Governance of basic services provision in sub-Saharan Africa and the need to shift gear

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Abstract

During 1970 to mid 1980s, governments' policies on basic services in sub-Saharan Africa (SSA) had an almost exclusive focus on directly provided, publicly-funded. This approach coupled with disintegration of the economic structures resulted in steep decline in people's access to basic services. Recent developments however show that policies and strategies have changed and so is people's access to the services. Decentralisation within the state and from the state to market and to civil society has been implemented in an unprecedented fashion in a number of countries. In addition, the strategy of 'unbundled' chain of service production has resulted in increasingly complex institutional arrangements between governments and non-state actors. Using data on the provision of primary education, primary health care, sanitation and solid waste collection, and drinking water from a number of countries in SSA, this paper shows that the new approach has not only changed how basic services are provided and managed but has also influenced improvements in coverage and people's access, though quality varies and inequalities between localities have not much declined.

The paper acknowledges that given the nature of basic services with its problems of externalities, non-rivalry and excludability, and the socio-economic, cultural and political context of SSA, the central state has a crucial role to play in achieving a greater systemic rationality in the new approach. The central and local governments need to coordinate the various components that constitute the service production chain as well as multiple agents that are involved in delivery. This steering rather than rowing role has been minimal in SSA; hence the potential capacity of the new approach to achieve the highest level of accessibility and equity is under-utilised. The paper suggests three enabling roles that central and local governments need to play in order to plug the gap between the present situation and what may be desirable as far as the provision of basic services through multiple institutional modalities is concerned.

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INTRODUCTION

Basic services are essential human needs considered to be primarily the responsibility of the state and often delivered by governments. Basic services include water, sanitation and solid waste collection, primary education, and primary health care. In sub-Saharan Africa (SSA), the disintegration of political and economic structures during the 1980s brought a sharp decline in the provision of basic services. Shrinking government budgets meant that in many countries basic services functioned with insufficient resources to meet operational cost. Even where governments found the resources through loans and aid to provide services, delivery and management were still poor and large segments of the population were left out. Many cities in particular were described as being 'in crisis' following governments' failure to maintain existing services let alone provide new ones (Stren & White, 1989; Amin & Lloyd, 1990). Studies conducted in Nairobi (Obudho, 1997; Karanja, 2003), Lagos, Benin City and Kaduna (Onibokun, 1989; Ogu, 1997), Kumasi (Adarkwa & Post, 2001), Kinshasa (Piermay, 1997) and Abidjan (Attahi, 1991; Dubresson, 1997) showed that refuse was not collected and piles of garbage were allowed to rot in the streets. Schools were overcrowded; drains were choked, resulting in floods; water supply was erratic; and many people lived in overcrowded houses and unserviced plots. In the rural areas where between 60-80% of the population lived, the situation was worse than the cities. Donor governments and their agencies responded to the deteriorating conditions initially by providing direct local level support but in most cases they selected and designed aid programmes to their own perceptions of need and areas of interest. Their approach also reflected short-term humanitarian measures rather than long term investment plans. Although, economic and political disintegration as well as lack of long-term investment development guidelines contributed significantly to the crisis, one factor that attracted major criticism was that in many SSA countries, only the government was formally responsible for the provision of basic services in its entirety.

Recent developments in SSA however show that decentralisation within the state and from the state to market and to civil society are changing the institutional arrangements based on which basic services are provided, managed and regulated. Decentralisation has compelled central governments (CGs) to transfer some of their responsibilities, finances, authority and management to elected local governments (LGs). Subsequent application of management reforms (NPM)[1] is leading to refocusing of government organisations on efficiency, effectiveness, cost reduction and quality of delivery thereby completely changing the traditional public sector model that government organisations are used to, separating policy, planning, financing, delivery, management, and regulation. States have further began to unbundle the production chain of services delivery into separately managed components and are sharing these with non-state actors instead of behaving like a 'dinosaur'. Through these changes, governments are not only encouraging multiple agents and modalities to deliver basic services, but are also addressing power, authority and resource imbalances arising between the CG and LGs, as well as between government and non-state actors.

[1] This involves greater financial devolution, explicit standards of measuring performance, clear specification of relationships between inputs and outputs, and beliefs in the market mechanisms of competition and competitive tendering (Hood,1991).

Although the degree of success in this approach has become debateable in the literature (Robinson, 2007; Conyers, 2007), a clear observation is that in many African countries, CGs' roles in basic services provision have fundamentally changed with LGs and non-state actors beginning to play a substantial role. However, recognition of the changing role of governments and adoption of multiple institutional modalities in service provision are two things, implementation of the new approaches to deliver improved people's access, coverage and quality of services is another. The questions being asked in this paper are: How are CGs and LGs managing the growing diversity and complexity of basic services provision in this new institutional set-up? In an environment where multiple institutions of central, regional, and LGs as well as donor agencies, international development NGOs, profit and non-profit organisations all contribute to influence policy formulation, planning, financing, delivery, management, and regulation, how can such a web of interconnectedness be streamlined? How can CG which has primary responsibilities for service provision steer the unbundled chain of production to achieve greater coordination at a minimal cost? What new roles are required to be played by these multiple actors and do government agencies have the capacity to manage the new approach effectively so that quality of delivery will not deteriorate and costs rise? What lessons are there to be learned? To what extent can these lessons help to redirect policy formulation and implementation so as to improve the provision of basic services? These are some of the issues that we will return to in our analyses of the current situation of basic services provision in SSA.

It is important to stress the following caveats: Given the diversity of countries in SSA, it is difficult to have a true representation in a single paper. Hence, the countries that are chosen in the paper are illustrative of rather than representative. Second, for lack of detailed base lines the paper does not take into proper consideration the starting points of different countries in the application of policy and operational reforms. Third, the facts presented are based on authors' own field study, collection of country reports, glossing over of (cross-)country studies, and personal interviews and observations. As a result, there is considerable variation in the degree of details of various countries.

The paper is divided into five sections. Section one provides a literature review on the organisation of service provision and the characteristics that influence the choice of an institutional modality for its delivery. Section two focuses on the four basic services, policy reforms, and the type of working arrangements that exist between government agencies and non-state actors towards basic services provision in SSA. The cases of Uganda and Ghana are given much focus. Section three discusses some of the outcomes of the new approach in terms of accessibility and coverage, quality and equity, cost implications, and coordination. Section four presents enabling government roles that need to be considered in an effort to streamline the efficacy of the new approach, while section five concludes.

PROVISION OF BASIC SERVICES

According to the literature, provision of services may be organized through markets, in which a variety of enterprises operate for profit; through government administration, where they are provided in accordance with politically determined rules and procedures; and through networks involving communities and self-help groups. Economic theory suggests that when services are organized through the market, competition requires numerous buyers

and sellers such that no single entity can dominate. It also requires low cost of entry and exit such that there are no barriers to setting up or winding down businesses. This makes the market competitive and marked by arm's-length relations between buyers and sellers. It is doubtful, however, whether a competitive market can be the place for exchange of all types of services. It is argued that consumption of basic services such as sanitation and solid waste (SSW), primary education, and primary health care (PHC) have elements of externality, excludability and non-rivalry problems (public good characteristics) and thus should not be left to individual decisions. And because one of the roles of the state is to ensure the welfare of its citizens, services that depict public good characteristics should be financed by the state.

In addition, government intervention has been defended by pointing to the existence of market failure. Market failure may exist when the nature of a service requires a natural monopoly for its provision (water supply system), where the necessary investment cost so huge yet investment return are uncertain (major highway), where the wider society would benefit from its provision but direct beneficiaries are unable to pay (vaccination), and where consumers or producers have little knowledge about the importance of the service to make informed choices (primary education). There is considerable literature on situations where it is more appropriate to keep the delivery of a service directly under public authority (Ascher, 1987; Gidman et al., 1999; Kessides, 1993; Roth, 1987; Cointreau-Levine, 1999; Batley, 1996). Although these palpable reasons are quite legitimate, there have been profound attacks on public sector delivery. Without the discipline of competition, critics contend, the public sector develops bureaucratic habits and has no incentives to control costs or deliver effectively. The arguments on this point are also voluminous (Kettl, 1993; World Bank, 1997, 1994). The third approach for delivering a service is through the community. The community approach has become necessary because of market and government failure. In many low-income communities, sufficiently organized community groups have considerable potential for managing and financing basic services (UNCHS, 1994).

Nonetheless, literature contends that with technology improvement, there is an ambiguity over many of the arguments concerning possible market failure. That is, with technology, a service once described as non-excludable can become the subject of exclusion and a market mechanism can be introduced. Helmsing (1997:5) also argues that the category into which a good or service falls is not always the same in each country or historical period but depends on institutional factors, which may change over time and vary from country to country. Following these criticisms, the broad assumption that goods and services with externality, excludability, and non-rivalry characteristics be paid for through public funds and delivered by public organizations cannot be sustained in many contexts. In recent times the argument has shifted to services that lie between public and private goods. These goods and services are considered meritorious to citizens whether individuals can pay for their consumption or not. Examples of merit goods and services are primary education, safe drinking water, primary health care, and sanitation and solid waste collection generally described in this paper as basic services.

Sanitation & Solid Waste (SSW) Collection and Disposal Services

Sanitation refers to the management of liquid waste including sewerage systems and public latrines while solid waste refers to the collection, disposal and management of domestic waste generated by households, market places, open spaces and streets. In SSA, sanitation in the form of underground sewerage systems is few and usually found in old inner settlements.

A great number of the sewerage systems in the inner cities do not function so households build private septic tanks in which faecal sludge is stored for a period of time after which a sludge tanker empties the septic tank. The excreta are transported to a public treatment plant where they are available or directly into the sea untreated. Using different technologies, public latrines facilities are usually built in poor neighbourhoods where households can not afford private latrine and in market and lorry parks for people in transition from one place to another (Awortwi, 2006a). Kitchen wastes on the other hand are allowed to run-off and seep through the ground. In SSA, domestic waste has a high organic content and coupled with humid climatic conditions, they ensure faster decomposition. The implication is that when left uncollected, they turn into benign habitat for disease vectors. They are the major causes of diarrhoea and typhoid diseases.

Primary Health Care (PHC)

The primary health care (PHC) philosophy embodies the idea that poor health and major causes of hospitalization - malaria, measles, upper respiratory infection, diarrhoea, and until recently, HIV/AIDS- in SSA are products of environmental factors that are preventable. The strategic components for dealing with them include: education concerning health problems and methods of preventing and controlling them; promotion of proper nutrition; an adequate supply of safe water and sanitation; maternal & child health care including family planning; immunization against the major infectious diseases; prevention and control of local endemic diseases; appropriate treatment of common diseases and injuries; and promotion of essential drugs (WHO, 1978; La Fond, 1995). Improvements in PHC delivery in SSA involve malaria treatment, vaccines for pregnant women, refrigeration to store vaccines in rural areas, equipment for proper sterilisation, efficient waste management, safe drinking water, and education on HIV infection.

Primary Education

Primary school consists of the first years of formal structured education that occurs during childhood. In most countries children start primary education at the age of four to six and continued until they are twelve. Some educational systems may include transition to secondary education as part of basic education. This may extend basic education to fourteen years. Provision of primary education consists of building classrooms and provision of furniture, curricula development, employment and payment of teachers, supply of teaching materials and school uniform, feeding of school children, supervision and management of schools, and standardisation of quality of delivery.

Water

Drinking water systems usually comprise of a source of water, network of pipes, appurtenances (valves, bends, metering, and reservoirs) and distribution. In many SSA, urban water supply is mainly pipe borne while rural water supply is mainly wells, bore holes (with & without pump) and streams. Small town water systems consist of usually a mechanized bore holes, pump house, power source, pipelines, an elevated reservoir, and standpipes. But with increasing urbanization, many new developing areas and urban fringes have rural-like water supply systems.

SSW, PHC, primary education, and drinking water as described above can be supplied by the free market, but given their characteristics, the market will fail to produce the right quantity or price that society needs, hence political determination is needed as an important part of

service production. SSW, PHC, and primary education services have externality and excludability problems, and on the reasons of public health concern, they have remained essentially public service and have over the years been provided and delivered by governments in SSA. In terms of water although urban and small town piped water supply is technically excludable and rivalry which gives a sufficient basis to be classified as a private good, given its nature (water is life), government is tasked to play a role to ensure survival of people who may be disenfranchised by the market. However, if political determination of the quantity and price of basic goods and services becomes too inclusive, the size of a government expands while that of the market and community shrinks. Taxes and public policies also become expansive as part of governments' administrative and management procedures. This was one of the reasons why many states in SSA became 'dinosaurs' in basic services provision: taking on board all the responsibilities and delivered them free of charge, leading to large, fiscally unaffordable and unmanageable sizes of governments, got suffocated and eventually collapsed.

POLICY REFORMS IN BASIC SERVICES PROVISIONS IN SSA

In SSA, during 1970 to early 1980s governments' policies on basic services had an almost exclusive focus on directly provided, publicly-funded. The inability of governments to budget for their maintenance led to serious deterioration. Further withdrawal of governments from provision as a result of structural adjustment policies led many citizens and households to find their own coping mechanisms either through the informal market, collective action or combination of parallel markets. However by late 1980s many countries in SSA had begun the process of decentralising the state responsibilities from CG to state agencies and lower levels of governments, and from state to market and to NGOs and community organisations. Decentralisation to the market was organised through privatisation and corporatisation of state organisations. This 'first generation' reform, the policy of privatisation was confined to state-owned enterprises that produced tradeable goods (industry, manufacturing and agricultural services) and hardly included basic services (Cook & Kirk-Patrick, 1995). The state perceived these services as merit goods to which every citizen should have equal and free access.

The movements toward decentralisation within the state have oscillated between limited transfers of power and resources from CG to sub-national agencies of government to devolution of authority to elected LGs in an unprecedented fashion in a number of countries. Through administrative and sectoral decentralisation, LGs have been given more responsibilities in basic services provision. One of the rationales for this is that LGs being closer to communities will be able to identify differences in citizens' preferences in services delivery, be able to identify local resources needed to support service delivery, and become more accountable to citizens for the allocation of resources. In other words, the policy can generate financial, efficiency, effectiveness and quality gains in the delivery of basic services at the local level. Financially, the policy is attractive to governments in SSA because it reduces the burden on the treasury as some of the responsibilities are transferred to LGs and to private organisations, including community based organisations (CBOs) that may be able to deliver services at lower cost.

The current, 'second generation', approach to reforming the provision of basic services has been through more systematic unbundling of service production. Unbundling the service

production chain and involves splitting ownership, control, and execution of the following activities: policy, planning, financing, delivery, management, maintenance and regulation. The task of policy is to determine the direction and guiding principles as well as overall objectives to achieve; planning involves setting specific objectives, assessment of alternative approaches, identification of available and potential actors to be involved, determination of funding/financing level, service delivery strategy, specification of services, determination of quantity and quality level to be supplied, and determination of cost implications. Financing involves the source and acquisition of funds, mode of acquisition, and cost recovery measures. Construction looks at technical and technological know-how, while delivery involves direct distribution of the service to end-users. The management component involves organizing labour and other factors of production including coordination and contracting of other actors in an effective and efficient manner to ensure sustainability of the service, while regulation focuses on standardization, entry requirement, competitive practices, and quality control. In general, the failure of the state to provide basic services adequately created gaps, which non-state actors only partially filled. The situation then could be described as one in which systemic rationality was low. This 'second generation' approach has sought to deliberately unbundle the production chain so as to formally accommodate multiple state actors (CG deconcentrated agencies and elected LGs) and non-state actors (commercial private enterprises, international NGOs, donor agencies, CBOs, and FBOs).

Again unlike the previous approach, the current strategy for reforming basic services is double edged-sword. On the one end, the government formally allows commercial private enterprises to deliver services for profit and faith based organisations (FBOs) and CBOs for humanitarian services in order to compensate for government own failures. Informal service providers are tacitly accepted and decriminalised. On the other end, governments begin to try to regulate the activities of non-state actors so as to ensure equity, reduce exploitation, control quality, and maintain minimum national standards. The recent policy direction which emphasizes the participation of multiple non-state actors has the support of donor governments through their agencies (Danida, USAID, GTZ, CIDA, and SIDA) and multi-national organisations (World Bank and UNDP). Donors' change of approach from unilateral direct local support based on their own perceptions of need and areas of interest to sector-wide approaches (SWAp) has given CGs a renewed role in influencing the way basic services are financed, provided and managed in SSA. Profiles of the current situation in two countries are presented.

Basic Services Provision in Uganda

Policy formulation of basic services is the responsibility of CG through the respective ministries in charge of health, education, and social services. There are also parallel donor working groups[2] for health, education, water, and sanitation, whose working relationship with government influences policy formulation in so many areas. Government ministries are responsible for disseminating policy guidelines to LGs before district planning and budgeting processes begin. Although actual planning for basic services provision has been decentralised from CG to LGs, the overarching planning framework is the national poverty

[2] The World Bank, development agencies (DANIDA, USAID, DED, JICA), international NGOs (SNV) and development co-operation of the Diplomatic mission and Embassies.

eradication action plan (PEAP) and the MDGs. As one of the few countries in Africa where the provision of health, education, SSW, and water have been fully decentralized to LGs, the CG ministries still actively play a leading role in planning. Each sectoral ministry has a five year national strategic plan that is supposed to be prepared in consultation with the LGs. CBOs and user groups participate in the planning process mainly in projects financed by NGOs, donors, and communities themselves.

Financing basic services is the responsibility of many actors. In education for instance, parents are supposed to co-finance scholastic materials, uniform for their children, as well as contribute money and labour towards the construction of the classrooms. The CG only pays the salaries of teachers through earmarked funds that are transferred to LGs and also supplies the books. The same financing principles apply to water, PHC and SSW services. Donors play a significant role in funding basic services provision. In the 1990s, Mills reported that donor support to health care in Uganda exceeded government spending by a considerable margin (Mills, 1997). Two of the biggest PHC interventions in Uganda: the Essential Drug Programme and the Expanded Programme of Immunisation which began as emergency programmes are fully funded by donors. Tables 1a, 1b & 1c show the roles that various actors play in the provision of PHC, primary education and drinking water respectively in Uganda.

Table 1a: The role of multiple actors in the provision of PHC in Uganda

Production Chain	State		Non-state			
	CG	LG	Private commercial enterprise	NGOs	Donor agencies	CBOs/user groups
Policy formulation	x				x	
Planning	x	x		x		x
Financing	x	x	x	x	x	x
Delivery		x	x			x
Management		x				x
Regulation	x	x				

Table 1b: The role of multiple actors in the chain of Primary Education provision in Uganda

Production Chain	State		Non-state		
	CG	LG	Private commercial enterprise	Donor agencies	CBOs/ User groups
Policy formulation	x			x	
Planning	x	x			x
Financing	x	x	x	x	x
Delivery		x	x		
Management		x	x		x
Regulation	x	x			

Table 1c: The role of multiple actors in the chain of Drinking Water production in Uganda

Production Chain	State		Non-state			
	CG	LG	Private	NGOs	Donor	CBOs/

			commercial enterprise		agencies	User groups
Policy formulation	x				x	
Planning	x	x				x
Financing	x	x	x	x	x	x
Construction		x	x	x		
Delivery		x	x			
Management		x	x			x
Regulation	x	x				

The PHC sector has the largest number of non-state actors. Prominent are the village drug distributors who keep a consignment of malaria drugs within the community to provide first aid to patience. They operate in the form of health unit management committee of users, considered as the owners of the health facility. Village drug distributors are volunteers. With the exception of a few elite schools in Kampala which are patronized by the children of middle to high income households almost all primary schools in Uganda are in the hands of LGs. School management committees comprising of parents and teachers are beginning to assert considerable ownership and management of primary schools. The management of schools by FBOs (churches) was abolished in 1997 as part of LGs reforms.

In terms of water supply, in 1998 the government contracted out the management of urban water to a private operator (Kampala Revenue Improvement Project, KRIP) to run the services for 42 months (1998-2001) after years of inefficiency and mismanagement by national water and sewerage corporation (NWSC). KRIP is responsible for operations of water distribution, sales, and revenue collection but excluding water production and sewerage services. Many small towns have rural like water services (boreholes and wells). Small towns' piped water supply are either managed by the community or contracted out to private companies. Maintenance is mainly by the users themselves unless major rehabilitations that LGs and NGOs come in to support. Rural water is operated and managed entirely by the user groups. Generally people do not pay directly for waste collection so LGs absorb the cost through the general revenue and CG transfers. In the capital city, the LG (Kampala City Council- KCC) has contracted out solid waste collection (SWC) to commercial private organizations and CBOs. LGs manage the final disposal site and are supposed to monitor and regulate the roles that these non-state actors play in the service provision.

Basic Services Provision in Ghana

Formulation of policies on basic services is the responsibility of government sectoral ministries. Donor agencies have parallel working groups through which they provide financial and technical support and also use that to influence national policies. With the adoption of decentralization policy in 1988, the planning function was given to LGs but sectoral ministries play a substantial role in actual implementation. In health, the government policy emphasizes the need to support PHC. As a result, basic health services like health posts, clinics, traditional birth attendants, and midwifery were implanted in rural areas at a level below the district hospital. However, attempts to re-orientate the provision from curative to preventive are more of an institutionalized frustration. General under-funding at

the primary level encourages patients to bypass sub-district facilities in favour of hospitals (Mills, 1995:85).

In water supply, before the 1990s, the ministry of works & housing and Ghana Water & Sewerage Corporation (GWSC) were the two agents involved in formulating water policy, planning, production, distribution, management, and regulation. As part of the reform process, the urban and rural water supply systems were separated in 1994. Urban water supply and management became the responsibility of GWSC while rural and small town water supply came under the responsibility of Community Water and Sanitation Agency (CWSA). CWSA is an autonomous agency that formulates policies on community water and sanitation as well as monitoring and evaluating projects. In 1998, GWSC was converted to a limited liability company (GWCL) with the responsibility of providing urban water on commercial principles and to attract private sector participation. The restructuring of water supply system also resulted in the separation of production, distribution, management, and regulation. While GWCL remains responsible for production, distribution of water is by multiple commercial actors (including small water vendors). Regulation involving fixing and adjustment of tariff is the responsibility of Public Utilities Regulatory Commission (PURC). By June 2005 a 5 year management contract had been signed by the government with a private organization to operate urban water supply (Nyarko, 2007). In Ghana, with the exception of overall policy framework (MLG, 1999), SSW provision is fully devolved to LGs. LGs are primary responsible for planning, management, and regulation, while collection and disposal are mainly by multiple non-state actors.

Cost sharing between government and users has been introduced in all basic services. A user fee policy (cash & carry) was introduced in 1987 in all public health care facilities (Asenso-Okyere, 1995) and in 2006 the government adopted a nationwide health insurance scheme. In primary education, the cost of constructing the building is the responsibility of the LG and Parents-Teacher Association (PTA) at the community level. European Union micro projects and HIPC funds have enabled LGs to construct more primary schools and also provide meals to school children. It is the responsibility of LGs to finance rural water provision. Generally, donor agencies including DANIDA, DfID, EU, JICA, GTZ, Dutch Embassy, UNICEF have provided substantial support to rural & small town water supply. In the urban areas, poor neighbourhoods and newly developing areas get their supply through hundred of water vendors or lorry tanks. In 1986, the government of Ghana removed subsidy for operational expenditure of drinking water and increased tariff by 500%, followed by 25% (1987), 25% (1988) and 15% (1989) (Gyau-Boakye & Ampomah, 2004). Since then water tariff takes a commercial rate. Tables 2a, 2b & 2c show the roles that various actors play in the provision of primary education, drinking water and SSW services respectively in Ghana.

Table 2a: The role of multiple actors in the chain of Primary Education provision in Ghana

Production Chain	State		Non-state		
	CG	LG	Commercial enterprise	Donor agencies	CBOs/ User groups
Policy formulation	x			x	
Planning		x			
Financing	x	x	x	x	x

Delivery		x	x		
Management	x	x	x		x
Regulation	x				

Table 2b: The role of multiple actors in the chain of Drinking Water production in Ghana

Production Chain	State			Non-state			
	CG agencies	LG	Company	commercial enterprises	NGOs	Donor agencies	CBOs /Users
Policy formulation	x				x	x	
Planning	x	x					x
Financing	x	x				x	x
Construction			x	x	x		
Delivery			x	x			
Management			x	x			x
Regulation	x	x					

Table 2c: The role of multiple actors in the chain of SSW Services provision in Ghana

Production Chain	State		Non-state			
	CG	LG	commercial enterprises	NGOs	Donor agencies	CBOs/User groups
Policy formulation	x					
Planning		x		x		x
Financing		x	x		x	x
Delivery		x	x			x
Management		x				x
Regulation		x				

Community members participate in the management of primary schools through Parent's Teachers Association (PTA). School management committees are established to monitor, supervise, and provide financial support while the Ministry of Education and Ghana Education Service regulate a standardized delivery of primary education through deconcentrated agencies at the LG level. In terms of health, District Health Management Team is responsible for integrated primary health care delivery. User groups participate in the delivery and management of PHC care through community health agents and community health committees. Rural water supply is owned and managed by communities. Under the community ownership and management arrangement, the communities elect their representatives to form the water and sanitation development board (WSDB) to manage the water system. There are three management systems in community water supply: (a) community manages, operates and maintains the system; (b) community manages, operates while private companies undertake periodic maintenance and rehabilitation; (c) community owns but private sector undertakes operation and maintenance (Nyarko, 2007). By 2001, 254 small towns with the population of 2000-50000 operate water systems in a form of community management (CWSA, 2003).

The unbundling of production chain of basic services into different small components and decentralisation of different responsibilities to state and non-state actors have resulted in many countries the development of a myriad of formal institutional arrangements generally referred to as public-private partnerships (PPPs) and public-community partnerships (PCPs). Unlike the previous approach of policy neglect and restrictive rules that criminalised non-state actors forcing many of them to go underground, in the new partnership approach, the government delegates the right of participation in basic services provision to non-state organisations through a web of formal contractual and tacit agreements so as to retain some level of control in their provision. The degree of control depends on a government's strategic interest, availability of non-state enterprises, and their technical and financial capacity. This is a partnership of roles rather than the traditional partnership that involves pooling of finances together to undertake a venture where profits are shared based on capital contribution by the parties involved. The spectrum of partnerships is wide. They include contracting-out, franchising, concession, and leasing (World Bank, 1994; Batley, 1996; Bennette et. al., 1999; Baud, 2000; Awortwi, 2003 & 2006). The language of partnerships[3] is increasingly appearing in policy documents relating to service provision (Mills, 1997; MLG, 1999). Many countries in SSA have pushed ahead with implementation of public-private mix in the provision of basic services.

In Ghanaian cities, a plethora of multiple PPPs & PCPs for the delivery of public sanitation and solid waste collection services has developed (see table 3). In each of these institutional partnerships, there are differences in the roles of the LG and non-state actors.

Table 3: Public-Private Partnerships for delivering SSW services in Ghanaian cities

Type of service	Type of partnership arrangement	Accra	Kumasi	Tema
Solid Waste Collection (SWC)	Contracting- out	*	*	*
	Contracting-in			*
	Sub-contracting	*		
	Franchising	*	*	*
	Open competition		*	
	Leasing	*	*	
Public Sanitation (PL)	Affermage/management option	*	*	*
	Build, operate & transfer (BOT)	*	*	
	Rehabilitate, operate & transfer (ROT)			*
	Build, operate and own (BOO)	*	*	*
	Pseudo private	*	*	*

Awortwi, 2006:229

In La Côte d'Ivoire, the government has given a concessionary contract to the Societé d'eaux de Côte d'Ivoire (SODECI) to supply water to Abidjan and other towns. In Dolphin Coast,

[3] Partnerships have become a part of the new international policy agenda considering the prominence that the subject was given as a strategy for implementing the millennium development goals (MDGs).

South Africa, a long-term concession in the form of PPP contract has been given to an international organisation to manage water supply. In Dar es Salaam, Accra, Conakry and Lagos, water vendors get their supply from the government water reservoir. In Malawi, 20% of the 770 health clinics are operated by private voluntary organizations (Olowu, 1999:132; Rakodi, 2003:10), while FBOs own the majority of schools, though funded by the State (Batley, 2006:242). In Nasarawa, near Abuja (Nigeria), the state government has entered into a concession contract with an indigenous private company to supply water to poor neighbourhoods (Larbi, *et al*, 2004). By 2000 there were in existence PPPs in the provision of water in Tanzania, Mali, Niger, Zambia, Uganda, Cote d'Ivoire, and Guinea while preparations were far advanced in Togo and Congo. WUP estimates that 34 out of 48 countries in Africa have initiated PPPs in the provision of water (WUP, 2000). In South Africa, Ghana, and Uganda non-clinical health services such as cleaning, catering, pharmacy, laundry, maintenance, printing and security has been contracted out to commercial private enterprises. The list goes on and on.

OUTCOMES OF THE NEW APPROACH

While there have been major shifts of policies and strategies in the provision of basic services, systematic documentation of evidence of improvements is very little and fragmented. Hence there are differences of view (optimisms, pessimisms, and cautiousness') about the new direction. Current literature review by Robinson (2007) and Conyers (2007) have sought to put doubts on the current processes and their impact on improving basic services like health, education, water and sanitation. In her analyses from limited information on Africa (Oyugi, 2000b; Ribot, 2003; Mitullah, 2004; Crook & Manor, 1998), Conyers concluded that 'decentralisation has done little to improve the quantity, quality or equity of public services in the region (2007:21). Our contribution here is not to critique their conclusions but to provide additional insights to nuance their conclusions shedding more light on the (highly variable) situation in SSA.

Accessibility and Service Delivery Coverage

Staring from very poor coverage in the mid 1980s to early 1990s, accessibility rates to basic services have been rising in a number of African countries (see tables 4 & 5). Countries like Ghana, Mali, Senegal, Uganda, and Zimbabwe are performing remarkably well in terms of people's access to sanitation, safe water, health services and primary education (enrolment and completion). These are also the countries that have incrementally decentralised and have achieved moderately to high progress in three indices of political, administrative and fiscal decentralisation according to World Bank, 2003; Ndegwa & Levy, 2003 assessment reports.

Table 4: Percentage of population with access to some basic services

Countries	*Sanitation*			*Safe water*			*Health services*		
	1985	*1990*	*2002*	*1985*	*1990*	*2002*	*1985*	*1991*	*1992-99*
Côte D'Ivoire	50	18	29	17	43	46	-	60	-
Ethiopia	19	4	6	16	22	25	44	55	55
Ghana	26	43	58	56	54	79	64	76	76
Kenya	44	42	48	27	45	62	-	-	77
Malawi	60	36	46	32	41	67	54	80	35

Mali	21	36	45	17	34	48	35	-	40
Mozambique	20	-	27	15	-	42	40	30	39
Senegal	55	35	52	44	66	72	40	40	90
Uganda	13	43	41	16	44	56	42	71	49
Zambia	47	41	45	48	50	55	70	75	-
Zimbabwe	26	49	57	52	77	83	71	-	85

Source: African Development Bank (2005:265); World Bank (2005:294-95)

Table 5: Primary school enrolment and completion rate

Countries	*Primary School enrolment rate*		*Primary School completion rate*	
	1990	2001/02	*1988-94*	*2000-04*
Côte D'Ivoire	67	80	22	39
Ethiopia	33	64	46	51
Ghana	75	81	61	62
Kenya	95	96	85	73
Malawi	68	146	36	71
Mali	27	57	12	40
Mozambique	67	99	28	53
Senegal	59	75	45	48
Uganda	71	136	-	63
Zambia	99	79	-	69
Zimbabwe	116	99	96	81

Source: African Development Bank (2005:266)

Do the figures, as presented in tables 4 and 5, call for optimisms, pessimisms, or cautiousness with regard to the second generation of reform? Although there are problems of determining the causal relationship between policies, strategies and provision of basic services, there is no doubt that the data provides evidence that accessibility to basic services has improved in many SSA countries during the past decade in which both unbundling and decentralisation strategies have been adopted. The role of donors may have contributed significantly in the expansion of basic services provision in Ghana and Uganda, (for instance through SWAPs and the use of HIPC fund for construction of primary schools and feeding of school children in Ghana). However, one cannot dispute the fact that the period has also seen improvements in financial transfers to LGs, and more recognition and acceptance of multiple non-state actors' delivery of services in areas that the state had found it difficult to reach. While tables 4 & 5 show a general improvement in coverage, qualitative survey also shows that inequities in service delivery between localities have not reduced substantially. For instance, although about 80% of urban dwellers in Ghana have access to pipe borne water, only 18.8% have it in rural areas (GSS, 2000). Even within cities, there are disparities between poor and rich neighbourhoods, and between newly developing areas and inner cities. Robinson's analyses in Asia, Africa, and Latin America show that inequities are widespread (Robinson, 2007).

Quality of service delivery

While accessibility and service delivery coverage have improved, a subjective indicator about quality does not provide encouraging results. For example, Awortwi (2004a) report card on SWC in Ghana shows that only 25% of residents feel that the quality of services has

improved as a result of contracting out delivery to commercial private companies. In the urban areas that about 80% of the population have access to pipe borne water, about 48% received it outside their premises from water vendors, tankers, and from neighbours. Sourcing domestic drinking water through this channel has been found to be contaminated by microbial germs even when the water source is uncontaminated (Clasen & Bastable, 2003). In Uganda, enrolment in primary education has increased rapidly but there is acute shortage of classrooms, teachers and materials thereby affecting the quality of pupil's early development in the rural districts. A study by Obwona et al, (2000:23) shows that in 5 out of 7 LGs, the number of teachers is between 25-40% below the satisfactory level; 8 out of 10 LGs have only 40-50% of quality health services; while sanitation reveals a quite depressing picture, with most of LGs scoring below 60%. In poorer areas of Dolphine Coast in South Africa, PPPs have resulted in reduction in service levels with disconnections of house water pipes. These pipes have been replaced by communal standpipes.

One other cause of poor quality service delivery resulting from the new approach is LGs inability to manage PPP modalities to promote accountability. In Dolphine Coast, the Borough council that is responsible for managing the PPP contract did not have the capacity to effectively regulate private delivery resulting in the problem (Delay *et al*, 2004). Collaborative approach requires carefully structured contractually based relationship with clear responsibility and accountability between state and non-state agencies. However, in a number of countries, the rush to implement new approaches has led to less attention being placed on developing capacities to monitor and supervise. Not much attention is given to the government agency in charge of undertaking the job in terms of resources, material transfers, and training. With poor salaries, commercial private agents easily manipulate the already unmotivated government monitoring officers. The absence of logistics not only breeds indifference to monitoring staff, but it also provides opportunity for non-state actors to get away with shoddy work. In Malawi, Batley reports that where Save the Children Fund involves communities in the recruitment and discipline of teachers, local accountability seems to produce better results in school performance (Batley, 2006). In many countries LGs have not systematically involved service users and groups in monitoring to complement that of government.

Cost savings to governments

Literature on PPPs provides evidence that where they are effectively implemented, competitively contracted services leads to cheaper cost to government (McDavid, 1985; Domberger et.al., 1986; Kettl; 1993:160; Proust, 1997). The OECD survey of experiences in Australia, Denmark, Iceland, Sweden, and the UK showed that savings from contracting out ranged from 5% to 50%, although Keating's report a year later showed 20% (OECD, 1997; Keating, 1998). However, results from the Ghanaian study show that the new approach has rather led to significant cost increases per units. LGs in Accra and Kumasi were paying more than twice the cost of SWC than they used to before contracting out. This came about as a result of collusion and corruption by government staff that affected contract prices. In the two cities because LGs' own revenue generation was not enough to cover the corrupt deals, CGs had to come to their aid and financed about 75% of the cost of private delivery from 1996 to 2001. In addition, LGs contracted SWC out to one private company (CCWL in Accra, and KWML in Kumasi) and created a long-term private monopoly agreement. The contracts were not competitively tendered. Since one of the main objectives in reforming the system was to reduce CG's annual deficit, the PPP contracts were prematurely abrogated and

a new round of contracting-out procedure was conducted. Furthermore, contracting out of SSW services to non-state actors rarely accompanied by a significant reduction in LG staff. LGs still have on their payrolls a large number of unessential personnel because the CG has not devolved to LGs the power to hire and fire workers (Awortwi, 2004b). In Uganda, KRIP was awarded the contract of managing water supply in Kampala without competitive tendering. In her review of other studies in Africa, Conyers (2007) also shows that the new approach has not led to significant cost savings to government except in cases where it has coincided with a drastic reduction in the quality of services delivery.

One other objective sought from decentralisation is the possibility to transfer some of the cost of financing basic services to users and households so as to reduce the treasury's burden. However, in SSA, majority of households have incomes that fall below the poverty line when simply defined as earnings below US$1 a day. In Ghana, surveys conducted by AMA/Colan Consult (1995) and Ghana Living Standards Survey (1987) show that many low-income households spend an average of 66.4% of their meagre income on food. Most users, in this income category, may want to exercise prudence in spending the remaining 33%. So given the opportunity, they would spend nothing on basic services such as sanitation, SWC, and PHC even if the fee was small. There is therefore a weak connection between service provision and user fees. Although application of users fees in financing basic services have occurred as part of the reforms, in Uganda, Ghana and Senegal where service coverage has seen remarkable improvement, very few areas are fully financed by user charges. People in rural areas regard water supply as free and will only contribute when there is breakdown in the infrastructure. In Kampala (Uganda), even high income households and neighbourhoods do not pay for SWC.

Weak coordination in the new approach

Although there are efforts to unbundle the production chain of basic services and allocate appropriate responsibilities to different actors, in many countries, there are considerable overlaps, ambiguity, and fragmentation in the present arrangements. Clear allocation of responsibilities between state agencies at central and local levels on one hand and between state and non-state actors on the other is weak and sometimes ineffective, dysfunctional and costly. In Ghana there is no clear responsibility between sectoral ministries and agencies and LGs authorities as far as health and education are concerned. While LGs are responsible for planning, delivery and management of clinics and primary schools, education and health operate under deconcentrated CG agencies under the ministries of education and health respectively. Public officers in these two sectors are accountable *not* to LG but to CG ministries. In Uganda, although education and health are fully devolved to LG, the CG through the ministries still play a substantial role to influence local planning, financing and regulation. While there is no doubt that given the nature of basic services to society, it is necessary that CGs continue to play a role in achieving greater systemic rationality in the various unbundled components of the production chain, *the act of steering leaves much to be desired*. It has needlessly become costly as decentralisation of state responsibilities to LGs and non-state actors often lead to creation of new organisations and functions with high administrative and overhead costs. For instance, since the inception of major decentralisation policy, Ghana has moved from 65 LG units to 138, while Uganda from 13 to 57. This trend in itself has probably more to do with the politics of decentralisation than with efficiency and effectiveness of basic service delivery.

Government relationships with commercial private enterprises and non-profit organisations are also weak and haphazard. In many countries PPPs & PCPs are already been implemented without a coherent national framework and strategy for systematic involvement and regulation. A study by Collignon and Vezina (2000) in ten cities found a striking absence of any form of dialogue between government authorities and non-state actors in the provision of water and sanitation. The purchaser-provider split management policy which enables a government to separate its demand-side functions (planning the service, defining the work to be undertaken by non-state actors, contract preparation, tendering procedures, and fulfilment of contractual obligations) from the supply side (delivery of services), has been implemented haphazardly. As a result, in the spirit of the system there is little or no accountability between the state as a major purchaser of basic service and non-state agents as providers. Governments incompetence in steering the process (collecting data to facilitate contracting process, negotiating contracts, setting service standards, drawing requisite budget, tendering competitively, and measuring the performance of contracted services) has hampered an otherwise potentially new approach to achieve the higher level of access, equity, and cost reduction in service provision. In the urban water provision in Ghana, small enterprises are beyond any kind of strict regulation by the National Standard Board. A study by Kumaranayake *et al,* (2000) in Tanzania and Zimbabwe on ways of regulating health services found that where governments tried to regulate commercial enterprises, existing regulation is couched in legal frameworks that have failed to keep pace with realities. Governments often neglect them while the enterprises in return treat government with suspicion, distrust and scepticisms. In undertaking LG contracts in Ghana, commercial private enterprises face risks of arbitrary termination of contracts and reluctance by LGs to enact and enforce regulatory rules that will support their operations.

NGOs/CBOs/FBOs provide about one-third of health care in Africa. In many countries, they cater specifically for the needs of the more deprived rural areas. In Tanzania, private non-profit hospitals account for about 50% of all hospitals and about 3% of all health centres (Castrol-Leal, 2000:67); Churches contribute 40% of the clinical needs of the population in Ghana (Gilson, et al, 1997:281). Consequently, they have received increasing levels of funding from central and LGs. The irony is that while formal contracts are usually discussed in relation to government contractual relationship with commercial private enterprises, the same emphasis is not put on non-profit organisations. An informal mutual agreement rooted in public official circulars is usually the terms of reference. In Malawi, Batley reports of loose agreements between the government and Christian Hospital Association (CHAM) for the latter to provide health services in areas where there are no government health care centres. They have operated for decades on the basis of trust (Batley, 2006:248). In Accra (Ghana), AKCPP, La Mansaamo Kpee and Manhean Sanitation Enterprises Committee have provided SSW services in the form of community management for over a decade without any formal written contract with the LGs. The informal nature of agreements between non-profit organisations and governments is reflected in their unspecified or indefinite length of relationship, irregular revisions and lack of accountability for the funds received (Gilson et. al. 1997). In Ghana and Zimbabwe where governments have provided financial support to FBOs to deliver health care services, Russell *et al,* (1997) and Smithson *et al*, (1997) provide evidence that government failed to clearly specify the quantity and quality of services to deliver but have counted on the goodwill and trust. Where governments have seriously collaborated with non-profit organisations, it has been through the facilitation of donor agencies. Quite often the government's role ends the moment

donor support ceases. Batley provides example of family planning clinics in Malawi (Batley, 2006: 247). While PHC was introduced at the instance of donors, the government has taken less interest in taking responsibility for it. In almost all SSA, there is little evidence of formal contracting of basic education service delivery between government and non-profit organisations (LaRocque, 2005). Batley argues that the relationship between government and non-profit organisations in health and education provision in Africa has been a constant shift in the rules of the game between collaboration, laissesz-faire, and control with the greatest ambivalence in education sector where the state has sought but failed wholly to assert its dominance (Batley, 2006:243).

ENABLING GOVERNMENTS: THE MISSING LINK IN THE TRANSFORMATION PROCESS

To achieve maximum synergy and complementarities in the new approach, decentralisation and unbundled processes of service production need to be complimented by an enabling government approach (Helmsing, 1997, 2002). The latter is missing from the transformation process in SSA. The enabling role requires CGs to run less but manage better and differently through institutionalisation of three new responsibilities: (i) setting clear national policies to govern the 'unbundled chain' of service production; (ii) institutionalising structures that will regulate the organisation of the market of basic services; (iii) facilitating efforts of LGs & non-state actors to plan and implement programmes and activities within such networks.

Enabling CG Roles in 'Unbundled' Chain of Service Production & Multiple Institutional Modalities

Given the fact that the state retains the overall responsibility for service coverage, quality, and equity, the first task required by the CG in the new approach is to draw clear national policies in three areas: (i) policy objectives to be attained in the provision of each of the services; (ii) policy on all the various components that constitute the production chain; and (iii) policy on roles and responsibilities between state agencies, LGs and non-state actors. It is on the basis of these policies that both state agencies (LG and deconcentrated departments) and non-state actors are restricted, allowed or enabled and coordinated in a systemic rational way. Policy ambiguities often lead to non-state actors' role being described as informal (sometime illegal) however crucial they are in African societies. In multiple institutional partnerships, accountability is better enforced when each of the actors has a clear sense of allocation of work and responsibility to provide. Once policy guidelines on these three areas are clearly drawn, planning, delivery and management should be left to LGs and non-state actors to implement based on local circumstances and context.

The second task of an enabling government that should follow policy formulation is a comprehensive regulation of the demand and supply sides of the service market for all (potential) service providers. Although the market of basic services in SSA is characterised by easy free-riding; difficulties in cost recovery; and large externalities, the CG can organise it in such a way that a regulated market can be promoted. A flexible regulatory framework that will promote competition in the supply side is the key issue here. A widespread conclusion from a number of studies in service improvement is that introduction of competition has a more significant effect on performance than change of ownership (Bartley, 1996:749; Awortwi, 2003:299). Restructuring the market to create competition involves issuance of

licenses/permits to actors, the introduction of compulsory competitive tendering of government services, writing of short-term contracts, institutionalisation of service delivery standards, monitoring and performance assessment, reporting, and sanctions for underperformance. It is important for CGs to set national standards and procedures based on which these activities are organised. Although there is a risk that by undertaking this broad regulatory framework CG's involvement remains strong, it is important for example that LGs should create competition and not monopoly. For instance in the provision of SWC, the CG can institutionalise a regulatory fiat which will compel LGs to divide their jurisdiction into smaller areas and allow many small enterprises to bid for the right to deliver instead of awarding contracts to a single contractor. By so doing, CGs help to create competition in the service for an area even when there is no competition in the service in the area. In SSA, many small enterprises have the capacity to deliver services in small jurisdictions. Under the new management principles, competition in service delivery can still take place within government departments through contracting-in where CGs sign performance agreements with LGs and deconcentrated departments and their officers. In contracting-in, the LGs delivery role should be separated from regulation (monitoring & supervision).

The third role of an enabling CG is facilitating efforts of LGs and non-state actors to perform their roles effectively. The recognition that CGs have given to LGs and non-state actors as far as delivery of basic services is concern is fine but that is not enough. It is time that CGs move beyond recognition to play facilitative roles (Awortwi, 2004b). The first facilitative role will require substantial decentralization of CG powers, financial resources and human capacity to LGs. Serious commitment to decentralization by making laws, designing programmes, and following them through and not just political statements. One of the problems that put constraints on the new approach to sustaining improvements in accessibility and service delivery coverage is inadequate funding. The funding problem comes from the way decentralisation policies are implemented. It has resulted in the transfer from CG to LGs services, which are difficult to charge for (unfunded mandates). An enabling government will have to transfer adequate financial resources to LGs. Decentralisation of basic services to LGs without necessary fiscal transfers disables LGs effectiveness in the new approach. While it is true that the more non-state actors are involved in basic service delivery, the larger the service delivery coverage and accessibility, the inability of LGs to pay commercial non-state enterprises for services provision is leading to uneasiness in PPP approaches. If services are provided through CBOs without LG financial support, sustainability of the modality gets truncated. Where LGs services are contracted out to commercial private enterprises, inadequate financial capacity to pay often leads to poor quality delivery and or exclusion of some users. Not only CG financial transfers to LGs need to improve but also CGs should give authority to LGs to charge and raise fees where necessary to recover the cost of service provision in their jurisdictions. In much of SSA, fiscal decentralization policies are weak with CG controlling far substantial part of financial resources and authority.

A fourth facilitative role of the CG is technical assistance and training of human resources and leadership at LG level to institutionalise and manage PPPs and PCPs . Given that crucial responsibilities in the chain of service production (planning, management, and regulation) have been given LGs and delivery to multiple non-state actors, there is a need for LGs officers to acquire new technical and managerial competences than is traditionally provided

for in public administration training. These new responsibilities are more complex and demanding than the act of delivering. The new competences training requirements are negotiation, procurements, contract design, PPPs, stakeholder analysis, performance assessment, data collection, and evaluation techniques (Awortwi, 2006b). There is also the need for CG to facilitate leadership training at LG levels. LG leadership or Mayorship needs to become proactive in leveraging resources from non-state actors in their jurisdiction. Rather than simply signing contracts with non-state actors and assuming that basic services delivery would improve, LG leadership should be trained to become political entrepreneurs and transformational leaders who spend more time collaborating with non-state actors and integrating their programs to LG. A good example of such enabling role would be the Community Water & Sanitation Agency created in 198 in Ghana to assist LGs and rural and small town water boards. A recent study has shown that small town water boards on average outperform the privatised National Ghana Water Company Limited (Nyarko, 2007)

Enabling LGs Roles in 'Unbundled' Chain of Service Production & Multiple Institutional Modalities

Given the proximity of LGs to localities and service delivery points, changes in CG roles would also require cascading effects on the roles of LGs. Planning, co-financing, delivery, management, and regulation (monitoring & reporting) will become the new roles of LGs.

Planning for basic service production

Planning towards improving people's access to and equity in basic services would require a stock-taking approach in basic services in LGs' jurisdictions. A scalogram analysis can show which community has access to a particular service, the degree of quality being provided, the type of service providers, determination of their capacity and needs, estimation of funding/financing requirements per capita, assessment of users' ability and willingness to co-finance delivery, and a determination of cost implications. This initial assessment is necessary for a coherent piece-meal planning and development of basic services at the local level. Planning at the local level will then form the basis of national sectoral plans instead of the other way round.

Co-financing basic services provision at the local level

While it is true that LGs are constrained by inadequate CG transfers, sustainability of current improvements is bound to fall if there are no improvements in effort by LGs to raise local revenue to complement CG transfers. In many countries, CG transfers constitute the largest proportion, about 81.3% in Uganda; 64% in Ghana, 60% in Malawi, and 80% in Ethiopia. In Ghana, Uganda, Tanzania, as in many other countries in SSA, LGs efforts in local revenue mobilisation have declined as CGs began to transfer funds to finance LGs activities. Furthermore, there are doubts on the effective allocation of LG own revenue. In Uganda wage bill constitutes more than 50% of LG expenditure while cost of services delivery constitute only 21% (Obwona, et.al., 2000:19). Once a CG gives authority to LGs to charge and raise fees, there is a need for LGs to improve the efficiency and effectiveness of their revenue collection methods. LGs can improve revenue collection if they also contract out to agents (either in-house or to commercial enterprises) and provide incentives to those who collect the revenue in the form of commissions. In Kampala, Uganda this has improved substantially the collection of parking fees in the city centre. Evidence from Tanzania (Fjeldstad, 2001) also suggests that when councillors are fully involved in preparing councils' budget, their attitude to tax collection improves.

Delivery of Services: Switching between Multiple Agents and Modalities

The current approach in service delivery involves multiple agents of public, private and community delivery and modalities of partnerships. Each modality has inherent strengths and weaknesses, and therefore works better in different circumstances and contexts. To determine which of the partnership modalities to use, LGs need to consider two important criteria: (i) users' ability and willingness to pay and (ii) LGs' capacity to manage multiple actors and partnerships. The matrix below maps this for the delivery of SSW.

		LG Capacity to Manage	
		HIGH	LOW
Users Ability & Willingness to Pay	HIGH	I	II
	LOW	III	IV

I Public/Private franchising
II Private Franchising
III Contracting-out to commercial enterprises
IV Contracting and Franchising to CBOs

When users' willingness to pay survey reveals how much users can pay for a service, there will be a need to consider switching a modality vis-à-vis full or partial cost recovery. Private sector franchising are better options for middle- to high-income areas where willingness to pay is high[4]. Contracting out then becomes the choice modality where users' ability and willingness to pay is low. Delivery is provided either through semi-autonomous LG department or through commercial private enterprises and paid for through the general tax revenue. Where many users have a tendency to dump indiscriminately, community-based delivery where users themselves are members of the organization is a better option. The assumption is that members will co-ordinate, check and enforce behaviour on a face-to-face basis. While development actors are increasingly recognising the importance of community based approaches to basic services delivery in low-income areas, LGs have not done much to facilitate their efforts. In Ghana, community delivery of SWC showed better quality at lower price than commercial private and LG direct delivery yet LGs did not find it appropriate to support community organisations (Awortwi, 2003). While LG have tried to assist CBOs, it has been benevolence, centred on occasional material support in the form of donations rather than a policy of enablement. UNCHS research conducted by Helmsing & Wils (1999) shows that community management needs an enabling framework of technical and institutionalised support policies and programmes. Community management approach is enabled and become more sustainable when CBOs have direct contractual relationship with LGs to provide services. In practical terms, LGs would be expected to design into details all

[4] Public information and educational awareness may positively influence people's attitude towards demand for the service and may change their unwillingness to pay attitudes.

the tasks needed to implement the activity and hand them over to the CBO for execution. Here technical capacity is the essence and their ability to mobilise and organise collective action is not crucial (Krishna, 2003). Where CBOs play sub-contracting role, the expected enabling role by LG would be to recognise the jurisdictions in which they operate, enact by-laws to limit users' free-riding behaviour, enforce sanction for non-compliance, and pay for the services that CBOs deliver in cases where direct fee collection is impossible (Helmsing, 2002).

The second considerable factor will be the capacity of the LG to manage a particular modality. Contracting out tends to have paradoxical results, which suggests that the LG should have substantial capacity to regulate and monitor before undertaking it (Awortwi, 2004b).

Management of Multiple Agents and Modalities of Service Delivery
As LGs begin to adopt policy enablement on multiple modalities of partnerships with non-state actors, formal written contract should as much as possible be placed at the centre and should form the basis of defining the relationship between themselves and non-state actors as far as the provision of basic services is concerned. Under no circumstance should LG relationships with non-state actors be based on trust alone. Although non-profit organisations (FBOs & CBOs) are less likely to behave opportunistically, being under contract with LGs helps to improve accountability upwards and downwards.

Regulating Service Quality and Implementation of Clear Rules of Multiple Partnerships
LG regulation of service delivery must cover all three dimensions: (i) Monitoring & supervision of quality of services delivery by agents based on appropriate national standards. This upward responsibility to the state is based on the fact that LGs need to account for the financial transfers they receive from CG and the fact that there is the need to reduce inequities in service quality among localities. (ii) Implementation of transparent rules of contracting that ensures competition among agents and between partnership modalities. This will involve implementation of open competitive bidding, contract management procedures, regular monitoring and reporting, and strict enforcement of sanctions for under-performance. (iii) Delegation or involvement of citizens/users in monitoring service delivery by multiple agents will help improve accountability upwards to LGs and downwards to the community.

CONCLUSION

In this paper, we have presented and discussed issues concerning the provision of basic services. We have shown that the mode of provision has undergone manifold changes in SSA. In many sectors the coverage has improved as more people enjoy access to basic services. The 'dinosaur' roles of the state have been unbundled as more non-state actors are now formally partnering state agencies to deliver services. The process has received enormous support from donors through SWAps. Although decentralisation within the state (from CG to LGs) and from the state to NGOs/FBOs/CBOs has resulted in multiple institutional partnerships, systemic rationality is still low. Hence, the potential of the second generation approach to achieving higher service coverage and equity is underutilised in SSA. Calling the results from this new approach 'half-empty' rather than 'half-full' as some

commentators and analysts would like to, and to spin the problem around the general characteristics of African states, which hamper any form of service delivery, whether centralised or decentralised, is unhelpful. Such propositions do not provide justice to many of the positive changes that are taking place in SSA. However, to be able to exploit the full potential of the new approach, there is a need to shift gear and fix many of the problems that hamper its effectiveness. This means developing enabling roles for central and LGs. The involvement of non-state actors and institutionalisation of multiple institutional modalities does change the role of governments from rowing to steering and enabling others to row in unison. This refers to policy formulation, regulation and facilitation. We have discussed the new enabling government roles and suggested further step-by-step procedures on how to proceed.

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