Evaluation of performance of local governments in health planning and target achievements under health basket funding system in Phase 1 Councils in Tanzania

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Abstract

Globally, local governments (LGs) are established to ensure that community-oriented development priorities are set and national policies are implemented with adequate community participation. In Africa, little is known on the performance of LGs in priority-setting, financial planning, resource allocation and budget control. We are add evidence from a study conducted to evaluate the performance of 37 LG councils in health planning, budget control and target achievements and factors influencing the observed LG performance in Tanzania.

Methods: Interviews were conducted with heads of health facilities and LG council health managers and regional level officers. Overall, 37 councils and 21 regions were covered from where primary and secondary data were collected and analyzed involving multidisciplinary team.

In all councils found with health plans, district and regional level officers acknowledged the national health basket funding system (HBFS) as having increased budget allocations for LG councils and such councils' autonomy to set their priorities for health using standard national guidelines. The concerns expressed by LG council health management teams (CHMTs) and health facility heads were related to the criteria used by central government authorities and their allied development partners to set budget ceilings for specific cost centres which all council have to adhere to. All LG council's health plans reviewed showed 'community initiatives' component, but none indicated explicitly and convincingly the specific activities to be covered. CHMT members alleged central government authorities and offices of council executive directors (DEDs) for delaying to disburse the funds requested for supporting the planned health activities/services at council levels. DED's offices were also alleged for excessively interfering CHMTs on issues of use of vehicles among other management

affairs. Lack of qualified and full-time health accountants lowered some CHMTs' capacity to set realistic budgets for health activities, monitor health budget expenditure, and submit the required health plans to higher levels.

LGs could not achieve the predetermined policy objectives or targets set in situations whereby they cannot exercise their autonomy to set priorities and access funds for the planned activities, realize clear policy guidelines and good leadership relationships among themselves.
Keyword: decentralization, health-care reform, local government Tanzania

Introduction

International experts' view on local governments' effectiveness in health budgeting:

One of the great challenges reported as continuing to face developing countries' local governments (LGs) is how to set priorities reasonably in a manner that can address various community needs properly. However, identifying the needs and setting priorities is one thing and actually allocate the resources and implement the activities required to satisfy such needs is another thing. According to Kapiri and Martin [1], priority setting is one of the most difficult issues faced by health policy makers, particularly those in developing countries. The issue of priority setting in these countries is generally fraught with uncertainty due to lack of credible information, weak priority setting institutions, and unclear priority setting processes. Records show that over the last two decades, research was able to identify that most low and middle income countries have adopted a top-down and highly centralized system of priority setting, resource allocation and service delivery. As a result, local structures even in the so called decentralized systems are found being forced to implement the decisions passed already by higher authorities [2]. The latter approach is said to be expensive, cumbersome, rigid and too slow to adapt (if at all) to new information [3]. Arrangements leading to a more locally driven priority setting, budgeting and actual resource allocation system are considered and advocated to be much better and replace the traditional ones. This would allow more reliable data guided decisions to be passed in time and by ensuring appropriate mechanisms for incorporating the preferences of all the key stakeholders in the priority setting processes. For this to be accomplished, there must be clear definition of needs, decision-making power structures, guidelines and mechanisms for enforcing the recommended ways-of-doing including mechanisms for accountability in reasonable manner without excessive political interferences [4-7].

Proponents of decentralization in form of devolution suggest the need for understanding the process of priority setting and programme implementation at various LG levels within a particular period of time. However, the caution that this can only be possible if there are arrangements for periodic evaluation of the opportunities available for and performance of different actors in the decision making and programme implementation processes. This would allow the evaluators establish evidence on the success or failure of the programmes instituted and suggest the potential policy options [1]. Unfortunately, so far throughout, Africa evidence on the participation, performance or achievements of health authorities and communities in the existing LG councils in relation to priority setting and resource allocation processes is still scanty. This includes the mechanisms involved in setting budgets and utilizing resources allocated for the priorities identified [8]. Experts tend to argue that in any sector – be it in a developing country or a developed one, the reforms become meaningful if they are actually implemented and once implemented do yield positive (expected) outcomes or results [9]. LGR involve among other things the delegation of managerial (including planning) powers to local decision structures and stakeholders which may take various different [10]. The practicability and performance of each of the different forms of decentralization can be evaluated and conclusion made in different ways depending on the contexts in which the reforms concerned exist. Thus, it is important for the evaluators to understand that the application of one element or a mixture of elements of these reforms may have advantages and/or shortcomings, and this means that the decision made to choose whatever approach should be evidence guided [11-14].

Among the six key building blocks of a country's health system, the financing and governance (or leadership) blocks are of paramount importance, others being health workforce, health information systems and health service delivery [15]. Reaching the best financing approach for the health sector including effective and equitable budgeting has not

at all been easy in many developing countries. This is because most of these countries have for a long time been using a conventional or traditional health service budgeting system whereby the budget for their health sectors has been relying on the amount expected from the tax-revenue and donor (development partners) funded programmes using block grants and receipts in kind channelled through annual government budget allocations. The health basket funding system (HBFS) adopted in LG councils, as the main focus of this paper, is an element of a sector-wide approach (SWAp) to planning and resource allocation which was introduced later in Tanzania [16] and several other countries in Africa including Ghana, Malawi, Uganda, South Africa, and Zambia, to mention some [17-20]. This system has generally been introduced in the last two decades with the aim of enabling countries move away from the traditional system of priority setting based on vertically focused health programmes and centrally controlled budgets to a more comprehensive health planning and locally controlled health budget structures [21-22]. The SWAP system delegates the financial planning including resource budgeting and managerial autonomy to LG authorities (LGAs) as a way of empowering them to pass important decisions representing local community needs and priorities in health. By so doing, it allows central government authorities to concentrate on broad policy formulation, regulation, monitoring and evaluation [16].

Overview of LGs, health sector budgeting and resource allocation in Tanzania:

In Tanzania, the new phase of LGR aiming at delegating more decision-making powers to LGs was introduced in early 1980s. This followed the LG Act of 1982 which led to the formation of district, town and municipal councils. The latter Act was reviewed in 1992 in attempt strengthen the performance of LGA after gaining experience in the last 10 years during the one-party political system era. In 1993 the one-party political system was replaced with multi-party democratic system, marking a political liberalisation which interfered with the organization and exercise of the LGs' mandates [23-24]. Previously, LG administration issues in Tanzania were coordinated by the Ministry responsible for Regional Administration and LG (RALG) under the President's Office (abbreviated as PORALG) [25-26]. Later on, RALG issues were transferred to be dealt with under the Prime Minister's Office (PMO) (as abbreviated as PMO-RALG). This office took the responsibility of ensuring that all development activities (including those related to health) undertaken by LGs were conforming to the existing Government's policy guidelines [27]. The Ministry of Health remained being an overseer of overall health policy formulation and health service delivery and reporting on health issues [21], as well as designing specific policy guidelines including those related to resource allocation and budgeting for the health services and health sector at large in liaison with PMO [16]. These new reforms lead to a change of the naming of 'district health management team' (DHMT) to 'Council Health management Team' (CHMT). The term/abbreviation 'CHMT' replaced DHMT as the former seemed to be more suitable for representing LG councils located in urban areas and those in rural areas than the latter. The appointment of [district] council executive directors (abbreviated as DEDs) was left in the powers of the ministry responsible for RALG. A CHMT is led by district medical officer (DMO), sometimes called Council Medical Officer of Health. DMO is appointed at Ministry of Health but works in the LG council and can be fired if found not to fit by meeting the requirements of the council administration concerned. As the officer in-charge of health services at council level, DMO reports to DED on health administrative issues concerning health centres and dispensaries, but reports other issues directly to the central level at the MoH either directly or the regional health secretariat or Regional Medical Officer (RMO). At council level, the DED is the Secretary of the Council Management Team [21]. DED is employed by, and reports to, the minister in-charge of RALG. The reports from previous studies reveal that this sort of reporting overlaps or overrides between the DMOs and DEDs for the two ministries has created some administrative problems including those related to health priority setting and financial management at council levels even after the national HBFS was introduced [21, 25].

National HBFS guidelines stipulated that CHMT, local health facility committees and private sector agencies have responsibility of prioritizing in their plans the health service activities to be carried out in each quarter of the year with budgets indicated for each activity [28]. Each plan has to indicate among other key elements the component of community participation. Then the plans have to be submitted for review at the Full Council Meeting which is attended by all ward (small local constituency) councillors as well as the members of the Council Management Team. Among the attendees of the latter Meeting are DEDs, district planning officers and district treasurers. The Full Council after scrutinizing the plans gives the final decision or recommendation on how the allocation of health basket funds from the government should

be. The DMO is a member of the Full Council Meeting. It was also recommended that utilisation of Health Block Grants and health basket funds is accompanied with a number of regulations and ceilings that have to be adhered [16].

From the beginning, implementation of the HSBFS in Tanzania was planned to be take pass through three phases involving LG councils. The funds for Phase I councils were scheduled to be disbursed in July 1999 [28-29]. In conformity to the policy of minimum essential health service package, the government defined certain health services to be financed under the HSBF system and set standard budget ceilings for different cost centres. These could act as guidelines which each of LG council had to comply with while developing their financial budget plans and expenditure for each quarter. Through this kind of arrangement, the ceilings set for different cost centres out of the overall (total) budgets approved for each LG council were required to be as follows: community initiatives (5%), district hospital (35%), urban health centre (15%), dispensaries (15%), council health development (10%), and 'unallocated' i.e. amount designated for any available voluntary agency (e.g. faith-based) health facility (10%) [28]. These allocations were reviewed in 2004 as follows: 5-10% (community initiatives), 15-20% (health centre), 10-15% (Voluntary Agency Hospital), 25-35% (Council Hospital), and 15-20% (Office of the DMO) [30]. The PMO-RALG in cooperation with the MoH was left with the task of evaluating the performance and adherence of each council in relation to such guidelines. There has also been a HBF Steering Committee whose members include the MoH, PMO-RALG and the resource contributors (various donors who meet each quarter in a year to review financial and progress reports from the councils based on which decisions on next quarters' disbursements were to be made [22, 25]. Also, there a Health Sector Review is performed periodically by external evaluators representing development partners supporting the government's HBFS. The team involved reports on the progress and achievements made in the health sector, focusing on programmes supported by the partners through a SWAP system [16, 21, 26, 31-32]. However, evidence from the evaluations carried out and from other kind of research is inadequately documented in peer review journals with wider regional or international coverage.

Objectives of the present paper:

In light of the justification given above, we present the findings from a study which was carried out to evaluate various stakeholders' perceptions and experience on their participation and performance in health priority setting, district health planning and implementation of various health activities within their LG structures in Tanzania. Particular focus has been on how priorities were set, how health budgets for particular cost centres or services were determined, and administrative logistical issues which seemed to promote or hinder CHMT's ability to perform their planned activities/duties and achieving their targets for various activities. The study covered 37 LG Councils that were nationally grouped as Phase-1 of the HBFS implementation.

Methodology

Study conception, context and design:

In 2000, the MoH officers and other stakeholders in Morogoro, Tanzania to identify, discuss and agree on a set of indicators to be used for evaluating the success several elements of the reforms (including financing reforms) introduced in the health sector. Thus 19 indicators have been identified based on which each council was supposed to refer to as a guide when developing the council's comprehensive health plans (CCHP). These plans are the ones which could be evaluated by an external team after a specified period following the actual implementation of such plans in order to determine how far each council achieved its targets. The National Institute for Medical Research (NIMR) was among the stakeholders which facilitated the individual LG councils to set the targets for various health activities/services to be implemented in their areas. Under the auspices of the MoH, the NIMR was assigned a task of evaluating each council's performance in relation to the targets set for various activities on annual basis. The present paper presents one of the evaluation tasks NIMR carried out for this purpose. The study took a cross-sectional survey in design and was descriptive in nature, employing a mixture of qualitative and quantitative techniques, and having been conducted in 2003. Among the specific objectives, one was to determine whether the allocated funds were disbursed in time and used as planned by the CHMTs. Others were (ii) to assess the community initiatives in the councils including whether and how local community members participated in needs identification and implementing the planned activities; and (iii) identify the underlying factors for the performance of the individual councils in relation to the targets set. The key domain variables included in the analytical framework are highlighted below under the data collection sub-section.

Sampling methods:
The 37 councils selected are located in different

regions, covering the whole country, and therefore, representing different geographical, socio-economic and health service infrastructure characteristics which cannot all be reported in this paper. As for the study population, a purposeful sampling was made to select the managerial and administrative officers holding different positions in the LG councils and central government departments. Specifically, included were the officers from central and LG authorities, health officers at council and regional levels, and in-charges of health facilities (most of which were located in rural settings). At the regional level (21 regions covered), we approached regional health secretaries (RAS) working as representative of offices of the regional commissioners (RCs) and where possible RC were involved. Others include regional planning officers (RPLOs), regional treasurers or accountants (RT/RAs), regional hospital secretaries/administrators, regional hospital medical superintendents (RHMS), and regional medical officers (RMOs). The RAS leads the regional health secretariat and acts as the linking body between the central government and LGAs in the districts and councils [27]. At council level, the DMO and his CHMT as well as the council hospital superintendent (where applicable) were involved. The in-charges of health facilities acted as representatives of the community members' voice

since they were active participants in the local primary health care committees in which locally elected leaders participate [16, 33]. In summary, the sample variables and frame for population groups, areas and characteristic covered are presented (Table1).

Table 1. Study population covered by the present study in 37 LG councils

Study Individuals/Sites	Sample size	Characteristics	Study location	Sampling Technique
Councils	37	Phase I of national HBFS implementation	15 - urban, 22 Rural Councils	Purposeful
Regions	21	Diverse socio-economic, health infrastructure, demographic and other geographical conditions	Different geographical areas/zones in the country	As above
Regional Officers	At least 3 including the RAS, RMO, RPLO, RT (Accountants), and where possible RCs	Central and LG officers at regional level overseeing the functioning of central and LG departmental officers at regional and council levels [16]	As above	Purposeful and Convenient
Council Officers	At least 8 per Council (since a CHMT alone comprises of 8 core members all of which working in health service activities; others were 3 officers from the office of DEDs (including DEDs or Acting DEDs, DPLOs and DTs)	Responsible for setting CCHPs, distribution of vaccines and other key financial and non-financial resources, human resource management, administration and service supervision at Council levels and reporting to Full LG Council, RMO/RAS (Regional Health Secretariat) and MoH headquarters among other duties [MoH & PMO-RALG 2011]	As above	As above
Health facility Representatives		Heads (in-charges) of health service activities performed at health facility level	Rural and urban settings, and inclusive of public and designated voluntary agency e.g. faith-based) facilities (hospitals, health centres and dispensaries)	As above
Community Representatives	0	Views of community was partially reflected by those obtained from the health facility in-charges as members of community health committees and local health service boards	As above	As above

Data collection:

Primary data

A multi-disciplinary team of research scientists was involved and this included health economists, political scientists, public health specialists, physicians, epidemiologists and sociologists. At level of each LG council CHMT members participated in a focus group discussion (FGD) and systematic review of the accounts and other official health documents collected from regional, central and district levels. This means, 37 FGDs have been conducted. However, at least 2 CHMT members (including DMOs and Council Hospital superintendent) also participated in separate individual interviews aimed at soliciting more views expressed independently. Focus has been on particular issues which could not be purposely or well discussed by such officers' during their participation in FGDs. At regional level, the study attempted to investigate the respondents' perception of health sector reform (HSR) and LGR processes in relation to LG council priority setting and budget planning and control, health service supervisory roles of CHMTs and the CHMT's attempt to seek advice from region LGA about issues related to council health planning and budgeting. At district level, investigation was done on such aspects as those addressing how feedback between different departments and decision-making levels with regard to health planning and budget control was being shared, CHMT's autonomy to plan and exercise their plans, accessibility of health basket funds, and reasonableness of the criteria set at national level for evaluating their performances. Stakeholders were given a room to express themselves on how they felt about the performance indicators, criteria for setting HBF budget ceilings, and specific services under the so called 'community initiatives' budget component fundable under the HBFS. Moreover, at both regional and district council levels, several questions were aligned toward obtaining the stakeholders' view on the achievements, whether there were a supportive environment for the LG councils to implement the HBFS As anticipated/required. Interviews and FGD guides addressed the same study themes as mentioned above; the only difference was on the mode of the question design and application which depended on the target stakeholder.

Secondary data

In order to inform our readers about the current status, the findings from the latter survey have been corroborated (or supported with) by an update of a systematic review of published and unpublished reports on health sector planning including budgeting issues and the performance of LG authorities at district, town, city and municipal council level in Tanzania, as well as health management information documents at health facility and district levels.

Data Analysis:

Generic Formula used for evaluating council's performance

As for the quantitative data based on the performance indicators used, reference was made to the baseline data for 1999 when the HBFS was introduced in attempt to compute the actual performance of individual councils in comparison with the performance targets set by CHMTs using each service indicator for the year 2001. The formula used in the calculated is as follows:

$$\%\ of\ achievement/Performance\ = \frac{Actual\ Performance\ (up\ to\ end\ of\ year\ 2001) - Baseline\ level\ data}{Expected\ Output\ (Target\ up\ to\ year\ 2001) - Baseline\ level\ Data}$$

The above formula was designed by the study team and approved by departmental directors, managers and planners at the MoH and was envisioned to be the basis for determining the degree to which each council was able to achieve their pre-set targets and if they were realistic in setting such targets in the contexts of their own settings. The MoH set a benchmark that a council that would be found to have achieved at least 80% of their performance indicator target out of the 19 indicators defined would be judged as having 'successfully achieved' and that any performance less than 80% would imply inadequate performance [34]. Data for year 2000 was not used instead of those for 2001 as compared with those for 1999 because the interval of one year (1999-2000) was too short (regarded as a probation period) to help judge the performance of the councils, and after all such councils had to be familiar first with the government HBFS. The term 'target' has been defined as a desired amount of progress towards an objective through a number and quality of specified activities that have to be carried out before the objective can be reached [16].

Qualitative data were analysed manually (no software programme was used) by the social scientists. Using a qualitative content analysis approach, the field notes taken by hand were scrutinized along with transcriptions made out of the record-taped FGDs and individual interviews with the officers concerned. Only key information is presented.

Ethical considerations:

In both data collection and analysis, any seemingly to be confidential information was excluded or where it deemed necessary to take some content of such information care was taken to keep the names of the reporters unanimous. The study participants were assured of this before they were enrolled into the study. Those willing to participate did sign informed consent forms prepared and kept by the study team.

RESULTS

Perceived advantages of national HBFS on local councils' health budgeting capacity

All regional and district level officers acknowledged that the HBFS has enabled the LG council officer responsible for health planning to be more careful by setting health priorities by referring to the guidelines distributed in 1999 and 2000 by the government. They also realized increased: financial budget allocated for specific health services. This includes the use of the funds obtained to renovate health facilities, purchase some of the essential medical equipment and drugs when there is shortages; opportunities for short term in-service-training of the existing health personnel on health service management aspects; budgetary allocations including funds for supporting health service related utilities such as water and electric power bills at health facility levels and funds for meeting some important transportation costs. This experience was also shared with the in-charges interviewed at all the health facilities visited. It was lamented that previously before the HBFS started there was a hard time when the training opportunities for the frontline health service workers on specific health service issues were either occasionally missed or could cover a few workers; several health service activities remained poorly funded while others were postponed due to lack of funds. CHMT members and health facility heads in all 37 councils also commended the government for distributing the HBFS guidelines to all councils for use as reference materials to guide council level planners and activity implementers. Otherwise, council teams were using their own formats of planning which made it difficult to scrutinize before approval at higher (regional and national/central) levels.

Regional LG officers reported their being dissatisfied with what they called to be 'low capacity' of CHMT in developing the required CCHPs which have to be submitted to regional authorities for scrutiny before being sent to central level for re-review and approval for funding. After review at either of the regional level, some of the plans are sent back to the respective councils for revision before such plans are sent to the central levels (MoH and Ministry of Finance). This process although important seemed to irritate some of the CHMTs who used to do things as usual. Shortage of planning and managerial skills in the respective regions was identified as a chronic problem.

Concerns about budget ceilings and ambiguities noted in the HBFS guidelines:

Majority of CHMT members and all the heads of the health facilities confronted were concerned about some of the guidelines being too binding to the LG councils to set the budgets with great flexibility depending on the existing needs. The ceilings set were reported to underestimate the resource requirements for specific cost centres. However, some councils decided to be flexible by setting the budgets for some cost centres in ways which were somehow different from the so perceived to be predefined and strict government HBFS budget ceilings. For instance, the councils which did not have either a district (government or faith-based designated) hospital or any urban-based health centre decided to spend the budget portion required to be allocated for such facilities as per the national HBFS guidelines on alternative activities or cost centres. For instance, the budget for the non-existing hospital/health centre could be allocated for such activities as CHMT/DMO's office expenditures on health service supervision to peripheral level facilities. Alternatively, the budget portion for a non-existing hospital could be added on budgets for dispensaries and health centres.

While some of the councils had poorly organized data keeping system in relation to budgets allocated and funds utilised on various activities planned as per the HBFS guidelines, others were smart at these records. Generally, less than 50% of the councils visited had complete accounts records which were systematically kept for the funds received under the national HBFS arrangement (Table 2).

Table 2. LG Council's adherence to Government HSBF planning guidelines for budget setting based on specified cost centre ceilings for year 2001

Details about HBF budget setting in relation to Gov't Ceilings	Cost Centres and Number and % of Councils Reporting out of 37 councils studied						
	CHMTs	***DH***	***UHC***	***RHC***	***DISP***	***Comm. I***	***Un-allocated***
Equal to the ceilings	18 (48.6%)	14(38%)	10 (27%)	10 (27%)	14(37.8)	19(51.4%)	18 (48.6%)
Higher than the ceilings	9(24.3%)	9 (24.3%)	5 (13.5%)	10 (27%)	15(40.5%)	7(19%)	0(0.0%)
Lower than the ceilings	9(24.3%)	10 (27%)	6 (16.2%	5 (13.5%)	5 (13.5%)	8(22%)	8 (21.6%)
No data provided	1(2.7%)	4 (10.8%)	16(43%)	12 (32.4)	12(32.4%)	3(8.1%)	11 (29.7%)

CHMTs' ability to achieve targets for planned supportive health service supervision:

Awareness on the supervision responsibilities

The supportive supervision of health service activities carried out at health facility and community levels in the councils were generally reported as being a responsibility of CHMTs. Meanwhile, Regional Health Management Teams (RHMTs) were considered as being responsible for supervising or overseeing the duties performed by the CHMTs on various matters under their jurisdiction or as the policy guidelines suggested.

However, findings from interviews and discussions with CHMT and health facility based stakeholders and review of health service management documents revealed supportive supervision sometimes were not achieved. It was noted that while the national guidelines required that each facility be visited at least 4 times (once per quarter) a year, supervision was not performed in some quarters in some of the councils (Tables 3 & 4).

Table 3. Performance of CHMT's in the planned supportive supervision visits supported by the HBFS in 37 local government councils

Health facility level	= Target	> Target	< Target	= Baseline	< Baseline	> Baseline
	Number of Councils out 37 councils with records of targets for 2001 & baseline					
Hospital	7	1	18	7	12	9
Heath-Centres	5	2	18	4	15	10
Dispensaries	4	2	24	2	18	14

Table 4. Performance of CHMT's out of 37 councils in terms supportive health service supervision supported by the HSBFS in 2001 in 37 local government councils

Target Level	Proportion (%) of 37 councils by level of performance and cost centre				
	Council Hospital	Health Centres	Dispensaries	Overall (for all H-F Levels)	Remarks
> Target	21.6	18.9	16.2	< 30	< expected
< Target	48.6	10.8	5.4	< 30	< expected
< Target though > Baseline	24.3	27	37.8	< 30	< expected

Meanwhile, lack of records for some of the councils on matters relating to health service supervision as well as finance including timing of transfer of funds from central level to LG councils made it difficult for the evaluation team to ascertain the performance of such councils.

As reported in more than half of the councils, the supervisory visits were sometimes done without using specific checklists. The main domain areas for supportive supervision covered such issues as antenatal care, other reproductive and child health services including family planning, vaccination/immunization, rational drug use, and health education services on preventive, curative and rehabilitative health issues, as well as health information management.

In all councils surveyed, council economists (DPLOs), health managers, and health administrators argued that the observed achievements of various activities in their councils were somehow influenced by other factors which were beyond the ability of the council authorities to control alone. Some councils (e.g. Kiteto) were reported to be 'very large' in terms of area coverage and with a large area which is bushy and dwelt by such dangerous animals and snakes. This discouraged the frontline health workers and health service supervisors who fear to use bicycles or motorbikes to reach remote areas, hence affecting their scheduled health service activities especially those related to maternal and child health services.

The data reviewed indicated that the targets set for supervision to be achieved in 2001 as compared to those in 1999 varied by levels of health facilities and LG councils. The mean coverage targeted for carrying out supportive supervision in 2001 by all the 37 councils was 99.2% with reference to the district/referral hospital level (range: 80.0%-100.0%). The mean coverage rate of supportive supervisory visits performed at peripheral health facility levels in 2001 was 76.6% (range: 5.0%-100.0%). Overall data on supportive supervision in hospitals indicated that only 27.6% (n=10) of the councils had either not changed their supervisory schedules or conducted more supervisory visits than their baseline level of performance rate as recorded in 1999. As lamented in more details later, availability of funds and human resources and increased supervisors commitment for this activity were identified as facilitating factors to the observed level of performance for this activity.

At the level of health centres, the mean rate of the actual supervisory visits conducted in 1999 by all the study councils was 83.1% (range: 9.0%-100.0%). In 2001, the data for all 37 councils indicated that mean supervisory visits coverage rate was 97.0% (range: 70.0%-100.0%). The rate targeted to be covered in the same latter year was 75.0% (range: 11.0%-100.0%). Again, this was viewed as an indicator of how the study council teams were able to set realistic and achievable targets by demonstrating their ability to achieve and even exceeding what they had planned.

At dispensary levels data for all the study councils on the supervisory visits carried out in 1999 showed that the mean actual coverage rate amounted to 77.9% (range: 10.0%-100.0%). This marked a decreased performance in 2001 as compared to the coverage rate of 96.3% (range: 60.0%-100.0%) in 1999 (Table 3).

As illustrated further (Figure 1), not all supervisory visits planned by all the 37 councils were conducted in 2001. Some LG councils did not reach the target they had achieved in 1999 for various reasons.

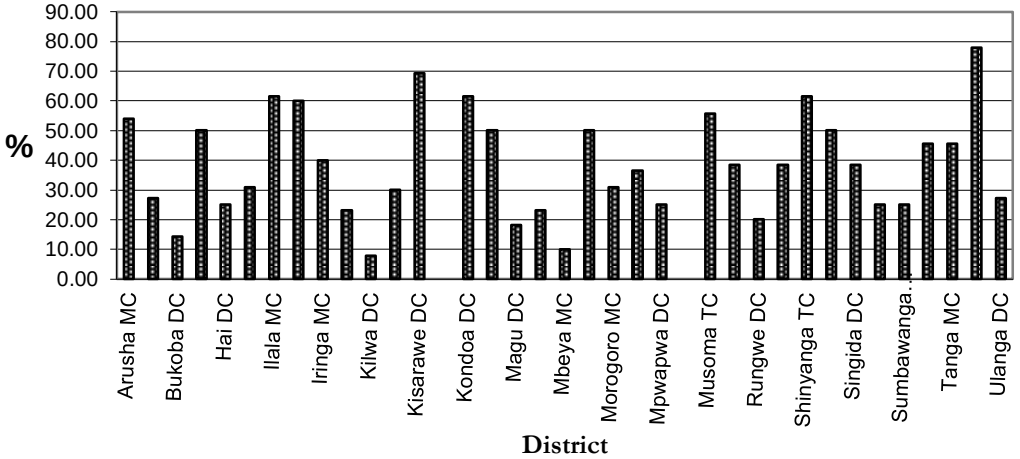

Fig.1: Factors behind the observed/reported performance and achievements

Inadequate capacity in financial accounting and management systems

As indicated by reports from both the FGDs and interviews with the council and regional level officers, a general shortage/lack of qualified accountants seemed to contribute affecting the systematic financial management in all the councils visited. It was not uncommon for the accounts data/records to be dealt with by health officers with no background in financial accounting and this increased even the workload to the still few personnel working in the DMO's office. These personnel found themselves having to spend much more time on dealing with health accounts matters needed to be reported at the LG council level (DED's Office and Full Council Meeting) and at the central (MoH) level. By so doing the staff concerned had limited or no time to perform other duties.

Competing interests or priorities between DED's and DMO's offices

Reports were given at CHMT levels regarding occasionally seeming to be confusing or competing interests leading to unexpected decisions between officers working directly under the office of DEDs and those working under the office of DMOs when it came to matters relating to health priority setting or other management issues. DED might order DMO to release cars for use in order to perform particular duties at council level while the same cars are required for particular health service activities. So any opposition made by the DMOs might be perceived negatively by some of the council officers (including some of the DEDs) as if the DMOs concerned were opposed to the concept of resource sharing between sectors and government departments. At times this resulted into unnecessary prolonged conflicts between the two departmental officers. This conflicting situation was perceived by some of the CHMT members and health facility in-charges as resulting from the multiple planning and budgeting guidelines received at council levels from the PMO-RALG and MoH. The CHMT allegedly pinpointed the DED's office failing to agree with some of the health priorities set by the CHMT in the council health plans or requests for the release of funds to meet particular planned activities in time. Regional-level officers did not deny to have occasionally been receiving complaints from CHMTs against excessive interference by the DED's offices as well as allegations against DED office's delays to approve budget requests submitted by DMO's office

Time of reception of health basket funds by CHMTs from central and council levels

In all 37 councils visited. CHMTs showed reservations about late reception of the health basket funds from the central level. They also reported such funds being sent through the each council's general account (Account Number 6) which accommodates the funds sent by the government for other purposes such as payment of other administrative expenses. As a result, it was not uncommon to find some of the finance managers at council level spending part of the health basket funds on activities other than those planned by the CHMTs. Several respondents in some of the councils greatly criticised the DED's office withdrawing such funds without consent from the office of DMOs. Sometimes, the funds from central level reach the council and the office of DEDs notice this immediately but still delay to inform the office of the DMO. This makes CHMTs delay to implement some of their planned activities and consequently failing to achieve some of the targets.

Allegations about DED's office delaying to notify the DMO's office about the funds sent from central level were not denied by the officers working in the DED's office and some of the DEDs. On their part, these officers reported CHMTs' late submission of their financial accounts reports and requests to the DED office for review before they could get their requests for the funds approved. While this fact was opposed by the DMOs and their subordinates in some of the councils their counterparts in other councils admitted it. Those admitting failures in sending their financial reporting and requests to DED's offices gave justification that this happened due to lack of specialized health accountants to deal such accounts matters.

As for the late reception of health basket funds from central level, a review of documents confirmed that the funds allocated for a particular quarter reached the council in the next one quarter or after two other quarters (Table 5).

Table 5. Quarterly timing of reception of health basket funds at council level as received from the Central Government in 2001 (only councils found with records are reported in this case)

Reference Quarter	Quarter in which the HBF were received from the Government, Number of Councils that had records (N = 37)			
	Q1	Q2	Q3	Q4
Q1	10 (27%)	15 (40.5%)	-	-
Q2	3 (8.1%)	14 (37.8%)	7 (18.9%)	1 (2.7%)
Q3	-	-	9 (24.3%)	16 (43.2%)
Q4	-	1 (2.7%)	-	8 (21.6%)

It can be seen that 40.5% (n=15) of the councils had received the health basket funds for the first quarter in the second quarter of the year. Nearly the same situation happened during the second quarter whereby funds for that quarter were received in the third quarter in 37.8% (n=14) of all the councils, while 18.9% (n=7) and 2.7% (n=1) received such late funds in the third and fourth quarters respectively. It can also be seen that 43.2% (n=16) of all the councils studied received funds for the third quarter in the fourth quarter, etc, and only 24.3% (n=9) of all the councils were able to receive their third quarter funds in the same quarter. In some of the councils the expected disbursement for the fourth quarter of year 2001 was carried forward to the first quarter of year 2002, hence the activities planned to be implemented in the last quarter of 2001 could not be carried out before receiving the funds for that quarter. Meanwhile, the majority, 63.2% (n=23) of the councils (data not shown in Table 4) had their fourth quarter disbursements for year 2001 carried forward to the first quarters of year 2002.

Community Initiatives:

Il all councils visited, expenditure on community initiatives was pegged against 5%, and of all councils for which data were availed, 52.4% of the allocated funds were set to cater for community initiated projects and used according to the prescribed guidelines. Nearly nineteen percent (18.9%) of all councils had allocated funds to this category far above of 5% ceiling while 21.6% of the councils allocated their funds far below this benchmark.

Despite all the councils' plans showing a component of fundable community initiatives, no clear definition or specification was stated regarding what such community initiatives were and how the community would be organized to participate in whatever activities were planned to be performed. Reports from regional LG Officers indicated a general perception that local community members were not adequately sensitized on HSR and LGR and their responsibility to participate in cost-sharing programmes apart from not being informed well about and priority setting process under the national HBFS. Opinions obtained between September 2011 and May 2012 from interviews with officers in ten districts identified from different regions revealed that some of the local councillors elected by community members to represent them were unable to identify and present the real needs of the communities at various decision-making meetings while others deliberately kept on challenging any good ideas brought forward by CHMT members when the idea so presented seemed to be supported by the councillors representing the opposition political parties. This has delayed final decision on priorities to be passed for immediate implementation.

Discussion

Role of CHMTs' planning capacity under national HBFS on actual performance or achievements of CHMTs in health services:

The acknowledgement given by all council stakeholders about the distributed national HBFS guidelines and training opportunities on various health service matters having helped to enhance the capacity of councils to set realistic health priorities and achievable targets based on some objective criteria is good news. It is pleasing to see that most of the councils were able to achieve their targets for the planned activities except for the component of supportive health service supervision and having acknowledged the HBFS' advantages over the system used in the period beforehand. Nevertheless, reports on shortages of staff with proper accounting skills at CHMT levels leading some of the health plans and financial requests presented at higher levels being rejected are a revelation of the low/limited health financial planning and accounting capacity most of the LG councils have had. As the findings presented above reflect, there have been uncoordinated efforts in establishing council health plans between the office of the DEDs and CHMTs on one hand and between

the CHMTs and regional LGAs on the other hand. Meanwhile, the perceived to be too much binding national guidelines for health budgeting and financial utilisation was contrary to national decentralization by devolution policy hand in hand with the guidelines for council planning under the HBFS [28]. In relation to the latter guidelines, the government made clear that councils should use such guidelines just their guidance when setting priorities rather than being treated as rubber stamps, as long as they adhere to the stipulated budget ceilings and earmarking budgets to specified essential services/activities. Thus, there seems to have been either a misinterpretation of such guidelines which seemed to be unclear to the majority of the council officers when it came to the issue of setting realistic budgets in light of the budget ceilings specified to be adhered to for particular cost centres. However, those councils which were able to set either far below or above particular ceilings such as the community initiatives might have realized their autonomy to do so despite the existence of the government ceilings.

Meanwhile, variations in LG performances indicated by different levels of target achievements reflect possible differences in LG capacities in priority setting and actual implementation of the planned activities rather than merely differences in the amounts of the resources allocated. Uneven capacity and performance at LG levels seems to be acute, with imbalance between urban and rural councils. This has also been recognized by other evaluators in Tanzania [24], South Africa [3-4], Nigeria [35], Uganda [19] and other developing countries [1]. Moreover, the need for addressing it if realistic priorities, performance targets and indicators have to be set to allow fair evaluation processes has been identified by other experts [1].

Budget ceilings and criteria for allocation of Health Basket Funds:

Apparently, the only single criterion used by the government to allocate $ 0.5 per capita for the HBF was so crude in that it did not take into account such important factors as differences in the area coverage (sizes) of the councils, topography, vegetation cover, drainage pattern, climate, demographic dynamics including population mobility, and epidemiologic situations. As perceived by some of the council respondents, this resource allocation formula was inequitable and possibly contributed to the observed differences in the performance of different councils in the activities/areas highlighted by the data presented. Some urban districts such as those located in large cities like Dar es Salaam, Mwanza, Mbeya and Arusha had higher population density/size, to be able to be allocated more resources under the HBFS than most of rural councils. However, the latter councils generally cover larger areas, scattered population and are poorly equipped in terms of both health facility and transportation infrastructure. Therefore, these councils were likely to incur more expenses at least on fuel, vehicle maintenance than the urban based councils. The urban councils have tarmac roads and easier means of communication and telecommunication, a vibrant private health sector and other alternative sources of funding.

Moreover, the formula used to arrive at a US$0.5 per capita allocation of the health basket funds was not known if at all it existed. It was also not clear why health centres and dispensaries were initially allocated 10% of the budget each as compared to 15% of the budget allocated for the council hospital. This is strange since lower level facilities known as the first points contacted by majority of populations especially those living in rural areas and who are poor and more disadvantaged than the urban residents. Following these observations, the government issued new guidelines indicating that the formula used for setting the ceilings for resource allocation for medical and health supplies for primary health care facilities considered three elements, namely, council's population size, poverty index and council's under-five mortality rate [16].

Criteria used for setting and evaluating health performance targets:

As discussed above regarding unclear criteria at central level to set budget ceilings for various cost centres and the target of each council to achieve at least 80% of the planned activities, none of the councils studied gave details showing how the targets set for different health activities were arrived at. Apparently, the targets have been set presumptively through guesswork. Meanwhile, the mathematical formula indicated above as having been used to set an indicator for evaluating each of the individual council's health service activities is subject to debate. Future evaluation studies might need to review this and come up with more realistic decision criteria of formula, bearing in mind that debate has prevailed on how a true representative formula could be determined [7, 26].

Effects of late disbursements of health basket funds on CHMTs' performances:

Reports about late reception of approval of the funds requested both from central and district council levels reveal that CHMTs were still facing

administrative bureaucracy at higher levels which slowed their ability to perform of their duties. As noted from the present study, it sounds awkward for council leaders to unnecessarily delay to send information to health departments regarding the budget approved and funds sent for various health activities planned or to utilize the funds budgeted for particular health activities on other areas without giving information or seeking approval from the DMO's office. Following the experience noted from different districts/regions, the government recently gave a statement saying that "It should be noted that vehicles procured/allocated to the health sector are to be used strictly for health activities" [16]. It is expected that this stance would help to remove the reported malpractices and interferences.

Key study limitations

The survey was conducted by officers from NIMR who despite their personal impartiality nature as one of their job ethics, might not have been trusted by some respondents who believed that NIMR represented the MoH officers who might not be happy if they heard about particular matters at LG council or health facility level if such matters were perceived by the respondents to be sensitive. The assessment exercise was done immediately after some of the financial reforms (i.e. basket funding) have been introduced in the health system, allowing a short time for the candidates being evaluated to get used of the situation. Communities were not given chance to be heard of their experiences and opinions regarding HSR and priority settings issues in the LG councils. The data presented in the present paper needs might sound old if they were not supported with the updates from the documents reviewed from recent research and consultancies.

Conclusion and Policy Options

The HBF system has been well intentioned by the government and its allied development partners to encourage LGs focus on health problems in a multisectoral and comprehensive manner and strengthen their capacity in priority setting for health services. However, the present study observed some weaknesses at council levels as well as at central levels in relation to how priorities were being identified/set and budgeted for funds under the national HBFS. CHMTs still lacked the capacity required especially in the area of financial planning and accounting and this affect priority setting and performance reporting. National (government) HBFS guidelines were still misinterpreted partly to their seeming to be ambiguous and dictating LG councils to perform particular duties/activities. Councils that for one reason or another have not reached some of their predetermined performance targets were partly limited by inadequate and untimely budgetary allocations, leave alone the uncertainty in the indicators used for evaluating their performances in relation to other councils. All in all, the HBF has resulted into some acknowledged positive changes in the councils, and with time, the councils are likely to realize more remarkable progress. Lessons can be learned from success stories in the councils that seemed to have outstandingly performed to achieve their targets and those that failed to do achieve what they planned. The annual Joint Health Review for the MoH which involve external evaluators should be used as a stepping stone for the government to consider other criteria for allocating health budgets for councils. Meanwhile, we suggest the need for continued orientation of LG actors on how to exercise various managerial and administrative powers that would help to avoid or reduce unnecessary conflicts among themselves if the objectives have to be achieved. As other authors recommend [3-4, 36], greater attention should be given to the obstacles preventing the worst performing councils from performing as planned/expected. This is not only for Tanzania but also for other countries where SWAP and decentralization mechanisms are part of national policies.

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