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Effectiveness of Decentralisation by Devolution Approaches in Public healthcare services Delivery in Ilala Municipal Council and Geita Town Council, Tanzania

Effectiveness of Decentralisation by Devolution Approaches in Public healthcare services Delivery in Ilala Municipal Council and Geita Town Council, Tanzania

Africanus Calist Sarwatt[1], Omary Magasha Yusuf[1] & Adam Matiko Charles[2]
[1]*Institute of Rural Development Planning, Tanzania*
[2]*The Mwalimu Nyerere Memorial Academy, Tanzania*

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Abstract
This study investigates the effectiveness of Decentralisation by Devolution (D-by-D) in public healthcare service delivery within Ilala Municipal Council and Geita Town Council, Tanzania. Employing a mixed-methods approach, including quantitative surveys and qualitative interviews with local key informants, the research reveals critical insights into how D-by-D frameworks impact healthcare quality and accessibility. Findings indicate that while some approaches, such as project monitoring and budget allocation, are perceived as effective, others—particularly multi-stakeholder involvement, participation, and strategic planning—are regarded as ineffective. The average effectiveness score across both councils suggests a moderate perception of D-by-D functioning, yet significant gaps exist regarding community engagement, resource allocation, and local governance capabilities. Challenges include inadequate funding, personnel shortages, and a lack of transparency, which hinder the realization of Decentralisation's intended benefits. The study underscores a prevalent sense of skepticism regarding healthcare quality in both councils and highlights the necessity for reforms to better align local health priorities with community needs. To enhance the effectiveness of D-by-D, the research recommends strengthening financial support to Local Government Authorities, enhancing human resource capacity, fostering community participation, and promoting accountability and transparency in healthcare governance. This research contributes to the understanding of local governance in Tanzania and offers essential insights for policymakers aiming to improve healthcare outcomes through decentralized frameworks.

Introduction

Decentralisation refers to the systematic transfer of powers, responsibilities, and resources from central governments to local authorities to enhance local decision-making capacity and improve the efficiency of public service delivery (World Bank, 2020). This process encompasses multiple dimensions—political, administrative, and fiscal—that can be implemented separately or together depending on contextual needs and governance goals. Decentralisation reforms often target crucial public service sectors such as healthcare, education, and sanitation, which are vital for enhancing the quality of life within communities (Gadisa, 2022). These reforms navigate diverse technical, pragmatic, and political dynamics, reflecting local needs and aspirations while improving service delivery frameworks (Mollel, 2020).

Globally, the D-by-D model has been embraced across various jurisdictions, including the United States, Australia, and several African countries such as South Africa and Kenya. These nations have established constitutional frameworks delineating powers between different levels of government, highlighting the increasing trend towards decentralisation (OECD, 2021). In Tanzania, the D-by-D approach was formalised in the late 1990s through the Local Government Reform Program (LGRP), which aimed to bolster local governance structures and empower communities in decision-making processes (URT, 1998; Muro & Namusonge, 2015). Despite the potential advantages of decentralisation, implementing D-by-D in public healthcare service delivery within Tanzania presents numerous challenges. Insufficient budgetary allocations, delays in resource availability, and suboptimal governance practices impede effective service delivery (Oleribe et al., 2019; Kigume & Maluka, 2018). Local governments, while tasked with healthcare provision, often struggle with human resource deficiencies and limited funding, adversely affecting their capacity to deliver essential services (Mdee & Thorley, 2016; Wang & Rosemberg, 2018).

Significantly, evidence suggests that local communities in Tanzania frequently feel excluded from the decision-making processes, undermining the fundamental objectives of decentralisation (Mdee & Thorley, 2016). The ineffective implementation of D-by-D can degrade the quality of healthcare services, as local authorities may lack the necessary autonomy and resources to implement meaningful reforms (Pelizzo et al., 2018). his paper evaluates the effectiveness of decentralisation by devolution in public healthcare service delivery within Ilala Municipal Council and Geita Town Council.

Materials and Methods

Study Area

The study was conducted in Ilala Municipal and Geita Town Councils. Ilala Municipal Council (IMC) is situated in the Dar es Salaam region, positioned between longitudes 39° and 40° east and latitudes 6° and 7° south of the Equator. According to the National Population Census of 2022, IMC had a population of approximately 1,649,912, with a nearly equal gender distribution (National Bureau of Statistics Tanzania, 2022). Politically, the council is divided into 36 wards. Notably, on 24 February 2021, President John Magufuli dissolved the Dar es Salaam City Council, subsequently upgrading Ilala Municipal Council to the status of Dar es Salaam City Council.

Geita Town Council (GTC), on the other hand, is located between 2°8' and 3°28' south of the Equator and between 32°45' and 37° east of Greenwich, covering an area of 1,080.3 square kilometres (URT, 2012). Politically, GTC is divided into 13 wards, with a demographic profile recorded in the 2022 census showing a population of 361,671, characterised by ethnic diversity, primarily comprising the Sukuma (65%) and Zinza (30%) (National Bureau of Statistics Tanzania, 2022).

Study Design and Data Collection

The study employed a mixed-methods approach to investigate the effectiveness of decentralisation by devolution (D-by-D) approaches in public healthcare service delivery. Quantitative data was gathered through questionnaires from healthcare workers, community members, and local authorities at Ilala Municipal Council and Geita Town Council. Semi-structured interviews were conducted with local key informants to provide in-depth insights. In contrast, document reviews of policy documents, healthcare reports, and relevant literature provided a contextualised understanding of the D-by-D approach's objectives and challenges. This three-pronged approach facilitated a comprehensive understanding of the complexities of D-by-D implementation in public healthcare service delivery.

Ethical Considerations

The Kampala International University in Tanzania approved this study. The research clearance was then sent to the Regional Administrative Secretaries in each study region (Dar es Salaam and

Geita Regions) for approval in their administrative areas. Informed consent was obtained, ensuring participants understood the study's aims and their rights, including the right to withdraw. Anonymising data upheld confidentiality, and approval from relevant ethics committees was secured. Care was taken during interviews to ensure participants felt safe sharing their insights, prioritising ethical integrity to foster trust and respect.

Data Analysis

The study utilised quantitative and qualitative data from questionnaires and semi-structured interviews. Quantitative data from healthcare workers, community members, and local authorities in Ilala Municipal and Geita Town Councils was analysed using descriptive statistics (means and standard deviations) to evaluate perceptions of the effectiveness of Decentralisation by Devolution (D-by-D) approaches in public healthcare. Qualitative data from interviews were transcribed and analysed thematically. Key themes related to the effectiveness of D-by-D emerged, including community engagement challenges, financial autonomy, and human resource capacity. This mixed-methods approach provided a comprehensive understanding of the effectiveness of D-by-D in enhancing healthcare service delivery and identified strengths and areas for improvement.

Results and Discussion

Effectiveness of Approaches of D-by-D in Public Healthcare Service Delivery

Table 1: Effectiveness of approaches of D-by-D in Public healthcare service delivery in IMC (n=228)

Item	Mean	Std. Deviation	Interpretation
1. Multi-stakeholder involvement approach.	2.23	1.19641	Low
2. Project and program monitoring and implementation approach.	3.75	1.11282	Very high
3. Financing and budget allocation approach.	3.22	1.13956	High
4. Strategic planning approach.	1.58	1.25554	Very low
5. Transparency and accountability approach.	2.03	1.01441	Low
6. Participation and inclusion approach.	2.45	1.26371	Low
7. Managerial capacity approach.	3.26	1.31259	Very High
8. Employees' performance.	2.22	1.10402	Low
Total average score	**2.60**	**1.17654**	**High**

Key of Rating Scale

Mean range	Description	Interpretation
1.00 — 1.74	Not effective	Very low agreement
1.75 — 2.49	Less effective	Low agreement
2.50 — 3.24	Effective	High agreement
3.25 — 4.00	Most effective	Very high agreement

The evaluation of the effectiveness of decentralisation by devolution (D-by-D) approaches in public healthcare service delivery within Ilala Municipal Council (IMC) in Table 1 revealed varying perceptions across eight assessed strategies. Among these, the "project and program monitoring and implementation" approach emerged as the most effective, achieving a mean score of 3.75. In contrast, the "multi-stakeholder involvement" and "employees' performance" approaches were rated as less effective, with scores of 2.23 and 2.22, respectively. The "financing and budget allocation" approach garnered a positive rating of 3.22, indicating effective utilisation, whereas strategic planning was viewed unfavourably with a low score of 1.58. The average mean score for all approaches was 2.60, categorised as "effective," though it highlighted a gap between the perceived effectiveness of certain strategies and the overall performance of public health service

delivery at IMC. While some approaches demonstrated effectiveness, there remain substantial areas for improvement in implementing D-by-D practices within the council.

Table 2: Effectiveness of approaches of D-by-D in Public healthcare service delivery in GTC (n=196)

Item	Mean	Std. Deviation	Interpretation
1. Multi-stakeholder involvement approach.	2.72	1.13479	High
2. Project and program monitoring and implementation approach.	3.15	1.03977	High
3. Financing and budget allocation approach.	3.10	1.22373	High
4. Strategic planning approach.	2.38	1.97470	Low
5. Transparency and accountability approach.	2.88	1.12543	High
6. Participation and inclusion approach.	2.33	1.02694	Low
7. Managerial capacity approach.	1.99	1.06015	Low
8. Employees' performance.	1.62	1.04325	Very low
Total average score	**2.52**	1.15567	**High**

Findings in Table 2 regarding Geita Town Council (GTC), respondents rated various approaches for decentralisation by devolution (D-by-D) in public healthcare service delivery, yielding mixed results. The "multi-stakeholder involvement", "project and program monitoring", "financing and budget allocation", and "transparency and accountability" approaches were rated as "effective", with mean scores ranging from 2.72 to 3.15, indicating agreement among respondents. Conversely, the "strategic planning", "participation and inclusion", "managerial capacity", and "employees' performance" approaches received "less effective" ratings, with scores ranging from 1.62 to 2.38, suggesting disagreement or strong disagreement. These findings highlight the effectiveness of certain approaches in implementing D-by-D in public healthcare service delivery in GTC while also identifying areas for improvement.

From the findings, four out of the eight approaches to decentralisation by devolution (D-by-D) in public healthcare service delivery were rated as either "effective" or "most effective," while the other four received ratings of "less effective" or "not effective." The overall average mean score for D-by-D approaches in Geita Town Council (GTC) was 2.52, which falls within the "2.50–3.24" mean range, indicating "high agreement." This suggests a generally effective application of D-by-D approaches in GTC. However, the score still leaves a gap of 1.48 points from the maximum mean score of 4.00, with 2.52 positioned just above the highest rating for "less effective." In Ilala Municipal Council (IMC), six out of twelve identified roles were rated between "high" and "very high," resulting in a total average mean score of 2.58, also suggesting "agreement" despite disparities in performance across different roles. Conversely, in GTC, most roles received "low" or "very low" ratings, yielding an average mean score of 2.41, categorised as "low response" and indicating "disagreement" among respondents regarding quality performance in public healthcare delivery under D-by-D. Further investigation is required to explore the influence of various roles on the effectiveness of D-by-D within the public healthcare framework.

Interview findings on the effectiveness of D-by-D approaches in public healthcare service delivery
A segment of the questionnaire findings for IMC and GTC was compared with interview data. In this context, some responses from IMC are presented first.

A local government officer from IMC said:

> Local authorities often face significant challenges that hinder their ability to execute these priorities effectively…. Moreover, local governments across the country find themselves in a position of dependence on the central government for key financial and staffing decisions....Interestingly, politicians, who are generally aware of the challenges faced by local governments, contribute to this dilemma by portraying local leaders as ineffective. This portrayal not only exacerbates the frustration of local officials but also places them

> under immense pressure, as they navigate the complexities of implementing health priorities in the face of systemic limitations.

Another local government officer from IMC disclosed the following:

> Community inclusion in healthcare planning occurs at times, but it is not a consistent practice. While plans are established, they often fail to be effectively implemented…... When implementation does occur, it frequently suffers from poor execution. Additionally, unforeseen challenges, such as disease outbreaks or newly mandated government initiatives, can arise, leading to a shift in focus that pushes existing priorities aside. This situation presents a significant challenge for local authorities, who may outwardly project a sense of competence, yet internally struggle with the pressures of managing these competing demands.

Concerning the manner in which the 'participation and inclusion approach' was tailored, experience by some informants from GTC showed some effectiveness. The following interview responses were noted.

A local government officer from GTC said:

> In practice, priorities related to community health—similar to other highlighted priorities—must be incorporated into strategic plans. This inclusion is evident not only in long-term planning but also in short-term initiatives, and I consistently observe this approach being implemented responsibly.

Another local government officer from GTC had this to say:

> In the context of healthcare planning at the council level, public health priorities are generally taken into account when they are present. There are occasions when there may not be any immediate or critical concerns affecting community health at the time plans are being developed. However, councils must exercise caution when integrating priorities into their plans. This careful approach is necessary because some priorities may be dictated by regional administrative authorities.

In general, interview participants concurred that district council health plans incorporated community health priorities. However, several interviewees pointed out various obstacles that hindered the effectiveness of these efforts. These challenges included a staff shortage, delays in the release of funds from the central government, and emergencies such as sudden disease outbreaks or epidemics. At times, these issues disrupted the consistent inclusion of community health priorities in the councils' plans.

Additionally, some insights from the interviews highlighted the concept of 'fiscal improvements' and assessed how effectively it contributed to delivering public healthcare services within the framework of Decentralisation (D-by-D).

A key informant from IMC said:

> I believe that Decentralisation has, to a certain degree, facilitated greater autonomy in budget preparation and expenditure at the council level. Importantly, this process eliminates the need for councils to send these plans through the regional or central offices, streamlining the communication and planning efforts. Furthermore, this autonomy in budgetary planning fosters more active participation from ward leaders and representatives in the planning and decision-making processes conducted at the council level.

Another key informant in IMC had this to say:

> Absolutely. If decentralisation has significantly influenced the public health sector and if local councils, such as town councils, have been granted the autonomy to prepare and execute their own budgets, this framework can make it easier for local communities at the ward level to advocate for the inclusion of their priorities in the council's budgetary plans. However, this opportunity is not always feasible in practice. The ability to incorporate these priorities largely depends on the council's capacity to generate sufficient funding or revenue.

Overall, the findings from the interviews indicated that some key informants, particularly those from the IMC, recognised effectiveness in representing ward priorities within the councils' public health plans and budgets. In contrast, some representatives from the GTC reported that they did not see effective representation. This suggests that, in the realm of public healthcare service delivery, the D-by-D policy may not have been applied consistently across all councils, or it may have been enforced inconsistently by the central government.

On the other hand, interviewees were also asked to evaluate the health facilities in their areas, specifically whether these facilities provided satisfactory and seamless health services. The responses were as follows:

At GTC, one key informant said:

> Long-standing deficiencies in the capacity of health facilities continue to hinder our ability to provide adequate care. Additionally, the shortage of qualified and experienced personnel remains a significant challenge. Financial constraints further complicate the situation, as government budget allocations consistently fall short of what is needed.

Another key informant at GTC disclosed:

> To be frank, while we and the current political leadership are making strides toward improving the quality of services in our community, there is still a significant amount of work to be done. Firstly, the capacity of our health facilities is insufficient to meet the needs of our population, which obstructs our ability to provide satisfactory services. Secondly, there is a notable shortage of specialists and experts in various health services at the council level, forcing us to refer many patients to regional and tertiary hospitals, creating further strain on the system.

A member of CHMT from GTC said:

> D-by-D has implemented a significant number of improvements in the delivery of health services. In my opinion, this system proves to be effective largely due to the ongoing enhancements being made by the government. For example, across the nation, Local Government Authorities (LGAs) have introduced voluntary Community Health Workers (CHWs) who receive health-related training to effectively disseminate important information to community members. These CHWs are integrated into the structure of the LGAs, with two assigned to each village or ward, thereby ensuring a greater reach and accessibility of health services within the community.

Another key informant from GTC said:

> In order to attain the desired levels of efficiency, it is essential to reduce bureaucratic layers. The effectiveness of Decentralisation hinges on various factors, including the specific context, the structure of governance, the functions being carried out, and the outcomes that arise from this shift in authority. The positive effects of Decentralisation often lead to an improvement in the economic well-being and living conditions of a country's citizens.

One key informant from IMC said:

> One major issue is our inability to provide sufficient motivation and a conducive working environment for healthcare workers, which is often tied to the limitations of our economy—particularly regarding the budget allocated for wages and healthcare facilities. Additionally, a significant obstacle in delivering public healthcare services is the lack of effective community engagement and awareness.

Another respondent from IMC said:

> I would say my answer is both "yes" and "no," and this dual perspective arises from the need to consider the differing operations of various healthcare facilities. For instance, let's examine the contrast between those managed by the national government and those in the public sector. In my region, private healthcare facilities often outnumber government-run ones and, at times, appear to perform better.

A member of CHMT from IMC said:

> The council is committed to employing a multi-stakeholder strategy for the delivery of health services. While this approach fosters greater involvement and collaboration, it also presents challenges within the context of Decentralisation. Engaging a wide array of stakeholders—including healthcare facilities, healthcare personnel, local communities, government officials, and other relevant parties—can be quite complex.

A Ward Councillor from IMC said:

> In my opinion, the D-by-D approach is an effective strategy for health service delivery. In this framework, the central government delegates certain powers and responsibilities to the LGAs, which are then responsible for executing the projects. The central government primarily focuses on monitoring and overseeing the implementation of these plans. This approach encompasses a broad spectrum of health service operations.

A local government official from IMC said:

> I find it difficult to perceive the effectiveness of the D-by-D approach due to the subpar implementation of various health projects. Several factors contribute to the inadequate performance of employees within public institutions. Key issues include insufficient salaries, unfavourable working conditions, ineffective leadership, and a shortage of both qualified and trustworthy personnel. Additionally, instances of corruption among high-ranking officials can further undermine the efficiency of these organisations.

In examining the effectiveness of health services at various facilities, all the interviewees expressed scepticism regarding the assertion that these facilities were functioning smoothly and satisfactorily. This indicates that, at least in the GTC and IMC, many health facilities were not operating effectively within the framework of the D-by-D approach. Most interviewees acknowledged that while some minor progress had been made, much work remained to be done to enhance the quality and effectiveness of the services offered.

The interviewees highlighted several conditions that hindered the achievement of adequate health services. Key challenges identified included a shortage of qualified and competent personnel, inadequate budget allocations from the government, limited capacity of healthcare facilities, and insufficient motivation among staff members. Additionally, there was a noted lack of public awareness regarding health issues, as well as a lack of innovative approaches to service delivery. These factors collectively impede the realisation of adequate health services, underscoring the need for significant improvements in resources and operational strategies.

Discussion of Findings

Through a comparative analysis of responses from both councils, several prominent themes emerge regarding stakeholder perceptions, implementation challenges, and the overall efficacy of the D-by-D framework in addressing local health needs.

Mixed effectiveness of approaches

Quantitative data revealed distinct perceptions regarding the various D-by-D approaches. The high "project and programme monitoring and implementation" score in both councils underscores its effectiveness in enhancing healthcare delivery. This finding reinforces the work of Oleribe et al. (2019), which emphasises the importance of monitoring to ensure accountability and responsiveness in service provision. Similarly, both councils rated the "strategic planning" approach ineffective, indicating a lack of robust frameworks to guide healthcare initiatives. Conversely, unlike IMC's low rating, GTC's higher rating for "multi-stakeholder involvement" suggests that active and inclusive engagement may foster improved perceptions and effectiveness in implementing healthcare strategies. Therefore, these findings align with the recommendations of Vitálišová, Murray-Svidroňová, and Jakuš-Muthová (2021), who advocate for the involvement of stakeholders in all local government development initiatives.

Community engagement challenges

Quantitative findings indicated low effectiveness ratings for community participation approaches, mirroring concerns from interviewees who reported systemic obstacles to meaningful community engagement. This aligns with findings from Mdee and Thorley (2016), which suggest that local populations often feel sidelined in decision-making processes. Local officials from both councils articulated challenges such as low public awareness and logistical hurdles that impede effective health programme execution. This underlines a disconnection between service delivery and community needs, indicating a critical need for improved communication and outreach to empower community involvement in health decisions.

Resource allocation and financial autonomy

Both councils favourably viewed the "financing and budget allocation" approach, suggesting some progress in managing resources under the D-by-D framework. Nonetheless, the continued reliance on central government funding, as highlighted by interview participants, highlights vulnerabilities in local operational capabilities, echoing previous literature regarding the necessity of financial independence. The findings align with those of Davidson and Schragger (2021), who noted that this reliance creates vulnerabilities in the operational capabilities of Local Government Authorities (LGAs).

Competence of healthcare personnel

Significant challenges concerning human resource capacity have emerged. The low scores for "managerial capacity" and "employees' performance" indicate ongoing staffing deficiencies in both councils, underscoring the need for investment in workforce training and conditions. Interview responses revealed that issues such as low morale and insufficient support are having a negative impact on service delivery, suggesting a critical area that requires intervention. These results are consistent with past findings, which indicate a dire need for investment in human capacity within Tanzanian local councils (Kigume & Maluka, 2018).

Perception of healthcare quality

Despite recognising some effective D-by-D approaches, interviewees expressed scepticism regarding the quality of care delivered by local health facilities. Frequently cited barriers included persistent issues such as inadequate funding and personnel shortages, indicating an urgent need for systemic reforms within the healthcare framework to improve service quality and public satisfaction. These findings resonate with Pelizzo et al. (2018), who highlighted that insufficient

medical equipment, trained personnel, and adequate funding were significant obstacles to achieving satisfactory health outcomes.

The interviewees' consistent expression of doubt about service delivery quality suggests a pressing need for reforms to tackle systemic issues across the healthcare system. This includes investing in health infrastructure, enhancing employee training, and improving public awareness about health issues, which aligns with the recommendations of Wang and Rosemberg (2018).

Conclusion

The findings emphasise the necessity for a multifaceted approach to enhance the effectiveness of Decentralisation by Devolution in public healthcare delivery. Local government authorities can significantly improve healthcare outcomes by tackling the interrelated challenges of financial autonomy, community engagement, human resource capacity, and strategic planning. Ultimately, the successful implementation of D-by-D frameworks depends on policymakers' ability to adapt and refine their strategies in response to local needs and contexts, fostering more responsive, inclusive, and effective public healthcare systems that better serve their communities.

The study underscores the necessity for improved local governance autonomy, enhanced community engagement, and substantial investment in human resource capacity to optimise healthcare outcomes. The findings suggest that local authorities must adopt flexible and inclusive strategies to incorporate community needs and foster accountability, while policymakers should implement evidence-based reforms tailored to local contexts. This research contributes valuable insights to the global dialogue on decentralisation, offering lessons for similar initiatives in other developing regions.

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