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Street-level Bureaucrats and Service Delivery in Selected LGAs in Tanzania: Copying with Restraints of Health and Education Services

Denis Kamugisha[1] & Eliza Mwakasangula[2]

1. Department of Public Service-Humana Resource Management, School of Public Administration and Management, Mzumbe University, P.O. Box 2, Mzumbe, Morogoro, Tanzania. Email: dekamugisha@mzumbe.ac.tz
2. Department of Public Service-Humana Resource Management, School of Public Administration and Management, Mzumbe University, P. O. Box 2, Mzumbe, Morogoro, Tanzania. Email: efaty@mzumbe.ac.tz

ABSTRACT

This paper examines the manner street-level bureaucrats (agents) interact with the principal (government, citizens, etc.) in the regular course of their jobs to deliver services particularly health and education as informed by agent theory. Although service delivery involves numerous actors, the role of street-level bureaucrats (SLBs) cannot be underrated. SLBs are government employees, teachers and health staff in this context, who are thought to exhibit significant independence in job decision-making, unveil potential extensive impact on clients' lives and exercise both de jure and de facto discretion. It is believed that in the due course of rendering services, SLBs experience some difficulties like operating under scarce resources, a situation that forces SLBs to exercise their discretionary clout in dealing with service delivery restraints as a response to tenets of SLBs theory. Although the existence of aforesaid situations is not highly contested, there is not enough theoretical evidence that explains service delivery dynamics in selected LGAs and the manner SLBs exercise de jure and de facto discretion to cope with the status quo. To bridge this fissure, the qualitative approach, spatial quasi-design, semi-structured interviews, documentary reviews and observation were accorded to gather some insights from selected areas regarding service delivery dynamics and the manner SLBs pursue their agenda mainly focusing on the delivery of aforesaid services. Study findings revealed that service delivery in selected LGAs is at a snail's pace due to several restraints and that in the due course of their operations, SLBs devise some mechanisms to cope with service delivery restraints regardless of whether SLBs interface leads to either positive or negative outcomes.

Keywords: Street level bureaucracy, discretion, key stakeholders and service delivery.

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1.0 Introduction

Street-level Bureaucrats (SLBs) are people employed by the government to constantly interact with citizens and other stakeholders in the regular course of their jobs, exhibiting significant independence in job decision-making; and having a potentially extensive impact on the lives of their clients; in this case, teachers and health staff are such people. Normally, the role of SLBs starts at the end of the policy chain. In line with that Lipsky (1980), when SLBs encounter some difficulties in rendering services they use their discretionary autonomy to deal with the challenge. This paper focuses on the SLB's role, however, the delivery of robust services with a bias on primary health care and primary education cannot be complete without reciprocal interaction among citizens, agents and principals (Davidovitz & Cohen, 2022; Akosa & Asare 2017; Ringold *et al.*, 2012; Ahmed *et al.*, 2005). This is because no single person has all the necessary resources to handle complicated issues. It is possible to tackle complicated scenarios where collaborative efforts make partners who share resources, responsibilities, knowledge, benefits and risks (Osborne 2010; Knox 2002). Where an interface is unpromising in-service delivery, it can result in blockage which affects mostly the disadvantaged groups, the poor - men and women altogether.

The literature comparing Africa with other developing countries on the state of service delivery, particularly education and health, reveals that *'poor people suffer the most when the public sector fails to deliver'* (Davidovitz and Cohen, 2022; Lotta and Marques, 2020; Bold and colleagues, 2010). This can be attributed to weak relationships and the incapacity of key actors bestowed with decision-making powers to manage scarce resources. Although the interface between key actors as an elixir to robust service delivery has not been refuted, numerous scholars have not thoroughly unpacked street-level bureaucrats' role regarding how they can enhance robust service delivery particularly health and education while interacting with clients. According to Akosa and Asare (2017), street-level bureaucrats, teachers and health workers can exercise both *de jure* and *'de facto'* discretion. Discretion as *'de jur*y can officially be recognized as a right or entitlement to decide, *'de facto' is the opposite, that is, the informal power to act* in their operations (Evans 2010:33). In a nutshell, these concepts unearth the differences between what workers or frontline policy implementers are lawfully endorsed to do *(de jure)* and what they are informally able to do in practice *(de facto)* to address community-wide predicaments (Johannessen 2019; Akosa and Asare 2017; Lipsky 1980). In trying to fulfil their quest, agents can either comply with state policies *(de jure)* or informally construct or reconstruct their own organizations' policies (*de facto*). *De jure* may be effective if all the necessary enforcement mechanisms are active.

On the other hand, as contended by Lipsky (1980), frontline teachers and health workers in this context, under a difficult environment can still enhance service delivery by exercising their discretionary powers (*de facto*) to deal with the status quo. despite the importance of the important role of frontline teachers and health workers in service delivery in the public sector, there are limited insights on the roles of street-level bureaucrats in Tanzanian literature. Anchored on principal-agent theory, 'street-level policy' is formed in an interactionism approach between agents and clients. This refutes the notion that the principals (e.g., government officials and parliamentarians) are alone in enacting policy. It is argued in this

article that street-level bureaucrats exercise both *de jure* and *de facto* discretion to bring anticipated change. Nevertheless, SLBs may get the job done with limited resources. Despite this fact, there is not enough theoretical evidence that explains the manner SLBs exercise *de jure* and *de facto discretion* to make the job done with inadequate resources. Consequently, this paper used the principal-agent theory and street-level bureaucracy theory to address four questions: first, what is the state of service delivery? Second, how do street-level bureaucrats operate as de facto or dejure policymakers? Third, how do street-level bureaucrats exercise their discretion to interact with clients in implementing government policies? Four, how do street-level bureaucrats operate under limited resources to enhance or limit the delivery of health and education services and to further explicate whether such strategies depend on the nature of services in operation? This is imperative because there are hardly any studies which have tried to look at the nature of SLBs interactions across diverse services, in this case, health and education.

2. Research Methods

The qualitative approach, spatial quasi-design, semi-structured interviews, documentary review and observation were used to obtain data on how street-level bureaucrats (SLBs) develop mechanisms to cope with restraints of service delivery particularly primary education and primary health care in Tanzania. The data were collected from Mvomero District and Moshi Municipal Councils. The two councils exhibit different characteristics. While Mvomero is characterized by a relatively low-income, rural area, peasant agriculture, dominated by Luguru-speaking people, Moshi is characterized by a relatively high-income, urban area, dominated by Chaga-speaking people, peri-urban agriculture and growing business entrepreneurs. A qualitative approach was employed to gain some insights into how SLBs in selected LGAs express the deterrents they encounter in executing public policy and the manner they cope with such situations. This was facilitated by a cross-case analysis. There are two categories of cross-case analysis, namely, pure and quasi. The study did not use pure experiments because it involves randomization and natural experiments. It used the spatial quasi-design which primarily focuses on the fact the intervention comes from the government, unlike a pure experiment where the intervention comes from an individual. Government interventions include institutional legal frameworks the government design to guide the operations of LGAs across the country. The use of spatial quasi-design aimed at gaining an understanding of how government interventions including policies, legislations and decrees apply across different selected councils with different characteristics. In line with that most different systems designs (MDSD) were used to compare the two councils. While the former aimed at understanding how the same government policies and legislation are applicable in different contexts regarding the delivery of health and education services, the latter aimed at finding out whether contextual variation (characteristics) explains service delivery outcomes by agents (teachers and health staff).

Further, national documents including policies, guidelines, legislation, research reports and programmes were used to get some clues on SLBs' behaviours and how they translate from theory to practice. Four primary schools namely Mnazi and Njoro in Moshi and Dakawa and Mongwe in Mvomero and four primary health facilities, which are Mnazi, Njoro, Dakawa and Mongwe were selected whereby from each category five frontline workers were depicted

conveniently to make a total of 40 respondents. The two councils were selected purposively based on their differentiating characteristics to understand how the same government policies and legal frameworks apply to different contexts. Semi-structured interviews were held with frontline workers, in this context, primary school teachers and primary health care staff. The researcher obtained study permits from selected LGAs and direct consent from teachers and health staff who freely participated in giving information. This went hand in hand with visiting and observing study sites, that is, the selected primary health facilities and primary schools to see the nature of human resources, physical resources and financial resources. the collected data were analysed using content analysis.

3.0 Theoretical Framework

The key concepts discussed in this paper cover service delivery, street-level bureaucracy and discretion in connecting to principal-agent theory.

3.1 Service Delivery

There is no universal consensus on the meaning of service delivery. It simply embraces the interplay between policymakers, citizens and street-level bureaucrats (Ringold *et al.*, 2012, Ahmed *et al.*, 2005). The same is accorded by the principal agent perspective where the mutual interface between agents, clients and principal is crucial for service delivery. These actors can facilitate a combination of various inputs to enhance the delivery of a series of interventions (WHO in Kamugisha, 2019). Services can be categorized as collective, particular and quasi-collective (OECD 2010; Gildenhuys, 2010). Public (collective) services have indirect quid pro quo as they cannot easily be charged by the price per unit consumed. Other features of public services are as follows: they are financed only by taxation, they do not easily exclude key players from free riders, they are non-exclusive, they cannot be sold, they are supplied and divided into consumption units, they are non - apportionable, they do not deplete or diminish in utilization, they are inexhaustible, they are not competitive, and they are monopolistic. The converse is particular (private) services which are competitive, apportionable, exclusive, exhaustible, and financed by consumer tariffs. A combination of collective and particular services results in quasi-collective (joint) services. These are particular services subsidized through tax income by the government which are provided on humanitarian grounds to avoid negative spillover effects. They are quasi-collective services especially when their spillover effects by all means cannot be handled by an individual. For instance, the outbreaks of diseases such as cholera, coronavirus (COVID-19), SARS and MERS all together, need both national and international interventions. Another example can be drawn from education on illiteracy, especially for people who belong to economically retrograde sections. If the masses cannot afford it, then, the government has to intervene. When the delivery of such services is left to an individual, its repercussions are likely to be disastrous to both the local and international community. Conversely, cases with mild spillover effects can still be left to be handled by an individual in terms of paying the cost of their delivery, given that there are appropriate systems for doing so. Where systems or legal frameworks (de jure) cannot be enforced to eradicate service delivery deterrents, then, street-level bureaucrats can devise their ways (de facto) to bridge the fissure, the deed which may either comply with the state's policy or not.

3.2 Features of Street-level Bureaucrats

Any successful implementation of a programme, a project or activity depends on policy implementers, particularly those whose level of contact with the clients is high. Street-level bureaucrats are agents or frontline policy implementers who usually encounter difficult moments in the due course of rendering services. They are *'public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work'* (Chang and Brewer, 2022; Cohen, 2021; Lipsky cited in Akosa and Asare 2017:1). In this context, they mean primary school teachers and health workers from the selected LGAs who interact with clients and exercise their discretion. Whereas, at one point, street-level bureaucrats are regarded as frontline implementers of state policies, on the other hand, they are viewed as de facto policymakers who exercise discretionary powers (administrative discretion) to effect a change. Therefore, SLBs exhibit certain features:

First, street-level bureaucrats have discretion powers because the nature of the service they provide calls for human judgment that cannot be programmed and for which cannot be substituted by machines (Chang & Brewer, 2022; Cohen, 2021; Hupe, 2014; Hupe & Hill, 2007). This means that rules and discretion are interrelated. While rules specify officials' obligations and duties, discretion accords agents' freedom to act. In support of this, Davis (1969 as cited in Kamugisha 2019) comments that *a public officer has discretion wherever the effective limits on his power leave him free to choose among possible courses of action and inaction'.* Although street-level bureaucrats have a relatively high amount of discretion to bring anticipated change, their work is prone to relatively high levels of insecurity related to a heavy workload, unfavourable operational environment and limited resources in terms of staff, infrastructure, and finances (Lipsky, 1969). Second, street-level bureaucrats are professionals defined by their *'occupational or professional ideologies'* (Akosa & Asare, 2017:3). In fulfilling their obligations, they operate as both vertical and horizontal networks, and thus, practice multiple accountability roles. Third, although street-level bureaucrats' clients come from the population they serve, in practice, they have no voluntary clients because, for the most part, they are not their reference group (Lipsky, 1969:2). For instance, clients of health staff are the sick and for primary school teacher clients are the pupils who meet on an involuntary basis even though results of their interface may culminate to a positive outcome such as school performance.

Fourth, SLBs play vital roles in influencing policy execution through their attitudes and values (Keiser, 2010). They (SLBs) also play a role in policy-making (Lipsky, 1980). In the policy-making and implementation process, Lipsky (1980) asserts that street-level bureaucrats exercise their roles through a relatively high degree of discretion and autonomy. So, they are de facto policymakers (Akosa & Asare, 2017). Fifth, when they encounter difficulties in translating policy into practice, street-level bureaucrats always try to simplify their work by defining their subjective orientations in conveniently implementing policy. According to Weatherley and Lipsky (2002: 172), street-level bureaucrats can operate freely by developing procedures routinely, rationing their existing resources, modifying or improving their goals, setting their priorities and controlling recipients' service demands. Sixth, according to Goffman (1983), street-level bureaucrats conduct face-to-face interaction with clients, which enables the client to assert their demands with full interactional force. This goes to show that teachers and health

staff who are street-level bureaucrats play a vital role in enhancing policy-making, interpretation and execution in a local context.

3.3 Administrative Discretion

The term discretion as defined by Lipsky (1980) and Evans (2010), means the extent of freedom a worker can exercise in a specific context and the factors that give rise to this freedom in that context. It is about the power or autonomy to decide or act according to one's judgment (Akosa & Asare, 2017). Dworkin (1978) views discretion as a space of autonomous decision-making surrounded by a belt of restrictions. Discretion does not only imply a *'belt of restrictions'* but also some scope remains for the actor's judgment. Evans (2010:33) categorizes discretion into two: *de jure* and *de facto*. Whereas, the former entails 'official recognition of a right or entitlement to decide', the latter means 'the power to act, although not necessarily officially recognized. *De jure* and *de facto* aspects cover granted discretion and discretion in use respectively. These two aspects in this regard capture the difference between what teachers and health workers are formally allowed to do (granted discretion) and what they are informally able to do on the ground if left on their own (discretion in use) respectively. This shows that frontline workers either use legal frameworks or their judgment in making decisions or choices depending on the prevailing scenarios. So, one can contend that agents (street-level bureaucrats) usually exercise their freedom or autonomy to make choices about the objectives they want to achieve by complying with the principal interests, and clients' wishes or follow own self-interests which can turn into either their positive or negative outcomes (Chang & Brewer, 2022; Cohen, 2021; Tummers, 2011).

SLBs activities turn to positive results especially when it involves making healthy choices in the absence of formal rules, depending on circumstances by considering the end of an outcome. It is an unprejudiced decision considering the effects of the majority (teleological decision). Frontline workers are compelled to make discretionary choices with *'justice' 'righteousness',* and *'effectiveness'* (Dillman 2002, Burke 1996). This keeps frontline workers on the moral pathway of doing 'right, and justice and enhances accountability for one who transgresses it. The exercise promotes justice, equity, fairness, equality, flexibility, creative and reactive capacity; and the use of information prudently and humanely when dealing with complex predicaments (Kamugisha 2019). Discretion may also lead to negative results. We learn from Aristotle that *'treating unequal in the same manner is an abuse of discretion or it is injustice the same as treating the equals unequally'*. Mistreating the *'equals'* and *'unequal'* makes the exercise of discretion a source of malfeasance from selective enforcement, prejudice, favouritism, segregation, stigmatization, and biased interpretation (Ball *et. al.*, 1985).

3.4 Principal-Agent Theory

The Principal-Agent Theory t shows the relationship between the principal (government officials) and the agent (teachers and health staff). Although this theory is rooted in economics, it is currently used in numerous fields including sociology, education, health, political science, accounting, finance and public administration. Jensen and Meckling (1976: 308), the founders of this theory present Principal-Agent Theory as a contract under which one or more persons engage another person to perform some service on their behalf which involves delegating some

decision-making authority to the agent, and in this context, teachers and health staff are accountable to LGAs and citizens. Sekwat (2000) calls it the 'principal-agent relationship.' Although the government has to create a good environment for agents to perform their tasks well, the experience has shown that, in some circumstances, the government fails to keep its promise, for instance, it may not ensure key resources are available in time to motivate agents to perform their duties as required. A lack of resources or incentives may force the agents, teachers and health workers to devise coping strategies. The Principal-Agent Theory can be manifested when the principals delegate work or responsibilities to the agents who are street-level bureaucrats to address societal wider predicaments due to abundant assignments bestowed to the principals. In performing their activities, street-level bureaucrats, teachers and health staff in this context, can implement their own *de facto* policies. To use Fleisher's (1991) lens, principals cannot disentangle from agents because they perform the job efficiently and cost-effectively even more than the principal; they work better because the principal lacks certain skills and expertise to offer desired services; and they can act as entrepreneurs to resolve collective action dilemmas.

During their operations, these teachers and health staff may either execute state policies in place (de jure) or formulate their policies (de facto) to suit the prevailing conditions. They are regarded as 'public officials who grant access to government programmes and provide services within them' (Johannessen 2019: 513). They are also *'de facto policymakers that informally construct or reconstruct their organizations' policies… interact directly with the public and supply goods and services to the public'* (Lipsky, 1980; Akosa & Asare, 2017). Furthermore, street-level bureaucrats are entrepreneurs of some sort who exercise their discretion and collaborate with clients (citizens) to address wider societal predicaments with or without adequate resources such as human resources, financial resources and physical resources. The manner they interact refutes the notion that the principals are alone in policy-making as supported by Johannessen (2019). This was addressed by Lipsky (1980:xii) by arguing,

> *'Public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators because in important ways it is made in the crowded offices and daily encounters of street-level workers.*

Further, Lipsky (1980:3) added,

> *'The actions of most public service workers constitute the services delivered by the government.'*

We learn also from Johannessen (2019:513) that,

> *'Frontline workers interact directly with clients and have considerable discretion in how they operate…. public policy is ultimately enacted in their encounters with citizens.'*

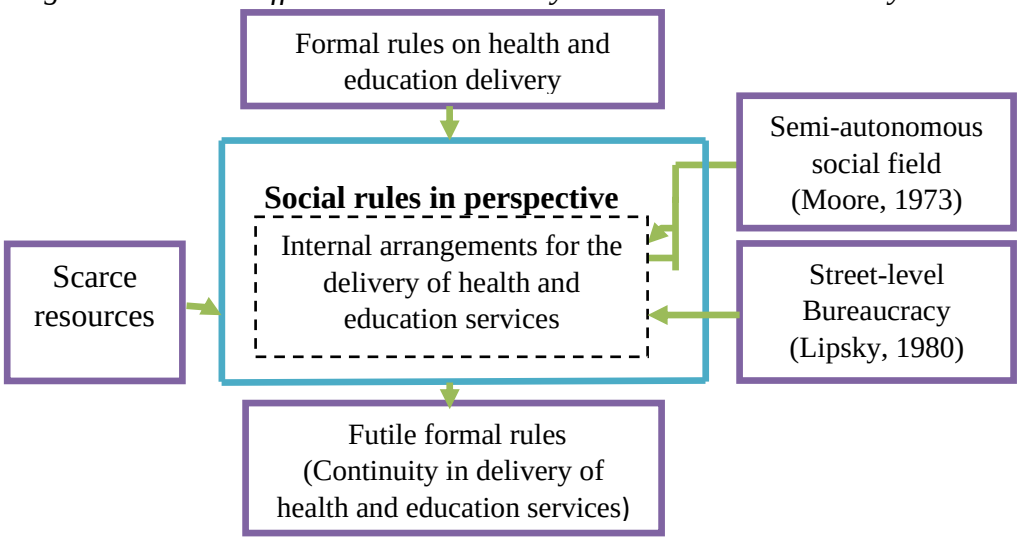
So, one can argue that public policy is made by principals (government officials, parliamentarians, councillors), agents (street-level bureaucrats) and clients (citizens).

This implies that numerous street-level bureaucrats work at the end of the policy chain and exercise both autonomy and discretion that enable them to influence policy outcomes (Akosa & Asare, 2017; Mikael Sevä, 2015; Tummers & Bekkers, 2014). They engage with citizens who have limited time and amount of information to make robust decisions. It is imperative to note that the rules street-level bureaucrats take on board sometimes do not relate thoroughly with the specific situation of citizens involved due to the contextual diversity. In response to this, they become *de facto* policymakers. This is possible because they exercise a certain degree of discretion or autonomy (Lipsky 1980; Huber & Shipan, 2002; Tummers *et al.*, 2009). As policymaking needs a plethora of actors, so as its execution. This implies that street-level bureaucrats can exercise their discretion in policy making and implementation to suit their environment to address people's interests and sometimes address their interests. And sometimes the principal may not be in the position to control how teachers and health staff in this context behave in due course of rendering services.

3.5 A Link between Street-level Bureaucrats and Exercise of Discretion

The roles of street-level bureaucrats may either be positive or negative or comprehensive but equivocal. However, when performing their jobs or roles, 'discretion' becomes crucial. According to Lipsky (1980: iii), *'discretion provides the opportunity to intervene on behalf of clients as well as to discriminate among them.'* While exercising discretion, street-level bureaucrats, teachers and health staff in this context, may become flexible in undertaking their roles. Through discretion teachers or health staff, for example, can devise the best way to deal with specific challenges depending on one's ability to make decisions or circumstances. Regardless of the nature of services and the key actors, what is imperative is the ability to make use of the prevailing circumstances to make decisions. Holding other factors constant, the question is, does the nature of a service matter or otherwise for one to behave in a certain manner? Apart from clients, discretion can also be exercised through agents' experience (Sherman, 1984) and the nature of the prevailing circumstances (Bronitt & Stenning, 2011). From Michael Lipsky (1969, 1980, 2010), we learn that although street-level bureaucrats implement public policy, they also operate in a difficult environment, particularly at the end of the policy chain. When things are in order, it is not always easy to note their role, but when things are bad it is easy to note their presence as Figure 1 illustrates.

Figure 1: Limited Effectiveness in Primary Health Care and Primary Education



Source: Adapted from Kamugisha (2019) and Wilhelm (2011)

Figure 1 illustrates that some of the challenging moments for SLBs in their operations involve the following; first, they encounter inadequate resources with high exerted demand for services particularly health and education in this context. In the context of education, resources may fall under several characterizations including teachers and their quarters, textbooks, classrooms, desks, and capitation grants (Mbelle, 2008; Wilhelm, 2011). When these aspects are scanty may, the delivery of education becomes challenging, something that calls SLBs (teachers) to behave in a certain manner to deal with service delivery predicaments. In the context of health, resources according to the National standards (cited by Mollel (2010) cover various aspects including health staff, health staff quarters, equipment, drugs and other supplies. Despite the diverse nature of aforesaid services, what the services have in common, according to Lipsky (1980) is, that health staff or teachers develop some strategies to address whatever challenges or obstacles they encounter in the course of performing their jobs. For instance, if resources are inadequate, available scarce resources may be used to perform certain activities which can be manageable. Second, SLBs also render services, let's say health and education, which extend to circumstances with physical or psychological threats. The best option may be to identify the threats and devise mechanisms to prevent them from happening. Third, SLBs develop certain mechanisms to deal with certain circumstances because the bureaucrat's authority devises plans which fail to be implemented. They normally *'talk the talk but do not walk the talk'* as enshrined in policies and legislations of their creation. Fourth, SLBs come in because bureaucratic authority usually set expectations of job performance that are vague and contradictory, leading to unattainable idealized dimensions. In this situation, SLBs, teachers and health staff become de facto policymakers.

Figure 1 exemplifies the point of departure of this article. The main thesis is that all bureaucrats who work at the end of the policy chain have both autonomy and discretion, something that enables them to influence policy outcomes. Street-level bureaucrats (agents) in their operations,

experience limited resources at their disposal including human resources (i.e. teachers and health staff) allocated in various primary schools and health facilities, financial resources and physical resources (i.e. drugs and other supplies, microscope, autoclave or sterilizer, delivery bed, stethoscope, delivery kit, diagnostic set, ambulance bag, BP monitor, desks, classrooms, pit latrine drop holes, textbooks and staff quarters) which call for internal arrangements that translate policy into practice. It means that under limited resources teachers and health workers may internally organize their operations within resource constraints. The coping strategies that are developed intend to ensure that service delivery continues.

This is the main thesis of Lipsky (1980), which is complemented by Moore (1973) who asserts that such strategies may affect public policy intentions. Based on Lipsky (1980) as used in Figure 1, street-level bureaucrats, teachers and health workers in this context, may modify or simplify their concept of work by redefining their objectives to align with scarce resources. Besides, teachers and health workers engage with citizens (clients) who have limited time and amount of information to make decisions on health and education issues. Since the rules teachers and health workers implement do not relate to the specific situation of the citizens involved, de facto policies may be developed to cope with the status quo. Despite the plethora of studies regarding street-level bureaucrats, few scholars have focused on how street-level bureaucrats exercise their discretion either positively or negatively. Furthermore, scholars who have laboured in this area do not accord sound insights on theoretical evidence regarding how street-level bureaucrats exercise their discretion and autonomy. The bureaucrats addressed here are those concerned with traditional Lipskyan Street-level bureaucrats who interact daily with clients (citizens) face to face, particularly teachers and health workers in this context.

3.6 Exercise of Discretion and Service Delivery in Tanzania

The ongoing situation in Tanzania regarding the delivery of social services particularly primary education and primary health care reflects Figure 1 and theoretical tenets. This shows how principal (government officials) from the centre have exercised their discretion by devolving autonomy (financial, human and physical resources) to LGAs. Due to incapacity, street-level bureaucrats at the end of the policy chain are thought to exercise discretion to a certain degree to deal with service delivery predicaments (Lipsky, 1980). It is also argued that the strategies street-level bureaucrats (e.g., teachers and health workers) put in place to deal with the deterrents of aforesaid services affect the public policy intentions. The fact that the aforementioned services in Tanzania, are ineffective as reported in some studies (WHO, 2017; Mackfallen, 2017; UNDP, 2016; Kessy & McCourt, 2010) calls for the exercise of discretion by teachers and health workers. According to Dada (2013), the exercise of discretion sounds better in the devolved system than in the rigid system, meaning that it increases from the de-concentration to a devolved system. The trajectory of the development of LGAs in Tanzania has followed suit. The unicentric, individualism (multicentric) and pluralistic systems tell it all.

As it may be recalled, the service delivery state in the unicentric system (1960-1985) was in shambles because the de-concentration system was at its zenith. In this situation, the exercise of discretion by teachers and health workers was problematic. This is because the state was both a planner and a player's overall development cycle. In this regard, it was difficult for SLBs to use their discretion to address the problems of the people. This is reflected even in the instruments

that were adopted such that enacted policies and legislations restricted the provision of social services particularly education and health services to the state (Education Act No. 25 of 1978; National Health Policy, 1990). This state of affairs was reflected in low life expectancy of around 40 years and illiteracy above 85 per cent in the early 1960s (Kessy, 2011; Mushi, 2009; Max, 1991; URT, 1990). Even though trained teachers and health workers were few, those available could not thoroughly exercise their discretionary power to cope with the status quo. Street-level bureaucrats danced to the tune of de-concentration modus operandi. Although in the multicentric (1986-1990) system, the mode of governance shifted from de-concentration to privatization, a significant shift from collectivism to individualism did not bring the desired change propagated by International Monetary Fund (IMF) and the World Bank (WB). It can be argued that due to the inability of frontline policy implementers to use their discretion, the privatization of state-owned enterprises (SOEs) and staff retrenchment policies increased resources incapacity which in turn increased bottlenecks of social services rather than decreasing them (Masue, 2014; Mollel, 2010; Mushi, 2009; Mukandala & Peter, 2004). This is because the emphasis was put more on the 'market' forces than on the 'state' (Sorensen & Torfing, 2004). To sum up, all that one could say in this era is that the exercise of discretion had more detrimental effects than the opposite. The situation was anticipated to change into a more democratic (pluralistic) system.

In the pluralistic system, the exercise of discretion by street-level bureaucrats improved a great deal. This was due to the proliferation of national policies and ratification of international protocols that emphasized the public-private mix, networking and participation of policymakers (officials), citizens (clients) and street-level bureaucrats (agents) on service delivery particularly in the 1990s (Akosa & Asare, 2017; Chaligha, 2014; Ringold et al., 2012; Ahmed et al., 2005). The most significant change in this era compared to previous periods was the increasing discretionary powers of these actors. Such protocols include the Alma Ata Declaration (1978), which emphasized equal participation between men and women in health service delivery. This was followed by the Astana Declaration (2018), which aimed at increasing the engagement of frontline volunteers in providing health services at the lower level. Other portfolios include Strategic Development Goals (SDGs) (2016- 2030) covering the improvement of decision-making for both health and education services; National Health Policy (URT, 2007, 1990), which focused on the engagement of people to improve health services; Community Health Fund (CHF) (1999); the National Health Insurance Fund (NHIF) (2001), which focused on clients participation on health-related matters and the National Education Policy (URT, 2014), which aimed at improving education through citizen engagement. Despite the milestones reached as a result of government commitment to devolve substantial autonomy to LGAs and to ensure robust delivery of essential services, the mutual interface between the central government and Local Government Authorities was blurred. Despite these challenges, some milestones regarding the exercising of desecration as compared with the past improved a great deal as a result of the onset of new instruments justified by the state of service delivery explicated in detail below.

3.6.1 State of Health Service in Tanzania

Understanding the state of service delivery is imperative because it may portray some fissures which SLBs may cope with. Statistics on health service provision in LGAs in Tanzania do not largely meet the established thresholds (WHO, 2017; UNDP, 2016). This implies that service

delivery is still problematic as reflected in statistics on child mortality rate, maternal mortality rate, children stunting rate, physical resources and finances. The evidence indicates that while the child mortality rate fell from 99 to 51 per 1000 live births from 1999 to 2010 (WHO 2017; Mackfallen 2017:2), 51 per cent is still above the recommended world average rate of 37. Regarding the maternal mortality rate per 100,000 births, the trends of 578 (2005), 454 (2010), 432 (2012), and 556 (2015) are still above the world average of 210 (Mackfallen, 2017; URT, 2014). The same applies to the under-5 mortality rate which is 67/1000 (WHO, 2017). The state of stunting rate of that under five (5) is still high at a tune of 38, 42, and 35 per cent in 2008, 2010 and 2012 respectively. Regarding financial support, experience has shown that there is always a deficit between the approved and the actual budget for the health sector. For instance, whereas in FY 2013/14, the allocation for health accounted for 10 per cent, in FY 2017/2018, this allocation dropped to 7 per cent. Furthermore, the recurrent spending within the Ministry fell from 44 per cent in FY 2013/2014 to 30 per cent in 2017/2018 as a result of the fiscal deficit from development partners (DPs) whose support declined from 92 to 57 per cent between FY 2013/2014 and FY 2017/2018 respectively. Regarding health staff and equipment distribution to health facilities, the gap is burgeoning between urban and rural areas (WHO 2017:12). The reports by UNICEF (2018) and show that 'health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care' (WHO, 2017: p. 2)

3.7.2 State of Primary Education in Tanzania

Understanding the state of service delivery is imperative because it may portray some fissures which SLBs may cope with as summarized in Table 1.

Table 1: Primary Education Performance Indicators

KPI	2015/16*	2017	2018	2019	2020**	2025**
Gross Enrolment Ratio	93	96.6	105.5	110.3	109	104
Net Enrolment Rate	84	84	91.1	95.4	90	95
Survival Rate from Standard 1 to the Last Grade of Basic Education Cycle 2 (Form IV) %	34	33.7	48.4	43.4	64	75
Average Dropout Rate in Primary Education %	10.3	1.3	0.7	0.89	5	1
Out-of-school Children of Basic Education School Age %	29	20.2	14	6	19	8
Pupil/Qualified Teacher Ratio in Primary Education %	51	48	52	55	49	45
Pupil/Teacher Ratio in Primary Education%	44	50	54	58	-	-
Pass Rates in the Primary School Leaving Examinations (PSLE)	67.8	70.36	72.76	75.6	75	80
Std II Learners Achieving the National Benchmark in Reading with Comprehension %	12	-	-	-	30	50
Std II Learners Achieving the National Benchmark in Mathematics%	8	-	-	-	20	35
National Budget (excluding debt servicing) Allocated to the Education Sector (total across all Ministries)	24.8	22.1	21.2	20.9	20.8	21.3

Source: AESPR (2019), BEST (2019), *baseline **targets

Statistics on education provision in Local Government Authorities (LGAs) in Tanzania do not largely meet established thresholds (BEST, 2019; AESPR, 2019; UNDP, 2016). Some bottlenecks shown in Table 1 indicate that while the teacher pupil ratio 1:40the current national ratio stands at 1:58. Suggested pit latrine drop holes-pupils ratio is 1:20 for girls 1:25 for boys. Up to 2017, the national ratio stood at one pit latrine drop hole to fifty-six boys (1:56) and one to fifty-five girls (1:55) (AESPR, 2019). According to the Annual Education Sector Performance Report (AESPR, 2019), the government constructed 7457 toilets only. The book-pupils ratio requires that one pupil uses one book per subject (1:1), but the national ratio stands at one book being shared by five pupils (1:5). According to AESPR (2019) and BEST (2019) reports the pass rate is less than 80 per cent threshold; the enrolment in primary schools has increased by 4.9 per cent from 10,111,255 pupils in 2018 to 10,601,616 pupils in 2019; pupils' ability to read and do arithmetic has decreased, and the national budget allocated to education has decreased across the country as indicated in Table I.

3.7 Coping with Restraints of Service Delivery

Despite the national statistics on health and education provision being at a snail's pace as reported in sections 3.5 and 3.6, this paper used data from Mvomero District and Moshi Municipal Councils, first, to either approve or disapprove the national wide statistics; second, to explain how street-level bureaucrats operate as de facto policymakers; third, to explicate how they exercise their discretion to implement state's policies and fourth, to determine how the councils operate under difficult environment including limited resources to enhance service delivery. The experience from Mvomero District and Moshi Municipal Councils reveals that teachers and health staff characteristics, who are street-level bureaucrats in this context, correspond with principal-agent theoretical characteristics and street-level bureaucracy theory. this is because, first, they are implementers of government policies; second, they are de facto policymakers; third, they operate under difficult environments such as limited resources such as staff. Based on the two cases, it is without a doubt that street-level bureaucrats in some circumstances may implement public policies and that under difficult conditions they may formulate de facto policies to suit prevailing environments as explained in detail in the following section. In line with this, SLBs engage clients to address challenges regarding service delivery, particularly health and education. Furthermore, they operate in different environments which shape their behaviour. Although the environments of the two cases differ in terms of location, language, culture, income and performance, the policies and legislation applied in these environments are similar.

3.7.1. Coping with Health Service Restraints

Anchored on the delivery of health services, some insights gathered from selected LGAs through observation indicate that street-level bureaucrats' operations are impeded by an inadequate number of qualified staff, financial and physical resources (i.e. microscope, autoclave, delivery beds, stethoscopes, delivery kits, weighing scales, diagnostic set, ambulance bag and Blood Pressure (BP) monitor. The study findings indicate that the four selected dispensaries exhibit great variation regarding the distribution of inadequate equipment. The deficit accounted for 43, 73, 67 and 83 per cent at Mnazi, Njoro, Dakawa and Mongwe respectively. This shows that the last three dispensaries experience a critical shortage of working tools more than the first

dispensary. This implies that some equipment for use at selected dispensaries may not be sterilized due to the lack of an autoclave; patients may not have blood tests because the dispensary lacks a microscope; people's hearts and lungs may not be checked because of lacking stethoscope; children's weight may not be measured because of lacking a weighing scale and blood pressure (BP) cannot be measured due to absence of a BP monitor and the like.

The data from selected health facilities (i.e., Mnazi, Njoro, Dakawa and Mongwe) show that inadequate resources such as health staff, equipment or tools, drugs or medicines, and health staff quarters compelled street-level bureaucrats, health workers in this regard, to devise some mechanisms to cope with the situation as follows. In the absence of autoclave, health workers used traditional knowledge of sterilizing equipment through boiling water as the coping mechanisms. In the nonexistence of a microscope, they used the conventional mode of listening to clients and thereafter prescribed medicine. In the absence of a stethoscope, health staff used traditional means of listening to a patient or cross-examining the patient. Further, in the absence of a delivery bed, they laid mattresses on the floor; a lack of a weighing scale, compelled staff to borrow such scales from a nearby butchery or retailing shop or a private dispensary; in the absence of a (BP) monitor, health workers advise patients to go to a nearby health centre or a private dispensary for diagnosis as summarized in Table 2.

Table 2: Characteristics of Selected Dispensaries

N/S	Characteristics of Health Facility	N.S	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**

Source: field data (2019)

Further, the study finding from interviews indicate that, frontline workers cope with staff inadequacy by doing *'what is in their reach' or 'doing what one is capable of doing'* and in some occasions, they engage nearby staff from private dispensaries mainly as part of social obligations; they use traditional mode to listen to patients' predicaments and prescribe medicine without a test especially during peak hours; during stock out, they advised patients to go to nearby private dispensaries for diagnosis. When constrained with financial resources, as was noted in Moshi, street-level bureaucrats engage clients to address community-wide problems

through fundraising. As observed by one of the health in-charge from Moshi Municipal Council, dispensaries engaged clients to address one of the health stubborn predicaments, where a group of business people raised TZS 2,500,000. This experience tallies with what Akosa and Asare (2017) amplified that street-level bureaucrats can engage clients to address community predicaments.

The strategies were different from those used in Mongwe dispensaries by some health staff when encountering critical predicaments. At Mongwe health facility, there were many cases of staff attrition as a result of failing to withstand fire from the kitchen, meaning failing to cope. Despite these experiences, some agents (health workers) in selected LGAs also explained that due to the meagre wages they get from the government, they devise some mechanisms to increase their income. For instance, it was revealed that street-level bureaucrats cope with meagre salaries and other pecuniary motivational packages by engaging in other activities to sustain livelihood, which includes opening pharmacies for retailing drugs and other supplies and seeking part-time alternative employment from private dispensaries. Generally, this section shows that Lipsky's theory applies at one point because in addressing health quandaries, some health staff or workers can develop strategies to address the status quo. On the other hand, street-level bureaucrats exit critical challenges through attrition. This shows that it is not always the case that any encounter can be tolerated suggesting a need to improve the theory.

3.7.2. Coping with Primary Education Restraints

Before dwelling on coping strategies, it is important to first unearth the state of the art as summarized in Table 3.

Table 3: Characteristics of Selected Primary Schools

N/s	School Features	N.S	Mnazi (Mo)	Njoro (Mo)	Total	Dakawa (Mv)	Mongwe (Mv)	Total
	Standard indicators	N.S	Actual	Actual	Actual	Actual	Actual	Actual
1	Boys PLH Pupils Ratio	1:25	1:33	1:47	40	1:49	1:29	39
2	Girls' PLH Pupils Ratio	1:20	1:35	1:43	39	1:25	1:29	27
3	Teacher-Pupil Ratio (TPR)	1:45	1:39	1:30	35	1:38	1:70	54
4	Book-Pupil Ratio (BPR)	1:1	1:2	1:2	2	1:24	1:31	28
5	Classroom-Pupil Ratio (1:45)	1:45	1:76	1:49	63	1:121	1:58	90
6	Desk-Pupil Ratio (DPR 1:2)	1:2	1:3	1:2	3	1:3	1:3	3

Source: field data (2019)

Based on the field data on the delivery of primary education and some insights gathered from selected LGAs, the findings indicate that primary school teachers' operations are hampered by an inadequate number of qualified teachers and limited financial and physical resources which compromise robust delivery of education services. Findings in Table 3 show that selected schools lack key infrastructures and equipment including pit latrine drop holes (PLDH), textbooks (BPR), classrooms (CPR), desks (DPR), Teachers (TPR) and staff quarters. in this

respect, one can learn that street-level bureaucrats develop some strategies to cope with such inadequacies.

Based on the characteristics of selected primary schools shown in Table 3, the study findings show that the delivery of primary education is ineffective. This is justified by available statistics from the field which indicate that the stipulated standard for PLDH is one to twenty-five (1:25) for boys and one to twenty (1:20) for girls, the observed situation across selected primary schools for boys was found to be 1:33, 1:47, 1:49, 1:29 at Mnazi, Njoro, Dakawa, and Mongwe, respectively, (see Table 3 item No.1). And for girls, the observed: pattern was 1:35, 1:43, 1:25, 1:29 at Mnazi, Njoro, Dakawa, and Mongwe, respectively, (see Table 3 item No. 2). For TPR the documentary statistics reveal that while the required threshold is one teacher to forty-five pupils (1:45), the observed state was 1:39, 1:30, 1:38, 1:70 at Mnazi, Njoro, Dakawa, and Mongwe, (Table 3 item No. 3). This shows that there are relatively enough teachers in the first three schools where one teacher serves not more than 45 pupils as opposed to Mongwe primary school where one teacher serves 70 pupils. Despite this fact, through interviews school head teachers reported the availability of a few teachers specialized in standard I and II.

Based on BPR (see Table 3 item No.4), while the BPR Standard is one book to one pupil (1:1) through, the observation revealed 1:2, 1:2, 1:24, 1:31 at Mnazi, Njoro, Dakawa, and Mongwe, respectively. Based on these statistics, while the first two schools are closer to acceptable estimates, the last two are far off. Despite these variations, all selected primary schools exhibit similar characteristics of not having the required threshold of 1:1. Regarding the class size (see Table 3 item No.5), the statistics from documentary reviews indicate that while the required threshold is one class to forty-five pupils (1:45), the observed state was 1:76, 1:49, 1:121, 1:58 at Mnazi, Njoro, Dakawa and Mongwe, implying overcrowding of pupils in selected schools. Regarding DPR (see Table 3 item No. 6), while the threshold is one desk to two pupils (1:2), the observed state was 1:3, 1:2, 1:3, 1:3 at Mnazi, Njoro, Dakawa and Mongwe.

These results are similar across elected schools in two councils because no school meets the acceptable threshold for all items. This implies that primary education delivery in selected primary schools may not be effective due to inadequacy of qualified staff, existence of overcrowding due to limited infrastructure, challenges on pupils' hygiene due to a lack of adequate pit latrine drop holes which may have severe consequences to girls than is the case with boys, especially during menstruation period. Inadequacy of classrooms and desks was also thought to impede learning processes. Various ways of coping with the challenge were reported.

Teachers at Mnazi, Njoro, Dakawa and Mongwe primary schools developed several strategies to address inadequacy of teachers by introducing informal teaching arrangements after normal class sessions in return for a small token. They concentrated much on examination classes particularly Standards Four and Seven to prepare them for sitting for national examinations. They also involve parents to support this these programmes through fundraising for raising money for tutor payments and pupils' meal. The amount of support varied according to context. Clients from Mvomero contributed more food than cash as \opposed to their counterparts in other districts. These findings relate to what Akosa and Asare (2017) revealed that street-level bureaucrats innovatively interact with stakeholders to address community-wide challenges particularly those relating to the delivery of primary health care and primary education.

Further, a shortage of teachers compelled the existing ones to adjust to the prevailing environments. Teachers usually concentrate on examination class pupils by subjecting them to the review of past national examinations papers, tuition and writing past national examinations. Due to high workloads, they choose a course to teach; reduced costs by engaging senior pupils to teach simple subjects. This also involves rationing teaching time by reducing the number of teaching days to provide more time to deal with their businesses, self-reliant activities, and engaging in entrepreneurial and extra-curricular activities. Where *'shortage'* was not in terms of number but qualifications as for the case of Mnazi, Njoro, Dakawa, and Mongwe primary schools, classes I and II were assigned to unqualified teachers as a temporary measure while waiting for recruitment of newly qualified staff.

As for meagre salaries, teachers engaged in other activities to sustain a living including opening gentlemen and ladies' salons, motorbike taxi services, agricultural activities and poultry and some sort of animal keeping; shared houses to live communally; forming SACCOS to facilitate members borrowing to supplement their incomes.

Furthermore, street-level bureaucrats, and teachers in this context, coped with inadequate pit latrine drop holes (PLDH), textbooks (BPR), classrooms (CPR), desks (DPR) Teachers (TPR) and staff quarters in various ways. Regarding pit latrine drops holes, teachers allowed pupils to take a break every half an hour to reduce big queues of accessing PLDH during recess, although they complained that managing big queues takes up a lot of their time. With inadequate textbooks (BPR), teachers engaged pupils in sharing books, photo start copies, or jotted down some notes and take-home assignments for pupils to copy. As for the shortage of classrooms (CPR), classes were combined allowing two teachers to manage a session, while one is teaching the other is managing discipline. With desks (DPR) challenges, school head teachers engaged clients to contribute some funds which varied from place to place as follows: Njoro, Mnazi, Dakawa and Mongwe (3000, 3000, 1500, 500-1500) respectively.

3.7.3. SLBs De-facto Service Delivery Policies

Insights from Mvomero District and Moshi Municipal Councils show similarities and differences regarding the manner street-level bureaucrats, health staff and teachers address their challenges across selected cases. The similarities are reflected in the manner teachers and health workers operate or develop strategies to enhance robust service delivery. They develop similar strategies in the course of their operations by acting as de facto policymakers. Strategies teachers and health staff adopted to deal with the inadequacies in certain situations contradict the execution of state policies and legislations. The fact that public health staff seek help from private organizations in addressing a lack of equipment; using the conventional mode of listening to patients and thereafter prescribing medicine are examples of such cases. "Seeking help from private dispensaries" and "prescribing medicine to patients without diagnosis devices" contradict the following legislations such as the National Health Policy (1990, 2007). Although the legislation does not mandate health staff to hire staff or borrow drugs or other supplies from private organizations, sterilizing equipment using traditional means, engaging in other activities to sustain a living, and prescribing medicine to patients without a test contradict the execution of health policies and other legislations.

The same trend was reported in the delivery of education. Teachers' absenteeism, agents engaging parents to raise funds for tuition, scheduling teaching days, and engaging pupils in teaching younger ones, are strategies viewed as functions of staff flexibility in implementing public policy, although not legally acceptable. These deeds contradict Education Act No. 25 of 1978; Public Service Management and Employment Policy of 1999; Public Service Regulations (2003) and Policy Paper on Local Government Reform (1998) and National Education Policy (2014, 1995). The differences were noted especially when agents involved clients to do some fundraising to address the challenges, the clients' involvement varied from place to place. While people from Moshi could raise more funds, those from Mvomero could contribute materials as a response to a challenge. Furthermore, the effective interface between agents (street-level bureaucrats) and clients (citizens) resolved grassroots predicaments.

4.0 Discussion

This paper used the principal-agent theory and street-level bureaucracy theory to address a number of issues covering a need to understand the state of service delivery (health and education) at LGAs, identify street-level bureaucrats and the manner they exercise their discretionary powers as policy implementers (*de jure*) and *de facto* policymakers. Others include, the manner stree-level bureaucrats exercise their discretion to interact with clients in implementing the public policied understand how street-level bureaucrats operate under limited resources to enhance the delivery of aforesaid services.

Through the agent theory, we have learned that the interaction between agents (teachers and health workers) and the principal (government), plus other actors, has not led to robust service delivery in selected LGAs as shown in Tables 2 and 3. We have learned that the interaction between central government and local government has not been mutual. This means that the centre has always been controlling or directing the local government on what to do. in addition, the agents have limited capacity to question the principals from both central and Local Government Authorities. This is in contrast to the principle of mutual interaction which addresses a win–win situation,win–wine principal may not render services at the expense of the agents who need to be accorded a sound environment to keep them highly motivated to perform their work thoroughly. Due to the lack of mutual interface between the principals and agents, plus other actors, service delivery is found to be at a pathetic state as the indicated in tforesaid tables. The limitation of this theory is that it explains only the linear relationship. It does not cover all the key actors regarding service delivery. However, since the study focused on two stakeholders (principals and agents), the theory was deemed relevant. However, the theory is further limited in the sense that it cannot tell street-level bureaucrats can make *de facto* policies and the conditions associated with that. To address these aspects, the street-level bureaucrats' theory was used to unravel the manner street-level bureaucrats exercise their discretionary powers as policy implementers *(de jure)* and policymakers at the end of the policy chain *(de facto).*

SLBs theory underscores the imperatives of unpacking administrative discretion at the end of the policy chain. Anchored on the principal-agent perspective, the paper explicates the existing relationship between the principal, the agent and clients and how street-level bureaucrats (agents), primary school teachers and primary health facility workers in this context, exercise

their discretion in the course of delivering the aforesaid services. Although the principal needs the agents, the latter also needs clients to perform their duties. This contests the notion that principals are alone in policy formulation and implementation processes. This is because the principals do not have all the knowledge and expertise needed for fulfilling their duties. The insights from this study reveal that street-level bureaucrats have requisite knowledge, skills and experience and may have a positive attitude and can quickly learn the environment they are in and devise mechanisms to address the impending challenge. Based on SLBs theory, it can be argued that street-level bureaucrats are de jure policy implementers, and de facto policymakers, and in their dealings, street-level bureaucrats usually encounter some difficulties covering the working environment, limited resources, and the like. The challenge with street-level bureaucrats is that they exhibit numerous roles (comprehensive) which seem to be vague as a result of their contradictory and incongruous nature. Further, street-level bureaucrats exercise their discretion guided by diverse challengesthe they encounter in undertaking their responsibilities. Further, street-level bureaucrats exercise their discretionary powers either positively and/or negatively based on agents' (teachers and health workers) behaviour even with limited incentives. This implies that it would be imperative if Tanzania reforms fTanzania'sirely on street-level bureaucrats' endeavours and how they exercise their administrative discretion in policy making and implementation from a bottom-up approach involving street-level officials to meet policy goals and desired development.

5.0 Conclusion

The studied cases have shown that street-level bureaucrats have the potential of demonstrating their ability to develop various strategies or ways to cope with service delivery disincentives, particularly on health and education in the context of Tanzania. These strategies usually try to limit the implementation of public policies in a semi-autonomous social field because social rules and norms are critical in shaping people's actions. This viewpoint explicates the way street-level bureaucrats use their discretion (de facto) in implementing public policies in difficult environments so that service beneficiaries are not let down. This can be demonstrated by how street-level bureaucrats manage substantial workloads, rationing material resources, and modifying their work to achieve the intended objectives. They also use their discretion to judge whether they do or do not conform to public policy intentions. They may decide to ration teaching or prescription of drugs without diagnosing patients, or leave the offce when it is time for attending to clients or customers to allow themselves time to engage in entrepreneurial activities which are contrary to thisublic Service Act of 2003 and other types of legislation. Or they may accept or abide by the existing guidelines, status, decrees, directives and legislation, and liaise with beneficiaries - community members, to address service delivery aspects such as education and health amicably. Since street-level bureaucrats' behaviours in a semi-autonomous social field are more shaped by their desires to deliver services than by meeting their interests, the government should motivate them and raise their working morale without conditions. Even though street-level bureaucrats experience resource limitations in the course of rendering essential services, they can still deliver services and meet their responsibilities or duties.

6.0 Policy Implication

The gist of this work was threefold; first, to acknowledge that street-level bureaucrats work in a difficult environment coupled with limited resources. Second, to find the strategies street-level bureaucrats use to deal with inadequacies in Mvomero District and Moshi Municipal Councils in Tanzania. Third, to determine the manner street-level bureaucrats exercise discretionary powers bestowed to them. The experience from studied cases acknowledges the application of the principal-agent theory that encourages interaction between the principals (policymakers), clients (citizens) and street-level bureaucrats (agents) although this does not always result in substantial autonomy being devolved to LGAs. This shows that de jure (state's policies) and de facto (nonofficial) policies may lead to both negative and positive outcomes. Since LGAs have granted some autonomy to street-level bureaucrats, the government (centre) should nurture them to fulfil the responsibilities assigned to them, by motivating them to manage, allocate and monitor their revenue sources. This would reduce LGA's dependence on the centre and enable street-level bureaucrats, teachers and health staff to cope with service delivery deterrents or inadequacy. If the government were to be more responsive, the governed should establish feasible and workable policies that would motivate teachers and health staff to carry out their civic duties effectively. These policies would bear fruits and be enforceable, enabling service providers to focus on teaching and prescription health services without having to devise their ways of coping with difficult environments.

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