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Navigating the Challenges of Primary Health Care in Selected Local Government Authorities in Tanzania: Bringing Lipsky's Theory in Its Requisite Panorama

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Abstract

Introduction

The robust delivery of primary health care (PHC) service is a complex interplay of key stakeholders, including policymakers, citizens, the government, parliamentarians, academics, and street-level bureaucrats - health staff in this context. While each of these players has a stake in ensuring robust PHC delivery, this paper specifically examines the role of street-level bureaucrats (SLBs) in dealing with service delivery challenges in Local Government Authorities (LGAs) in Tanzania. Although the engagement with these actors gained momentum in the decentralization reforms of the 1990s, their contribution has been slow. The question remains: How can SLBs cope with LGAs' predicaments to enhance service delivery? Lipsky's (1980) theory focuses on this contention by proposing that under challenging encounters, SLBs can develop specific patterns of practices to deal with the status quo.

Methods

Data were collected through interviews with policymakers at Mvomero District and Moshi Municipal Councils. To assess the effectiveness of primary health care services attributes such as authority, accountability, and access were closely examined. A thematic review of the literature was conducted to corroborate the findings from the interviews.

Results

The findings indicate that SLBs can cope with complex and challenging situations related to PHC delivery by rationing resources, simplifying their work environment, or exiting from turbulent environments. Although the engagement of SLBs gained momentum during the decentralization reforms of the 1990s, their contribution has been slow. The primary factor hindering their effectiveness is the inability to establish a mutually beneficial relationship between the Central Government and LGAs.

Conclusion

The government's attempts to control SLBs' behaviors, including limiting their intrinsic and extrinsic motivation, undermine their client responsiveness. Empowering SLBs and fostering a more collaborative relationship between the central government and LGAs is essential to enhance PHC delivery.

Keywords: *Street level bureaucracy, citizens, policymakers, service delivery, Local Government Authorities*

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INTRODUCTION

Governments worldwide, including Tanzania, strive to deliver sufficient, reliable, predictable, and effective primary health care (PHC) services to their citizens (Bustreoa, F., et al. 2020). Their commitment is expressed in their constitutions, legislations, and policy documents (Wangari, 2017). Even though that is the case, aspects mentioned above translating the aforementioned aspect on the ground is not easy. As the World Health Organization (2017) and Wagana et al. (2017) highlight, global health systems struggle to provide equitable, high-quality, and comprehensive healthcare to all citizens. This quandary is coupled with scarce resources at local government authorities (LGAs), partly due to the concentration of government powers at the apex (Muia, 2008).

To address thoroughly this quandary, the need to reduce government powers has mainly been felt since the onset of decentralization; various governments across the world, Tanzania inclusive, have been thriving to devolve their traditional functions and responsibilities to local governments (Mookherjee, 2014; Ringold et al., 2012; IHI, 2014; Ringold et al., 2012; IHI, 2011; Cheema & Rondinelli, 2007). This involved cascading management clout to communities to manage the delivery of social services, including PHC services for all, as emphasized in the Alma Ata Declaration (1978) and currently in the Astana Declaration (2018). The new PHC declaration affirms the *'commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind'*. It repeats the commitment to the four (4) core principles of the Alma-Ata Convention.

The main reasons for granting autonomy to Local Government Authorities (LGAs) are as follows: firstly, the Central Government has consistently failed to provide adequate social services such as healthcare to the people. Secondly, social services are best utilized at the local level. Lastly, LGAs are better positioned than the Central Government to deliver public services due to their proximity and access to local information (Wangari, 2017; Mookherjee, 2014). In theory, LGAs are likely to have discretionary power to address local problems, including those related to the healthcare sector. However, this may not always be the case in practice as many developing countries, including Tanzania, fail to provide services that consistently meet the required standards (WHO, 2017; Surjawoto, 2012).

Based on this dilemma, two things are unavoidable. First, citizens' voices or exits are thought to be due to the decline in the quality of essential services (WHO, 2022). The phenomenon of voice or exit, where individuals either vocally express their dissatisfaction with services or opt to discontinue using them entirely, is not universally feasible. This largely stems from the reluctance of citizens to demand accountability for substandard services, attributable to their relatively limited influence as clients. The notion of client power necessitates direct accountability, mandating active citizen participation in decision-making processes vis-à-vis service providers, specifically street-level bureaucrats. Second, the cessation of public services, such as primary health care facilities, does not occur in instances of diminished operational efficiency. Notably, service provision perseveres, albeit at a markedly sluggish pace, implying the involvement of underlying factors behind the scenes.

Guided by street-level bureaucracy theory (SLBy), this paper attempts to unveil these forces operating behind the scenes that keep the ball rolling under challenging environments. Therefore, this paper addresses four key aspects; it first unveils vital conceptual issues and accords the state of health service delivery in selected LGAs. Second, it unearths health service delivery challenges. Third, it elucidates how SLBs develop a pattern of practices to handle service delivery challenges. Fourth, it explicates how established patterns of practices limit central government control over semiautonomous social fields in the health sub-sector.

METHODS

The study used a qualitative approach, spatial quasi-design, semi-structured interviews, and documentary review. It involved reviewing various documents, legislations, research reports, and policies and observing street-level bureaucrats in Tanzania dealing with primary health care service delivery challenges. Data was collected from selected LGAs such as Mvomero (rural) and Moshi (urban) councils. The aim was to understand how health workers in these areas express their concerns regarding public policy formation and execution. Spatial quasi-design was used because government interventions like policies, legislations, guidelines, and directives govern the operations of LGAs across the country. The objective was to understand how government interventions apply across different selected councils. Additionally, semi-structured interviews were conducted with frontline workers, and study permits were obtained from selected LGAs. In contrast, direct consent was obtained from health staff and government officials who provided information. Visits to and observations of study sites were also conducted. The four primary health facilities selected were Mnazi, Njoro, Dakawa, and Mongwe, from their respective councils.

CONCEPTUAL ISSUES

Michael Lipsky's Theory in Its Requisite Panorama

Bringing this theory into perspective is imperative because, for many developing countries, service delivery and primary health care (PHC) in this context suffer significantly due to

existing incongruence between policy-making and implementation. In a requisite panorama, what we see as policy implementers are policymakers. Based on Lipsky (1980) and Mgonja, J., & Tundui, H. (2012)., some lower-ranking public employees who are viewed as policy implementers utilize a specific level of discretion to determine public policy. Kamugisha (2021) believes that at the end of a policy chain, there is a vacuum that street-level bureaucrats normally utilize to maneuver policy. Using Lipsky's (1980, 2010) lens, public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators because, in meaningful ways, it is made in crowded offices and daily encounters of street-level workers. This shows that a successful implementation of any programme or project, or activity depends on frontline policy implementers, particularly those whose level of contact with service recipients is high. In this context, frontline policy implementers are public officers, like health staff, who interact with citizens in their responsibilities and exhibit significant discretion in allocating benefits or sometimes sanctions. Service recipients, called 'street-level bureaucrats' (SLBs), are pivotal in actualizing public policy. This phenomenon elucidates the enduring dichotomy between policy formulation and implementation, as contextualized by Woodrow Wilson in 1887.

Despite concerted efforts by numerous nations, including Tanzania, to devise policies and establish enforcement mechanisms such as legal frameworks to foster closer governmental-citizen proximity, anecdotal evidence indicates that practical implementation often lacks clarity. Focusing on countries that reformed their public sectors, including LGAs, especially in Africa, in order to increase the interface between stakeholders, the experience shows that service delivery, mainly primary health care (PHC), in many African countries, is 'often poor or nonexistent' (Bold et al., 2010:2, Anangisye, W. A., & Mabagala, M. (2021).). Scholars justify this contention by showing that health clinics are not open when they are supposed to be, health workers are frequently absent from clinics, and, when present, spend a significant amount of time not serving intended beneficiaries. Equipment is always nonexistent, even when available, is not used, or is not in good order. Drugs and vaccines, in many cases, are misused, and financial allocations are expropriated. This is partly due to the disruption of short and long routes of accountability. Lipsky (1980) developed strategies to explicate the mechanisms that would be taken into fingertips to deal with the predicament. This scenario appeals to the theory in perspective. Numerous conditions are implemented to use Lipsky's (1980, 1969) theory. In light of the current context, it is evident that health resources, both personal and organizational, are insufficient, while there is a high demand for services.

The question is what can be done to meet the ever-growing demand for health services with meager resources covering financial, physical - infrastructures, equipment, and technical health staff and support staff. Second, work proceeds when a clear physical or psychological threat exists and/or the bureaucrat's authority is regularly challenged. When things are not moving rightly, health staff are likely to encounter psychological threats, including anxiety, depression, guilt, shock, loss of self-esteem, sleep deprivation, use of hypnosis, deception or mental stresses, infections, and the like. The physical threats may cover natural events, including floods, earthquakes, tornados, and environmental conditions like extreme temperatures, high humidity, heavy rains, and lightning, which may harm health staff lives. For instance, drugs and other supplies can only be sustained in a user-friendly environment.

Third, it works where job performance expectations are ambiguous or contradictory, including unattainable idealized dimensions. For instance, when employees' work conditions are difficult, they may not be productive. Creating a conducive work environment may increase working morale and enhance productivity. This lacuna may inculcate the street-level bureaucrats (SLBs) to devise mechanisms to address the fissures. During challenging encounters, SLBs may first develop practice patterns to limit demand and maximize the utilization of available resources. This is because SLBs normally organize operations within their resource constraints. Second, they modify their concept of work to lower or otherwise restrict their objectives and thus reduce the gap between available resources and achieving objectives. Third, they modify their concept of their service recipients to make the acceptable gap between accomplishments and objectives. Figure 1 explicates this process.

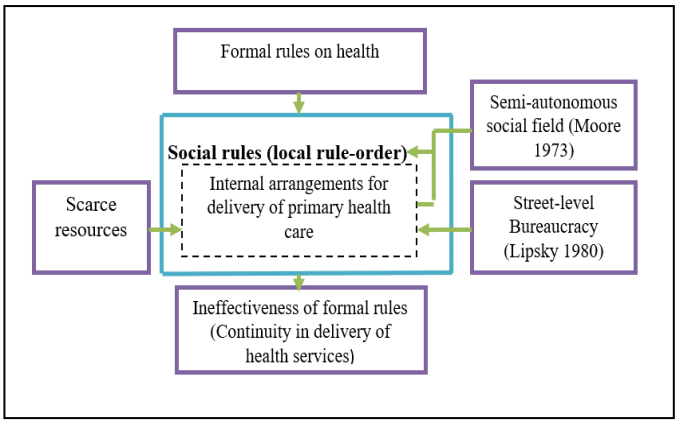

Figure 1:Limited effectiveness in dispensaries adapted from Kamugisha (2019), Wilhelm (2011)

Based on the insights presented in Figure 1, it can be posited that when healthcare workers at the lower echelons encounter challenging work environments, such as limited resources, two notable outcomes are probable. Firstly, they may devise strategies to manage service delivery challenges, particularly those associated with primary healthcare provision. It is pivotal to acknowledge that scholarly work, notably by Kamugisha (2019) and Bold et al. (2010), has delineated health-related impediments, encompassing fragmented health systems, inadequate infrastructure, equipment, and human resources – both in quantity and qualifications. This underscores the potential for healthcare

workers in such circumstances to devise mechanisms to mitigate these challenges, safeguarding continual service delivery. Secondly, protracted healthcare practices may evolve into social norms within semi-autonomous social spheres, imposing enduring moral responsibilities that are challenging to defy readily. Street-level bureaucracy theory (SLBs) reflects the ongoing situation in Tanzania regarding service delivery, as indicated in Figure 1. This figure shows what is happening in developing countries, including Tanzania. Before and after the 1990s marked the decentralization reform era, Tanzania experienced a growing demand for social services, mainly primary health care (PHC). This demand has persisted despite various country regions' financial resources, staffing, equipment, and physical infrastructure constraints.

The government has undertaken deliberate measures to address these challenges by enhancing health facility infrastructure, refurbishing health facilities, providing staffing and incentives, allocating financial resources, and fostering awareness among citizens to encourage the uptake of essential health interventions. Nevertheless, the figure shows that to deal with health-related problems, operational arrangements that take place internally can translate into social rules, which, in the long run, can limit government control over semi-autonomous social fields. This means that social rules can limit the effectiveness of public policies and legislations that guide SLBs' behavior and how financial, human, and physical resources must be distributed. This can partly be explicated by the disjointed interface among policymakers, citizens, and street-level bureaucrats, which makes service delivery like PHC suffer. Adherence to the line of accountability varies between developed and developing countries. Therefore, copying strategies to address the effects of disjointed accountability on service delivery may not be effective.

Service Delivery

In any system of government, be it federal or unitary, service delivery involves the interaction among policymakers, citizens, and street-level bureaucrats who can influence different government decisions (WHO 2017; UNDP, 2016; Ringold et al., 2012). The interface of the actors above exists in either system to share risks and opportunities (Knox, 2002). The two systems converge because both strive to ensure service delivery to citizens. The divergence between the two systems is that the federal system enhances symbiotic interaction between stakeholders more than the unitary system. The former is more democratic than the latter. In this system, service beneficiaries can exercise their client power when service delivery declines quality via voice or exit (UNDP, 2016; Sujarwoto, 2012). Comparing the two systems, one can agree with scholars like Dada (2013) and Doh (2013) that the mutual interface among actors increases along a continuum from de-concentration to devolution, and so service delivery in this regard. This is because the line of accountability, whether short or long, is clearly defined in a democratic environment.

In a unitary system, especially in developing countries, the line of accountability is mainly incoherent. Bold and colleagues (2010) associate incoherence with limited service delivery outcomes, particularly in countries where government powers are mainly concentrated at the apex. Such systems hamper the percolation of resources and autonomy into LGAs. This deed is a result of a conventional system of governance that hinders the center from deliberately cascading substantial autonomy to lower tiers of government for several reasons, including the fear of local corruption, weak local capacity to manage public finances, maintaining proper accounting procedures, and communal & ethnic insurrection (Kamugisha, 2019). Whether these claims are valid, it is indecorous to blame the local government's inefficiency or incompetence because this may partly elucidate the predicament. As Liviga (2011) argues, many factors other than those contribute to that state of affairs. Even if the factors mentioned above were the real reasons for LGAs' wastefulness, it could not establish an adequate account of the central government's control over LGAs. This is because the center also suffers from the same predicament of unfortunate performance. The notion of wretched performance results from the incapacity to observe the short and long routes of accountability, which may limit service outcomes, as explained in detail below.

Service Delivery: Short and Long Routes of Accountability

Service delivery can be realized if 'short' and 'long' routes of accountability are comprehensively practiced. Along the long route, citizens can influence policymakers through 'voice' and 'exit' strategies. Comparing the unitary and federal systems, the long route is more appealing in the federal system, where health workers are likely to account for their actions or inactions. In principle, 'voice' and 'exit' strategies are not exhaustively executed in unitary governments because service recipients regularly encounter information asymmetry, a fact that hampers the demand for accountability. This is primarily the example of the unitary systems where frontline policy-implementers devise their own or local policies due to policy failure. On the contrary, where citizens are strong, policymakers can influence service delivery through frontline policy implementers by implementing feasible policies, legislations, and monitoring and evaluation procedures (compact). In a short route of accountability (client power), service beneficiaries can directly, individually, or collectively participate in influencing, supervising, and monitoring service delivery (Ringold et al., 2012).

A symbiotic interface between actors does not exist in a unitary system because most powers are concentrated at the apex (Beuerman, 2010). This shows that in many developing countries, de-concentration of power is more widely exercised than devolution, which is mainly pronounced in a federal system. The controversy found in a unitary system corresponds with what Faguet (2012) found in several African countries that reformed their public sector, including LGAs, by commenting that reform outcomes look the same

on paper across countries, but on the ground, present are different perspectives. This may explain service delivery ineffectiveness due to stakeholders' failure to put public policy into practice because stakeholders exhibit different interests, experiences, and knowledge (Knox, 2002). The interface between key stakeholders is illustrated in Figure 2, which indicates the interplay among various stakeholders that is essential for strengthening primary healthcare and other health services worldwide.

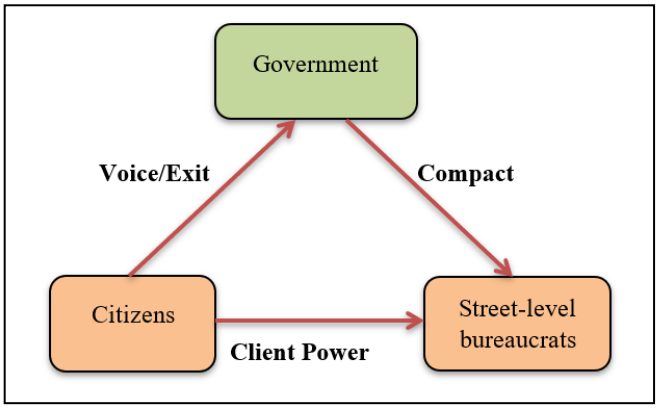

Figure 2: As modified from Ringold et al., 2012

Firstly, the figure sheds light on the interaction between the central government and LGAs, which can influence or hamper service delivery. Theoretically, the two exist under an agreed-upon mutual interface. The center must cascade autonomy, such as decision-making clout regarding finances, staffing, infrastructure, etc. The LGAs are responsible for engaging citizens in planning, allocating resources, and addressing various challenges. The experience from developing countries presents contending views regarding the relationships between the Center and LGAs because LGAs have been deprived of their substantial autonomy.

The interface between the two is not symbiotic because LGAs are seen as creatures of the statutes and administrative machinery (McKinlay, 2013). LGAs are viewed as state instruments, which is something that makes them unautonomous. Using Liviga's (2011) lens, LGAs in Tanzania play a facilitative role, and the central government is the main provider of essential services, including health. This practice contravenes all notions of devolvement of autonomy to sub-states (LGAs) anticipated by reformers. This has partly been associated with ineffective service delivery in LGAs. In this scenario, one can question how LGAs operate. Possibly, this situation brings Lipsky (1980) into perspective, where frontline policy implementers are thought to cope with the status quo.

Secondly, the figures show the interface between LGAs' council officials and councilors. This is possible when there is consensus among staff and citizen representatives, who can interact to address jurisdictional matters, including health issues, through allocating scarce resources, among others. The conflict between actors in the social fields can hamper the achievement of this objective (Warioba, 2008). When councilors address their concerns apart from the people coupled with officials' interests, then people's development plans suffer a great deal, plunging sub-states into a mess. This may inculcate endless confrontations between actors. Typically, heated debates (conflicts) revolve around how LGAs raise revenue and expend it (Ringold et al., 2012). This can be resolved by allocating resources focusing on evidence-based priorities accorded by people. Numerous studies, including that of Warioba and Warioba (2012), indicate mistrust between government and non-government actors. This aligns with what Gildenhuys (2010) found somewhere: mistrust between parties limits the allocation and utilization of resources. In this situation, street-level bureaucrats can devise specific mechanisms to deal with the situation.

Thirdly, to enhance service delivery, the interface between policymakers and citizens must be manifested through mechanisms for giving people a voice for downward accountability (UNDP, 2016). According to Ringold and colleagues (2012), channels for giving people a voice include votes, taxes, representation in parliament, local councils, and grievance redress mechanisms. As long as taxes are drawn from citizens, they should be allocated to meet their expectations. If they are misappropriated, citizens will get low-quality services. According to Sujarwoto (2012) and Hirschman (1970), when a service declines in quality, citizens may hold policymakers accountable for their actions or inaction or cease using such services. Ceasing using public services may not be the case in monopolistic situations because there is no option. For instance, if there is only a public dispensary in the social field, citizens will have no choice but to use what is available. Based on Kamugisha (2019), when clients are not satisfied with the quality of primary health care, for instance, they may opt for faith organizations and traditional healers as mechanisms to deal with the scenario. The failure of modern health systems may partly explain this. Where there is competition, citizens may go for private services only if they are affordable and public health services are not of good quality. Street-level bureaucrats will take the lead at the end of this policy chain.

Fourthly, the interaction between policymakers, particularly the government and street-level bureaucrats (SLBs), can facilitate service delivery. WHO (2017), UNDP (2016), as well as Ringold and colleagues (2012) reports, indicate that for this to happen, feasible policies, regulations, rules, circulars, procedures, incentive arrangements, management of public finance, and formal controls must be in place as well as enforceable mechanisms (compact). The paradox is that while many governments or countries globally formulate such laws and put down mechanisms for enforcing them to enhance better services, several developing countries, including Tanzania, experience mixed outcomes across a variety of services, as reflected in Robinson (2007), writings in the context of Latin American countries where it is believed that decentralization across services brings upon different outcomes. This can partly be explicated by a lack of legal framework, a gap in the existing legal framework, and

a weakness in the enforcement mechanism. Service providers' challenges, including intrinsic and extrinsic values, may not be heard and addressed, reducing staff working morale. In this environment, staff, particularly those in the health sector, may find themselves looking for an alternative way to cope with the status quo.

Fifth, the interface between citizens and street-level bureaucrats (SLBs) has to be expressed through 'client power,' which implies direct influence by citizens on SLBs - service providers (Ringold et al., 2012) or health staff in this context. One of citizens' roles includes participation directly in decision-making organs such as primary health facility committees. This is a kind of decentralization in the form of devolution, where members of these committees oversee the management of primary health facilities by promising high accountability. Mubyazi and Hutton (2003) found that countries that devolved management clout to communities and committee members experienced accrued benefits, for they used their discretion to address local problems even though these scholars do not tell us about the experiences and level of education of the entire committee members. This is imperative because, in many cases, citizens in these committees lack knowledge and experience regarding management clout, which limits the demand for accountability.

Using Mali, Benin, Guinea, and Mozambique experiences, Mehrotra (2006) reveals that devolving considerable autonomy to locally elected communities escalates access to feasible health services like immunization, cutting the infant mortality rate. This is not a dogma because Robinson (2007) pointed out that decentralization outcomes vary according to context and service. According to Alsop and colleagues (2006) and Alsop and Heinsohn (2005), client power or citizen participation can be measured by looking at prevailing opportunities, their uses, and immediate (outcomes) or long-term outcomes (impact). Lipsky (1980) and Moore (1973) impliedly accord that in many areas where devolved significant autonomy does not reflect the practice, it sets conditions for investigating the manner frontline policy implementers may develop patterns of practices to cope with the status quo and in a long run limit effectiveness of the center over semiautonomous social fields.

Trends of Service Delivery in Tanzania

Service delivery in Tanzania follows the decentralization epitome, which covers both forms and dimensions. Forms of decentralization include de-concentration (power transferred to periphery units of administration of the center), delegation (power transferred to specialized agencies), devolution (power devolved to LGAs), privatization (focuses on the private sector), and partnership (focuses on civil society organizations, CSOs). Dimensions of decentralization cover administrative, political, financial, and economic (market) (Kamugisha, 2019; Steiner, 2007). Service delivery trends in Tanzania, therefore, can be placed in three categories, namely, unicentric system (state supremacy), multicentric system (economic or market forces), and pluralistic system (partnership).

Service Delivery State: Unicentric System

This system can be traced from the 1970s to the early 1980s when the Tanzanian Government abolished Local Government Authorities (a de-concentration form of decentralization). In this era, centralization of power was at its zenith. It was used as a catalyst for enhancing access to public services, including delivery of PHC, which was found to be in pathetic conditions during the colonial and post-colonial eras. For instance, life expectancy was between 30 and 40 years in the early 1960s (URT, 1990). However, it was argued that for newly independent states, de-concentration aimed at bringing unity, escalating the provision of essential services, and abolishing all forms of discrimination; in practice, these efforts increased social, economic, and political predicaments. LGAs lacked trained and technical personnel as well as fiscal resources mobilization and, as a result, became unable to run and maintain functions entrusted to them; eventually, modern health service delivery suffered a great deal (Kamugisha, 2021; Kamugisha, 2019; Kessy, 2011; Max, 1991).

The question may be, why did this happen? According to Liviga (2011), LGAs failed to deliver goods because some decisions were politically driven rather than based on technical assessment and professionalism. For instance, the decision to forcibly move people into planned villages (Ujamaa Policy) disrupted agriculture, leading to a decline in exports and food shortages, increasing malnutrition and food insecurity. Other factors contributing to LGA incapacity include increased oil prices in 1974, drought, famine, and waging war between Tanzania and Uganda in 1978. This deed increased resource mobilization and utilization predicaments across all sectors, including the health sector, which deteriorated seriously in terms of coverage (quantity) and standards (quality) (Mollel, 2010). The central government remained mainly a planner and player, limiting LGAs' discretionary powers. Although there are limited insights on how LGAs managed with the status quo, service delivery proceeded in a multicentric System differently.

Service Delivery State: Multicentric System

This period can be traced back from the mid-1980s to the early 1990s, which impacted Tanzania. It witnessed a significant shift from collectivism to individualism (privatization form of decentralization). In a nutshell, this period emphasized the 'market' rather than the 'state' (Masue, 2014; Masue 2010; Sorensen & Torfing, 2004). Service delivery in Tanzania responded more to market forces that the government controls over all means of the economy. In response to recommendations from the International Monetary Fund (IMF) and the World Bank (WB), Tanzania implemented structural adjustment programs (SAPs) to enhance its financial capacity for developing a sustainable budget and providing crucial services like primary health care to its citizens. However, instead of achieving economic

recovery, adopting neoliberal policies led to economic constraints, higher external debt, and various socio-economic and environmental issues. Consequently, there was an increase in bottlenecks affecting social services, including primary health care, rather than an improvement (Mukandala & Peter, 2004). Commenting on these bottlenecks, Mukandala and Peter (2004:13) said that:

In the mid-1980s…the health sector was in a pathetic state. Hospitals, health centers, and dispensaries faced shortages of medicines, poor or inadequate health facilities, inadequate and unqualified staff, and inadequate and dilapidated infrastructure, including buildings for clinical services, offices, staff houses, and waste collection and drainage facilities. Similarly, government-owned health facilities became the last resort for people seeking primary health services.

These aspects reveal that the delivery of social services, including health, in Tanzania up to the 1980s was in a critical state fueled by the execution of neo-liberal policies. Due to these problems, scholars like Tibaijuka and Anna (1998:7) commented that 'the 1980s era has been branded a lost decade for development'. It is true because the stakeholders in this era were frustrated that citizens suffered a great deal, and all coping strategies were to the detriment of the masses. Child mortality rate, maternal mortality rate, and the like were at zenith. The lack of vibrant healthcare systems compelled citizens to treat themselves by using medicinal plants, particularly cheap roadside treatment, inclining themselves to health hazards caused by the unidentified source of these pitiable medications (Ndhlala et al., 2009). The situation improved to some extent in the pluralistic system.

Service Delivery State: Pluralistic System

The pluralistic system, spanning from the 1990s to the 2000s, had a significant impact on the government of Tanzania. This era brought about notable changes compared to previous periods, including the proliferation of national policies and the ratification of international protocols. These actions were deliberate efforts to increase the discretionary powers of the public sector, including Local Government Authorities (LGAs). This era embraced a devolution form of decentralization and was seen as a solution to improve the delivery of essential services, particularly primary health care (PHC).

The pluralistic system, also known as the public-private mix, was emphasized by international protocols such as the Alma Ata Declaration (1978), the objectives of which were reshaped by the Astana Declaration (2018); Strategic et al. (SDGs) (2016-2030); and Africa Agenda 2063. Nationally, similar emphasis was placed on this system through policies such as the Policy Paper on Local Government Reforms; National Health Policy (URT, 2007, 1990); National et al. (NHSR) (1994) proposals; Community et al. (CHF) (1999); National et al. (NHIF) (2001); Health et al. (HSSP) I (1999-2004), II (2005-2009), III (2009-2015), and IV (2016-2020); Tanzania Vision, 2025; and the Primary Health Services Development Programme (PHSDP).

These strategies aim to improve health systems and resources, including qualified staff covering doctors, clinical officers, assistant clinical officers, pharmacists, health officers, nurse assistants, nursing officers, midwives, and nursing attendants. The strategies also aimed at improving the supply of physical resources like microscopes, autoclaves, delivery beds, stethoscopes, delivery kits, weighing scales, diagnostic sets, ambulance bags, Blood Pressure (BP) monitors, drugs, and other supplies. It also involved the construction/renovation of primary health facilities or buildings, offices, staff houses, and waste collection and drainage facilities. Further, it aimed to improve the devolvement of financial resources, including capitation grants to LGAs. The central government has overseen the process, resulting in limited positive outcomes. The center failed to provide all essential resources partly due to a lack of resources, commitment, or interest. According to Ringold and colleagues (2012), the effects of such aspects in low- and middle-income countries include failures in the quality of public service delivery demonstrated by high rates of absenteeism among health staff, leakages of public funds intended for health clinics, or social assistance benefits, and shortages as well as stock-outs of pharmaceuticals. Although studies conducted in LGAs in Tanzania have shown the same service delivery hitches, there is no organized information on how frontline policy implementers develop strategies to cope with the existing predicaments (Matimbwa et al., O. S. 2019).

Service Delivery State: Existing Indicators

Generally, studies conducted in Tanzania justify that service delivery in LGAs does not essentially meet established thresholds (WHO, 2017; UNDP, 2016). Although WHO (2017) indicates that the child mortality rate fell from 99 to 51 per 1000 live births from 1999 to 2010 respectively, Mackfallen (2017:2) argues that it is above the world average of 37, implying that many efforts are still needed to meet stipulated standards. While the trends of maternal mortality rate per 100,000 births were 578 (2005), 454 (2010), 432 (2012), and 556 (2015), the world average is 210 (WHO, 2017; 2015; Mackfallen, 2017; URT, 2014). This means that the predicament regarding the maternal mortality rate is still high. The under-5 Mortality rate is 67/1000 (WHO, 2017), and this is still a big problem. While the proportion of births attended by skilled health personnel was anticipated to be 90 percent, it stands at 50.5 percent, implying that many clients are attended by unqualified personnel.

The trend of under-five (5) stunting rate was 38 (2008), 42 (2010), and 35 percent (2011) (URT, 2014). Regarding financial resources, while in FY 2013/14, the allocation for health accounted for 10, in FY 2017/2018, it was 7 percent (UNICEF, 2018). The recurrent spending within the Ministry fell from 44 percent in FY 2013/2014 to 30 percent in 2017/2018. Development partner's (DP) contribution to the development budget declined from 92 percent to 57 percent

between FY 2013/2014 and 2017/2018, respectively. The evidence shows that human resources is maldistributed, with dispensaries in rural areas being worst affected (WHO, 2017, p. 12). The same applies to equipment. Generally, UNICEF (2018) and WHO (2017: 2) reports show that *"health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care*".

Service Delivery Challenges

To understand service delivery challenges, particularly primary health care in Mvomero District and Moshi Municipal Councils, attributes such as authority, accountability, and access were accorded great attention.

Authority

Interviewed policymakers in Mvomero and Moshi Councils indicated that they possess more discretionary power to make decisions compared to the pre-reform era of the 1990s. This increased autonomy was corroborated by councilors, with one from Moshi Council commenting that...; one of Moshi councilors commented that "councilors have the power to sack any council official including the director in case of a violation of rules or squandering of resources" (interview: April 2020). In line with that, one council official in Mvomero pointed out that "the council has "the council has the discretion to make its by-laws, solicit its own resources, *and allocate them to address jurisdictional matters"* (DED: February 2020). Based on these responses, one can think that LGAs have autonomy. The notion of autonomy is very complex. The fact that many LGAs have limited resources regardless of available potential revenue sources portrays limited autonomy, as the Acting Municipal Executive Director (MED) commented.

"Local governments' power to levy taxes is granted, although in some cases, autonomy is limited. The council's own sources of revenue, such as property tax and hotel levy, have been shifted to TRA. With the meager revenues, the directives still require the council to set 60 percent of its own source revenue (OSR) for development, transfer 20 percent to LLGs, allocate 5 percent to women's groups, 5 percent to youth groups, and render 5 percent as co-funding to donor-funded projects, excluding other unplanned activities. LGAs still get conditional and unconditional grants" (MED: April 2020).

Based on the recruitment process, numerous actors interviewed commented that LGAs can use their discretionary authority only to deploy staff and internal transfers. Nevertheless, staff distribution (deployment) is affected by informal networks through memos, as the District Medical Officer (DMO) commented:

"Councils receive many memos from government officials, friends, and influential businessmen and women to allocate staff to certain primary health facilities" (DMO: February 2020).

This implies that LGAs are not able to exercise their clout as anticipated. This contradicts the Policy Paper on Local Government Reforms (1998), which states that *"local government councils will be free to make policy and operational decisions consistent with the laws…and government policies without interference by central government institutions"* (URT, 1998: 3). Based on this there is no shadow of a doubt that there is a mismatch between theory and practice.

Responses from interviews with the District Executive Director (DED), Municipal Executive Director (MED), and Ward Health Officer (WHO) on infrastructure also showed that many primary health facilities operate with a deficit of equipment and staff. This is partly explicated by over-dependence on the central government, which does not cascade substantial autonomy to LGAs. The contradiction is embedded in the Policy Paper on Local Governments Reforms (1998), which, on the one hand, encourages inter-governmental relations and, on the other, accords central government overriding powers under the Tanzanian constitution, which again jeopardizes articles 145 and 146 of the 1977 constitution. Further, Local Government Acts No. 7 and 8 of 1982, amended in 1999 and 2006, give the Minister of Local Government clouts to create, abolish, and re-establish LGAs without their consent, evidencing that LGAs have limited autonomy.

Results from councils above indicate that although in some scenarios, selected LGAs can exercise their discretion to address jurisdictional matters, to a large extent, they have limited autonomy to address their problems regarding service delivery, particularly health services. It can be deduced that the interface between the center (principal) and LGAs (agent) hardly culminates into a symbiotic relationship in Tanzania, meaning that while LGAs facilitate service delivery, the center (central government) is the main provider. The fact that the center does to cascade substantial autonomy to LGAs entails that frontline police implementers will find some ways to deal with the existing fissure.

Accountability

There are various ways of looking at accountability. The focus here is on citizens' ability to demand accountability when experiencing delays and theft cases in due course of trying to get access to essential services accountability when experiencing delays and theft cases in due course of trying to get access to essential services, particularly health services. It is imperative to note that citizens are obliged to demand accountability, which is in line with scholars' viewpoints, including Sujarwoto's (2012) assertion that citizens can either voice or exit when service declines in quality. The lingering question here is whether citizens' decisions always follow suit. Responding to the question that wanted citizens from selected areas to share their experiences regarding options when encountering delays and theft cases in trying to access services like primary health care in Tanzania, numerous insights were accorded, as summarized in Table 1.

Table 1: Extent of Citizens Demand for Accountability

Levels	What can you do when encountering delays in getting public services			What can you do when suspecting a health officer of stealing		
	Mvomero (frequency)	Moshi (frequency)	Total Percentage	Mvomero (frequency)	Moshi (frequency)	Total Percentage
Don't know what to do	15	4	19	13	3	16
Lodge complaints through proper channels	4	12	16	8	30	38
Use connections with influential people	2	12	14	1	1	2
Offer tips or bribe	8	2	10	2	1	3
Do nothing because nothing can be done	21	20	41	26	15	41
Total	50	50	100	50	50	100

The study findings from selected LGAs reveal that many citizens are unaware of proper procedures for addressing delays (19%) or suspected theft (16%). This issue is more pronounced in rural Mvomero than in urban Moshi. While 16% of citizens in Mvomero can file complaints for delays, 38% can do so for suspected theft. Overall, Moshi residents are more likely to report such cases. Furthermore, 41% of Mvomero and Moshi citizens believe reporting delays or suspected theft is futile. This suggests a lack of confidence in the accountability mechanisms. The study highlights a significant rural-urban disparity in citizens' ability to demand accountability, raising concerns about the effectiveness of frontline policy interventions.

Access: Equipment and Staff

Access may entail both availability and affordability of services. The focus here was on equipment distribution in selected primary health facilities. Study findings indicated that primary health facilities exhibit a significant shortage of equipment, including a Microscope, an Autoclave (sterilizer), a Delivery bed, a Stethoscope, a Delivery kit, a Weighing scale, a Diagnostic set, an Ambulance bug, and a BP monitor. Based on stipulated standards, the variation is noted in Kiboriloni, Njoro, Dakawa, and Mongwe (43, 73, 67, and 83) primary health facilities, respectively. This implies that some equipment may not be sterilized due to lack of an autoclave; blood tests may not be taken because there is no microscope; people's hearts and lungs may not be checked because there is no stethoscope; children's weight may not be measured because there is no weighing scale, patients in critical breathing condition may not be treated because there is no ambulance bag, and that people's blood pressure (BP) cannot be measured due to absence of BP monitor.

Regarding the state of health staff, study findings reveal a difference across selected dispensaries. The number of health staff based on national standards per dispensary is fifteen (15). In detail, this means the following: at least a clinical officer, assistant clinical officer, pharmacist, health officer, nurse assistant, nursing officers, midwife, and nursing attendants are required. Based on percentages, the four studied dispensaries demonstrated a deficit in human resources: 7, 27, 40, and 80 (Mnazi et al.). This implies that there will be unmanageable queues during peak hours due to inadequate staff to take off clients. The characteristics of selected health facilities are given in Table 2.

Table 2: Comparison of Characteristics of Selected Dispensaries

N/S	Characteristics of Health Facility	Number of Required Equipment	Kiboriloni (Mnazi)		Njoro		Dakawa		Mongwe	
	Equipment (percentage)		Actual	% Variation	Actual	% Variation	Actual	% Variation	Actual	% Variation
1	Microscope	4	4	0	1	3	0	4	0	4
2	Autoclave/sterilizer	2	0	2	0	2	0	2	0	2
3	Delivery bed	2	1	1	1	1	3	-1	0	2
4	Stethoscope	4	4	0	2	2	2	2	2	2
5	Delivery kit	2	0	2	0	2	1	1	1	1
6	Weighing scale	4	4	0	2	2	2	2	1	3
7	Diagnostic set	4	0	4	0	4	0	4	0	4
8	Ambulance bug	4	0	4	0	4	1	3	0	4
9	BP monitor	4	4	0	2	2	1	3	1	3
	Total Items	**30**	**17**	**13**	**8**	**22**	**10**	**20**	**5**	**25**
		100	**57**	**43**	**27**	**73**	**33**	**67**	**17**	**83**

As shown in Table 2, inadequate resources like equipment and staff result from the complex interdependence of government institutions, particularly those relating to the delivery of health services. Such institutions include the Ministry of Finance and Planning (MoFP), the Ministry of Public Service Management and Good Governance (PO - PSMGG), the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), and the President's Office-Regional Administration and Local Government (PO - RALG). The complex interaction of these institutions can be associated with the delay of service delivery due to centralization, which limits the autonomy of LGAs in dealing with health staff, finances, decisions, and physical resources. This is because the MoFP approves the budget of MoHCDGEC, which prepares personnel emoluments (PE) before recruiting health staff to LGAs. The PO - PSMGG has to approve PE from MoHCDGEC after the MoFP approves the respective ministries' budgets. Where necessary, the PO - PSMGG can adjust the number of health staff requested by LGAs before issuing the staffing certificate (permit) to allow the respective Ministry to proceed with the recruitment process.

Copying with Service Delivery Challenges

This part strives to accord strategies street-level bureaucrats (SLBs) developed to cope with service delivery challenges in brief in selected LGAs in Tanzania. Challenges pointed out in selected areas include many, such as a shortage of staff, equipment, staff quarters, BP monitors, delivery beds, weighing scales, financial resources, entrepreneurial activities, and the interface between public and private.

Due to staff shortage evidenced by selected LGAs, the interview with the health in-charge at Njoro dispensary pointed out how they cope with the challenge that *"during peak hours health officers usually engage in the traditional mode of listening to a patient's problems and after that, prescribes the medicine without bothering to do a test, for instance, blood slide test for malaria"* (Health Facility in-Charge: April 2020). As viewed by Lipsky (2010, 1980, 1969), this coping strategy embraces the modification mode of dealing with overcrowding.

Based on health worker interview at Mongwe dispensary, as a result of inadequacy regarding equipment, study findings showed how they cope with the situation where *"one executes what is in his/her reach; when patients are too many to handle, let say in peak hours"* (Health Worker: March 2020). Standing on Lipsky's (1980) shoulders, this deed embraces the routinization tenet.

In the absence of a BP monitor, the Health Facility in-Charge reported in an interview that *"we are sometimes compelled to advise a patient to go to the health center or a private dispensary for diagnosis"* (Health Facility in-Charge, Njoro: April 2020). Lipsky (1980) may view this as simplification.

Due to a shortage of weighing scales, a nurse at Mnazi dispensary was interviewed and reported that *"sometimes help is sought from nearby private dispensary"* (Nurse: March 2020). The legal framework does not provide such an arrangement. Lipsky (1980) views this as simplification.

Regarding the shortage of staff houses, during interviews, the Health Facility in-Charge of Mongwe dispensary pointed out:

Most health officers live outside the health facility premises. Some officers have secured accommodation nearby, and others travel a long way to the health facility daily. We can do nothing at night for emergency cases (Health Facility in-Charge: February 2020).

It was also reported that dispensaries have limited resources, particularly finance, to manage their operations because some sources are unfeasible. "We engage communities through dispensary committees and neighborhood meetings to deliberate on dispensary issues, although citizens contribute very little" (Health Facility in-Charge-Njoro Dispensary: April 2020). Lipsky (1980) may view this as rationing.

It was also reported that there is informal cooperation between public and private dispensaries, especially at times when health workers are in great demand, as the Health Facility in-Charge at Dakawa dispensary commented:

We have many casualties at the moment. We work as a team with nearby dispensaries, which may involve hiring them for a while. Furthermore, when patients' conditions become severe, we transfer them to the referral hospital (Health Facility in-Charge: March 2020).

Based on the tenets of street-level bureaucracy theory, public health staff working together with private dispensary staff may be subject to routinization, rationing, and simplification. Based on the study findings, 'exit' was another strategy for coping with challenging encounters that were not cherished in Lipsky's (1980) perspective. The central tenet of the theory is that when SLBs face a challenging environment, they will devise some ways to deal with it. Findings from Mvomero (rural) revealed that some customs and traditions, like witchcraft, increase staff attrition in social fields. This implies that challenging environments are not always tolerated. It may involve one disentangling with it. Study findings also indicated that due to limited financial resources to lower levels, health workers engage in an entrepreneurial form of activities as a complement to existing fissures of incapacity, including running parallel private dispensaries and retailing shops, which in turn increases staff absenteeism, a type of modification in Lipsky (1980) lens. Illegal absenteeism is also associated with endless staff follow-ups of their demands to council headquarters, including payment of leave, arrears, and promotion.

Study findings also showed that street-level bureaucrats, health staff in this context, can cope with scarce resources by liaising with communities to address complex problems, as was reported by the health in-charge at Kiboriloni that; 'the primary health facility administration managed to paint two (2) wards for the amount of TZS 250,000/- that Kiboriloni business people raised after the administration requesting their organization to paint the wards' (health in-charge: March 2020). This implies that citizens can play a great deal in issues regarding development.

In a nutshell, how street-level bureaucrats (SLBs) deal with challenging encounters in due course of delivering essential services is in line with tenets of the theory, which indicates that SLBs can translate public policy into action in their own way. This may be congruent or incongruent with public policy intentions from the parliament or local government organs. In brief, it is not always the case that whenever SLBs encounter difficult moments in undertaking their responsibilities, they will develop a pattern of practices to cope with the status quo; they may opt to quit from turbulent storms. On the contrary, in the long run, coping strategies may limit government control over semiautonomous social fields, as explicated in detail in the following section.

Coping Strategies and Law Enforcement

Strategies to address service delivery challenges in LGAs may align or diverge from public policy objectives. Non-compliance can hinder the central government's control over semi-autonomous social sectors. Firstly, the study identified several practices that deviate from policy intentions, including health staff seeking private dispensary assistance during stockouts or equipment shortages and health officers relying on traditional patient consultation and medication prescription methods. These actions, such as seeking private care and prescribing medication without testing, contradict public dispensaries' intended service delivery model. This undermines the implementation of health policies (1990, 2007) and other relevant legislation.

Secondly, dispensing in selected primary health facilities does not always conform to stipulated regulations (Public et al. Policy of January 1999), Health Policy (URT, 2007, 1990), Public Service Regulations (2003), and Policy Paper on Local Government Reforms (1998). The legislation does not allow public dispensary in-charges and other health

workers to hire staff or borrow tools from private dispensaries, sterilize equipment using traditional means, and prescribe medicine to patients without a test. Legislations do not allow SLBs to engage in entrepreneurial activities, increasing health staff absenteeism rates.

Thirdly, the legislation (see the Public Service Regulations of 2003) requires public servants, including health staff, to be at their workplaces (dispensaries) during official hours. However, this is not always taken into account. Illegal absenteeism is sometimes seen as a function of staff flexibility in enforcing formal rules.

DISCUSSION

Service delivery in the context of local government involves the interface between policymakers (local government officials, service recipients or beneficiaries, or citizens) and street-level bureaucrats (primary health staff in this context) (Kamugisha 2019; Ringold and colleagues, 2012; Buhari-Gali, A., et al. (2022). According to Osborne (2010), the interface between actors like bureaucrats, citizens, and SLBs embraces partnership, which is imperative in enhancing effective service delivery. These people can provide needed resources which may not necessarily be financed by the central government. Based on Miller (1999: 349) lens, the partnership is more than a sum of its parts; it adds value through the synergy of joint working and transformational learning process, that is, learning from each other; it also leads to information, resources, and risks sharing; enhances effective communication; and avoidance of duplication and inefficiencies.

On the other hand, the stakeholders' interface is complex because it exhibits diverse interests. This can be justified by the interface between central and local governments, particularly in the unitary systems, where the center has overriding powers over LGAs. In this interface, citizens (principals) are the most vulnerable group because they normally encounter information asymmetry, which partly affects them to demand accountability, as explicated by study findings from Mvomero District and Moshi Municipal Councils. The study findings reveal that health workers' working environment is always hard because they operate in an environment with limited financial, human, and physical resources. This is justified by primary health facility fissures, including limited staff, tools, and other supplies. In line with that, health workers do not have enough intrinsic and extrinsic resources.

In order to cope with the status quo, study findings showed that street-level bureaucrats (SLBs) developed and executed their local policies. This is evidenced by health staff making themselves absent from primary health facilities, staff engagement in entrepreneurial activities, including retailing pharmaceuticals, in stock outs scenarios directing clients to get drugs from retailing shops, and the like. These practices greatly limit the enforcement of bylaws due to built social obligations or trust that guide citizens' behaviors in the social fields. Under such conditions, legislation enforcement becomes complicated or, when enforced, does not bring previously anticipated results. It is imperative to comprehend that although SLBs find ways to deal with challenging environments regardless of whether their strategies comply with policy intentions or not, it is revealed that in some situations, SLBs, health staff in this context, will not devise strategies to cope with the problematic environment but rather vacate from the awful environment.

CONCLUSION

Based on study findings from Mvomero District and Moshi Municipal Councils, street-level bureaucrats (SLBs) can develop patterns of practices to cope with the challenges of primary health care and, in the long run, limit central government control over respective semi-autonomous social fields. In this regard, three main observations were made: First, it has been established that SLBs have discretionary power to translate policy into action and that their actions are what service beneficiaries experience. Further, under challenging environments, SLBs - health staff in this context assume their responsibilities, including managing heavy workloads due to staff shortage, equipment, and financial resources. Second, it has been proved that SLBs, in exercising their discretion, either conform to public policy intentions or abuse their discretion. On the one hand, when SLBs encounter challenging environments, they either routinize, modify, simplify, or ration their concept of work to undertake their duties and responsibilities by engaging in entrepreneurial activities. This deed contradicts the Public Service Act of 2003 and other legislations. On the other hand, SLBs may conform to policy intentions by liaising with citizens to address broader health predicaments, including soliciting funds for the rehabilitation of primary health facilities.

Third, it was clinched that SLBs' behaviors are influenced by internal arrangements within internal environments (social fields) in which they work rather than primarily being a response to personal preferences and interests. Further, government efforts to control SLBs' behaviors, like health staff, in this context, in any way, including limiting their intrinsic and extrinsic motivation, only undermine SLBs' responsiveness to clients. For instance, SLBs may engage in entrepreneurial activities, limiting their ability to undertake their duties and responsibilities; due to challenging encounters, they may engage in entrepreneurial activities, limiting their ability to undertake their duties and responsibilities as required by the law, thus making people suffer. Finally, although street-level bureaucrats' work environment is problematic since it is constrained by resources, including finances, human resources, equipment, and the like, SLBs can still accord primary health care service if they are intrinsically and extrinsically motivated, particularly in terms of mindset and civic duties to increase their working morale and commitment.

POLICY IMPLICATIONS

This paper aimed to shed light on the role of street-level bureaucrats using Mvomero District and Moshi Municipal Councils as reference points. Based on key findings, several policy implications have been identified. The experiences from the cases above reveal that the interface among policymakers, citizens, and street-level bureaucrats does not culminate in the devolvement of substantial autonomy to sub-states or LGAs. Since the center grants autonomy in the unitary system, it is imperative to note that the central government must remain in the role of supporting and nurturing sub-states or LGAs. This may be accomplished if the center eliminates existing contradictions between policy and legislation to enhance the symbiotic interface between the central government and LGAs. This will provide opportune moments for LGAs to identify as many sources of revenue as possible to reduce their dependence on the central government. The mutual interface between the center and LGAs will address service delivery challenges, particularly those relating to the provision of primary health care. Motivating staff intrinsically and extrinsically, in terms of mindset and civic duties, will be possible if the government is responsive to the governed by formulating feasible policies and enforcement mechanisms. This will give street-level bureaucrats and primary health facilities staff a leeway to concentrate on their assigned duties of caring for both out and patients. Otherwise, street-level bureaucrats will have to devise their ways to cope with the challenging environments in the semiautonomous social field, as Lipsky (1980) suggests.

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Conflicts of interest

The authors declare that they have no contending interest

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Authors` contributions

DK designed the study, collected data, analysed it, interpreted it, and drafted the manuscript. AM participated in the study design and critically reviewed the manuscript.

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