Desk Study:
Decentralization Practices in Selected Countries

Education and Health Functions Assigned to Lower Level Local Government

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Table of Contents

Acronyms and Abbreviations

BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
DFID	Department for International Development
EU	European Union
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
IP3	The First Three Years' Implementation Plan (2011-2013) of the National Program for Sub-National Democratic Development
LAMC	Law on Administration and Management of Communes/ Sangkats
LG	Local Government
LLG	Lower Level Local Government
MoI	Ministry of Interior
NCDD	National Committee for Sub-National Democratic Development
NCDD-S	NCDD Secretariat
National League	National League of Commune/Sangkat Councils
OL	Organic Law
SMC	School Management Committee
SNA	Sub-National Authority
Sida	Swedish International Development Cooperation Agency
RGC	Royal Government of Cambodia
TA	Technical Assistance
VDC	Village Development Committee (Nepal LLG)

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Introduction

The EU-SPACE Program[1] is supporting the RGC and related stakeholders in realizing the intent of the National Program for Sub-National Democratic Development (2010-2019) and the Three-Year Implementation Plan (IP3) to bring about decentralization through the transfer of functions to the Councils. Commune councils have been brought to life nearly a decade ago through the 2001 Law on the Administration and Management of Communes/Sangkat (LAMC). However, these local governments have yet to be given significant specific functions. With the 2008 Organic Law on sub-national administrations (SNA)[2], all Councils are to be empowered through the transfer of functions that are currently undertaken by the central government (or its deconcentrated units in the field). The law makes clear that the transfer mechanism is the main way that councils, including Commune councils, will be empowered to undertake governance and development.

Toward this end, the National League of Commune/Sangkat Councils of Cambodia (National League), a local government association, is taking a proactive approach to functional review by developing its own proposal for a set of 'starter functions' for transfer to Commune/Sangkat Councils; a set of functions that is expected to include education and health related functions.

The National League, with support from GIZ/EU-SPACE, has prepared this desk study of functional assignment practices in several countries, to provide an empirical basis and guidance for the choices facing the National League in education and health. The countries have been selected because they have attained a measure of decentralization to local government. Moreover, the local government in question is roughly equivalent in scale and capacity to the Cambodian Commune.

In selecting the comparator countries, in addition to issues of scale/capacity, the authors[3] have focused on countries where they have undertaken professional work in functional assignment or related fields of governance. Issues of data availability also colored the choices. It must be said that it is exceedingly difficult to find functional assignment information for most countries, particularly for the lowest level government – it tends to be given little attention, or information is deeply buried in the grey literature.

Notwithstanding the data constraints, the report was able to encompass a sufficient number of comparator countries. Table 1 provides structural details of the lower level local government (LLG) in question. Countries selected are mainly unitary states (like Cambodia), but India's states are also included (the states largely set local government policy). For each of these countries, this report sketches the relevant legal framework and practice. Where information can be found, some evaluative comments are also added. An attempt is made to conclude what is noteworthy for each country case.

[1] The EU Program on Strengthening Performance, Accountability and Civic Engagement (SPACE) of Democratic Councils in Cambodia is co-funded by the EU Delegation, Sida, DFID and BMZ, and is implemented by GIZ. It will be referred to as GIZ/EU-SPACE throughout the text.

[2] Law on the Administrative Management of the Capital, Provinces, Municipalities, Districts and Khans, 2008.

[3] Sarah Walkenfort, Gabriele Ferrazzi, and Shelley Flam.

Table 1: Structure of LLG for Cambodia and Comparator Countries

Country/ State	Lower Level of Government (LLG) of interest	LLG Personnel (on average)	Allocated budget and/or total revenues
Cambodia	**Commune/Sangkat** Average population of 8,637 (population range is from 313 to 78,315)[4]	1 clerk (personnel of Ministry of Interior), some Communes/Sangkats may have additional own-staff (5 to 11 councilors)	Approx USD 24,500 for 2011 from Commune/Sangkat Fund[5] (many have additional resources through development partner programs)
India/ Himachal Pradesh	**Gram Panchayats** For village/group of villages (1-5,000) - Average population of 1,691	5 to 13 councilors[6] supported by one or more secretary/assistant	Some taxes, but mostly ad hoc grant in aids from the state. The latter average around USD 2000/Gram Panchayat, or USD 1.3 per capita. [7]
India/ Kerala	**Gram Panchayats** Average population of 23,789	1 Secretary , 1 Junior Superintendent/Head Clerk, 6 Clerks, 1 Peon	Approx USD 336,625 per Gram Panchayat / USD 14.2 per capita[8]
Indonesia	**Village government** (mostly formal, but some traditional villages as well). Average size about 3,000	Village head, with 1 Secretary, and one or more assistants. Hamlet chiefs appointed by village head.	Approximately USD 12,000 per village, from central government.[9]
Nepal	Villages (VDCs) Wide range of population, with average[10] of about 5,000	VDC Secretary, and a shared technician	About USD 4,500/VDC (close to a dollar per capita)
Philippines	Legally prescribed minimum population for a **Barangay** is 2,000, 5,000 for Manila and other highly urbanized cities	1 chief executive and 7 council members, a sangguniang kabataan (youth council chairman), 1 secretary, 1 treasurer[11]	2003 example: urban Lingsat Barangay in provincial capital city, with a population of approx 8409,[12] had a per capita budget of approx. USD10.3
Tanzania	**Village Councils (less than 20,000)** Average size is less than 3,000	Villages do not have their own staff – they have an Executive Officer and some extension workers that are district staff [13]	A core grant for all levels of LG amounts to USD 1.5 per capita, but 'sector windows' have been added so that per capita spending is now close to USD 6.5
Uganda[14]	**Sub-county Councils** Average population 27,000 **Town Councils** Average population 19,000	Chair, Vice Chair and Secretaries of LGs are full time staff members. All civil servants employed by and accountable to the LG.	No information available.

[4] National Committee for Sub-National Democratic Development, Commune/Sangkat Database, 2009
[5] Sub-decree 93, on Transfer of Financial Resources to Commune/Sangkat Fund and Letter No.6568 SHV/HM of Ministry of Economy and Finance dated October 27, 2010.
[6] Status of Panchayati Raj System in Himachal Pradesh, obtained from http://hppanchayat.nic.in/pdf%20files/PRSetup.pdf
[7] Ibid.
[8] Vijayanand, S.M. (2009). Kerala - A Case Study of Classical Democratic Decentralization.
[9] Takeshi, Ito (2007). Institutional Choices in the Shadow of History: Decentralization in Indonesia, World Resources Institute, Working Paper 34, December.
[10] ADB (2009). Nepal: Regional Development Strategy, Technical Assistance Consultant's Report, Project Number: 37404, September.
[11] The Local Government Code of the Philippines, URL: http://www.chanrobles.com/localgov3.htm, 16 June 2010.
[12] http://www.sanfernandocity.gov.ph/gov/brgy/lingsat.php, 23 July 2010.
[13] Tidemand, Per (2009). Sector Budget Support in Practice, Desk Study Local Government Sector in Tanzania, in Government of Tanzania (2009). Developing a System of Intergovernmental Grants in Tanzania, Workshop documentation.
[14] Onyach-Olaa, Martin (2003). Lessons from Experiences in Decentralizing Infrastructure & service delivery in rural areas, Uganda case study.

Drawing from national experiences, the National League is now examining current and potential Commune/Sangkat council functions in education, health, land and natural resource and environmental management.[15] Drawing on international examples, this international study complements the National League's domestic desk study. The study contained in this report can also be used as a resource for other stakeholders dealing in other sectors, and the decision-makers in the RGC functional assignment (FA) process.

The study is organized as follows:

- Section 1: functional assignment in education and health is explained for each country, with a concluding comment that highlights the key lessons to be learned.
- Section 2: the FA is contrasted/compared across countries, employing a typology of functions[16]
- Section 3: Implications for the FA process in Cambodia is drawn, particularly for the Commune level

1. Himachal Pradesh, India

In 1992, an amendment to the Indian Constitution was passed requiring all state governments to create either a three or two-tier system of Panchayats in rural areas (at village, intermediate (block) and district levels if fully elaborated) and a two-tier system in urban municipalities. Panchayats are local governance bodies rooted in pre-colonial times. Today, they are democratically elected. At village level they are called Gram Panchayat, Panchayat Samiti at the block level and Zilla Parishad at district level.[17] The Himachal Panchayat system is composed of 12 districts, 75 blocks, and 3243 Gram Panchayats. The Gram Panchayat may actually be best seen as the executive side of the Gram Sahba (the lower level village and ward based participatory forums). The Gram Panchayat consists of elected ward members and a directly elected Panchayat president. Each Gram Panchayat has at least one trained secretary/assistant.[18] This lowest level of formal local government, must in a sense "compete" for functions with the larger scale Panchayat.

One of the difficulties seen in Indian state devolution has been the challenge in defining explicitly and in an exclusive way the roles of these three levels. A key part of the 1992 amendment to the Constitution was a list of 29 functions (already deemed to be in the hands of the states) that can in turn be devolved to the Panchayats. States are free to set the pace and design their own approach to decentralization within this constitutional framework. Key problems identified with this arrangement in the literature are the slow pace of state-led devolution, the "rigid patriarchal structure which inhibits women participation in public affairs, and the lack of governance experience of most elected representatives – who are first-timers with little or no prior knowledge of the functioning of Panchayats."[19]

[15] National League of Commune/Sangkat Councils (2010). Desk Study: Commune/Sangkat Councils - Current and Potential Future Functions in Education, Health, Land Use Management, Forestry and Fisheries, September 2010.
[16] The National League Cambodian desk study relies on the same typology of functions.
[17] Mukundan, Mullikottu-Veettil and Mark Bray (2004). The Decentralization of Education in Kerala State, India: Rhetoric and Reality, *International Review of Education* 50: 227f.
[18] Ahal, Rajeev and Silvio Decurtins (2004). Experiences in Panchayat-based planning in the mountains of Himachal Pradesh, India, *PLA Notes,* 49: 58-63.
[19] Manoj, Rai (2004). Legal Framework for Citizen Participation in Local Government in South Asian Region, Synthesis Report.

As a result of the above challenges, functional assignment has proceeded slowly in Himachal Pradesh (HP), lagging other states like Kerala for instance. However, the pace has picked up some momentum in recent years, with some ministries in the State government taking steps to bring it to its conclusion.

In 2008, an activity (functions) mapping workshop brought together representatives from sector departments and from the Department of Panchayat Raj to discuss functional assignment. It was decided that "at least one selected department should have completed activity mapping [functional assignment] and commenced implementation"[20] by the middle of 2008. It took longer to get to this end point, but by mid-2009 good results had been achieved at least in the rural drinking water sector, and work on other sectors was continuing.

The process of activity mapping eventually led to the notification (regulation) of devolution for several sectors, but little information is available on the implementation of this regulatory change. Positive aspects of the HP effort are the bringing together of the right stakeholders, and the efforts made to ensure that lessons learned were considered.[21]

1.1 Education

In education, Gram Panchayats and other local governance institutions have been responsible for school assets, enrollment management and monitoring. During the 2008 activity mapping workshop facilitated by GIZ[22], participants identified as the aim for functional assignment in education the widening of discretionary space of local governments in the areas of budget preparation and personnel management. Participants suggested that Gram Panchayats be involved in –

- implementation of policies and programs of the State Government
- budget preparation and allocation of finances and funds
- recruitment and maintenance of teaching and non-teaching staff at different levels
- dealing with "establishment matters" concerning teaching and non-teaching staff employed
- cooperation with other departments.[23]

1.2 Health

The health system of Himachal Pradesh remains quite centralized. Although local user committees, PARIKAS, have been established, they are not representative bodies except for the PARIKAS president who is also the chairperson of the Gram Panchayat.[24]

Participants in the above mentioned activity mapping workshop determined that "the entire functioning of health sub-centers, including finance and functionaries, should be handed over to village panchayats for effective implementation of health related activities because they know

[20] Ferrazzi, Gabriele and Rainer Rohdewohld (2009). Functional Assignment in Multi-Level Government Volume II, GIZ-supported Application of Functional Assignment, Eschborn.
[21] For more information on West Bengal see Rohdewohld, Rainer (2007). Proceedings of the Exploratory Workshop on Activity Mapping and Functional Assignment in Himachal Pradesh, December.
[22] Although GIZ was formed only on 1 January 2011, this paper refers to GIZ throughout the text even with regard to activities supported by German Development Cooperation before this date.
[23] GIZ (2008). Proceedings of the Training Workshop on Activity Mapping for Government of Himachal Pradesh, May, pp.73-82; for the actual assignment, that is the "status quo" scenario, see Appendix I.
[24] Himachal Pradesh", URL: http://www.whoindia.org/LinkFiles/Health_Sector_Reform_himachalP-Bw.pdf, June 16, 2010, p.17.

the ground realities better than anybody else."[25] In January 2009, the State issued a regulation to decentralize control over state health sub-centers to Gram Panchyats. Funds from the State Department are to be transferred to them in the form of earmarked funds, primarily for hiring nurses and midwives. The plan, however, applies "only for Gram Panchayats that currently lack a health sub-center. For all existing sub-centers, the traditional centralized approach continues unchanged."[26]

1.3 Conclusions

Central government/state ministries can be reluctant to decentralize to the lowest level of government, for reasons of capacity concerns among others. It takes time to raise awareness of the benefits of this reform, and to work through the process in a way that gains consensus and readiness to implement. A good process will eventually lead to some significant functions being transferred and, importantly, to the decision to accompany these with functionaries and funding.

2. Kerala, India

As alluded to above, Kerala State has been a leading State in the effort to devolve to the Panchayat, achieving significant progress in the 1990's. It also has a three-tiered Panchayat structure, with 14 districts, further divided into 62 taluks, and at the lowest level of formal government 1007 Gram Panchayats. The average size of these units is more than ten times that of the Himachal Pradesh units.

2.1 Education

Kerala "has achieved universal primary education, near total literacy, and near gender equality in access to education"[27] and, therefore, is a model worth a close look. The 1994 State Panchayat Act states that Gram Panchayats are responsible for overall management of government pre-primary schools and government primary schools. The Zilla Panchayat is responsible for management of upper primary schools. Block Panchayats were not allocated any specific roles.

Shortly after the 1994 Act was adopted, an additional and grass-roots supported decentralization initiative was introduced that is considered "an unusual, perhaps unique, decentralization experiment"[28] - the Kerala People's Campaign for Decentralized Planning.[29] The initiative saw State government make a genuine effort to empower local governments, including transferring substantial funds to them. The Campaign, which intensively involved citizens in the planning process, was most active in the 1996 to 2001 period, yielding changes in the education and health sectors in particular. In this initiative:

[25] GIZ (2008), op. cit., pg.107.
[26] Ali, Rabia et.al (2008). Improving Health Services in Himachal Pradesh, Princeton, pg. 27, obtained at http://wws.princeton.edu/research/pwreports_f08/WWS591g.pdf
[27] Mukundan and Bray (2004), Op. Cit., pg.228.
[28] Elamon, Joy et al. (2004). Decentralization of Health Services. The Kerala People's Campaign, *International Journal of Health Services*, 34, pg. 683.
[29] For an explanation on the planning procedure see http://www.lsg.kerala.gov.in/htm/PDF/report_decentralised_planning.pdf, pg.59.

> "35 to 40 percent of the state development plan's budget [was allotted] to local government bodies to spend as they chose within certain broad parameters. Village assemblies listed problems, then elected task forces drew up projects that were prioritized by village and municipal elected council members. Democratically elected development block councils and district councils processed the local proposals and added projects to fill in gaps or reduce conflicts."[30]

While these were heady days for decentralization, on the ground results were mixed. Looking at one district, Mukundan and Bray, it was found that almost 90% of implemented projects were related to school noon feeding programs (a tradition dating back to the 1960s), the maintenance of facilities and distribution of scholarships. Thus, "there was little change in the administrative system and functioning of local schools."[31] Personnel management, curriculum outline and inspections remained functions of the State.

Despite this conclusion, Gram Panchayats in Kerala State are seen as the key actor for physical facilities for primary education. They are responsible for preparing designs and estimates for school buildings, and for school construction and maintenance. Funds for facilities come partly from the State and partly from the Gram Panchayat budget.[32] Moreover, in 2000, Panchayats did take on one significant personnel management function – the appointment of temporary teachers in any school under their management.[33]

2.2 Health

The 1994 State Panchayat Act in Kerala also provides for the entire primary and secondary level health institutions and their staff to be transferred to local governments. Gram Panchayats have responsibility for primary health centers, Block Panchayats run community health centers and Zilla Panchayats are responsible for Taluk hospitals. Only tertiary and specialized health institutions are left with the State. Corresponding finances have also been transferred, but the powers to employ staff, to transfer them and to pay their salaries remain with the State sector department (as seen in the case of education).[34]

Observers conclude that the People's Campaign fostered "conditions for a more effective and efficient extension of needed public health facilities such as latrines and safe drinking water, as well as improvements in primary health centers and *taluk* [or sub-district] hospitals"[35]. Furthermore, projects undertaken mostly reflected the needs and interests of communities and improved equality of access to public health services. According to one analysis:

> "In the initial stages, especially during the People's Plan Campaign, there were efforts by many local governments to mobilize additional resources for the health sector. In many places, the stagnation of the earlier years in the improvement of PHCs was breached. Secondary level health facilities like the Taluk hospitals also benefited much from the local level planning in the initial stages. On the whole all these have improved the access and outreach of health care in those areas. "[36]

[30] Ibid.
[31] Mukundan and Bray (2004), op. cit., pg. 232.
[32] Pritchett, Lance and Pande, Varat (2006). Making Primary Education Work for India's Rural Poor. A Proposal for Effective Decentralization, *Social Development Papers*, 95, pg. 78.
[33] Ibid., pg.78.
[34] http://www.lsg.kerala.gov.in/htm/PDF/report_decentralised_planning.pdf, pg.98.
[35] Ibid., pg.705.
[36] http://www.lsg.kerala.gov.in/htm/PDF/report_decentralised_planning.pdf, pg.98.

2.3 Conclusions

The Kerala experience leads to several conclusions. Decentralization, including to the lowest level of government, can improve service delivery. The Kerala case also reveals the important role of citizens' demand in speeding up decentralization. Moreover, the experience underscores that functional assignment to the lowest level has to be seen in terms of how the assignment fits with that of higher levels of local government – recognizing their linkages and their system characteristics. The scale of the LLG also could be a significant factor. The larger Gram Panchayats in Kerala appear to have made greater progress in gaining functions and resources than the smaller Gram Panchayat in Himachal Pradesh state.

3. Indonesia

The standing of Indonesia's 67,000 village governments, and specifically their governmental functions, is rather murky in the national legal framework. Decentralization has been formally focused on the 500 or so districts and cities (second regional tier) with the 33 provincial governments (first regional tier) tending to act as a supervision/supporting level – often on behalf of the central government. While the Constitution respects traditional forms of governance, it does not mention the village explicitly. In the Suharto era, village government was regulated through a law that was separate from that governing regional government (provinces and districts/cities). This changed in 1999, when the village was subsumed under the revised law on regional government, and was situated under the stewardship of the district government. Villages retained their vague "traditional" roles, and were to receive delegated tasks from the functions held by the district government. Villages in Indonesia have an elected head and an appointed advisory body, but otherwise are only staffed by one state official (secretary) and normally up to three assistants.

In late 2006, the Ministry of Home Affairs issued its regulations to flesh out the menu of functions that can be delegated to villages.[37] This delegation has not happened to any significant degree across the nearly 400 districts of Indonesia.[38] However, some districts have taken steps to delegate, and local initiatives (tolerated or encouraged within an ambiguous legal framework) have also indicated that the village level can do more or, in some cases, return to the roles that were once its domain.

3.1 Education

The Ministry of Home Affairs regulations allow the districts to delegate the following education-related functions to the village government:

- Facilitate the release of land for building schools (kindergarten to high school);
- Contribute to the equipping and maintenance and rehabilitation of school facilities, including informal education;
- Contribute to the financial package for teachers;
- Facilitate the provision of skills training;
- Guide the citizen reading centre;

[37] Minister of Home Affairs Regulation No. 30 2006 on the Method for Transferring District/City Functions to the Village.
[38] Ferrazzi, Gabriele (2008). Assignment of governmental functions in Indonesia: reforms and prospects, Decentralization Support Facility, GIZ.

- Facilitate and motivate citizen study groups.

Very few cases of delegation can be seen in Indonesia, although there is district-village cooperation, but with the district firmly in control of funds and management. Villages do undertake activities from their own funds (village fund, which flows through the districts to villages) but these are project-based – villages cannot be said to be responsible for functions.

3.2 Health

In the health sector, the ministerial regulation allows delegation to villages for:

- Basic instructions on overcoming communicable diseases;
- Guidance to the health clinic and midwife;
- Facilitate and motivate the movement for mothers;
- Guidance and monitoring of traditional health practitioners;
- Facilitation of the implementation of nutrition supplement programs;
- Management of village health post;
- Management of village health insurance;
- Management of family medicine plants;
- Provision of village health facilities;
- Promotion of health;
- Monitoring and avoidance of drugs/addictive substances in the village;
- Monitoring of dissemination and use of contraceptives;
- Guidance on family planning.

As in the case of education, villages take on some projects related to health, but do not yet take on responsibility for the functions listed above.

3.3 Conclusions

The focus of decentralization in Indonesia was the district level, and this has some important advantages, particularly in terms of capacity (deconcentrated units were brought under the district government control, thereby delivering “capacity” to them). However, the experience shows that even when a mechanism is given for a meso level government to continue with decentralization (delegating to the lowest level of government) this does not readily happen. It is important then to find incentives for the meso level to engage meaningfully with the LLG or to define the functions of the LLG directly by the state/central government. In comparison to the near absence of district delegation to LLGs seen in the first decade of decentralization reforms, the list put forward by the central government is a huge step for LLG. It remains to be seen if districts will now feel they must realize this “menu” or what further action will be needed by the central government to ensure that LLGs do receive these functions.

4. Nepal

The Local Self-Governance Acts of 1999 (LSGA) provide for the creation of more empowered local government in Nepal. The local government system has two tiers, the bottom tier consisting of 3,913 village and 58 municipal bodies. Districts, 75 in total, constitute the other tier.

Nepal is a unitary state but is restructuring to become a federal state. The early drafting of the new constitution suggests that the village level, referred to as the VDC (Village Development Committee), will become the focus of local government development. At the present time the VDC has only a secretary, and usually one assistant. VDCs do obtain some technical support by sharing a junior engineer between several VDCs.

Village councils consist of 53 persons of whom only the two chairpersons and five more members are directly elected by the citizens. The rest are nominated.[39] With the conflict and political turmoil in Nepal, however, since July 2002 local government bodies operate without locally elected representatives. [40] They employ an "All Party Mechanism" (advisory body of local party members) to provide a political dimension, while awaiting the restoration of local elections.

Implementation of the LSGA has been incomplete, largely due to the centralistic orientation of the state and violent conflict. Discussions are now taking place about a future constitution and the role of local bodies.[41] Consequently, the description given in this section may hold in the short term only. The Interim Constitution of 2007, which is currently in force, is the first Constitution of Nepal to include a separate section on local self-government. It does not, however, provide clarity in terms of functional assignment.[42] A Constitutional Assembly Committee now has recently proposed a distribution of functions for the centre, state and village government, but this has yet to be widely discussed.

4.1 Education

There have been two parallel developments in recent years in the education sector. The number of community managed schools has risen considerably and, since 2001, communities have managed about 8,000 schools through school management committees (SMCs). These are partly appointed and partly elected (e.g., parents). Second, the discretionary space of SMCs has been enhanced. In 2004, SMCs were given the power to hire and fire teachers and to take responsibility for their career advancement. So far, community managed schools have shown slightly better results than other public schools in terms of learning achievements.

At the same time, the LSGA foresaw the involvement of local bodies in education, principally the VDCs and district development committees (DDCs). Specifically for the VDCs, the LSGA intended them to undertake the following functions in education:[43]

- establish pre-primary schools, to give permission to establish them and to operate and manage the same;
- supervise and manage the schools being operated within the village development area;
- assist in providing primary level education in mother tongue within the village development area;

[39] Manoj, Rai (2004), op. cit., pg.17.
[40] Alternative mechanisms (lacking democratic legitimacy) have been put in place in 2007. Multi-party-committees were appointed at all levels of local governance representing the major parties which serve as an advisory body to the executive officers tasked with taking decisions; see Mumenthaler, Marielle and Thomas Taraschewski (2009). Functional Assignment in Nepal, pg.2.
[41] The promulgation of a new constitution was originally foreseen for the 28th of May this year, but had to be postponed. The timetable for drafting the constitution has been amended already ten times now; see http://timesofindia.indiatimes.com/world/south-asia/Nepals-new-constitution-turning-into-mirage/articleshow/5630618.cms. It has recently been extended for another year. See the relating UN Secretary General's expression of concern at http://www.unmin.org.np/downloads/pressreleases/SG.Statement.28May10.ENG.pdf , 11th of June 2010.
[42] Center for Constitutional Dialogue (2009). Local Self-Governance: Nepal Participatory Constitution-Building, Kathmandu, pg.5.
[43] Article 28 d) in the Local Self Governance Act of 1999.

- make programmes on adult education and informal education and to carry out or cause to be carried out the same;
- establish and operate or cause to be established or operated libraries;
- make arrangements for providing scholarships to the students of oppressed ethnic communities who are extremely backward on economic point of view.

The Act, however, was not implemented as envisaged and sectoral regulations regarding community managed schools did not take the LSGA into account.

At present, therefore, Nepal has two models of educational decentralization: the LSGA that proposes management through representative districts and VDCs, while later provisions propose school management by district and village education user committees and SMCs.[44] It appears that the VDCs and DDCs contribute to the financing of schools, and have some influence through the double roles of VDC/DDC officials sitting on the user committees and SMCs, but the VDCs/DDCs cannot be said to be fulfilling the functional responsibilities foreseen in the LSGA.

4.2 Health

There has been a form of decentralization of health services from 2002/03 onwards with the handing over of management responsibility for sub-health posts to newly established implementation and management committees (SHPIs); 1417 health service outlets were handed over by 2008 (42%). Each sub-health post serves on average 8,454 people, and covers 47 square kilometers.

According to the LSGA, VDCs have a meaningful role to play in health care, as indicated in the functions listed below:[45]

- operate and manage village level health centre, health post and sub-health posts;
- prepare programmes on primary health education and sanitation and disposal of wastes and garbage in the village development area and to implement the same;
- provide assistance in the development and expansion of herbs;
- launch programmes on family planning and maternity and child care.

In practice, the VDCs have not been given the funds or technical capacity to follow through on these LSGA mandates. They sometimes provide modest funding from their small budgets for some of these activities, but this is done on an ad hoc manner; they cannot be said to be "responsible" for health functions.[46]

SHPIs on the other hand are responsible for all aspects of management, including ensuring quality of health services by sub-health posts. The chairperson of the VDC and eight stakeholders involved in health service delivery make up the committee (these members are appointed).

[44] Belbase, Lekh Nath et.al. (2007). Improving Local Service Delivery for the MDGs in Asia, Case Study of the Education Sector in Nepal, Foundation for Human Development and Research Inputs and Development Action, Kathmandu, pg.22.
[45] Article 28 g) in the Local Self Governance Act of 1999.
[46] Drawn from field notes prepared on October 10/2010 by Gabriele Ferrazzi, Team Leader for the Mid-Term Review of the Local Governance and Community Development Programme of the Government of Nepal, conducted in September 2010.

It is also worth noting that the LSGA, though not practiced as intended, does differentiate (albeit not in a perfect way) between the functions of the DDC and VDC, pertaining to the health sector. The LSGA gives to the VDC the responsibility "To operate and manage village level health centre, health post and sub-health posts." As for the DDC, it is "To operate and manage, and cause to be operated and managed, the district level health posts, hospitals, Ayurvedic dispensaries, health centres, health offices etc." The Municipality responsibilities seem to overlap with those of the VDC, but it is important to note that there is no overlap in fact as there are no VDCs in municipalities. In any case, until the Nepali state decides to sort out the modality of decentralization, through user/SMC or to VDC/DDC/Municipality, the language of the LSGA will not carry much weight.

4.3 Conclusions

It is not enough to have a legal framework that, on paper, empowers the LLGs. In Nepal the LSGA provides LLGs with significant functions in health and education, but the Act has not been adequately implemented. The Nepal case shows that sectoral practices (aided by donors in many cases) undermine "decentralization legislation." Sectoral ministries believe that they are in fact decentralizing, directly to community groups. This form of decentralization undoubtedly has its advantages. However, by design or neglect, it can marginalize the role of the LLGs, and stunt their growth. The challenge for Nepal is to find a way to make the most of LLGs, either by closer engagement in "community driven development/service delivery" or by truly assuming responsibility for the functions (as intended in the LSGA).

5. The Philippines

The Philippines has 79 provinces and highly urbanized cities on a first governance layer; 115 cities and 1,425 municipalities on its second layer; and 43,000 barangays at the lowest level of governance.[47] Functions transferred to municipalities are more extensive than those transferred to barangays.[48] Provincial, city, municipal and barangay councils may all enact ordinances and approve resolutions, appropriate funds, and pursue the 'General Welfare Clause' of the Philippines' Local Government Code.[49] However, in practice, the local governments are restricted to those functions that have been explicitly transferred to them.

5.1 Education

On the basis of enrollment figures that have grown considerably over the last three decades, the Asian Development Bank states that the Philippines' achievements in the education sector are "among the most impressive in the region"[50]. It is not known, however, whether the achievement can be attributed to decentralization efforts, particularly given that most functions in the sector remain with the departments (and are executed through deconcentrated units).

Although the share of the education budget of local government units (LGUs) apparently overtook the budget of the central ministry by 1998 as a result of the 1991 Local Government

[47] http://www.adb.org/documents/manuals/serve_and_preserve/Chapter04.PDF
[48] The Local Government Code of the Philippines, Section 17b.
[49] http://www.unescap.org/huset/lgstudy/new-countrypaper/Philippines/Philippines.pdf
[50] Behrman, Jere R. et al. (2002). Promoting Effective Schooling through Education Decentralization, Manila, pg.38.

Code[51], there has been hardly any noteworthy shift of discretionary power to lower governance levels. The role of the baranguay in education is actually quite limited in the 1991 Local Government Code. It can support infrastructure development, and provide an "Information and reading center."[52] Except for the construction and maintenance of public primary and secondary school buildings, functions transferred to municipal and city governments, all functions remain in the hands of central government (except for the special cases, such as in the Autonomous Region in Mulsim Mindanao).

In the Philippines, in addition to LGUs, local school boards were established, comprised of appointed and elected local officials, teachers and other school staff representatives. These propose an education budget to the LGUs, advise them and are themselves consulted by the department of education on the appointment of key local education officials.[53]

As alluded to earlier, deconcentration has been the primary reform approach, with sub-national education offices established since 1991. These offices develop their own regional education plans and budgets, and they have full responsibility for the management of human resources and for monitoring and evaluation.[54]

A school-based management approach, adopted in 2005, was meant to "empower all schools and their communities". The approach, however, only led to a re-organization of line department functions together with the establishment of new mechanisms to assure the competency of heads of school.[55]

5.2 Health

By 1993, the majority of central government service delivery health functions and resources were transferred to LGUs. Most of those functions and resources were transferred to provincial and city governments, but some were transferred to municipal and barangay institutions. Municipal governments were given responsibility for the administration of primary health care and other national program services through municipal health offices and corresponding rural health units (RHUs) and barangay health stations (BHSs). Barangay governments, whose constituencies are closest in number to Cambodian Communes, are responsible for the maintenance of physical structures of RHUs and BHSs.[56] This is consistent with the rather general provisions of the Local Government Code of 1991, which calls for the baranguay to provide:

- health and social welfare services which include maintenance of barangay health center and day-care center;
- services and facilities related to general hygiene and sanitation, beautification, and solid waste collection. [57]

[51] Ibid., pg.43: "LGU spending on education is largely financed through the Special Education Fund (SEF), which is financed by revenue from a 1 percent tax on real property within the jurisdiction of the LGU."
[52] Section 17.b)1. in the 1991 Local Government Code.
[53] Capuno, Joseph F. (2008). A Case Study of the Decentralization of Health and Education Services in the Philippines, HDN Discussion Paper Series, 3, pg.9.
[54] Ibid., pg.11.
[55] Ibid., pg.13.
[56] Bossert, Thomas et al. (2000). Decentralization of Health Systems: Preliminary Review of Four Country Case Studies, Maryland, pp. 55-56.
[57] Section 17.b)1. in the 1991 Local Government Code.

Notably, all health sector indicators (infant mortality rate, under-5 mortality rate and life expectancy) have improved since 1991. Attribution of these successes to the decentralization of health functions at the barangay level is difficult to make. Reports state that "the range of quality of decentralized health services is rather wide"[58] and "most people in rural areas would rather go directly to a higher-level health facility and bypass the one nearest them."[59] In fact, there is little systematic data available in terms of quality and performance with respect to decentralized health service delivery: "LGU expenditures on health have kept pace with inflation and population growth, but disaggregated information on how these expenditures are being used has yet to be presented."[60]

5.3 Conclusions

The role of the barangays in education is not well elaborated in the Local Government Code; it appears rather limited. It is potentially more significant in health. However, the more substantial roles are seen at the municipal/city level. Even here, however, decentralization has not progressed in practice as far as the Code would suggest; there is still a heavy role being played by the central government, in part through its deconcentrated units.

6. Tanzania

Tanzania is divided into 26 regions, and further subdivided into 99 districts. In rural areas, District Councils are further subdivided into township council and village council authorities (10,200), closely coordinated by the district Council. More power placed at the district level rather than at the village level. Important decisions, such as planning, prioritization, budgeting and resource sharing, are made at the district level. The challenge has been how to decentralize further downwards and empower village (and ward – intermediate between village and district) level governments.[61]

The village level in Tanzania is a fully fledged local government in the sense that it is elected, plans, collects revenues and passes by-laws. However, it is rather weak as it has essentially no supporting staff. The Executive Officer and extension workers at this level are district staff.

6.1 Education

School management committees (SMCs) play a strong role in managing education service delivery in Tanzania, a feature common in other African countries such as Uganda and Kenya. Tanzania has moved fastest and has also provided part of its education budget to the school level. In fact, schools are the main unit for implementation of education policy and they provide inputs in planning. District councils mainly play coordination and supervision roles. There is no indication in the literature that lower level local government (LLG) plays any significant role.

Funds transferred from central government to schools are in the form of grants of approximately 10 $ per student. SMCs help to manage these funds and must develop an annual school improvement plan which includes mobilizing additional contributions in cash and kind from the

[58] Ibid., p.18.
[59] World Bank (2001). Filipino Report Card on Pro-Poor Services, Washington, DC.
[60] Bossert, Thomas et al. (2000), op. cit., pg. 63.
[61] Steffensen, Jesper et al. (2004). A Comparative Analysis of Decentralization in Kenya, Tanzania and Uganda.

community. Other central grants support school construction and rehabilitation, also managed by SMCs with support from villages.

Key functions of SMCs are to: submit school plans to the district; manage school budgets (grants and community contributions); advise village councils in matters of interest to school development; support day-to day running of schools; act as a link between school management and the community; organize the tendering process for facility construction; and purchase school equipment by local procurement.[62]

Enrollment figures for primary and secondary education have risen considerably in recent years and citizen surveys indicate that 78% of citizens perceive that government is doing well in addressing educational needs. No studies were found, however, that clearly attribute improvements to functions and resources having been transferred to SMCs.[63]

6.2 Health

Tanzania's health strategy focuses on local government and the health facilities level for service delivery. A sector-wide approach has been introduced and, in principle, bottom-up planning has been adopted. However, the focus is on the district level. New planning tools were introduced at this level; districts prepare the plan by establishing health boards composed of district council health staff and other stakeholders. At the facility level, user committees have been established (health facility committees), which have mobilized and distributed funds needed for rehabilitation of facilities. In reality, however, stakeholder involvement is not consistent or comprehensive. Lower levels of local government (LLGs), in particular, are not giving much input to the planning process.[64]

Tanzania's health sector reform emphasizes public-private partnerships. Results of this are apparent in Ilala Municipality, for example, where 60 % of health services are delivered by the private sector.[65] The emphasis on NGOs and the private sector in health service delivery has been at the expense of devolution to elected LGUs.[66]

In terms of results, citizen surveys indicate that while there have been improvements in health services in recent years, progress is still slow. In 2006, less than 20% of citizens surveyed were satisfied with services provided at health centers.[67]

6.3 Conclusions

Tanzania is another country where decentralization has largely bypassed the LLG. Progress in outputs and outcomes has been slow in both education and health. It is not clear how much of the progress seen, or not seen, accounts for this strategy of making light use of LLGs. It is in any case difficult to know the "counter-factual" – what would have happened if the LLG had been given a significant or dominant role.

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[62] Steffensen, Jesper et al. (2004), op. cit., pg. 28.
[63] Fjeldstad, Odd-Helge et al. (2008). Disparities exist in citizens' perceptions of service delivery by local government authorities in Tanzania, REPOA Brief 13, pg. 3.
[64] Tideman, Per et al. (2007). Local Level Service Delivery, Decentralisation and Governance: A Comparative Study of Uganda, Kenya and Tanzania Education, Health and Agriculture Sectors, Final Report, pp. 49-55.
[65] Ibid.
[66] Ibid.
[67] Fjeldstad, Odd-Helge et al. (2008), op. cit., pg. 4.

7. Uganda

There are five levels of local governance in Uganda. Sub-counties (903 as of 2005)/town Councils (174 as of 2010) and District Councils (112 as of 2010) have the main budgetary, programmatic and personnel related functions, while at the parish and county levels only relatively minor administrative roles have been transferred. Villages primarily provide conflict resolution and security related functions which, according to the literature, have been quite successful.[68] However they are not fully fledged local governments as seen in Tanzania for instance. The more relevant comparator for this report's analysis is therefore the sub-county/town councils, which are equivalent in scale to many Cambodian Communes.

7.1 Education

In the education sector, Uganda introduced reform in 1996 to provide schools and their SMCs more direct control of funds, but with correspondingly less scope for involvement in resource allocation by local government. Gehrsberg and Winkler describe the recent financing mechanism in the education sector as follows:

> "Uganda's grant system is calculated centrally and released as a conditional block grant to districts, which in turn, release all funds to schools on the basis of enrollment. The ministry has also released guidelines to schools for allocation of funds, for example, 50% for scholastic materials, 5% for administration, and so on. The School Management Committee manages the money at school level. The amounts received from the district office are posted publicly in the school."[69]

They have important inspection roles and roles in hiring teachers and supervision of primary school teachers. The center, however, still has strong control in the latter area, through control of funding and through central monitoring. Districts recruit teachers, therefore, but teachers' salary is both determined and provided by the central government. While the district governments in Uganda are more involved in the management of education than their Tanzanian counterparts, the involvement is still rather limited, and the LLGs (parishes, counties and villages) do not play a significant role.

As seen in other countries, the SMCs have been given new responsibilities in recent years, such as purchase of school books and small expenditure items. SMCs also have monitoring and reporting responsibilities; however, they are not yet fully performing these.[70]

7.2 Health

District level responsibilities have been expanded under decentralization reform, but LLG participation in decision-making and the planning process has not been institutionalized. District responsibilities are: health service delivery; recruitment, deployment, retention and management of personnel for district health services; passing by-laws related to health; planning and

[68] Wunsch, James S. and Dan Ottemoeller (2003). Uganda - Multiple Levels of Local Governance, in Olowu, Dele et al. (Eds.) Local Governance in Africa. The Challenges of Democratic Decentralization, pp. 275-283.
[69] Gehrsberg, Alec Ian and Donald R. Winkler (2003). Education Decentralization in Africa: A Review of Recent Policy and Practice, pg. 20.
[70] Ssewankambo, Emmanuel et al. (2007). Local Service Delivery, Decentralisation and Local Governance. A Comparative Study of Uganda, Kenya and Tanzania. Education, Health and Agriculture Sectors. Uganda Case Report (for JICA), 2007, p.41-45.

budgeting; additional resource mobilization and allocation for health services; and supervision and monitoring of health service delivery in districts.[71]

In order to perform these functions, district health committees (DHCs) and district health teams (DHTs) were established:

> "The DHC is an elected group under the district council and provides legislative policymaking and oversight of the district-level health sector, where this does not circumvent the national policymaking and regulatory prerogatives of the Ministry of Health. The DHT is the district government's executive administrator of the health department, and is charged with advising the DHC on technical matters, implementing health policy, and managing service delivery." [72]

DHTs are composed of district health staff and civil society service providers. Annual work plans and budgets are prepared by the committee. The parish and sub-county level submit their priorities.[73]

Decentralization legislation focuses on devolution of functions to district and sub-county levels, the sub-county's functions being of most interest here. Sub-county functions, however, are not extensive. They mainly forward priorities to upper levels, and plan for investments only so far as they have own-resources, although they do have some responsibility for implementing programs. In some districts, there are examples of bottom-up planning based on sub-county government work plans. In general, however, the district level has the greater say.[74]

Some functions are delivered at the village level by user groups, called village health teams (VHTs), which serve a population of approximately 1,000. VHTs are composed of 9 to 10 people selected by the village, of which 1/3 must be women. VHTs serve as the first link between the community and formal health providers and they facilitate community mobilization and empowerment for health action. VHTs are responsible for:

- identifying community's health needs and taking appropriate measures
- mobilizing additional resources and monitoring resource utilization for their health programs, including the performance of health centers
- mobilizing communities using gender-specific strategies, such as for immunization, malaria control, sanitation and construction, and promoting health-seeking behavior and lifestyle
- selecting community health workers, and ensuring a gender balance
- overseeing activities of community health workers
- maintaining a register of members of households and their health status.

The literature suggests, however, that "the establishment of village health teams has been slow and not well coordinated and hence the linkage between the formal health system and the community remains weak"[75].

[71] Ibid., pg.70.
[72] Bossert, Thomas et al. (2000), op. cit., pg. 42-45.
[73] Subcounties are the third layer of administration from below (after villages and wards) and have an average population of 27,000. Districts are the highest layer of local government and have an average population of 307,025. Between them are found the county councils; see Ssewankambo et al. (2007), op. cit., pg.12.
[74] Ssewankambo, Emmanuel et al. (2007), op. cit., pg.73.; Bossert, Thomas et al. (2000), op. cit., pg. 41.
[75] Ssewankambo, Emmanuel et al. (2007), op. cit., pg.72.

7.3 Conclusions

The overall approach in Uganda remains quite centralized. The district has a significant role in education but the national government role is quite heavy. LLGs (parishes, counties and villages) are not involved during planning, implementation or monitoring of education services. In the health sector the LLGs do appear to have a role, but this is largely on the planning (proposing) side. Villages are active in supporting village health teams, but this is also a limited role.

8. Further discussion of findings

8.1 Typology of functions

Having examined the arrangements in education and health sectors by country, this section offers a comparative analysis relying on the typology of functions in Table 2, derived from the structure of the functions that are being taken up by LLGs in the countries examined.

The unbundling of the functions in Table 2 is done according to generic management functions for easy comparison to the Cambodian desk study that uses the same typology. It is equally possible, however, to unbundle the sector (education or health) by the kind of specific services contained in the sector, identifying those services that are entrusted to the LLG. Because the services entrusted to LLGs tend to be similar across countries, varying mainly on the extent to which the service is entrusted to LLGs, it is useful to note how a particular service (e.g., primary education) is “shared” between levels of government along the management functions that constitute the service.

Table 2: Typology of Functions

Category	Sub-category
Policy	• Participation in policy development • Definition of development policies • Definition of regulations & standards
Control	• Monitoring • Enforcement of sanctions
Planning and Budgeting	• Participation • Definition
Financing	• Direct source of financial transfer • Authorization of funding • Asset and personnel management
Operations	• Implementation of service • Conduct surveys and management of statistics • Trainings, capacity development • Authorization/contracting • Coordination • Communication
Infrastructure	• Construction/ Equipment • Maintenance/ Repair

8.2 Education

Internationally, central governments have maintained control of education **policy-making**. Decisions on the overall modeling of the education system and on curricula are made at the national level. This is true for education that is of a basic nature (e.g., early child education, primary education) that may be assigned to LLGs, as well as higher level education (that is usually not assigned to LLGs).

LLGs play a role in **control** of education services given their proximity to schools. In most countries studied, LLGs report on student and teacher attendance to line ministries. Functions entrusted to LLGs or more specialized governance institutions (e.g., School Management Committees) are ensuring full enrollment and attendance of teachers and students, and conducting day-to-day inspections and some aspects of supervision of school operations. For instance, in Nepal, SMCs are responsible for regularly updating the district level ministry offices on academic activities of the school. The scope of control functions appears to be somewhat limited. The literature is not clear whether "to ensure" enrollment and attendance includes enforcement action (e.g., applying sanctions), but it appears in practice that this is in many cases beyond the reach of LLGs or SMCs.

Regarding **planning and budgeting**, responsibilities have been given to LLGs in some cases, as in Kerala, where Gram Panchayats must develop "plans for physical expansion" and "plans for quality improvement". This is also the case in Nepal, where the VDCs must formulate education plans and local policies and develop programs for adult and informal education. At this level, an educational committee is established to take the lead, with nominal participation of

the VDC. It is however common to see the LLGs fall short of meaningful planning (directly or through established village committees), vacating the field to the deconcentrated ministry bodies, in conjunction with SMCs. In Tanzania and the Philippines, SMCs are the institutions charged with submitting school plans to district governments. Education planning, therefore, is more influenced by SMCs than by elected bodies that exist at the lowest levels.

Where the role of the LLGs is weak or bypassed, the LLGs are nonetheless invited or allowed to contribute funds to the community driven efforts or to users directly. For instance, in Uganda, LLGs are responsible for scholarships. A similar orientation is now being encouraged by the Education Ministry in Nepal, though the LSGA would give the VDCs a more comprehensive management role over primary education.

Personnel management is often exercised at higher levels of government. This appears to be due to the difficulties of LLG/SMC to attract teachers to remote or disadvantaged areas. The argument used is that higher level governments are more able to impose equity in personnel distribution. This is true in general, but LLGs can also be effective in attracting personnel if they are given resources and allowed to craft incentives.

Although comprehensive personnel management is beyond most LLGs, in some countries the LLGs are given a partial role. In India, Gram Panchayats select teachers – according to the legal framework. As the States have been slow to implement the national legislation assigning functions to Gram Panchayats, however, it may well be that teacher selection, in reality, is rarely done by local government. The exception may be Kerala where *temporary* staff is locally selected. In Tanzania, lower local councils have a say in setting targets for teacher management and in defining how many teachers will be dispatched to which locations. In Nepal, SMCs are involved in assigning duties to teachers when they arrive, and in appointing eligible candidates for obtaining a teaching license.

In the field of **operations**, overall management responsibility of education institutions has been transferred to LLGs in Kerala (pre-primary and primary schools, industrial training institutes), to VDCs in Nepal and, the literature suggests, to SMCs in Uganda (committees prepare school plans). Further operational functions are, for instance, to conduct literacy programs (Kerala), to implement adult and non-formal education (throughout India), to establish information and reading centers (Nepal), to assist in providing primary level education in mother tongue (Nepal, VDCs) and to ensure a conducive “academic environment” (Nepal, SMCs). Gram Panchayats in India are responsible for promoting vocational education and selecting beneficiaries. In terms of authorizing activities, Nepalese VDCs give permission to establish and operate schools. Tanzanian LLGs are responsible for coordinating the provision of school books. Nepalese VDCs coordinate education programs and adult and informal education programs. Awareness-raising activities were devolved in India where village governments were given responsibility for the Total Literacy Campaign.

For **infrastructure**, the role of LLGs can be quite strong. Responsibility for school construction was transferred to LLGs in several of the countries studied for this report. In many cases, the construction or procurement included related facilities and items such as student dormitories, libraries, furniture and sports equipment. Books and study material are often managed in a centralized way (e.g., in Indonesia), but in some cases also by LLGs/SMCs; in India, the Philippines and Uganda.

8.3 Health

Again, as to be expected, central government retains the overall **policy-making** function in all the countries studied. This does not mean that LLGs have no policy making role, but it is circumscribed by the policy framework provided by higher level government.

In Himachal Pradesh, Tanzania and Nepal, **control** functions have been transferred to LLGs, including the responsibility to report outbreaks of epidemics and the monitoring and inspection of all health facilities.

In terms of **planning and budgeting**, the Philippines and Kerala stand out as the two countries that have devolved planning to the LLGs. Indonesia encourages village government to do annual planning, but this is largely in the form of "projects" rather than an integrated and longer term view of village health facilities. In general, allowing LLGs to plan can mean to simply offer local views of what is needed and what should be priority; if the LLGs are not provided with the budgets to follow through on the plans, then the planning is not very meaningful – it is the government level that makes the allocative decisions that is really doing the planning (with some consideration of the "planning" that is conducted by the LLGs perhaps).

The report is short on the **financing** arrangements of LLGs in health. As in the case of education, to the extent that LLGs have some resources, there is the possibility for LLGs to make financial contributions to health facilities, for their construction or operation. From personal experience in these countries, the researchers note that it is unusual for the LLG to receive adequate funding to fulfill comprehensive (governance driven) local plans, as opposed to ad-hoc contributions towards plans made and financed by higher levels.

In terms of **operational** functions in local health services, there is generally more discretionary space given to LLGs in the surveyed countries than for other aspects of management. But here again, the decentralization is at times directly aimed to the delivery institutions. It is not always easy to determine what the division of labour is when LLGs and delivery institutions both receive functions from higher level government. In any case, the LLG/local institutions combination have received operational management responsibilities in Kerala (dispensaries and primary health centers and sub-centers, child welfare centers and maternity homes), throughout India (health units other than health centers), in the Philippines (barangay health stations, day care centers, also purchase of medication, medical supplies and equipment), in Tanzania (district and other hospitals, health centers and dispensaries) and in Nepal (village level health/sub-health centers and posts). Preventive care functions are often transferred, including organizing school health check-ups (Himachal Pradesh), immunization (Kerala, Himachal Pradesh), maintaining sanitation (Kerala), offering continuous basic preventive care/preventive health care programs (Tanzania, Nepal) and maternity care and family planning (Himachal Pradesh, Kerala, Philippines, Uganda, Nepal). The same topics are often the subject matters of awareness-raising functions (Uganda, Nepal).

As seen in the case of education, Indonesia is once again conspicuous for giving a negligible role to its village governments when it comes to health services. Villages are enjoined to support the local health post, in an ad-hoc way, but the function is not specifically assigned to the village government. Rather, the district government has the function of managing the health post (and higher level primary health care centres) and encourages village volunteers to manage the village health post. The management of professional **personnel** is also a district level function in Indonesia, and in other countries it is as centralized, or even more so.

As in the case of education, LLGs are generally allowed to contribute to service delivery **infrastructure** – in this case pertaining to health; basic sanitation, water provision, and health posts for instance. In some cases specific infrastructure development functions are assigned to LLGs, as seen in Nepal, Himachal Pradesh and the Philippines. This assignment is not always realized in practice, for reasons of inadequate funding and measures to attain the capacity required to discharge such functions.

9. Final conclusions

9.1 Education sector

The analysis undertaken in the previous section shows a fairly wide range of roles for LLGs in education, particularly in terms of legislation. Pre-primary (e.g., child education), primary education and informal education are in part managed, or influenced, by LLGs in the surveyed countries. In some cases however, the LLG has practically no role in education (e.g., the village government in Indonesia, and parishes in Pakistan). In only some countries LLGs are given operational or infrastructure responsibility.

Where the LLGs are given a role through legislation, this role is often not fully realized in practice, as noted in India and Nepal for instance. Hence, if progress has been noted in the implementation of these services, and their welfare results, the attribution of this success must go to a number of actors. The particular contribution of LLGs is difficult to discern in these institutional arrangements. In some countries, the practical role of the LLG is negligible, and any progress seen in the services can certainly be attributed to other actors. For instance, in the Tanzanian model, funds are directly transferred to schools and managed by school boards; the noted increase in citizen satisfaction with education service delivery cannot be attributed to the LLGs.

In several countries, specialized governance institutions, such as SMCs, have intentionally (or otherwise) been cast as an alternative to LLGs in the management of educational services. There is emerging analysis worldwide to suggest that well designed SMCs do indeed have a positive effect on education quality and reach. However, there is insufficient exploration of the contribution that LLGs can make in conjunction with the SMCs. In some countries, the guidance role normally done by the Ministries (through their deconcentrated offices) is in some measure shared with, or transferred, to LLG. In principle, there appears to be scope for all three actors to play a meaningful role in educational services delivered at local level; the deconcentrated units of the ministry, LLGs and SMCs/local education committees.

The particular division of labour between the three key actors mentioned above will reflect historical developments and investments in capacity. But the latter in particular are, or ought to be, purposeful choices. Future choices in Cambodia on the relative roles of these three actors should be made with a full appreciation for local circumstances and the roles that LLGs are successfully playing elsewhere when properly framed and supported.

9.2 Health sector

The cases covered in this report show, in a similar way to the education sector, that LLGs are able to play meaningful roles in local health service delivery. The functions most commonly

transferred to local institutions appear to be functions related to preventive care, awareness-raising and monitoring. Ad-hoc contributions to planning (need/proposal submission) and infrastructure development (partial contributions) were also possible, though these do not constitute an “own function” approach.

The opportunity to play meaningful roles for LLGs has not been given in all of the surveyed countries. In Tanzania, Uganda, Nepal and Himachal Pradesh, functions have been mostly transferred to user committees – and these responsibilities have been rather light. In Indonesia and Pakistan, LLGs have essentially been excluded (decentralization has only reached down to the district level). The reviewed cases show that the Philippines and Kerala have devolved most extensively in the health sector. In the case of the Philippines, functions were mostly devolved to provincial and city governments, but lower levels also received a share of responsibilities. As with the earlier education sector discussion, when both LLGs and health facilities are given roles, it is difficult to untangle how these roles have played out and which actor was predominant in accounting for progress made in service delivery.

The health sector experiences indicate that the ability of the LLGs to mobilize civil society is key to making improvements in service delivery. The “Kerala’s People Campaign” achieved good results in the health sector. Kerala has a long tradition of social movements and civil society is well established. Hence, in thinking about the Cambodian case, it may be helpful to note the comparative advantage of district (or deconcentrated central government units if these continue to exist), health facilities management structures/local committees and Communes/Sangkats in relating to civil society.