Challenges For and Against Decentralization by Devolution in Public Health Service Delivery in Tanzania: A case of Ilala Municipal Council and Geita Town Council

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ABSTRACT

The purpose of the study conducted was to examine and analyze the specific challenges associated with Decentralization by Devolution (D-by-D) in the delivery of public health services in Ilala Municipal Council (IMC) and Geita Town Council (GTC). In order to achieve this objective, the study adopted an exploratory design, which employed both quantitative and qualitative research approaches to thoroughly investigate the practicality and effectiveness of decentralization by devolution in the realm of public health service delivery. To gather the necessary data for analysis, the researchers employed a combination of stratified, simple random, and purposive sampling techniques. These methods allowed them to select a representative sample of 424 participants from six strategically chosen wards within the two councils. The data collection process encompassed the use of questionnaires, interviews, and documentary reviews, enabling the researchers to obtain a comprehensive understanding of the challenges faced in the implementation of D-by-D in public health services. The findings of the study unveiled a range of challenges encountered in the D-by-D approach to public health service delivery in both IMC and GTC. These challenges were identified and analyzed, shedding light on the specific areas where improvements and interventions were required. The study concluded that there were six major challenges that the decentralization by devolution system faced in the delivery of public health services in both IMC and GTC, thus emphasizing the significance of addressing these issues for the betterment of healthcare provision. Based on the research outcomes, the study recommended various measures to tackle the challenges identified. One prominent suggestion was the urgent need for capacity building among healthcare workers. The government, in collaboration with other key stakeholders such as the private sector and training institutions, was urged to take the lead in providing the necessary training and skills enhancement opportunities to healthcare professionals. This collaborative effort aimed to empower healthcare workers with the knowledge and expertise required to overcome the challenges associated with D-by-D in public health service delivery.

Keyword: *Decentralization by Devolution; Public Health Service Delivery; Ilala Municipal Council; Geita Town Council*

1. INTRODUCTION

Historically, inception of decentralization by devolutionary ideals can be traced as far back as 507 Before Christ (B.C.) to the Athenian leader, Cleisthenes, who introduced a system of political reforms labeled ‘demokratia’ or

'rule by the people.' It is referred to as the birth of democracy, abolishing elite rule allowed for creation of mountain-side courts open to the 40,000 free, male citizens of Athens. Led by lottery selected jurors, such meetings allowed residents of Athens to make decisions, which directly affected their communities [1]. Today, decentralization policy deals with separation of powers between the central government and local government authorities (LGAs). Power separation of between the two government bodies can be through de-concentration form whereby local bodies are subordinate to the central government (CG), or devolution form when the local bodies are, to some extent, autonomous [2].

Literature from around the world has documented the desire to adopt a D-by-D strategy of governance. This is due to the fact that D-by-D helps to bring about public services such as education, water and health closer to people, In due regard, they will have further opportunities to participate more actively in decision-making process of local policies and activities than in centrally decided ones. The services then become highly responsive and tailored for different needs for different localities [3]. In each and every social service sector, D-by-D and services delivery remain a global agenda for debate, which have attracted serious attention within the public administration research and practice [4]. The proponents of D-by-D argue that smaller organizations, which have decision-making autonomy, are highly close to people, and they are greatly active, innovative, and responsive to needs of people they serve [5]. Also, it is argued that decision-makers' skills and knowledge at the local government level are often too limited to make and implement good decisions about delivery including management of health services [5].

In Tanzania, in 1998, a new policy was founded on the principle of D-by-D through the Local Government Reform Program (LGRP), which reflected good intentions of the government to improve local government institutions [2]. The D-by-D policy is based on the principle of subsidiarity. Local governments, through their elected leaders, have responsibility for social services development and public service provision within their areas of jurisdiction; facilitation of maintenance of law and order and promotion of local development through participatory processes [6]. Additionally, D-by-D policy focused on participation of local communities in developmental decision-making process. The D-by-D policy assumed that social services are only sustainable if they are based on support from local communities [7]. Mwiru [8] pointed out that during early years after independence, especially after Arusha Declaration of 1967, they encompassed a period of self-help projects whereby community members worked together to build schools, roads and village health posts using their own labour and materials. They carried out such activities for the purpose of promoting development within their communities and the country, in general. Adoption of D-by-D since the year 1998 aims at devolving more services and improving service delivery such as health services [7]. The government commitment to decentralization system and public health service delivery has emanated from the constitution of the United Republic of Tanzania with further evidence in Articles 145 and 146, which aim at transferring authority to people through establishment of LGAs [9].

Despite noted constitutional provisions, it is important to highlight that in principle, decentralization does not imply total independence of LGs from the state, but description of powers that are delegated by central government [10]. However, this obligation entrusted to central government is a limit to local autonomy and creates a basic structural tension in Tanzania [2]. For instance, Human Resource (HR) policies in local government have remained contradictory with the principal legalization guiding decentralization policies. The contradictions arose between the decentralization policy (1998) and the public service regulations over recruitment of LGAs' staff. The policy paper on decentralization stipulated that all HR functions would be devolved to LGAs [11]. On the contrary, the Public Service Regulations (2002) stated that the Public Service Commission (PSC), at national level, should be in-charge of all HR issues in LGAs. This contradiction was not cleared even after a revision of the Public Service Regulations (2003), which added that, "every local council shall have a Council Employment Board (CEB) which will facilitate the appointment of public servants of the local government authorities working under directives issued by the PSC" [12]. Unfortunately, the same regulations oblige the LGAs to ask for permission from the PSC to recruit their own staff [13]. Besides, personnel for health and education sectors were explicitly exempted by President's Office,

Public Service Management from decentralized and merit-based procedures for recruitment on the basis of ensuring quality control [14].

Through health sector reforms (HSR), the D-by-D of health service delivery in Tanzania in the 1990s was expected to facilitate greater equity and quality of health care, obtain greater value for money through cost-effective measures and improve functioning as well as performance of health systems [15]. There has been a hot debate as to whether or not funds received from the central government to the LGAs are sufficient to run the laid down programme. Most scholars argue strongly that LGAs are seriously underfunded by the central government, and the anticipated funds do not reach the LGAs timely [16].

Ringo, Khamis, Peter and Pazi [17] noted that, Tanzania is a nation where the appeals and possibilities of decentralization have conceivably been greater than most. Ecologically, Tanzania is a huge and diverse grouping of regions and districts where an effective system of centralized planning would be complicated, even if there was the need and capacity to develop one. Therefore, D-by-D under Tanzanian conditions is a practical necessity aimed at reducing the burden on central decision makers and the impact of distortions including delays in local government service delivery such as those related to health. However, despite the current fifth phase of Tanzanian government being recognized in achieving commendable progress in implementation of D-by-D, the delivery of services such as construction of infrastructure (roads and railways) as well as expansion of health and educational facilities is still accused of failing to facilitate the required standards and quality [18].

Moreover, the current situation in IMC and GTC shows that health centers face several challenges such as inadequate health employees; low work morale among employees; and insufficient basic including other sophisticated medical equipment as well as drugs in some health units. On the other hand, citizens do not feel like their voices are, in practice, being heard [19]. This limits LGAs' effectiveness in addressing challenges faced by the poor. Furthermore, in the current distribution of functions in the public health sector, lower-level officials do not have authority to design policies and programs due to limited decision-making powers established by the law under Local Government (District Authorities) Act Number 7 of 1982 as amended by Act Number 6 of 1999. In terms of quality improvement, devolution of health services could entail efforts that are not just concentrated in selected areas and, instead, all LGAs should implement quality improvement measures [19]. Hence, based on that account, this study sought to identify the specific challenges of D-by-D in public health services delivery in the LGAs, in Tanzania by focusing on IMC and GTC.

2. STUDY METHODOLOGY

2.1 Study Area

This study was conducted in Ilala Municipal Council (IMC). Ilala Municipality has the status of an Administrative district that lies between longitude 39o and 40o east and between latitude 60 and 70 south of the Equator. It is a part of Dar es Salaam region which is located in the extreme eastern corner of the Region, bordering by Indian Ocean for a distance of about 10 kilometers to the east. On the southern part it is bordered by Temeke and Kigamboni Municipality, whereas on its western part it is bordered by Kisarawe district and on its Northern part it is bordered by Kinondoni and Ubungo Municipality. Ilala Municipality has a total surface area of 210.1 sq.kms: 3.1 sq.kms is water area, leaving 98.5% of the area as land area (207.0sq.kms). Large parts of the land area belong to Ukonga Division covering 170.0 sq.kms which is equivalent to 80.9% and the remaining 19.1% is in Ilala Division (14.5%) and Kariakoo Division (4.6%) [20]. However, on Wednesday February 24, 2021 President John Magufuli dissolved Dar es Salaam City Council and upgraded Ilala Municipal Council to Dar es Salaam City Council.

This study was also conducted in Geita Town Council (GTC). GTC was established through Government Notice (G.N) 280 of 24th August, 2012 of which it's Certificate of establishment was signed on 5th September, 2012. The establishment of GTC was according to the Local Government Act (Urban Authorities) No.8 of 1982. GTC lies between 1,100 to 1,300 meters above the sea level. It lies between 2o8' to 3o28' South of the Equator and 32o 45 to 37o East of Greenwich. The Council shares its borders with Geita rural District Council to the West and South; Sengerema District Council and Nyang'wale District Council to the East. The Council covers 1080.3km2. The Council is divided into two divisions namely Kasamwa and Geita town. There are 13 Wards 65 Mitaa and 13 villages with 47 Hamlets. Politically GTC has one constituency (Geita Town) represented by elected Member of Parliament. The 13 elected Councilors each represents their respective wards. In addition, there are four appointed women Councilors for special seats. This implies that the Full Council has 17 members. Villages and Mitaa are headed by Village chairperson and Mtaa Chairperson respectively.

2.2 Study Design, Data Collection and Analysis

According to Blaiki, Ong and Grooves [21], the main purposes of the research design are to make the researcher's decision explicit; ensure that the decisions are consistent with each other; allow for critical evaluation of the individual design elements, and the overall research design, before significant work commences. The study used exploratory design that involved use of quantitative and qualitative research approaches to explore the applicability of decentralization by devolution in public health service delivery. Exploratory research design was used because there is more to explore regarding the subject matter under investigation. In due regard, the study aimed at discovering more about the subject matter that has been researched but there were still some other gaps needing further exploration. Furthermore, the researcher employed case study strategy to get in-depth meaning of the subject matter under inquiry.

Questionnaires were used as the main data collection instruments because of their efficiency and effectiveness in soliciting reliable and valid data [22]. Quantitative information was collected by using close-ended questions from the targeted study population. Questionnaires were used to collect quantitative information from respondents (local community members of IMC and GTC). They were distributed to a total number of four hundred and twenty-four (424) respondents and each one was given a copy. The data collected were in form of Likert scale response modes.

In order to interpret the mean scores, the following scale was used.

Table 1: Mean Score Interpretation

Mean Range	Description	Interpretation
3.25-4.00	Strongly Agree	Very High
2.50-3.24	Agree	High
1.75-2.49	Disagree	Low
1.00-1.74	Strongly Disagree	Very Low

Moreover, the study used interview as a complementary data collection tool. According to the study done by Whitten and Bentley [23] insists that, this technique helps the researcher to collect additional information from individuals through conversation. Therefore, interviews were arranged to allow a portion of targeted respondents to freely provide their views related to the problem that was being investigated. The interviews involved key informants who were ward councilors and local government officials.

3. RESULTS AND DISCUSSION

3.1 Challenges For and Against Decentralization by Devolution in Public Health Service Delivery

This section presents the study's findings on the objective that sought to identify 'challenges for and against decentralization by devolution in public health service delivery.' The first part of findings (summarized in Table 2) presents results for IMC and the second part (summarized in Table 2) presents results for GTC on the same specific objective. A detailed analysis of correspondence and differentiation between findings of the two sides follows thereafter.

Table 2: Challenges for and against decentralization by devolution in public health service delivery in IMC (n=228)

Item	Mean	Std. Deviation	Interpretation
1. Lack of political will among the LGAs staff and.	1.76	1.09232	Low
2. Responsibilities are unclear at all levels of the system.	2.31	1.09356	Low
3. Decentralized power to levy taxes is subjected in theory but not observed in practice.	3.03	1.27633	High
4. Untimely release of donor funding.	3.45	1.31133	Very high
5. Mismanagement of funds in implementation of projects such as the construction of health centers.	1.80	1.25663	Low
6. Unclear roles, functions, and structure.	2.67	1.12422	High
7. Loss of local autonomy.	2.85	1.11235	High
8. Lack of transparency.	3.19	1.13479	High
9. Weak mechanisms of accountability.	3.20	1.03977	High
10. Lack of effective citizens' participation.	3.26	1.22373	Very high
11. Conflictual relationship with the national government.	1.82	1.19641	Low
12. Lack of critical legal and institutional infrastructure.	1.75	1.11282	Low
13. Human resource deficiency and capacity gaps.	3.43	1.13956	Very high
14. Inadequate budgetary allocation to public health sector.	3.27	1.25554	Very high
15. Poor leadership and management.	3.14	1.01441	High
16. Contradictions rooted from the constitution.	1.28	1.26371	Very low
17. Corruption.	2.53	1.31259	High
18. Considerable dissatisfaction among service providers especially health professionals.	3.20	1.10402	High
Total average score	2.65	1.16395	High

As it can be seen in Table 2, many challenges for and against D-by-D were pointed out for IMC and rated 'high' or 'very high' and a few challenges were rated either 'low' or 'very low' by respondents as the mean and standard deviation scores indicate. The rating and interpretation for each item are further presented.

For the challenge, 'Lack of political will among the LGAs staff,' respondents offered a 'low' rating at 1.76 mean score (Table 2), which was interpreted 'disagreement.' Thus, in light of respondents' views and experience, lack of political will among the LGA's staff was an insignificant challenge for and against D-by-D in the delivery of public health services in IMC. Political will may not be a problem here because the LGA staff tends to operate under stipulated roles of public service and political agendas (usually from stakeholders such as ward executives and members of parliament) may be accommodated according to directives, mainly from the central government.

Regarding the point that 'Responsibilities are unclear at all levels of the system,' there was 'low' rating at 2.31 mean score (Table 2), which was considered to imply 'disagreement.' Therefore, in these findings, respondents considered the premise that 'responsibilities were unclear at all levels of the system' not to be a significant challenge. This finding might be due to different reasons. First, lack of clarity for expected roles pertained to D-by-D might be occurring in some areas of the process, not in the whole system. Second, due to the fact that usually D-by-D occurs in the connected system between LGAs and the central government, it is expected that the central government as the delegator of roles will have set clear roles, which would later serve to enable easy follow-up and monitoring the LGAs' operation on decentralized roles.

The challenge called 'Decentralized power to levy taxes is subjected in theory but not observed in practice,' was rated high at 3.03 mean score (Table 2), which meant 'agreement' among respondents. Thus, this particular point was considered to be a significant challenge and it may be associated with several reasons. First, as other findings have shown, LGAs and health care institutions usually do not have enough as well as adequate staff teams, which suggest that they may lack sufficient and credible task forces for the role of tax collection. In addition, many sources of taxes are usually not enough to meet the service demands to be covered in the public health sector.

The challenged, namely, 'Untimely release of donor funding' was rated 'very high' at 3.45 mean score (Table 2) and was interpreted to be 'strong agreement.' Thus, respondents in this study very highly pointed out to untimely release of donor funding to be a quite significant challenge. This challenge tends to occur almost in all sectors. It tends to be especially common for decentralized tasks that need to be funded by the central government or through donors who provide funds through the central government. Usually, there is a time gap between the period when the LGAs and their healthcare services need the money and the time of the government or donors to complete procedures of releasing the money into LGAs' systems.

The challenge, namely, 'Mismanagement of funds in the implementation of projects such as the construction of health centers' was rated significantly 'low' at 1.80 mean score (Table 2). Therefore, most of the respondents viewed mismanagement of funds as a quite less significant challenge for and against D-by-D in public health service delivery in IMC. Although this challenge tends to be highlighted by many researchers from other places, it is very likely that for the case of this study, the operation of the Tanzania fifth phase government, which seriously fought against embezzlement and misuse of funds has been contributing to lessening this challenge in all sectors, including the public health sector and in its processes of implementing D-by-D. This study was conducted during the Tanzania fifth phase regime.

The challenge, 'Unclear roles, functions, and structure' was rated 'high' at 2.67 mean score (Table 2), which was considered to suggest 'agreement' by respondents. Thus, in the current findings, existence of unclear roles, functions, and structure was a significant challenge in implementation of D-by-D on delivery of public health services in IMC. This suggests that the central government has not invested enough time, expertise, and attention in making this process a success through creation of well-framed structures and responsibility matrixes. Quite differently, past researchers have highlighted on this factor to contribute to hampering processes of D-by-D implementation in public health service delivery.

Also, 'Loss of local autonomy' was rated 'high' at 2.55 mean score (Table 2), which was interpreted as 'agreement.' Thus, according to respondents' views, the LGAs at times tend to have strained autonomy in the process of implementing D-by-D in delivery of public health services. This means that either the central government does not delegate full power or entertains interruptions even when full power was delegated. This particular challenge may relate to the challenge of absence of clear roles and structures, which brings about inefficiency in implementation of D-by-D. Noted inefficiency at LGA level, in turn, may tend to force higher rank officials and the central government to frequently intervene in LGAs' operations.

In addition, 'Lack of transparency' as a challenge was rated 'high' at3.19 mean value (Table 2), which was interpreted as 'agreement.' Thus, there was significant agreement by respondents that lack of transparence was a challenge for and against D-by-D in delivery of public health services in IMC. Transparency relates mostly to the factor of 'clarity' in stipulated roles and if there is a 'clear structure' on how the LGAs work with the central government. Thus, in these findings, lack of transparency would relate to the problem of unclear functions and structure rated 'high' by respondents.

The challenge called 'Weak mechanisms of accountability' was rated 'high' at 3.20 mean value (Table 2) and it was interpreted as 'agreement.' Thus, there were weak mechanisms of accountability in IMC as a challenge toward implementation of D-by-D in delivery of public health services. As for the challenge of absence of transparency, when there are no clear roles, functions, and frameworks of operation, it diminishes the potential for accountability among servants.

There was a 'very high' rating for the challenge, namely, 'Lack of effective citizens' participation,' at 3.26 mean score (Table 2), which was interpreted 'strong agreement.' Therefore, IMC's respondents in the current study realized lack of effective citizens' participation to be a very significant challenge surrounding the process of D-by-D in delivery of public health services. Enhancing citizens' participation requires a good political will, strong leadership at LGA, and awareness as well as sensitization campaigns. These aspects were not realized in the current study area (IMC). The observation would have contributed to the challenge of effective citizens' participation on implementation of D-by-D in delivery of public health services.

The challenge labeled 'Conflictual relationship with the national government' was rated 'low' at 1.82 mean score (Table 2) interpreted as 'disagreement'. Thus, for respondents in the current study (from IMC), conflictual relationship with the national government was not a significant challenge. Conflictual relationship between public health officials at LGA and the national government could be avoided if officials in the national government are credible professionals with a background in public health. Such officials properly understand dynamics of the sector and can be related to officers and other workers in LGAs. The Tanzania fifth phase government emphasized on necessity for having credible and competent high-rank leaders and public officials in all sectors, and the ongoing reforms should have contributed to the trend of findings depicted in this study.

Moreover, 'Lack of critical legal and institutional infrastructure' was significantly rated 'low' at 1.75 mean score (Table 2) as a challenge for and against D-by-D in the delivery of public health services in IMC. The mean value was interpreted as 'disagreement,' which implies that, to a large extent, respondents did not consider the assertion to be a significant challenge. As for many public service sectors, at baseline, the basic and day-to-day functions of health workers tend not to be directly related with stipulations and laws in the constitution.

The challenge, named, 'Human resource deficiency and capacity gaps' was rated 'very high' at 3.43 mean score, (Table 2) which suggested 'strong agreement.' Thus, there was strong agreement among respondents in IMC that human resource deficiency and capacity gaps entailed a significant challenge for and against D-by-D in the delivery of public health services. Several factors including low budget allocations in the public health, lack of advanced as well as world-class education in public health together with the country's low investment in science higher education and professionalism, contribute to making human resource deficiency a serious problem in the public health sector and in implementation of the D-by-D element in this sector.

The challenge called 'Inadequate budgetary allocation to public health sector' was alike rated 'very high at 3.27 mean score (Table 2), which implied 'strong agreement' on the side of respondents. In due regard, respondents in this study, pointed to inadequate budgetary allocation to public health sector as a very significant challenge surrounding implementation of D-by-D in delivery of public health services. Tanzania is a low middle-income country with a low economic capacity. Its low middle economic level tends to be reflected in the size of its budget,

which usually allocates significantly insufficient money to public service projects and sectors, including the public health sector and the operation of LGAs. Due to this reality, it is reasonable that 'inadequate budgetary allocation to public health sector' would be realized in the current study as one of the challenges facing D-by-D in the delivery of public health services in IMC.

The factor 'Poor leadership and management' was rated 'high' at 3.14 mean score (Table 2) as a challenge for D-by-D in the delivery of public health services. The 3.14 mean score suggested 'agreement' from respondents that poor leadership and management was a considerable challenge. Quality of leadership and management depend on the general structure of operation, workforce adequacy and satisfaction. In these findings, these elements did not exist at good levels for IMC.

The challenge, namely, 'Contradictions rooted from the constitution' was rated 'very low' at 1.28 mean score (Table 2), which was interpreted as 'strong disagreement.' Therefore, respondents disregarded on contradictions rooted from the constitution as in any way being a challenge for and against D-by-D in the delivery of public health services. Usually, public health and implementation of D-by-D in public health service delivery is not a sector, whose operations highly depend on directives rooted in the constitutions. Mostly, political and general public service roles attached to this sector find a direct link in the constitution. Moreover, they are not day-to-day operations that are expected to determine quality performance.

The challenge 'Corruption' was rated slightly high at 2.53 mean score (Table 2), which was interpreted to be 'agreement.' Thus, there was considerable agreement among respondents that corruption was a challenge in implementation of D-by-D in the public health sector in IMC. Several other factors raised in this section of findings could contribute to the challenge of corruption including lack of clear structures and stipulation of roles, which may create room for some unfaithful officials to be corrupt. In addition, problems such as low wages to healthcare workers and LGA workers tend to relate to the phenomenon of corruption.

Lastly, the challenge, namely, 'Considerable dissatisfaction among service providers, especially health professionals' was rated 'high' with 3.20 mean score (Table 2), which was interpreted as 'agreement.' Thus, there was a considerable agreement among respondents in IMC on dissatisfaction among service providers to be a challenge in the process of D-by-D in the delivery of public health services. Dissatisfaction is usually associated with several factors related to healthcare workers' welfare that have been existing in the Tanzanian health sector including insufficient wages, unsatisfying work environments, and insufficient human labor employed in healthcare institutions.

Table 3: Challenges for and against decentralization by devolution in public health service delivery in GTC (n=190)

Item	Mean	Std. Deviation	Interpretation
1. Lack of political will among the LGAs staff and.	1.91	1.12543	Low
2. Responsibilities are unclear at all levels of the system.	2.42	1.02694	Low
3. Decentralized power to levy taxes is subjected in theory but not observed in practice.	2.40	1.06015	Low
4. Untimely release of donor funding.	3.19	1.13956	High
5. Mismanagement of funds in implementation of projects such as the construction of health centers.	2.35	1.25554	Low
6. Unclear roles, functions, and structure.	2.43	1.01441	Low
7. Loss of local autonomy.	2.85	1.26371	High
8. Lack of transparency.	2.39	1.31259	Low
9. Weak mechanisms of accountability.	3.20	1.31456	High
10. Lack of effective citizens' participation.	3.06	1.29532	High
11. Conflictual relationship with the national government.	2.00	1.21288	Low

12. Lack of critical legal and institutional infrastructure.	2.15	1.13456	Low
13. Human resource deficiency and capacity gaps.	3.22	1.09872	High
14. Inadequate budgetary allocation to public health sector.	3.19	1.09738	High
15. Poor leadership and management.	3.27	1.39472	Very high
16. Contradictions rooted from the constitution.	1.70	1.31122	Very low
17. Corruption.	2.23	1.09899	Low
18. Considerable dissatisfaction among service providers especially health professionals.	3.01	1.44523	High
Total average score	2.61	1.58723	High

As Table 3 indicates, there were varying ratings from respondents for several challenges posed as facing D-by-D in delivery of public health services in GTC. The extent of rating for each posed challenge and accompanying interpretation are presented in subsequent paragraphs.

The challenge named 'Lack of political will among the LGAs staff' was rated 'low' at 1.91 mean score (Table 3), which suggested 'disagreement' by respondents. Thus, in light of respondents' views, lack of political will among the LGA staff was not a significant challenge for D-by-D in delivery of public health services in GTC. Political will would not be a significant challenge because the LGA staff tend to operate under stipulated roles of public service. Thus, political agendas (usually from stakeholders such as ward executives and members of parliament) tend to be accommodated according to directives, mainly from the central government.

The challenge 'Responsibilities are unclear at all levels of the system' was rated slightly 'low' at 2.42 mean score (Table 3), which was interpreted as 'disagreement.' Therefore, from the findings, respondents considered lack of clarity in responsibilities at all levels of the system not to be a significant challenge facing D-by-D in delivery of public health services in GTC. It may be due to various factors. First, the assertion in the posed statement had words "at all levels of the system," which was too generalizing, while experience of clarity might be occurring only in some aspects pertained to D-by-D. Second, due to the fact that usually D-by-D occurs in the collaborative context between LGAs and the central government, it is expected that the central government as the delegator of roles works to set clear roles, which would later serve to enable it do effective follow-up and monitoring on operations of LGAs on decentralized roles.

The challenge, namely, 'Decentralized power to levy taxes is not observed in practice' was rated 'low' at 2.40 mean score (Table 3), which suggested 'disagreement' by respondents. Interpretatively, respondents in this study from GTC did not view this assertion as a significant factor against D-by-D in the delivery of public health services.

The challenge, namely, 'Untimely release of donor funding' was rated 'high' at 3.19 mean score (Table 3), which was considered to imply 'agreement' by respondents. Therefore, this point was considered to be a significant challenge for GTC. These findings may relate to several other factors. Usually, there is a time gap between the period when the LGAs and their healthcare services need money for healthcare projects and the time when the government or donors settle issues related to procedures of releasing the money into LGAs' systems. This tends to be the case, especially for decentralized tasks that need to be funded by the government or through donors who provide funds through the central government.

The challenge called 'Mismanagement of funds in implementation of projects such as the construction of health centers' was rated 'low' at 2.35 mean score (Table 3), which was considered 'disagreeing response.' Therefore, to a large extent, respondents in GTC viewed mismanagement of funds as a less significant challenge toward implementation of D-by-D in public health service delivery. It is noted that for the case of this finding, accountability among public service officials in the Tanzania fifth phase government was associated with the trend

of data. Such government phase worked deliberately hard to fight against embezzlement and misuse of funds. Such efforts should have contributed to lessening this challenge in public sectors, including the healthcare sector and its processes related to implementing D-by-D.

The challenge of 'Unclear roles, functions, and structure' was rated 'low' at 2.43 mean score (Table 3). The mean value was interpreted as 'disagreeing response.' Thus, from findings for GTC, respondents did not consider existence of unclear roles, functions, and structure to be a significant challenge in implementation of D-by-D toward delivering public health services. This suggests that the central government heavily invested attention and other resources in making the process of defining roles and functions well-articulated.

The challenge called 'Loss of local autonomy' was rated 'high' at 2.85 mean score (Table 3), which was interpreted 'agreeing response.' Thus, the respondents for GTC agreed that at times the LGAs lost autonomy in implementation of decentralized roles (by devolution) in delivery of public health services. It means that the council experienced either of the two phenomena: (1) the central government does not delegate full power (by devolution) for some roles in the public health service sector or (2) the central government practices interruption even in roles where full power was delegated. This particular challenge may relate to the challenge of absence of clear roles and structures, which brings about inefficiency in the implementation of D-by-D through which issues of power limit and role would have been addressed.

The challenge 'Lack of transparency' was rated 'low' at 2.39 mean score (Table 3), which was interpreted as 'disagreement.' Thus, there was considerable disagreement among respondents concerning lack of transparency to be the challenge for D-by-D in delivery of public health services in GTC. From the findings, it was observed that there were clear structures and clarity of roles and that would have contributed to enabling transparency to occur between the GTC operations and operations of the central government and thus, making transparency part of the LGA's routine operations rather than a challenge.

The factor 'Weak mechanisms of accountability' was rated 'high' at 3.20 mean score (Table 3), which suggested 'agreement' on the side of respondents. Thus, from the respondents' views, weak mechanisms of accountability existed in GTC as one of the challenges facing delivery of public health services in the context of D-by-D. In the context of GTC, weak mechanisms of accountability would occur due to such factors as poor leadership at LGA levels and absence of effective collaboration between LGA and the governing bodies, which are yet to be addressed.

The challenge, namely, 'Lack of effective citizen participation' was rated 'high' at 3.06 mean score (Table 3). Thus, respondents offered an 'agreeing response' on Lack of effective citizens' participation to be a significant challenger for and against D-by-D in the offering of public health services in GTC. Arguably, GTC did not invest efforts on enhancing citizens' participation. Such efforts would include using good mobilization skills by leaders at LGA levels to encourage citizens' involvement as well as bringing forth extensive education together with motivation campaigns in the community.

The factor 'Conflictual relationship with the national government' was rated 'low' at 2.00 means score (Table 3), which suggested 'disagreeing response' by respondents. Therefore, in the current study, respondents from GTC did not support existence of conflictual relationship with the national government to be a challenged for D-by-D in delivery of public health services. Conflictual relationship between public health officials at LGAs and the national government could be avoided by making sure to employ proficient officials in the national government and LGAs. Such competent officials will be likely to do better in many areas including avoiding and managing potential conflicts that may arise in the context of collaboration between two parties.

The challenge, namely, 'Lack of critical legal and institutional infrastructure' was rated 'low' at 2.15 mean score (Table 3), which implied 'disagreement' by respondents. Thus, from the findings for GTC, lack of critical legal and

institutional infrastructure was not viewed as a challenge for D-by-D in provision of public healthcare. That may be due to various reasons. First, the Tanzanian constitution does not properly cover matters of D-by-D in delivery of public health because this is a new movement in the Tanzanian domain of leadership. Thus, it makes the challenge unlikely. Second, at baseline, most functions in the public health sector occurring routinely in the framework of D-by-D tend not to be directly related with stipulations and laws in the constitution.

The challenge called 'Human resource deficiency and capacity gaps' was rated 'high' at 3.22 mean score (Table 3), which implied 'agreeing response' by respondents. Therefore, it was agreed among most respondents that human resource deficiency and capacity gaps were significant challenges in the realm of D-by-D in provision of public health care services. Several reasons can be considered to carry the potential for causing these findings. They include insufficient funding (through budget) to the health sector, lack of quality science education in the health sector, and lack of deliberate investment by the government to improve working conditions in the health care sector.

The factor, namely, 'Inadequate budgetary allocation to public health sector' was rated 'high' at 3.19 mean score (Table 3), which implied 'agreement' by respondents. Thus, GTC's respondents in this study pointed out inadequate budgetary allocation to public health sector as a significant challenge that keeps facing D-by-D processes in provision of public health services. Being one of the countries operating at a low middle economic capacity, Tanzania frequently allocates insufficient funds in its ministries and sectors including the health sector. Arguably, the element of D-by-D in the public health sector of GTC should be part of areas of operation that get affected by low budgetary allocations.

The challenge of 'Poor leadership and management' was rated 'high' at 3.27 mean score (Table 3), which was interpreted to be 'agreement.' Thus, among respondents in GTC, the challenge of poor leadership and management was pointed out to be a significant challenge in implementation of D-by-D to deliver public health services. The quality of leadership and management depends on general structure of operation and on workforce adequacy as well as satisfaction. In these findings, these elements did not exist at good levels for GTC.

The posed challenge, 'Contradictions rooted from the constitution' was rated 'very low' at 1.70 mean score (Table 3), which was interpreted as 'strong disagreement' by respondents. Therefore, in light of respondents' views in the context of GTC, there were no contradictions from the constitution that stood as a significant challenge against D-by-D in delivery of public health services. As for item "12" (on 'lack of critical legal and institutional infrastructure).

The challenge 'Corruption' was rated 'low' at a slightly low mean score of 2.23 (Table 3), which suggested 'disagreement' by respondents. Although several past-time researchers observed corruption to be a significant hindrance in public health implementation of D-by-D, this seemed not to be the case for GTC. Arguably, the low rating on corruption in these findings can be attributed to accountability and integrity among LGA officials and other workers in healthcare institution.

Lastly, the challenge, 'Considerable dissatisfaction among service providers, especially health professionals' was rated 'high' at 3.01 mean score (see Table 3), which was interpreted 'agreeing response.' Thus, there was high agreement from respondents in GTC that dissatisfaction among service providers was a challenge in the process of D-by-D in delivery of public health services. Service providers' dissatisfaction was attributed to several factors related to welfare of healthcare workers observed in the Tanzania health sector, including discouraging work environments, lack of enough workers in health care facilities, and inadequate salaries.

3.2 Perception on Challenges For and Against Implementation of D-By-D in Delivery of Public Health Services for Both IMC and GTC

Besides, interview findings revealed some notable challenges for and against implementation of D-by-D in delivery of public health services for both IMC and GTC. Below are the interview findings;

A budget and planning officer from IMC responded that,

> "Of course, 'yes.' There has been the problem of personnel capacity in healthcare institutions and even in administrative positions at the council level. By personnel capacity, I mean both their availability or number and their credentials. So, usually you do not find many candidates when you want to employ and you still find few candidates when you are looking for specific credentials. Thus, because availability of personnel is a key factor in service delivery and accessibility, I can say that the public health sector still needs to invest more efforts in the area of securing a reliable workforce."

At IMC, another key informant and officer said:

> "There are several challenges. I think I would not talk about those everyone keeps mentioning like scarcity of workers in facilities or low citizens' engagement. For my case of Ilala municipality, I think there are two challenges. One is lack of strategic and visionary planning by leaders in the health sector. Look, for example, at the issue of rapid population increase in the city and plans that are put in place to deliver sufficient public health services, there is no correlation. As a result, available public health facilities end up being overcrowded. Second, I think we are lacking good strategies of workforce creation in the health sector. This second problem is rooted from the system of tertiary and higher education levels as well as how it collaborates with the healthcare job sector to prepare a desired workforce."

All interviewees from IMC said that accessibility, availability, utilization, and coverage of public health services were notable issues. It means that there were no effective accessibility, availability, utilization, and coverage of public health services in the councils. Several reasons were mentioned. The most commonly mentioned problem was shortage of workforce and inadequate workforce. Other challenges were presence of few health facilities, lack of awareness as well as knowledge by the public, and poor visionary planning in the health sector.

Moreover, there were notable challenges pertaining to availability, responsiveness, and number of medical practitioners in healthcare facilities.

An officer at IMC responded:

> "When it comes for available number of medical staff, it is insufficient, in most cases. Many people know and we have been hearing in the media as well as in political platforms about the need to encourage young people to pursue higher education in healthcare fields. This is because there has been a serious gap of availability of personnel in the sector and we keep seeing this gap even in the facilities found in our areas."

Another officer at IMC said:

> "Regarding the issue of sufficient number of medical staff, there are variations with respect to the sections and departments that one can point out. Usually, the laboratory technicians' sections may be not so lacking of staff, but the nursing, medical doctor domain and others that need specialists like gynecology, neurology, and psychiatry, there is a big gap between the demand for staff and service from the community. However, we have witnessed sufficient availability at work (if that is what you mean by 'availability') at least in recent years. This, to some extent, has to do with the discipline that the current regime of political leadership has been creating public offices and service institutions. So, serious attendance and availability at work have been mostly observed. Of course, there may be a few cases for those who tend to leave early or arrive late because of known reasons, maybe someone is schooling and working or works for the busy intensive care section and usually sleeps for a few hours."

Further specific challenges that decentralization by devolution system faced in public health services delivery were noted from interviewees.

An officer and key informant from IMC responded:

> "There is a challenge of community knowledge and awareness. This is a challenge because at times D-by-D has to be implemented while involving citizens' participation, particularly in planning and decision-making. Then, when the public (the citizens) are not knowledgeable and aware of D-by-D and what it tends to achieve, they pave fora big challenge. It is the reason and even difficult for officials at the council level to mobilize the community on involvement in decentralized roles of public healthcare. There is also the challenge of the central government not delegating full responsibility or intervening in the autonomy of district and municipal councils unnecessarily."

Another officer and key informant from IMC responded:

> "There is serious lack of policy clarity on this D-by-D strategy at the central government level. It seems that the central government lacks a comprehensive and well-articulated strategy to put the D-by-D into use. In addition, there are seems to be lack of knowledge on the policy even among the healthcare community —things are not clearly put forth. In short, there seems to be a lot of inconveniences around this policy such that comprehensive legal efforts may be needed to avoid it being a source of conflicts and collisions between LGAS and the national government."

Regarding challenges faced by GTC, some informants, while responding to interviews, gave the following remarks:

A key informant and planning officer at GTC said:

> "Yes, there are challenges in availability and utilization of public health services. The major challenges I see, especially in my area, Geita, include presence of few health facilities like hospitals and dispensaries as well as shortage of workers in existing facilities. In due regard, one can find a fair number of nursing officers in these facilities, but the medical doctors are usually few in our facilities and they are overloaded with work."

At GTC, another key informant and officer said:

> "Yes, to some degree. Of course, there are problems that we keep highlighting and many are almost found in many places, not just Ilala Municipal. They include shortage of personnel, shortage of equipment, and poor motivation to workers. But, if you leave those aside, I think there is also another big problem, lack of knowledge and awareness on public health among citizens and at times, among health care workers. I think public health and other forms of healthcare are not clearly addressed terminologies among the public and they have significant impact on delivery and accessibility. So, I say that while the government (and maybe private actors) is setting up public health services, it is important to sensitize the public about it."

In these findings, insufficient health facilities were especially a problem for GTC. In the said council, the number of health facilities was indicated to be quite low by the United Republic of Tanzania President's Office, Regional Administration and Local Government (URT PO-RALG), [24]. According to available data, until 2018, with a population of 192,707, GTC had 20 health facilities with the following distribution: eight public dispensaries and six private dispensaries. On health centres, there are two public health centres and two privately owned. There are two privately owned maternity-based hospitals, two private hospital, one Voluntary Counselling and Testing (VCT) centre and one public regional referral hospital. The situation of GTC shows that there were 20 villages/hamlets with health facilities and 58 villages/hamlets with no health facilities. There were nine wards with health centres while four wards did not have. This implies that 74.36 percent of villages/hamlets in GTC lacked dispensaries and 25.64

percent of wards had no health facilities. This was contrary to the Government Policy of having a dispensary for every village and a health centre for every ward [24].

Moreover, through interviews, respondents revealed some challenges pertaining to smooth health service delivery and the reasons they attached to those.

At GTC, a respondent said:

> "For the health centers and offices available in my area, staff availability and attendance to work are at least satisfying. You can occasionally come across a few cases of stubbornness in that area, but it is always a matter of individual cases rather than being a culture or habit for majority. For the number being sufficient for smooth service delivery, that rarely happens. We all know the problem of an insufficient workforce in our health facilities and it has been a prevailing issue. The medical profession has not succeeded at solving it."

Generally, the interviewees were clear about the distinction between availability at work and having sufficient number of medical staff at the health facilities. They asserted that members of the medical staff were always available at work places and agreed that it was not a serious problem. However, their number was observed to be insufficient in all cases. The reasons for the number being insufficient could be recaptured in two remarks by interviewees from GTC and IMC, respectively:

> "We all know the problem of an insufficient workforce in our health facilities such that it has been a prevailing issue and the medical profession has not succeeded at solving it."

> "This is because there has been a serious gap of availability of personnel in the [health] sector and we keep on seeing this gap even in the facilities found in our areas."

Regarding availability and attendance at work, some interviewees associated the observed discipline with the discipline that the fifth phase regime of political leadership created in public offices and service institutions. As observed by the researcher, the characteristic of the Tanzania fifth phase regime was that of promoting accountability, hard work, integrity, and corruption-free services among government officials and other public servants. The Tanzania government regime that came into power in 2015 seriously disciplined government officials (including high rank officials such as ministers) when they became significantly short of these qualities. As a result, working discipline among public servants, including those in health facilities has almost become a norm.

Another specified challenge was noted for GTC as an officer and key informant from the area responded:

> "Personally, I see two major challenges. First, there is lack of a good resource capacity and existence of operational inadequacy at councils' level to properly implement the D-by-D model. It works at both the central government and council levels. The national government is expected to fund projects and supply workforce to the LGAs, and if the funds as well as workforce are insufficient (which they are), effectiveness would not be realised. Second, even if resource capacity was there, there is still another challenge I see, we seem to lack detailed documented guidelines and laws on this issue. It seems to be a new model of operating yet to be tailored to our local context and of course, have this tailoring documented well and guided by laws."

When responding to the question, 'what were the specific challenges that decentralization by devolution system faced in public health services delivery?' Interviewees identified several challenges. The following six challenges were captured from their responses: insufficient community knowledge and awareness; serious lack of policy clarity on the D-by-D strategy at the government level and in the community; the government lacking a comprehensive and well-articulated strategy to put the D-by-D into use in the public health sector; and lack of operational adequacy

including a good resource capacity to well implement the D-by-D model. Others included hurting of autonomous operations of municipal and district councils by the central government; and lack of detailed documented guidelines together with laws on this issue.

Certainly, the challenge of human resources capacity and adequacy had been noted in the government documents to be significant, especially for IMC and GTC. Ilala Municipal Council [20] had documented on scarcity of key personnel in its facilities. In 2018, the Municipal Council had 197 doctors with an average population per doctor of 33.3 percent as Table 4.3c indicates.

3.3 Discussion of the Findings

Findings of this study concur with those of Conyers [25] who found that inadequacy of human resources capabilities is a big threat to decentralization. Human capital is always limited, generally, in most countries. With decentralization, the scarce human resources are further divided in to the devolved units and thus, affecting adequacy as well as availability of human capital. It is well documented through research that most of decentralized units across the world have exposure to shortage of skilled and experienced manpower for the correct staff to ensure that decentralization works. Due to such lack, the decentralized units are left to operate with minimal human resources and staff within the units [25]. Additionally, such inadequacies are exposed to lack of proper equipment to affect the goal of serving its citizenry.

Findings of this study agree with those of Ssonko [26] who found that autonomy and interference from the central government are rampant. In an ideal decentralized unit, governments at the local level are responsible for relevant government functions, but this is not the case, in reality. The leadership in the decentralized units, in this case, are usually controlled by the central or national government. The control starts from where funds are involved. In this case, the central or national government controls funds that it has a responsibility to make distribution to the decentralized units [26]. The resultant effect is that the decentralized units will have a high level of dependency on the central or national government as far as running its operations is concerned. It is evidenced that despite having decentralized units, substantial power and authority always remains within the central government. Furthermore, majority of roles that government levels are responsible for have not been clearly defined, ending up causing policy conflict. It is quite common to get employees that are appointed by the central government working in the decentralized units. As such, the units do not enjoy autonomy and cases of conflict end up being rampant [26].

Findings of this study also correspond with those of Fiorino, Galli, and Padovano [27] who found that overdependence of local governments and health authorities on central transfers undermines accountability and also, results in blame-shifting to the upper tiers. Additionally, Fiorino *et al.,* [27] found that another concern with decentralization in developing countries is that much of it remains essentially a paper exercise, when in practice, continues to exercise the greater portion of authority through corruption, resources misused and a centralized-bureaucratic mentality. The centre finds it extremely difficult to give away its powers associated with finance and decision-making authority. A further major concern is that the finances allocated for implementation of health sector decentralization are often mostly donor-oriented.

Findings of this study correspond with those of Fiorino *et al.,* [27] who found that expanding competencies of local governments may breed malfeasance, since local bureaucrats may be poorly trained and thus, inefficient in delivering public goods and services. When the relationship between citizens and government officials is closer and more frequent, the potential briber needs to affect only a limited segment of the government [27]. This is all the truer if local bureaucrats are poorly trained and less efficient than those operating in the top notches of government. Finally, it was suggested that greater decentralization multiplies the government units about which each citizen must be informed. Such increase in information costs worsens the agency relationship between citizen and elected officials as well as expands the room for malfeasance [27].

Findings of this study are in agreement with those of Bird and Rodriguez [28] who found that the negative correlation holds up in developing countries with older and fewer parties in government. Looking at political rather than fiscal indicators, they report that a federal structure is associated with higher perceived corruption.

Findings of this study concur with those of Regmi and colleagues [29] who found little evidence that the size of municipal governments affects corruption, while smaller units of local governments at the bottom tier (excluding municipalities) seem to be associated with more widespread corrupt behaviour.

Findings of this study agree with those of Ssonko [26] found out that taken separately, measures of government fragmentation do not seem to affect corruption, while fiscal decentralization seems to reduce it. This effect appears reinforced if fiscal decentralization is combined with a high degree of horizontal government fragmentation at the local level. All in all, the variety of samples and estimation techniques, the different definitions of decentralization and corruption that the various studies adopt explain these differences in the results.

Furthermore, findings of this study correspond with those of Frumence and colleagues [30] who demonstrated that the case for decentralization may be weakened in developing countries because poverty can limit preference differentiation and decentralization typically leads to increases in public overhead expenditures, potentially undermining both productive and allocative efficiency.

Regarding inadequate funds, Lyon and colleagues [31] offer the first supportive evidence here. While analysing the situation of 'fiscal decentralization' in Tanzania, following the first phase of decentralization under the 1998 policy, they reported that most LGAs are still very dependent on transfers from Central Government despite growing local revenues. With over 90 percent of revenues, on average, coming from this source, the level of vulnerability to delayed, reduced or no transfers is a major constraint. Because of lack of reliable, timely and consistent funding and funds flow, already approved budgets cannot be implemented. Therefore, the LGAs are forced to make planning, budgeting and expenditure decisions in an environment of significant uncertainty. Their data showed that some councils got as little as 35 percent of their approved development budget in 2016/2017 (for example, Iringa DC, Njombe TC, Mpanda MC, Mtwara Mikindani MC, Mwanza CC). This affects the reputation of the councils, their ability to implement as planned and the ability to deliver services. Again, according to NFYDP II (2015), in the context of D-by-D in Tanzania, inadequate financial allocations and human resources remain the primary challenges hindering further achievements in provision of quality public health services like water, health, and other services.

Concerning loss of autonomy by councils as LGAs, a study by Kigume and co-workers [32] on analysis of decision space in planning, allocation, and use of financial resources in the context of decentralisation and health services delivery in Tanzania, found related findings. In their findings, tit was disclosed that the district health managers felt that they had moderate Decision Space (DS) over planning and budgeting process. There was consensus among the district health managers that they only had a small room to accommodate locally defined priorities and needs.

Moreover, Lyon and colleagues [31] cited on the challenge of strained autonomy on the side of LGAs. In highlighting the challenges from the initial phase of D-by-D implementation in Tanzania, Lyon and colleagues [31] pointed out that LGA autonomy is limited by the high degree of control by central government over local government decision-making. The LGAs are, in many cases, not consulted before policy measures are decided by the central government.

However, the study by Kigume and Maluka [33] showed that LGAs such as district and town councils had autonomy to mobilise and use locally-generated funds to finance different healthcare activities in their areas. In that study, which partly looked at decision space in planning, allocation, and use of financial resources, it was revealed that health facilities in several districts own bank accounts into which they deposit funds from user fees, health insurance, and community health fund. The bank accounts were managed by the members of the health facility governing committees, selected by the community members and names approved by the District Executive Director

(DED). The districts had wider authority in determining and modifying user fees rates as well as community health fund annual contribution rates in the health facilities. In addition, the district councils had power to modify user fee rates within their districts. This finding was supported by responses from many health care providers in IMC and GTC.

Regarding the challenge of responsibilities being unclear at various levels in the system, the URT [34] offers some corresponding data. While entailing on implementation strategy for decentralisation policy of 2019, the URT posed that there is a challenge of lack of a clear framework structure and well framed guidelines on the D-by-D policy. It adds that the process has been guided by policy paper that is not fully endorsed as a policy. Hence, resulting into unfinished tools and guidelines to smoothly institutionalize as well as operationalize the D-by-D (URT, 2019). Realizing that the current style of implementing D-by-D was not well articulated, URT [34] insisted that there is need to have a new framework that will effectively guide sector policy implementation at LGA level. This could, for instance, include development of more precise and realistic sector service delivery norms that Ministries, Departments and Agencies (MDAs) would use for lobbying for sector conditional LGA grant allocations and subsequent monitoring and evaluation (M&E).

Concerning gaps and inadequacy in human resources capacity, Lyon and co-workers [31] assessed implementation of D-by-D in Tanzania. In their studies, it was revealed that all sampled LGAs had inadequate staff in all the five priority sectors, namely, health, education, water, agriculture and livestock, and infrastructure. Furthermore, most of the visited grassroot levels (ward, villages and hamlets) had no assistant planning officers despite existence of such cadre, which was intended to improve planning matters at the said levels.

In addition to the challenges cited by Kigume and colleagues [32] as well as Lyon and co-workers [31], there are other additional challenges facing LGAs in the framework of D-by-D. One of such challenges is the central government's act of dictating issues of funds and grants to LGAs. The study by Kigume and Maluka [33] showed that in budgeting and spending of the so-called Health Block Grant and Health Basket Fund (HBF) resources, local government authorities were required to comply with the centrally defined guidelines. The annual allocation of Health Block Grants and HBFs from Central Government to the local government authorities was based on a formula that was determined by the central government. The funds were allocated based on the following criteria: population (70%), poverty count (10%), district medical vehicle route (10%), and under-5 mortality (10%). In addition, at the district level, allocation of funds was done through budget ceiling, which was determined by the central government. Districts were not allowed to allocate funds beyond these determined ceilings [32].

Lyon and co-authors [31] pointed on the challenge of gap between principles and practice**.** While highlighting on 'what's not working' regarding staffing in the context of the initial phase of D-by-D, Lyon and colleagues [31] pointed out that some ministries recruit and deploy directly (health and education), which cause issues of inconsistency and go against principles of D-by-D. In addition, there is confusion, for example, over who appoints Heads of Departments (HoDs) in LGAs and who decides on promotions, either PO-RALG or PO-PSM. The authors commented that such decisions not based on merit, but on politics, when proper procedure is not followed and when selection criteria are applied inconsistently cause demotivation and even absenteeism. Moreover, when disciplinary action is required, there is confusion over responsibilities between, for example, for teachers, the Teachers' Service Commission (TSC) and the LGAs.

Besides, Kigume and colleagues [32] showed that there was a challenge of bureaucracy, which affected Councils to exercise autonomy on locally generated funds. The researchers showed that although several district councils had been granted high autonomy to mobilise and use locally-generated funds, the ability of the local government to effectively use locally generated funds was constrained by bureaucratic procedures of the central government, particularly in procurement of medicines and medical supplies. The health service providers and district health managers expressed the challenges they were facing in getting medicines from the Medical Supply Department [(MSD)]. It was discovered that health facilities were required to deposit funds to MSD before being assured of

availability of medicines. As a result, health facilities deposited funds to the MSD account while the supplier had no medicines to deliver. It was further found that when the MSD was out of stock, it did not return the funds to the health facilities to enable them purchase medicines from other sources.

Furthermore, some general challenges in implementation of D-by-D at LGAs level were cited by the URT [34] to include delayed service provision, poor time management by staff and minimal accountability as well as transparency. Others included minimal political will, poor records management, shortage of health workers, and resistance to change characterizing public health service. The URT (2019) reports further that the challenges remained so and persisted.

4. CONCLUSION AND RECOMMENDATION

4.1 Conclusion

The study concluded that there were six major challenges that decentralization by devolution system faced in public health services delivery in both IMC and GTC. They included insufficient community knowledge and awareness; serious lack of policy clarity on the D-by-D strategy at the government level and in the community; the government lacking a comprehensive and well-articulated strategy to put the D-by-D into use in the public health sector; lack of operational adequacy and a good resource capacity to well implement the D-by-D model; hurting of autonomous operations of municipal as well as district councils by the central government; and lack of detailed documented guidelines and laws on this issue. Supportive literatures were included in this presentation and analysis.

4.2 Recommendations

Toward making D-by-D a success in delivery of public health services at LGA level, there should be capacity building of healthcare workers by the government taking the lead in collaboration with other actors such as the private sector and training institutions. Moreover, health facilities should be properly facilitated in regard to other physical resources. This would happen through providing equipment, supplying enough workers, and ensuring timely delivery of funds. Such measures would certainly improve performance of facilities and their workforces.

There should be provision of motivation and creation of good working environment by all responsible stakeholders. This would happen through paying of desirable wages to workers, furnishing workplace infrastructures, and having a consisted strategy of offering recognition and promotion. Thus, it would improve working morale, commitment, and responsiveness.

There should be keen efforts to tackle the issue of building public awareness and knowledge. This should happen via community-based campaigns and sensitization programs aimed at creating awareness, building knowledge, and tuning people's perceptions and attitudes. This would work positively on the side of improving the leadership task of mobilizing community participation, and hence, accessibility of public health services.

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