on cooperation and trust at the village level using a gender perspective. The chapter seeks to answer the fourth research question regarding the effects of cooperation and trust on decision-making processes and provision of water and health services, and whether the reforms enlarged cooperation and trust at the local level. The chapter demonstrates that the reforms have strengthened both formal cooperation aimed at improving public services and the informal mechanisms of social networks and groups. Decentralization outcomes in terms of increased citizen's participation in decision-making processes and improved services influence political trust, and also here gender relations proved to play an important role.

Chapter 8 presents the general conclusions and synthesis of the study. It highlights the main findings and conclusions based on each of the research questions, gives a general discussion on the theoretical and methodological issues emerging from the study, and it provides some policy recommendations and issues for further research.

Chapter 2

Research context and methodology

This chapter discusses the context, methodological design and data collection methods used in this study. The first part of the chapter introduces the context of the study: the country and the study districts. The research design adopted in the study, particularly the use of the embedded case study and the longitudinal perspective is then explained. This is followed by reflections on the fieldwork processes showing how the three research phases were implemented. A major part of the chapter is devoted to the data collection methods that were employed to answer the research questions with emphasis on the use of mixed methods combining quantitative and qualitative techniques, and how both quantitative and qualitative data were processed and analysed. The chapter concludes by explaining measures taken to address ethical issues in the study.

2.1 Tanzania and the study area

2.1.1 Tanzania

The United Republic of Tanzania comprises the territory formerly known as Tanganyika (now mainland Tanzania) and Zanzibar which is made up of the islands of Unguja and Pemba. Tanganyika gained independence in 1961 and was united with Zanzibar in 1964 to form Tanzania. The country is located in Eastern Africa between longitude 29° and 41° east, and latitude 1° and 12° south. Tanzania covers a land area of 945,203 km² including inland waters. It borders on the Indian Ocean to the east, and has land borders with eight countries: Kenya and Uganda to the north; Rwanda, Burundi and Democratic Republic of Congo (across Lake Tanganyika) on the west; and Zambia, Malawi and Mozambique to the south. Administratively, the country is divided in 30 regions, 25 in mainland Tanzania and 5 in Zanzibar (URT, 2013). Dodoma is the official capital and seat of Tanzania's Union Parliament. Dar es Salaam (the former capital) remains home to government ministries and major institutions, including diplomatic missions.

According to the 2012 national census, the current population of Tanzania is 44.9 million with a population growth rate of 2.7 percent and population density of 51 persons per square kilometre with variation across regions (URT, 2013). The majority of the population (77%) lives in rural areas where farming is the main economic activity (URT, 2006). There are about 120 ethnic groups on mainland Tanzania, none exceeding 10 percent of the population. The official languages are Kiswahili and English, although Kiswahili is by far the more widely spoken. Tanzania's economy relies heavily on agriculture, which accounts for nearly half of the gross domestic product and employs 80 percent of the workforce. Other sectors which have shown significant growth over the last decade are tourism and mining (URT, 2011a).

Tanzania is a unitary state with a two-tier government system: central and local governments. Local governments are enshrined in the Union Constitution of 1977 and national laws. Article 145(1) of the constitution gives recognition to local governments stating that “there shall be established local government authorities in each region, district, urban area and village in the United Republic, which shall be of the type and designation prescribed by law to be enacted by Parliament or by the House of Representatives.” Article 146(1) states that: “the purpose of having local government authorities is to transfer authority to the people. Local government authorities shall have the right and power to participate, and to involve the people, in the planning and implementation of development programmes within their respective areas and generally throughout the country” (URT, 1977). Local governments are classified into either urban authorities (city, municipal and town councils) or rural authorities (district councils and township authorities). The main legislative texts are the Local Government (District Authorities) Act No. 7 of 1982 and the Local Government (Urban Authorities) Act No. 8 of 1982, which provide for establishment of rural and urban LGAs, respectively. These Acts were amended in 1999 by the Local Government Laws (Miscellaneous Amendments) Act (No.6) 1999. Local government is a non-union matter, and therefore, Zanzibar has different local government set-up and legislation including the

Zanzibar Municipal Council Act No.3 of 1995 and the District and Town Councils Act No. 4 of 1995. The focus of this study is on mainland Tanzania which has been involved in the current reforms.

By June 2012, there were 133 LGAs in mainland Tanzania, comprising 27 urban councils (five city councils, 17 municipal councils and five town councils) and 106 district councils. District councils are further divided into 2,555 administrative wards, 10,397 villages and 50,836 *vitongoji* (hamlets) (Venugopal and Yilmaz, 2010). Each LGA is responsible in its area of jurisdiction for maintenance and facilitation of peace, order and good governance; for the promotion of the social welfare and economic wellbeing of the people; and for the furtherance of social and economic development. The district council is the LGA's main decision-making organ and is composed of all ward councillors, special seat (women) councillors and parliamentarians representing constituencies within the council area. Each district council has three standing committees, namely for finance, administration and planning; for education, health and water; and on economic affairs. The district executive director (DED) is the head of council administration and accounting officer, assisted by heads of departments and units. Council elections are held after every five years along with those of the president and parliament. The last election was held in October 2010. To ensure gender representation in district councils, there is a legal requirement to reserve at least 30 percent of all seats for women.

The present study was carried out in the districts of Kondoa and Kongwa in Dodoma Region (Figure 2.1) as part an embedded or multi-level case study design. The two districts were purposively selected to add variation and ensure that the findings are not biased by doing the research in one district only. The two districts have similar characteristics, but also differ in some other aspects. Both are rural districts located within the semi-arid central plateau characterised by low and unreliable rainfall ranging between 500-800mm per annum with long dry periods. Kondoa was among the 38 districts participating in the first phase of the reform in 2000, whereas Kongwa joined the reform in 2005. Thus, it was possible to gain an in-depth insight and make comparisons between and within the two districts. A brief description of each district is presented below whereas Table 2.1 compares the key statistics and figures for the two districts.

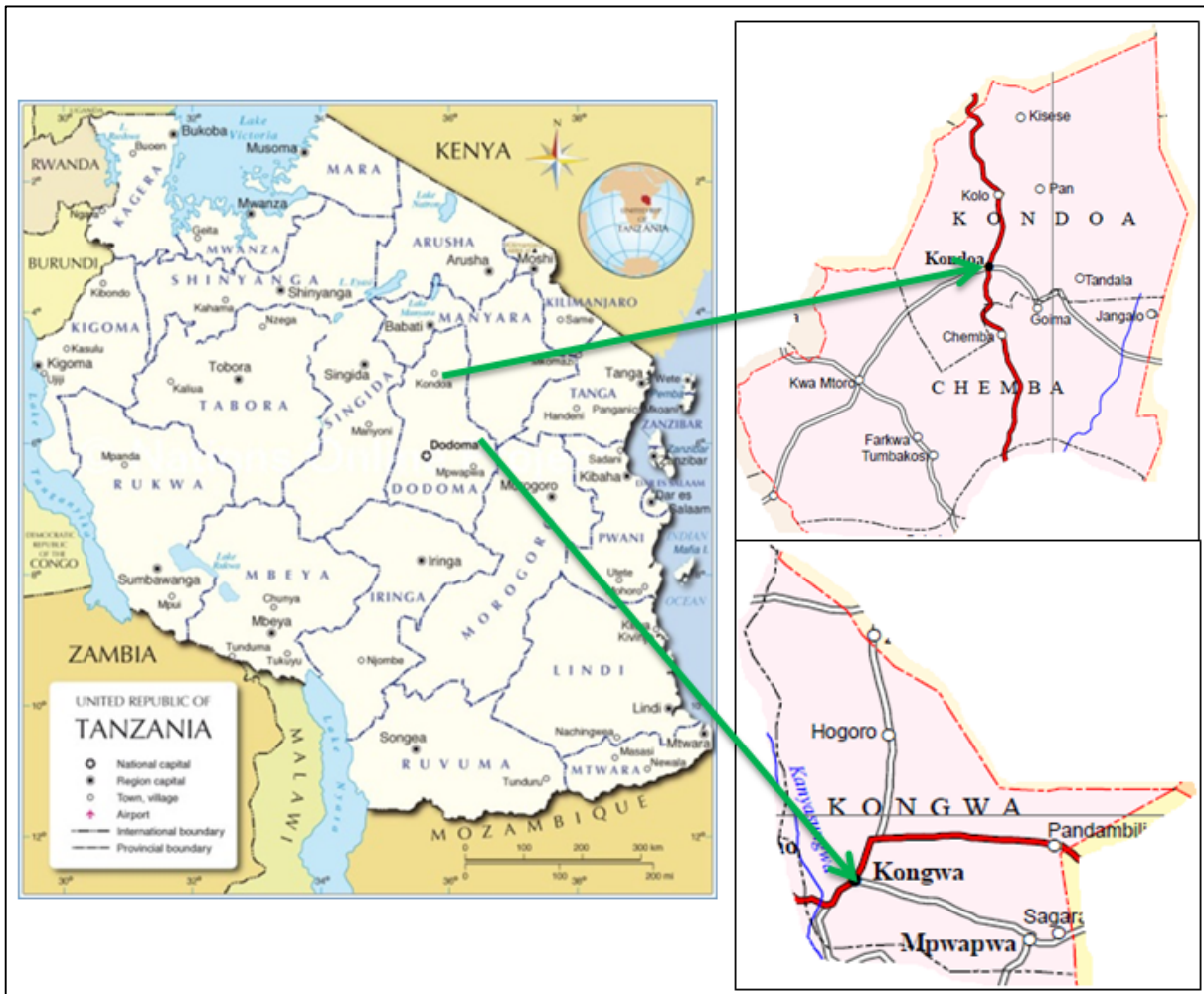


Figure 2.1: Maps of Tanzania, Kondoa and Kongwa (Source: Nations Online, 2011)

2.1.2 Kondoa

Kondoa district is one of the 46 old colonial districts established by the British in 1926 under the Native Authorities Ordinance, 1926 (Chapter 72 of the Laws). After independence, the Tanzanian government adopted the colonial districts including Kondoa. The district is located in the northern part of Dodoma region, about 160 km from Dodoma Municipality, the regional headquarters, and covers an area of 13,210 km². It borders on the districts of Bahi and Chamwino in the south, Kiteto and Kongwa in the east, Hanang and Singida Rural in the west, and Babati in the north. The district population is 505,415: 254,103 males and 251,312 females with a population growth rate of 1.6 percent (URT, 2006, 2013).

Kondoa is mainly inhabited by Bantu speaking people who account for over 80 percent of the district population. These include the Rangi, Gogo, Zigua and Nguu. Other ethnic groups found in the district are the Sandawe, Burunge, Barbaig and Masaai. These ethnic groups have some characteristic differences in terms of economic activities, some depending on pastoralism while others primarily depend on subsistence farming. Agriculture and livestock production account for about 95 percent of the district income and the

remaining five percent is from other sectors like small scale industries, mining and bee keeping. Average farm size varies from three hectares in intensified agricultural areas to six hectares in lowlands. The main food crops are maize, cassava, beans, bulrush millet and sorghum. Major cash crops are maize, groundnuts, sunflower, sesame and pigeon peas (Kondoa District Council, 2012).

Administratively, Kondoa district is divided into seven divisions, 42 wards and 193 villages². In addition, there is Kondoa township authority covering six wards and 23 villages and *mitaa*³ (Kondoa District Council, 2012). The district council is composed of 67 councillors (including three parliamentarians) and 19 of them are women. There are 23 heads of departments of whom only one is a woman. At the village level, again, only one woman is a village chairperson among the 203 village and *mitaa* chairpersons. The district is accessible by road throughout the year, though with difficulties during the rainy season because none of the roads is tarmac. Trunk and regional roads including the 'Great North Road' are gravelled and have a total length of 356 km. District roads which are under the management of the district council have a total length of 470 km whereas village feeder roads have a network of 684 km. The district is connected to the national grid which supplies power to Kondoa township and few villages (Kondoa District Council, 2011, 2012).

In terms of health services, the district has 78 health facilities including one hospital, six rural health centres and 71 dispensaries. Most of these (64 health facilities or 82%) are owned by the government under the management of the district council, 10 dispensaries belong to voluntary agencies mainly Faith Based Organisations and another four dispensaries are owned by the private sector. These health infrastructures are in different conditions with more than half of them (54%) requiring major rehabilitation and one-tenth need to be demolished and reconstructed. Current estimates show that about 76 percent of the district population lives within five kilometres from the nearest health facility. The district hospital is supplied with electricity, four rural health centres have solar power energy and 15 health facilities are linked by radio calls (Kondoa District Council, 2011). Access to water services is critical as only about one third (34%) of the district population has access to potable water from protected sources within 400m from their households, against a target of 65 percent. The main water sources include 201 hand pumps in 54 villages, 27 gravity schemes covering 42 villages, 136 pumped boreholes in 111 villages and five dams in five villages (Kondoa District Council, 2012). There also exist a number of unprotected sources including hand dug sand wells, springs and seasonal rivers.

2.1.3 Kongwa

Compared to Kondoa, Kongwa is a relatively new district. It was established in 1996 after splitting Mpwapwa district into two districts. Kongwa town, the district headquarters has, however, a long history dating back to the early 1940s when it started as a centre for British

²At the time of conducting this research, plans were underway to split the district into two districts: Kondoa and Chemba.

³*Mtaa* (literally translated as 'street') is the lowest administrative level in urban areas, equivalent to a hamlet (*kitongoji*) in rural areas.

colonial activities following the establishment of groundnuts estates. Kongwa district is located on the east of Dodoma Municipality, about 86 km from the regional headquarters and occupies an area of 4,041 km². The major ethnic groups in the district are the Gogo and Kaguru. Others, though in small proportions are the Hehe, Bena and Nguu. The district economy depends entirely on subsistence farming and livestock production, and to a lesser extent on natural resources harvesting and trade. The main food and cash crops grown include maize, millet, groundnuts, sunflower, beans and horticultural crops along the streams like Tubugwe and Chamkoroma (Kongwa District Council, 2010).

Table 2.1: Key statistics and figures of study districts in 2012

Variable	Kondoa	Kongwa
Year of establishment	1926	1996
Year the district joined local government reforms	2000	2005
Land area (km ²)	13,210	4,041
Population	505,415	309,973
Annual population growth rate (%)	1.6	3.0
Population density (persons per km ²)	34.0	76.8
Average household size	4.8	5.0
Administrative units		
Number of divisions	8	3
Number of wards	48	22
Number of villages	193	74
Distance from regional headquarters (Dodoma)	160km	86km
Health indicators		
Infant mortality rate (IMR)	48/1000	28/1000
Under five children mortality rate (U5MR)	120/1000	98/1000
Maternal mortality ratio (MMR)	109/100,000	120/100,000
Child immunization coverage (%)	94	91
Proportion of assisted deliveries at health facilities (%)	73	82
Proportion of family planning users (%)	81	49
Health facilities		
Hospital	1	1
Rural health centres	6	4
Dispensaries	71	44
Proportion of population accessing health facilities within 5km (%)	76	58
Water sources		
Boreholes	136	45
Shallow wells	201	11
Gravity schemes	27	10
Charcoal dams	12	-
Dams	5	-
Proportion of population accessing potable water within 400m (%)	34	51

Sources: Compiled by author from URT (2006, 2013); Kondoa District Council (2011, 2012); Kongwa District Council (2010, 2011).

Kongwa district is divided into three divisions, 22 wards and 74 villages. Total population is 309,973 (149,221 males and 160,752 females) with a population growth rate of 3.0 percent (URT, 2006, 2013). The district council has 31 councillors (including one parliamentarian), eight of them are women, and one woman is a village chairperson out of the 74 village chairpersons. Kongwa district has a total road network of 801 km. More than half of this network is village feeder roads (410 km) and 114 km is district roads which are earth roads. Regional roads have a total length of 212 km and are gravelled while the trunk road (Dodoma - Dar es Salaam highway) is the shortest (65 km) and is tarmac (Kongwa District Council, 2010, 2011). Electricity supply is available in Kongwa township and few business centres including Mlali, Kibaigwa, Pandambili, Mtanana and Mbande.

More than half (58%) of the district population lives within five kilometres walking distance from the nearest health facility. The district has one hospital, four rural health centres and 44 dispensaries; 35 dispensaries are owned by government through the district council, five by the private sector and four by religious organizations. Most of the health infrastructures are in good condition requiring only minor repairs (81%) while only four percent need major repair. Malaria is the major health problem in the district and the leading cause of morbidity among under five-children and adults (Kongwa District Council, 2011). About half (51%) of the district population has access to protected water sources within 400m walking distance. The main sources include 45 pumped boreholes, 11 shallow wells and 10 gravity schemes.

2.2 Research design

Every empirical research has a research design, whether explicit or implicit. Yin (2003:19) defines a research design as a “plan that guides the researcher in the process of collecting, analysing and interpreting data.” It is the logic that links the data to be collected (and the conclusions to be drawn) to the initial questions of the study. Consequently, it acts as a logical “model of proof” that allows the researcher to draw inferences about causal relations among the variables under investigation. De Vaus (2001:9) argues that a research design is the logical structure of inquiry whose function is “to ensure that the evidence obtained enables the researcher to answer the questions or test theories unambiguously as possible.” Kumar (2005) suggests two other functions of a research design. The first is about identification of procedures and logistical arrangements required to undertake a study, and the second emphasizes the importance of these procedures to ensure their validity, objectivity and accuracy. This study used an embedded case study design, applying a longitudinal perspective, and using a combination of qualitative and quantitative methods.

2.2.1 An embedded case study design

This study adopted an embedded case study design with multiple units of analysis at different levels (Yin, 2003): district councils, villages, households and individual men and women within households and villages. A case study design was considered ideal for the study because of its relevance in exploring subjects and issues when the boundaries between the phenomenon and context are not clearly evident, where ‘why’ and ‘how’ questions are being

asked, and where the researcher has no control over the events under study (Yin, 2003; Gray, 2004). Further, a case study provides an opportunity for intensive analysis of specific details which may not be possible to analyse by other designs (Kumar, 2005). In this study, the formal local government and informal institutions, service providers and users, gender roles and needs, and cooperation and trust relations are intertwined in a set of inter-relationships and, therefore, could best be studied using a case study approach. Because local government service delivery functions are implemented, managed and delivered at different levels, this study considered the district, village and household as important units of analysis to enable comparison between and within these levels.

At the higher level, the district (or LGA) was used as a unit of analysis because it is the focal point for planning, decision making, resource allocation and expenditure, and agency for coordinating the implementation of service delivery functions. Although the two study districts cannot be claimed to be representative of all rural LGAs in the country (which is one of the limitations of case studies), they are part of the multi-level case study that represent typical examples of rural LGAs in Tanzania, thus, relevant in studying the process and impact of decentralization on service delivery outcomes. This is consistent with Mol (2008) who argues that case studies offer points of contrast, comparison or reference to other situations.

At the sub-district level, the village was used as a unit of analysis because in rural Tanzania, it is the second lowest administrative and governance level which is crucial in terms of planning, decision making, management and service delivery arrangements. Households in the same village are exposed to the same leadership and management arrangements, and are likely to collectively use the same water sources and health facilities. Many decision-making processes and communication of decisions from higher levels also take place at this level. Both the formal and informal institutions of local governance in terms of rules, norms and associational groups are involved at this level. Whereas formal institutions have power by the virtue of the state and formal rule of law, informal ones acquire power through customary influences and beliefs. Thus, the village is an important unit for analysing the institutional framework for service users' participation, cooperation and trust, and service provision because the type of village might as well account for the differences. This study was carried out in ten villages (five in each district) that were purposively selected. The selection criteria were developed based on preliminary interviews and discussions with district officials and review of documents. The criteria included the village location within the district, availability and type of water sources, management arrangements for water sources, and presence or absence of a health facility (Table 2.2). Overall, the ten villages were typical of rural areas in Tanzania, and were considered adequate to make the villages representative of their districts.

The household was also used as another unit of analysis because it is an arena where much of daily life takes place and the centre of processes that determine the welfare of individual members. It is within this "arena of everyday life", this basic unit of human social organization, that activities to provide for people's basic needs are undertaken (Niehof and Price, 2001:19). Rudie (1995:228) defines a household as "a co-residential unit, usually family-based in some way, which takes care of resources management and primary needs of its

members.” Despite its wide application in household studies, this definition has, however, been criticised on the ground that notions of family-based, co-residence and joint resource management do not capture the diversity of living arrangements, livelihood opportunities and changing modes of generating livelihood (Nombo, 2007; Gartaula, 2011, 2013). There could be many ways of defining and classifying households because “boundaries around households are fluid rather than stable” (Pennartz and Niehof, 1999:3).

Despite the limitations, Rudie’s (1995) definition is used because it captures important household dimensions which are relevant in the context this study. First, the ‘family’ dimension is useful in the analysis of processes in the ‘domestic sphere’ as family ties are assumed to provide moral claims to the home, house, support and care (Niehof, 2011). What things are considered as ‘domestic’ or ‘public’ and how ‘masculinity’ or ‘femininity’ are conceptualised, do not only depend on the extra-household social norms, but also are influenced by the intra-household processes (Kevane, 2000). Second, provision for ‘primary needs’ is crucial in explaining gender roles and needs and whether households meet practical gender needs for their members in accessing water and health services. Third, ‘resource management and decision making’ determine the type and degree of household members’ participation in decision-making processes in public spaces at different levels. In this case, the household is conceptualised as partly responsible for framing gender roles and needs, and for determining individual members’ access to resources, opportunities and services.

In addition, this study sees the household as having permeable boundaries and as being embedded within the wider social structures (Niehof, 2011). According to Pennartz and Niehof (1999), households are interwoven within the social cultural environment, they are active agents with the ability to influence changes within broad structural constraints, and can act as mediating agencies between the individual and society. Subscribing to Kevane’s (2000:107) argument on the importance of social norms in regulating the “socially permissible” activities of women, I recognize the complex interactions between intra-household and extra-household social norms and the resultant bargaining processes which impact household processes. For example, I see decision-making processes as indivisibly interwoven with larger and encompassing processes going on within households and within societal context (Pennartz and Niehof, 1999).

Table 2.2: Study villages and their selection criteria

District	Village name	Village selection criteria			
		Location	Type of water source	Management of water sources	Health services
Kondoa	Potea	Kondoa north, 46kms from the district capital	Borehole constructed under WSDP in 2008	Village water committee	Dispensary under construction. Villagers use dispensaries in Mnenia, Bumbuta or health centre at Pahi village
	Mulua	Kondoa north, 16kms from the district capital	Shallow well and traditional sources	Village water committee	No health facility in the village. Villagers use district hospital in Kondoa town
	Kidoka	Kondoa south, 65kms from the district capital	Borehole constructed under WSDP in 2008	Private operator under village water committee	Dispensary in the village constructed in 1972 and renovated in 2005
	Khubunko	Kondoa south, 85km from the district capital	Old borehole (not operational), traditional sources	Village water committee	A recently constructed dispensary in the village
	Humekwa	Kondoa south 90km from the district capital	Borehole constructed under WSDP in 2002	Village water committee	No health facility. Villagers use a dispensary in Humekwa village in the neighbouring Chamwino district
Kongwa	Songambe A	Northern part of the district, 46km from the district capital	Borehole constructed in 1970. A new borehole is under construction	Village water committee	Dispensary in the village constructed in 2006
	Chamae	Northern part of the district, 34km from the district capital	Borehole constructed under WSDP in 2008	Private operator under village water committee	Dispensary under construction. Villagers use a dispensary in Hogoro village
	Sagara A	Southern part of the district, 22km from the district capital	Gravity scheme	Village water committee	Completed dispensary building but not operational yet. Villagers use a dispensary in Sagara B village
	Mlanga	5km from district headquarters	Gravity scheme	Village water committee	No health facility in the village. Villagers use district hospital in Kongwa town
	Manungu	12km from district capital	Borehole constructed under WSDP in 2006	Village water committee	No health facility in the village. Villagers use district hospital or dispensary in Mbande village

2.2.2 Longitudinal perspective

Studying the process and impact of decentralization on service delivery outcomes could have benefited from a longitudinal approach. Longitudinal studies measure changes to ascertain trends in factual data over time (de Vaus, 2001; Grinnell, 2001; Kumar, 2005). According to Pennartz and Niehof (1999), a longitudinal approach is important when the researcher is interested in uncovering the dynamics of a process. This would require visiting the study area to collect information a number of times at regular intervals, usually over a longer period of time (Kumar, 2005; Axinn and Pearce, 2006). This was, however, not feasible due to limited time and resources. In addition, the reforms which the study seeks to evaluate their impact have been on-going processes for over a decade now. This could mean that the study should have as well been going on throughout this period. This reflects the common cited limitations of longitudinal studies, namely: (their) being more costly, time-consuming and requiring careful planning and an orientation towards long-term rather than short-term research goals (cf. Grinnell, 2001; Kumar, 2005; Axinn and Pearce, 2006).

To overcome these limitations, this study incorporated a longitudinal perspective by following up on already existing information from village and district officials, by asking retrospective questions to service users as part of the survey, analysing the perceptions of key informants, and by documenting case studies and life histories. This helped to determine whether there have been any changes on how service users participate in decision-making processes, on levels of cooperation and trust, on what service users perceive as improvements or decreases in water and health services, and on what factors they perceive to have caused these changes (if any). The focus of the study was on 'perceived' changes from the viewpoint of users and not on the 'objective' changes through a longitudinal approach. This was further supported by detailed case studies where each village was visited several times over a period of one year to learn about different processes including decision making and service delivery arrangements. In general, the information generated through these approaches helped to make comparisons on the situation before and after the reforms.

2.3 Reflections on the fieldwork process

The fieldwork for this study was carried out for one year from September 2011 to August 2012 in three overlapping phases: exploratory phase, household survey and in-depth qualitative study.

2.3.1 Phase one: exploratory study

The first phase involved a number of exploratory visits to the study districts and villages to familiarize with the research areas, collect relevant available secondary data and conduct interviews with district council officials. Available district annual development plans, mid-term expenditure framework budgets, council comprehensive health plans and district profiles were reviewed whereas key statistics and figures on district council compositions were solicited from council clerks. Semi-structured and unstructured interviews were held with

district planning officers, community development officers, medical officers and water engineers to get an overview of the planning process and service delivery levels and arrangements in these areas. This procedure was also used to develop the criteria to select the study villages. During this phase, research permits were obtained from regional and district authorities and two research assistants were recruited. Research assistants were community development officers in their respective districts, therefore, were knowledgeable about the study areas and acted as link persons between the researcher, district officials and village leaders throughout the research process. Each study village was visited two to three times⁴ to build rapport with village leaders, plan for the fieldwork and collect key village data. During these “brief focused ethnographic overviews” (Scrimshaw, 1990:95), semi-structured and unstructured interviews with village chairpersons, village executive officers, village councils, water committees and health committees were also conducted. This process was also used to confirm the different village selection criteria developed with district council officials. Table 2.3 shows some of the demographic characteristics of the study villages. Overall, this phase provided important preliminary information for understanding the institutional arrangements for the reforms which was crucial for answering the first research question, and for partly addressing the third research question on service coverage levels in the study districts and villages.

Table 2.3: Demographic characteristics of study villages

District	Village name	Population			Hamlets	Households	Major ethnic groups
		Male	Female	Total			
Kondoa	Kidoka	1506	1768	3274	4	784	Rangi, Gogo, Masaai, Bulunge, Sandawe
	Potea	1796	1203	2999	4	438	Rangi
	Mulua	962	1064	2026	5	623	Rangi
	Khubunko	531	559	1090	3	259	Sandawe, Masaai
	Humekwa	620	728	1348	4	294	Gogo, Masaai, Sandawe, Bulunge
Kongwa	Mlanga	2762	2781	5543	4	809	Gogo, Kaguru
	Songambe A	5894	6919	12813	5	2296	Gogo, Kaguru, Rangi, Bena, Nguu
	Manungu	2447	2873	5320	3	534	Gogo, Kaguru
	Chamae	1521	1567	3238	5	810	Kaguru, Gogo, Hehe, Nguu
	Sagara A	2052	3014	5066	4	1135	Kaguru, Gogo

Source: Compiled by author based on data obtained from Village Executive Officers (2011).

2.3.2 Phase two: household survey

The second phase involved a household survey in ten villages that were selected in the first phase. The main research instrument used in this phase was a structured questionnaire with

⁴The number of times a village was visited depended on how readily the information needed by the researcher was available and whether village leaders could be reached on phone or not.

open and closed-ended questions. The questionnaire was designed by the researcher in English, but was then translated into Kiswahili, a language which is spoken by most people in Tanzania, to facilitate common understanding between the researcher, enumerators and respondents. Translation was initially done by the researcher and reviewed by three other people (including one with linguistic expertise) to ensure that the original meaning in the English version was maintained. This step was also taken as a measure to minimize the problems that might have resulted from translating during interviews. As Grootaert *et al.* (2004) point out, many inconsistencies arise when translation is done in the process of interviewing, the flow of the interview is slowed down, and this may affect the quality and comparability of the collected data.

In this study, four enumerators (two females and two males) were recruited to assist the researcher in this phase. Three of the enumerators were fresh Bachelor degree graduates, but had been previously involved in field research in the study districts. The other enumerator had over 20 years' experience in carrying out community field research particularly with baseline surveys and project evaluations in the study districts. Enumerators were trained to familiarize themselves with the objectives of the study, interviewing skills and the household questionnaire. The questionnaire was pretested during field training of enumerators in Masena hamlet in the village of Songambe A to see how well it would work in practice. Based on the observations from this exercise especially on the wording and sequencing of questions, the household questionnaire was revised accordingly. The household survey provided useful quantitative data on how men and women participate in decision-making processes (research question 2), on access to water and health services (research question 3) and on cooperation and trust levels (research question 4).

2.3.2 Phase three: in-depth qualitative study

The third phase was a detailed qualitative study using the emic or insider's view (Headland *et al.*, 1990). Because qualitative studies are time-consuming and do not necessarily require large numbers of respondents (Axinn and Pearce, 2006), two villages were purposively selected for this phase. Potea in Kondoa district was selected because of the problematic health services in the area, while Songambe A in Kongwa district was included in the in-depth study because of problematic water services. Focus group discussions (FGDs), semi-structured interviews and non-participant observation were used as methods of data collection in this phase. Interview and FGD checklists were prepared after preliminary analysis of survey data. This phase was also used to clarify some of the information obtained in previous phases with district officials and village leaders and follow-up emerging issues and themes. Detailed case studies of these villages were also documented during this phase.

Of particular interest in the village of Potea was how villagers had shown demand for a health facility, a desire which was yet to be realised because the district council provided out-dated drawings which were too technical for village leaders to understand. In Songambe A, a particular focus was on the problematic water services because of the old borehole that has existed since early 1970s. The district council had come in to intervene by drilling a new borehole, but villagers were yet to raise the required five percentage contribution of the total

initial cost of the borehole. Songambele A also represented a successful story of how decentralization reforms had contributed to improving availability of health services through construction of a village dispensary. The qualitative data obtained from this phase complemented the survey and secondary data, and was helpful in addressing the second, third and fourth research questions. Table 2.4 is a summary of the research phases, the methods used in each phase and how they link to the four research questions presented in Chapter 1.

Table 2.4: Research phases and data collection methods

Phase	Data collection methods	Research question
Exploratory phase (September – October 2011)	Analysis of secondary data, semi-structured and unstructured interviews, observations	1,3
Household survey (November 2011 – February 2012)	Household survey, observations	2, 3 and 4
In-depth qualitative study (March – August 2012)	Semi-structured and unstructured interviews, FGDs, observations, life histories, documenting case studies	2,3 and 4

2.4 Mixed data collection methods

The nature of this study necessitated the use of mixed methods of data collection from multiple sources of evidence to get deeper insights into the process and outcomes of decentralization at the local level, and subsequently contribute to validity and reliability of research findings. Mixed methods are data collection strategies that combine elements of qualitative methods such as in-depth interviews, exploratory interviews, observation, focus group discussions or life histories with elements of quantitative methods such as structured interviews and surveys, either simultaneously or sequentially (Creswell, 2003; Axinn and Pearce, 2006). Quantitative methods are well acknowledged for their strength in studying large populations where random sampling, statistical analysis and drawing generalizations about causal relationships are possible. However, they are often criticised for their bias towards ideal behaviour because they tend to view reality as singular and static, and for their inability to explore sensitive topics. Whereas it is possible to identify real versus ideal behaviour and explore sensitive topics when using qualitative methods, these methods have limited possibilities of statistical testing, are time consuming and use small samples which are problematic in making generalizations (Scrimshaw, 1990; Niehof, 1999).

Since all methods and approaches have their strengths and weaknesses and are only appropriate for certain research questions, a combination of methods helps to counter-balance their weaknesses (Axinn and Pearce, 2006; Diefenbach, 2009). According to Scrimshaw (1990), combining quantitative and qualitative methods helps to understand the

process being studied in culturally appropriate terms, to obtain accurate information on behaviour and interpret the meanings behind the behaviour. As Niehof (1999:36) notes: “although quantitative data deal with numbers and qualitative data with meanings, the two are mutually dependent. Meanings cannot be ignored when dealing with numbers, and numbers cannot be ignored when dealing with meanings.” Scrimshaw (1990:88-89) also sees validity and reliability as other reasons for integrating quantitative and qualitative techniques. Validity is defined as the accuracy of scientific measurement, “the degree to which scientific observations measure what they purport to measure”, whereas reliability refers to “replicability: the extent to which scientific observations can be repeated and obtain the same results.” She argues that qualitative methods are more accurate in terms of validity, and quantitative methods are better in terms of reliability or replicability. Hence, qualitative and quantitative methods complement each other, and their combined application optimises both validity and reliability of research findings (Niehof, 1999; Nombo, 2007). In this study, the survey was used to collect quantitative data, whereas semi-structured and unstructured interviews, FGDs, observation, case studies and life histories were used to collect qualitative data.

The use of mixed methods also relates to the importance of incorporating emic and etic perspectives in the research design. According to Headland *et al.* (1990), the etic or outsider’s view examines extrinsic constructs, accounts, descriptions and analyses that are meaningful to scientific observers. In this study, the exploratory study and household survey were inclined towards this view. The emic or insider’s view focuses on the cultural constructs and social processes meaningful to members of society being studied (Headland *et al.*, 1990). To elicit emic views, a detailed qualitative study was conducted (third phase). This was crucial because citizens’ participation in decision-making processes, gender roles and needs, cooperation and trust relations and even perceptions of whether there is improved access to social services are qualitative processes and, therefore, the need for an in-depth qualitative inquiry. The different data methods collection used in this study are discussed in the following sections.

2.4.1 Household survey

One of the advantages of surveys is their ability to collect data from large samples using standardized questions in an objective manner (Scrimshaw, 1990; Creswell, 2003; Axinn and Pearce, 2006). In this study, a household survey was conducted in ten villages covering 332 households, with a minimum of 30 households in each village. Grinnell (2001) proposes a sample size of at least 10 percent (with a minimum of 30 per category) as sufficient to provide reasonable control over sampling error, a rule that was observed in this study. In each village, simple random sampling using village registers was used to obtain study households, but in situations where village registers were not available convenience sampling was used. Enumerators were accompanied by hamlet leaders who introduced them to households. In each household, questionnaires were administered preferably to the older female member of the household and in cases where the older female member was not present, the male older member was interviewed. The household questionnaire comprised five parts, each aiming at collecting information on particular aspects related to the research questions. These were

socio-economic and demographic characteristics of households, access to water services, access to health services, participation in decision-making processes, and trust and cooperation (see Appendix 1). Household interviews took between 45 to 60 minutes to complete, and each enumerator interviewed eight households per day, on average.

Table 2.5 shows the socio-demographic characteristics of household interviewees including duration of stay in the village, sex, age, household headship, household size, education level, religion and ethnicity. The majority of respondents were either natives (67%) or had lived in the study villages for more than ten years (28%). This suggests that most respondents had sufficient knowledge about their villages, including about the issues that were investigated in this study and, therefore, could provide relevant information. About two thirds of respondents (65%) were women, 35 percent were men. The plan was to have more women respondents than men in the sample because women are the main principal care-givers in households. As a matter of fact, it turned out that in many households surveyed, it was the adult female members who were found at home at the time their households were visited for the survey.

With regard to age, more than one third of respondents were between 30 through 44 years (40%) and about another one third were between 45 through 64 years (31%). The mean age of respondents was 42 years, although men were significantly ($p=0.00$) older (47 years) than women respondents (40 years). Thus, a high percentage of respondents was within the active productive age group. In terms of household headship, there were more male-headed households (88%) than female-headed-households (12%). The percentage of female-headed households in the study districts was generally lower than national average for rural households which was 32 percent in the 2002 national census (URT, 2006) and 25 percent in 2010 (URT, 2010b). More than half of households (51%) had between four to six members, about one third (35%) had seven or more members, and few had one to three members (14%). Average household size was higher in Kongwa (6.04) than in Kondoa (5.82), but the difference is not significant. Male-headed households had an average size of 6.11, which was significantly ($p=0.00$) larger than female-headed households, which had a mean size of 4.6. Overall, household size in the study districts is higher than the Dodoma regional average of 4.6 and the national average of 4.8 (URT, 2013).

The level of education attainment of respondents differed significantly between the districts, and between men and women. More respondents in Kondoa (77%) had primary education than in Kongwa (70%), and a relatively higher proportion of respondents in Kongwa had no formal education (27%) than in Kondoa (18%). In terms of gender, more male respondents (80%) had primary education than female respondents (70%). Levels of educational attainment were generally higher in the study villages than the Dodoma regional levels reported in the national demographic and health survey: only 24 percent had completed primary education, 38 percent some primary education and 33 percent had no primary education (URT, 2010b).

Both ethnic and religious compositions were significantly ($p=0.00$) different between the two study districts. Kongwa had few ethnic groups whereas Kondoa was more diverse with many groups across the study villages. In Kondoa, the study villages comprised the Rangi (45%), Gogo (26%), Sandawe (20%), Hehe (4%) and other tribes (3%). In contrast, close to

three quarters of respondents in the Kongwa villages were Gogo (74%), the major ethnic group in the region, followed by Kaguru (17%), others (6%) and Hehe (4%). In terms of religion, more than half of respondents in Kondoa were Muslims (55%) and 44 percent were Christians, mostly Catholic (21%) and Anglican (17%). On the opposite, almost all respondents in Kongwa were Christians (96%) and most of them were Anglican (80%) and few belonged to other Christian denominations.

Table 2.5: Characteristics of survey respondents (n=332)

Variable	Categories	Kondoa	Kongwa	Total
Duration of stay in village	Since birth	118(72.0)	103(61.3)	221(66.6)
	Less than 10 years	9(5.5)	9(5.4)	18(5.4)
	More than 10 years	37(22.6)	56(33.3)	93(28.0)
Sex	Male	50(30.5)	65(38.7)	115(34.6)
	Female	114(69.5)	103(61.3)	217(65.4)
Age	15-29 years	34(20.7)	33(19.6)	67(20.2)
	30-44 years	60(36.6)	72(42.9)	132(39.8)
	45-64 years	51(31.1)	53(31.5)	104(31.3)
	65+ years	19(11.6)	10(6.0)	29(8.7)
	Mean age (years)	42.7	42.3	42.5
Household headship	Male headed	140(85.4)	152(90.5)	292(88.0)
	Female headed	24(14.7)	16(9.5)	40(12.0)
Household size	Small (1-3 members)	27(16.5)	18(10.7)	45(13.6)
	Medium (4-6 members)	80(48.8)	90(53.6)	170(51.2)
	Large (7+ members)	57(34.8)	60(35.7)	117(35.2)
	Mean household size	5.82	6.04	5.93
Education level	Adult education	8(4.9)	3(1.8)	11(3.3)
	Primary education	126(76.8)	117(69.6)	243(73.2)
	Secondary education	1(0.6)	2(1.2)	3(0.9)
	No formal education	29(17.7)	46(27.4)	75(22.6)
Religion	Christian	73(44.5)	162(96.4)	235(70.8)
	Muslim	90(54.9)	2(1.2)	92(27.7)
	Traditional religion	1(0.6)	4(2.4)	5(1.5)
Ethnicity	Gogo	42(25.6)	124(73.8)	166(50.0)
	Kaguru	1(0.6)	28(16.7)	29(8.7)
	Rangi	73(44.5)	0(0)	73(22)
	Sandawe	32(19.5)	0(0)	32(9.6)
	Bulunge	4(2.4)	0(0)	4(1.2)
	Hehe	7(4.3)	6(3.6)	13(22.0)
	Others ⁵	5(3.0)	10 (6.0)	15(4.5)

Figures in bracket are percentages.

2.4.2 Semi-structured and unstructured interviews

Semi-structured and unstructured interviews were important data collection methods throughout this study. Axinn and Pearce (2006) view semi-structured or less-structured interviews as critical in qualitative research because of their flexibility, which allows inter-

⁵Other tribes are Zigua, Nyambo, Nyaturu, Zanaki, Masaai, Taita, Nyamwezi, Nguu, Zaramo and Sukuma.

actions between the researcher and respondents. In this type of interviews, respondents can change the course of the conversation and bring up new issues that the researcher might not have thought of. Kumar (2005:122) calls this flexibility “complete freedom in content and structure” because questions can be formulated in different ways, the researcher can use different wording to explain questions, and interviews can be ordered in any sequence.

In this study, these methods formed the core of the exploratory and in-depth qualitative study phases. In the first, unstructured interviews aimed at getting a general picture of the planning and decision-making processes, service delivery arrangements and coverage levels were conducted with district officials and village leaders. Unstructured interviews were also held with district officials during follow-up visits to clarify some issues that were observed in the villages. In the third phase, semi-structured interviews were held with village leaders in the villages of Potea and Songambe A using interview checklists that were developed after preliminary analysis of survey data. Issues covered included perceptions on improvements and challenges in access to water and health services, what has contributed to the changes, users’ participation in management of services, payment mechanisms for such services, organisation of village meetings and perceptions on trust and cooperation within the community (Appendix 2). Except for the unstructured interviews with district officials which were mostly conducted by the researcher only, all other interviews were conducted by the researcher and research assistants and field notes were taken throughout the processes. Semi-structured interviews with village leaders were also recorded using a digital voice recorder, which were then transcribed into field notes after every interview.

2.4.3 Focus group discussions

Focus group discussions are among the well-known and widely used methods in qualitative research. Morgan (1996:130) defines focus group discussions as “a research technique that collects data through group interaction on a topic determined by the researcher.” Although FGDs share many of the characteristics of unstructured interviews, they also differ in a number of ways. According to Axinn and Pearce (2006), FGDs explicitly call for participants to interact with one another in formulating responses, a process which allows participants to feel confident, thus encouraging them to discuss issues they would not in individual interviews. Kumar (2005) views FGDs as useful in exploring perceptions, experiences, and understandings of a group of people with some common experience on the issue being investigated. The goal of FGDs is to get closer to research participants’ understanding of the research topic in order to gain insight not only into attitudes and opinions, but also into experiences and perspectives (Morgan, 1996). A major limitation of FGDs is that participants might be hesitant to share ideas in front of their peers, while they would offer those in individual interviews (Axinn and Pearce, 2006). However, FGDs can be used in combination with other methods such as surveys and individual interviews which helps to overcome this limitation (Morgan, 1996).

In this study, four FGDs were conducted in each of the two villages (Potea and Songambe A) with village water committees, village health committees, and groups of men and women. FGD checklists were developed after preliminary analysis of survey data to take

into account emerging themes and issues which required more detailed exploration in this phase. While most of the discussion topics were common to all groups, few were very specific to some groups. Specific issues for water and health committees included criteria for membership into the committees (including issues of age and gender), their roles and responsibilities, and how patriarchy influences membership and decision-making in these committees (Appendices 3 and 4). For community groups, specific discussion issues included perceptions on appropriateness of services to needs of men and women, family planning, and cooperation and trust relations (Appendix 5).

Morgan (1996) suggests a range of four to six FGDs as adequate because beyond this, data become saturated and little new information emerges after the first few groups. This suggestion was observed in this study by concentrating on few community groups that were relevant in the context of the study. FGDs were held with village water and health committees which included men and women, because of their role in decision-making and management of these services at the village level. In addition, separate FGDs for male and female community members were held so as to learn how perceptions and experiences of the on-going processes in their communities are the same or different among men and women, and whether gender influences such processes. Except for the committees of which each member was invited, twelve persons were invited to participate in each of the other FGDs. Considerations were made to ensure representation of different groups in the community in terms of age, hamlet and social status in the community. All FGDs were conducted by the researcher and assistant researchers where field notes were taken, and digital recording was done. The number of FGD participants ranged from 6 to 13, and discussions took about 80 minutes, on average. In total, 69 participants (44 men and 25 women) were involved in the FGDs.

2.4.4 Non-participant observation

Observation as a method of data collection is “a purposive, systematic and selective way of watching and listening to an interaction or phenomenon as it takes place” (Kumar, 2005:119). Observations have the advantages of being relatively unstructured, can yield unique sources of insight and reflection, and allow the researcher to put themselves “into the shoes” of respondents (Axinn and Pearce, 2006:8). In this study, the researcher attended four district council meetings (two in each district) as an observer to learn how decision-making processes take place. In each district, one budget council meeting and a normal council meeting was attended. This method was also used throughout the research process to ascertain availability and use of water and health services in the study villages. In many instances, the researcher and assistant researchers would hang around water domestic points or village dispensary to observe the type of facilities and how community members used them. At the beginning, village leaders accompanied the researcher and his assistants to these facilities, but as they became used to the areas (especially in the villages where the in-depth qualitative study was done), the team could move around on their own, hold informal discussions with service users and even take photos. This approach provided opportunities for the researcher to see the reality on the ground and, therefore, generate real life data. The

method was also used to verify and complement information obtained through other methods.

2.4.5 Life histories

The life history method entails reconstruction of an individual's life experiences, documenting events in chronological order and assessing the importance and meaning of those events (Kakuru and Paradza, 2007). Life histories are important in gender related studies because they help to contextualise individual's experiences within a wider web of meanings (Leydesdorff, 1999). Kakuru and Paradza (2007) highlight other advantages of this approach including the 'humanising' effect on research participants, which allows the researcher to 'see' the research participants in their own context. The method allows in-depth exploration of a particular issue, hence generates knowledge characterised by multiple voices, perspectives, truths and meanings. The method also brings the researcher into the same emotional and social space as the storyteller, thereby narrowing the distance between the researcher and the participant.

In this study, five life histories of women in different leadership positions were documented. These women were identified in the course of the fieldwork processes and were selected to represent variations in type of leadership positions, age, religion and marital status. One of them was a special seats district councillor, two were village councillors, one was a hamlet chairperson and another was a member of a village water committee. Their age was between 31 and 56 years, most them being in their 40s. Three were Muslims and two were Christians, and four were married whereas one was a widow. In addition to socio-demographic characteristics which acted as entry points in the interview process, issues that were documented included their experiences in leadership positions, barriers for effective women's participation in local decision-making organs and presence of local organisations for women empowerment. Views on how, as women leaders, they had been involved in ensuring access to water and health services for their communities, and whether they perceived any changes in these services were also documented. Table 2.6 summarises the characteristics of life histories' participants. In the following chapters, particularly in Chapter 4, parts of the life histories are used in the text.

Table 2.6: Characteristics of life histories participants

Name ⁶	Age (years)	Religion	Marital status	Leadership position	Experience in leadership
RNS	40	Christian	Married with five children	Village councillor and member of social welfare committee	Since 2008
ANK	47	Muslim	Married with three children	Special seats district councillor and former village chairperson	Since 1988
JBH	42	Christian	Married with eight children	Hamlet chairperson	Since 1989
SHP	56	Muslim	Widow with six grown-up children	Member of village water committee and former village councillor	Since 1992
AJS	31	Muslim	Married with three children	Village councillor and member of social welfare committee	Since 2007

2.5 Data processing and analysis

Quantitative data obtained from household survey were coded and entered into the Statistical Package for Social Sciences (IBM SPSS Statistics 19) to make them amenable for statistical analysis. Summary frequencies were run at the end of data entry exercise to check for completeness and accuracy of the data entered. Analysis of survey data was based on descriptive statistics, bivariate, analysis of variance and multivariate analyses. Multivariate analyses mainly involved multiple linear regression analyses. In some cases, binary logistic regression analysis was used because it can accommodate multiple predictors whether categorical or continuous, and was considered relevant in this study because most of the explanatory variables are categorical in nature (Field, 2009).

With regard to qualitative data, field notes and voice clips from semi-structured and unstructured interviews, and FGDs were transcribed and analysed using qualitative content analysis. Hsieh and Shannon (2005:1278) define qualitative content analysis as “subjective interpretation of the content of text data through systematic classification and identifying themes or patterns.” It is one of the commonly used methods to analyse text data such as verbal, print or electronic that might have been obtained from narrative responses, open-ended survey questions, interviews, FGDs and observations. The goal of qualitative content analysis is to provide knowledge and understanding of the phenomenon under study by focusing on the underlying meanings or the content of the words (Patton, 2002; Hsieh and Shannon, 2005). The use of qualitative content analysis in this study helped to interpret and construct meanings from the text. The presentation and discussion of research findings in the empirical chapters, therefore, weaves together quantitative and qualitative data, illustra-

⁶Pseudonyms were used to conceal participants’ identity.

ting survey findings with concrete examples and illustrations, and validating qualitative findings with survey data (Scrimshaw, 1990).

2.6 Ethical considerations

A number of measures were taken to address issues of research ethics in this study. Before commencing the fieldwork process, research permits were obtained from regional and district authorities. At the regional level, a permit was issued by the Regional Administrative Secretary who introduced the researcher to District Administrative Secretaries in the two study districts. At the district level, the District Administrative Secretaries introduced the researcher to DEDs. The later issued letters to introduce the researcher to village executive officers of respective study villages. The exploratory visits to each study village carried out in the first phase helped to introduce the study and the research team to village leaders. During data collection processes, all respondents were asked for their consent to participate in the research after explaining to them the aims of the research and how the information obtained from them was to be used. The fact that enumerators were accompanied by hamlet leaders during the household survey also helped to increase respondents' confidence and willingness to be interviewed. Another ethical consideration was anonymity and confidentiality of respondents and the information provided. In this case, the researcher assigned pseudonyms to respondents, particularly those whose life histories were documented, and throughout the data collection and processing, data were aggregated to ensure non-traceability of respondents.

Chapter 3

Institutional arrangements for decentralized service delivery⁷

This chapter reviews recent literature and research on decentralized service delivery in Tanzania. It uses 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 principal-agent 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.

⁷This chapter has been published as: Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2013). Institutional arrangements for decentralized water and health services delivery in Rural Tanzania: differences and constraints. *Basic Research Journal of Social and Political Sciences*, 1(4):77-88.

3.1 Introduction

Tanzania has undergone major decentralization reforms over the past one decade through local government reforms 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). The recent reforms which started in 1996 have been described as more ‘holistic’ and ‘far-reaching’ (URT, 2008a). Local government reforms are being implemented under the policy of ‘decentralization by devolution’ with a goal of restructuring LGAs so that they can respond more effectively and efficiently to identified local priorities of service delivery (URT, 1996, 1998, 2008a, 2009a).

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 (e.g. Cleaver and Toner, 2006; Jiménez and Pérez-Foguet, 2010a, b; de Palencia and Pérez-Foguet, 2011) and the health sector (e.g. 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 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 chapter 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 at different levels. 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, 2004:1). Decentralization for service delivery entails restructuring institutions and 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 processes 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 chapter.

3.2 Methodology

The present chapter forms part of a research project on the 'gender perspectives on decentralization reforms in service delivery in rural Tanzania' carried out in the districts of Kondoa and Kongwa. The chapter 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 chapter.

3.3 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 a 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, an important analytical perspective to explain the relations between the actors within the institutional arrangements.

3.4 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 local government reforms 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.

3.5 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, 2009a; 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 LGAs⁸ 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

⁸Initially, the government focused on one third of LGAs and subsequently all 133 LGAs were incorporated in the reforms (URT, 2008a).

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, 2008a). In order to create an enabling institutional and legal framework, local government reforms 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).

The local government reforms 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 overriding 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, 2009a). In the next section, we address the implications of these reforms and institutional arrangements on water and health services delivery at the local level.

3.6 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 the local government reforms 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, community based organisations 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&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 2007. 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)⁹, 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 local government reforms, 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 percent of the required staff in the water department and Kondoa 50 percent. Weak technical, administrative and financial capacities in local governments have been cited as major obstacles to efficient and effective service delivery and in some cases used as justifications 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&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

⁹Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) is the ministry responsible for local governments in Tanzania

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 budgets 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 principal-agent 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, 2009a), 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&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 personnel 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 (2004:41) 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 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 percent to 56 percent 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.

Cleaver and Toner (2006) examined one water user association in Uchira village in Moshi Rural district and conclude that managing water sources at the local level does not necessarily lead to community ownership. While acknowledging that rural water supply has improved and women no longer have to walk 12km in the dry season to the nearest water point, they also point out that local institutions are shaped by historical processes, wider social structures, and prevailing community norms and relationships, hence, are susceptible to 'local elite capture' (cf. Crook, 2003; Devas and Grant, 2003; Bergh, 2004; Rondinelli, 2006). The power relations between representative bodies such as village councils and village water entities, are also a challenge (Cleaver and Toner, 2006; Giné and Pérez-Foguet, 2008). This reflects what was observed in the field, namely that management of water sources through village water committees is not very effective because of interferences by village councils, untimely banking of water funds and at times funds are diverted to other village expenditures.

3.7 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 healthcare 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 local government reforms, 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 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; Tidermand *et al.*, 2008; Yoshida, 2008; Maluka *et al.*, 2010).

There has been an increase in resource allocation to district councils through central government transfers with around 29 percent 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 (2009a: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). In both districts, health centres and dispensaries which are rural based are seriously understaffed as reflected by deficits of 70 percent and 60 percent of required health personnel in Kondo and 60 percent and 49 percent 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. Various committees and service boards as centrally determined by MoHSW and PMO-RALG have been established at all levels (Table 3.1). 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, 2010:82). 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 representatives in the committees) and higher level agents (technical district staff).

At sub-district level, studies show that establishment of health facility committees 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 healthcare 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&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, 2009a: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, interviews 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.

Table 3.1: Composition and roles of health committees and service boards

Name of committee/board and level	Composition	Functions
Council Health Service Board (district)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Ensure that the population receives appropriate and affordable healthcare 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)	<ul style="list-style-type: none"> • District medical officer • District health secretary • District health officer • District nursing officer • District pharmacist • District medical laboratory technologist • District dental surgeon 	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • One member of the CHSB • District medical officer • One representative of the MoHSW 	development plans and their implementation
Health Centre Committee (health centre)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 • Oversee the availability of essential supplies of drugs and medical equipment
Ward Health Committee (ward)	<ul style="list-style-type: none"> • 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 healthcare facility within the ward • One representative from community based organisations • One representative from the ward development committee 	<ul style="list-style-type: none"> • 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
Dispensary Committee (dispensary)	<ul style="list-style-type: none"> • Three members from dispensary users • One representative from a private health facility • One representative from a voluntary health facility • One representative of ward development committee • One representative of village council • In-charge of dispensary (secretary) 	<ul style="list-style-type: none"> • 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).

3.8 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&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 healthcare 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 healthcare 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 and health facility 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, 2009a), 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.

3.9 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, it is crucial to assess from the users' perspectives the extent to which the delivery of gender-sensitive water and health services to rural households has improved after the reforms. The lens is also important to assess whether decentralization reforms have increased opportunities for service users' participation in decision-making processes, how different community groups participate in these processes, and how gender roles and needs are reflected in the decision-making processes regarding service delivery.

Chapter 4

Service users' participation¹⁰

This chapter examines the impact of decentralization reforms on service users' participation for delivery of water and health services in rural Tanzania, using a gender perspective and principal-agent theory. The chapter investigates how decentralization has fostered spaces for participation and how men and women use these spaces, and identifies factors that constrain or encourage women's participation. It shows that decentralization reforms have created spaces for service users' participation at the local level. Participation in these spaces, however, differs between men and women, and is influenced by the socio-cultural norms within the household and community. Men have gained more leverage than women to exercise their agency as principals. Women's participation is contributing to addressing practical gender needs, but the strategic gender needs have been less adequately addressed because gendered power relations have been largely untouched by the reforms.

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4.1 Introduction

This chapter examines the impact of decentralization reforms on service users' participation in decision-making processes regarding the delivery of water and health services at the village level in rural Tanzania, using a gender perspective. There is a growing body of literature on gender and decentralization that emphasizes the importance of women's participation in local decision-making processes (Agarwal, 2001, 2010; Maharaj and Maharaj, 2004; Agrawal *et al.*, 2006; Todes *et al.*, 2010). Based on the premise that decentralization 'brings government and services closer to the people' (Devas and Grant 2003; Bergh, 2004; Maharaj and Maharaj, 2004), women's participation in local structures is seen as a means of increasing gender-sensitivity to local conditions and priorities, thus enabling greater influence of women over planning and service delivery (Beall and Todes, 2004; Maharaj and Maharaj, 2004; Hicks, 2011). This helps to ensure better understanding of the gender dimensions of service requirements and community needs (Beall, 2005; Lakwo, 2009; Matembe, 2010). Others view it as a way of empowerment to transform unequal power relations, enable new actors (in particular women) to gain influence in development processes, increase women's bargaining power in the private and public spheres, and address gender inequality and close gender gaps (Agarwal, 2001; Bryld, 2001; Agrawal *et al.*, 2006; Goetz, 2007; Todes *et al.*, 2010).

However, despite the popularity of decentralization reforms in recent decades, and a long history of initiatives to mainstream gender in development (Todes *et al.*, 2010), much of the debate on gender and politics in sub-Saharan Africa has been on women's representation in political institutions at national and regional levels. Studies on gender and decentralization in sub-Saharan Africa are few and mainly focus on women's participation in district or municipal structures, rarely going beyond these levels to the lower village levels. Examples include studies in Ghana (e.g. Gyimah and Thompson, 2008), Uganda (e.g. Lakwo, 2009; Matembe, 2010), and South Africa (e.g. Todes *et al.*, 2010; Hicks, 2011). The evidence from these studies, as well as those from rural India where the village-level *panchayat* institutions have been extensively studied (e.g. Bryld, 2001; Jayal, 2006; Ban and Rao, 2008), show that women's participation in local institutions remains low, and is determined by the socio-cultural rules and norms, relationships, structures, processes of local governance, and the historical and political context of communities (Bryld, 2001; Ban and Rao, 2008; Hicks, 2011). In addition, women's triple role in production, reproduction and community management (Moser, 1993) leave them with very limited time to participate in local governance (Gyimah and Thompson, 2008). Hence, increasing women's bargaining power and involvement in decision-making processes at different levels requires changing these structural constraints to render them more responsive to women (Agarwal, 2001).

Against this background, the present chapter focuses on the experiences of women's participation in village level institutions in Tanzania. After more than a decade of implementing decentralization reforms, recent studies in Tanzania show that the extent of people's participation in planning and decision-making processes at the local level is limited, minimal or ineffective (Kessy and McCourt, 2010; Norman and Masoi, 2010; Venugopal and Yilmaz, 2010), and that institutional arrangements under decentralization are not facilitating participation for local development (Mollel, 2010). However, empirical studies looking at the

gender dimensions of these processes are scant. Although it is widely acknowledged that men and women have different access to decision-making processes due to socially constructed gender roles and needs, most studies are gender-neutral and assume that decentralization affects men and women equally. In Tanzania (and in other sub-Saharan African countries) most studies on gender and politics have focused on women's representation in parliaments (e.g. Meena, 2003; Ballington and Karan, 2005; Shayo, 2005) or district councils (e.g. Meena, 2003; PMO-RALG, 2006). The village level where decisions that directly affect the lives of men and women are made, has been much less examined.

Thus, whether decentralization results in increased participation and decisions that are in the interests of village-level service users in general, and of women in particular, remains an empirical question that warrants further investigation. This chapter addresses this issue by suggesting answers to the following questions. First, to what extent have decentralization reforms enhanced the opportunities for service users to participate in decision-making processes? Second, how do men and women make use of these opportunities to participate in decision-making processes regarding the delivery of public services? Third, how are practical and strategic gender needs reflected in decision-making processes about service delivery at the local level? Fourth, which factors constrain or promote women's participation in these processes? The chapter contributes to the literature on gender and decentralization in Tanzania using the cases of water and health services. It focuses on the micro-level processes at the village level where men and women, the actors in and beneficiaries of decentralization reforms, live. Analysis at the village level is crucial for revealing the interfaces between the macro- and micro-level processes, and between the formal and informal institutions. The following section presents the theoretical framework that informs this analysis.

4.2 Decentralization, participation and gender: A theoretical framework

Three main concepts are central to our analysis in this chapter: decentralization, participation and gender. Decentralization is broadly defined as "the transfer of power and responsibility to plan, make decisions and manage public functions from a higher level of government to a lower one" (Conyers, 1990:19). The literature treats decentralization and participation as having a "symbiotic relationship" (Bergh, 2004:781), where men and women are often assumed to participate equally in local politics (Lakwo, 2009). Decentralization is expected to foster women's participation in local decision-making structures because it focuses on basic services that address women's needs (Beall, 2005; Lakwo, 2009; Matembe, 2010). However, a closer look suggests that this relationship is not straight-forward, given the hegemonic power relations and gender inequalities at the local level, that become evident when incorporating a gender perspective into our analysis (Matembe, 2010). This entails looking at the influence of gender on people's opportunities, social roles and interactions (FAO, 1999) and exploring how men and women contribute to and benefit from local governance as citizens or as service users (Beall, 1996). Our second research question thus relates to men's and women's agency in decision-making processes, and the third and fourth consider the content and extent of women's participation in decision-making processes and

the factors that constrain or encourage their participation. All of these questions are necessary in unpacking the gender perspective.

In addition, the chapter uses principal-agent theory to explain whether participation in decision-making processes enables service users to exercise their roles as principals. In the context of decentralization, there is a complex ‘agency relationship’ where local governments act as agents for two different principals: the national government and the citizens or service users. The theory is a useful analytical tool because it focuses both on the relationship between actors in decentralized institutions and on the duties and responsibilities that the decentralization reforms impose on these actors (Hiskey, 2010). The theory helps explaining how participation in decision-making processes is structured at the village level. Despite its widespread use in decentralization literature (e.g. Bossert 1998; Bossert and Beauvais, 2002; Brinkerhoff and Azfar, 2010; Hiskey, 2010), this theory has, however, not been linked to gender. This chapter addresses this missing connection.

The assumption is that decentralization reforms have created formal local institutions that provide opportunities for men and women to participate and exercise their agency as principals or as agents representing other service users. We refer to these institutions as spaces for participation. To examine the effectiveness of participation in these spaces, we draw on the typology of participation developed by Agarwal (2001), as presented in Table 4.1. We argue that achieving effective participation entails a shift from the lower level, where participation merely involves attending meetings, towards the higher levels, where men and women have ‘voice’ and influence in reaching decisions (Agarwal, 2001, 2010).

Table 4.1: Typology of gendered participation in village structures

Level of participation	Characteristic features	Gender needs addressed
Passive participation	Attendance in public meetings and listening without speaking up or having influence in decision making	None
Consultative participation	Being asked to give opinions in specific matters without guarantee of influencing the decisions e.g. in preparation of village annual plans	Practical
Activity-specific participation	Being asked to undertake specific tasks such as labour or material contributions in construction of service infrastructure	Practical
Active participation	Membership in village councils and committees	Practical and strategic
Interactive participation	Having voice and influence in reaching decisions in public meetings and committees; holding influential leadership positions in committees	Practical and strategic

Source: Adapted from Agarwal (2001) and modified by authors

The strong point of the typology is that it emphasizes 'how' men and women participate in the available spaces and whether their participation can be considered effective in addressing women's practical and strategic gender needs (Moser, 1993). Practical gender needs relate to the immediate perceived necessities articulated from women's experiences, and are based on the sexual division of labour within the household and community. Strategic gender needs relate to women's subordination to men and the need for equal organisational and structural relationships between men and women (Moser, 1993). This categorization is relevant in the context of decentralization because women's participation is expected to champion women's interests (Beall, 2005; Lakwo, 2009; Matembe, 2010).

We measured practical gender needs in terms of topics men and women talk about in meetings and their involvement in the construction of service infrastructure. Strategic gender needs were measured in terms of women's ability to speak up and influence decisions in meetings and the extent to which women hold influential leadership positions in village committees. Convenience of public meetings to women in terms of time, venue and language is used as an indicator of gender roles and gender division of labour. Gender is further seen as intersecting with other variables such as age, ethnicity and religion, which all play a role in enabling or constraining effective women's participation. The specific discussion must be situated in the context of decentralization reforms in Tanzania and the spaces for participation created by the reforms at different administrative levels.

4.3 Gendered participation spaces: The rural context

Since independence in 1961, decentralization in Tanzania has been implemented as a means of increasing people's participation in development and improving local service delivery (Tordoff, 1994; Cooksey and Kikula, 2005). Early decentralization attempts from the 1960s to mid-1990s, however, did not lead to increased people's participation because they were checked with a tendency towards administrative deconcentration (Cooksey and Kikula, 2005). Over the past decade, however, participation has gained impetus after the commencement of local government reforms implemented through the policy of 'decentralization by devolution'. The current reforms aim to establish broad based community awareness and people's participation, and to promote principles of democracy, transparency and accountability. Local government authorities are expected to "facilitate the participation of the people in deciding on matters affecting their lives, planning and executing their development programs" (URT, 1998:4, 2004:35).

Women's participation and gender are also consistently affirmed in the reform policy documents. The Local Government Reform Agenda states an intent "to promote the participation of women in management of local authorities" (URT, 1996:20). The Policy Paper on Local Government Reform states that local government reforms aim "to establish a democratic and gender-sensitive administrative set-up in local governments" (URT, 1998:13). The Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) recognises women as "potential drivers of change for decentralization" stating that "most women have something to gain" from decentralization reforms (PMO-RALG, 2006:5). Although the Local Government Reform Program II notes that marginalization of women's

interests in village and district plans was one of the problems encountered in the first phase of the reforms, again, it advocates gender mainstreaming, particularly in the composition of councils (URT, 2009a).

Consequently, the reforms have created a number of spaces for service users to participate in decision-making processes at the local level. These include hamlet (*kitongoji*) meetings, village assemblies, village councils and committees and district full council meetings. Figure 4.1 shows the relationship between these spaces at different levels. The hamlet is the lowest administrative level where residents elect a chairperson who represents them in the village council. The hamlet chairperson can organise residents' meetings to discuss development issues of the hamlet, although it is not stipulated how often such meetings should be held. The village assembly and village council are the major decision-making spaces at the village level. The village assembly is composed of all adult members of the village, and it elects the village chairperson, a village council of 15–25 members, and other village committees (Shivji and Peter 2003; Venugopal and Yilmaz, 2010). The legal framework guarantees women's representation in village structures stating that "not less than one quarter of the total members of village councils should be women." This is implemented through a quota system in addition to normal local election procedures (Shivji and Peter, 2003:27). The village assembly meets every three months while the village council meets monthly.

The most important decision-making space at the district level is the full council meeting which meets once every three months and involves ward councillors, special seat councillors (women), parliamentarians representing constituencies in the district and heads of district council administration. Citizens can also attend full council meetings as observers (Kessy and McCourt, 2010; Venugopal and Yilmaz, 2010). Other spaces for participation are consultation meetings during preparation of village plans organised at either the hamlet or the village level and in the construction and rehabilitation of service infrastructures such as rural water supply schemes, village dispensaries, rural health centres or primary schools. So, how and to what extent do men and women make use of these spaces and, thus, participate in decision-making processes? We address these questions using a gender perspective and principal-agent theory, after a description of the methodology.

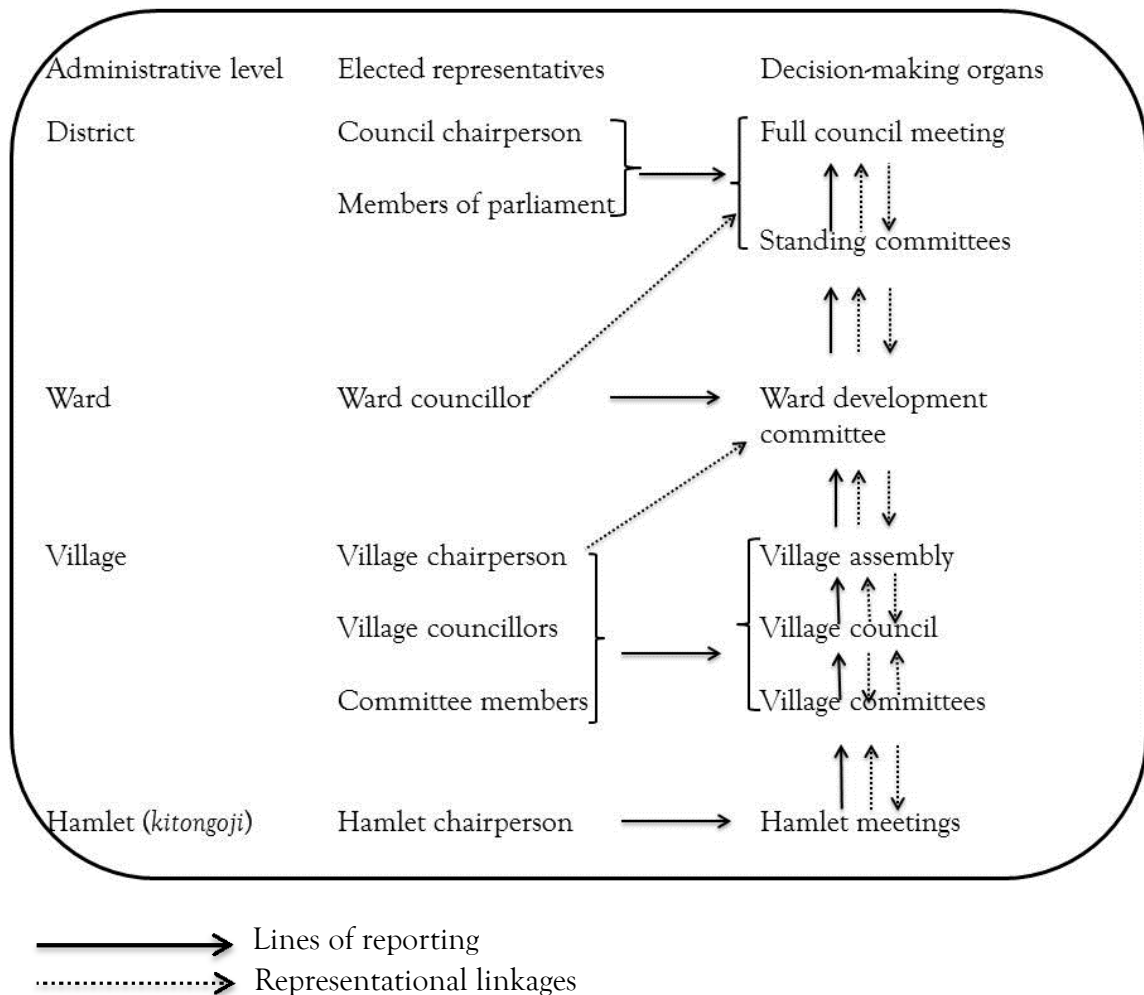


Figure 4.1: Local government decision making spaces

4.4 Study design and methodology

The present chapter is based on empirical research carried out between September 2011 and August 2012 in the rural districts of Kondoa and Kongwa in the Dodoma Region in Tanzania. The two districts were purposively selected because they differ in terms of both the phase at which they joined the reforms and in their ethnic and religious composition. Kondoa joined the reforms from the start in 2000 whereas Kongwa was only included in 2005. Kondoa has a more diverse number of ethnic groups including the Rangi, Gogo, Sandawe, Hehe, Bulunge, Masaai and Barbaig. The major ethnic groups in Kongwa are Gogo, Kaguru and Hehe. More than half of respondents (55%) in Kondoa are Muslim, while in Kongwa the majority (96%) is Christian. The fieldwork was carried out in ten selected villages, five in each district (Table 4.2), most of which had been involved in construction of water and/or health service infrastructures in recent years as part of the reforms. Although the findings from two districts may not justify general conclusions on gender and decentralization throughout the country, they do serve to identify mechanisms of gendered participation in local institutions by service users, and suggest the problems that constrain effective women's participation in specific contexts.

Table 4.2: Location and research participants in the study villages

District	Village	Distance from the district capital (km)	Number of surveyed households	Interviewees and focus groups' participants
Kondoa	Kidoka	65	32	34
	Potea	46	32	47
	Mulua	16	34	8
	Khubunko	85	34	7
	Humekwa	90	32	11
Kongwa	Mlanga	5	35	5
	Songambebe A	46	33	50
	Manungu	12	33	5
	Chamae	34	33	5
	Sagara A	22	34	11

Data were collected using a combination of quantitative and qualitative methods as a strategy for enriching our understanding of the issue (Niehof, 1999; Axinn and Pearce 2006), and contributing to both the validity and reliability of findings (Scrimshaw, 1990). A household survey was conducted among 332 randomly selected households, with a minimum of 30 households in each village, allowing a reasonable control over sampling error (Grinnell, 2001). Overall, 115 men and 217 women participated in the survey. Qualitative data were collected through semi-structured and unstructured interviews with district council officials and village leaders. Eight focus group discussions were done with groups of men, women, village water committees and village health committees. Five life histories of individual women leaders were also collected to learn about their experience in local decision-making processes. These qualitative methods provided an opportunity to explore different issues in a flexible manner and to capture the richness of experiences and perceptions of the respondents in their own terms. Review and analysis of available data at district and village levels provided relevant secondary data to complement the primary data.

The household survey data were coded and analysed, frequency distributions, mean scores and chi-square tests were computed for most variables. Binary logistic regression was used to determine the factors associated with respondents' ability to speak up and influence decisions in public meetings. Field notes from interviews and focus group discussions were transcribed and analysed using qualitative content analysis so as to interpret and construct meanings from the text. We present and discuss our findings, below, weaving together the survey and qualitative data, illustrating survey findings with examples, and validating qualitative findings with survey data.

4.5 Decentralization and participation by service users

A consideration of four forms of participation allows us to examine how men and women participate, respectively, in the spaces created by the decentralization reforms. These include: attendance at public meetings, participation in the construction of service infrastructure, membership of village committees, and the ability to speak up and influence decisions (see Table 4.1).

4.5.1 Attendance in public meetings

The majority of surveyed households (91%) reported that at least one member had attended public meetings over the year preceding the survey: 87% village assemblies, 72% hamlet meetings, and 33% village committee meetings (Table 4.3). Only about half of respondents (52%) reported having attended village planning meetings. Villagers as principals, men and women alike, do not see themselves as having influence in these 'consultation' processes because in most cases village plans are not implemented as planned partly due to limited funding from the district councils.

Although district full council meetings are open to the public, citizen's attendance was very low (2%). In two full council meetings (one in each district) observed by the author, only 30 citizens in Kondoa (22 men and 8 women) and 10 in Kongwa (all men) attended the meeting. Most citizens do not attend full council meetings due to long distances and associated travel costs to the district council headquarters where meetings are held, as well as lack of information on meeting schedules which are mostly posted on council headquarters notice boards, and rarely in ward and village offices. The law allows citizens to attend full council meetings as observers (the passive form of participation) but not to speak up (the interactive form of participation). This implies that decision making at the district level is the responsibility of agents (councillors and parliamentarians). Whether the outcomes of these decision-making processes reflect the voice of the principals, depends on the efforts of the councillors (agents) to consult and represent the views of their constituencies. There are no clearly established consultation mechanisms between councillors and citizens. It remains the discretion of the councillor to convene meetings with constituencies. As a result, such consultations may be haphazard and biased (Devas and Grant, 2003) and do not necessarily represent the views of different groups within the community.

Attendance at village public meetings differed significantly between districts, with many respondents in Kongwa reporting having attended hamlet meetings (77%) while in Kondoa many attended village assemblies (92%). The district council officials stated that the reforms have been successful in increasing the number of village statutory meetings, including assemblies, councils and committee meetings. Village executive officers are required to report to the district council the number of statutory meetings held in their villages, which acts as a catalyst for such meetings to be held. When villagers (principals) demand such meetings, village leaders (agents) are compelled to convene them. Villagers also ask for financial reports in these meetings, an indication that principals are demanding accountability from their agents. Comparatively, citizens' attendance in village assemblies in our

sample is almost twice what was reported at national level which was only 44 percent in 2006 (URT, 2009b) and higher than that reported by Kessy and McCourt (2010) in Mwanza City Council and Moshi Rural district where 55 percent of the respondents reported having attended village assemblies over the last 12 months.

Table 4.3: Citizens' attendance in public meetings over the last 12 months by district (n=331)

Type of meeting	Kondoa	Kongwa	Both	Chi-square values
Hamlet meetings	110(67.1)	128(76.6)	238(71.9)	$\chi^2=4.132, p=0.042^{**}$
Village assemblies	151(92.1)	137(82.0)	288(87.0)	$\chi^2=7.375, p=0.007^{***}$
Village committee meetings	57(34.8)	51(30.5)	108(32.6)	$\chi^2=0.669, p=0.413$
Preparation of village plans	84(51.2)	89(53.0)	173(52.1)	$\chi^2=0.103, p=0.749$
Full council meetings	5(3.0)	3(1.8)	8(2.4)	$\chi^2=0.538, p=0.463$

Figures in brackets are percentages. ^{**}Significant at 5% level, ^{***}Significant at 1% level.

A review of village records for 2010/2011 and 2011/2012, however, revealed that none of the study villages had held the four annual village assemblies as required by law. This means that the frequency of public meetings is still low, thus limiting the opportunities for service users to voice their concerns and to exercise their agency as principals. At the national level, URT (2009b) shows that just over half (56%) of respondents in 2006 reported that their village assembly had met in the last three months, a situation which does not appear to have substantially improved. The problem appears to be widespread including in other countries; studies in Uganda also point to low attendance at community meetings given the perception that decisions in such meetings are a prerogative of elected representatives (Francis and James, 2003), as well as because meetings at village level do not happen as frequently as they should (Devas and Grant, 2003).

In most households, more men than women attended public meetings. While the proportion of women was generally low for all meetings, the higher the level of the meeting the higher the proportion of men (Table 4.4).

Table 4.4: Citizen's attendance in public meetings over the last 12 months by gender

Type of meeting	Who attended the meetings?		
	Men	Women	Both men and women
Hamlet meetings	66(27.7)	63(26.5)	109(45.8)
Village assemblies	91(31.6)	70(24.3)	127(44.1)
Village committee meetings	55(50.9)	31(28.7)	22(20.4)
Preparation of village plans	88(50.0)	51(29.0)	37(21.0)
Full council meetings	5(62.5)	2(25.0)	1(12.5)

Figures in brackets are percentages.

The relatively high proportion of both men and women in hamlet meetings and village assemblies was partly because of the proximity to the venues of the meetings. Presumably, the more spatially closer to home the meeting is held, the more likely that both men and women will attend. These findings are in agreement with what was shown by URT (2009b) that women were slightly under represented in village meetings.

In some villages, however, leaders noted that more women than men attend village meetings. In Humekwa, a village leader said: *“most men in this village have a tendency of neglecting meetings, they usually send their wives.”* A woman village councillor in Sagara A remarked: *“it is the women who mostly attend village meetings compared to men who are always busy in their local brew clubs.”* In Kidoka, a village with more than three major ethnic groups, ethnicity played a role as well. In some ethnic groups, women were said to have more freedom to attend public meetings than in others. A leader in this village noted: *“in this village, it is the Rangi women who mostly attend the meetings, but not the Gogo and Masaai women who are afraid of sitting in a meeting with men because of their culture.”* This shows that actual participation in the formal spaces created by the reforms differs with context. It also shows that gendered attendance is a cultural issue where gender also intersects with ethnicity. As Pennartz and Niehof (1999) point out, the relationship between decision-making and power depends on the benefits and status of the specific decision-making area. Shivji and Peter (2003) observed that in some parts of the country (Muleba and Sengerema districts), the majority of those who attend public meetings are women, while in other parts (Lindi Rural district), there are hardly any women in meetings, not even the village councillors.

Table 4.5: Respondents' perceptions on convenience of public meetings to women by sex

Criteria	Response	Men (n=114)	Women (n=212)	Both (n=326)
Time of meetings	Not convenient	22(19.3)	31(14.6)	53(16.2)
	Convenient	87(76.3)	176(82.6)	263(80.4)
	Very convenient	5(4.4)	6(2.8)	11(3.4)
	Mean score	1.85	1.89	1.87
Venue of meetings	Not convenient	36(31.6)	61(28.6)	97(29.7)
	Convenient	75(65.8)	150(70.4)	225(68.8)
	Very convenient	3(2.6)	2(0.9)	5(1.5)
	Mean score	1.71	1.72	1.72
Language used	Not convenient	10(8.8)	15(7.0)	25(7.6)
	Convenient	98(86.0)	186(87.3)	284(86.9)
	Very convenient	6(5.8)	12(5.6)	18(5.5)
	Mean score	1.96	1.99	1.98

Figures in brackets are percentages.

4.5.2 Participation in construction and rehabilitation of service infrastructure

The majority of respondents (88%) reported having participated in construction or rehabilitation of water and health service infrastructures over the past ten years (90% in Kongwa and 87% in Kondoa). More households had participated in water infrastructures (77%) than

in health (57%), reflecting the fact that six of the study villages (Humekwa, Potea, Kidoka, Manungu, Chamae and Songambe A) had constructed boreholes through the decentralized Water Sector Development Program. Construction of village dispensaries had been implemented in the villages of Khubunko, Chamae, Songambe A, Sagara A and Potea, although not many households appeared to have taken part in these activities.

For both services, more men than women were reported to have had participated in these activities. Nevertheless, in about half of households (50% in water and 46% in health), both men and women had participated in these initiatives (Table 4.6). In construction of water wells and boreholes, 32 percent of the households indicated that only men had participated compared to 18 percent reporting only women. In village dispensaries, 37 percent of households reported men only compared to 17 percent that reported women only. Although women are the principal care givers in households and main users of water and health services, their participation in these services related activities is somewhat lower than that of men.

Table 4.6: Citizen’s participation in service infrastructure activities by district and sex (n=332)

Variable	Categories	Water wells and boreholes	Village dispensaries
District	Kondo	127 (77.4)	82 (50.0)
	Kongwa	130 (77.4)	107 (64.5)
	Both districts	257 (77.4)	189(57.3)
Sex	Men	83(32.3)	70(37.0)
	Women	46(17.9)	32(17.9)
	Both men and women	128(49.8)	87(46.0)

Figures in brackets are percentages.

In terms of how service users participated in these activities, three forms of participation were identified: provision of unskilled labour, cash contribution, or a combination of the two. Many respondents participated in construction of water infrastructures through cash contribution (43%) and most (62%) contributed their labour in construction of village dispensaries (Table 4.7).

Table 4.7: Type of participation in construction or rehabilitation of water sources

Type of participation	Water infrastructure (n=257)	Health infrastructure (n=189)
Labour contribution	97 (37.7)	117(61.9)
Cash contribution	112(43.4)	49(25.9)
Labour and cash contribution	48(18.6)	23(12.2)

Figures in brackets are percentages.

The relatively high participation in water services infrastructure projects through cash was because villages were required to raise five percent of the total initial costs for drilling, pump and engine installation, and for water distribution. In some villages, each adult

member contributed a fixed amount (e.g. in Chamae and Humekwa) while in others each household contributed a fixed amount regardless of household size (e.g. in Songambebe A, Potea and Kidoka). In most male-headed households, it was the husband or older male member who was responsible for paying this contribution. In villages that had constructed new dispensaries, women participated by collecting and bringing sand, stones, gravel and water to building sites while men were involved in brick making and other masonry work. This 'activity-specific' form of participation is common in many 'participatory development projects' and reproduces the traditional gender division of labour within the community.

4.5.3 Membership of village committees

The village council has three standing committees: for planning and finance, social welfare, and security. In addition, it can establish other committees depending on the needs of the village or as directed by the district or central government. The most common ones in all villages are water, health, school, environment and disaster management committees. In this study, the proportion of women in village councils ranged from 24 percent to 48 percent, with an average of 34 percent (Table 4.8). At the global level, the figure of one-third has gained popularity as the critical mass for gender quotas in various institutions from parliament to village councils (Agarwal, 2010). The affirmative action imposed by the reforms that village councils should have at least one-fourth women councillors (Shivji and Peter, 2003) mainly through the 'special' women seats appears to have an effect: 90 percent of the study villages are above the one-fourth and 70 percent above the one-third thresholds.

The proportion of women was higher in the social welfare, health and water committees than in the security, village councils or planning and finance committees. The former relate more to women's practical gender needs and were seen as 'feminine', while the latter were seen as 'masculine'. Very few women held leadership positions in the committees, and if they did, mostly as secretaries or treasurers. Women's presence in village structures in our study thus exhibits the form of 'active' participation but rarely the 'interactive' form of participation. This parallels findings elsewhere. Hemson's (2002) study on women's participation in rural water committees in South Africa showed that women tended to hold the less powerful positions as 'vices' or 'auxiliaries' to the main positions. Agarwal (2010) found that women in community forestry institutions in rural India and Nepal usually occupied 'supportive' leadership positions as vice-presidents, joint secretaries and co-treasurers. In Kenya, Friis-Hansein *et al.*, (2012) reported that while membership in farmer field school groups was dominated by women, elected leadership positions tended to be held by men, apart from the post of group treasurer, which was often held by a woman. These findings raise the question, then, of the extent to which women's presence in village structures has enabled them to articulate their needs, both practical and strategic and perhaps translate them into locally relevant policy outcomes, by speaking up and influencing decisions in these spaces. We turn to this question in the next sub-section, as we move up the ladder of participation from 'active' to 'interactive' participation.

Table 4.8: Proportion of women in village committees by village

Village	Proportion of women in the committee (%)					
	Village council	Planning and finance	Security	Social welfare	Water	Health
Kidoka	36.0	50.0	44.4	44.4	50.0	62.5
Potea	28.0	20.0	25.0	37.5	37.5	50.0
Mulua	32.0	60.0	14.3	77.8	50.0	12.5
Khubunko	48.0	25.0	30.0	70.0	30.0	nd*
Humekwa	29.2	33.3	33.3	22.2	56.3	35.0
Mlanga	24.0	25.0	11.1	44.4	20.3	30.0
Manungu	32.0	33.3	25.0	33.3	33.3	50.0
Songambele A	38.1	71.4	12.5	33.3	33.3	38.1
Chamae	35.0	25.0	0.0	75.0	50.0	50.0
Sagara A	34.8	50.0	22.2	50.0	42.9	54.5
Overall	33.7	39.3	21.8	48.8	40.3	42.5

*nd = no data could be obtained

4.5.4 Speaking up and influence in meetings

The survey findings show that fewer than half of respondents who attended public meetings either spoke up (45%) or felt they were able to influence decisions (49%) in such meetings. Nevertheless, significantly ($p=0.00$) more men than women reported to either having spoken up or felt that they had influence (Table 4.9). The focus group discussions revealed that despite the relatively high number of women in public meetings, very few of them speak up. In Potea, focus group discussion participants explained that only three women speak up in public meetings, and in Songambele A between five and seven. One participant (a woman) in Potea said: “if a woman is too talkative in public meetings, men will say don’t marry from that household, their women are very noisy.” While in the south Asian context Agarwal (2010:107) concluded that “the greater the percentage of women in a meeting, the more likely that some or most of them will speak up”, our findings show that despite women’s numerical strength in public meetings, many of them participate only ‘passively’. Apparently, the gendered power relations have not been transformed to allow women’s equal access to ‘effective’ and ‘interactive’ participation. Because of this, men have gained more leverage to play their roles as principals in public meetings than their female counterparts.

Table 4.9: Proportion of respondents who can speak up and influence decisions by sex

Variable	Male	Female	Both	Chi-square values
Can speak up (n=301)	67(63.8)	69(35.2)	136(45.2)	$\chi^2=22.588, p=0.000^{***}$
Have influence (n=299)	71(68.3)	74(37.9)	145(48.5)	$\chi^2=24.965, p=0.000^{***}$

Figures in brackets are percentages. *** Significant at 1% level.

The findings also revealed gender variations on what men and women spoke about in public meetings. Women mostly talked about water, health and education services for their children. It was argued that women have first-hand experiences with these services and, therefore, know better what is working and what needs to be improved. Men talk about financial matters, roads, elections or recalling village leaders. One interviewee (a man) in Songambe A said: "it is the women who take children to clinics and fetch water. If there are any problems in these services, they are the first ones to experience them. So, if they don't speak about them, how do we [men] know if there is problem?" Another woman added: "although we are always silent most of the time leaving men to talk about their politics, we just wait for our topics [water and health], that is where we talk and they have to listen to us." ANK, a special seats councillor and former village chairperson explained how she had facilitated the construction of a village dispensary and a new borehole amidst resistances from male village councillors because they did not see them as priorities. There are thus 'masculine' and 'feminine' topics for discussions, and domains of decision making. Practical gender needs like water and health services are acknowledged by men and women as being a women's domain.

In addition to gender, other factors associated with the ability to speak up and influence decisions in public meetings were education and occupation (Table 4.10).

Table 4.10: Factors influencing ability to speak up and influence in public meetings

Explanatory variables	Speaking up (n=297)		Influence (n=295)	
	R ² = 0.175,		R ² = 0.167,	
	Log likelihood = 351.977		Log likelihood = 354.667	
	B coefficient	Std error	B coefficient	Std error
Sex (1=male)	0.946***	0.286	0.922***	0.286
Household size	0.166***	0.058	0.027	0.055
Marital status (1=married)	0.012	0.424	0.152	0.412
Age (years)	0.015	0.011	0.027***	0.010
Education (1=educated)	1.075***	0.373	0.793**	0.360
Occupation (1=farmer)	-0.638	0.566	-0.728	0.593
Occupation (2=farmer and livestock keeper)	1.236**	0.628	1.638**	0.654
Household income	0.000	0.000	0.000	0.000
Religion (1= Christian)	-0.311	1.020	0.143	1.023
Religion (2 = Muslim)	0.369	1.179	0.294	1.187
Ethnicity (1=Gogo)	0.531	0.526	0.846	0.520
Ethnicity (2=Kaguru)	0.758	0.663	0.767	0.654
Ethnicity (3=Rangi)	0.008	0.737	0.712	0.747
Ethnicity (4=Sandawe)	-0.307	0.656	0.309	0.635
Constant	-2.614	1.423*	-2.581*	1.427

*Significant at 10% level, **Significant at 5% level, ***Significant at 1% level.

Literate villagers were more likely to speak up and influence decisions. Livestock keepers were more likely to speak up because having a large herd of cattle is considered as a sign of wealth and respect in the community. Family size had an influence on speaking up

because having many children means more prestige and respect in the community for both men and women. Age was positively associated with ability to influence decisions, again for both men and women. Older women in their late forties or fifties, married and mostly with grand children were more respected, more likely to be committee members, and could speak up and be listened to. They were regarded as 'gender-neutral' and could mix with men in public settings. These women often talked to village leaders in public, or privately after meetings, to exert pressure on them for the improvement of certain services of interest to women. Other women in the village gave their opinions and asked these women to speak on their behalf. Young women are often refused permission to involve themselves in public affairs by their husbands, since these are still regarded as 'men's domain'. Gender thus intersects with age, as it does with ethnicity (see above) in shaping the extent of participation. These patterns reflect the power relations interwoven within both the formal and informal community structures. Perhaps because of this, few women participate 'effectively' and 'interactively' in local spaces and are able to address both the practical and strategic gender needs.

4.5.5 Factors constraining women's participation in decision-making processes

A number of constraints to effective women's participation in decision-making processes were identified: patriarchy, household responsibilities, complicated election procedures and personal qualities of women. Many respondents mentioned the patriarchal system prevailing at household and community levels as a major constraint. The fact that there is a Swahili term for patriarchy, *mfumo dume*, which literally means 'a male-dominated system', shows that patriarchy is an emic concept within the community, although men and women conceptualise it differently. Men expressed patriarchy using phrases like: 'women are inferior to men', 'men disrespect women leaders', 'a woman's place is in the home doing what is told by her husband', 'decision-making is the responsibility of men and not women' or 'we (men) cannot be led by women.' Women expressed patriarchy using phrases like: 'they (men) don't respect us', 'women are denied by their husbands to join village committees', 'they (men) say a woman leader cannot help us in anything', 'they (men) say women are weak', 'young men are just rude to women' or 'they (men) discriminate against us.' This suggests that men see patriarchy as a given feature of society, while women identify it a social problem, and express the dissatisfaction they experience in their communities. Feelings of being sidelined, marginalised, excluded, discriminated and denied dominate among women (Hicks, 2011), "they reinforce internally what is stated externally" and inhibit women's effective participation in local structures (Hemson, 2002:13).

When asked why this was happening, women in one mixed focus group discussion in Songambe A replied: "*ask these men who behave like bulls.*" Peer pressure especially among young men, ethnicity, and the custom of paying bride price were reported as contributing to the perceptions that men 'buy' their wives and therefore must exercise 'control' over them. One male respondent in Potea commented: "*my wife cannot stay outside the home doing community work for many hours. To me that is a sign of disrespect.*" Another man in Songambe A

remarked: *"I don't allow my wife to contest for any leadership position in this village. I contest for leadership and she only votes for me."*

Village leaders explained that in most cases it is men who competed for leadership positions. Most women village councillors and committee members came through the 'special' women seats and rarely through the normal election procedures involving competition with men. In the village of Potea, even getting the required number of 'special' seats for women on the village council and committees was said to be quite challenging. One village leader told us: *"We have serious problems getting women in the village committees as required by law. In the past, we used to advertise committee vacancies and ask people to apply, but no women would turn out. Nowadays, we just ask people in a meeting to mention names of potential candidates and vote for them in a public meeting."* However, even this strategy seemed not to work quite well because *"some women are elected in public meetings to become members of village committees, but most of them drop out because their husbands refuse them to join the committee. The husband might even be present in the meeting when the wife is elected and does not say anything publicly, but the moment they get home the trouble begins"* (said a man village leader). Explaining her more than 20 years' experience in leadership at village and ward levels, ANK noted: *"when I was a village chairperson, many men were questioning, why they were led by a woman. Don't we have men to take up this position?, they said."* In Potea where most of the population is Muslim, respondents associated patriarchy with religion arguing that Muslim women are not allowed to stay outside their homes for many hours, although this was not a serious issue in other villages. This shows the intersection between gender and religion, which are both influenced by patriarchy.

Most respondents did acknowledge that things were changing, though slowly, among other reasons because of economic groups with mixed membership and because women's economic activities involve travelling outside the village or interacting with outsiders. Community awareness and sensitization initiatives by NGOs, politicians and government officials from the district, regional or national levels were also contributing to the change, although with limitations. The district gender officer in Kondoa said that the district council was conducting gender awareness meetings at village level, but only three villages were reached in the previous year. Kongwa district did not have a gender desk and gender issues were handled by the community development department.

Household responsibilities due to the gender division of labour were another constraint noted by the interviewees. In particular, membership in village committees was said to be time-consuming, making it difficult for most women to combine household responsibilities and committee work. While this is true for some women, particularly those with young children, this idea was dismissed by some of the women leaders interviewed. They explained how they were able to combine committee work with household responsibilities. ANK said that: *"leadership is not like being an executive officer where you have to be in the village office on daily basis. All you need to know is when you have meetings or other committee work and plan accordingly. I have done this for more than 20 years and I have always managed to handle both my leadership and family responsibilities. My family does not complain that I don't do my household work."* SHP, a member of the village water committee and former village councillor pointed out that: *"I have time to do my household work and committee work. I have no problems combining both;*

all I do is to plan.” These observations support the idea that “women have ingrained organisational abilities which allow them to plan their day successfully and create a balance” (Maharaj and Maharaj, 2004:269). This also challenges the men’s conviction that women are unable to fulfil leadership roles because of their household responsibilities.

Women leaders mentioned the complicated election processes as another constraint. For village councillors, this included being a member of a political party, filling in application forms that must go through party committees for scrutiny and appraisal, and campaigning. Since few women belong to a political party (Shayo, 2005), most women are ‘institutionally’ excluded from village leadership. The women village councillors who went through these processes reported that the ‘playing ground’ was not equal for men and women. RNS commented: *“I competed with men, but the election procedures were difficult. Many of my competitors [men] had friends in the party committees who supported them, they had money to bribe voters, and many laughed at me that I was just wasting my time.”* ANK said: *“in the past elections were very objective, how you expressed yourself in campaign meetings mattered a lot. But nowadays, elections are crowded with corruption and other rough games. Most women are afraid of confronting all these problems.”* Devas and Grant (2003) and Venugopal and Yilmaz (2010) found that vote buying and vote bargaining are common features of local level elections. These practices exclude those who cannot afford such political purchases, particularly women.

Other constraints related to assumed personal qualities of women, such as being shy and uncomfortable in speaking among men, lack of self-confidence, lack of experience in public affairs, and fear of making ‘mistakes’ and being laughed at or ridiculed. Again, these factors are related to socio-cultural norms which circumscribe women’s activities and behaviour in the public domain. This shows that despite the mechanisms instituted by the reforms to increase women’s participation in decision-making processes, their participation is inhibited by social dynamics of inclusion and exclusion at the intra-household and extra-household levels (cf. Devas and Grant, 2003; Conyers, 2007; Matembe, 2010).

The experience of the five women leaders interviewed in depth shows that despite the challenges they were facing, their participation was an empowering process. The life histories revealed that many of them were afraid of speaking up in public meetings or sitting in meetings with men in the past, but are now able to do these things. These women can argue and convincingly pursue their interests and those of the women they represent, thus meeting both practical and strategic gender needs by participating ‘actively’ and ‘interactively’ with men. They were motivated by their participation in local leadership and were able to challenge the community stereotypes of women leaders because the community recognised their potential. Some were also involved in mobilizing other women to be engaged in local politics and in the formation of women groups to help women earn additional incomes. RNS reported how she had facilitated the formation of a group of 15 women involved in a piggery project and another group of 30 women running a village community bank. At group meetings women discuss different issues including public services. These local organisations function as informal institutions for women to meet their practical gender needs, but also gradually encompass strategic gender needs.

4.6 Conclusion

The foregoing discussion shows that decentralization reforms have created spaces for service users' participation in the form of village assemblies, councils, committees, and consultations during preparation of annual village plans. Participation in these spaces is realized through attending meetings, construction of service infrastructures (through labour, cash or both), membership in committees, speaking up and influencing decisions in meetings. Attendance in lower-level hamlet and village meetings is higher compared to high-level district council meetings. The quota system imposed by the reforms of at least one-fourth women members in village councils and committees has contributed to increasing the proportion of women in the local structures, enabling some women to participate actively and to address both the practical and strategic gender needs.

In some aspects, the factors constraining service users' participation in these spaces are not gender specific, but are related to the institutional set-up and power levels. Villagers as principals, men and women alike, perceive themselves as having little influence on their agents. They participate passively, by consultation or through activity-specific spaces. Some constraints, however, are more specific to women. Despite their numerical strength in public meetings, most of them do not speak up and have low influence. Thus, there is a missing link between attendance and influence because women's attendance in public meetings is generally 'passive'. Indeed, speaking up and influencing decisions in public meetings is more complicated than just attending them. As has been found elsewhere in the world, village women tend not to speak in male-dominated forums even when they have something to say (Devas and Grant, 2003; Agarwal, 2010). Thus, it is relatively easy to increase the number and range of people who participate in local institutions, but much more difficult to increase the extent to which they influence decision making, due primarily to the local power structures that determine how decisions are made (Pennartz and Niehof, 1999; Conyers, 2007). While holding leadership positions in committees is an important indicator for effective women's participation in local institutions (Agarwal, 2010), signifying a move towards the 'interactive' form of participation, few women in fact hold leadership positions in village committees. The few who did were mostly present in the less influential ones. The patriarchal system is a major constraint to women's effective participation, reflecting Sachs's (2010) argument that patriarchy constantly reproduces itself and filters through the practices of male bureaucrats who are likely hold influential positions.

The reforms have mainly focused on creating and strengthening formal institutions such as councils and committees, but not on addressing the informal power structures that influence the behaviour of the different actors in these institutions. The formal local structures are more "responsive to informal institutions, systems, and relations of power than to formal rules and procedures" (Beall, 2005:257). Consequently, stereotypical behaviour and perceptions against women that exist within the community continue to be reflected in these spaces and influence decision-making processes. This interface between formal and informal institutions at the village level is to the advantage of men and limits capability women to participate effectively and to exercise their agency as principals in village decision-making spaces. While decentralization is thus carried out in the expectation that it can help to

address gender inequalities, it in fact often reproduces them, because the socio-cultural barriers that have long prevented women from effective participation in local decision-making processes are not addressed.

Gender roles and needs are given some consideration in organising public meetings and in reaching decisions on services that have direct implications for women's lives. Women's participation is thus in some way helping to address the *practical* gender needs in fields that both men and women consider a women's domain. However, because the norms that justify social inequality have hardly changed, women's opportunities to address their *strategic* gender needs are minimal. Few women leaders have the power and bargaining ability to ensure that women's interests are reflected in decision-making processes, enabling them to participate 'actively' and 'interactively' and do something about both women's practical and strategic gender needs. Activities and programs that contribute to women's empowerment, such as local initiatives in the form of income generating activities, economic activities involving interactions with outsiders, and community awareness initiatives by NGOs and government agencies could all be seen as catalysts for change to address strategic gender needs.

Chapter 5

Users' perspectives on decentralized rural water services¹¹

This chapter examines the impact of decentralization reforms on improving access to domestic water supply using a users' and a gender perspective. The chapter addresses the question whether and to what extent the delivery of gender-sensitive water services to rural households improved after the reforms. Household- and village-level data were obtained through a household survey and qualitative methods. The findings show an increase of the proportion of households using improved sources of domestic water between 2002 and 2011. However, transaction costs in terms of distance and time to collect water are still major limitations. More than half of users travel over a kilometre and use more than an hour to collect water in the dry season. Despite the increased proportion of women in water management committees, the outcomes of these decentralized arrangements differ for men and women. Overall, the reforms have produced contradictory effects by improving access to water supply for some users, and creating or reinforcing existing inter- and intra-village inequalities.

¹¹A shorter version of this chapter has been accepted as: Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. Users' perspectives on decentralized rural water services in rural Tanzania. *Gender, Place and Culture* .

5.1 Introduction

In recent decades, the provision of domestic water has been high on the international development agenda. The International Drinking Water Supply and Sanitation Decade 1981-1990 aimed to achieve full access to water and sanitation for all by 1990. These targets still are a top priority for development (Singh *et al.*, 2005; Jiménez and Perez-Foguet, 2010a). The Dublin Principles of 1992 represented a re-orientation from the previous focus on the urban water supply sub-sector to rural water supply (Lane and Jarman, 1998; Jiménez and Perez-Foguet, 2010a). As part of the 7th Millennium Development Goal (MDG) the target is to reduce by half the proportion of people without access to safe drinking water and sanitation by 2015 (Gleitsmann *et al.*, 2007; Falk *et al.*, 2009; WHO and UNICEF, 2010; Wallace and Porter, 2010). In July 2010, the United Nations General Assembly adopted a resolution that “recognized the right to safe and clean drinking water and sanitation as a human right” (Sultana and Loftus 2012:1). These developments have entailed changes in the governance of domestic water supply in countries like Tanzania.

Water governance refers to the system of actors, resources, mechanisms and processes that mediate a society’s access to water (de Palencia and Perez-Foguet, 2011). Partly due to the failure of centralised government services to provide reliable water services, particularly in rural areas, in many countries water governance is currently shaped by decentralization processes (de Palencia and Perez-Foguet, 2011; UNESCO, 2012). It is argued that decentralization has the potential to improve the allocative and productive efficiency of water services delivery, with potential benefits for women (UNESCO, 2012). Accordingly, the current emphasis is on participatory approaches involving users, planners and policy makers at all levels; recognising the role of women as providers, users and guardians of water; and seeing water as an economic good (Lane and Jarman, 1998; Wilder and Lankao, 2006; Laurie, 2011). Service users are expected to initiate demand and implement and finance the long-term delivery of water services (URT, 2002; Jiménez and Perez-Foguet, 2010a). The assumption is that water systems are better designed, better maintained and better sustained if users are involved (Laurie, 2005). However, evidence shows that decentralization does not always result in improved rural water supply. In many cases, users’ participation is often understood in non-political ways with little understanding of how decentralization can translate into effective management and outcomes (Laurie, 2011).

At the same time, in the literature, there is considerable discussion on gender and water access and governance because water is a ‘gender issue’ (Wallace and Potter, 2010; Laurie, 2011). Men and women have different requirements for and access to water and, different roles and responsibilities in relation to water provision and management due to the gendered power relations at household and community levels (Wallace and Porter, 2010; Laurie, 2011). Women’s access to an improved, convenient, reliable and safe water source close to the home is recognised as a basic need (Singh *et al.*, 2005; Wallace and Porter, 2010). The role of women as water providers and managers is well established in water literature. Women and girls do most of the domestic water collection, storage and household distribution. Where no standpipes or other sources are available, they spend hours on this task

(Singh *et al.*, 2005; IOB, 2007; Wallace and Porter, 2010; Laurie, 2011). Access to domestic water supply contributes to better health for women and families, thus, addressing women's practical gender needs (Moser, 1993), and is critical for advancing the human rights of women (Brown, 2010). Women also participate in a range of water management institutions at the community level. Thus, they are key actors in water provision and management (Laurie, 2011).

Despite the recognition of the 'gender-water nexus' in national and international frameworks, gender issues remain under-theorized and marginal in much of the decentralized water literature. Historically, women's interests have been under-represented in domestic water supply development interventions (Laurie, 2011). Recent studies have mostly focused on how to involve women in water management institutions. The commitment to being gender-sensitive in water projects has been narrowly translated into women's participation in decentralised local institutions such as village water committees. Other dimensions of social differences that shape women's access to water, are often overlooked (Harris, 2009; Cleaver and Hamada, 2010). Little attention has been paid to the workings of local level institutions and their impact on improving gender-sensitive access to water services. Evidence shows that women's participation in decentralized water management structures does not necessarily lead to more gender-sensitive outcomes (Harris, 2009). In Tanzania, as in many other countries, women function within a system of structural and gender-based inequality that influences their access to water, and their involvement in water governance (Brown, 2010).

This chapter contributes to this debate by examining the impact of decentralization reforms on service delivery outcomes in rural villages in Tanzania, using a users' and a gender perspective. The two perspectives are relevant in providing contextual information on service users' knowledge and experiences about local situations as beneficiaries of decentralised water services. The users' perspective is a bottom-up perspective that emphasizes the interests of users in service delivery processes with the aim of the users taking control of and benefiting from these processes (Kabeer, 1992; Hardon-Baars, 1997). This perspective has mostly been applied in family planning studies (e.g. Bruce, 1980; Kabeer, 1992) and agricultural research and development (cf. Campilan, 1996; Hardon-Baars, 1996, 1997; Niehof *et al.*, 2003). This article draws on the users' perspective because the reforms aim at "bringing service management and provision closer to the end-users" (URT, 2008a:6). In addition, though partly overlapping with the users' perspective, the article incorporates a gender perspective because of the 'gendered nature' of water (cf. Brown, 2010; Wallace and Porter, 2010).

The chapter explores the question of to what extent the delivery of gender-sensitive domestic water services to rural households improved after the decentralization reforms. Gender-sensitive water services are defined as services that address the "gender-specific needs" of men and women "based on the goal of providing men and women with equal opportunities to flourish in their productive and private lives" (World Bank, 2010:11). The next section puts the context of decentralised rural water supply in Tanzania in a historical perspective that reflects changing national and international policies.

5.2 Historical overview of rural water supply in Tanzania

Tanzania's water sector reform needs to be understood in the context of new national and international approaches to public management (Batley, 2004; Larbi, 2005). Between the 1960s and 1970s, the government and development partners implemented large water investment schemes aimed at delivering improved and safe water services to rural areas. In 1970, the central government took responsibility for operation and maintenance (O&M) due to a failure of LGAs to manage and maintain water infrastructures, and from this time on water became a 'free good' in rural areas (Cleaver and Toner, 2006; Jiménez and Pérez-Foguet, 2010a). In 1971, a 20-year Rural Water Supply Program was launched with the aim of providing access to adequate, safe and reliable water supply to the whole population by 1991 (URT, 2008b). This target was not attained: only 46 percent of the rural population had access to water supply in 1991 (World Bank, 1999). Unsustainability of water schemes due to lack of timely maintenance and repair was identified as the main problem (World Bank, 1999; Kaliba *et al.*, 2003; Cleaver and Toner, 2006). This situation was attributed to the lack of users' participation, the use of inappropriate technologies, the use of top-down approaches and the lack of decentralization as a result of the abolishment of LGAs in 1972 (Kaliba *et al.*, 2003; Cleaver and Toner, 2006; URT, 2008b).

The water policy launched in 1991 emphasized community participation, decentralized management, use of appropriate technology and cost sharing for rural water supply (URT, 2002). However, it failed to address the problems that had constrained earlier initiatives, such as non-involvement of the private sector, participation of users being limited to provision of free labour, and an inadequate legal and institutional framework. The policy was also implemented at a time when the country was undergoing major economic and socio-political changes, including the structural adjustment programs that policy makers had to deal with (URT, 2008b). There were only limited improvements in rural water supply. Coverage did hardly increase (estimated at 50% in 2002) and, in some places, even deteriorated further (URT, 2002).

In 2002, a new water policy was launched as a response to the shortfalls identified in the 1991 policy. The 2002 policy recognizes access to clean and safe water as a basic need and right for all, and aims to provide adequate, affordable and sustainable water supply services to the rural population. It embodies principles of decentralization and subsidiarity in managing rural water services (URT, 2002, 2008b). The policy recognises women as "principal actors in the provision and management of water services" arguing that "rural water supply should be based on what both men and women in rural communities know, want and are able to manage, maintain and pay for" (URT, 2002:32,36). Consequently, delivery of rural water supply has been decentralised to local government authorities (LGAs) and the role of the central government has been confined to policy making, regulation, monitoring and performance assessment (URT, 2002; IOB, 2007). In 2007, a twenty-year nationwide Water Sector Development Programme (WSDP) was launched following a pilot phase implemented between 2002 and 2007 in twelve districts (URT, 2008c). WSDP is implemented at village level, and LGAs are responsible for village selection, technical support and monitoring (IOB, 2007; URT, 2008c; Masanyiwa *et al.*, 2013). WSDP reflects the international shift in water

governance from an 'interventionist' state towards managing water services through poly-centric governance (Cleaver and Toner, 2006; Falk *et al.*, 2009; Termeer *et al.*, 2010), and the wider public sector reforms in the country.

In Tanzania, water supply coverage in rural areas has only shown modest progress over the past two decades, from 48 percent in 1990 to 58 percent in 2010 (URT, 2008d, 2010a, 2011a, 2011b), with average district coverage levels ranging from 37 percent to 96 percent (URT, 2008d). However, only 21 percent of the 133 LGAs implementing WSDP have achieved the 65 percent coverage that was set for 2010 (URT, 2008d). In most districts, the outcomes of the reforms fall short of the expectations. Most of the data on water access only reflect the situation at district level based on the routine data system that monitors the presence and functionality of water infrastructure (URT, 2009b). Statistics on household-level access to water based on national surveys also do not pay attention to gender differences, despite its 'gendered nature' (cf. Brown, 2010; Wallace and Porter, 2010).

Studies on decentralized water services in Tanzania have revealed the limitations of decentralized structures in managing and improving equitable access to water (e.g. Cleaver and Toner, 2006) concluding that decentralization is not beneficial for citizens per se, as it creates opportunities for some and risks for others (e.g. Jiménez and Perez-Foguet, 2010b). Many studies, however, do not capture the 'human factor' of the process and outcomes of decentralization from the users' perspective. Despite the assertions about the role of service users in managing water sources and in operation and maintenance, many studies often conceptualise service users as passive actors (Singh *et al.*, 2005) or treat them as objects rather than subjects (Rakodi, 2000). Similarly, there is little gendered analysis on the impact of the reforms on service delivery outcomes. Thus, the question of the extent to which decentralization reforms have contributed to improving gender-sensitive access to water supply of rural households is a valid one. We pursue this question using the lenses of a users' and a gender perspective, after a description of the methodology.

5.3 Study area and methodology

The fieldwork for this study was carried out between September 2011 and August 2012 in the rural districts of Kondoa and Kongwa in Dodoma region. The districts are located within the semi-arid zone of central Tanzania where ground water is the main source of water supply and is only found at a considerable high depth (Kaliba *et al.*, 2003). Most rural water schemes here are either deep boreholes with mechanised pumps or gravity schemes. There are few shallow boreholes with hand pumps. During the rainy season, small sandy river beds and hand dug wells fill with water and become primary sources of water for many households. The two districts were among the twelve pilot districts for WSDP in 2003 before it was extended to other districts in 2007 (URT, 2008c). The study was carried out in ten villages (five in each district), purposively selected on the basis of their location within the district, type of water source and management arrangements for the sources. Six of the study villages had WSDP-constructed boreholes, two had gravity schemes and two depended on hand pumps and traditional sources.

Many user-satisfaction studies use sample surveys to ascertain patterns of use and levels of satisfaction, but such methods provide little scope for the users to influence the research process (Rakodi, 2000). Also because the aim of this study was to analyse the qualitative impacts of decentralization, both quantitative and qualitative methods of data collection were used to enhance the validity and reliability of the results (cf. Scrimshaw, 1990; Axinn and Pearce, 2006). A household survey was carried out in 332 households, involving 115 men and 217 women, using a structured questionnaire. Additionally, six focus group discussions (FGDs) were held with groups of men, women and village water committees (VWCs) in two villages in which 33 men and 21 women participated, and interviews were conducted with village leaders and district council officials to capture their perspectives. Non-participant observation was used throughout the research process to ascertain availability and use of water sources in the study villages. Case studies of two villages were documented to obtain detailed qualitative information on water supply arrangements. Analysis of secondary data from district water departments and villages complemented the primary data.

Domestic water supply was defined as “water used for all usual domestic purposes including consumption, bathing and food preparation” (Howard and Bartram, 2003:2). Household access to domestic water supply was assessed in terms of type of water source, distance and time spent on collecting water, both in the rainy and dry seasons, and per capita water-use. The Tanzanian national water policy defines the minimum basic service level for domestic water supply in rural areas as “a protected, year-round supply of 25 litres of potable water per capita per day (lpcd) through water points located within 400 metres from the farthest homestead and serving 250 persons per outlet” (URT, 2002:34). Gender was operationalized in terms of division of labour in fetching domestic water, and the appropriateness of the location and technology of water sources to the needs of women and girls. The causal relations between the reforms and water supply were assessed in terms of improvements and satisfaction as perceived by the users.

The survey data were analysed at the household level and qualitative data at the village level. Frequency distributions, means and correlations were computed for most of survey variables. One-way analysis of variance was performed to compare means on distance, time and per capita water-use, and to determine statistically significant differences using the Tukey-HSD post-hoc test. Multiple linear regressions were run to identify the variables associated with quantity of water collected and users’ satisfaction. The qualitative data were transcribed and analysed using qualitative content analysis which helped to interpret and construct meanings from the text.

5.4 The case villages

5.4.1 The case of Songambe A

Songambe A village is located 46km from Kongwa district headquarters along a gravel road to the neighbouring Kiteto district. The village has a population of 12,800 distributed over 2,300 households and five hamlets. The main water source is an old borehole constructed in

1970. In the 2011/2012 financial year, the borehole was rehabilitated by the district council. There are three distribution points (DPs), also used by households in the neighbouring Songambe B village which was formerly part of Songambe A. Due to frequent break-downs and the water demand exceeding the borehole supply capacity, many households use hand dug wells and sand river beds. Management of the borehole is through an elected VWC of 12 members: eight men and four women. Formerly, VWC members were responsible for supervising fetching of water at the DPs, collecting water user fees, monitoring cleanliness around the borehole, DPs and water reserve tanks, and doing minor repairs. More recently, the village council has contracted a private operator to run the borehole. The role of the VWC is now to supervise the provider to ensure a continuous flow of water and make sure that the private operator deposits 20 percent of the revenue collections to the village water bank account. Service users pay Tshs. 50 (US\$ 0.03)¹² per 20-litre bucket of water. There are no water metres at the DPs, so that the VWC cannot ascertain whether what is remitted by the private operator reflects the actual amount collected.

In the 2010/2011 financial year, the district council approved drilling of a second borehole to address the water problems in the village. The new borehole is meant to supply water in the two villages, and is planned to have three DPs and one cattle trough. Drilling of the borehole has been completed, but the construction of the water reserve tank, DPs and laying of the distribution network are yet to be accomplished. The two villages are required to raise Tshs. 17 million (US\$ 10,888), which is five percent of the initial capital as required by the water policy. This was translated into Tshs. 4,000 (US\$ 2.60) per household and Tshs. 1,000 (US\$ 0.60) per cow. Up to August 2012, almost two years since the start of the project, the village had not achieved the target: only four million (about 24% of the target) had been raised. Villagers blame their leadership for insufficiently coordinating the contributions, as some households have already contributed while others have not.

5.4.2 The case of Humekwa

Humekwa village is located 90km on the south of Kondoa district. The village has a population of 1,350 distributed over 300 households. There is one borehole that was constructed under WSDP in 2003. In the past, villagers depended on hand dug wells and they had to spend up to seven hours to get a bucket of water in the dry season. Villagers participated by contributing Tshs. 5000 (US\$ 3.20) per adult household member and providing unskilled labour in digging trenches and collecting sand and stones. The borehole was planned to have one DP in each of the four hamlets, one in the primary school, and a cattle trough. Laying of the distribution network to DPs was, however, not completed. As a result, water is not pumped to the reserve tank and villagers have improvised one DP by cutting one of the pipelines at the centre of the village. The same DP is used by both domestic users and livestock. Village leaders are concerned about the contractor leaving the project unaccomplished, but could not intervene because the contractor was engaged and supervised by the district council. They have reported the matter to the district water

¹² This is based on exchange rate of one US\$ = 1561.42 Tanzanian Shillings (Tshs).

department, but no definite measures have been taken despite frequent promises from local politicians and district council officials to resolve the issue.

Water service provision is managed by the VWC, which is composed of 16 members: seven men and nine women. Two VWC members are on duty each week to oversee water provision and collect user fees. The VWC was trained by facilitators from the district council on management of the borehole, carrying out minor repairs, and safeguarding cleanliness around the borehole and reserve tank. Water users pay Tshs. 40 (US\$ 0.03) per 20-litre bucket of water. Daily user fees collections range from Tshs. 2000 (US\$ 1.30) during the rainy season to 50,000 (US\$ 32) in the dry season. The water fees collected are kept by the VWC treasurer and are spent on buying diesel to run the water engine (about two litres per day), and on paying allowances to security guards and VWC members on supervision duty. The village has a water bank account, but it is inactive and the money collected is not banked. The amount collected during the rainy season is not enough to meet O&M expenses because of few water users, necessitating the borehole to be closed for a few months. It is revived again when the demand increases in the dry season.

5.4.3 Discussion of the cases

The two cases reveal the on-going decentralized interventions aimed at improving access to water services in rural villages. Both villages have boreholes with standing pipes as their main source of domestic water supply, although DPs do not cover all hamlets. Management of water sources is decentralised to village level institutions, either through the VWCs or private operators. These arrangements have largely transferred ownership, finance and management of water sources to users. Both men and women are represented in local water management committees. Elsewhere, we have shown that the proportion of women in VWCs in the study villages ranges from 20 percent to 56 percent (Masanyiwa *et al.*, 2013). So, what are the perceptions of users on these decentralised arrangements, and to what extent do they ensure access to gender-sensitive domestic water supply? We address these questions in the following section that presents and discusses the results of the study, weaving together the survey and qualitative data.

5.5 Results and discussion

5.5.1 Main sources of domestic water supply

The source of water is an important indicator of the suitability of the water for drinking and other domestic uses. Sources that are likely to provide suitable water for domestic use are classified as 'improved sources' and include household connections, public standpipe, borehole, protected well, protected spring and rain water harvesting (URT, 2008a, 2010b). Table 5.1 shows the changes in the number of improved water sources in both districts between 2003 and 2011, many of which constructed through the WSDP. The survey results showed that 61 percent and 65 percent of households used improved sources in the rainy and dry seasons, respectively. Significantly ($p=0.00$) more households in Kongwa used improved sources than in Kondoa in both seasons. Although the survey was conducted

during the dry season, the use of the main sources of domestic water appeared to be rather stable across the seasons: 87 percent of respondents were using the same sources throughout the year (94% in Kongwa and 73% in Kondo). District data showed that the proportion of the population with access to domestic water supply from improved sources between 2002 and 2011 increased from 23 percent to 34 percent in Kondo and from 29 percent to 51 percent in Kongwa. Still, overall coverage in both districts was below the national average of 58 percent. Neither of the districts had met the national target of 65 percent that was set for 2010, and are unlikely to meet the MDG target of 74 percent by 2015 (URT, 2010a, 2011a, 2011b).

Table 5.1: Improved water sources in Kondo and Kongwa between 2003 and 2011

District	Type of source	2003	2011	Percentage increase
Kondo	Borehole	73	136	86.3
	Shallow wells	71	201	183.1
	Gravity schemes	26	27	3.8
	Total	170	364	114.1
Kongwa	Boreholes	40	45	12.5
	Shallow wells	7	11	57.1
	Gravity schemes	6	10	66.7
	Total	53	66	24.5

Nevertheless, 45 percent of the households in Kondo and 25 percent in Kongwa relied on unimproved water sources in the dry season. Survey results thus suggest that the high demand for improved sources at the village level has not been met. Each year, the district council selects only ten villages to receive WSDP support based on a combination of need and demand. In practice, however, village selection is mainly based on the ability of villagers to contribute part of the capital costs and to meet O&M costs (Brown, 2010; Masanyiwa *et al.*, 2013). Villagers raise five percent of the total initial costs for borehole drilling, pump and engine installation, and water distribution. The actual amount depends on the depth of the borehole and the length of the distribution network, and the payment modalities as agreed by villagers in village assemblies (Masanyiwa *et al.*, 2013). In some villages, contributions were organised at individual level requiring each adult household member to contribute; ranging from Tshs. 2000 (US\$ 1.28) in Chamae to Tshs. 5000 (US\$ 3.20) in Humekwa. In others, the contribution was per household, and varied from Tshs. 1500 (US\$ 0.10) in Kidoka to Tshs. 8200 (US\$ 5.25) in Potea. Jiménez and Perez-Foguet (2010b) found that the mechanisms for village selection and implementation of WSDP in LGAs perpetuate existing inequalities because they tend to favour bigger villages that are better connected to their district headquarters and have more influential politicians.

The village data on the population per water distribution point revealed that all study villages served more population per DP than the policy requirement of 250 persons per outlet (URT, 2002). Hence, the presence of an improved source in a village does not necessarily ensure access for all households. The findings also contest the definition of access used

by district routine data which defines access to domestic water supply based on the number of households expected to utilise an improved source within a village (URT, 2009b). In this study, some households had limited access because DPs were inadequate to meet the actual village water requirements. For instance, most households in the remote hamlets of Miomboni, Mgomole and Mlimani in the village of Humekwa were too far from the DP and rarely used the borehole. In Songambe A, households in the hamlets of Masena and Chang’ombe relied on unimproved sources because the nearest DPs were more than five kilometres away.

To assess users’ perceptions on changes in the number of improved sources in their villages over the past ten years, respondents were asked to rank the change on a scale of one to four (from ‘deteriorated to ‘significantly improved’). The results revealed that 39 percent of users saw ‘no improvement’, while 37 percent indicated ‘some improvement’. Significantly ($p=0.00$) more users in Kondoa indicated either ‘no improvement’ or ‘deteriorated’ with a mean score of 2.4 (which could be interpreted as ‘no improvement’) than in Kongwa with a mean score of 2.7 (implying ‘somewhat improved’). There was no significant difference between the views of men and women, possibly because they were all using the same sources, whether improved or unimproved (Table 5.2).

The views of FGD participants support the survey findings. In Potea, women FGD participants explained that there was ‘moderate’ improvement in access to water services in their village. Before the construction of the new borehole, villagers depended on hand dug wells and had to travel to neighbouring villages in the dry season. Men FGD participants said that: “*there is some improvement compared to the past when we had very serious water problems in this village. However, water is still insufficient to meet our daily needs.*” In Kidoka, one woman VWC member told us that: “*we no longer walk the five miles to Haneti village in the middle of the night escorted by our husbands to collect a bucket of water, like we used to do in the past.*” A somewhat different picture was observed in Songambe A where women FGD participants explained that: “*in the past we were getting sufficient water, but because our borehole is very old many distribution points are not functioning and the only three functional ones do not meet the demands of the village population.*” Although a new borehole was under construction, most users in this village felt that the water supply had deteriorated over the past few years.

Table 5.2: Users’ views on the change in numbers of improved sources by district and sex (n=331)

Criteria	Category	Deteriorated	No improvement	Somewhat improved	Significantly improved	Mean score	Chi-square values
District	Kondoa	23(14.0)	71(43.3)	58(35.4)	12(7.3)	2.4	$\chi^2=13.448$, $p=0.004^{***}$
	Kongwa	13(7.8)	58(34.7)	64(38.3)	32(19.2)	2.7	
	Both	36(10.9)	129(39.0)	122(36.9)	44(13.3)	2.5	
Sex	Men	17(14.9)	44(38.6)	39(34.2)	14(12.3)	2.4	$\chi^2=3.076$, $p=0.380$
	Women	19(8.8)	85(39.2)	83(38.2)	30(13.8)	2.6	
	Both	36(10.9)	129(39.0)	122(36.9)	44(13.3)	2.5	

Figures in brackets are percentages. ***Significant at 1% level.

5.5.2 Who fetches domestic water and how?

In studying gender-water relations, it is important to understand who does what and how, and what such relations mean for access to gender-sensitive water services (Sultana, 2009). In this study, respondents were asked to rank the frequency of fetching water according to gender and age of household members on a scale of one to four (from 'never at all' to 'everyday'). Over half of respondents (57%) indicated that women were fetching water every day, followed by girls (20%) and 51 percent said men never fetched water at all. Women had the highest mean score (3.4), followed by girls (2.8), boys (2.0) and men (1.7). In most households (76%), water was carried on the head in a 20-litre bucket. Few households carried water both on the head and by bicycles (10%), eight percent used bicycles, and six percent used oxen or hand drawn carts. Male-headed households (32%) were significantly ($p=0.00$) more likely to use bicycles or carts to transport water than female-headed households (20%), possibly because female-headed households cannot afford these means of transport. Data on household income showed that female-headed households had a significantly ($F_{(1,329)}=4.872$, $p=0.03$) lower mean annual income (Tshs. 261,875 or US\$ 168) than male-headed households (Tshs. 825,606 or US\$ 529). The means of transport was indeed a major issue for households living far away from improved sources, necessitating some of them to hire men with bicycles or carts to fetch water for them, especially in the dry season.

These findings corroborate earlier observations that women and girls in rural areas bear the primary responsibility for domestic water provision. In Shinyanga, IOB (2007) found that women fetched water more often than girls, boys or men, and girls ranked second. Thompson *et al.* (2003) show that the principal mode of domestic water transport has remained unchanged over the past three decades; women and children continue to walk from the source, carrying water on their heads. As a consequence, they are prone to health problems such as headaches, general fatigue and pains in the chest, neck and waist. PMO-RALG (2006) explains that whether water is near or far, women have the responsibility to fetch and carry water for domestic uses on their heads, while men transport water on bicycles and mainly for sale. This reflects the central role played by women in domestic water provision (Lane and Jarman, 1998; Wilder and Lankao, 2006; Gleitsmann *et al.*, 2007), which is often underpinned by socio-cultural norms and thus is a key gender issue. Men do not fetch domestic water as it is considered a 'feminine' duty (Sultana, 2009).

5.5.3 Distance and time to main water sources

The presence of an improved water source in a village is a poor measure of whether households have access to water (MoWLD *et al.*, 2002). The effort required to fetch water may favour some households and exclude others from using the water source. Since there were no household connections in the study area, distance and time were used as indicators of the collection effort. Whereas the national water policy uses the indicator 'within 400 metres' from the household, none of the previous national surveys have used this indicator. The nearest coding bracket used is 'within less than 1km' (MoWLD *et al.*, 2002). We used both distances to compare with previous studies and ascertain the extent to which the policy target

has been achieved. The findings showed that 52 percent and 48 percent of users collected water within less than 1km in the rainy and dry seasons, respectively. The mean distance to water sources was 1.2km in the rainy season and 1.3km in the dry season. Significantly ($p=0.05$) more users in Kongwa (54%) collected water within 1km than in Kondoa (43%) in the dry season. When the definition of access was narrowed down to include only those collecting water within 400 metres, only 37 percent and 35 percent of users had access to an improved source in the rainy and dry seasons, respectively.

Many service users (42%) indicated ‘no improvement’ in reducing distances to water sources over the past ten years and 38 percent reported ‘some improvement’. The views of users on this variable showed neither significant differences between districts nor between men and women. The mean scores for all groups were close to three, implying ‘some improvement’ in reducing distances to water sources (Table 5.3). These findings show that despite the efforts in water infrastructure development as indicated in Table 5.1, the situation in some villages has not substantially changed. Over half of households (52%) still has to travel more than one kilometre to the nearest water point in the dry season, almost similar to what was reported by the household budget survey in 2007 (URT, 2007a).

Table 5.3: Users’ views on reduced distance to sources by district and sex (n=331)

Criteria	Category	Deteriorated	No improvement	Somewhat improved	Significantly improved	Mean score	Chi-square values
District	Kondoa	3(1.8)	74(45.1)	65(39.6)	22(13.4)	2.65	$\chi^2=5.135$, p= 0.162
	Kongwa	6(3.6)	65(38.9)	60(35.9)	36(21.6)	2.76	
	Both	9(2.7)	139(42.0)	125(38.0)	58(17.5)	2.70	
Sex	Men	4(3.5)	52(45.6)	39(34.2)	19(16.7)	2.64	$\chi^2=1.596$, p= 0.660
	Women	5(2.3)	87(40.1)	86(39.6)	39(18.0)	2.73	
	Both	9(2.7)	139(42.0)	125(38.0)	58(17.5)	2.70	

Figures in brackets are percentages.

In theory, the time spent on collecting water should be closely related to the distance from the source, but distance does not truly measure the collection effort because in many cases water users spend long times queuing (Thompson *et al.*, 2003). Hence, respondents were asked to indicate the time spent on a round trip i.e. going to the water source, waiting, collecting water and returning home. Less time required for water collection leaves more time for other economic activities for women as well as for children’s school attendance (MoWLD *et al.*, 2002; URT, 2012). Since most national surveys in Tanzania use 30 minutes as a cut-off point in defining having access to an improved source (MoWLD *et al.*, 2002; URT, 2007a, 2010b, 2012), we adopted this as well for reasons of comparison.

The results showed that 56 percent and 53 percent of users were getting water within 30 minutes in the rainy and dry seasons, respectively. Significantly ($p=0.00$) more households (64%) in Kongwa collected water within 30 minutes than in Kondoa (42%) in the dry season. Female-headed households used more time (57min in the rainy and 59min in the dry season) than male-headed households (49min in the rainy and 54min in the dry seasons). As shown above, about one third of male-headed households used bicycles or carts to transport water.

The mean time used to collect water from improved sources in the dry season was significantly ($F_{(1,329)}=25.209, p=0.00$) lower (43min) than from unimproved sources (76min). At national level, URT (2012) shows that 47 percent of rural households had access to improved sources within 30 minutes in 2010, which was 28 percent in 2007.

The time spent on water collection can be a substantial burden, particularly for those who spend more than one hour on a round trip. The mean collection times in the study area are higher than those reported by IOB (2007), which were 27 minutes and 48 minutes for improved and unimproved sources, respectively. Estimations based on the amount of domestic water collected per household per day showed that on average, households make up to five trips to the water source per day. In all villages and hamlets without improved sources, women were concerned about the long time they ‘wasted’ on water collection at the expense of other household activities. In Songambe A, women interviewees reported spending more than one hour on a round trip, whereas this was up to six hours in Mulua. In Humekwa, a woman interviewee stated that: “*we spend many hours fetching water because there is only one stand point which is too far from most households.*”

Thompson *et al.* (2003) show that on average households in East Africa make about four round trips of water collection per day, which could mean a time expenditure of about three hours when using improved sources and five hours for unimproved sources in the dry season. More critically, this burden falls disproportionately on women and girls. In Tanzania, the Tanzania Gender Networking Programme (2009) shows that on average, women aged 18–49 years spend 277 minutes (more than four hours) on unpaid work including water collection each day, compared to only 76 minutes for men. Thus, women’s workload is much heavier than men’s. This parallels studies on time use and unpaid work elsewhere, which show that “women tend to spend substantially more time than men on both household maintenance and care of persons across all countries” (Budlender, 2012 as cited in Kidder, 2013:607).

5.5.4 Per capita quantity of water collected

The quantity of water collected and used by households is an important measure of domestic water supply because it depends on accessibility as determined by distance, time, reliability and cost (Howard and Bartram 2003). There are different minimum threshold levels on the quantity of water that is required to meet domestic uses and promote good health, some suggesting at least 20 lpcd (e.g. World Bank, 2004) and others 25 lpcd (e.g. URT, 2002). Howard and Bartram (2003) propose four ‘service levels’ instead of a specific quantity of water used. They include ‘no access’ (less than 5 lpcd), ‘basic access’ (unlikely to exceed 20 lpcd), ‘intermediate access’ (50 lpcd) and optimal access (100 lpcd or more). In this study, the mean quantity of water collected was 19 lpcd (18 lpcd in Kongwa and 20 lpcd in Kondoia). The majority of households (74%) collected 5-20 lpcd, the ‘basic access’ level of Howard and Bartram (2003) but below the national threshold of 25 lpcd (URT, 2002). URT (2002) shows that water usage in rural areas ranges from 5 lpcd in acutely water scarce areas to 30 lpcd in other areas. Thompson *et al.*, (2003) indicate that households using unpiped water use an

average of 19.7 lpcd. A recent study found that rural Ugandans use an average of 15.4 lpcd regardless of the time and distance to the source (Mellor *et al.*, 2012).

Per capita water usage was significantly ($F_{(2,329)}=5.902$, $p=0.00$) associated with household size. Small households (1-3 members) used a significantly larger quantity per person (27 lpcd) than medium size households with 4-6 members (19 lpcd) and large households with seven or more members (15 lpcd). A post-hoc Tukey-HSD test confirmed the significance of the differences. Further analysis using linear regression (Table 5.4) revealed that households involved in brewing activities collected large quantities of water, not only for this economic activity but also for domestic uses. The short distance to unimproved sources in the rainy season influenced households to collect large quantities of water. Time used to fetch water in the dry season was also a key determinant for the quantity of water collected. These findings contest those of IOB (2007) and Mellor *et al.* (2012) who found that the amount of water collected is not correlated with distance and time. In this study, both distance and time were associated with seasonality. However, the findings confirm the conclusion by WHO and UNICEF (2010) that households spending more than half an hour per round trip are likely to collect less water and may fail to meet their households' minimum daily requirements.

Table 5.4: Variables associated with quantity of water collected (n=331)

Explanatory variable	B coefficient	Std. Error	p-value
Household size	-12.289	4.398	0.027**
User fee per 20-litre bucket	0.091	0.011	0.000***
Age of household head	3.487	0.374	0.000***
Non-farm activities (1=brewing)	10.554	1.693	0.000***
Distance to water source in rainy season	44.329	8.455	0.001***
Time used to fetch water in dry season	-0.706	0.097	0.000***
Constant	-32.978	15.307	0.068

$R^2 = 0.963$. $F_{(6,13)}=30.101$, $p=0.000$. **Significant at 5%, ***Significant at 1% level.

5.5.5 Payment arrangements for water services

The payment arrangements for water services to meet O&M costs depended on the type of water source in the village as agreed by users in village assemblies. In villages with pumped boreholes, users paid a fixed amount per a 20-litre bucket on a 'pay as you fetch' basis. The price ranged from Tshs.20 in Kidoka to Tshs.50 in Songambebe A and the mean was Tshs.32. In villages with hand pumps (Mulua and Khubunko), water was provided free of charge, but ad hoc contributions were solicited from users in case of pump breakdowns to meet maintenance costs. Two of the study villages had gravity schemes, with different payment arrangements. In Sagara A, users paid Tshs. 50 on a 'pay as you fetch' basis, while in Mlanga water was provided free of charge. Comparatively, users in Kongwa paid significantly ($F_{(1,180)}=6.326$, $p=0.01$) higher user fees (Tshs.36) than in Kondoa (Tshs.27). Based on the total amount of domestic water collected per household per day, households spent an average of Tshs. 182 per day on water services. In all villages, the elderly and people with disabilities were exempted from paying user fees.

A large majority of users (92%) indicated that they were able to afford the user fee. Male-headed households (93%) were more likely to afford water user fees than female-headed households (81%). Those who could not afford the fees relied on unimproved sources of water, which were likely to be contaminated, hence posing health risks to users. This challenges the concept of access to domestic water as a basic need and human right, especially where the inability to pay is due to poverty (Rakodi, 2000). Since the Dublin Principles of 1992 that, in part, framed water as an economic good, studies have shown that full cost recovery improves access for those who can afford to pay, excluding the poor from water provision (Sultana and Loftus, 2012). Thus, the 'right' to water is to affordable water, hence subjective and ambiguous.

The FGDs revealed that most users were willing to pay user fees as long as water supply was assured. Many users felt responsible for meeting O&M costs through user fees in order to sustain water infrastructures and have a reliable water supply. Kaliba *et al.* (2003) found that water users in central Tanzania are willing to contribute more resources to improve services especially in villages where there is a strong users' satisfaction. But our findings also indicate that user fees may reinforce gender inequalities of access to water services because in most households women have limited access to and control over financial resources. In this study, 74 percent of respondents in the male-headed households reported that men paid the user fee. This suggests that women are largely dependent on men for access to and control over domestic water supply (cf. Cleaver and Hamada, 2010, Laurie, 2011).

There were widespread complaints about the lack of transparency from village leaders on the management and allocation of the generated revenues. In villages without private operators, revenues collected from user fees were low and hardly enough to buy diesel. They were mostly kept by VWC treasurers and could hardly be accounted for. A woman FGD participant in Potea complained: "*We buy up to eight buckets of water per household per day. We wonder why there are frequent pump breakdowns despite all the money they [village leaders] collect, which we don't know how it is spent.*" Although village leaders are required to give financial reports (including on water fees revenues) in village assemblies, which are held every three months, this was rarely done in most villages. Villages using private operators seemed to be successful in collecting higher revenues to cover fuel costs and ensure timely banking. District council officials preferred private operators to VWCs due to better cost recovery for O&M. VWCs were said to be ineffective because of interferences from village councils and local politicians. Rakodi (2000) points out that day-to-day management of water services is likely to be more efficient if it is distanced from the political arena.

5.5.6 Appropriateness of water sources to women

Most users viewed water sources as either 'appropriate' or 'very appropriate' to women and girls: 70 percent for the source location and 80 percent for the source type. There were significant differences on users' views on 'appropriateness' between districts, but not between men and women (Tables 5.5 and 5.6). Users who saw water sources as 'not appropriate' were mainly concerned with long distances to DPs, long waiting queues especially in the dry season, and multiple use of sources. The majority (74%) of respondents collected domestic

water from sources that were also used for other purposes, mainly watering livestock, brick-making and gardening. Our interviews with district water engineers revealed that water for livestock was considered in the design and construction of rural water schemes by ensuring that each borehole has a cattle trough. However, we observed that many cattle troughs were not functioning, and where they did, it took considerable time and diesel to pump water to fill them. In Potea, VWC members explained that the gate valve was broken and, therefore, water was not pumped to the cattle trough. In Humekwa, where the same DP was used by both livestock and domestic users, one woman leader remarked: “Men force to water their cattle first and women have to wait.” Mulua village had a more critical situation with only one hand pump located downstream close to a sandy river. The VWC members told us that “between September and November, people walk up to six kilometres to the well, mostly at night because of very long queues in the day. There are many conflicts between domestic users (women) and livestock keepers (men) at the well, each struggling to get this limited resource.” A female VWC member added: “Livestock keepers spend the whole night watering their livestock. When we go to fetch water in the morning, we either find it very dirty or there is no water at all. The only option we have is to fetch water at night which is very risky to women and children.”

Table 5.5: Users’ views on the appropriateness of water sources to women by district (n=332)

Criteria	Ranking	Kondoa	Kongwa	Both	Chi-square values
Location of water source	Not appropriate	65(39.6)	33(19.8)	98(29.5)	$\chi^2=20.735$ $p= 0.000^{***}$
	Appropriate	64(39.0)	105(62.9)	169(50.9)	
	Very appropriate	35(21.3)	30(17.9)	65(19.6)	
	Mean score	1.82	1.98	1.90	
Type of water source	Not appropriate	47(28.7)	20(12.0)	67(20.2)	$\chi^2=18.717$ $p= 0.000^{***}$
	Appropriate	83(50.6)	121(72.5)	204(61.4)	
	Very appropriate	34(20.7)	27(16.1)	61(18.4)	
	Mean score	1.92	2.04	2.12	

Figures in brackets are percentages. ***Significant at 1% level.

These findings show that the ‘gender inappropriateness’ of water sources in the study area is not about the design or technology of the source (cf. Regmi and Fawcet, 1999; Singh *et al.*, 2005; Gleitsmann *et al.*, 2007), but has to do with inadequate number of DPs, their location within the village, and the multiple uses of sources. Men and women alike judge the appropriateness of a source by women’s ease of access to water rather than technological design. The findings also show that women’s gender needs of having access to domestic water conflicts with men’s productive gender needs. Because of the socio-cultural norms and power relations in the community, women are more likely to lose out in the process. Brown (2010) found that in a number of cases where new boreholes had been constructed, water use was prioritised for brick-making or agricultural activities, supporting men’s ability to generate income while undermining women’s access to domestic water. Indeed, as Laurie (2011:178) posits: “gender roles and relations around water are neither fixed nor separate from wider

socio-economic livelihood issues.” Thus, decentralized water arrangements can lead to different outcomes for men and women reflecting social relations and processes in the community (Cleaver and Hamada, 2010).

Table 5.6: Users’ perceptions on gender appropriateness of water sources by sex (n=332)

Criteria	Ranking	Men	Women	Both	Chi-square values
Location of water source	Not appropriate	32(28.1)	66(30.4)	98(29.5)	$\chi^2=0.326$ $p=0.850$
	Appropriate	59(51.8)	110(50.7)	169(50.9)	
	Very appropriate	24(20.9)	41(18.9)	65(19.6)	
	Mean score	1.92	1.89	1.90	
Type of water source	Not appropriate	21(18.4)	46(21.2)	67(20.2)	$\chi^2=0.655$ $p=0.721$
	Appropriate	74(64.9)	130(59.9)	204(61.4)	
	Very appropriate	20(17.4)	41(18.9)	61(18.4)	
	Mean score	1.98	1.98	1.98	

Figures in brackets are percentages.

5.5.7 Users’ satisfaction with water services

More than two thirds (68%) of users were either ‘satisfied’ or ‘very satisfied’ with the water services, which is above the national average of 42 percent (URT, 2009b). The levels of satisfaction differed significantly ($p=0.03$) between districts, but not between men and women (Table 5.7). The high proportion of satisfied users could imply that they acknowledge some improvements in water supply in recent years due to WSDP interventions. The mean distance to water sources in the dry season was significantly ($F_{(1,330)}=5.546$, $p=0.00$) higher for users ‘not satisfied at all’ (1.5km) than those ‘very satisfied’ (0.5km). The mean water collection time in the dry season was also significantly different between the groups ($F_{(1,330)}=22.898$, $p=0.00$). Users who were ‘very satisfied’ spent 22 minutes, significantly less than the 51 minutes for the ‘somewhat satisfied’ and 80 minutes for users ‘not satisfied at all’. The mean user fee was significantly ($F_{(1,330)}=7.026$, $p=0.00$) lower for the ‘very satisfied’ users (Tshs.25) than the ones who were ‘somewhat satisfied’ (Tshs.30) and ‘not satisfied at all’ (Tshs.45).

Table 5.7: Users’ satisfaction with domestic water supply by district and sex (n=332)

Criteria	Category	Not satisfied at all	Somewhat satisfied	Very satisfied	Chi-square values
District	Kondoa	61(37.2)	79(48.2)	24(14.6)	$\chi^2=7.250$ $p=0.027^{**}$
	Kongwa	44(26.2)	83(49.4)	41(24.4)	
	Both	105(31.6)	162(48.8)	65(19.6)	
Sex	Men	34(29.6)	57(49.6)	24(20.9)	$\chi^2=0.408$ $p=0.816$
	Women	71(32.7)	105(48.4)	41(18.9)	
	Both	105(31.6)	162(48.8)	65(19.6)	

Figures in brackets are percentages. ** Significant at 5% level.

The regression results (Table 5.8) show that seasonality had an influence on users' satisfaction. Users who used the same source throughout the year were more likely to be satisfied than the ones who switched to unimproved sources in the rainy season. The time used to fetch water in the rainy season was shorter than in the dry season, which had an influence on users' satisfaction. Location of the water source was also an important determinant of users' satisfaction. The World Bank (2010) found that users' satisfaction with drinking water supply in rural India did not depend on household characteristics but on the household's location in the village because of its implications for the distance to the source and the time to collect water, variables which feature prominently in this study as well. The level of users' trust in the water pump attendant also influenced users' satisfaction since pump attendants interact with users at the point of service delivery. This user-provider relationship, whether good or bad, has implications for how users perceive the service.

The ability of service users to complain about the situation of water supply also featured as a crucial factor. The majority of the 'dissatisfied' users (79%) complained about the situation mostly to village leaders (64%), in public meetings (12%), to ward councillors (10%), district council officials (8%) or to their members of parliament (7%). Female-headed households (38%) were more likely to complain than male headed-households (31%), presumably because of domestic water supply being seen as 'feminine'. Domestic water supply is considered a 'women's domain' and it is the women who talk about it in public meetings. These findings show that there are some formal mechanisms through which users can exercise voice and demand accountability from service providers and local politicians, which is an important success factor for decentralised service delivery (Rakodi, 2000).

Table 5.8: Variables associated with user's satisfaction with water services (n=330)

Explanatory variable	B coefficient	Std. Error	p-value
Sex of respondent (1=female)	-0.033	0.058	0.568
Household size	-0.010	0.012	0.398
Water source used throughout the year (1=yes)	0.219	0.086	0.011***
Appropriateness of source location (1= appropriate)	0.121	0.070	0.000***
Time to fetch water in rainy season	0.002	0.001	0.000***
Level of trust to water pump attendant (1= to a large extent)	0.210	0.063	0.001***
Need to improve water services (1=yes)	0.208	0.066	0.002***
Ability to complain if not satisfied (1=yes)	0.783	0.064	0.000***
Constant	0.455	0.196	0.021**

$R^2 = 0.531$, $F_{(8,327)}=45.088$, $p=0.000$. **Significant at 5% level. ***Significant at 1% level.

5.6 Conclusion

This chapter has examined the impact of decentralization reforms on rural water supply using a users' and a gender perspective. The findings show that the evidence is mixed. On a positive note, the numbers of improved sources have increased in both districts, as have the proportions of households using these sources. Management of water sources is decentralised

to village level institutions with technical inputs from the district water departments. Most users are willing to pay user fees, which reveals responsibility among users and an increased efficiency of the system. However, the inadequacies in water sources management and the lack of transparency from village leaders give rise to frequent complaints. Theoretically, decentralised service delivery should improve accountability mechanisms and responsiveness to users' complaints (Rakodi, 2000). The concerns of water users require context specific solutions. The inability of village leaders and district council officials to respond promptly to users' concerns challenges the notion that local governments are more likely to be responsive to local needs. District councils and village leaders need to respond better to users' concerns.

The reforms have also reinforced the existing inter- and intra-village inequalities in access to domestic water supply. Since district councils do not have the financial and technical capacity to support water projects in all villages, many villages are yet to benefit from the WSDP and still depend on unimproved sources. Within the villages with improved sources, not all households have access to these due to inadequate numbers of DPs and their location within the village. There are also inequalities between those who can afford to pay water user fees and those who cannot, and thus compelling the latter to rely on unimproved sources. This shows that the intra-village inequalities have not been addressed by the reforms, which supports the argument by Cleaver and Toner (2006) that local level governance cannot be automatically assumed to overcome inequalities in distribution and access to water.

The findings also show the overlap and differences between the users' and the gender perspective. In terms of governance, the reforms have been successful in increasing women's representation in village water committees. However, the outcomes of these decentralized arrangements differ between men and women due to social relations at the local level. Women and girls are the main drawers of domestic water and carry it mostly on their heads, whereas men and boys do it 'occasionally' and mostly use bicycles or carts. Many female-headed households are disadvantaged in several ways: they live far away from improved water sources, have no means to transport water, and, therefore, need to make multiple trips and spend more time on water collection, and are unable to pay water user fees. Because of this, many of them may not collect sufficient water for domestic uses.

Women's practical gender needs to have adequate access to domestic water sometimes conflict with men's gender needs for water for livestock or brick-making. This problem is escalated by the rising number of cattle. Especially in the dry season when there is water scarcity, the increased water requirement for livestock competes with domestic water needs. Although productive water needs (men's domain) and domestic water needs (women's domain) are both in the common interest of the household, it is women and girls who carry the immediate burden of domestic water provision. Thus, the competing priorities over water use between men and women at household and village levels are not resolved by the reforms to ensure that water services are actually 'gender-sensitive'. Domestic water is considered a 'women's domain', but not a domain with priority. Equitable access to water supply by women is, therefore, necessary for women to meet their practical gender needs and contribute to their household's health and welfare. Thus, policy makers and actors at different levels should create the necessary conditions for ensuring that women play a central role in setting priorities and in managing water facilities so as to enable them to have influence and

Decision making under the tree

control over the services, for the well-being of their own households and that of the community.

Chapter 6

A gendered users' perspective on decentralized primary health services¹³

This chapter draws on a gendered users' perspective to address the question whether the delivery of gender-sensitive primary health services has improved after the reforms. The chapter is based on empirical data collected through a household survey, interviews, focus group discussions, case studies and analysis of secondary data. The analysis shows that the reforms have generated mixed effects: they have contributed to improving the availability of health facilities in some villages but have also reinforced inter-village inequalities. Men and women hold similar views on the perceived changes and appropriateness to women on a number of services. Gender inequalities are, however, reflected in the significantly low membership of female-headed households in the community health fund and their inability to pay the user fees, and in the fact that women's reproductive and maternal health needs are as yet insufficiently addressed. Although over half of users are satisfied with the services, more women than men are dissatisfied. The reforms appear to have put much emphasis on building health infrastructure and less on quality issues as perceived by users.

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6.1 Introduction

Over the past few decades, Tanzania has implemented major health sector reforms (HSRs) in a context of decentralization. At the same time, compared to other components of HSRs¹⁴, there is considerable attention in the health management literature on decentralization, usually as part of the broader political and economic reforms (Cassels, 1995; Jeppsson and Okuonzi, 2000; Bossert and Beauvais, 2002; Lambo and Sambo, 2003; Eley *et al.*, 2005; Hutchinson *et al.*, 2006; Bossert and Mitchell, 2011). Decentralization, a process which involves the transfer of the fiscal, administrative and political authority from the central government to local governments, is viewed as a strategy for improving the access, equity and quality of primary health services. Its proponents argue that decentralization has the potential to improve the allocative efficiency, accountability and responsiveness of health services to users, thus improving the user-provider interactions (Akin *et al.*, 2005; UNICEF, 2007; Guanais and Macinko, 2009). It is expected that local governments will more frequently involve users in priority setting and decision making than central governments (Jeppsson and Okuonzi, 2000; Bossert and Beauvais, 2002; Lambo and Sambo, 2003; Akin *et al.*, 2005; Eley *et al.*, 2005). Despite the extensive theoretical support for the positive effects of decentralization, there is limited evidence of a positive impact on primary healthcare services. Thus, whether the expectations are justified, is an issue that warrants investigation.

When applying a users' perspective to investigate this, the factor of gender should be considered because of the different health needs of men and women, their unequal control over household resources to allocate to healthcare, and the gendered division of labour in care work (Standing, 1997; Vlassoff and Moreno, 2002; Niehof, 2004; Razavi, 2007). Gender refers to "the different cultural roles and expectations of men and women" that are socially constructed (van Wijk *et al.*, 1996:708; Vlassof and Moreno, 2002). In the health sector, gender is an important variable because it affects men's and women's access to healthcare, healthcare-seeking behaviour, health status and the way health policies and programmes are designed and implemented (Vlassof and Moreno, 2002). Women users have different biological-based health needs, particularly regarding reproductive and maternal health, and because their access to health services is affected by gender inequalities. In this, gender also intersects with other inequalities and disadvantages in healthcare such as those deriving from age, class, religion and ethnicity (van Wijk *et al.*, 1996; Standing, 1997; Sen and Östlin, 2008). In 1994, the Cairo International Conference on Population and Development (ICPD) recognised "women's health needs and well-being as important in their own right, not as a means towards the ends of fertility reduction or child health" (DeJong, 2000:945). Because women's access to and utilization of health services are influenced by cultural and ideological factors, gender-sensitive healthcare should take into account the socially constructed and culturally underpinned differences between men and women (van Wijk *et al.*, 1996; Standing, 1997; Vlassof and Moreno, 2002; Sen and Östlin, 2008). However, as Vlassof and

¹⁴Cassels (1995) outlines six components of HSRs, namely: improving the performance of civil service, decentralization, improving the functioning of national ministries of health, broadening health financing options, introducing managed competition, and working with the private sector.

Moreno (2002) show, gender roles and needs, and in particular women's roles and needs, although central to decentralization processes, have been largely ignored in many studies. In this chapter, we intend to address this gap by applying a gendered users' perspective in investigating the effects of the decentralization processes in the health sector in a rural area in Tanzania.

The rest of the chapter is structured as follows. The following section explains the theory and practice of decentralization in Tanzania, identifies gaps in the literature, and outlines the objectives of the study. We then explain how we measured the key concepts and, subsequently, describe the methodology and the detailed case studies. In the next section, we present and discuss the results. First, we provide a general picture of the health services situation in the study area since the implementation of the decentralization reforms. Then, we focus on the gendered users' perspective, with particular emphasis on women users. The chapter concludes with a reflection on the results of the research regarding the question whether the users of healthcare services, and in particular women, experience the intended benefits of the decentralization reforms.

6.2 Theory and practice of health sector reforms in Tanzania

The current reforms in Tanzania aim at improving the access and quality of primary healthcare services by strengthening the planning and management capacity of local government authorities (LGAs), and through construction, rehabilitation, extension and provision of equipment to health facilities (URT, 2007b). Like in other developing countries, the reforms were implemented in the context of already declining public services due to the economic crises of the 1970s and 1980s (World Bank, 1999, 2004; Batley, 2004; Ahmad *et al.*, 2005; Mehrotra, 2006). In practice, decentralization has meant the transfer of the administration and management of primary health services from the Ministry of Health and Social Welfare (MoHSW) to LGAs, health facilities and users (Munishi, 2003; URT, 2003, 2007b; Mamdani and Bangser, 2004; Mubyazi *et al.*, 2004; Semali *et al.*, 2005; Boon, 2007; COWI and EPOS, 2007). The national health policy spells out that health services at district level have been devolved to LGAs to increase their mandate in health services provision. Under this arrangement, it is the duty of the LGAs to ensure that health facilities and services at the district and lower levels are of acceptable quality and managed by qualified personnel according to staffing levels set by the Ministry of Health (URT, 2003).

In Tanzania, primary healthcare facilities form the base of the pyramidal structure of health services, which is made up of dispensaries, health centres and district hospitals (URT, 2003, 2007b; Maluka *et al.*, 2010). In 2007, there were 4679 dispensaries, 481 health centres and 95 district hospitals. Although the private sector is also involved in health services provision, the government still owns 64 percent of all health facilities (URT, 2007b). Thus, the government remains a major provider of primary health services, especially in rural areas. To test the validity of the assumptions of the positive effects decentralization from a gendered users' perspective, it is important to understand how decentralization works and whether it contributes to improved services at the local level.

A few studies have investigated different aspects of the reforms. Examples include studies focusing on decentralized healthcare financing through a community health fund (Munishi, 2003; Kamuzora and Gilson, 2007), the impact of decentralization on the control of communicable diseases (Mubyazi *et al.*, 2004), stakeholder involvement in a decentralized programme on immunization (Semali *et al.*, 2005), accountability and representation in health boards and committees (Boon, 2007), and the effects of decentralization on recruitment and distribution of health workers (Munga *et al.*, 2009). However, little is known about the impact of the reforms on the access, quality and appropriateness of primary health services in rural areas from a users' perspective. Similarly, the possible implications of the reforms for gender-sensitive health services have received almost no attention. A joint external evaluation of the health sector (COWI and EPOS, 2007:95) attests that "gender is not regularly discussed or considered relevant in efforts to improve health service quality."

This chapter, therefore, aims to gain insight into the impact of decentralization reforms on access, quality and appropriateness of primary healthcare services using a gendered users' perspective. It focuses on the questions of whether the delivery of primary healthcare services has improved for users after the decentralization reforms, and whether these services can be considered gender-sensitive. Gender-sensitive healthcare can be defined as care that is "available, accessible, affordable, appropriate and acceptable" for general as well as gender-specific health needs of men and women (van Wijk *et al.*, 1996:708). A gender-sensitive healthcare takes into account the socially constructed gender differences between men and women in all aspects of care including curative health, preventive health, information and education, infrastructure, policy making and financing (van Wijk *et al.*, 1996). Additionally, access to and appropriateness of health services might be evaluated differently by men and women since they are positioned differently in relation to healthcare services, and are more likely to experience different specific barriers (Standing, 1997).

6.3 Measuring the effects of decentralization on health services

In this study, the impact of decentralization reforms on primary healthcare services was measured with regard to access, quality and appropriateness for users of the services, with a particular focus on women users. Access was measured in terms of availability of health facilities, distance to the facilities, cost sharing arrangements and users' ability to pay. Following Standing (1997:3), we see 'access' as a useful and straightforward concept to operationalize especially from a gender perspective because it emphasizes the "problems of access and under-utilization of health services by women." The causal relations between the reforms and improved quality of services was assessed in terms of users' perceived changes on seven indicators: drug availability, availability of essential facilities, availability of health staff, their trustworthiness, proximity of the health facility, quality of health facility buildings and availability of health related information, and their levels of satisfaction. Our focus was on the 'perceived quality' of care from the viewpoint of users and not the 'technical' aspects of care (Gilson *et al.*, 1994; Atkinson and Haran, 2005).

In this study, gender was conceptualised in terms of men's and women's access to gender-sensitive and affordable primary healthcare, and the gendered division of labour

within the household. In turn, this was assessed by comparing the views of men and women on the perceived changes on the different aspects of health and healthcare, and on the deemed appropriateness for women of seven health services: antenatal, delivery, postnatal, family planning, immunization, child health, and treatment of common diseases. Despite the challenges of conceptualizing and operationalizing a gendered analysis especially in a context where women are more disadvantaged than men, we argue that a comparative analysis of men's and women's views is useful in revealing the gendered users' perspective.

6.4 Study design and methodology

The research on which this chapter is based was carried out between 2011 and 2012 in two rural districts, Kondoa and Kongwa, in the Dodoma Region, central Tanzania. The study used an embedded case study design with units of analysis at three levels: district, village and household. These levels were considered important because the administration and management of decentralized health services is implemented at the district level, most health facilities are based at the village level, and individuals within households are the ultimate users of such services. We see the household as not only the “producer of health” but also as the “principal financier” of health services (Mehrotra and Jarrett, 2002:1688; Niehof, 2004), which makes it a relevant unit of analysis. In each district, five villages were purposively selected for the study because of the differing availability of health infrastructure. They included villages with operating dispensaries (Kidoka and Songambe A), those with dispensaries that were constructed but not yet operational at the time of the study (Khubunko and Sagara A), villages with on-going dispensary construction (Potea and Chamae) and those without dispensaries at all (Mulua, Humekwa, Manungu and Mlanga). Some of these villages were easily accessible from their district council headquarters while others could be accessed with difficulties. None of the villages had a private health facility, hence for most of the villagers the public dispensary or health centre in the village or nearby village was the only healthcare option available.

The study used a combination of quantitative and qualitative methods of data collection. A survey was conducted among 332 households, interviewing 115 male and 217 female respondents, and using a structured questionnaire. Semi-structured and unstructured interviews were held with district medical officers (DMOs), village leaders and health staff in-charge of dispensaries, to get an overview of the management and functioning of the facilities. In the villages of Potea and Songambe A, which were selected for a detailed case study, six focus group discussions (FGDs) were conducted with groups of men, women, and village health committees, in which 32 men and 22 women participated. FGD participants were drawn from different hamlets and socio-economic backgrounds within the villages to represent the diverse categories of users. Relevant secondary data from the Comprehensive Council Health Plans (CCHPs) was reviewed and analysed to complement the primary data. The survey data were analysed for descriptive statistics, correlations, analysis of variance and multiple linear regression. Qualitative data from interviews and FGDs were analysed using qualitative content analysis which involved reading through the field notes and transcripts to

identify key themes and patterns relevant to the research questions and concepts (Patton, 2002).

To contextualize the results of the survey and the focus group discussions, the next section presents the case studies of the selected two villages. The cases highlight the village-specific pathways of the decentralization reforms in the health sector and the problems that are encountered at the local level.

6.5 The case villages

6.5.1 The case of Potea

Potea is a remote village in the northern part of Kondoa district about 46km from the district capital. In 2012, the village population was estimated to be about 3000 living in 438 households and four hamlets. The village does not have a dispensary, a situation which necessitates villagers to obtain health services from dispensaries in the neighbouring villages of Bumbuta, Mnenia, Kisaki or Pahi. In the rainy season, it is almost impossible to travel outside the village as it becomes 'land locked' by sand rivers, hence the wish of villagers to have a dispensary of their own. In 2002, villagers started constructing a dispensary building by mobilising locally available resources such as by making bricks, collecting and bringing sand, stones, gravel and water to the construction site, and hiring local masons. As part of the reforms, the district council promised to complement community efforts by roofing and finishing the building, and by providing medical staff, supplies and facilities for the dispensary.

However, the wish of the villagers to have an operational dispensary turned into a nightmare when the DMO inspected the site and found that the building was too small and its design not in accordance with the official guidelines. According to the DMO, a dispensary building should be big enough to accommodate all primary healthcare services with rooms for consultation, dispensing, delivery, recovery and clinic services. This requires a plot size of 10-15 acres to allow future expansion into a health centre or hospital depending on population growth and the demand for health services. The intended dispensary, however, was built on a two-acre plot using a standard design of 1985 that was no longer valid. It seemed that the former DMO had given the villagers old drawings, which they had not been aware of.

As a result, villagers were asked by the district council to demolish the building and start constructing a new one using the new standard guidelines. This proposal sparked different reactions among the villagers. Some saw it as a problem of the district council because it was the district council officials who had provided the old drawings. Others blamed their village and ward leaders for not following up the matter with the district council and for not providing feedback to the villagers. Some villagers felt that the issue was being politically motivated, since the village council was dominated by the opposition party and local politicians could use the issue for their own political agenda and to win votes during elections. On its part, the district council confirmed that it was aware of the issue and was ready to support the village but on the condition that the village would meet the set requirements.

6.5.2 The case of Songambe A

Songambe A village is located in the northern part of Kongwa district about 46km from the district headquarters. The village has a public dispensary that was constructed by the district council between 2006 and 2008 as part of the reforms. Villagers provided labour by making bricks, contributing sand, stones and water, and by paying Tshs. 2000 (US\$1.30) per household for local masons. Before the new dispensary was built, the villagers had to go to a dispensary in the neighbouring village of Hogolo (about 8km away) for medical services. The dispensary serves a catchment area of four villages (Songambe A, Songambe B, Mtungu Chole and Muungano) with an estimated number of about 13,800 users, out of whom only 4500 (about 33%) live within 5km from the dispensary.

Service provision in the dispensary is managed by two staff, a clinical officer and a Maternal and Child Health Aide, while it should have five medical staff (two clinical officers and three nurses). The two staff members diagnose and treat common diseases and refer serious cases to the nearest health centre or district hospital. The dispensary also offers maternal and child health (MCH) and family planning services. Once per month, the dispensary staff organises outreach for MCH services to the villages and hamlets that are located far from the dispensary, using bicycles. However, in the rainy season outreach services are virtually impossible because some of these areas are inaccessible due to poor road conditions and seasonal rivers.

The dispensary committee, composed of five men and three women, is responsible for service provision at the dispensary. Together the eight members represent the users, private service providers (drug shops owners), village council, and dispensary staff. Every three months, the dispensary staff and committee put a request for drugs to the national medical stores department (MSD)¹⁵ through the district council. The budget comes from cost sharing revenues and funding from the district council. However, in most cases drugs are not delivered on time, leaving the dispensary for up to six months without drugs. The users complained that drugs and other supplies are often out of stock at the dispensary, leading to poor quality services.

6.5.3 Discussion of the cases

The two cases illustrate the on-going decentralized interventions aimed at improving access and quality of primary health services in rural villages. These interventions include putting up the physical infrastructure, and running and managing the facilities. The case of Potea shows how problems may arise from the delegation of technical responsibilities such as construction of a dispensary to local communities that lack the required expertise. This raises the question of the technical limits to decentralization. The case of Songambe A is an example of where decentralization has contributed to the establishment of a village dispensary through joint efforts between the LGA and the users. The case also shows the different

¹⁵The Medical Stores Department (MSD) is a semi-autonomous department under the MoHSW which is responsible for procurement, storage and distribution of drugs (Semali *et al.*, 2005).

actors in the management of the facility: the users, the dispensary committee and dispensary staff at the lower level, and the district council and central government at the higher level.

So, to what extent have these interventions contributed to improving the access, quality and appropriateness of health services? What are the views of users, men and women, on these arrangements? We turn to these questions in the next section as we present and discuss the results using a gendered users' perspective. First, we shall describe the users' views on the availability of health services, distance to the facilities and cost sharing, and, second, their perceptions on improvement, appropriateness and satisfaction with the services.

6.6 Results and discussion

6.6.1 Availability of health services

One of the objectives of the on-going reforms in the country is to improve the availability of health services "through rehabilitation of existing health facilities and construction of new ones" (URT, 2007b:6). The survey findings showed that only 22 percent of the respondents used the health facility in their own village, the majority (78%) using facilities in other villages. Most users (72%) got health services from dispensaries, 21 percent from the district hospital and 7 percent from health centres. District data showed that between 2003 and 2011, the number of health facilities increased by 35 percent and 89 percent in Kondoa and Kongwa, respectively (Table 6.1). This has partly contributed to increasing service coverage by about 76 percent and 58 percent of the population living within 5km from the nearest facility in Kondoa and Kongwa, respectively. In both districts, the new facilities were mostly public dispensaries, implying that dispensaries are the main health facility for the majority of users in rural areas. The national health policy recognizes the dispensary as the backbone of rural healthcare services, providing reproductive and child health services, diagnostic health services and essential drugs (URT, 2003). The increase of dispensaries between 2003 and 2011 in Kondoa and Kongwa confirms the findings by Lambo and Sambo (2003) who show that in many sub-Saharan African countries implementing health sector reforms primary health facilities at the base rapidly expanded and, thereby, enhanced access to healthcare.

The Primary Health Services Development Programme 2007-2017 that was launched in 2007 to "accelerate the provision of primary health care" within the framework of the reforms, aims at establishing a dispensary in every village and a health centre in every ward (URT, 2007b:5). Despite the fact that the reforms indeed increased the number of health facilities, only about 38 and 59 percent of the villages in Kondoa and Kongwa, respectively, had dispensaries. This indicates inter-village inequalities in the availability of health facilities. The average population served by most dispensaries also exceeded the target of 5,000 (URT, 2003, 2007b). The majority of dispensaries in Kongwa (86%) and more than half (54%) in Kondoa were serving a population of more than 5,000. The two dispensaries in the study area had a catchment area of four villages each, with the one in Kidoka serving a population of 7,000 and that in Songambe A 13,800 users. Consequently, these facilities have to serve too many people, while they also experience critical shortages of staff, inadequate drugs, medical equipment and other supplies (URT, 2007b).

Table 6.1: Number of health facilities in Kondoa and Kongwa between 2003 and 2011

District	Health facility	2003	2011	Percentage increase
Kondoa	Hospital	1	1	0.0
	Rural health centres	4	6	50.0
	Dispensaries	53	71	34.0
	Total	58	78	34.5
Kongwa	Hospital	1	1	0.0
	Rural health centres	2	4	100.0
	Dispensaries	23	44	91.3
	Total	26	49	88.5

Sources: Kondoa District Council (2003, 2011); Kongwa District Council (2003, 2011).

6.6.2 Distance to health facilities

The distance from the home to the health facility is an important determinant of access to health services and health seeking behaviour (Gilson *et al.*, 1994; Hjortsberg and Mwikisa, 2002). At national level, the commonly used norm is ‘within 5km’ from the nearest facility (URT, 2007b, 2009b), although some national surveys use ‘within 10km’ (e.g. URT, 2007a). In this study, 62 percent of users were living within 5km, significantly less than the national average of 90 percent (URT, 2007b). The mean distance to the nearest health facility was 5.8km. In Kondoa it was 6.2km and in Kongwa 5.3km ($F_{(1,330)}=4.157$, $p=0.04$). Significantly ($p=0.00$) more users (80%) in villages with dispensaries lived within 5km from the nearest health facility than in villages without health facilities (58%). Indeed, more than one third (35%) of respondents in villages without health facilities identified distance as a major problem constraining their access to health services. The mean distance to the health facility was significantly ($F_{(1,329)}=23.134$, $p=0.00$) lower (3.5km) for users in villages with health facilities than in villages without (6.3km). Similarly, the mean distance to a dispensary in the village was significantly lower (3.5km) than to a health centre in another village (5.5km) or the district hospital (11.7km) ($F_{(4,330)}=88.032$, $p=0.00$).

Statements in the interviews and FGDs support these observations. Comments like: “We are very far from the district hospital where we get health services” (woman interviewee in Mulua), “from here to the dispensary is very far” (women FGD participants in Potea), or “when one gets sick at night, it is very difficult to get to the dispensary because it is far and we have no transport” (man interviewee in Humekwa), were common in villages without health facilities. In Mulua, village leaders explained that in the rainy season most people cannot reach the district hospital (about 16km away) because the village is almost ‘cut off’ from the transportation network by seasonal rivers. Women FGD participants in Potea narrated that pregnant women “just have to pray to God for them to deliver safely at home because they cannot walk to the nearest dispensary, especially in the rainy season.” One woman recalled: “during my last delivery, I was assisted by a traditional birth attendant because it was raining and could not walk the six kilometres to Bumbuta dispensary.” FGD participants in this village indeed indicated that most pregnant women relied on traditional birth attendants (TBAs) for delivery services.

TBAs are elderly women who are usually self-taught or informally trained to conduct normal deliveries, provide post-natal care, and advise women on preparation for delivery and attending antenatal care (Nombo, 2007). In Kondoa, about 48 percent of the home deliveries were reportedly handled by TBAs, although the proportion could be higher in villages without health facilities. The TBAs are trusted and have good social relations with their clients since they are members of the same community. As opposed to the distant health facilities, TBAs are geographically, as well as socially and culturally close to their clientele. Their payment varies from recognition to in-kind gifts and moderate cash payments. A TBA who participated in the women FGD in Potea testified that: “*We are given washing soap or other small gifts by our clients as a sign of appreciation.*” The interviews with the DMOs revealed that there were contradictory views at the national level on whether to officially recognise and train TBAs. While some argue that training the TBAs could encourage pregnant women not to use the health facilities, others see it as unavoidable because of shortage of facilities and professional staff, especially in rural areas. As a result, training of TBAs had been suspended and whether or not training and supporting TBAs remained the discretion of the DMOs in their respective districts. These policy contradictions have negative consequences for women’s maternal health because of the many pregnant women who rely on TBAs. They also reflect an unresolved debate at the international level on whether governments in developing countries should support or obstruct the involvement of TBAs in child delivery and train them (Campbell and Graham, 2006; Rasch, 2007).

The findings show that access to health services was constrained by geographical isolation, poor infrastructures and transportation options. Service users in villages without health facilities spent many hours on travelling long distances, mostly on foot, by bicycle or motorcycle, to reach the health facilities. Evidence from other studies shows an inverse relationship between distance or travel time to health facilities and utilization of healthcare facilities (Hjortsberg and Mwikisa, 2002; Hjortsberg, 2003; Peters *et al.*, 2008). A study by Hjortsberg and Mwikisa (2002) in Zambia reports that 56 percent of households in rural areas perceived distance as a major problem in access to health services. Peters *et al.* (2008) demonstrate that remote health facilities entail more travel expenditures. This is inhibiting to obtaining care, especially for the poor. More critically, the burden of seeking healthcare from these distant facilities falls disproportionately on women because they have specific needs that derive from the biological and reproductive health risks. Additionally, since according to the normative gendered division of labour in the household women are the primary caregivers, placing greater burdens on women’s time results in higher opportunity costs for them (Standing, 1997; Nanda, 2002; Sen and Östlin, 2008). Since emergency obstetric care is not available at the dispensaries, women must travel long distances to the district hospital in case of complications, or go without care altogether (WDP, 2004). Campbell and Graham (2006) argue that the location of delivery, attendance at delivery, and how quickly transport to referral-level care can be arranged, are crucial factors in intrapartum care. In Kondoa, the DMO had set up two ‘waiting wards’ at the district hospital for pregnant women at the end of their term, who were referred by health staff of the dispensaries and health centres who were required to timely recognize ‘danger signs’ indicating complications. The initiative is

intended to ensure timely availability of emergency obstetric care, which is an important strategy in reducing maternal mortality (Campbell and Graham, 2006; Rasch, 2007).

6.6.3 Cost sharing arrangements and affordability to pay for health services

The rationale for introducing cost sharing in the public health sector as part of the reforms was to generate additional revenues to improve the availability and quality of health services (Munishi, 2003; URT, 2003; Mamdani and Bangser, 2004; Kamuzora and Gilson, 2007). In this study, two cost sharing arrangements were identified: user fees per visit to the health facility and the community health fund (CHF). Most respondents (73%) were paying user fees per visit at the point of service delivery, only 27 percent paid through the CHF (Table 6.2). CHF is a district-based voluntary health insurance scheme that was introduced in the country in 1996 in Igunga district and has subsequently been rolled out to other districts including Kondo and Kongwa. The scheme aims at providing an opportunity for seasonal income earners in the informal sector to pay for their health services before they fall sick (Munishi, 2003; URT, 2003; Kamuzora and Gilson, 2007; Tidermand *et al.*, 2008). CHF members paid an annual fee of Tshs. 10,000 (US\$ 6.40) in Kondo and Tshs. 5,000 (US\$ 3.20) in Kongwa. Membership benefits included basic healthcare services for up to six household members. Significantly ($p=0.00$) more respondents in Kongwa (35%) were CHF members than in Kondo (20%) partly because the annual fee in Kongwa is half of the fee in Kondo. Male-headed households (30%) were significantly ($p=0.02$) more likely to be CHF members than female-headed households (13%).

The interviews with the DMOs, dispensary staff and analysis of secondary data revealed that CHF membership was generally low. By June 2012, there were 7973 CHF members (9% of all households) in Kondo and 7375 members (15% of all households) in Kongwa. Inability to pay the annual fee, low quality of services and discrimination against CHF members by service providers in favour of users paying user fees, were the most common reasons given for not joining the scheme. These findings confirm earlier studies in Tanzania which show that CHF struggles with low membership in the participating districts ranging from 3 to 26 percent (Munishi, 2003; Kamuzora and Gilson, 2007; Tidermand *et al.*, 2008). This situation does not seem to have changed over the past few years.

For non-CHF members, healthcare charges entailed paying a consultation fee ranging from Tshs. 200 (US\$ 0.13) in Kidoka to Tshs. 1000 (US\$ 0.64) in Songambele A, and about Tshs. 3000 (US\$ 1.92) to buy drugs. However, most users complained about the frequent shortage of drugs in the facilities, compelling them to buy drugs from private shops. This meant additional costs on top of the other costs incurred in terms of time spent on travelling and queuing, and transportation. *"The amount you pay is not predictable. You pay Tshs. 3000 or 4000 if you are lucky to find medicine in the dispensary, but in most cases we pay more than that because we are told to buy medicine from shops"* (women FGD in Potea). In fact, the shortage of drugs was the second most cited problem by survey respondents (64%). WDP (2004) found that in the long run paying user fees could be a more costly alternative although for the poor it is the only option.

Table 6.2: Cost sharing arrangements by district and household headship (n=332)

Criteria	Category	Pay per visit	CHF	Chi-square values
District	Kondoa	131(79.9)	33(20.1)	$\chi^2=8.651$ $p= 0.003^{***}$
	Kongwa	110(65.5)	58(34.5)	
	Both	241(72.6)	91(27.4)	
Household headship	Male-headed households	206(70.5)	86(29.5)	$\chi^2=5.081$ $p= 0.024^{**}$
	Female-headed households	35(87.5)	5(12.5)	
	Both	241(72.6)	91(27.4)	

Figures in brackets are percentages. **Significant at 5%, ***Significant at 1%.

The majority of respondents (71%) could afford the user fees, a significantly ($p=0.00$) higher proportion of male-headed households (74%) than female-headed households (48%). The results from the linear regression revealed other factors associated with users' ability to pay (Table 6.3). Farming households were unlikely to be able to pay, presumably because of their significantly lower incomes compared to households keeping livestock or running a small-scale business. Using a facility in another village meant more costs in terms of transport in addition to user fees, thus contributing to the inability to pay. A significantly ($p=0.03$) higher proportion of respondents (68%) in villages without health facilities than in villages with facilities (53%) mentioned high costs as a major problem. Membership in village groups, mostly income generating groups of women, was positively associated with ability to pay. Households with members in such groups had relatively higher incomes than non-members. Users' perceptions of the appropriateness of treatment of common illnesses of women and the availability of health staff were also significant factors. This could imply that users could be willing to pay if they perceived they would get quality services. In this way, decentralization could contribute to motivating users to pay for the services provided their payment would enhance quality of care. However, the findings on changes in quality of care as perceived by the users demonstrate that the situation on the ground is quite different.

The national health policy provides for exemptions from paying user fees for the poor and vulnerable in order to increase access of health services to those who cannot afford to pay for public services such as maternal and child health (URT, 2003). Interviews with the DMOs and dispensary staff revealed that groups exempted from paying the user fees include pregnant women, under-five children, the elderly, and people with illnesses such as AIDS and tuberculosis. Antenatal care and family planning services are also exempted. However, from the FGDs it transpired that in practice, the exemption rules are not consistently applied. Groups that are in policy 'exempted', could still be required to pay by the service providers. In Potea, a male FGD participant indicated that: "We only hear in the media that children, pregnant women and the elderly should get free medical services, but in reality everybody pays." Another male FGD participant in Songambe A remarked: "there is nothing like free medical services. My wife gave birth at the village dispensary a few days ago and I had to pay Tshs. 5000" (US\$ 3.20). Mamdani and Bangser (2004) relate this inconsistent implementation of the exemption rules to the failure of health service providers to follow the procedures and the users' lack of insistence on their rights. While the users may not insist because they fear that

insistence on free services would jeopardize their treatment, for providers there is little incentive to exempt people from paying because they need income from user fees (Nanda, 2002; Nombo, 2007). Evidence from other studies shows that most women do not benefit from exemptions rules because they do not know about them. Those who do know, get this information through informal contacts (Nanda, 2002; Mamdani and Bangser, 2004; WDP, 2004; Nombo, 2007).

Table 6.3: Variables associated with users' affordability to pay health user fees (n=297)

Explanatory variable	B coefficient	Std. Error	p-value
Household headship (1= male headed)	0.268	0.077	0.001***
Occupation (1=farming)	-0.184	0.055	0.001***
Health facility used by household (1=dispensary in the village)	0.049	0.014	0.000***
Membership in groups (1=yes)	0.110	0.052	0.034**
CHF membership (1=yes)	0.148	0.056	0.009***
Appropriateness of treatment of common diseases (1=not appropriate)	-0.080	0.028	0.004***
Improved availability of health staff (1= no changes)	-0.158	0.058	0.007***

$R^2 = 0.173$, $F_{(7,297)} = 8.696$, $p=0.00$, **Significant at 5%, ***Significant at 1%.

6.6.4 Users' perceived changes in quality of health services

Service users' perception of quality of care is critical in understanding the relationship between quality of care and utilization of health services (Baltussen *et al.*, 2002; Baltussen and Ye, 2006). The survey respondents were asked to rank change in the quality of health services on a four-point scale (from 'deteriorated' to 'significantly improved'). Most respondents indicated either 'no changes' or 'some improvement' on all indicators. The mean scores for all the seven indicators were close to three which could be interpreted as 'some improvement'. Most respondents were relatively positive on items relating to the trustworthiness of health staff and the quality of the building (mean score of 2.9), but less on the proximity of the facilities (mean score of 2.5). On none of the indicators the ranking of men and women showed a significant difference (Table 6.4), possibly because both men and women were using the same health facilities, and, therefore, were likely to be experiencing similar challenges. Significantly ($p=0.02$) more respondents in Kondoa (52%) than in Kongwa (41%) saw 'no changes' in the availability of essential facilities. In Kondoa, slightly more than one tenth of respondents (13%) were of the opinion that availability of health staff had 'deteriorated', while in Kongwa this was only one percent ($p=0.00$). More respondents in Kondoa (64%) than in Kongwa (51%) indicated 'no changes' on the proximity to the facilities ($p=0.00$) because of the longer average distance to health facilities in the former. This indicates that there were more perceived changes in Kongwa than in Kondoa.

Table 6.4: Users' perceptions on improved quality of health services by sex (n=332)

Criteria	Deteriorated	No changes	Somewhat improved	Significantly improved	Mean score
Drug availability	22(6.6)	129(39.0)	151(45.6)	29(8.8)	2.6
Availability of essential facilities	11(3.3)	152(46.1)	141(42.7)	26(7.9)	2.6
Availability of health staff	22(6.7)	145(43.9)	116(35.2)	47(14.2)	2.6
Trustworthiness of health staff	5(1.6)	115(34.8)	132(40.0)	78(23.6)	2.9
Proximity of health facility	3(0.9)	190(57.6)	103(31.2)	34(10.3)	2.5
Quality of buildings at health facility	0(0)	128(39.3)	106(32.5)	92(28.2)	2.9
Availability of health related information	0(0)	153(46.5)	122(37.1)	54(16.4)	2.7

Figures in brackets are percentages.

When asked about the problems encountered in accessing services in the nearest facility, about two thirds of respondents indicated high treatment costs (65%) and shortage of drugs (64%) followed by long waiting times (52%). Other concerns were: few staff (33%), shortage of facilities (31%), not enough female staff (28%) and lack of attention by the health staff (15%). A less common but serious complaint was corruption (mentioned by 6% of respondents). "They (dispensary staff) tell us that there is no medicine, but those who give a bribe get the medicines" (men FGD in Songambe A). "It is the poor who suffer; if you are able to go with something in your hands to give to the nurse or doctor, you will get the best care" (women FGD in Songambe A). Significantly ($p=0.00$) more women (73%) than men (50%) were concerned about high treatment costs. Similarly, a significantly ($p=0.00$) higher proportion of women (56%) than men (43%) complained about the long waiting times. This shows how the different roles of men and women influence the assessment of quality of care (cf. van Wijk *et al.*, 1996; Standing, 1997). In general, the majority of respondents (83%) across the districts, men and women alike, felt that health services were the most important social services that needed to be improved in their villages.

The in-depth qualitative study generated mixed perspectives. Most users in villages with dispensaries saw 'some changes' while those in villages without dispensaries saw 'no changes' or 'deterioration'. For example, most interviewees and FGD participants in Songambe A acknowledged that the construction of the dispensary in their village had made it "relatively easier to get medical services than in the past when we had to walk 8km to the nearest dispensary." "Even if one falls sick late at night, you can easily rush to the dispensary and knock at the doctor or the nurse for help" (man FGD participant). "Many children now get vaccinations compared to when we had no dispensary in the village" (woman FGD participant). Kidoka village has a dispensary that was built in the 1970s and rehabilitated under the on-going reforms in 2005. In this village, most interviewees were of the opinion that "the quality of health services had deteriorated" because the capacity of the dispensary was no longer sufficient to meet the demands of the increasing population in the catchment area. In Potea, women FGD participants told us that "availability and quality of health services is very bad because we spend many hours travelling to the dispensary and queuing." According to them, the quality of services in the nearby dispensary was "poor because there are only two dispensary staff to attend patients from four villages

and the dispensary is often experiencing shortage of drugs.” Village leaders in Humekwa said: “The situation has not changed; we still experience the same problems we have encountered for many years.”

These findings indicate that the presence of a dispensary in the village is a key factor in the users’ perception of quality of health care, although other indicators such as availability of drugs, availability of health staff, distance to the facilities, trustworthiness of staff and waiting times were also important. These findings are in line with those by Lambo and Sambo (2003) who note that despite the reforms, the majority of the people in sub-Saharan Africa still have limited access to quality services, both in terms of technical quality and quality as perceived by users. URT (2007b) shows that despite the remarkable improvements over the years since the advent of HSRs, the quality of health services in most areas is still unsatisfactory due to shortage of facilities, inadequate medical equipment, and shortage of human resources, medicines, and supplies. As is reflected in the users’ views in our study (Table 6.4) and given similar problems reported by studies more than a decade ago just at the beginning of the reforms (cf. Mwisongo *et al.*, 2000) and in previous national surveys (e.g. URT, 2007a), it can be concluded that progress in improving the quality of services has been slow.

6.6.5 Appropriateness of health services to women

Most respondents, men and women alike, viewed most of the services offered in the nearest facility as ‘appropriate’ to women (Table 6.5). The views of men and women did not differ significantly on five out of the seven aspects. Although antenatal and postnatal clinic services address specifically women’s health needs, in the study area, they are provided on certain dates once per month either by users visiting the health facility or through the outreach services provided by health staff in villages without the facilities (see the case of Songambe A). The same applies to child immunization services. Both men and women viewed this arrangement as ‘appropriate’ to women because it is not too time consuming. Men and women also held similar views on the appropriateness of child health services and on treatment of common illnesses, presumably because both are involved through attending health facilities as users and in making decisions on whether to seek healthcare and allocate the financial resources needed.

There were, however, significant differences ($p=0.00$) between the views of men and women on two issues: childbirth and family planning. Almost half (47%) of women said that delivery services were ‘not appropriate’ compared to 25 percent of men. Women FGDs revealed that all dispensaries had inadequate delivery facilities such as beds and other items like gloves and syringes. “When you are about to deliver, you just pray that you don’t find other women in the same situation at the dispensary, because there is only one bed and one nurse” and that “sometimes pregnant women share a bed or even sleep on the floor”, said women in the Potea FGD. Other problems were the long distances to the facilities, unfriendly services and lack of money to pay for the services or buy some items. “One pregnant woman from this village died on her way to the dispensary last year” (women FGD in Potea). In Humekwa, one woman village leader insisted that: “I know many cases of women who have delivered on their way to the dispensary.” The fact that these problems were mostly identified by women reflects the

argument by van Wijk *et al.* (1996:708) that “more health care is not always better health care from the viewpoint of women.”

District data showed that between 2003 and 2011, the proportion of professionally assisted deliveries had increased from 27 percent to 73 percent in Kondoa, and from 64 percent to 82 percent in Kongwa. However, the rate of home deliveries was still high at about 27 percent in Kondoa and 18 percent in Kongwa. The maternal mortality ratios (MMR) in Kondoa and Kongwa were 109 and 120, respectively. These rates are well below the national average of 454 per 100,000 live births (URT, 2011b). However, as revealed in the interviews with the DMOs, since the figures are based on cases reported by the health facilities and do not include the high proportions of home deliveries occurring in remote villages without health facilities, they most probably underestimate the level of maternal mortality.

With regard to family planning services, significantly ($p=0.00$) more men (42%) than women (7%) saw them as ‘not appropriate’. The proportion of family planning users in both districts was higher than the national average of 34 percent (URT, 2010b): 81 and 64 percent in Kondoa and Kongwa, respectively. The qualitative in-depth study revealed that most men consider family planning services ‘inappropriate’, not in terms of the technical quality of the services but in relation to socio-cultural norms. Many husbands do not allow their wives to use family planning methods because they want many children. One woman FGD participant in Potea said: “Men do not care about the difficult experiences we go through; all they want to see is more children even if it is every year.” Another added: “men always insist that using family planning means bringing poverty into the household.” Among the Gogo and Rangi (the main ethnic groups in the study area) having many children is culturally perceived as a sign of wealth and prestige. In Potea where majority of the population is Muslim, men FGD participants told us that “every child comes with his/her opportunities from God” and, therefore, there is no need for family planning. Most men FGD participants dismissed the question on family planning arguing that it was “a women’s issue which should be asked to women.”

Others indicated that men had limited knowledge since most family planning programs and interventions focused on women and excluded men. While health facilities offer a variety of family planning methods, most women users preferred injectables which can be administered secretly at the facilities without their husbands knowing. This shows the different perspectives men and women have on family planning. The men did not respond to our focus on the ‘appropriateness’ of the services but objected to the idea of family planning itself. For women, appropriate family planning services meant the availability of injectables and other acceptable methods. However, while the services were available, women’s access was obstructed by their husbands who did not want their wives to use contraception. This shows the implications of the power differentials between men and women for women’s reproductive and sexual health (cf. DeJong, 2000), which are reinforced by ethnicity and religion.

Table 6.5: Users' perceptions on the appropriateness of health services by sex (n=332)

Criteria	Sex	Not appropriate	Appropriate	Very appropriate	Chi-square values
Antenatal clinic services for pregnant women	Male	23(20.5)	83(74.1)	6(5.4)	$\chi^2=1.580$ $p= 0.454$
	Female	33(15.3)	167(77.7)	15(7.0)	
	Both	56(17.1)	250(76.5)	21(6.4)	
Delivery services	Male	29(25.4)	78(68.4)	7(6.1)	$\chi^2=13.968$ $p= 0.001^{***}$
	Female	101(46.5)	106(48.8)	10(4.6)	
	Both	130(39.3)	184(55.6)	17(5.1)	
Postnatal clinic services for lactating mothers	Male	18(16.2)	86(77.5)	7(6.3)	$\chi^2=3.169$ $p= 0.205$
	Female	21(9.7)	177(81.9)	18(8.3)	
	Both	39(11.9)	263(80.4)	25(7.6)	
Family planning services	Male	48(42.1)	63(55.3)	3(2.6)	$\chi^2=60.607$ $p= 0.000^{***}$
	Female	15(6.9)	187(86.2)	15(6.9)	
	Both	63(19.0)	250(75.5)	18(5.4)	
Immunization services	Male	9(8.0)	92(82.1)	11(9.8)	$\chi^2=3.153$ $p= 0.207$
	Female	16(7.4)	163(75.5)	37(17.1)	
	Both	25(7.6)	255(77.7)	48(14.6)	
Child health services	Male	18(15.9)	92(81.4)	3(2.7)	$\chi^2=3.419$ $p= 0.181$
	Female	23(10.6)	180(83.3)	13(6.0)	
	Both	41(2.5)	272(82.7)	16(4.9)	
Treatment of common diseases	Male	20(17.7)	92(81.6)	1(0.9)	$\chi^2=2.711$ $p= 0.258$
	Female	37(17.1)	170(78.7)	9(4.2)	
	Both	57(17.3)	262(79.6)	10(3.0)	

Figures in brackets are percentages. ***Significant at 1%.

6.6.6 Users' satisfaction with health services

Users' satisfaction is an important indicator of service quality (Gilson *et al.*, 1994; Atkinson and Haran, 2005). The findings showed that 59 percent of respondents were either 'somewhat satisfied' (52%) or 'very satisfied' (7%) with the services. At national level, in 2009, 64 percent of users were satisfied with services in government facilities (URT, 2012), a slight decline from 69 percent in 2007 (URT, 2007a). However, the national figures do not distinguish between urban and rural areas. Users in rural areas could be more dissatisfied than urban users. Gender is negatively associated with users' satisfaction (Table 6.6). Women were more likely to be dissatisfied than men, possibly because women made more frequent visits to health facilities, and therefore, had more first-hand experience with the shortcomings of the facilities. The study of Atkinson and Haran (2005) also shows an association between gender and users' satisfaction. The appropriateness of delivery services and treatment of common illnesses of women also featured as important variables, pointing to women's different needs and expectations regarding healthcare (van Wijk *et al.*, 1996; Atkinson and Haran, 2005). The perceived quality and appropriateness of the services in addressing women's needs is, therefore, a critical issue since it contributes to meeting women's practical gender needs, particularly in their role as caregivers.

In our study, household size is negatively related to users' satisfaction. Large households tended to be more dissatisfied than small households, presumably due to the fact that in large households demands for health services are likely to be higher, entailing a higher frequency of visits to the facilities. The level of trust in the health staff was another important determinant of users' satisfaction. Users who trusted the staff 'to a large extent' were significantly more likely to be satisfied. This shows the importance of the user-provider interaction in mediating access to services for users' perceptions. A study on community satisfaction with primary healthcare services in Morogoro, Tanzania (Gilson *et al.*, 1994) identifies trust in the provider as a key factor in users' selection of the providers and, consequently, users' satisfaction.

As documented in other studies (e.g. Gilson *et al.*, 1994; Baltussen and Ye, 2006) also in our study the availability of drugs emerged as a key determinant of users' satisfaction, which has implications for the utilization of health services. About two thirds of our respondents reported shortage of drugs as a serious problem. In the FGDs complaints could be heard such as: "We have a dispensary, but no medicines" (female participant in Songambe A), "the only medicine available every time we go to the dispensary is panadol" (male participant in Songambe A), or "they [dispensary staff] always tell us that there is no medicine, go and buy from the shops" (female participant in Potea). In policy, the responsibility for the procurement of drugs has been delegated to health facilities through the health facility committees with technical support from the DMOs (see the case of Songambe A). According to our interviews with dispensary staff, however, health facilities experienced frequent and sometimes prolonged shortage of drugs due to delayed delivery of drugs from the MSD. In some cases, the facilities received drugs that had expired or were about to expire, drugs with no labels, or even drugs that had not been requested. Previous studies in Tanzania have reported similar findings. For instance, Munishi (2003:122) shows that shortage of drugs has been a "chronic problem which has affected quality of care." Mamdani and Bangser (2004:11) report that most complains from the patients' perspective "focused on lack of drugs and supplies." COWI and EPOS (2007) found that health facilities experience delays of receiving drugs from 3 to 90 days. This situation does not appear to have changed, despite the policy changes.

Table 6.6: Variables associated with users' satisfaction with health services (n=328)

Explanatory variable	B coefficient	Std. Error	p-value
Sex (1= female)	-0.147	0.066	0.027**
Household size	-0.029	0.013	0.025**
Extent of trust to health staff (1=to a large extent)	0.122	0.051	0.017**
Appropriateness of delivery services (1=appropriate)	0.206	0.056	0.000***
Appropriateness of treatment of common diseases (1=appropriate)	0.235	0.076	0.002***
Shortage of drugs as a problem (1=yes)	0.163	0.066	0.014***

$R^2 = 0.173$, $F_{(6,328)}=11.253$, $p=0.00$, **Significant at 5%, ***Significant at 1%.

6.7 Conclusion

This chapter has examined the effects of the decentralization reforms on the access, quality and appropriateness of health services using a gendered users' perspective. In terms of access, it is evident from our findings that decentralization reforms have contributed to increasing the availability of health facilities, particularly dispensaries, thereby raising the service coverage in both districts. The management and administration of primary healthcare services has been decentralized to LGAs, facilities and users, although the centre still maintains control over the 'technical quality' of the health infrastructure and services, which sometimes conflicts with local initiatives. However, there is still inadequate infrastructure to provide full primary healthcare coverage. This is a major obstacle for many users, especially women, who travel considerable distances to access healthcare. This limits women in meeting their own health needs and their practical gender needs as caregivers. It is especially problematic for pregnant women who seek ante-natal and delivery services. As a result, TBAs are still important providers of delivery services, particularly in villages without health facilities. Hence, adopting the 'health care model' where trained TBAs are incorporated within the health system and supported to work under close supervision of trained midwives (Rasch, 2007) could be beneficial especially in the present context of severe shortage of human resources in health facilities.

The findings further show that although cost sharing measures in terms of user fees and CHF are intended to complement government financing so as to improve the quality of services, they also obstruct healthcare access for poor and female-headed households. Mamdani and Bangser (2004) argue that the rural poor, who are 'highly responsive' to healthcare costs, are at risk of exclusion due to the inability to pay. Others have also shown that user fees are regressive and inequitable, and can lead to decreased utilization of health services among the poor (Nanda, 2002; Lambo and Sambo, 2003; Tolhurst and Nyonator, 2006; Peters *et al.*, 2008). For women it is more difficult to pay for healthcare because they often lack the decision-making power and control of financial resources. In some cases, women make a 'trade off' not to seek healthcare in order to meet other household needs, or they do not make use of health services because they have no cash income or because women's health is given low priority (Nanda, 2002; Vlassof and Moreno, 2002; Nombo, 2007; Sen and Östlin, 2008).

Women constitute a significant proportion of potential beneficiaries of exemptions and if the rules were properly applied, this could contribute to improving gender equity in access to health services. However, in the study area the exemption rules were not effectively implemented. Poor and female-headed households were in fact also excluded from the CHF insurance scheme because of their inability to pay the annual lump sum. Hence, considering the high burden of morbidity in rural areas and particularly among poor households, low-income households are likely to experience difficulties in accessing the healthcare they need (Mehrotra and Jarrett, 2002). Consequently, decentralizing healthcare financing to users can have a negative impact on access to health services for groups such as the poor and female headed households, thereby reinforcing existing inequalities. UNICEF (2007) also argues that decentralization can also lead to unintended consequences such as aggravating existing

gender inequalities. This shows how gender intersects with other social inequalities such as poverty, thus limiting women's access to health services. Measures which could have a major positive impact on women's health such as exemptions should, therefore, be considered priorities in the reforms.

With regard to quality issues as perceived by the users, the findings show that the reforms have focused mostly on building and rehabilitation of health facilities but that less has been achieved in other respects, such as adequate staffing and availability of drugs and other essential supplies. It seems easier to involve users in the physical construction of the health infrastructure than in running and managing the facilities. However, users are not only concerned about the availability of facilities, but also about the quality of their services, for which the district councils and the Ministry of Health are responsible. Among users and dispensary staff the consistent shortage of drugs is frequently cited as a serious problem. Policy makers should address these inadequacies, particularly the drug purchasing and distribution arrangements, in order to improve quality of services in rural areas.

Women are particularly concerned about the 'inappropriateness' of delivery services. They also hold quite different views from men on the 'appropriateness' of family planning services, in which men were not interested because they mostly reject the idea of family planning. Despite the globally voiced recognition of women's right to autonomy in reproductive health decisions (DeJong, 2000), also our findings show that gender power relations still play a critical role in safeguarding women's reproductive health, and that gender intersects with ethnicity and religion to compound their disadvantaged position. Thus, decentralization in the healthcare sector should in fact be gender-sensitive healthcare aimed at meeting the health needs of both men and women.

Overall, the use of the gendered users' perspective has revealed the interplay and differences between men's and women's perspectives on different aspects of healthcare. While men and women hold similar opinions on some aspects, there are also marked differences. This confirms the fact that men and women are actually different users and, therefore, their views should not be conflated under the umbrella of 'users' perspectives' in general. Understanding their similarities and differences should be the entry point for policy makers and health planners in making primary healthcare services 'gender-sensitive'.

Chapter 7

Cooperation and trust in the context of decentralization reforms¹⁶

This chapter investigates the impact of decentralization reforms on cooperation and trust at the village level in Tanzania, using a gender perspective. The chapter draws on survey and qualitative data from ten villages in two rural districts. The findings show that the reforms have strengthened 'formal' cooperative efforts and social networks and groups aimed at improving public services and poverty reduction. Participation in these arrangements depends on the culturally underpinned gender relations. Citizen's participation in decision-making processes and users' satisfaction with water and health services are significantly related to social and political trust, in which gender plays a role as well. There is a two-way interface between trust and decentralization reforms whereby 'good' decentralization outcomes generate trust while 'bad' outcomes decrease trust. The study also shows that political trust is a multi-layered concept which should be analysed by considering the different administrative levels at which it occurs.

¹⁶An abridged version of this chapter has been published as: Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2014) Cooperation and trust in the context of decentralization reforms in Rural Tanzania. *The International Journal of Social Sciences and Human Studies* Volume 6 Issue 1, pp. 139-156.

7.1 Introduction

Decentralization is a dominant theme in policy and literature on local governance and service delivery in Tanzania. Among other things, the current decentralization reforms which started in the late 1990s aim at changing the power relations and responsibilities between the different actors at the central and local levels (URT, 1998, 2009a). The reforms envisage to “enable the citizens at all levels to participate in decision-making processes, demand transparency and accountability in the devolved systems for allocation and use of public resources, and in planning and delivery of public services” (URT, 2009a:29). This policy objective echoes the consensus of many analysts that increasing citizens’ participation in decision-making processes through decentralization implies greater accountability and transparency among different actors (Evans, 1996; Blair, 2000; Ribot, 2002; Devas and Grant, 2003; Francis and James, 2003; Diaz-Serrano and Rodriguez-Pose, 2012). Blair (2000:35), for example, argues that participation and accountability are key objectives of decentralization reforms aimed at “bringing as many citizens as possible into the political arena and assuring that political leaders are responsible to the citizens for their actions.” Francis and James (2003:326) state that decentralization is “a cornerstone of good governance both in promoting local accountability and transparency, and enfranchising local populations.”

While decentralization reforms aim at altering the social and political structures (Mendoza-Botelho, 2013), it is not clear how these reforms penetrate the social structures, and affect or are affected by cooperation and trust relations at the local level. In Tanzania, there is a dearth of information on the impact of decentralization reforms on cooperation and trust, and how this affects decision-making processes and delivery of public services. Similarly, the gender dimensions of cooperation and trust have received almost no attention in previous studies. The few existing studies show that there is ‘trust-deficit’ between administrators and politicians at the district level (Jacobsen, 1999) and that there is a “strong sense of distrust between the citizens and their local leaders, and between the councillors and local staff” (Braathen *et al.*, 2005:12). This chapter, therefore, investigates the impact of decentralization reforms on cooperation and trust at the village level in Tanzania using a gender lens. The chapter addresses the questions: how does trust between local leaders and citizens affect decision-making processes and provision of water and health services, and to what extent have decentralization reforms increased cooperation and trust at the village level?

The central concepts in this chapter are decentralization, cooperation and trust, which are all gendered processes. Decentralization is defined as “the transfer of power and responsibility to plan, make decisions and manage public functions from a higher level of government to a lower one” (Conyers, 1990:19). In simple terms, cooperation relates to the notion of ‘mutual help’ which can be seen as collective action that aims at satisfying collective goals or meeting individual needs through pooling resources (Msonganzila, 2013). According to Meinzen-Dick *et al.* (2004), collective action entails involvement of a group of people in pursuit of a perceived shared interest within the group. In this chapter, cooperation is identical to collective action and the two concepts are used synonymously. Trust refers to “a mental status of favourable expectations” (Breeman, 2006:20). In other words, a person exhibits trust

if he/she believes that another actor (a person, group or institution) is willing and able to act in the interest of this person, even if there is no possibility to monitor the other actor's intentions or actions (Jacobsen, 1999). The remainder of the chapter is organised as follows. The next section presents the theoretical links between decentralization, cooperation and trust, viewing them from a gender perspective. We then describe how we have measured the key concepts and the methodology used in the study. Subsequently, we present and discuss the empirical findings and highlight the main conclusions of the study.

7.2 Decentralization, cooperation, trust and gender: A theoretical framework

The literature shows two opposite lines of arguments regarding the linkages between decentralization, cooperation and trust. Some scholars see cooperation and trust as prerequisites for decentralization while others view them as outcomes of decentralization. The first view posits that for participation and accountability to work effectively, a certain degree of cooperation and trust among the actors is required (World Bank, 1997; Ribot, 2002; Cleaver, 2005; Essau, 2008). In this, cooperation and trust are seen as indicators for meaningful decentralization (Fisher, 1999), because they foster collective action, participation and people's belief in community-based structures (Evans, 1996; Narayan and Pritchett, 1999; Nombo, 2007; Kuenzi, 2008). It is argued that how citizens interact with their leaders and participate in decision-making processes, depends on their level of trust in local politicians, political institutions and service providers (Jacobsen, 1999; Essau, 2008). The second view treats decentralization as a strategy to empower citizens and build cooperation and trust because it promotes partnership between local leaders and citizens by bringing government officials and services closer to the people (Crook and Manor, 2000; Blind, 2006; Mendoza-Botelho, 2013). The combination of trust, cooperation and collective action is seen as contributing to effective service delivery, the main goal of decentralization reforms (Mendoza-Botelho, 2013). It is argued that the inability of the government to deliver what it should and to act in the interest of the people can contribute to distrust between the citizens and the government (Essau, 2008). Thus, decentralization reforms which are aimed at increasing citizens' participation and improving service delivery may affect cooperation and trust, while cooperation and trust can also shape decentralization outcomes. This study looks at both mechanisms.

In the context of the current reforms in Tanzania, decision-making powers and service delivery functions have been decentralized to three administrative levels: district councils, wards and villages (URT, 2009a). In practice, this has meant the establishment of participation spaces and accountability mechanisms in form of local elections, public meetings, participatory planning processes and other initiatives for promoting transparency and citizens' access to information (Venugopal and Yilmaz, 2010; Masanyiwa *et al.*, 2013). In theory, these mechanisms are vital in promoting synergetic relations between the government and citizens (Evans, 1996), and in increasing citizens' trust in local government institutions, local leaders and service providers (World Bank, 1997; Ribot, 2002). Social capital theory suggests that cooperation and trust, and participation in public activities make it more likely for people to be active citizens and to engage in government institutions (Andersson, 2004;

Cleaver, 2005). Since increased trust between actors can facilitate their cooperation, and such cooperation is necessary for effective outcomes, we see a link between decentralization, cooperation and trust, that we aim to unravel using a gender perspective.

Levi and Stoker (2000) describe trust as a relational concept which involves an individual making herself vulnerable to another individual, group or institution that has the capacity to do her harm or betray her. Essau (2008) sees trust as an element that results in people surrendering their powers to institutions to make decisions on their behalf and to act in their interest. According to her, the liberal democratic model presupposes “a trusting electorate willing to surrender trust and allow the state to deliver on its mandate” and “a vigilant electorate that takes on its roles and responsibilities as citizens through participating in policy-making processes” (Essau, 2008:357). The literature on trust shows two main types: political and social trust. Political trust happens when citizens appraise a government and its institutions and political leaders as promise-keeping, efficient, fair and honest (Blind, 2006). This form of trust is also called ‘institutionalized trust’ since it relates to citizens’ confidence in the formal governance institutions including formal procedures, political and judicial systems (Groenewald, 2012). This distinction, however, can be subtle as sometimes people trust institutions not because of their validity but because they trust the people that represent them (Mendoza-Botelho, 2013). An alternative perspective relates to the notions of ‘linking’ and ‘vertical’ social capital because political trust connects citizens with the key institutions and representatives including service providers (Grootaert *et al.*, 2004:4).

Social trust, which refers to “citizens’ confidence in each other as members of a social community” (Blind, 2006:5), is inseparable from political trust partly because “social resources feed into the political processes” (Beall, 2001:359). Social trust is viewed as an essential ‘lubricant’ for cooperation in all aspects of public life since it reinforces expectations about collective action and reciprocity (Misztal, 2001) and as the ‘glue’ that holds societies together (Molyneux, 2002). Social trust is ‘horizontal’, as embedded in ‘bonding’ social capital (ties with closely related people) and ‘bridging’ social capital (ties with ‘other kind’ of people) (Grootaert *et al.*, 2004; Bezanson, 2006; Patulny and Svendsen, 2007). Sub-categories of social trust are ‘personalized trust’, existing within established relationships and social networks, and ‘generalized trust’, when trust is extended to strangers (Patulny and Svendsen, 2007; Groenewald, 2012). Both political and social trust influence people’s compliance with institutional rules and willingness to contribute to collective arrangements. Lack of trust can generate low accountability, ‘free-riding’ attitudes or create a situation where people refuse to pay taxes and/or to recognise and cooperate with their leaders (Mendoza-Botelho, 2013).

While many social capital studies treat cooperation and trust as gender-neutral concepts (Molyneux, 2002; Bezanson, 2006), in reality social capital is embedded in power relations as part of the wider social structures (Evans, 1996). Molyneux (2002) states that social capital approaches have an implicit tendency to idealize communities and treat them as existing without structured power relations and conflict. Beall (2001) argues that social networks and associational life can be constrained by gender dynamics and the stereotypes underpinning them. Hence, cooperation and trust have to be understood within their cultural and political context in which gender plays an important role (Beall, 2001; Molyneux, 2002; Cleaver, 2005; Bezanson, 2006). Thus, this chapter uses a gender perspe-

ctive in order to understand the role of gender in shaping cooperation and trust among the actors in decentralised institutions and service delivery arrangements. Molyneux (2002) explains that a gender perspective is essential in unravelling the social divisions and power relations at the household and community levels, and whether women deploy their social capital to enhance their leverage over political processes and service delivery arrangements. Since power relations within societies are reflected and reproduced by social relations, including the intra-household and extra-household gender relations (Molyneux, 2002), employing a gender perspective can provide a better understanding on how men and women exercise their agency in these processes.

7.3 Measuring cooperation and trust at village level

Social capital has been described as a 'container concept' with multiple dimensions (Groenewald, 2012). Our focus in this chapter is on the notions of cooperation and trust at the village level, because these dimensions of social capital are crucial in explaining the outcomes of the decentralization reforms, a process that entails political and social transformation (Mendoza-Botelho, 2013). In investigating their effects on decision-making processes and the provision of public services in the context of decentralization, we incorporate a gender perspective.

Cooperation was measured in terms of people's participation in formal and informal collective action activities and membership in groups and social networks in the villages. Social trust was operationalized as the respondents' level of trust in members of the kin and ethnic group, neighbours, friends and strangers (cf. Grootaert *et al.*, 2004). The respondents were also asked about their perceptions on the general level of trust in their villages and whether it had changed over the past ten years. Political trust was assessed in terms of the respondents' trust in local leaders, service providers and local institutions. Instead of asking villagers about their trust in government in general, we focused on specific officials and institutions. Villagers have close contacts with these local authorities. Therefore, their responses reflect concrete experiences rather than abstract principles (cf. Tao *et al.*, 2011). Gender is a cross-cutting theme in this study and was operationalized in terms of the gender division of labour in collective action activities, differences between men and women in group membership and social networks and in their trust in different people and local institutions.

7.4 Methodology

The data used in this chapter derive from a field research carried out between 2011 and 2012 in two rural districts in Tanzania, namely Kondoa and Kongwa. The fieldwork was undertaken in ten purposively selected villages most of which had been involved in construction of water and/or health service infrastructures in recent years as part of the ongoing local government reforms. The survey data were collected from a random sample of 332 households, involving 115 male and 217 female respondents and using a structured questionnaire. The qualitative data were obtained through semi-structured and unstructured interviews with district council officials and village leaders, and eight focus group discussions

with groups of men, women, village water committees and village health committees. Although it was possible to quantify most of the variables, cooperation and trust are essentially qualitative variables. In this way, a mix of survey and qualitative methods helped to capture the respondents' perspectives (Patulny and Svendsen, 2007) and was useful in interpreting the data (Meinzen-Dick *et al.*, 2004).

Qualitative data from the interviews and FGDs were analysed by reading through the field notes and transcripts to identify key themes and patterns relevant to the research questions and concepts (Patton, 2002). Descriptive statistics mainly frequencies and mean scores, and correlations were computed for most of the survey variables. Binary logistic regression was used to identify the determinants of group membership because the dependent variable is dichotomous. Factor analysis using the Principal Component Analysis was performed on 16 trust variables (see Table 7.1) to reduce the multidimensionality of trust and identify the underlying common factors across the variables (cf. Narayan and Cassidy, 2001; Grootaert *et al.* 2004; Field, 2009). Both the Kaiser-Meyer-Okin measure of sampling adequacy (0.858) and Bartlett's test of sphericity ($p=0.00$) confirmed the suitability of the data for Principal Component Analysis (Field, 2009). Based on Kaiser's criterion, four components with eigen-values greater than one were considered as separate factors and variables with factor loadings higher than 0.5 were considered as making up the factors (Field, 2009).

Table 7.1: Rotated component matrix for trust variables

Variable (level of trust in)	Factor loadings*			
	Component 1	Component 2	Component 3	Component 4
People in the kin	0.168		0.742	0.214
Friends and neighbours	0.170	0.175	0.789	-0.212
People in the ethnic group	0.197	0.110	0.814	-0.202
Strangers in the village	0.355	0.101	0.321	-0.495
Hamlet chairperson		0.722	0.191	
Village chairperson	0.189	0.738		
Village executive officer	0.450	0.525		0.234
Ward executive officer	0.698	0.328	0.124	
Ward councillor	0.753	0.126	0.232	-0.158
Health staff in nearest health facility	0.300	0.684		-0.169
Water pump attendant	0.405	0.320	0.302	0.532
Village water committee				0.826
Village council	0.550	0.509	0.186	0.121
Ward development committee	0.779	0.273	0.104	-0.167
District council staff	0.749	0.109	0.107	-0.261
Member of parliament	0.689		0.179	

* Factors loadings higher than 0.05 are shown in bold.

Table 7.1 shows that the first factor (component 1) is strongly loaded with trust in the ward development committee, ward councillor, district council staff and members of parliament. We call this 'higher level political trust'. The second factor (component 2) has high factor loadings for trust in the village chairperson, hamlet chairperson, staff at the

nearest health facility, village executive officer and village council. This factor signifies 'lower level political trust'. The third factor (component 3) is related to trust in people in the kin and ethnic group, friends, and neighbours, was labelled 'personalised trust'. The last factor (component 4) is loaded highly with trust in the water pump attendants and village water committees, and we called it 'institutionalized trust in water service providers'. This categorization conforms to the dimensions of trust discussed earlier. Personalised trust is a form of social trust while the other three categories are forms of political or institutionalized trust (cf. Grootaert *et al.*, 2004; Blind, 2006; Groenewald, 2012). Since political trust is a multi-layered concept, using factor analysis it was differentiated into three categories.

The next step was to find the determinants of both social and political trust. This was done by linear regression analysis with personalized and political trust as the dependent variables. The scores for all variables highly loading on one factor were added to create an index for each of the four factors. Gender related variables such as sex of respondent and household headship, and socio-demographic variables including age, household size, ethnicity, religion and duration of stay in the village, were included in the analysis as independent variables because many have been found to be related to social capital (Kuenzi, 2008). Decision-making process indicators such as attendance in public meetings, participation in preparation of village plans and construction of service infrastructure, and decentralization outcome indicators related to users' satisfaction with water and health services were also included as independent variables. Group membership as a measure of cooperation was another independent variable.

7.5. Results and discussion

7.5.1 Cooperation in collective action activities

People's participation in local development projects through collective action in Tanzanian villages has a long history dating back to the *Ujamaa* villages of the early 1970s and 1980s (Jennings, 2003; Cleaver, 2005; Msonganzila, 2013). The on-going reforms have revitalized collective action by emphasizing community participation in development projects in order to enhance community ownership and sustainability of the service infrastructures (URT, 2009a). Villagers participate in cooperative activities such as repairing roads, construction of schools and dispensaries, and digging boreholes or pipelines. Over three quarters of our respondents (77%) reported they had participated in the construction or rehabilitation of water facilities and 57 percent in health services infrastructures. Most respondents felt that their participation was necessary in order to ensure availability of public services in their villages. Significantly ($p=0.03$) more men than women indicated that 'more than half' of villagers contribute their time and money to common development projects in their villages (Table 7.2). Men had a significantly ($p=0.01$) higher mean score than women, which could be interpreted as 'more than half' while that of women could be interpreted as 'about half', suggesting that women have a lower estimation of cooperative efforts at the local level.

Table 7.2: Perceptions on the proportion of people contributing time and money to common projects by sex (n=330)

Rating	Men	Women	Both	Chi-square value
Less than half	9(8.0)	29(13.4)	35(11.5)	$\chi^2=9.045$ $p=0.029^{**}$
About half	22(19.5)	59(27.2)	81(24.5)	
More than half	71(62.8)	121(55.8)	192(58.2)	
Everyone	11(9.7)	8(3.7)	19(5.8)	
Mean score	3.74	3.50	3.58	

Figures in brackets are percentages. ******Significant at 5% level.

Collective labour activities and contributions are organised at hamlet and village levels, and local leaders are responsible for coordinating these activities with technical inputs from the district council officials. The interviews and FGDs revealed that most people in the villages turn up for these collective action activities. For example, village leaders in Sagara A estimated that about 90 percent of the adults in the village participate in such activities. Women mainly contribute their labour while men mostly contribute in cash. When both men and women contribute their labour, the activities they perform differ according to their gender roles. Village and ward leaders also fine villagers who do not turn up for these activities or fail to contribute otherwise. This means that the ‘right ways’ of participating in collective action may place heavy burdens on some people, especially the poor, in terms of time and financial resources, which reinforces existing power relations of authority within the community (Clever, 2005). This also reveals the normative gender division of labour and the power relations reinforced by cultural norms within households and community. Molyneux (2002) notes that women’s involvement in such cooperative activities can be seen as a natural extension of their responsibilities within the ‘social reproduction domain’ which is taken for granted or assumed cost-free to women.

Mendoza-Botelho (2013) argues that as part of decentralization reforms community participation is not just a formality but a basic condition for local governance. Accordingly, in Tanzania community participation in form of labour, cash or material contributions is a prerequisite for villages to receive district financial and technical support for development projects. This form of collective action is assumed to reduce the costs of development projects, enhance efficiency by mobilizing local resources, and to be sustainable because it is in the collective interest of the people (Molyneux, 2002). Collective action activities are also seen as necessary in ‘linking’ citizens with the government because citizens have particular service needs, and feel that their participation can contribute to improving the situation (Clever, 2005). Despite the importance of local leaders in coordinating collective action (Meinzen-Dick *et al.*, 2004), the outcomes depend on the power and trust relations between the actors, because citizens want to experience the benefits of their participation through improved services (Essau, 2008). Although collective action has the potential to build trust (Evans, 1996; Anderson, 2004; Clever, 2005), it can also erode citizens’ trust in their leaders if the expected benefits are not realized. The case of the village dispensary in the village of Potea where citizens had been involved in the construction and were stopped by the district

council because they had not used the correct guidelines, illustrates this point. In Potea, women FGD participants expressed a high degree of distrust in the local leaders and district officials. *“We gave our labour and money to pay the masons, the leaders promised us that we only needed to construct the walls, and the government [district council] would do the roofing and finishing. We did our part, but the government has done nothing for us all these years”*, said a woman. Men FGD participants added: *“This issue is talked about in every village meeting, but we do not see any solution. Why should we trust them [local leaders and district council officials] while they have failed to solve this problem for more than ten years now?”*

Apart from participating in ‘formal’ collective activities, people also cooperate in informally organised economic and social activities in the community. These include collective labour arrangements in farming, weddings and other festivals, funerals, providing assistance to friends and neighbours in cases of illnesses and borrowing money. People with oxen-drawn ploughs and carts usually hire them out to other villagers for cash or to be paid for after harvest. In all study villages, citizens and leaders stated that people were generally very cooperative towards each other. When asked about the likelihood of men versus women to cooperate to solve common problems in the village, 66 percent of the respondents indicated both men and women, 27 percent said men only and 7 percent women only. The interviews and FGDs, however, revealed that women were generally more ‘cooperative’ than men. It was argued that women spend more time together in activities that are culturally seen as ‘feminine’ such as fetching water, collecting firewood or attending clinics, as opposed to men who are mostly involved in ‘public domain’ activities.

7.5.2 Cooperation through membership in groups and social networks

Membership and participation in groups and social networks are important aspects of collective action because they enhance trust among people who come together to tackle common problems (Narayan and Pritchett, 1999; Cleaver, 2005; Nombo, 2007). The survey findings showed that 39 percent of households belonged to at least one group. Female-headed households (47%) were more likely to be members of groups than male-headed households (37%). The number of groups households participated in ranged from one to seven, and the average was 1.3. Most of the households were members in burial and festival groups (44%), followed by savings and credit cooperative societies (32%) and religious groups (27%). Other groups were related to income generation (13%), political parties (10%), civil society or community based organisations (7%) and traditional dance groups (3%). Comparatively, group membership in the study villages is much lower than the 71 percent reported by Narayan and Pritchett (1999) or the 74 percent observed in Nombo’s (2007) study. However, as others have noted, an individual’s decision to participate in groups entails costs in terms of time and resources to contribute to the group (Molyneux, 2002; Cleaver, 2005), and is linked to the potential benefits that can be derived from it (Nombo, 2007). Thus, the balance of perceived costs and benefits of participating in groups could be barriers for some households. In this study, 34 percent of those who belonged to groups said the groups helped them to get money to pay for water and/or health services.

The findings showed significant ($p=0.00$) differences between the villages on group membership. The highest proportions of group membership were observed in the villages of Manungu (79%), Mlanga (61%) and Sagara A (52%), while Kidoka and Humekwa had the lowest proportions (16%). This implies that the village characteristics could have an influence on group membership and associational life within the village. Cleaver's (2005:901) study in the Usangu basin in Tanzania showed that "the type of associations predominating varied from village to village." In this study, the qualitative data revealed that the high proportion of group membership in some of the villages was partly due to presence of the savings and credit societies (SACCOS) and the village community banks (VICOBA). Both SACCOS and VICOBA are promoted by the district council and other actors to stimulate individual and group savings aimed at achieving the ultimate goal of decentralization reforms, which is poverty reduction.

From a gender perspective, it is important to understand who (within the household) is a member in the groups. The survey revealed that women were significantly more likely to be members than men. In fact, most of the social groups such as burial and festival groups, religious groups and the income generating groups, were basically women groups. Men were mostly involved in political parties and in the purely economic groups like SACCOS and VICOBA whereas women were involved in almost all forms of groups. The regression analysis results (Table 7.3) confirm that household headship is positively and significantly associated with group membership. Through the interviews and FGDs we established that women in the study area are more 'cooperative' among themselves than men and, therefore, more likely to join groups and social networks. A woman village leader in Sagara A said: "We have many women income generating groups in this village. We do not see men joining these groups or establishing their own, except very few who are now members of the village community bank." In Potea, women FGD participants explained that the village had seven exclusively women groups with more than 90 members. Similarly, village leaders in Mulua indicated that most women in the village were members of a number of groups, including the informal rotating credit schemes. This confirms the social capital perspective that sees "women as inherently social" (Cleaver, 2005:894), partly because of their social 'embeddedness' in family and neighbourhood (Molyneux, 2002). The findings reveal women's economic cooperation, although it is unclear whether the intra-household gender relations allow their control over the funds they generate (Molyneux, 2002).

These groups have created opportunities for women to meet and work together to improve their personal and household wellbeing and are also used as informal venues for women to discuss different issues, including the availability of public services in their villages. In this case, they act as informal organisations for mediating collective action and women's participation in the formal village structures. On the one hand, these groups could be a result of the poverty reduction interventions promoted by the district councils as part of decentralization reforms. On the other hand, they could as well result from the barriers women face in participating in the formal decision-making processes, compelling women to resort to informal mechanisms. "That is where we talk about our things which we are not free to discuss in public meetings", said women FGD participants in Potea. Essau (2008) argues that the specific

problems people face in their interactions with the government may contribute to the establishment of networks and associations within communities.

Significantly ($p=0.00$) more of the surveyed households in Kongwa (53%) than in Kondoa (25%) had membership in groups. In addition to the existence of SACCOS and VICOBA interventions in many villages in Kongwa as already shown, other possible reasons could be the high population density in the district and the ethnic and religious homogeneity. About three quarters (74%) of respondents in Kongwa belong to the Gogo ethnic group, and majority of them (96%) is Christian. Kondoa is ethnically and religiously more diverse. This explains why both ethnicity and religion came out as significant explanatory variables for group membership (Table 7.3). Since social groups and networks are built on trust among their participants, it is likely for people of the same ethnic or religious group to undertake collective action together. Kuenzi (2008) found that ethnic identity had a significant impact on membership in voluntary organisations in Nigeria and Ghana. In this study, age does not show a significant relationship with group membership but it has a positive coefficient, suggesting that the possibility of joining groups increases with age. This is not surprising given the way prestige and social responsibilities in the community increase with age (Kuenzi, 2008).

Table 7.3: Determinants of group membership (n=304)

Explanatory variable	B-coefficient	Standard error	p-value
District (1=Kongwa)	1.539	0.350	0.000***
Sex of household head (1=female)	0.843	0.422	0.046**
Age of household head (years)	0.013	0.009	0.162
Household size	0.045	0.057	0.432
Education of household head (1=educated)	-0.397	0.338	0.240
Ethnicity (1=Gogo)	0.639	0.338	0.059*
Religion (1= Christian)	0.809	0.436	0.064*
Occupation (1=farming)	0.112	0.291	0.700
Duration of stay in the village (1=since birth or more than 10 years)	0.252	0.681	0.711
Estimated annual income	0.000	0.000	0.305
Constant	-1.398	0.651	0.032**

Dependent variable: Group membership (1=yes), $-2\log$ Likelihood = 362.124, $\chi^2 = 42.093$, $df = 10$, $p=0.00$. *Significant at 10% level, **Significant at 5% level; ***Significant at 1% level.

7.5.3 Trust at the village level

The results on the levels of trust showed that most respondents, men and women alike, have high levels of trust in their kin, but low trust in strangers and village water committees (Table 7.4). This means that people have higher 'personalised' than 'political' or 'institutionalised trust'. Groenewald (2012:107) found the same in rural Mexico: "Households have higher scores on personalised trust than on generalized and institutionalised trust". As Nombo (2007:155) says, "family relations are important in fostering trust." The low level of trust in

the water committees is presumably due to the problems with the availability of water services and the lack of transparency about the revenues from water user fees. In most villages, village water committees currently are the main local institutions responsible for the management of the day-to-day functioning of water facilities. Respondents blamed them for the poor availability of the services and misappropriating water revenues. Many respondents in the villages where village water committees manage water facilities were dissatisfied with their services: 82 percent in Mulua, followed by Khubunko (47%), Songambe A (46%) and Sagara A (46%). Villages with private water operators and little direct involvement of the water committees (Chamae and Kidoka), reported only 3 percent dissatisfied users.

In theory, the citizens have the mandate to recall committee members but this depends on the responsiveness of the village council to convene a village assembly, the formal forum where villagers can exercise their agency. In Chamae, reportedly a former water committee was dissolved for allegedly misusing water revenues. In many villages, however, such a course of action was not possible because meetings were not regularly held as per policy requirement. Villagers felt that village leaders did not convene the meetings for fear of facing negative reactions and resistance from the villagers, which could threaten their positions. In the village of Songambe A, men FGD participants revealed that three members of the planning and finance committee had resigned because they were suspected of embezzling village funds, but no village assembly had been convened for over half a year to discuss the matter. Such unresolved issues and grievances may have contributed to citizens' low institutionalised trust in the water committees and other village leaders. The World Bank (1997) argues that information exchange and transparency are vital for informed public debate, and for increasing trust and confidence in the government. Consequently, "lack of trust may lead to a situation where true opinions are hidden because of fear of reactions" (Jacobsen, 1999:850).

To see if there were significant differences between men and women on the trust variables, a *t*-test was done. The findings show that men exhibit significantly ($p=0.01$) higher levels of trust in people in their ethnic group than women. Similarly, although not statistically significant, men have higher trust in people in kin, friends and neighbours than women. The low level of 'personalised trust' among women could be a result of living in a patriarchal system that is reinforced through family, marriage and kinship. Nombo (2007) shows that kinship and ethnicity are sites for reproduction and transmission of patriarchal relations in society, which may stifle women's freedom of speech and participation in decision-making. In the study area, where patrilineal kinship prevails, women also have no inheritance rights. Therefore, kinship and ethnicity could be sources of distrust as they reinforce women's subordination. However, women expressed higher levels of 'lower political trust' than men, as their significantly ($p=0.00$) higher trust scores for hamlet and village chairpersons show. Most women attend lower level meetings at hamlet and village levels, and therefore, have more frequent interactions with these lower level leaders. It could be observed that most men speak out in the meetings, while women just attend and listen. Perhaps because of this, men are more likely to be discontented with these leaders, which could lead to distrust. Women had significantly ($p=0.019$) lower trust in water pump attendants than men. Because fetching domestic water is women's work, this could be due to the specific problems women experi-

ence while fetching water, such as irregular opening hours of domestic water points, frequent pump breakdowns, or being unable to pay for the services. Bouckaert and van de Walle (2003) show that the frequency of use of the service and the directness of contact with the service providers has an influence on users' satisfaction and trust in service providers.

Table 7.4: Mean scores for trust levels by sex

Trust variable	Men	Women	Both	t-value	2-tail p-value
People in the kin	2.93	2.87	2.89	1.623	0.106
Friends and neighbours	2.63	2.56	2.58	1.280	0.202
People in the ethnic group	2.70	2.53	2.59	2.808	0.005***
Strangers in the village	2.19	2.15	2.16	0.619	0.536
Hamlet chairperson	2.61	2.78	2.72	-2.905	0.004***
Village chairperson	2.27	2.60	2.48	-4.423	0.000***
Village executive officer	2.30	2.34	2.33	-0.458	0.647
Ward executive officer	2.42	2.39	2.40	0.370	0.711
Ward councillor	2.43	2.40	2.41	0.335	0.738
Health staff in nearest health facility	2.44	2.53	2.50	-1.253	0.215
Water pump attendant	2.63	2.41	2.49	2.370	0.019**
Village water committee	2.11	2.01	2.05	0.963	0.336
Village council	2.29	2.38	2.35	-1.178	0.240
Ward development committee	2.31	2.25	2.27	0.836	0.404
District council staff	2.35	2.32	2.33	0.396	0.692
Member of parliament	2.49	2.43	2.45	0.773	0.440

Significant at 5% level, * Significant at 1% level.

When asked whether the level of trust in their villages had changed over the last ten years, about 70 percent of respondents said it had 'gotten worse', 15 percent indicated that it had 'remained the same' and another 15 percent said it had 'improved'. The views of men and women on this issue showed no significant differences. The main reasons for the decline of trust included the lack of transparency of leaders, unresponsiveness of local leaders and officials, and the poor availability of public services. Many villagers valued their leaders but gave them a low trust rating because they do not see them as 'promise keeping' and responsive. The FGD participants complained about the leaders' unfulfilled promises to improve availability of public services and their failure to hold regular meetings. They stated that many villagers have low trust in the leaders. Men FGD participants in Songambe A cited an example when some discontented villagers had gone to the point of closing the village office for some days to pressurize their leaders to convene a village assembly. "*How can we trust them [leaders] while we have many problems and they seem not to care about them? The last village assembly was held last year and even that one did not end up smoothly*", said men FGD participants. In the villages of Mulua, Kidoka, Humekwa and Sagara A, land related conflicts were also mentioned as causes for the declining level of trust. Although the sources of such conflicts are many and not only related to village leaders, villagers blame their leaders for not being fair and just

in resolving these conflicts, a situation which gives rise to distrust amongst the villagers themselves, and between villagers and leaders. While decentralization reforms aim at enabling citizens to “demand transparency and accountability” from their leaders (URT, 2009a:29), these findings suggest that poor transparency of village leaders contributes to eroding social and political trust.

7.5.4 Determinants of social and political trust

Table 7.5 shows the results of the regression analyses in which the four categories of trust described in section 7.4 are the dependent variables. In the first model, gender is negatively associated with personalised trust implying that women have low personalised trust. This confirms our earlier observation on how gender relations which are experienced and reproduced by the socio-cultural norms, can contribute to women’s low personalised trust. Cleavers (2005:903) observes that women are disadvantaged “through their reliance on patriarchal systems of family, marriage and local government.” Household size turns out to be negatively correlated with personalised trust. It could be that large households entail more domestic responsibilities, especially for women, which limits their time for socializing and thus contributes to low personalised trust. Ethnicity has a significant impact on personalised trust, suggesting that belonging to the largest ethnic group implies high personalised trust. Duration of stay in the village is also a significant factor. Most respondents had been living in the study area since birth (67%) or for than ten years (28%). Hence, they have strong ties with their neighbours and friends. Longer duration of stay in an area provides the opportunity for building social capital through interactions and enables people to develop strong ties and dense networks and to engage in reciprocal relations (Nombo, 2007). Attendance in public meetings is also significantly related to personalised trust, because public meetings provide opportunities for interactions and cooperation among villagers. This is an important finding considering that statutory public meetings at the village level are instrumental for the current reforms to promote people’s participation in decision-making processes and as accountability mechanism. We found that both ‘lower level’ and ‘higher level political trust’ are positively and significantly related to personalised trust. Kuenzi (2008) also found a significant correlation between political and interpersonal trust in Nigeria and Ghana.

The factors related to ‘lower level political trust’ are shown in the second model (Table 7.5). Again, attendance in public meetings is significantly associated with lower level political trust. Apart from being channels for citizens to voice their needs regarding public service delivery and other development issues, the meetings are also used for communicating policies and directives from higher government levels. Almost half (45%) of respondents depended on public meetings as their source of information for district council matters. However, this factor has a negative coefficient meaning that citizens who attend public meetings are more likely to have low political trust, presumably because they have no influence on how decisions are made and whether such decisions are implemented. As expected, users’ satisfaction with water and health services is positively and significantly related to this form of trust. These findings are line with Bouckaert and van de Walle (2003) who show

that the functioning of public services is an important criterion most citizens use to judge the trustworthiness of their leaders.

Table 7.5: Determinants of social and political trust

Explanatory variables	Unstandardized B-coefficients			
	Model 1 (personalised trust)	Model 2 (lower level political trust)	Model 3 (higher level political trust)	Model 4 (trust in water providers)
Sex of respondent (1=female)	-0.303*	0.121	0.184	-0.071
Age of respondent (years)	0.000	-0.006	0.010	0.004
Household size	-0.109***	0.052	0.022	0.026
Household headship (1=female headed)	0.145	0.390	-0.936*	-0.530**
Education of respondent (1=educated)	-0.207	0.242	-0.253	0.060
Ethnicity (1=Gogo)	0.486**	0.312	-0.100	0.718
Religion (1=Christian)	0.286	-0.690	0.451	-0.360
Duration of stay in the village (1= since birth or more than 10 years)	0.817**	0.443	0.157	-0.620*
Membership in groups (1=yes)	0.035	0.149	0.573**	-0.143
Attendance in public meetings (1=yes)	0.913***	-0.858*	0.901	-0.212
Participation in preparation of village plans (1=yes)	-0.099	-0.346	-0.032	0.272*
Participation in water infrastructure (1=yes)	0.039	-0.005	0.296	0.275
Participation in health infrastructure (1=yes)	0.127	-0.045	-0.282	-0.138
Satisfied with water services (1=yes)	0.357*	0.625**	0.160	0.871***
Satisfied with health services (1=yes)	0.089	0.735***	0.275**	0.150
Personalised trust		0.378***	0.449***	0.088
Lower level political trust	0.144***		0.592***	0.064
Higher level political trust	0.129***	0.448***		0.025
Institutionalised trust in water providers	0.102	0.194	0.101	
Constant	5.308***	2.669*	-0.593	2.366***
R ²	0.369	0.501	0.492	0.335
F-value	6.243	10.720	10.325	5.377

*Significant at 10% level, **Significant at 5% level, ***Significant at 1% level.

The third model shows that household headship is negatively associated with 'higher level political trust', possibly because women household heads are rarely involved in higher level decision-making. This means that gender is a one of the barriers to women's participation in decentralized institutions which contributes to low political trust. The positive relationship between group membership and this form of political trust could be a result of the district councils' interventions in promoting the formation of economic groups such as SACCOS, VICOBA and other income generating groups. Ward and district community

development officers in collaboration with local leaders are responsible for mobilizing, registering, training and mentoring these groups. In this case, social capital embodied by membership of groups and social networks contributes to political trust. Users' satisfaction with health services is also related to this type of trust, because provision of health services is seen as the responsibility of the government, in this case the district council. Thus, citizens who are satisfied with health services and live in villages with health facilities, see the government as responsive to their needs, hence have a high degree of trust in ward and district council officials.

The last model in Table 7.5 relates to institutionalised trust in water service providers. Gender is an important explanatory variable as shown by the significantly negative coefficient on household headship, meaning that female-headed households have low institutionalised trust in water providers. This is not surprising because more female headed households (40%) than male-headed households (31%) were dissatisfied with water services. Duration of stay in the village is also significantly and negatively correlated with trust in water providers implying that the longer a respondent has lived in the village, the lower the level of trust in water providers. Half of the respondents reported either 'no improvements' (39%) or 'deterioration' (11%) in the number of improved water sources in their villages. This means that their experience with the new decentralized water providers contributes to eroding trust. Participation in preparation of village plans is also a significant variable, implying that citizens who had participated in this were likely to have more trust in water providers. Again, users' satisfaction with water services is positively associated with trust in water providers, confirming the earlier observations on the same issue.

7.6 Conclusion

It is evident from the findings that decentralization reforms have invigorated 'formal' collective action activities aimed at improving availability of public services at the village level. These collective action arrangements are characterised by principal-agent interactions (Hiskey, 2010) with agents seemingly having more power over their principals than vice versa. This has negative consequences for political trust, especially when the expected benefits of people's involvement in the cooperative efforts are not realized. In some cases, there are also tensions between the local leaders and district council officials (also a principal-agent dynamic). When the central government and district councils do not deliver what they promised as part of the decentralisation reforms, local leaders cannot meet the expectations of their citizens. This causes loss of political trust.

Participation in formal and informal collective activities is influenced by the gender division of labour and the power relations within the household and society. Gender also influences membership in groups and social networks partly because they act as 'informal' venues for women to participate in decision-making processes. Groups and networks are valuable not only because they help women to meet basic needs for their households, but also for the role they play in building social and political trust and public connectedness, especially since women are mostly excluded from the formal political processes. This suggests that

women's mobilization in collective activities is mainly resonating around basic needs provision to meet the practical needs for their households (Molyneux, 2002). When women do participate in political processes their strategic gender needs could be met as well (Moser, 1993). Cleaver (2005), however, cautions that assuming that individuals, and in particular women, can use social networks and participation in informal institutions to move out of their disadvantaged position, can lead to individuals being seen as responsible for their own marginalisation and exclusion from formal processes. This may preclude the efforts to change the socio-cultural constraints limiting effective women's participation in formal structures.

Participation in decision-making processes is related to political trust. The direction of this relationship can be either positive or negative, depending on the nature of the interactions between the actors and its results. This means that decentralization processes are contributing to both building and eroding trust, and this also differs by administrative level and gender. For instance, the findings show that citizen's attendance in public meetings and their involvement in preparation of village plans and construction of water and health service infrastructure are negatively related to lower level political trust. Villagers perceive their leaders as not transparent, accountable and responsive to local needs and are discontented with the outcomes of these decision-making processes. At the higher level, attendance in public meetings is positively associated with 'higher level political trust' because citizens view their participation as an opportunity to interact with higher level leaders and officials, to voice their service delivery needs and to leverage resources from the government. This form of 'linking social capital' is crucial in connecting the villagers with the ward and district council officials, and helps to build political trust especially for men who are actively involved in higher level decision-making. But, it could also decrease women's political trust because they are mostly excluded from such processes.

Decentralization outcomes in terms of improved water and health services have significant effects on political trust at all levels. Citizens judge the ability of their leaders in terms of tangible service delivery outcomes. Poor accessibility of public services is associated with poor leadership and can lead to decreased political trust, especially among women who are the main users of water and health services. This suggests that decentralization reforms could contribute to increasing the level of political trust by improving public services. Our findings, however, show that the availability of water and health services shows considerable variation across villages. Consequently, political trust continues to dwindle, especially in villages where citizens see the government as not meeting their needs for improved water and health services.

Overall, this study has demonstrated that decentralization outcomes such as increased participation in decision-making processes and improved services have influence on social and political trust at the village level where gender relations also play an important role. The study has also empirically shown the two-way interface between trust and decentralization reforms. On the one hand, trust enhances participation in decentralized institutions and decision-making and 'good' decentralization outcomes can generate trust. On the other hand, 'bad' decentralization outcomes decrease trust. This study further reveals that political trust is a multi-layered concept due to the presence of multiple local institutions, local leaders and service providers at different administrative levels. Hence, it is important to consider these

Decision making under the tree

levels in analysing political trust so as to unravel its multi-dimensional character and the impact of gender on political trust at different levels.

Chapter 8

Conclusions and synthesis

8.1 Introduction

This study has investigated the impact of decentralization reforms on service delivery in two rural districts in Tanzania using a gender perspective. Decentralization has been a popular topic in the development policy and governance literature in Tanzania for many years. However, its impact on service delivery has only recently received attention. Many recent empirical studies in Tanzania have mainly focused on the fiscal, administrative and political dimensions of decentralization. Little attention has been paid to the local socio-cultural context in which decentralization is implemented and its impact on service delivery. Consequently, less is known about the process and the impact of the reforms on improving service delivery, and about the enabling and constraining factors for the expected benefits of decentralization at the local level.

The study used the cases of domestic rural water supply and primary healthcare services because of their importance in improving people's welfare, their collective provision, and their limited accessibility in most rural areas in Tanzania. Domestic water supply and primary healthcare services are also among the development interventions intended to meet women's practical gender needs. Although these services are shared by all household members, they are often identified as women's practical gender needs, not only by policy makers, but also by women themselves because the services are critical for women to enable them to assume their domestic responsibilities that almost universally are assigned to them (Moser, 1993; March *et al.*, 1999). Women's participation in planning, decision-making processes and management of these services also contributes to meeting their strategic gender needs by challenging the institutionalised forms of subordination and ensuring equality in local political processes (Moser, 1993).

Therefore, this study, used a gender perspective to examine the process and impact of decentralization reforms at village and household levels where the expected beneficiaries of the reforms live, are expected to participate in the decentralized decision-making structures, and to make use of decentralized public services. Throughout the thesis, however, the study findings are compared with general figures at district and national levels. In this way, the study was positioned within the broader national context, and to draw relevant lessons and conclusions that can be applied to other rural districts in the country.

The main research question in this study was: how does decentralization affect the user-provider interactions and delivery of gender-sensitive public services at the local level in rural areas in Tanzania? Specifically, the study concentrated on four thematic areas. In Chapter 3, the study investigated the institutional arrangements for decentralised public services delivery and the power relations between actors at different levels. In Chapter 4, the study focused on service user's participation in decision-making processes and how it contributes to meeting women's practical and strategic gender needs. Chapters 5 and 6 dealt with the impact of the reforms on access to gender-sensitive water and health services, respectively, for village- and household-level users. In Chapter 7, the study aimed at gaining insight on the impact of the reforms on cooperation and trust at the local level and their effects on decision-making processes and service delivery.

This final chapter presents the overall findings and general conclusions of the study as revealed in the preceding chapters. The chapter is divided in four parts. The second part revisits and discusses the main findings and conclusions by summarizing and reflecting on the answers to the research questions formulated in Chapter 1. This discussion is done in light of the theoretical perspectives and in view of the existing scientific knowledge. The third part provides a general discussion on the theoretical and methodological concerns emerging from the study. The last part offers some policy recommendations and interventions for further research.

8.2 Answering the research questions

8.2.1 Institutional arrangements for decentralized water and health services

Research question 1: *What are the main institutional characteristics of the current decentralization processes with regard to water and health services delivery in rural districts in Tanzania, and what are the factors that constrain the realization of decentralization?*

Chapter 3 addressed this question using principal-agent theory and broader decentralization frameworks. The study found that decentralization reforms have resulted into significant institutional changes in the form of administrative and elected representative structures to facilitate delivery and management of public services at the local level. The reforms have re-structured the district councils and village councils as the higher and lower levels of government, respectively, thereby assigning to these two structures the responsibility for the overall planning and coordination of service delivery functions at district and village levels. In principle, these institutional changes should have brought ‘government and services closer to the people’ (cf. Conyers, 1990; Devas and Grant, 2003; Bergh, 2004; Maharaj and Maharaj, 2004; World Bank, 2004; Ribot *et al.*, 2006). The effectiveness of these structures in realizing their decentralized mandates, however, depends on the central-local relations, their financial and technical capacity, the administrative level at which they function and the type of sector involved. This has implications for either improving or constraining service delivery, and for whether decentralization takes on the form of deconcentration, delegation or devolution, as discussed below.

The legal and institutional framework has devolved powers and responsibilities to district councils (agents) to enact by-laws, raise revenues, prepare development plans and budgets, and recruit their own personnel. This has resulted into increased degree of autonomy and financial resources to district councils. However, the scope and autonomy of district councils to address local service delivery needs is constrained because the central government ministries (principals) still retain significant powers especially with regard to financial and human resources allocation, and in determining priority interventions. Crook (2003:73) refers to this situation as “the politics of central-local relations” which “explains what interests might gain or lose from any set of institutional opportunities, policy initiatives and resource allocation.” In our case, the reforms do not seem to have achieved their aim of abolishing the previous central-local “command relations” (URT, 1998:15) because district councils are still regarded as implementing agents of central government policies and priorities at the expense of local development needs and priorities. Similar problems have been reported in other sub-Saharan African countries (cf. Andrews and Schroeder, 2003; Crook, 2003; Conyers, 2007) and in previous studies in Tanzania (e.g. Kessy and McCourt, 2010; Venugopal and Yilmaz, 2010). While some of the upward controls are justified as part of the balance required between local autonomy and upward accountability (de Visser, 2005; Venugopal and Yilmaz, 2010), there is excessive central government interference in the functioning of local governments. This contradicts the objectives of creating ‘largely autonomous’ local governments as envisioned in the reform policy documents (URT, 1996, 2009a).

The reforms did establish sector-specific service boards and committees with representatives from the users, administrators, local politicians and service providers (public and private) at each administrative level or service delivery point. In the health sector, these include the council health service boards, ward and village health committees, and health facility committees. In the water sector, they include the district water and sanitation teams, and village water committees. This arrangement has provided opportunities for service users to get involved in the management and monitoring of service delivery functions. Hence, theoretically the service committees have the potential to facilitate service users' participation (Mehrotra, 2006) and to promote bottom-up input into development programmes and projects (Manor, 2004; Jayal, 2006). These local institutions can be seen as "consisting of new sets of rules that structure the relationship" between village- and district-level actors (Singh, 2008:929). However, the corresponding central-local relations discussed above and the behaviour of district-level administrators have caused most village level service committees to in fact function more as 'delivery systems'. They implement existing and often centrally designed development projects (Manor, 2004) because they do not have the autonomy to plan and allocate resources.

At the village level, the study revealed the ambiguity about the power relations between village councils and service committees. The village assembly is theoretically the supreme decision-making organ at that level. It has the mandates to elect the village council and other committees, recall or dissolve the committees. There are some cases where water committees have been dissolved by village councils or where the village council decided to spend revenues collected from water user fees on other activities than the operation and maintenance of water sources for which they are meant. This shows that the formal remit of water committees is contributing to reinforcing upward accountability to village councils and higher level authorities but less in ensuring downward accountability to service users (Manor, 2004). Hence, there is confusion about the accountability of village water committees: are they answerable to the village council and other higher level administrative structures, or to service users? In the health sector, there is lack of clarity about the roles and functions of health facility committees and those of village and ward health committees which perform more or less similar functions at the same administrative levels.

An important finding is that the type of the sector plays a role in determining the type of institutional arrangements and the power relations between the actors in the institutions. The health sector has a more elaborate and clearly defined top-down arrangement from the village and health facility level upwards to the centre, whereas the water sector exhibits both top-down and bottom-up models. As a result, village-level service users are more involved in the management of water sources than primary healthcare facilities that are more centrally controlled by higher level agents at district and national levels. The difference can be attributed to the sectoral characteristics, which influence the capacity of actors, principals and agents to organise and assert control over each other (Batley, 2004). Different from water problems, the scope of primary health problems tends to extend beyond a local area. Health interventions are, therefore, more subject to central government involvement especially in setting priorities, financing, and human resource allocation and staffing. The case of the village dispensary in the village of Potea described in Chapter 6, for example, exemplifies the

problems that may arise from delegation of technical responsibilities to villagers who lack the technical expertise.

Viewing these findings in light of the decentralization typology presented in Chapter 1, it can be concluded that decentralization for public services delivery in the study area has been complex, involving devolution of some responsibilities and functions to district- and village-level actors, and retention of some powers by the central government in the form of deconcentration or delegation. This endorses the view point that the three types of decentralization can be implemented simultaneously (Rondinelli and Nellis, 1986; Manor, 1999). For instance, financial and human resource allocation and management exhibit the form of deconcentration because control over ‘implementation decisions’ is decentralized to district councils (Conyers, 2006). In policy, district councils have the power for planning and budgeting, but district plans and budgets have to be approved by central government. At the beginning of the reforms, the central government gave substantial powers to district councils to levy local taxes in addition to central government transfers. In 2003, a number of ‘nuisance taxes’ which were the main sources of district councils’ local revenue were abolished (Lund, 2007; Yoshida, 2008). This means that local tax raising authority was ‘withdrawn’ from district councils, thus creating a degree of accountability to the centre in the form of delegation (Rondinelli and Nellis, 1986; Litvack *et al.*, 1998; de Visser, 2005). Similarly, decentralization of primary healthcare services is more inclined towards deconcentration because the allocation of responsibilities is still “within the hierarchy of central government” (de Visser, 2005:14), although some responsibilities have been delegated to district councils and health facility committees.

The establishment and functioning of service committees especially in the water sector represents a move towards devolution, because they are aimed at strengthening service users’ voice and the relationship between service users and service providers (World Bank, 2004, 2010). The cases documented in Chapter 5 show that decentralization of rural water supply has not only devolved responsibilities to village councils and village water committees, but also externalised operation and maintenance costs to users. Village councils and water committees are in charge of managing water facilities in their villages with technical support from the district water departments. Some villages have contracted private operators to run their water facilities, suggesting that decentralization can also take the form of privatization. There is evidence to show that private operators are doing better in revenue collection for sustaining the operation and maintenance costs than village water committees. Despite the shortcomings highlighted above, these institutional arrangements in the water sector have partly achieved the principle of subsidiarity by bringing service provision closer to the users and devolving or delegating political and administrative powers to lower levels (URT, 1998, 2008a).

8.2.2 Service users’ participation in decision-making processes

Research question 2: *To what extent have decentralization reforms increased women’s opportunities for participation in local decision-making processes with regard to water and health services delivery, and how are women’s gender roles and needs reflected in these processes?*

The relevance of this question stems from both theoretical and policy arguments. Theoretically, decentralization is expected to foster people's participation in local decision-making structures including that of women (cf. Litvack *et al.*, 1998; Manor, 1999; Bryld, 2001; Bergh, 2004; Bardhan and Mookherjee, 2006; Ribot *et al.*, 2006; Lakwo, 2009). Decentralization policy documents in Tanzania view people's participation in planning and decision-making processes as crucial in mediating "the interaction between the LGAs and their citizens" (URT, 2009a:66). Chapter 4 focused on this question using the gender perspective and the principal-agent theory. This study contends that the impact of decentralization on women's participation in local decision-making processes is of great importance, but one that is often overlooked. Many commentators have stressed on the importance of community participation as a means of improving service delivery, but little attention has been paid to what happens within local communities. In Tanzania, as in other sub-Saharan African countries, most studies on gender and decentralization have focused on women's representation in higher level structures (districts and municipalities) but rarely on the lower village levels. This study moves this debate down to the village level.

The study showed that in order to enhance people's participation in decision-making processes, the reforms have created new institutional spaces for participation. These include hamlet and village-level public meetings, consultation meetings during preparation of village annual plans, district full council meetings, collective activities in construction of service infrastructure, and village councils and committees. Citizens are encouraged to participate actively in these spaces, which has increased the overall level of their participation. Attendance in lower level hamlet and village public meetings is high for both men and women. In most villages, however, the frequency of village assemblies is lower than stipulated by policy. Similarly, most villagers have little influence in village meetings because village plans are not consistently used as basis for district plans. It was established that less than half of those who attended public meetings either spoke up in them or felt they had influence in reaching decisions. For women this proportion was only about one third. These observations suggest that although most village public meetings are well attended, many citizens, particularly women, do not participate effectively and only engage in the 'passive' form of participation (cf. Agarwal, 2001, 2010). Despite women's numerical strength in public meetings, substantial male presence limits their voice. Thus, the formal institutional changes brought about by the reforms have not necessarily expanded women's influence in local decision-making processes due to socio-cultural norms and the power imbalance between men and women.

A key feature of the reforms has been the introduction of quota-based representation (known as 'special women seats' in Tanzania), which requires that women should account for at least one quarter of members in all village-level representative bodies. This initiative has contributed to increasing the proportion of women in village decision-making organs. In the study area, women account for about one third of the village councillors and up to 50 percent of members in other village committees. Clearly, without the affirmative action, women could not possibly have been elected to these institutions in such numbers. In fact, women's membership and participation in village committees is a move towards the 'active' form of participation (cf. Agarwal, 2001, 2010). Women committees members had relatively

more 'freedom' to speak up in committee meetings partly because of the small size of the committees. The gender composition of committees differed, with high proportions of women in service related committees such as social welfare, water and health that are traditionally seen as 'feminine'. In committees like those for planning and finance or security, women were less represented because these domains are seen as 'masculine'.

Despite the efforts to increase women's presence in village-level decision-making spaces, still, decision-making processes continue to be visibly male-dominated. Apart from the patriarchal system where women are denied the opportunities by their husbands to vie for local leadership positions, their household responsibilities and the complicated election procedures are also the main obstacles to effective participation for the majority of women. Lack of self-confidence and being less experienced in public affairs also inhibit women's active participation in local structures. In villages with a predominantly Muslim population religion is also a limiting factor, whereas age and ethnicity play a role in almost all the study villages. This implies that decentralized participation has not challenged the locally existing gender power relations, which are reproduced and reinforced through patriarchy and other social structures such as ethnicity and religion. Evidence from other studies shows that most women representatives cannot influence local decision-making because they lack the authority and self-confidence to participate on an equal basis with men (Conyers, 2007), and because of the socio-culturally underpinned subordinate position of women (Maharaj and Maharaj, 2004; Hicks, 2011). This supports the argument that ensuring effective and gender-sensitive participation in local decision-making processes requires more than meeting quantitative targets through affirmative action (Hicks, 2011). It also requires fundamental changes in men's attitudes and in patriarchal institutions (Maharaj and Maharaj, 2004).

Notwithstanding the limitations identified above, it is evident from the findings that the extent and quality of women's participation is gradually improving with increasing female presence in local decision-making structures and other public spaces. Thus, these findings should not be interpreted as if 'all women' were not effectively participating in the local decision-making spaces. In fact, three categories of women can be distinguished in the study area: those who were not participating at all (mainly the youth), those who participated 'passively' by just attending meetings or contributing their labour and money to construction of service infrastructures, and those who were actively involved in village committees and other public spaces. Despite the demanding domestic responsibilities, coupled by the political and social barriers, women in the third category were attempting to address the challenges of the private and public spheres with vitality and could effectively influence decisions in the interests of other women in their villages.

The implications of these results are two-fold. On the one hand, the findings signify increased women's participation in local decision-making structures as exemplified by the cases of successful women leaders. The current reforms have contributed to these improvements by generating new public spaces for interaction, negotiation and contestation between citizens and local leaders, and through the quota system for women. On the other hand, they indicate that the majority of women participate 'passively' and that they rely on the efforts and 'voice' of few women leaders. Hence, much still needs to be done to bring more women

into the public arena of local politics and to make local decision-making processes gender-sensitive.

The second part of the research question addresses the issue of whether women's participation in local structures has enabled them to articulate both their practical and strategic gender needs and perhaps even to translate them into locally relevant policy outcomes. In other words, the question is 'how' do they participate in these structures and whether their participation can be considered effective in addressing their gender needs. Women's opportunities to influence decision making in local structures depends on how and whether they represent women's interests, whether they can raise their voices and, when they do, whether they are listened to (Cornwall, 2003). Moser's (1993) framework of practical and strategic gender needs was used to investigate this because it "differentiate(s) between ways of reasoning about gender relations" (Molyneux, 1998:232). The study also looked at the gender division of labour and gender roles by examining the convenience of public meetings to women in order to explain how women's 'triple roles' in the reproductive, productive and community management domains were reflected in these processes (Moser, 1993; March *et al.*, 1999).

It was found that women's reproductive gender roles are considered in organising village public meetings especially regarding their timing. Gender roles and needs are also reflected in what men and women talk about in the meetings, and in reaching decisions that have direct implications for women's lives. In the meetings, women mainly talked about basic services such as water, health or education, which are seen as belonging to the women's domain or as an extension of their reproductive roles (March *et al.*, 1999). Women's participation in consultation processes during the preparation of village plans and in the construction of service infrastructures, also contributed to meeting their practical gender needs. Membership in village councils and committees, holding leadership positions in the committees, and ability to speak up and influence decisions in meetings were the most 'effective' and 'interactive' forms of participation that enabled women to address both the practical and strategic gender needs. However, few women and mostly leaders were able to achieve these higher levels of participation. Thus, women's participation in the available spaces did play a positive role in addressing a range of practical gender needs, but that their impact on the strategic gender needs was less remarkable.

The study revealed that the reforms have put emphasis on creating formal structures but have done little about transforming the informal socio-cultural norms that influence the intra- and extra-household gender relations. In most cases, the village level is used as focal point for mobilising and organising people's participation in planning, decision making and service delivery. Seemingly, village communities have been treated as homogeneous entities in which men and women participate on an equal basis. The existing differences in power relations and interests based on gender, age, ethnicity and religion have been taken for granted. For instance, it was found that most youth do not participate in the available public spaces and when they do, they have little influence. Similarly, most women used their social networks and groups as informal mechanisms to discuss different issues including the availability of public services in their villages, perhaps because they were excluded from or could not participate effectively in the formal structures. While some of these constraints are

beyond the scope of the reforms, the reforms have not adequately taken them into account. The current reforms have tended to ignore these problems instead of identifying how they can be tackled within the current political and administrative frameworks at the village level.

8.2.3 Impact of decentralization reforms on water and health services delivery

Research question 3: *To what extent has the delivery of gender-sensitive water and health services to rural households been improved, after the decentralization reforms?*

Chapters 5 and 6 focused on this research question. Although partly overlapping, Chapter 5 used a users' and a gender perspective, and Chapter 6 adopted a gendered users' perspective. With regard to both types of services, particular attention was paid to women users because of their disadvantaged position and their specific water and health needs compared to those of men. This was not intended to marginalize men's water and health needs, but to show the similarities and differences in the views and interests of men and women users in the local context.

The major finding of this study is that the effects of the reforms on the services are mixed. Access to the services has improved for some users but has also led to marginalization of other users. In the water sector, the reforms have contributed to increasing the number of improved water sources, thus raising the proportion of households with access to improved domestic water sources. Although water supply coverage in both districts is still below the national average of 58 percent, about half of the households in the study area (48%) have access to improved domestic water sources within 1km in the dry season. Similarly, the number of dispensaries and health centres has increased. Currently, close to two thirds (62%) of households in the study area live within 5km from the nearest health facility, although this is still below the national average of 90 percent. The proportions of professionally assisted deliveries and family planning users have also increased. Most users acknowledged 'some improvements' in the availability of water and health services over the past ten years, but more users (68%) were satisfied with water services than with health services (59%), perhaps because there were more tangible changes in the former than in the latter. Since there are no non-state service providers of domestic water and primary health services in the study villages and given the recent and on-going government interventions to construct service infrastructure, these improvements can be largely attributed to the decentralization reforms.

Men and women had similar views on the perceived improvements, and on the appropriateness for women of the water and health services on most aspects. In the water sector, both men and women held similar opinions with regard to the perceived changes in the number of improved water sources, reduced distance to sources, and on the time spent to fetch domestic water. In the health sector, a similar pattern was observed with regard to users' perceived changes in the quality of health services and on a number of aspects about the appropriateness for women of the services offered in the nearest health facility. However, the level of satisfaction differed significantly between men and women. More women users than men were dissatisfied with both services, presumably because women made frequent use of these services due to their specific health needs and because they are the main care takers of

the sick and providers of water in their households. These similarities and differences result from men's and women's day-to-day interaction and experience with the services as managers, providers and users. Therefore, they could be used as an entry point for policy makers and planners in making water and health services actually 'gender-sensitive' to the needs of both men and women. Our findings corroborate the observation by Bouckaert and van de Walle (2003) that frequency of use, homogeneity or heterogeneity of the service and directness of contact with the service have influence on users' satisfaction.

Decentralization in both sectors has also involved the introduction of user fees to complement government financing in order to improve the quality and sustainability of the services. Most users are willing to pay the fees provided that continuous water supply from improved sources is guaranteed and that the primary healthcare services are 'good'. Significantly more water service users (92%) could afford user fees than primary healthcare service users (71%), partly because health service users incur additional costs like those of transport and medication. In both cases, more female-headed than male-headed households were unable to pay the users fees. This means that user fees can contribute to unequal access to services especially among the poor. Similar findings were reported by other studies on water user fees (e.g. Rakodi, 2000; Cleaver and Hamada, 2010; Sultana and Loftus, 2012) and on cost sharing in health services (e.g. Tolhurst and Nyonator, 2006; Peters *et al.*, 2008). While exemptions are often used as a mechanism to address this problem (WDP, 2004), in the study area they were not effectively implemented. In the health sector for instance, user fees are officially exempted for children under five, pregnant mothers and the elderly, but many of them still ended up paying for drugs, transport and bribes. Many of these costs are beyond the reach of the very poor.

Despite the increased availability of service infrastructures in some villages, the study revealed that these improvements have not been shared equitably by all the expected beneficiaries, because of geographical isolation, socio-economic and gender differences. In some villages, availability of service infrastructure has not improved substantially because district councils cannot support all villages in their jurisdictions with new infrastructures due to limited financial and technical capacity. Chapter 5 showed that over half of water users still travelled more than a kilometre to the nearest water source and spent more than an hour on that activity in the dry season. Chapter 6 revealed that availability of health facilities was even more critical since only two of the ten study villages, and about half of all the villages in the two districts had health facilities. This poses a big challenge particularly for women users, many of whom relied on traditional birth attendants for delivery services or spent many hours in accessing healthcare from distant facilities. This implies that the success of the reforms in improving service delivery depends largely on the financial and technical capacity of district councils. However, as shown in Chapter 3, district councils are highly dependent on central government grants, which are insufficient to meet the high demands for service infrastructure in their jurisdictions.

Gender inequalities in access to water and health services were visible in a number of ways. Chapter 5 shows that in addition to their inability to pay user fees, many female-headed households lived far away from improved water sources and had no means to transport water. In villages where the same water points were used by both domestic users and livestock,

competing priorities over water use between men and women arose. This disadvantaged women in terms of time spent on accessing domestic water and, sometimes, water quality. Chapter 6 reveals that women's reproductive health needs were not sufficiently addressed by the existing health facilities and that gender power relations still played a critical role in meeting their reproductive health needs. This indicates that while decentralization reforms brought the services and their management closer to the people, accessibility is gendered and depends on social dynamics that are underpinned by the gendered power relations at household and community levels. Other socio-cultural variables such as age, religion and ethnicity intersect with gender and may compound women's disadvantaged position in access to water and health services.

Most users regarded the perceived quality of domestic water services (in terms of taste and colour) from the improved sources as good. Complaints were only reported in one village where the borehole was said to be producing salty (hard) water that could hardly be used for drinking or washing. Contrastingly, many users complained about the poor quality of primary health services, citing high user fees, shortage of drugs and other essential facilities, inadequate health staff, long queuing times, lack of attention by health staff, and corruption. Apparently, the reforms put more efforts into building health infrastructure than into improving the quality of services in the existing health facilities. Similar problems were reported more than a decade ago at the beginning of the reforms (cf. Mwisongo *et al.*, 2000). This means that the impact of the reforms on primary health services has been larger on the infrastructure than on 'service delivery' *per se* (Conyers, 2007) including improving the quality of services.

Because of the predominantly top-down relations between the central government and district councils, and the high demand for health facilities in many villages, district councils plan and budget for health infrastructure construction as one of the national priorities. This is also in line with the Primary Health Services Development Programme which requires districts and communities to construct a dispensary in every village and a health centre in every ward (URT, 2007b). However, there were concerns among district council officials and village-level service users that if the quality of services in the existing health facilities is poor, adding more health facilities without matching measures to improve the quality of services could perhaps worsen the situation. Because of limited resources, many respondents preferred to see improvements in the existing facilities before constructing new ones, especially in areas where most people live within five kilometres from the nearest facilities.

8.2.4 Impact of decentralization reforms on cooperation and trust

Research question 4: *How does trust between local leaders and citizens affect decision-making processes and provision of water and health services, and to what extent have the decentralization reforms increased cooperation and trust?*

This question aimed at investigating the two-way interface between cooperation, trust and decentralization reforms. In some of the literature, cooperation and trust are theorised as preconditions for successful decentralization reforms (e.g. World Bank, 1997; Fisher, 1999;

Ribot, 2002; Cleaver, 2005; Essau, 2008), while others see them as outcomes of the reforms (e.g. Crook and Manor, 2000; Blind, 2006; Mendoza-Botelho, 2013). This study looked at both mechanisms and linked them to a gender perspective, because cooperation, trust and decentralization processes operate in a 'gendered' socio-cultural and political context. This question was addressed in Chapter 7.

As the study shows, the reforms have enhanced people's participation in formal and informal cooperative activities by emphasizing local involvement in the construction of service infrastructure and membership of groups and representative bodies. Over three quarters of our respondents (77%) reported to have had participated in the construction of water sources, more than half of them in health infrastructure (57%) and over one third (39%) were members of social and economic groups. These initiatives were aimed at improving the availability and sustainability of public services at village level, and to contribute to poverty reduction which is the ultimate goal of decentralization reforms. Hence, this study revealed a positive link between decentralization and increased cooperative activities, particularly with regard to labour and cash contributions in the construction of service infrastructure, and through people's involvement in the social and economic groups. These participatory initiatives strengthen bonds of trust and reciprocity between society and the state (Mendoza-Botelho, 2013).

Participation in these arrangements was influenced by the culturally constructed gender power relations. Whereas more men than women participated in the construction of service infrastructure, women were significantly more likely to be members of groups than men. This underscores the fact that gender influences the way men and women participate in local cooperative efforts because cooperation takes place in a the socio-cultural context in which gender is an important variable. Gender also intersected with religion and ethnicity to influence cooperation through membership of groups and networks. This finding is congruent with other studies that show how gender constrains social networks and associational life at the community level (e.g. Beall, 2001; Molyneux, 2002; Cleaver, 2005; Bezanson, 2006). This means that the formal local institutional structures aimed at enhancing the participation of both men and women in collective action need to be viewed in the context of the culturally-embedded structures of social interaction, collective action and trust (Groenewald, 2012).

It was found that most respondents, men and women alike, had higher 'personalised' than 'political' or 'institutionalised trust'. Similar findings were reported by Nombo (2007) in Tanzania and by Groenewald (2012) in rural Mexico. Women had significantly lower levels of 'personalised trust' than men, partly because the patriarchal system which is reinforced through kinship and ethnicity obstructs women's associational life in the community. Women also reported lower trust levels in water pump attendants but higher 'lower political trust' than men. Hence, like other forms of social capital (Beall, 2001; Molyneux, 2002; Cleaver, 2005; Bezanson, 2006), this study confirms that trust is also gendered. The majority of respondents (70%) said that the level of trust in their villages had 'worsened' over the past ten years due to lack of transparency of leaders, unresponsiveness of local leaders and officials, and the poor availability of public services. Despite the increased level of citizen's participation in cooperative activities, decentralization was contributing to both building and

eroding trust, depending on the perceived outcomes of these activities. 'Good' perceived outcomes in terms of improved water and health services generated trust and 'bad' outcomes in terms unfulfilled promises, lack of transparency or unresponsiveness of local officials to local needs decreased trust.

The study found that political trust is a multi-layered variable in which citizens judge the trustworthiness of local institutions and political leaders at different administrative levels differently. Using factor analysis, political trust was unbundled into three categories: lower level political trust which was related to institutions and leaders at hamlet and village levels, higher level political trust signifying trust accorded to actors at ward and district levels, and institutionalised trust in village-level water service providers. Participation in decision-making processes was negatively associated with lower level political trust, but positively related to higher level political trust. In theory, citizens' participation in local structures is viewed to "create trust because it identifies and eventually harmonises interests and makes actions predictable" (Bouckaert and van de Walle, 2003:335). According to Mendoza-Botelho (2013:2), "active participation in community associations provides opportunities for citizens to discuss civic affairs, increase their awareness of political issues and argue about whether or not the government is doing everything it should to improve their welfare." Thus, the negative association between participation and lower level political trust observed in this study could imply that lower level leaders and officials have failed to inspire trust among their citizens, especially in villages where the availability of water and primary healthcare services is still poor.

Users' satisfaction with water and health services was positively correlated with social and political trust, suggesting that improved service delivery can contribute to increasing both forms of trust. As Bouckaert and van de Walle (2003:339) write: "Good governance is supposed to be reflected in satisfied and trusting citizens." The fact that many citizens showed low levels of trust in their local leaders and institutions, and that a good proportion were dissatisfied with water and health services suggests that the reforms have not met the expectations of most service users. Therefore, this study yields clear evidence that in order to realize the potentials of decentralization in increasing social and political trust, local leaders and service providers need to be accountable, transparent and responsive to service users' concerns. While this can be seen as of problem of lower level leaders, possibly because of their proximity to citizens, it is also important to note the tensions between village leaders and district council officials. In some cases, the central government and district councils did not deliver what they promised as part of the decentralization reforms. Consequently, village plans were not implemented according to expectation, leading to loss of political trust.

8.3 Theoretical and methodological implications of the research

8.3.1 Theoretical considerations

This study used a combination of governance theory and sociological theory, including an institutional, principal-agent, an actor, and a gender perspective. These theoretical perspectives are interrelated in a number of ways, hence, their combination was useful in advancing

our understanding of both the process and impact of the reforms in a specific political and socio-cultural context. An institutional perspective was used to examine the characteristics of district and village level institutions that are responsible for delivery of water and health services at the local level. This perspective was relevant because decentralization is an 'institutional reform' (Ribot, 2002) designed at the national level to promote citizens or service users' participation in the formal local decision-making structures, and to improve equitable delivery of social services. Consequently, implementation of decentralization reforms entails creating new or restructuring the existing institutional arrangements at the subnational levels (Azfar *et al.*, 2004; Batley, 2004; de Palencia and Pérez-Foguet, 2011). This is exactly what has been happening in Tanzania as revealed in this and previous studies.

However, given the 'micro-level' focus of the study, it was not possible to apply the institutional perspective in its entirety as conceived by its early proponents (e.g. North, 1989; Mitchell and Pigram, 1989). That would have required studying in detail the legislation and regulations, policies and guidelines, administrative structures, economic and financial arrangements, political structures and processes, historical and traditional customs and values, and key participants and actors both at the national and subnational levels (cf. Mitchell and Pigram, 1989; Kimaro and Sundeep, 2007). While some of these aspects were considered in this study, the main focus was on the design and functioning of district and village level institutions. Consequently, the principal-agent theory was used as an analytical framework to investigate these relations between actors at the national, district and village levels, and how this 'agency relationship' was facilitating or constraining the realization of the objectives of decentralization. This enabled us to see decentralization as a dynamic and evolving process in which the central government is shaping the roles of actors at the district and village levels.

In practice, decentralization reforms are implemented within a political and socio-cultural context at the district and sub-district levels. The actors in this process operate within a formal institutional framework created by decentralization and the informal institutions that are part of the local social structure. This 'interface' between the formal institutions and the informal day-to-day 'socially embedded' arrangements influences the behaviour of the different actors in these institutions. Because of this 'embedded' character of the formal and informal processes, this study included an actor orientation with a focus on the users' perspective. This was linked to a gender perspective because gender is an important socio-cultural variable which mediates the power relations between the actors in both the formal and informal structures, with respect to roles, relations and representations of men and women in the public and private spaces (Singh, 2008). Gender can shape both the process and the outcomes of decentralization because societies are 'gendered' in terms of their culture, rules and norms (March *et al.*, 1999). Combining the users' and the gender perspective was particularly useful in investigating the impact of the reforms on participation, on service delivery outcomes, and on cooperation and trust from the viewpoint of men and women. The general users' perspective represents the individual user, but does not reflect the differences between groups of users within their socio-cultural context (van Wijk *et al.*, 1996). The resulting gendered analysis revealed the similarities and differences between men's and women's views on the changes brought about by the reforms.

Overall, the main theoretical contribution of this study is that it puts the gender perspective at the centre, combined with an institutional and an actor's perspective, an interplay that is often overlooked in many decentralization studies. This has helped to position the local arena in a wider perspective taking into account the broader socio-cultural and political structures that influence the process and outcomes of decentralization in a particular context. Linking the principal-agent theory to gender, for example, revealed that decentralization has enabled more men than women to exercise their agency as principals in decision-making processes. The study showed that despite the increased proportion of women in service committees, the outcomes of these decentralized arrangements differed for men and women on a number of aspects. Similarly, the study revealed that cooperation and trust are gendered processes, which affects the functioning and effectiveness of decentralization reforms in a local context.

8.3.2 Methodological reflections

One of the methodological limitations of this study is about the complex relationship between decentralization and improved service delivery which is often questioned in the academic and policy literature. Decentralization has mostly been measured along the political, fiscal and administrative dimensions (cf. Bossert, 1998; Eaton and Schroeder, 2010). While the impact of decentralization on service delivery has been attempted in various sectors, it is probably more developed in the education sector than in others (Eaton and Schroeder, 2010). Some analysts argue that the assumed causal relations are difficult to demonstrate (Ribot, 2002; Conyers, 2007) or that the benefits of decentralized public services do not always materialize (World Bank, 2001). Conyers (2007) suggests that the impact of decentralization on service delivery is more indirect as it affects process factors such as access to local information, locus of decision-making power, resource availability and administrative performance, which in turn affect service delivery. Thus, this study looked at both the process and the outcome indicators of decentralization reforms. It revealed that decentralization indeed had positive effects on a number of process indicators, such as increased access to local information through the bottom-up participatory planning and decision-making processes, localising the power to implement decisions to district and village level actors, and increased availability of resources at the district level. In turn, the changes in these process indicators have contributed to improvements in service delivery outcomes especially with regard to enlarging the service infrastructure. While attributing the observed changes to decentralization reforms remains difficult, by studying the process of the reforms including the local historical and socio-cultural context in which the reforms were implemented, and by soliciting users' views on the perceived changes, it was possible to relate these changes to the reforms.

Measuring the impact of the reforms could also have benefited from a before-after comparison set-up or a longitudinal design. The first requires baseline data, the latter setting up a panel data set. Such panel data would have provided detailed information on the trends at the village and household levels on service users' participation, access to water and health services, and cooperation and trust levels. However, panel data sets are expensive to generate

and take more time than this study had available. While some of the secondary data from national surveys and district reports provided a proxy for the lacking baseline data, most of the data in these reports were aggregated at national or district levels, not at village or household levels. Similarly, such secondary data rarely included a gendered analysis. Thus, this study relied on retrospective data collected by analysing secondary data from village and district officials, retrospective questions to service users and key informants, and documenting case studies and life histories. These methods helped the respondents to recall how the situation was ten years ago as well as at present (cf. de Vaus, 2001). In this way, it was possible to obtain some indication of the extent to which things have changed over the past one decade of implementing the reforms and the factors that have contributed to these changes.

A second concern relates to generalizability of the study findings. Given the extended case study design used in this study, one may question whether evidence from two districts can provide convincing support to demonstrate the impact of decentralization reforms on service delivery. In fact, scientific generalizability or external validity of study findings is a major methodological concern of the case study design (de Vaus, 2001; Yin, 2003; Diefenbach, 2009). To address this issue, de Vaus (2001) suggests that a well-designed case study should study the case 'holistically' and avoid examining just some levels or parts of the case. Accordingly, this study investigated the 'embedded' levels within the districts including villages and households, and the different actors within these levels. The study also collected data from multiple sources of evidence and used different methods to investigate the same phenomenon. This triangulation of data sources and methods helped to make internal and external comparisons, and contributed to validity of research findings (Yin, 2003).

Yin (2003:10) offers another explanation to this limitation arguing that "case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes." The implicit theoretical hypothesis for this study was that decentralization increases service users' participation, service delivery, and trust through cooperation. The study wanted to establish if this hypothesis would actually be confirmed at the village and household levels from the view point of service users, and if confirmed, whether it affects men and women equally. The study findings indeed reveal positive effects in some aspects, but negative effects in others. Similarly, the findings show that in some aspects men and women benefit equally whereas in others they benefit differently. In other words, the findings have helped to expand our 'analytic generalization', but not 'statistical generalization' (Yin, 2003:10). Because the impacts of decentralization are context-specific and the opportunities and challenges for participation and service delivery differ across districts and villages, the lessons learned from this study are, therefore, only applicable to districts and villages that are comparable to the study area. Hence, doing a similar study in other districts and villages would allow for more general conclusions in other contexts.

8.4 Policy implications and future research

The overall conclusion of this study is that decentralization reforms in Tanzania present both opportunities and challenges for increasing people's participation, cooperation and trust,

addressing gender equality issues and improving service delivery at the village and household levels. Contrary to the earlier reforms of the 1970s and 1980s, the current reforms represent a bold and ambitious initiative to transform the local government system and to that end contribute to “accelerated and equitable socio-economic development, public service delivery and poverty reduction across the country” (URT, 2009a:28). The current reforms have the potential to improve the user-provider interactions leading to improved service delivery, but these benefits have not always materialized. In order to realize this potential, this thesis argues that there are quite a number of design and implementation issues that should be improved. This section, therefore, formulates some policy recommendations that require the attention of different actors at the national, district and village levels.

This study has shown that the existing central-local relations limit the autonomy of local governments to exercise their decentralized mandates and to address local service delivery needs in their areas of jurisdiction. This problem has also been reported in previous national reviews (e.g. URT, 2009a), but the situation does not seem to have changed. It is widely accepted that successful decentralization is about local governments being autonomous to make decisions and be accountable for them (de Visser, 2005; de Palencia and Pérez-Foguet, 2011). De Visser (2005) refers to this as the ‘principle of autonomy’ which is critical for ensuring that local governments fully exploit their potential to respond to local service delivery needs. To ensure successful implementation of the reforms in Tanzania, there is a need for policy makers at the national level to redefine the relationship, functions and roles of central and local governments contrary to the current practice where local governments are regarded as subordinate to central government. In particular, the roles and responsibilities of each actor especially in contested issues such as those related to financial resources allocation and management, human resources management and priority setting in developing plans need to be clearly articulated. Giving more autonomy to local governments will mean that district councils have the final decision-making power without interference from central government actors (de Visser, 2005). This will also require inclusion of gender issues in district plans and the use of gender-disaggregated data in the planning, implementation, monitoring and evaluation of development interventions. Similarly, sectoral ministries need to clarify which roles should be decentralized to village-level actors, and which ones to district- or higher-level actors to avoid conflicts between the bottom-up and top-down planning processes, and between actors at different levels.

Within the current decentralization framework in Tanzania, district councils are the main administrative and legislative organs responsible for coordinating the implementation of service delivery functions in their areas. This study revealed a number of institutional problems to be addressed at this level. One of them relates to the conflicting roles and responsibilities of village-level service committees vis-a-vis those of village councils, and the lack of a clear link between village- and district-level service boards and committees. In order to increase the autonomy of village service committees in decision-making and planning processes, and to create a direct link between service users and providers, district councils need to clarify their roles and responsibilities in relation to those of village councils. It would be useful to consider how accountability can be created between service committees and village councils, and with respect to the service users they serve. Providing regular gender-

sensitive training to service committee members focusing on skills and confidence building, role clarification and gender awareness (World Bank, 2010) can help to improve their capacity to manage service delivery functions. Presently, some training is provided to village-level service committees, but such programmes are limited, gender-neutral, and many service committees are not trained yet. In the health sector, there is a need to re-examine the necessity of having a separate committee for each health facility while village and ward health committees already exist and perform more or less similar functions. This issue was also raised in the review by COWI and EPOS (2007), but the practice appears to have not changed. One option would be to explore the possibilities of mainstreaming the roles and functions of dispensary and health centres' committees into village and ward health committees, to avoid having parallel structures at the same administrative level.

The study also identified a number of barriers to effective service users' participation in the planning and decision-making processes at the village level. For example, village assemblies are important participation spaces and accountability mechanisms for the majority of service users, but their frequency in most villages is still low. District councils could improve their current enforcement mechanisms to village leaders to ensure that statutory village meetings are regularly held. Attention should be paid to holding meetings at times and in locations that are convenient for women. The meetings and agenda have to be announced in advance, and they should address village financial issues and other village concerns adequately and transparently. That would improve accountability and trust. Village communities also need to strengthen their capacities to exercise their rights and responsibilities as principals in these fora. Local priorities emerging from village assemblies and consultation meetings should be used as the basis for district plans, to strike a better balance between local and national priorities. As Cooksey and Kikula (2005:28) observe, "currently the balance is tilted upwards." The existing participatory bottom-up planning process is still quite limited in scope and disconnected from district planning and funding mechanisms. Therefore, the issue is not about which issues should be accorded higher priority than others, but finding the right balance between local needs and national priorities.

In order to address the existing gender inequalities in decision-making processes and in access to domestic water supply and primary healthcare services, it is important that women's agency in village decision-making structures should become a central concern of the reforms. Representative structures and other village-level decision-making spaces should become more gender-representative and gender-sensitive. Introducing a quota system for women leaders in village councils and committees like that in rural India (cf. Bryld, 2001; Jayal, 2006; Ban and Rao, 2008; World Bank, 2010) in addition to the current system which addresses women membership only, could increase their effectiveness in these structures. Effective strategies to transform the socio-cultural norms that underlie women's subordinate position should also be explored. This will require more efforts by women themselves, community organisations and government agencies to promote women's empowerment and to remove the socio-cultural barriers constraining women's participation. Presently, there are some initiatives by district councils and NGOs to raise gender awareness at village level, but as yet such efforts have only reached few villages. Formation of economic women groups also contributes to women's economic and political empowerment because these groups are used

as informal institutions for women to meet their practical gender needs, but also gradually are addressing their strategic gender needs. Such efforts need scaling up to reach more villages and households. Gender inequality issues in access to water and health services should be an explicit focus of the reforms. Ensuring that women play a central role in setting priorities and in the management of services will enable them to take control and influence service provision and management, for the well-being of their own households and that of the community.

A common condition of every institutional set-up concerning service delivery would be to respect the right to basic services such as water and primary healthcare for all (de Palencia and Pérez-Foguet, 2011; Sultana and Loftus, 2012). Despite being recognized in policy documents (e.g. URT, 2002, 2003), universal access to basic services is not sufficiently considered in policy implementation including the current reforms. The main focus of the current reforms has been to increase service coverage, while other aspects like quality and equity in access to services remain largely overlooked. Currently, geographical isolation, poverty and gender differences are excluding some users from accessing these services. The central government and district councils must ensure that the delivery of basic services reaches those in need. National policies and plans need to change from an infrastructure to a service delivery approach that includes addressing quality and equity issues. This will also require strengthening the existing user-fee exemption mechanisms. Presently, these mechanisms are not consistently applied, especially by primary health service providers. Similarly, a balance between service users' participation in the management of services and an adequate support from the district councils and higher levels needs to be achieved. Further, the capacity and role of district councils to effectively monitor, regulate service delivery and provide technical support to villages should be strengthened.

Finally, because of the wider and diverse nature of Tanzanian rural districts and villages, further research on the impact of decentralization reforms on service delivery in other districts would help to provide more concrete conclusions and recommendations. One potential area for further research would be to use the gender perspective to investigate the impact of the reforms in districts with high levels of ethnic, religious and cultural diversity on both participation and access to services. This will help to capture the 'interface' between the formal and informal institutions, and the opportunities for and bottlenecks of gender-sensitive service delivery. Similarly, comparisons between urban and rural districts, or between public and private providers in areas where the latter exist would also be useful. Other service sectors which have been decentralized and play a significant role in the livelihoods of rural men and women such as agricultural extension services, could also be studied. Gender-disaggregated data collection at village and household levels accompanied by detailed qualitative case studies can help to provide insights on what is happening at these levels. A number of findings of this study will have relevance for other rural districts and villages and, therefore, can be used as a starting point for further research.

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Appendix 1: Household survey questionnaire

District name Ward name
 Village name Hamlet
 Interviewer's name Date of interview

Part 1: Socio-economic and demographic information

1. Please classify the household members under the following with household head as No. 1 (mark * on the respondent)

No.	Name of household member	Sex 1. Male 2. Female	Age(years)	Marital Status*	Relation to household head**	Highest education level attained***	Occupation****
1							
2							
3							
4							
5							

***Code: Marital status**
 1. Married
 2. Single
 3. Widowed
 4. Separated
 5. Divorced
 6. Not applicable

****Code: Relation to HH head**
 1. Head
 2. Spouse
 3. Son/daughter
 4. Grandson/granddaughter
 5. Father/mother
 6. Father/mother-in-law
 7. Son/daughter-in-law
 8. Sibling
 9. Nephew/niece
 10. Uncle/aunt
 11. Child from another family
 12. Other relative
 13. Other non-relative

*****Code: Education level**
 1. Adult education
 2. Completed primary education
 3. Did not complete primary education
 4. Completed secondary education
 5. Did not complete secondary education
 6. Vocational training
 7. College training
 8. University education
 9. No formal education
 10. Below school age

******Code: Occupation**
 1. Farming
 2. Farming and livestock keeping
 3. Business/trade
 4. Wage employment
 5. Manufacturing (artisan)
 6. Pupil/student
 7. Child
 8. Too old

******Code: Occupation**
 1. Farming
 2. Farming and livestock keeping
 3. Business/trade
 4. Wage employment
 5. Manufacturing (artisan)
 6. Pupil/student
 7. Child
 8. Too old

Decision making under the tree

2. Religion (denomination) of respondent
 1. Catholic
 2. Protestant (specify).....
 3. Muslim
 4. Traditional religion
3. What is your tribe/ethnic group?
4. For how long have you lived in this village?
 1. Since birth
 2. Less than 10 years
 3. More than 10 years
5. What is the major source of income for your household?
 1. Farming
 2. Non-farm activities
 3. Wage employment
 4. Others (specify)
6. If non-farm activities, what type of activities?
 1. Brewing
 2. Food vending
 3. Small scale business (kiosks, selling charcoal, fuel wood)
 4. Artisan (masonry, carpentry, welding, sewing etc)
 5. Causal labour
 6. Others (specify).....
7. What is your estimated income from the above activities?

Major source of income	How often do you earn from this activity?	Amount (Tshs)
	1. Annually/per season 2. Monthly 3. Weekly 4. Daily	
Farming		
Wage employment		
Brewing		
Food vending		
Small scale business		
Artisan		
Causal labour		
Other activities (specify)		

Part 2: Access to water services

8. What is the main source of domestic water for your household during the rainy season?
 1. Traditional unprotected well
 2. Seasonal river/stream/river bed
 3. Charcoal dam
 4. Unprotected spring
 5. Protected spring
 6. Protected well or hand pump
 7. Public standing point or tap
 8. Other source (specify).....
9. How far is this source from your household (..... kilometres)?
10. How long do you spend on a round trip fetching water from this source (..... minutes)?
11. How is domestic water ferried from this source to your household?
 1. Carrying containers on the head
 2. Bicycle
 3. Hand drawn cart
 4. Donkey or ox-drawn cart
 5. Other means (specify).....
12. Do you use the same source of domestic water throughout the year?
 1. Yes
 2. No
13. If no, what is your main source of domestic water in the dry season?
 1. Traditional unprotected well
 2. Seasonal river/stream/river bed
 3. Charcoal dam
 4. Unprotected spring

- 5. Protected spring
- 6. Protected well or hand pump
- 7. Public standing point or tap
- 8. Not applicable
- 14. How far is this source from your household (..... kilometres)?
- 15. How long do you spent on a round trip fetching water from this source (..... minutes)?
- 16. How is domestic water ferried from this source to your household?
 - 1. Carrying containers on the head
 - 2. Bicycle
 - 3. Hand drawn cart
 - 4. Donkey or ox-drawn cart
 - 5. Other means (specify).....
 - 6. Not applicable
- 17. On average, what amount of water for domestic uses does your household fetch per day?
 - 1. Drinking water..... litres
 - 2. Other domestic uses litres
 - 3. Totallitres
- 18. How frequent do different members of your household fetch water for domestic uses?

	Everyday	Almost always	Occasionally	Never at all
Women				
Girls				
Men				
Boys				

- 19. Considering the following aspects, how appropriate is the main source of domestic water to the needs of women and girls?

	Not appropriate	Appropriate	Very appropriate
Location of water source			
Type of water source (technology)			

- 20. Is the main source of domestic water used for other purposes too?
 - 1. Yes
 - 2. No
- 21. If yes, what are the other uses?
 - 1. Watering livestock
 - 2. Gardening or small scale irrigation
 - 3. Brick making
 - 4. Others (specify)
 - 5. Not applicable
- 22. Do you experience any problems due to multiple uses of this water source?
 - 1. Yes
 - 2. No
- 23. If yes, what are they?
- 24. How do you pay for the water services in your village?
 - 1. Flat rates on monthly basis (Tshs..... per month)
 - 2. Flat rates on annual basis/after harvesting season (Tshs..... per annum)
 - 3. Pay as you fetch (Tshs..... per 20-litre bucket of water)
 - 4. Water is provided free of charge
 - 5. Other payment mechanism (explain).....
- 25. Who mostly pays for water services in your household?
 - 1. Husband or older male member of the household
 - 2. Wife or older female member of the household
- 26. Does your household afford to pay for water services?
 - 1. Yes
 - 2. No
- 27. If no, what alternative strategies do you use to get access to domestic water supply?

40. Considering the following aspects, to what extent are the health services provided in this health facility appropriate to the health needs of women?

	Not appropriate	Appropriate	Very appropriate
Antenatal clinic services for pregnant women			
Delivery services			
Postnatal clinic services for lactating mothers			
Family planning services			
Immunization services			
Child health services			
Treatment of common diseases			

41. If you indicated 'not appropriate' on any of the above, please give reasons to support your answer.....

42. How do you pay for health services at this health facility?

1. Pay per visit to the health facility
2. Member of community health fund (CHF)
3. Other payment mechanism (specify).....

43. Do you afford to pay for medical services?

1. Yes
2. No

44. If no, what alternative strategies do you use to get access to medical services.....

45. Over the last ten years, have you or another member of your household been involved in construction or rehabilitation of a dispensary or health centre in your area?

1. Yes
2. No

46. If yes, who was involved and in what ways?

Who (refer to question 1)	How was s/he involved?

47. Considering the following aspects, has the quality of health services in your area improved over the last 10 years?

	Deteriorated	No changes	Somewhat improved	Significantly improved
Drug availability				
Availability of essential facilities at the health facility				
Availability of nurses and doctors				
Trustworthiness of nurses and doctors				
Proximity of health facility				
Quality of buildings at the health facility				
Availability of health related information				

Decision making under the tree

48. If there has been any improvements in health services in your area, to which institutions do you attribute these changes?

- | | |
|--|---------------------------|
| 1. District council | 2. Central government |
| 3. Tanzania Social Action Fund (TASAF) | 4. Community initiatives |
| 5. NGOs (mention) | 6. Others (specify) |
| 7. No improvement | |

49. What problems do you encounter when accessing health services from the nearest health facility?

- | | |
|---|--------------------------------------|
| 1. Lack of drugs | 2. Lack of essential facilities |
| 3. Services are too expensive (unable to pay) doctors | 4. Lack of attention from nurses and |
| 5. Long waiting times before getting services | 6. Absent doctors/nurses |
| 7. Lack female health providers | 8. Demand for illegal payments |
| 9. Other problems (mention)..... | |

50. Overall, how satisfied are you with health services in this village?

- | | | |
|-------------------------|-----------------------|-------------------|
| 1. Not satisfied at all | 2. Somewhat satisfied | 3. Very satisfied |
|-------------------------|-----------------------|-------------------|

51. If not satisfied, why?

Part 4: Participation in decision-making processes

52. Are you or another member of your household a member of any village or ward committee?

- | | |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

53. If yes, who is a member and in which committee?

Who (refer to question 1)	Which committee does s/he belong to?

54. Over the last one year, have you or other members of your household ever attended any hamlet, village, ward or district council meeting?

- | | |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

55. If yes, which meetings and who attended?

Type of meeting	Who attended the meeting (refer to question 1)?
Kitongoji meetings	
Village assembly	
Village committee meetings	
Full council meetings	
Other meeting (mention)	

56. If you have ever attended any of the above meetings, did you speak up at the meeting?

- | | | |
|--------|-------|-------------------|
| 1. Yes | 2. No | 3. Not applicable |
|--------|-------|-------------------|

57. If you have not attended any of the above meetings, why?.....

58. How much influence do you feel you have in making decisions in such meetings?

1. No influence
2. Influence over some decisions
3. Influence over most decisions

59. If you feel you have no influence, why?.....
60. How do you rate the involvement of women in decision-making organs in this village?
1. Very few women are involved
 2. Many women are involved
 3. Most women are involved
61. To what extent do women in this village express themselves in public meetings?
1. Very few women speak out
 2. Many women speak out
 3. Most women speak out
62. If the answer is (1), why?

63. Considering the following aspects, how convenient are public meetings to women in this village?

	Not convenient	Convenient	Very convenient
Time of meetings			
Place (venue)			
Language used			

64. In your opinion, what are the barriers hindering women’s active involvement in decision-making organs in this village?
65. What is your main source of information for district council matters?
1. Public meetings
 2. Kitongoji and village leaders
 3. Announcements on public notice boards (specify).....
 4. Local radio station
 5. Leaflets and posters
 6. Others (specify).....
66. Over the last one year, have you seen any of the following information posted in a public place such as village, ward or district council offices?

	Yes	No
Village financial reports		
Taxes and fees collected in your village		
District council budgets		
District council audited financial reports		
Financial allocations to key service sectors		

67. If yes to any of the above items, were they written in a format that you could easily understand?
1. Yes
 2. No
 3. I didn’t read
 4. Not applicable
68. Have you ever seen a suggestion box at your village or ward office?
1. Yes
 2. No
69. If yes, have you ever used it to raise your concerns to village or ward leaders?
1. Yes
 2. No
 3. Not applicable
70. If no, why?.....
-
71. Have you or other members of your household been involved in preparation of a village development plan?
1. Yes
 2. No
72. If yes, who was involved? (refer to question 1)
-

Decision making under the tree

73. If yes, please tell me the development projects that were identified as priorities for your village.....

74. Were the identified development projects implemented as priotized by villagers?

1. Yes 2. No

75. If no, why do you think they were not implemented as planned?

76. In your opinion, what are the three most important social services that should addressed in this village? 1..... 2. 3.

Part 5: Trust and cooperation

77. Are you aware of the existence of any groups or associations in this village?

1. Yes 2. No

78. If yes, are you or another member of your household a member of any group(s) in your village?

1. Yes 2. No

79. If yes, which group and who is a member?

Group	Who (refer to question 1)
Religious group	
Income generating or production group	
Savings and credit cooperative society	
Burial or festival group	
CBO or civic group	
Political party	
Others (mention)	

80. Does this group or association help you to get access to any of the following services?

	Yes	No
Domestic water supply		
Health services		
Money to pay for water or health services		
Information on village development projects		
Information on district council matters		

81. To what extent do you trust the following people?

	Not at all	To a small extent	Neither small nor great extent	To a great extent
People in your kin				
Friends and neighbours				
People from your ethnic group/tribe				
Strangers in the village				

82. To what extent do you trust the following leaders and institutions?

	Not at all	To a small extent	Neither small nor great extent	To a great extent
Hamlet (kitongoji) chairperson				
Village chairperson				
Village executive officer				
Ward executive officer				
Elected ward councillor				
Special seats' councillor				
Nurses and doctors at the nearest dispensary or health centre				
Water pump attendant				
Village water committee				
Village council				
Ward development committee				
District council staff				
Member of Parliament				

83. If you indicated 'not at all' or 'to a small extent' to any of the above leaders or institutions, please explain.....

84. Generally speaking, to what extent do people in this village trust each other?

1. Most women trust each other
2. Most men trust each other
3. Most women and men trust each other equally
4. Few women trust each other
5. Few men trust each other
6. Few men and women trust each other

85. To what extent do you think the level of trust in this village has changed over the last ten years?

1. Gotten worse
2. Remained the same
3. Improved

86. If it has gotten worse, why?.....

87. If it has improved, why?

88. What proportion of people in this village contributes time or money towards common development projects?

1. Everyone
2. More than half
3. About half
4. Less than half
5. No one

89. If there is a water supply problem in this village, who are most likely to cooperate to solve the problem?

1. Men
2. Women
3. Men and women equally

Thanks for Your Cooperation!

Appendix 2: Interview checklist for village leaders

1. What have been the major improvements in water and health services over the last ten years in this village? What factors have contributed to these changes? How have different community groups been involved in improving these services?
2. How often does the village prepare development plans? Who participates in preparing them and how, and who facilitates the process? To what extent are village plans integrated in district plans? To what extent does the village have discretion over its plans and financial resources?
3. How do people pay for water services in this village? Who sets the tariffs, which criteria are used, and who is responsible collecting and managing water funds? Are there any groups exempted from paying water tariffs?
4. How often are public village meetings held? How are they organised (time of the day, venue and language)? Between men and women, who mostly attends, who speaks; and why? How are villagers informed about an upcoming meeting?
5. To what extent are women involved in decision making organs in this village? Which committees have women as members and/or as leaders? Do women speak up in village meetings, on what matters, and do they have influence in reaching decisions? Have there been changes in the proportion of women in decision-making organs over the past ten years? What has contributed to these changes?
6. Are village financial reports presented in village assembly meetings or public notice boards, and how often?
7. To what extent do you think the level of trust in this village has changed over the last ten years, and what could be the causes? Is there a difference on the level of cooperation and trust between men and women in this village?

Appendix 3: FGD checklist for village water committees

- 1) Membership in village water committees
 - When was this committee elected? What is its composition?
 - What are the qualifications to become a member of VWC?
 - What is the proportion of young men and women in the VWC? Why are there few young men and women in the committee?
 - How does age influence relationships and decision making among VWC members?
- 2) Responsibilities of the committee
 - What are the main responsibilities of the VWC?
 - Has the committee been trained on its roles and responsibilities? Who facilitated the training, how long did it take, and what were the main topics covered?
 - Do both men and women in the VWC perform the same responsibilities or is there division of responsibilities? If so, who does what and why?
 - How do women rate their involvement in the VWC?
- 3) Decision making in the VWC
 - How often do women in the VWC attend meetings? How often do they speak up, and do they have influence in decision making?
 - How has the presence of women in VWC helped to improve water services? How has they helped to address women's water needs?
 - What barriers are constraining women's active involvement in VWC?
- 4) Patriarch system
 - How do you explain patriarch system? What are the examples of patriarch system?
 - What are factors contributing to the existence of patriarch system? How do religion and ethnicity contribute to patriarch system?
 - Is the system changing or not and in what ways? What factors are contributing to the change?
- 5) Payment and management of water funds
 - How do people pay for water services in this village?
 - Who sets the tariffs, which criteria are used, and who collects?
 - Are there any households failing to pay, what proportion?
 - Are there any groups that exempted from paying water tariffs?
 - Do you have an active water fund account? How is the money spent? And who decides?
- 6) What are the main challenges this village is facing in accessing water services?

Appendix 4: FGD checklist for village health committees

- 1) Membership in village health committees
 - When was this committee elected? What is its composition?
 - What are the qualifications to become a member of VHC?
 - Why religious leaders in the VHC?
 - What is the proportion of young men and women in the VHC? Why are there few young men and women in the committee?
 - How does age influence relationships and decision making among VWC members?
- 2) Responsibilities of the committee
 - What are the main responsibilities of the VHC?
 - Has the committee been trained on its roles and responsibilities? Who facilitated the training, how long did it take, and what were the main topics covered?
 - Do both men and women in the VHC perform the same responsibilities or is there division of responsibilities? If so, who does what and why?
 - How do women rate their involvement in the VHC?
- 3) Decision making in VHC
 - How often do women in VHC attend meetings? How often do they speak up, and do they have influence in decision making?
 - How has the presence of women in VHC helped to improve health services? How has they helped to address women's health needs?
 - What barriers are constraining women's active involvement in VHC?
- 4) Patriarch system
 - How do you explain patriarch system? What are the examples of patriarch system?
 - What are the factors contributing to the existence of patriarch system? How do religion and ethnicity contribute to patriarch system?
 - Is the system changing or not and in what ways? What factors are contributing to the change?
- 5) Payment mechanisms for health services
 - How do people pay for health services in this village?
 - Are there any households failing to pay, what proportion and what alternative health services do they use?
 - Are there any groups that exempted from paying health tariffs?
- 6) Family planning
 - Where do community members get family planning services, and how easily are they accessible?
 - Do men and women use family planning services?
 - Which methods are commonly used by men, and why?
 - Which methods are commonly used by women, and why?
 - Is family planning a private or public issue? Who decides on whether to use or not use FPM?
- 7) What are the main challenges this village is facing in accessing health services?

Appendix 5: FGD checklist for men and women groups

- 1) Improvements in access to water services
 - What have been the important improvements in access to water (availability, affordability, quality) in this area over the past ten years?
 - What factors have contributed to these changes?
 - Who has been involved and in what ways?
 - To what extent are community water priorities reflected in district plans?
- 2) Payment mechanisms for water services
 - How do people pay for water services in this village?
 - Who sets the tariffs, which criteria are used, and who collects?
 - Are there any households failing to pay, what proportion?
 - Are there any groups that exempted from paying water tariffs?
 - How is the money spent, who decides, and are you satisfied with water funds expenditures?
- 3) Appropriateness of water services to women needs
 - How appropriate are water services to the needs of women in terms of their location, time of opening and closing domestic points, type of source technology?
- 4) Improvements in access to health services
 - What have been the important improvements in access to health services (availability, affordability, quality) in this area over the past ten years?
 - What factors have contributed to these changes?
 - Who has been involved and in what ways?
 - To what extent are community health priorities reflected in district plans?
- 5) Payment mechanisms for health services
 - How do people pay for health services in this village?
 - Are there any households failing to pay, what proportion and what alternative health services do they use?
 - Are there any groups that exempted from paying health tariffs?
- 6) Family planning
 - Where do you get family planning services, and how easily are they accessible?
 - Do men and women use family planning services?
 - Which methods are commonly used by men, and why?
 - Which methods are commonly used by women, and why?
 - Is family planning a private or public issue? Who decides on whether to use or not use FPM?
- 7) What are the main challenges this village is facing in accessing water and health services?
- 8) Cooperation and trust relations in the community
 - To what extent do people in this village cooperate and trust each other? Are there differences on the level of cooperation and trust between men and women and if so, why?
 - To what extent to people cooperate with and trust their leaders such as kitongoji and village chairpersons, village executive officer, ward executive officer, councillor and member of parliament? Are there differences on the level of trust accorded to each of these leaders, and if so why?
 - Has the level of trust in this village improved or deteriorated over the last ten years, and why?

Summary

In recent decades, decentralization has been upheld by governments, donors and policy makers in many developing countries as a means of improving people's participation and public services delivery. In 1996, the government of Tanzania embarked on major local government reforms reflecting the global trends and as part of the wider public sector reforms. The reforms aim at improving the access, quality and equitable delivery of public services through a policy of 'decentralization by devolution'. Since then, many studies have examined the fiscal, administrative, legal and political aspects of the reforms. However, the gender dimensions of both the process and outcomes of the reforms have been less examined. In Tanzania, like in other sub-Saharan African countries, little is documented about decentralization and gender, especially at the village level. This study, therefore, examines the impact of decentralization reforms on service delivery in rural Tanzania using a gender perspective. The study addresses the question of how decentralization affects the user-provider interactions and gender-sensitivity of water and health services in the rural villages. Specifically, it focuses on the institutional characteristics for decentralized service delivery, the impact of the reforms on service users' participation in decision-making processes, on access to gender-sensitive water and health services, and on cooperation and trust at the village level.

To investigate this, the study draws on governance theory and sociological theory, including an institutional, principal-agent, an actor and a gender perspective. In this study, gender is seen as a cross-cutting perspective taking in account the wider socio-cultural and political structures that influence the process and outcomes of decentralization in a specific context. The study is based on quantitative and qualitative data obtained at district, village and household levels in the districts of Kondoa and Kongwa in the Dodoma Region in Tanzania. The fieldwork consisted of three overlapping phases: an exploratory phase, household survey and in-depth qualitative study. Mixed data collection methods were used because they enrich our understanding of the topic and contribute to the validity and reliability of findings. A household survey was used to collect quantitative data, whereas semi-structured and unstructured interviews, focus group discussions, observations, case studies and life histories were used to collect qualitative data. Overall, 513 respondents (236 men and 277 women) were involved in the study: 332 in the survey (115 men and 227 women), 69 in the focus group discussions (44 men and 25 women), 107 in the interviews (77 men and 30 women) and five women in life histories. In addition, review and analysis of available data at district and village levels provided secondary data to complement the primary data.

The study found that the reforms have resulted in a number of institutional changes by restructuring the district and village councils, and by establishing service boards and committees at each administrative level or service delivery point. These changes have increased local governments' autonomy to plan and implement service delivery functions, and service users' participation in planning and managing public services. However, the existing central-local relations limit local governments' autonomy to fully exercise their decentralized mandates and to address local service delivery needs. Local governments have limited

financial and technical capacity, and the central government controls their functions through intergovernmental transfers, guidelines and national priorities. At the village level, conflicting roles and responsibilities of village councils and service committees limit the latter to function effectively. Thus, decentralized service delivery in Tanzania takes on different forms where the nature of sector is an important factor in the kind of institutional arrangements.

It was revealed that decentralization reforms have created spaces for service users' participation in planning and decision-making processes. Men and women participate in these spaces through attending meetings, contributing labour, cash or both, in construction of service infrastructures, membership in committees, speaking up and influencing decisions in meetings. The majority of women participate passively by attending meetings, consultation or through activity-specific spaces. Although the proportion of women in village councils and committees has increased because of the quota-based representation, local decision-making processes continue to be largely male dominated. Women's participation contributes to meeting practical gender needs, but to a lesser extent addresses their strategic gender needs because of the gendered power relations which have been largely untouched by the reforms. The main constraints to effective women's participation include patriarchy, household responsibilities, complicated election procedures, lack of self-confidence and less experience in public affairs. Gender also intersects with religion, ethnicity, age and marital status, and may compound women's disadvantaged position in local decision-making structures. While decentralization is expected to address gender inequalities, instead it reproduces them, because it does not address the socio-cultural barriers that inhibit women's effective participation in local structures.

The study shows that the impact of reforms on water and health services delivery is mixed. Access to the services has improved for some users but decentralization has also led to marginalization of other users. The number of water and health services infrastructure has increased, thereby raising the service coverage. However, there is still inadequate infrastructure to provide full service coverage, and the situation is more critical in the health sector because most villages do not have their own health facilities. Despite improvements in coverage, less has been achieved in other respects, such as adequate staffing and availability of drugs and other essential supplies. Comparatively, more users are satisfied with water services than with health services. For both services, there are overlaps and differences between the users' and the gender perspectives. Men and women hold similar opinions on some aspects, but there are also marked differences. This confirms the fact that men and women are actually different users because they have different needs, and are positioned differently regarding their access to basic services. Understanding these similarities and differences is, thus, an important step in making basic services 'gender-sensitive'.

It was shown that the reforms have strengthened formal cooperation aimed at improving public services and the informal mechanisms of social networks and groups. Decentralization outcomes in terms of increased citizen's participation in decision-making processes and improved services influence political trust, and also here gender relations proved to play an important role. There is a two-way interface between trust and decentralization reforms: trust enhances participation in local institutions and 'good' decentralization outcomes can generate trust. Conversely, 'bad' decentralization outcomes decrease trust. The

study further revealed that political trust is a multi-layered concept where citizens judge local leaders and service providers at different administrative levels differently. These levels are crucial in analysing political trust and the impact of gender on political trust at different levels.

The general conclusion of this study is that the current decentralization reforms in Tanzania present both opportunities and challenges for increasing service users' participation, cooperation and trust, addressing gender equality issues and, for improving service delivery. In order to improve the user-provider interactions and service delivery, a number of design and implementation issues should be addressed. At the national level, policy makers need to address the existing imbalance in central-local relations by redefining the relationship, functions and roles of central and local governments. District councils need to clarify the roles and responsibilities of service committees in relation to those of village councils, provide regular gender-sensitive training to service committees, and integrate local needs into district plans. Village leaders should consider holding meetings at times and in locations that are convenient for women, announce meetings and agenda in advance, and address village concerns adequately and transparently in the meetings. Actors at all levels need to explore effective strategies for transforming the socio-cultural norms that underlie women's subordinate position in decision-making processes, and in their access to basic services.

Samenvatting

In de afgelopen decennia hebben overheden, donoren en beleidsmakers in ontwikkelingslanden decentralisatie gezien als een middel bij uitstek om de participatie van mensen in ontwikkelingsprocessen en in algemene dienstverlening te vergroten. Deze trend volgende, begon de regering van Tanzania in 1996 met een veelomvattend hervormingsprogramma van de publieke sector. De hervormingen zijn gericht op het verbeteren van de toegang tot en de kwaliteit en gelijkwaardig van overheidsdiensten door een beleid dat ‘decentralisatie door devolutie’ kan worden genoemd. Sindsdien is er veel onderzoek gedaan naar de fiscale, bestuurskundige, wettelijke en politieke aspecten van de hervormingen. De gender dimensie van zowel het proces als de uitkomsten van de hervormingen heeft echter veel minder aandacht gekregen. In Tanzania, zoals in veel andere Afrikaanse landen, is weinig bekend over decentralisatie en gender op dorpsniveau. Dit proefschrift gaat over de gevolgen van de hervormingen voor de overheidsdienstverlening op het platteland van Tanzania, gezien vanuit een gender perspectief, en toegespitst op de terreinen van watervoorziening en de primaire gezondheidszorg. Meer specifiek staat centraal hoe decentralisatie de interactie van de verleners en de gebruikers van overheidsdiensten beïnvloedt en hoe gender-sensitief de watervoorziening en de primaire gezondheidszorg in de dorpen in feite zijn. Hiertoe werden de institutionele kenmerken van de dienstverlening op deze terreinen, de participatie van gebruikers in de besluitvorming, de toegang tot deze diensten en samenwerking en vertrouwen op dorpsniveau onderzocht.

Om de vraagstelling te onderzoeken werden theoretische perspectieven uit de sociologie en bestuurskunde gebruikt, in het bijzonder een institutioneel perspectief, principal-agent theorie, een actor perspectief en een gender perspectief. Het gender perspectief werd op alle niveaus toegepast, inclusief op de bredere sociaal-culturele en politieke structuren die zo bepalend zijn voor het proces en de uitkomsten van decentralisatie in een specifieke context. In het onderzoek werden kwantitatieve en kwalitatieve data verzameld op de niveaus van district, dorp en huishouden in de districten Kondoa en Kongwa in het Dodoma gebied in Tanzania. Het veldwerk werd gedaan in drie elkaar overlappende fasen: een exploratieve fase, de survey fase, en de diepgaande kwalitatieve studie. Er werd een combinatie van onderzoeksmethoden gebruikt om de validiteit en betrouwbaarheid van de gegevens te versterken. Door middel van een huishoudsurvey werden kwantitatieve gegevens verzameld, terwijl kwalitatieve gegevens werden verzameld met behulp van half-gestructureerde interviews, focus groep discussies, persoonlijke case studies en observatie. In totaal waren 513 respondenten (236 mannen en 277 vrouwen) in de studie betrokken: 332 in de survey (115 mannen en 227 vrouwen), 69 in de focus groep discussies (44 mannen en 25 vrouwen), 107 in de diepte interviews (77 mannen en 30 vrouwen), en van vijf vrouwen werd de levensgeschiedenis opgetekend. Tevens werden secundaire bronnen op dorps- en districtsniveau geraadpleegd.

Uit het onderzoek komt naar voren dat de hervormingen hebben geleid tot herstructurering van de districts- en dorpsraden en tot meer bestuurlijke organen, zoals commissies, op alle niveaus. Door deze veranderingen is de autonomie van de lokale overheid om dienstverlening te plannen en te implementeren toegenomen en is de betrokkenheid van de gebruikers van de diensten vergroot. De bestaande centraal-lokale verhoudingen maken

echter dat lokale overheden hun mandaat niet volledig kunnen waarmaken en onvoldoende tegemoet kunnen komen aan de lokale behoeften aan dienstverlening. Lokale overheden hebben beperkte financiële en technische capaciteit en worden door de centrale overheid gecontroleerd door geldstromen, richtlijnen en nationale prioriteiten. Op dorpsniveau kunnen rolconflicten tussen de dorpsraden en de sectorcommissies (zoals water commissies) het goed functioneren van de sectorcommissies beletten. Kortom, decentralisatie leidt tot verschillende uitkomsten, waarbij de aard van de sector ook een rol speelt.

Het onderzoek wees ook uit dat de hervormingen ruimte hebben geschapen voor de participatie van gebruikers in planning en besluitvorming. Mannen en vrouwen worden hierin betrokken door het bijwonen van vergaderingen, een bijdrage aan de bouw van voorzieningen in de vorm van arbeid of geld, het lidmaatschap van commissies, en het spreken tijdens vergaderingen om zo beslissingen te beïnvloeden. In meerderheid participeren vrouwen passief, door vergaderingen bij te wonen of door geconsulteerd te worden, en hun participatie is meer sector-specifiek. Ofschoon als gevolg van het quota beleid het aandeel van vrouwen in dorpsraden en commissies is toegenomen, blijft de lokale besluitvorming gedomineerd door mannen. De vertegenwoordiging van vrouwen heeft effect als het gaat om praktische zaken die te maken hebben met hun vrouwelijke rol, maar beantwoordt nauwelijks aan de strategische behoefte van vrouwen aan inspraak en macht. De belemmeringen hierbij zijn de patriarchale cultuur, het tijdsbeslag van huishoudelijke plichten, gebrek aan zelfvertrouwen en het ontbreken van ervaring in het publieke domein. De gender verhoudingen worden mede beïnvloed door factoren zoals religie, etniciteit, leeftijd en huwelijkse staat, en deze factoren kunnen de belemmeringen voor een effectief optreden van vrouwen in het lokale publieke domein versterken. Terwijl decentralisatie gender ongelijkheid zou moeten verminderen, wordt deze in feite gereproduceerd omdat de sociaal-culturele barrières die effectieve participatie van vrouwen verhinderen onaangetast blijven.

Het onderzoek laat ook een gemengd beeld zien van de invloed van de hervormingen op de dienstverlening in de sectoren van watervoorziening en gezondheidszorg. De toegang van gebruikers tot de voorzieningen in deze sectoren verbeterde voor sommigen maar verslechterde voor anderen. Het aantal voorzieningen op beide terreinen nam toe, waarmee een groter bereik werd gerealiseerd. De infrastructuur is echter nog steeds niet toereikend voor toegang tot de voorzieningen voor iedereen. Dit is zorgwekkend vooral voor wat betreft de gezondheidszorg omdat de meeste dorpen geen eigen gezondheidszorgvoorziening hebben. Tevens de voorzieningen op dit terrein te maken van onvoldoende staf en gebrek aan medicijnen en andere faciliteiten. De veranderingen in de gezondheidszorgvoorzieningen worden door de gebruikers dan ook minder positief beoordeeld dan die in de watervoorziening. Terwijl mannen en vrouwen hebben dezelfde mening op sommige punten, verschillen zij van mening op andere punten. Dit heeft aantoonbaar te maken met de verschillende behoeften en prioriteiten van mannen en vrouwen als het gaat om toegang tot basis voorzieningen. Begrip van deze overeenkomsten en verschillen is een belangrijke eerste stap in het meer 'gender sensitief' maken van basis voorzieningen.

Het onderzoek wees uit dat de hervormingen de formele samenwerking gericht op verbetering van de dienstverlening en informele samenwerkingsverbanden zoals netwerken

en groepen hebben versterkt. Positieve uitkomsten zoals grotere betrokkenheid van burgers in besluitvorming en verbeteringen in de dienstverlening verstreken op hun beurt het vertrouwen in het politieke proces, waarbij ook de gender verhoudingen een rol bleken te spelen. Er is dus een wisselwerking tussen vertrouwen en decentralisatie: vertrouwen vergroot de participatie in lokale instituties en 'goede' uitkomsten van de hervormingen genereren vertrouwen, terwijl 'slechte' uitkomsten het vertrouwen verminderen. Uit het onderzoek bleek ook dat politiek vertrouwen een gelaagd concept is; burgers beoordelen leiders en dienstverleners verschillend op de verschillende niveaus. Voor de analyse van politiek vertrouwen is het belangrijk om de bestuurlijke niveaus te onderscheiden en er rekening mee te houden dat de invloed van gender op politiek vertrouwen per niveau kan verschillen.

De algemene conclusie is dat de huidige hervormingen zowel mogelijkheden bieden als uitdagingen opleveren voor grotere betrokkenheid van gebruikers bij de dienstverlening, meer samenwerking en vertrouwen, het terugdringen van gender ongelijkheid en verbeterde dienstverlening. Om daadwerkelijke verbetering te realiseren van de interactie tussen de gebruikers en verleners van diensten en van de dienstverlening zelf, moet een aantal zaken worden aangepakt. Op nationaal niveau moeten beleidsmakers iets doen aan de scheve verhoudingen tussen het centrale en het lokale niveau door de verantwoordelijkheden en rollen van de verschillende bestuurslagen tegen het licht te houden en waar nodig te herdefiniëren. Districtsraden dienen duidelijkheid te verschaffen over de rol en verantwoordelijkheden van de sector commissies vis-à-vis die van dorpsraden. Tevens moeten zij zorg dragen voor regelmatige en gender-sensitieve training van commissieleden en moeten zij de lokale behoeften en prioriteiten beter integreren in de planning op districtsniveau. Dorpsleiders moeten meer rekening houden met vrouwen bij het bepalen van de tijd en plaats van vergaderingen, moeten deze vergaderingen en de agenda's tijdig aankondigen, en moeten er voor zorgen dat lokaal belangrijke zaken adequaat en transparant worden behandeld. Op alle niveaus moeten de betrokken actoren proberen effectieve strategieën te vinden om iets te doen aan de ondergeschikte positie van vrouwen in de besluitvorming en dienen zij de toegang van vrouwen tot basisvoorzieningen te verbeteren.

About the Author

Zacharia Samwel Masanyiwa was born on 12th April 1972 in Magu district, Mwanza Region in North Western Tanzania. In 2000, he obtained a Bachelor of Science degree in Animal Science from Sokoine University of Agriculture (SUA), Tanzania. Between 2000 and 2005, he worked for World Vision Tanzania (a development, advocacy and relief NGO) in different capacities where he was involved in designing, implementation, coordination, monitoring and evaluation of community-based rural development projects. In September 2005, he was awarded the Commonwealth Shared Scholarship to pursue postgraduate studies at the University of Wolverhampton in the United Kingdom. While at Wolverhampton, he obtained a Postgraduate Diploma and a Master of Science degree in Development Training and Education in 2006 and 2007, respectively.

Since 2007, the author is an academic staff at the Institute of Rural Development Planning (IRDP) where he teaches a number of courses including Development Studies and Social Development Planning. He is also involved in carrying out research and consultancy activities especially those related to capacity building in local government authorities and evaluation of development projects. His research interests include decentralization, local governance, gender, poverty reduction and participatory development.

In October 2010, he obtained a sandwich scholarship through the NUFFIC funded NICHE/TZA/002 project to pursue his PhD with the Sociology of Consumption and Households Group at Wageningen University. As part of this PhD research project, the author has published the following articles:

- Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2013). Institutional arrangements for decentralized water and health services delivery in Rural Tanzania: differences and constraints. *Basic Research Journal of Social and Political Sciences*, 1(4):77-88.
- Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2013). A gendered users' perspective on decentralized primary health services in Rural Tanzania. *The International Journal of Health Planning and Management*. DOI:10.1002/hpm.2235.
- Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2014). Gender perspectives on decentralisation and service users' participation in rural Tanzania. *Journal of Modern African Studies*, 52(1):95-122. DOI: 10.1017/S0022278X13000815.
- Masanyiwa, Z.S., Niehof, A. and Termeer, C.J.A.M. (2014). Cooperation and trust in the context of decentralization reforms in Rural Tanzania. *The International Journal of Social Sciences and Human Studies*, 6 (1): 139-156.



Completed Training and Supervision Plan
Wageningen School of Social Sciences (WASS)
Zacharia Samwel Masanyiwa

Name of the learning activity	Department/Institute	Year	ECTS 1=28hrs
A) Project related competences			
Governance, Trust and Policy Change (PAP 30806)	WUR	2011	6.0
Rural Gender Studies (SCH 50303)	WUR	2011	4.0
Writing PhD Research Proposal	WUR	2010-2011	6.0
B) General research related competences			
Introduction Workshop WASS	WASS	2010	-
Research Methodology: From topic to proposal	WASS	2010	4.0
Qualitative Data Analysis: Procedures and Strategies (YRM 60806)	WUR	2010	6.0
Information Literacy PhD including Endnote Introduction	WUR Library	2011	0.6
Quantitative Methodology and Economics	CERES, Utrecht University	2011	2.0
A practical course on the methodology of field work	CERES, Utrecht University	2011	2.0
C) Career related competences/personal development			
Scientific Publishing	WGS	2011	0.3
Presentation Skills	WGS	2011	1.0
PhD Competence Assessment	WGS	2011	0.3
Mobilizing Your Scientific Network	WGS	2011	1.0
Techniques for Writing and Presenting a Scientific Paper	WGS	2012	1.2
Project and Time Management	WGS	2012	1.5
Presentations and Participation in SCH Research Seminars	WUR	2012-2013	1.0
'Village water committees or private operators? Comparing management approaches for rural public water facilities in Tanzania'	Conference on Water Economics, Statistics and Finance, Marbella, Spain	2013	1.0
'Users' perspectives on decentralized rural water services in Tanzania'	WASS PhD Day	2013	1.0
'Gender Perspectives on Decentralization and Service Users' Participation in Rural Tanzania'	Conference on Interdisciplinary Social Sciences, Charles University Prague, Czech Republic	2013	1.0
'Gender Perspectives on the Implications of Decentralization Reforms on Cooperation and Trust in Rural Tanzania'	International Conference on Social Sciences, Izmir, Turkey	2013	1.0
Total			40.9

