SOAS University of London

Masawe, Cresencia Apolinary (2016) Between rhetoric and reality : decentralisation and reproductive health service delivery in rural Tanzania. PhD Thesis. SOAS, University of London

http://eprints.soas.ac.uk/23649

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this thesis, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. AUTHOR (year of submission) "Full thesis title", name of the School or Department, PhD Thesis, pagination.

BETWEEN RHETORIC AND REALITY: DECENTRALISATION AND REPRODUCTIVE HEALTH SERVICE DELIVERY IN RURAL TANZANIA

Cresencia Apolinary Masawe

Thesis submitted for the degree of PhD in Development Studies

2015

Department of Development Studies

SOAS, University of London

Declaration

I have read and understood the SOAS-University of London definition of plagiarism and cheating given in the Research Degrees Handbook. I, Cresencia Apolinary Masawe, declare that the study titled ***'Between Rhetoric and Reality: Decentralisation and Reproductive Health Service Delivery in Rural Tanzania'*** is my own work, and that I have acknowledged all results and quotations from the published or unpublished work of other people.

Signed:

Date resubmitted after revisions: 10 April, 2016.

Abstract

Tanzanian government has been implementing decentralisation policy based on its theoretical benefits of improving public services delivery. This study provides empirical examination of the implementation of health sector decentralisation, showing how interactions of fiscal, administrative and political decentralisation have had improved access to reproductive health services. A qualitative research design was adopted in which single case study was employed. Data were collected through using in-depth interviews, focus group discussions, observations and documentary analysis. Forty seven key informant participants and fourteen focus group discussions with different backgrounds and perspectives, observation of health facilities and analysis of fifty two key policy documents provide data base for the research. The findings suggest that to some extent decentralisation have granted local authorities with some fiscal, administrative and political power for health service delivery. However, its implementation was manipulated by central government acts, holding decentralised powers which jeopardise the benefits of decentralisation The scant evidence shows that the impact of decentralisation is far from reality as much of the efforts have been to improve democratic without considering the supportive environment under which health service delivery can be enhanced. The supportive environment such working referral system, skilled personnel is lacking; hence the efforts of decentralisation to improve reproductive health service delivery are intended to fail. It is therefore, unfair to charge decentralisation for inefficiencies performance of health system due to the presence of capacity shortfalls, increased financial dependence and weak institutional arrangements that obstruct service delivery. The findings also emphasise on significance of considering all dimensions of decentralisation process when investigating its effects on service delivery. This is because there is an additional positive result coming from the interaction of two or more decentralisation dimensions on health outcomes.

Acknowledgements

I would like to thank all people who took time and effort to help in the accomplishment of this study. I am indebted to my supervisor, Dr Michael Jennings, for his encouragement and tireless guidance from the early stages of my doctoral programme. Dr Jennings, you have repeatedly offered me the motivation to pursue my research since the day I sent an email to express my interest in the subject. Thank you very much for being a great supervisor and God bless you always. My sincere thanks go to Dr Laura Hammond and Dr Elena Fiddian-Qasmiyeh, for their constructive criticism and suggestions to improve the quality of this study. Special thanks also go to the School of Oriental and African Studies (SOAS), for the sponsorship of my PhD studies through the Mo Ibrahim programme. Special gratitude is also extended to Angelica Barchiera, who made everything possible during my stay in London. Thanks to my colleagues at Dar es Salaam University College of Education, for their moral and material support throughout my study.

My appreciation also extends to my family: my lovely parents Apolinary Masawe and Dora Masawe; my sisters Priscilla, Erasmina, Eva and Irene; my brothers Deodatus, Evans and Arnold; and my brother-in-law Koshuma. Thanks to all my friends in Dar es Salaam: Evaline Mcharo, Mathew Silas, Fortunata Chuwa, Caludia Tesha and Thaddeus Assey, you were source of support. Thanks to my nieces Jasmine and Precious-Rosaline, for the inspirational words 'aunt every day we are praying for you, we wish to attend your graduation in London '. I have had an opportunity to learn and benefited from my classmates Alinafe, Lucy, Maltide, Nina, Karim, Shalin, Maria, Hannah and Alex, thank you all.

I am extending my sincere thanks to the Consortium for Health Policy and System Analysis in Africa for supporting my participation in two short courses on health policy analysis at the University of the Western Cape, South Africa. The courses were important in broadening my knowledge on health systems research. My heartfelt thanks go to Professor Peter Kamuzora, for his encouragements to health policy research. Thanks to the Bergen Summer School 2010 for the scholarship to attend the short course on Research on Reproductive Health.

My sincere thanks go to the Director of National Institute for Medical Research in Tanzania, for granting ethical clearance for conducting this study. I am indebted to all the participants who

participated in interviews and focus group discussions, for providing their time. I am grateful to the Ministry of Health and Social Welfare, Prime Minister's Office-Regional administration and Local Government offices in Dodoma, for their cooperation during the data collection. My sincere thanks are also extended to Wilbert Maganga, Gerald Mwanilwa, Mr Mushi and DMO of the case study council, for their extraordinary support.

Lastly, I am grateful to late my friend, Bernadeta John Minja, who made my stay in Dodoma comfortable for the whole period my fieldwork. Unfortunately the road accident took her life on 3rd March 2013, but I will always cherish your kindness and good memories of you shall remain with me forever, may your soul continue to rest in peace.

Table of contents

Declaration ii

Abstract iii

Acknowledgements iv

Table of contents vi

List of tables xiii

List of Figures xv

List of photos xvi

Abbreviations for chapter 1 xvii

CHAPTER 1:INTRODUCTORY CHAPTER 1

1.1. The re-revival of decentralisation 1

1.2 The link between decentralisation and reproductive health 2

1.3 Tanzania's health sector decentralisation 6

1.4 Rationale and contribution of the research 7

1.5 Research objectives 8

1.5.1 Specific objectives of the study were to: 8

1.5.2 Research questions 8

1.5.3 Sub-question 9

1.6 Preliminary arguments 9

1.7. Definition of key concepts 10

1.8 Structure of the thesis 11

Abbreviation for chapter 2 15

CHAPTER 2:LITERATURE REVIEW 16

2.1 Introduction **16**

2.2 The Policy process **18**

2.2.1 Agenda setting **20**

2.2.2 Policy formulation **20**

2.2.3 Policy adoption **21**

2.2.4 Policy implementation **22**

2.3 Decentralisation and health system reforms **25**

2.3.1 Conceptualisation of decentralisation **26**

2.3.2 Decentralisation and service delivery: theory and evidence **28**

2.3 3 Decentralisation as a vehicle of the improved health service delivery **30**

2.3.4 Evidence of the impact of fiscal, administrative and political decentralisation on health outcomes **33**

2.4 Framework for analysing decentralisation and its impact on service delivery **40**

2.4.1 Principal-agent framework **40**

2.4.2 Conceptualising the relationship between decentralisation and its impact **43**

2.4.3 Accountability framework **45**

2.4.4 Framing the conceptual framework for the study **52**

Abbreviation for Chapter 3 ..... **56**

CHAPTER 3:HEALTH SECTOR REFORMS AND DECENTRALISATION POLICY IN TANZANIA 58

3.0 Introduction **58**

3.1 Health sector reform in developing countries **58**

3.1.1 The reform content **62**

3.1.2 The Reform context **63**

(i)Economic context **64**

(a)After independence 1961-1967 .... **64**

(b)The Arusha Declaration and after 1968-1978 .... **65**

(c)Recession period 1979-1985 .... **66**

(d) The reform period 1986-1995 .... **67**

(ii) Epidemiological context **70**

(iii)Political context **72**

3 1.2 Decentralisation in Tanzania: historical background **73**

(i) Colonial era **73**

(ii) The First Decade of Independence **73**

(iii) Decentralisation through deconcentration (1972-1982) **74**

(iv) Decentralisation devolution (1996+) **75**

3.2. The Structure of the public health in Tanzania **78**

3.3 Health system performance indicators **81**

3.3.1 Health financing **82**

3.3.2 Human resources for health **86**

3.3.3 Health governance **89**

3.4 Reproductive health performance in Tanzania: A brief overview **91**

3.4.1 Maternal mortality **92**

3.4.2 Proportion of pregnant women starting ANC before 16 weeks' gestation age **93**

3.4.3 Proportion of births attended in health facility **93**

3.4.4Contraceptive prevalence rate **94**

3.4.5 Percentage of HIV-positive women receiving ARVs **94**

3.4.7 Proportion of mothers who received two doses of intermittent treatment (IPT) **95**

3.4.8 Fertility trend **95**

3.5 Chapter discussion and conclusion 96

Abbreviations for Chapter 4 99

CHAPTER 4:RESEARCH METHODOLOGY 100

4.1 Introduction 100

4.2 The research paradigm underpinning the study 100

4.3 Research approach: Case study 102

4.3.1 Study setting 104

4.3.2 Ethical considerations 106

4.3.3 Piloting the research tools 108

4.3.4 Sampling procedures 109

4.4 Methods of data collection and analysis 111

4.4.1 In-depth interviews 112

4.4.2Focus group discussions (FGDs) 113

4.4.3 Observation 115

4.4.4 Documentary review 116

4.5 Data analysis and interpretation 117

4.6 Trustworthiness, credibility and transferability 118

4.7 Triangulation 119

4.8 Limitations and challenges of the study 122

Abbreviations for Chapter 5 124

CHAPTER 5:HEALTH SECTOR DECENTRALISATION IN TANZANIA: POLICY PROCESS AND VIEWS OF NATIONAL AND LOCAL ACTORS 126

5.1 Introduction 126

5.2 Policy-making processes in Tanzania 127

5.2.1 National policy making 128

5.2.2 Local Government-level policy process 130

5.3 Health reform policy process 131

5.3.1 Policy process of health sector decentralisation: Context and content 134

5.4 Objectives of health sector decentralisation 138

5.4.1 Objectives of health sector decentralisation: Views of national actors 139

5.4.2 Objectives of health sector decentralisation: Views of council managers 142

5.4.3 Objectives of health sector decentralisation: Views of services providers 147

5.4.4 Objectives of health sector decentralisation: Views of the service users 149

5.5 Chapter discussion and conclusion 153

Abbreviations for chapter 6 158

CHAPTER 6:DECENTRALISATION AND REPRODUCTIVE HEALTH SERVICE DELVIERY IN RURAL TANZANIA 160

6.0 Introduction 160

6.1 Fiscal decentralisation 162

6.1.1 Council health budget management and expenditure 163

6.1.2 Source of council health funding 165

(ii)Budget between layers of government 166

(iii)Council fiscal discretionary 169

6.2 Administrative decentralisation 176

6.2.1 Hiring and firing of council health personnel 177

6.2.2 Supervision 180

6.2.3 Training 182

6.2.4 Human resource performance management 188

6.3 Political decentralisation 188

6.3.1 Community participation 189

(i)Community participation through village assembly 190

(ii)Community participation through user representation..........193

(i)Views about functioning of community participation structures (HFCs) 196

6.3.2 Accountability in local health service delivery..........200

(i)Types of accountability in the local health care system..........201

(a)Accountability through elected representatives..........201

(b)Accountability through health committees 203

(ii)Acts of downward and upward accountability..........206

(a)Answerability of health facility committees..........211

(b)Scope and intensity of accountability..........212

6.4 Discussion and conclusion..........215

Abbreviations for Chapter 7..........220

CHAPTER 7:IMPLICATIONS OF DECENTRALISATION ON REPRODUCTIVE HEALTH CARE SERVICES IN RURAL TANZANIA 221

7.0 Introduction..........221

7.1 Council reproductive health services indicators 221

(i)Maternal mortality..........225

(ii)Family planning services 226

(iii)Ante-natal services..........229

(vi) Facility delivery 230

(iv)Sexually transmitted infections..........231

(v)Adolescent services..........232

7.2 Impact of decentralisation on reproductive health services..........234

7.2.1 Implications on human resources..........234

7.2.2 Implications on council finance..........239

7.2.3 Implications on local decision making and community participation **241**

7.3.3 Decentralisation and its impact on reproductive health services **243**

7.5 Chapter discussion and conclusion **247**

Abbreviations for Chapter 8... **253**

CHAPTER 8:SUMMARY AND CONCLUSIONS 254

8.1 Introduction.. **254**

8.2 How much power has transferred to local government authorities?................................ **255**

8.2.1 Fiscal decentralisation and council health care delivery... **257**

8.2.2 Administrative decentralisation and health care delivery **262**

8.2.3 Political decentralisation and community participation.. **264**

8.2.5 Implications of decentralisation on reproductive health outcomes............................... **266**

8.3 Conclusion of the study **268**

Bibliography **276**

List of Annexes **308**

List of tables

Table 2-1: Five stages of the policy process ... 19
Table 2-2:Factors facilitating health system decentralisation ... 24
Table 2-3: Forms of decentralisation according to public administration typology ... 27
Table 2-4: Advantage and disadvantages of decentralisation ... 31
Table 2-5: Bossert's Framework for Mapping Decision Space ... 42
Table 3-1: Macro-economic data from 1961 to 1967 ... 65
Table 3-2: Macro-economic from 1968-1978 ... 66
Table 3-3 Macro-economic data from 1968 to 1978 ... 67
Table 3-4: Macro-economic data from 1986 to 1995 ... 68
Table 3-5: Trends in the indicators of investment in health and health status in Tanzania ... 69
Table 3-6:Reproductive health indicators in Tanzania ... 72
Table 3-7 Sources of public health funding ... 84
Table 3-8. Health expenditure as share of total government expenditures ... 85
Table 3-9: Human resource for health per population in Tanzania ... 87
Table 4-1: Summary of activities for the research project ... 117
Table 5-1: Summary of the actors opinions on health decentralisation ... 153
Table 6-1: Overview of local government finances, (Tshs. billions) ... 163
Table 6-2: Sources of health funds for 125 LGAs ... 166
Table 6-3: Guidance on the use of Council health Resources ... 168
Table6-4: Local government health spending ... 169
Table 6-5: Council allocation source for the FY2011/2012 ... 170
Table 6-6: Council budget allocation among the cost centres FY 2011 ... 170
Table 6-7: Council allocation to health interventions ... 173
Table 6-8 : Council Budget allocation for MNCH FY 2011/2012 ... 174
Table 6-9: Council donor funding for MNCH FY 2011/2012 ... 175
Table 7-1: Number of health facilities offering reproductive health services ... 223
Table 7-2: Case council –MMR from 2007 to 2011 ... 225
Table 7-3: Council antenatal clinic attendances from 2007 to 2010 ... 230
Table 7-4: Case study council- Place of delivery 2007 -2010 ... 230
Table 7-5 Case study of council – pregnant women tested for STI infections 2007 to 2010 ... 232

Table 7-6: Implications of decentralisation for reproductive health services in Tanzania 247
Table 8-1: Decision space of Council decentralised functions 257
Table 8-2: Council health indicators 267

List of Figures

Figure 2-1: Traditional service delivery pipeline framework 45
Figure 2-2: The framework of accountability in a decentralised system 51
Figure 2-3: A simple framework for understanding decentralisation and its impact on health service delivery 53
Figure 3-1: Technical and administrative relations in a decentralised health sector 81
Figure 3-2: Allocation to priority sectors in Tanzania 82
Figure 3-3: Overall national health budget trend from the FY 2010/11 to 2013/14 83
Figure 3-4: Government expenditure on major sectors in billion Tanzanian shilling 85
Figure 3-5 Deficit of human resources in health, by region 88
Figure 3-6: Percentage of the available healthcare personnel in LGAs 89
Figure 4-1: Distribution of the key informants by sex 113
Figure 4-2: Distribution of the FGDs participant at different levels 115
Figure 4-3 Pattern of data collection and triangulation 121
Figure 6-1: Proportion of central and LGAs health budgets 167
Figure 6-2: Relationship between health governance structure and local government 209
Figure 7-1: Council trends in contraceptives use from 2007 to 2010 228

List of photos

Photo 6-1: Constructed facilities through collaboration between local government and communities 192
Photo 7-1: Conditions in the delivery rooms of some of the facility visited 238

Abbreviations for chapter 1

CHSBs	Council health services boards
HFCs	Health facility committees
ICPD	International Conference on Population and Development
ICPD-POA	International Conference on Population and Development Program of Action
LGAs	Government authorities
MoH	Ministry of Health
RH	Reproductive health
RHS	Reproductive health Services
SOAS	School of Oriental and African Studies
URT	United Republic of Tanzania
WHO	World Health Organisation

CHAPTER 1

INTRODUCTORY CHAPTER

1.1. The re-revival of decentralisation

Decentralisation has been practiced in many countries across the globe for many decades. Since 1917, African countries have experimented with decentralisation of responsibilities from the central government to sub-national level (Ribot, 2002). Democratisation movements of the 1990s led to the revitalisation efforts towards decentralisation. The enthusiasm for decentralisation was grounded in the argument that it can improve public service delivery through matching public resources with local needs (Cabral, 2011, Langran, 2011, Conyers, 2007, Robinson, 2007, Green and Collins, 1994).International organisations, in particular the World Bank, have praised decentralisation efforts as a means of reducing inefficiencies of the central authorities which were linked with various forms of corruption, patronage, fraud and mismanagement of public resources (Collins et al., 2002, Litvack et al., 1998, World-Bank, 2000a). In Africa, decentralisation was therefore seen as a means to disempower central authorities that lack incentives to respond to the local needs (Shah, 1998).

Decentralisation of health systems is the common organisational change under health sector reform. The forms of decentralisation that are pursued include deconcentration, delegation and devolution (Mills, 1990). However, devolution is the common form of decentralisation frequently opted by many governments as means to deliver public health services. It entails the transfer of decision-making, planning (political), budgeting (financial), management, and resource allocation (administrative), of health care services from the central authorities to local government authorities (Mills, 1990). It is argued that by devolving power, authority, services and resources to the lower levels of government and involving local communities in planning, a sense of local ownership and participation is established thus leading to more sustainable health systems (World-Bank, 1993). However, devolution is not an all-or-nothing proposal central authorities might retain some of the responsibilities(Wunch, 2001), for example, purchasing

drugs, commodities including contraceptives, to negotiate for better prices, while local authorities retain functions for the management of personnel and service delivery.

The basic argument for health sector decentralisation is that local governments are better placed to respond to local needs (Beall, 2005). The logic is that by making the delivery of health services part of local administrators' responsibilities, they are allowed greater flexibility, efficiency, and accountability in resource use. Local control also enhances the potential for community involvement and accountability. When preferences for public goods differ across localities, decentralisation can allow benefit gains to be realised by providing local decision makers with the autonomy to alter the supply of public goods to better meet specific preferences (Ensor and Ronoh, 2005). These preferences are also more likely to be revealed by planners who are closer, and presumably, more accountable to constituents than centralised planners (Akin et al., 2004). Local control may also help cultivate community participation and improve accountability in health care delivery. In addition, since public health needs differ across communities, decentralisation can allow for better matching of the resources with the local situations. This way, local choices are more likely to be realised (Hutchinson and LaFond, 2004, Ensor and Ronoh, 2005).

An important question, though, is; what evidence exists that this is the reality? It is one thing to theorise decentralisation might present opportunities to improve community participation, accountability, and ultimately health outcomes. But does this fact materialise? The current study aims to provide the empirical evidence towards answering this question by examining what is happening on the ground.

1.2 The link between decentralisation and reproductive health

Prior to the International Conference on Population and Development (ICPD) in 1994, many countries had focused on population policies and programs for reduction of fertility. Health

reforms were challenged by the narrow focus on family planning services (Dixon-Mueller, 1993). This approach failed to recognise interpersonal dynamics between service providers and clients, and between decentralisation managers and service providers (Hardee and Yount, 1995). The ICPD-Program of Action (POA) adopted marks a shift towards recognising women's health rights, including the rights to control over their bodies, to privacy with an emphasis on privacy to access right information and choices (Aitken, 1999). Countries were called on to shift their focus from activities that effect population growth to more people-centred reproductive health rights and health needs. Governments pledged universal access to comprehensive reproductive health care including family planning information and services for women, men and adolescents by year 2015. It was suggested that RHS should be provided within the framework of Primary Health Care (PHC) (Lubben et al., 2002, Aitken, 1998).

Theoretically, the ICPD agenda and decentralisation have a lot in common (Nanda, 2000). Both are reform initiatives and conceptually share concerns regarding user participation, equity and PHC development (Langer et al., 2000). The ICPD recommends that governments promote community participation in the delivery of reproductive health services (RHS) by employing strategies such as decentralisation (Hardee and Smith, 2000). It is argued that the ICPD agenda cannot be effectively implemented without the existence of well-functioning services at all levels (Krasovec and Shaw, 2000). The risk is that, while decentralisation efforts focus on prevailing issues like re-organisation of services or financing, specific technical efforts for reproductive health can be neglected. Some of the successful vertical programs such as family planning could be compromised (Lubben et al., 2002).

The ICPD-POA calls for a multi-sectoral approach demands for the substantial human and financial resources. This has been a challenge as many of African health systems as most of the health sectors are extremely underfunded (Merrick, 1999). In addition to their obligations to the ICPD, most of the countries are simultaneously implementing health reforms that need investments in physical infrastructure and human resources. In addition, many of these countries

are facing the additional burden of the impact of the HIV/AIDS (Campbell White et al., 2006, Greene and Merrick, 2005).

Following the ICPD, most of the countries readjusted their population policies and family planning programs to reflect the ICPD objectives (Ravindran and Helen, 2005). However, most of this is merely rhetoric as neither governments nor international organisations have shown commitment to reproductive health which means that progress towards universal access to reproductive health has been slower than expected (Lozano et al., 2011). This is part due, to insufficient resources allocated for reproductive health interventions. Although, since the 2000s, overall funding for health care has increased in most countries, there are still imbalances in external donor expenditures across health sector programs. Funding and attention to RH has been reduced due to shift of donor's priorities towards disease treatment such HIV/AIDS, Malaria and Tuberculosis (Avelino et al., 2013). This shift has affected reproductive health services provided by both public and private sector institutions (Ravindran, 2005). For instance between 2002 and 2006, 53% of all health aid provided directly to developing countries was dedicated to the control and treatment of the HIV/AIDS, malaria and tuberculosis. The remaining assistance, about $2.25 per capita per year, is spent on all other health services, including family planning and maternal and child health (Avelino et al., 2013).

One of the shortcomings of healthcare systems is that many of them are unable to meet health needs of the entire population in particular those related to sexual and reproductive health. The primary concern in many public health systems is the existence of disparities in access to, and utilisation of health services and information, as well as imbalances in the available services and lack of responsiveness to women's expectations (Merrick, 2005). Reproductive health related problems have continued to be a major public health problem in many of the developing countries, accounting for 40% of the total global disease burden. Pregnancies and the consequences of childbirth remain the leading causes of death and disability among women (Lozano et al., 2012). Many women lack the means to prevent unwanted pregnancies, as well as the ability to prevent, and/or address the complications related to pregnancy.

Under decentralisation, local governments are playing a key role in setting health priorities and allocating health resources. This is likely to have had an impact on the delivery of the reproductive health care services. The design and implementation of both reproductive health and decentralisation reforms are likely to present both barriers and opportunities, or the one or the other, because of the way services were delivered prior to reform and after the reform (Campbell White et al., 2006). Though this subject has been debated in various studies including (Krasovec and Shaw, 2000, Birungi et al., 2006, Ramanathan et al., 2004, Mishtal, 2010, Berer, 2003), there is still little information on the relative progress of the countries that are implementing these two agendas, especially in light of potential synergies and conflicts between them. It has been noted that little is known about how decentralisation and health sector reforms are impacting on health service delivery (Berer, 2002).

The theoretical benefits of decentralisation are well established. However, large gaps exist with regard to the empirical evidence about the impact of decentralisation, in particular concerning its effects on reproductive health outcomes (WHO, 2004). The question of whether decentralisation can deliver the ICPD goals without adverse effects on reproductive health services is a major concern (Kaufman, 2000, Kaufman, 2002, Standing, 2002). However, there is little evidence concerning the effect of decentralisation on reproductive health. The relative lack of literature on this subject is due to the lack of specific tools for analysis, poor documentation of the reform initiatives and absence of mechanisms to monitor the impacts on health outcomes (Standing, 2002). Thus, analyses of the interactions between the decentralisation and ICPD initiatives are needed to improve the documentation and monitoring processes and outcomes. It is clear that very little progress has been made with respect to fulfilling the ICPD goals, in particular in Africa. In relation to Tanzania specifically, the key question is; how have decentralisations obstructed or facilitated the realisation of the ICPD goals ratified by Tanzanian government?

1.3 Tanzania's health sector decentralisation

Tanzania had taken a series of policy measures with the objective of improving service delivery. Decentralisation means the transfer of power for decision making, functional responsibilities and resources from central authorities to the local government authorities (LGAs) Decentralisation is pursued due to its potential benefits to enhance good governance, promote socio-economic development and reduction of poverty (URT, 1998c). The form of decentralisation adopted by the Tanzanian Government is "decentralisation by devolution" (D by D) (URT, 1998:13).

The Ministry of Health and Social Welfare (MoHSW) is one of the earliest sectors that took initiatives to implement decentralisation. The MoHSW started to devolve many of the non-core health functions to the LGAs in 1997, before the launching of the Local Government Reform (LGRP) in 2000 which granted district councils the power and authority to manage local health facilities and allocate local funds for council health staff salaries, and purchase of supplies and equipment. The MoHSW headquarters is responsible for making and monitoring health policies. However, the thrust of the government in every change made since independence has been equity in the provision of health services.

The National Health Policy (1990; revised 2003) highlighted the need for decentralisation in the health sector. The devolved power is aimed at improving transparency, accountability and legitimacy of the local health service through increased user participation in decision making. To support greater community participation, the MoHSW created governance structures both at council and community levels. Council Health Services Boards (CHSBs) were established at council level while Health Facility Committees (HFCs) were set up at lower levels. Council hospitals provide health services under supervision of CHSBs while health centres and dispensaries are supervised and managed by HFCs. Both were established as democratic organs with legal status to oversee the provision of health services (URT, 2001b). It was expected that committees and boards would lead to an increase in user representation and accountability. The thesis investigates whether decentralisation is creating institutional arrangements that transfer power and resources to downwardly accountable local actors who can deliver local services

efficiently. It will also pinpoint the extent to which local decision-making and resources are likely to respond to local health needs.

1.4 Rationale and contribution of the research

The rationale for this study emanates from the researcher's interest to examine whether, and how, the current decentralisation process has been implemented and its effect on public health service delivery. The provision of quality health care has continued to be one of the health system challenges in developing countries. A critical question is; what type of reforms should developing countries undertake in order to improve health service delivery and thereby boost the health status of the population? Decentralisation of authority to local government is one of the reforms within wider pubic reforms aimed at improving service delivery. Despite the fact that most countries pursue decentralisation with goals other than political and technical gains and improvement of service delivery, this has been one of the justifications for decentralisation provided by experts.

The implementation of decentralisation in Tanzania is slow and thus unable to bring about the expected outcomes, despite the political will of the government expressed in policy documents. After various attempts in the past by the government to reform the health system, overall reproductive health indicators remain low, although there are some little improvements. One of the reasons for this failure is inadequate implementation of pro-poor policies. This begs the question; where does the problem lie? Is it at policy or implementation level? Or, is it a content problem? Understanding the policy process is as important as evaluating the content of the policies when judging the outcomes (Gilson et al., 1994). The current study analyses various subjects related to policy process, linking decentralisation policy formulation to its implementation at both national and local levels. Thus, the study has a practical purpose to inform the implementation status of health decentralisation policy in Tanzania.

The study is also relevant from an academic perspective and it will contribute to the three key issues in the literature. The first relates to theoretical and empirical debate about decentralisation.

Even though there is general consensus that health sector decentralisation should be carried out by devolving political, administrative and financial aspects, there is limited evidence about where it has worked. Secondly, it will contribute to the literature that links decentralisation and its impacts on service delivery. Despite a great body of literature on the impact of decentralisation on government growth and macro-economic stability, only a few studies have evaluated the effects of decentralisation on health service delivery, let alone reproductive health.

Thirdly, the existing studies on decentralisation have analysed the impact of decentralisation on public service with regard to one dimension only (fiscal or political or administrative), rather than all three concurrently. While this approach has the advantage of presenting a more focused and detailed view, it tends to fall short in evaluating the effect of the decentralisation process as whole on a particular service. Analysing the interaction of all three dimensions of decentralisation in the same study may be able to produce stronger evidence about the relationship between decentralisation and access to health services and hence provide a stronger basis for providing policy advice in the future.

1.5 Research objectives

The general objective of this study was to understand the impact of decentralisation on health services delivery, in particular on reproductive health.

1.5.1 Specific objectives of the study were to:

(i) understand the implementation process of health sector decentralisation;
(ii) analyse actors' knowledge of decentralisation and how it impacts on implementation; and
(iii) assess the impact of three dimensions of decentralisation on access to and utilisation of reproductive health services.

1.5.2 Research questions

Specifically, the study sought to answer the following questions:

(i) What approaches and actions were taken to implement health sector decentralisation?
(ii) How does the actors' knowledge of decentralisation affect its implementation?

(iii) How do the three dimensions of decentralisation affect health services delivery especially reproductive health service?

1.5.3 Sub-question

(i) How did national and local actors view the effect of decentralisation on reproductive health services delivery?

(i) To what extent do decentralisation principles inform the design and implementation of reproductive health policies?

(iii) What do council indicators on reproductive health services explain about the relationship between decentralisation and services delivery?

Both questions and sub-questions guided the research process. These questions were used in the development of the various research tools, including guides for the in-depth interviews and focus group discussions as well to formulate themes for analysing documents. Lastly, the questions assisted in the process of analysing data and writing the thesis.

1.6 Preliminary arguments

This thesis is built on several assumptions. Firstly, that decentralisation is not an end in itself and not a panacea for health system problems, but a work in progress in reaching better health outcomes including improved reproductive health services and accountability for better quality of health of Tanzanians. This implies that decentralisation can be an important way of catalysing meaningful change process aimed at improving health outcomes including those of the reproductive health.

Secondly, improved health service delivery is based on a triangulation of the policy process, institutions and finances. However, institutional actors take a significant role in filling the policy

and financial gaps in attending health service delivery through local government authorities. The reasons why institutional actors are important are; (i) local actors such as councils play key role in service delivery; (ii) local institutions' demands for accountability from the different actors, when tapped, can deliver positive outcomes.

Based on these assumptions, I argued that the causes of the prevailing problems of the health sector, with respect to improved health outcomes for which the decentralisation policy is designed, lie in the nature of the policy and its design. I argue that there is a democratic deficit in the policy process and health sector in particular. Therefore, decentralisation has been more readily captured by the elites and it expands their ideas and interests through public policies. This means that the alliance of health bureaucrats and professionals, donors, political and NGO professionals influences policy goals and strategies by manipulating the democratic deficit of the government. As a result, when a policy is implemented, it replicates these interests, ideas and unequal power relations which lead to continued marginalisation of the intended beneficiaries.

These arguments are developed based on three grounds namely, policy process, policy actors and policy context. In other words, the impact of the decentralisation reform, or more precisely, the benefits of decentralisation, depend on the nature of the processes through which policies are formulated and implemented, the nature of the key actors who make and implement the decisions, and the socio-political context in which policies are formulated and implemented.

1.7. Definition of key concepts

In developing the study, the following key concepts were defined as follows to guide the study process:

Devolution: In this study democratic decentralisation/devolution refers to an act in which the central levels of government transfer some authority and resources to the elected local councils or local governments that are then downwardly accountable to the citizens within their

jurisdiction or geographical locations. The local residents elect their own leaders named councillors, through regular elections and these representatives exercise the oversight role of the council bureaucrats.

Actor: denotes a person, a group of people or organisation that performs any kind of action in relation to the public policies. In the health care system, three sets of actors have been identified namely; state actors, service providers and service users (WHO, 2000). In this thesis, the WHO categories of actors are used to study the decentralisation process in rural Tanzania.

Context: refers to variables in the social, political, economic, national and local setting which have a significant impact on decentralisation and reproductive health service delivery.

Capacity: refers to the skills of the actors in the formulation, adoption and implementation of the decentralisation policy.

Participation: refers to meaningful involvement and contribution of the policy makers, service providers, and service users to translate decentralisation policy objectives into practices.

Accountability: refers to the ability of citizens to sanction leaders and service providers in case of abuse. This includes the responsibility of the elected or appointed leaders to act in the interest of the local populations rather than other groups such as central bureaucrats.

Policy process: refers to the process by which the decentralisation policy was designed, the nature of stakeholder involvement and the way content was formulated. It also involves the translation of the decentralisation policies and plans into reality in producing the desired outcomes envisioned in the policy implementation.

1.8 Structure of the thesis

This study is presented in eight chapters. **Chapter 1** provides a general introduction to the study and presents a brief introduction to the research problem. The discussion then moves to locate the research problem in the global situation and links it to the Tanzanian context. A key argument supporting decentralisation reform is that it can improve public service delivery by

matching resources with local needs. Lastly, the chapter discusses the aims and objectives of the study and ends with an introduction of the key concepts that are relevant to the research problem.

Chapter 2 discusses the relevant literature of health system decentralisation. Specifically, the chapter lays down the basis for the analytical framework to examine decentralisation and its impact on health service delivery in the subsequent chapter. It begins with a discussion of the policy processes in relation to decentralisation. Thereafter relevant literature on fiscal, administrative and political decentralisation is presented, as well as its impact on health service delivery, with a focus on reproductive health. Finally, a conceptual framework for examining the relationship between decentralisation and its impact is presented. The study adapted a service delivery framework from the World Bank that incorporates accountability in the analysis of changes in health care-delivery resulting from decentralisation.

Chapter 3 presents the contextual factors that affect the health system in Tanzania. In doing so, a historical background is provided of the health system reforms and how decentralisation fits into the current reform to provide a clear link between the past and current reforms. The chapter also discusses the setting of the health services delivery system: its structure, the function of the line ministries, the national health budget, human resources and the role of heath governance in the provision of health services. The chapter then summarises the selected reproductive health indictors to understand the current status. Then, the relationship between decentralisation and its impact on reproductive health delivery is presented.

Chapter 4 presents the research methodology that was employed to generate answers to the research questions of the study. The chapter explains the study site, research design, methods and procedures for data collection and analysis. Ethical clearance to carry out this study was obtained from the School of Oriental and African Studies (SOAS). In Tanzania the ethical clearance was granted by the National Institute for Medical Research (NIMRI). The clearance letters are attached as appendices. The trustworthiness of the data collected through the qualitative case study research design is presented.

Chapter 5 presents the status of the implementation of health decentralisation in Tanzania. It examine the ways in which knowledge of various policy actors from national and local policy makers, council managers, service providers and users of the objectives of decentralisation affect its implementation. The chapter is organised into three main sections; a brief overview of public policy-making process in Tanzania is provided at the beginning in order to enable the reader to link the policy objectives to the practice in the subsequent chapters. The second section presents views of national and local actors in the objectives of decentralisation policy. And the third section presents discussion of the findings and the conclusion.

Chapter 6 presents an analysis of fiscal, administrative and political decentralisation and its effect on health services. The study found that, decentralisation has been happened. Council health managers had some discretionary powers for planning and budgeting, but financial control remains centralised. Because of inadequate funds allocated to the health sector, reproductive health interventions suffered, as they have to compete with other interventions. With regard to administrative decentralisation, councils have limited power over council health personnel. Furthermore, a lack of skilled healthcare personnel has been one of the barriers to communities to access services. Political decentralisation found that health services have been implemented through non-participatory processes, as health committees and elected councillors had limited power to influence health planning priorities. The findings presented criticise the planning process from a technical perspective. It was evident that the absence of adequate information on many sexual and reproductive health problems resulted in an underestimation of the disease burden caused by reproductive health conditions. The lack of data to establish the disease burden caused by reproductive health conditions has made RHS intervention invisible in health plans. These aspects marginalise benefits of decentralisation to improve health care delivery, as well as the ability to respond to local health needs.

Chapter 7 focuses on the district case base analysis, illustration the important changes brought by the three dimensions of decentralisation. The chapter first presents a description of key reproductive health indicators of the studied council, followed by views of national and local stakeholders on the effect of the fiscal, administrative and political decentralisation on health

care delivery including those RHS. Then, analysis of the impact of decentralisation is presented, followed by discussion and conclusion.

Chapter 8 is the conclusion to the study which provides a summary of the previous chapters and elaborates on all the key points that has emerged from the study. This chapter focuses on two main areas: firstly it offers a critical examination of the three dimensions of decentralisation in Tanzania. Secondly it examines the impact of decentralisation on reproductive health by giving some reflections on prospects of decentralisation. And also briefly examines challenges for the implementation of the health sector decentralisation

Abbreviation for chapter 2

CG	Central government
GDP	Gross domestic product
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune-deficiency Syndrome
HSR	Health system reforms
ICPD-POA	International Conference on Population and Development -Program of Action
ICPD	International Conference on Population and Development
LGAs	Local government authorities
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NGOs	Non-government organisations
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office for Regional and Local Government
POA	Program of action
PRS	Poverty reduction strategies
RH	Reproductive health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
WB	World Bank
WHO	World Health Organisation
ZNFPC	Zimbabwe's National Family Planning Council

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Literature on decentralisation and its effect on socio-economic variables are enormous. This chapter looks at the existing literature about the relationship between decentralisation and service delivery, with a focus on reproductive health care. More precisely, the chapter lays the foundation for the analytical framework to examine the above relationship in the subsequent chapters. The chapter starts with a discussion about theoretical frameworks for analysing public policy processes. Then it discusses general literature on decentralisation and services delivery, followed by specific literature on fiscal, political and administrative decentralisation and their effects on access and utilisation of reproductive health services.

The literature reviewed has noted that, decentralisation brought challenges and opportunities for health services delivery. However the outcomes depend on the policy design and political incentives for the central elites and their relations with local actors. In developing countries, decentralisation has been driven by political motivations rather than its theoretical benefits. It was found that decentralisation has been used to reinforce a coalition of central bureaucrats with local elites to strengthen power, instead of executing pro-poor polices. Moreover, institutional weaknesses and fiscal restrictions have limited the success of decentralisation. Limited evidence shows that decentralisation has expanded resources for health service delivery, in particular reproductive health services. Thus, the argument drawn from this chapter is that accountability is undermined by decentralisation processes; hence its impact on health service delivery is compromised.

This chapter is divided into three main sections based on the following aspects. The first section analyses public policy processes in relation to formulation and implementation. The section discusses concepts and forms of decentralisation and how it is related to the service delivery in

particular health services. The third section presents frameworks available in the literature for analysing decentralisation reforms and a conceptual framework that guides this study.

2.2 The Policy process

The policy process refers to the ways in which policies are originated, formulated, negotiated, communicated, implemented and evaluated in different socio-economic environments(Buse et al., 2005). It involves interactions of actors who are influenced by the political, economic and historical contexts in which policies are formulated and implemented (Walt, 1996, Sutton, 1990). In the literature there is no single definition of policy; authors have given various explanations which will be discussed below. However, policy passes through four different stages (Sabatier, 1999).

A traditional mode looks at policy as linear with a causal-effect relationship(Sabatier, 1990). Kingdon (1984:22) defines policy as a 'set of interrelated decisions taken by political actors or groups of actors concerning social goals and the means of achieving them. On the other hand Hammer & Berman (1995) define policy from the perspective of its content while Baker (1996) and Walt &Gilson (1994) define policy as the interplay between institutions, interests and ideas involving a number of decisions made through consensus. Last but not least, Dye (2004:18) argues that public policy is whatever government chooses 'to do or not to do'. It is a 'purposive course of action followed by an actor in dealing with a problem or matter of concern' (Anderson, 2006:8).

The policy process involves a series of activities or processes that occur within the political system hence it requires participation, coordination and negotiation among actors (Hammer and Berman, 1995, Kingdon, 1984). A policy can be found in the form of declaration of goals, made through authoritative decisions or budget speeches to deal with a given problem (Baker, 1996, Gilson and Walt, 1994, Sapru, 2004).The consequence of the policy process is that policy making happens in identifiable stages that can be examined separately (Anderson, 2006). There are five mentioned stages of public policy processes: policy agenda, policy formulation, policy adoption, policy implementation and policy evaluation (Anderson, 2006, Walt, 1996). These are illustrated in the table 2-1.

2-1: Five stages of the policy process				
Policy agenda	Policy Formulation	Policy adoption	Policy implementation	Policy evaluation
Problem that receives public officials' attention	Development of acceptable action for the public issues	Development of policy proposal	Translation of policy into practice by government	Efforts by government to determine policy effectiveness

Source: Anderson, 2006

Dye (2004) suggested six stages of the policy process :(i) problem identification (ii) agenda setting (iii) formulation, (iv) policy legislation (v) policy implementation and (vi) evaluation. In understanding policy outcomes literature, policy contents, political and technical factors are important (Agyepong and Adjei, 2008, Grindle and Thomas, 1991, Gilson et al., 1994). Arguably, on analysing the changes of a given policy, three approaches have been suggested to understand the dimensions of policy change. These include the policy cycle approach, the organisational approach and the policy change and learning model (Sapru, 2004). One of the mentioned reasons for policy change could be changes that have occurred in previous policies. Usually, new policy comes from existing policies or emerges from on-going programs. Therefore, a policy change occurs in the context of policy succession and in a domain between innovation and maintenance and policy termination (Hogwood and Peters, 1983). It is important to understand policy analysis from the perspectives of what policies are, why government pursues such policies and what their outcomes are (Ramji, 2009). Policy analysis is usually about 'who gets what' in policies and more importantly, 'why' and 'what' difference does it makes (Dye, 2004).

The literature identified a number of typologies in reference to public policy which can be either procedural or substantive Anderson (2006); Dye (2004). Likewise, literature offers a number of analytical approaches to study public policy process Anderson (2006); Dye (2004); Sapru, 2004). In public administration, Dye (2004) has proposed eight different analytical models to study policy: the institutional model, the process model, the rationale model, the incremental model, the group theory, the elite model, the public choice model and game theory(Dye, 2004). Both

operational research and system analysis could view it as synonymous for policy analysis. Under these settings policy analysis includes: identification of objectives, specification of alternatives, recommendations on policy actions, monitoring of policy outcomes and the evaluation of policy performance (Sapru, 2004). However, the commonly used analytical framework to explain policy process is through its five stages: agenda setting, policy formulation, adoption, implementation and evaluation (Anderson, 2006, Walt, 1996).

2.2.1 Agenda setting

Agenda setting explains how a problem becomes an agenda, well-articulated by several factors (Walt and Gilson, 1994, Kingdon, 2003, Sapru, 2004, Buse et al., 2005). When an issue and/or problem have received high feasibility, high legitimacy and high support it can become a policy agenda (Kingdon, 2003). Agenda setting is influenced by three independent streams of activities: (i) problem stream, (ii) policy stream and (iii) political stream. Each stream has its own process and a ‘policy window’ that allows some issue and problem to receive government attention(Kingdon, 2003).Then the agenda turns into an issue for debate and enters into the second phase of the policy process that is policy formulation.

2.2.2 Policy formulation

Public policies are formulated to address a certain problem (Walt, 1996). Policy formulation involves identification of various characteristics and dimensions of the societal problem that stimulate government actions (Anderson, 2006). The process seeks relevant and acceptable action in dealing with problems that are on the public agenda. Policy formulation is more of a political process which is guided by special groups of policy formulators (parliamentarians, government agencies, legislators or interest groups) which Dye (2004) refers to as policy ‘think tanks’

Actors who are involved in drafting the policy paperwork can facilitate other processes like the adoption of policy. There is a possibility that an issue will never leave agenda setting due to the influence of some of the actors that want to maintain the status quo (Ramji, 2009). Thus, lobbying coalition building is important during selection of policy proposals (Kingdon, 1995) and policy networks become an important element in describing the relationship of participants (Marsh, 1998). Functional activities are then blended into policy adoption whereby a policy plan, legitimacy and budget allocation are developed to create a program to address a given problem (Burgess, 2004).

Policy formulation is technical processes, which involve a number of activities, such as deciding on what to do about the problem and drafting administrative and legal measures, to facilitate policy adoption and implementation according to the agreed values. Anderson (2006) proposes several questions which policy makers should be able to answer: Is the proposal technically sound? Is it directed at the causes of the problem? To what extent will it resolve or lessen the problem? Are its budgetary costs reasonable? Is the proposal politically acceptable? Can it win the needed support of legislature or other public officials? If the proposal becomes law, will it be acceptable to the public?

2.2.3 Policy adoption

Policy adoption is also called the decision-making process. It gives the direction and content to policy action undertaken by public officials. A policy decision involves actions made by specific officials who can accept or reject suggested policy alternatives (Dye, 2004). For this reason, the unbiased and practical decisions of policy makers are important when the draft of policy is presented for comments before final approval. The process involves identification of problems, seeking possible alternatives and making selection of an alternative action (Dye, 2004). Comments from relevant experts and people involved during the development of policy are important in securing appropriate legal and other guidance including compliance with existing government laws. Thus policy proposals can be approved or disapproved, or referred for further discussion and future actions (Sapru, 2004).

2.2.4 Policy implementation

After adoption, implementation forms another important stage that involves putting policies into practice. It involves planned activities and strategies that should be clearly defined (Dye, 2004). Walt and Gilson (1994) regard implementation as a management and administrative affair in which the status measured by the extent to which policy action have achieved the stated objectives (Sabatier and Jenkins-Smith, 1993, Sabatier, 1986). The implementation process therefore, determines the success and/or failure of the policy. However, evidence shows that policy outcomes are comparatively different from policy intention (Grindle and Thomas, 1991).

In developing countries, policy implementation is characterised by numerous weaknesses and failures (Falcone, 1980). For instance policy elites usually initiate a policy agenda and formulate health policies without recognising important problems (WHO, 1998b, Green et al., 2001). As a result many health problems do not enter into the policy agenda (Lee et al., 1998). In some countries, policymakers might deny the existence of serious health problems or the multiple factors determining them (Hogwood& Gunn, 1984).

Implementation issues and challenge

Policy implementation passes through a number of barriers, usually resulting from lack of pre-conditions which might enable effective implementation (Hogwood and Gunn, 1984). Sabatier (1991) suggests five pre-conditions for the successful policy implementation: clear policy directives, sound managerial and technical skills, active support by officials, policy not affected by new policies set by government and the socio-economic conditions of the citizens (Sabatier, 1991). It is also suggested that for public policy to be real, two conditions must be met. Firstly, policy should be able to cause the effect but secondly it should be carried out as intended (Ramji, 2009). The first deals with the policy design, while the latter focuses on policy implementation. Normally policies are developed within the highest bureaucratic institutional levels with a number of the coordination points. Thus, the way in which policy is implemented in each responsible institution is important for its achievements.

Policy implementation passes through a number of processes, and organised by various institutions. Therefore, how policy is implemented in each responsible institution is important in the realisation of its objectives. Since policies are usually carried out through a ladder of bureaucratic agencies and coordination points they are likely to be exposed to implementation failures (Ratanawijitrasin et al., 2001). The common identified policy implementation failures in Africa include inconsistent policy objectives, weak institutional capacity, poor economic conditions, poor sector development and the poor information sharing among the layers of government (Leighton, 1996, Ayuk and Maroua, 2007).

It is suggested that policy performance evaluation should examine the results of the policy content and implementation. When policy fails to achieve its goals, the failure could result from either poor design or the way in which policy was implemented (WHO, 1998a, Ramji, 2009). Failure to detect which of the two factors led to poor policy performance makes it difficult to judge whether a particular policy is ineffective or not. Analysing how policy was designed and implemented generates evidence that is important in determining outcomes (Ratanawijitrasin et al., 2001). Although performance is vital, yet, in itself, it is not sufficient to understand if policy achieve what were intended to accomplish (Shiffman and Wu, 2003).

In developing countries like Tanzania, the relationship and interaction between policy makers and executives influence the implementation process considerably and might change policy goals and outcomes (Juma and Clark, 1995, Mukandala, 1992, Ayuk and Maroua, 2007). Thus, for the successful implementation of policy; context plays a key role in shaping policy outcomes (Collins et al., 2003, Reich, 1995, Reichenbach, 2002, Frenk, 1995, Saltman, 1997). Contextual factors that influence the implementation of health decentralisation policy include: (i) political and bureaucratic commitments, (ii) Capacity,(iii) existence of effective channels of community participation and accountability, and (iv) local control over resources to facilitate appropriate use of resources to match with local health needs (Saltman and Bankauskaite, 2006).

Policy implementation is not straight forward; there are challenges that affect successful implementation of policies. For the case of the health decentralisation some of the challenges it include such as:(i) mismatch between authority and responsibilities (ii) tensions and conflicts among the objectives (iii) capacity gaps (iv) tensions between vertical and horizontal integration and (v) political and process dimensions (Brinkerhoff and Leighton, 2002). In Brazil Collins et al., (2000) has identified three major challenges to enable a successful decentralisation process namely the policy making process, equity and the role of the state (Collins et al., 2000). In Nepal it was noted that lack of adequate legislation, poor human resource management, weak financial sources, lack of incentive system and lack of competencies at lower level undermine the implementation of health sector decentralisation (Collins et al., 2003). In Sub-Saharan Africa, Gilson and Travis (1997) have identified pre-conditions for effective implementation of the health decentralisation. These are summarised in table 2-2. However, these conditions are rarely met in most developing countries.

Table 2-2: Factors facilitating health system decentralisation

Factor	Comments
Consensus building	Highlights the importance of surveying the terrain and identifying factors in terms of the opponents and proponents of the reform.
Regulatory framework	Legislation and clear guidelines defining roles and responsibilities are useful.
Policy champions	Establishing implementation units to drive the HSR process enables focus and dedicated attention to implementation.
Phasing and piloting	A gradual and deliberately well-planned approach, with incremental scaling-up as capacity develops.
Restructuring	This is often an overlooked process, but it is important to restructure and re-define roles for the levels to avoid confusion about their respective new roles.
Capacity building	Must be appropriate to provide context to and equip officials at all levels with wide skills for their new roles. Lack of management capacity undermines implementation.

Source: Gilson and Travis (1997).

Mills et al., (1990), Green (2001), Bossert (1998) and Collins et al., (2003) are of the view that for the successful implementation of health decentralisation demands strong central-local relations and inter-sectoral coordination. However, in Uganda it was noted that no change was made in terms of inter-sectoral collaboration after health decentralisation. This was because

decentralisation has occurred beyond the health sector; therefore local authorities did not prioritised health services (Gilson and Travis, 1997). In Kenya decentralisation occurred across all sectors but resources were retained at the central government. This undermined the ability of local government authorities to implement health decentralisation(Ndavi et al., 2009).

Whatever the form of decentralisation is adopted, the national level continues to play a key coordination role. Thus, the roles and responsibilities of each level should be clearly defined (Mills, 1994, Gilson and Travis, 1997). Kawonga (2003) suggests that the choices of local governments are frequently more influenced by local context, personal characteristics and lack of incentives than the content of the decentralisation policy. For example in Zambia it was noted that districts did not adequately implement the essential health packages because the cost of the package exceeded resources available at the district level(Kawonga, 2005).

The argument stressed in this thesis is that the process by which health sector decentralisation policy was formulated and implemented is equally important in determining health outcomes. The study is more process oriented, seeking to analyse not only the effect, but also the process of how decentralisation of the health sector was carried out in order to generate lessons out of the experiences to illustrate improved health outcomes in this case reproductive health. It attempts to ask questions such as: who decide for health sector decentralisation? Where did the idea come from and who were involved in designing? Were service users represented in different decision-making levels? How did decentralisation impact on local accountability?

2.3 Decentralisation and health system reforms

Decentralisation has become a major component of health sector reform in many developing countries within the framework of overall decentralisation of the public sector. The key reason for decentralisation is to improve the implementation of government development programs and rectify inefficiencies of centralised public sector management(Rondinelli et al., 1983, Cheema et

al., 1983, Rondinelli, 1981, Conyers, 1981). The central argument is that it will allow greater local participation, which if there is a good collaboration and co-ordination between different levels government that are responsible for the health care delivery (JICA, 2008).

A similar argument was put forward with regard to health sector decentralisation. It was noted that health services were highly centralised, inefficient and unresponsive to the needs of clients, were biased in terms of hospital care, and primarily benefited the better off group (Saltman, 2008, Saltman and Bankauskaite, 2006, Mills et al., 2001). Basically, decentralisation was chosen as a way to address these systemic inefficiencies and improve responsiveness, (Menon, 2006, Bardhan and Mookherjee, 2006).

The case of Tanzania, decentralisation is implemented with the similar vision; to enhance efficiency in fulfilling development programs and public services delivery that were under the control of central government. Central government ministries controlled decision-making and resource allocation (both financial and human), directing local government authorities through Regional Administrations. This did not bring the required outcomes and the LGAs were abolished in 1972, resulting in reduction and poor provision of social services. LGAs were re-introduced in 1984 and the government adopted a Policy Paper on Local Government Reform in 1998 which put in focus the policy of "decentralisation by devolution" (D-by-D) The aim was to improve the quality of public service delivery, particularly to the poor by involving the people in decision making so as to promote good governance and reduce poverty.

2.3.1 Conceptualisation of decentralisation

While the definitions of decentralisation vary widely, the core meaning of decentralisation is the transfer of authorities and responsibilities or dispersal of power in public planning, management, decision-making and resources for public service delivery from the national government to sub-national levels (Conyers, 1981, Rondinelli, 1981, Cheema et al., 1983). Decentralisation and

centralisation are viewed as movements between two poles. Both central and local inputs are indispensable in any public health system to achieve the balance and direction in which a particular country decides to move. As decentralisation deal with power relationships at different levels of government (Olowu and Wunsch, 2004). It is important to consider the political environment before execution of decentralisation to avoid ineffective implementation (Green and Collins, 1994). Rondinelli et al. (1983) and Mills et al. (1990) identified four main forms of decentralisation in health delivery system as presented in table 2-3.

Table 2-3: Forms of decentralisation according to public administration typology

Deconcentration	Administrative responsibilities transferred to locally based office/s of the central Ministry of Health, within the health system
Delegation	Management responsibility transferred to a semi-autonomous entity outside the central government, for example health board, to improve efficiency and cost-containment in public organisations
Devolution	Political and administrative authority for health transferred to local authorities such as municipality or local council
Privatisation	Contractual agreements established between the public and private sector; either profit or not-for-profit, for delivery of the health service, but government exercises regulatory function. The aim is to improve efficiency by encouraging user participation.

Source: Mills et al., 1990.

Although the above classification of decentralisation is used frequently, it has been subjected to some criticism. In practice, more than one form of decentralisation co-exists within a health system of a country, such as devolution of service delivery to local authorities, accompanied by delegation of functions to management boards and committees (Brinkerhoff, 2003, George, 2003, Boon, 2008, Kessy et al., 2008). It has also been questioned whether de-concentration, delegation or privatisation should be included as forms of decentralisation as they are not true form of decentralisation (World-Bank, 2000a). De-concentration is seen more as an administrative intervention and does not shift any decision-making power to the local level (Saltman et al., 2007), while privatisation implies public sector give away the role of service provision to private providers rather than decentralising powers to the management level (Mayeh, Undated). Privatisation transfers responsibilities outside the government and private firms are involved, thus it is deceptive to be included as a form of decentralisation (Saltman et

al., 2007, Semali et al., 2005, Manor, 1999). Privatisation is not considered as a form of decentralisation in this study.

In some cases, genuine decentralisation has occurred, as in Bolivia, where responsibilities and resources were devolved to elected municipal governments (World Bank., 2004). Therefore in analysing decentralisation it is important to be precise about which form of decentralisation is taking place and to ask what has been decentralised, how much and to what extent. Depending on the form of decentralisation that is implemented, it has the potential to increase power sharing, address the needs of local population, and decrease regional inequities (Wunch, 2001, Ribot and Agrawal, 1999). In this study, devolution is analysed as a form of decentralisation in which powers and authority for reproductive health delivery is transferred to local government authorities. Devolution is opted for because it is a policy guide for the local service delivery that has been implemented in the Tanzanian health system. The local government authorities have been given a legal mandate for the delivery of primary health care (Ngware, 2000).

2.3.2 Decentralisation and service delivery: theory and evidence

An argument commonly cited in the literature about decentralisation and its impact on service delivery propounds the theoretical benefit of decentralisation is that it brings decision makers and decision making processes closer to the people. The explanation given about the benefits of decentralisation is found in conjunction with Tiebout (1956) and Musgrave (1959) arguing local decision-makers have access to better access to information on local conditions than central authorities, hence they can plan and offer services according to local needs and preferences. In turn, this is expected to improve efficiency and quality of services provided to the population (Beall, 2005, Beall, 2009).

Economists like Oates (1972) argue that decentralisation brings spill-over effect from public services through models which local authorities can adapt, while the central government

produces a common level of public goods for the entire population (Oates, 1972). Locally adapted policymaking and implementation encourage micro-accountability, and lead to greater efficiency of public management as a result of improved coordination and shorter decision-making hierarchies, better mobilisation and use of the public resources (Collins et al., 2002). In addition, local authorities can provide public goods at a lower cost since decentralisation promotes accountability and reduces corruption (Baltaci and Yilmaz, 2006). Decentralisation is seen as a solution to the local problems by employing participatory ways while searching for the resolutions (Rondinelli and Nellis, 1986).

Generally, decentralisation theorists and policy makers support decentralisation for the following reasons:: (i) improving allocative efficiency by better matching of public services to local preferences, and (ii) productive efficiency through increasing accountability of local people hence decreasing level of bureaucracy and better knowledge of local needs (Crook and Sverrisson, 2001a). The efficiency is achieved when services address the needs of the population appropriately (Robinson, 2007, George, 2003). It is argued that efficiency gains in service delivery have to be examined from the accountability perspective (Treisman, 2000). On the other hand, Rondinelli and Nellis (1986) argue that central authorities rarely have incentives to perceive citizens as their patrons. It is through political and administrative accountability that citizens hold government to account (Rondinelli and Nellis, 1986). Political accountability is when elected representatives account to their electorates, while administrative accountability is realised when managers and leaders achieve their targets (George, 2003).

The arguments that decentralisation promotes efficiency assume that decentralisation occurs within an institutional environment that offers political, administrative and financial authority to local authorities along with effective mechanisms of local accountability and central oversight (World-Bank, 2001). It is appealed that decentralisation aids to remove institutional and administrative barriers, thus enhance successful services delivery (Rondinelli et al., 1983). Decentralisation also produces a system of governance that is more effective and accountable to local people (Blair, 2000, Manor, 1999, Rondinelli et al., 1989).The benefits of decentralisation

depend on dimensions and forms of decentralisation that are found in practice(Olowu, 2001a, Olowu, 2001b).For example, under de-concentration, it could be easy for the central authority to ensure that national priorities are realised. Under devolution or delegation it may be necessary for the national government to order local authorities to allocate a portion of their budget to a type of service. As a result of such an order, national priorities can compromise local priorities. This can result in the local authority providing minimal services that are not accessible to the population. In this case, a concern is to define the type of services than can best be organised and provided by central and/or local authorities (Robinson, 2007).

2.3 3 Decentralisation as a vehicle of the improved health service delivery

Apart from the fact that decentralisation of the health sector is not an intentional process (World-Bank, 2000b). It is however driven by the theoretical benefits unveiled empirically through the improvement of health services delivery (Saltman, 2008). In the health system, decentralisation is motivated both fort the technical and political reasons. For political reasons, decentralisation is seen as a means to democratise governments and ensure greater community participation and accountability in health care delivery. For technical reasons, decentralisation is promoted for its ability to improve management, efficiency, quality, and equity (Mills et al., 2001). Generally, decentralisation aims at improving all aspects of health system performance (Cassels, 1995, Cassels and Janovsky, 1996, Reich, 1995).

Decentralisation in the health service is advocated as a means of offering opportunities for enhancing community participation and increasing accountability of health care delivery (Ahmad et al., 2005, Conyers, 2007). It is assumed that, by bringing the decision making process closer to users, decentralisation will increase public sector accountability and responsiveness (Mills, 1994, Khemani, 2004, George, 2003, Blair, 2000). Local participation can be effected, either directly where service users are involved, or through representation. User representation is taken as a mechanism to make decentralised institutions more effective through responsiveness and accountability (Ribot and Agrawal, 1999). Government is responsive through endorsing policies that respond to citizens' needs and is also accountable in such a way that citizens may sanction

government in case of abuse (George, 2003). Giving power to local institutions that are not accountable to service users cannot produce positive outcomes. Similarly, having local authorities without power and capacities cannot improve the delivery of public services (Ribot and Agrawal, 1999).

Mills (1990) argued that, for each decentralisation advantage, there is also a disadvantage, as presented in Table 2-4. There is no blueprint for whether decentralisation or the centralised model is the appropriate structure for service delivery.

Table 2-4: Advantage and disadvantages of decentralisation

Rationale	Advantages	Disadvantage
Efficacy	Local leaders are better informed about local problems and can make better decisions	Little empirical support and reason to believe that central authorities have better technical information on efficacy at lower level
Quality	Greater accountability may lead local leaders to improve quality	Consumers may not necessarily express quality concerns to local leaders
Financial soundness	Local leaders may be more aware of the trade-offs and fiscal constraints	Local leaders may be subject to pressures to increase inefficiency and may pass deficits on to higher administrative levels
Local choices & priorities	In democratic localities, decentralisation can allow more local choice and priority setting	A local elite may dominate local decision making and make choices that are not in the public interest
Equity	Local leaders can better target resources to vulnerable groups	On a national level, decentralisation may limit the ability to redistribute resources from richer localities to poorer localities
Efficiency	Local leaders can better target resources to vulnerable groups	Local leaders may be subject to pressures to increase inefficiency, including patronage among others

Source: Mills (1990:15)

The way in which the benefits of health care decentralisation can be realised, and the impact of different types of decentralisation, are not well articulated in the literature (Litvack and Seddon, 1999). The health services provisions are highly distinguished at different levels (primary, secondary and tertiary), and are made up of various components of healthcare services, such as planning, promotion, training and supervision. This makes it difficult to understand the decentralisation effects on those services. DeMello (2004) analysis of the Latin American countries has argued that the decentralisation of health care is more complex than other sectors because the dis-economies of scale tend to discourage local authorities from providing costly

curative health services. He further argues that the spill-over effects tend to discourage the sub-national provision of preventive health care (DeMello, 2004).

Arguably health sector decentralisation has becoming appealing to donors, policy makers and researchers because of the numerous theoretical benefits which include:

(i) A less unified health service that is better tailored to local preferences,
(ii) Improved implementation of health programmes. That is, day-to-day oversight and evaluation, which are necessary for implementation, are more likely to succeed under local accountability,
(iii) Reduced inequalities between urban and rural areas and between accessible and excluded regions. This is believed to occur due to the closeness and responsiveness of rural local authorities and providers to the needs of rural people,
(iv) Lower cost due to better targeted programmes. This argument assumes that local service providers would tend to have better information about the local communities to better allocate resources to target the poorer income groups, and
(v) Greater community involvement and higher chance of sustainability(Mills, 1994:24).

Kim's (2008) evaluation study on decentralisation and its impact on public service delivery, acknowledged that decentralisation itself does not increase effectiveness in service provision. Effectiveness depends on the quality of human capital and the institutions that provide public services. It was found that successful decentralisation benefits from centralised governance that promote decentralisation at the centre can undermine the establishment of sound local government by depriving it of the central government funds and staff that are needed to support local reforms (Kim, 2008). For instance, LGAs may have some degree of fiscal decentralisation with regard to planning and budgeting for the health services, but if they do not have the autonomy to manage their human resources including the ability or hire and fire personnel they may be unable to tailor services to local preferences in an efficient manner

2.3.4 Evidence of the impact of fiscal, administrative and political decentralisation on health outcomes

There is little empirical evidence that countries with more decentralised systems have achieved better health outcomes. A Limited number of studies have confirmed the proposed benefits of decentralisation for health service delivery. But health sector decentralisation and its impact on the management of service delivery has been hardly evaluated (DeMello, 2004). In the case of Africa there is very limited evidence about the impact of decentralisation on health service delivery let alone on reproductive health services delivery. The little available evidence is found to be limited in terms of quality, quantity and equity of service (Conyers, 2007).

In Tanzania, a number of decentralisation studies have been carried out, but many of them focus on specific dimensions of decentralisation such as the fiscal aspects (Boex, 2003, Boex, 2008, Fjeldstad and Semboja, 2000, Fjeldstad et al., 2004, Fjeldstad, 2004), political devolution (Kessy and McCourt, 2010, Chaligha, 2008, Mollel, 2010) and local government discretion and accountability (Mubyazi et al., 2007, Boon, 2008, Maluka et al., 2010a, COWI, 2007, Venugopal and Yilmaz, 2010, Borghi et al., 2011, Mshana et al., 2007). A few researchers have examined the relationship between the process of decentralisation the process and its effect on health service delivery for example (JICA, 2008, Gilson et al., 1994, Hutchinson, 2002). Although these studies highlight the impact of decentralisation on health services delivery in general no one focused on reproductive health services delivery. In addition, no attention was paid to the interplay between the three dimensions of decentralisation and how it produces health outcomes.

Fiscal decentralisation

In rural China, Yee (2001) examined the relationship between several indicators of healthcare performance: the number of doctors per 10 000 people, mortality rates, hospital beds per 10 000 people, and local healthcare expenditures and various measures of decentralisation using a data panel of 29 Chinese provinces for the period 1980 to 1993. Among the indicators used was fiscal decentralisation, which relied on the ratio of local government expenditure to central government expenditure, and the ratio of local government expenditure to total government expenditure. The regression analysis, based on either fixed effect or random effect estimations, showed that fiscal

decentralisation had been beneficial to health service delivery in terms of reducing mortality rates and increasing local expenditure on health care (Yee, 2001).

However, this finding is misleading in terms of the variables used to measure health performance, as doctors per 10 000 people, hospital beds per 10 000 people and local healthcare expenditure are not variables measuring health outcomes, but variables for measuring health investment (Chen, 2004).He used the provincial panel datasets from 1995 to 2000 to estimate the effects of fiscal decentralisation on healthcare performance by measuring health indicator input, that is doctors per 1 000 people and hospital beds per 1 000 people. When health outcome indicators such as average death rate, incidence of infections and mortality from infection were used it was found that decentralisation is harmful to health status (Chen, 2004). The county-level study using panel data showed that fiscal decentralisation lowers the mortality rate(Uchimura and Jütting, 2007). Another study measured the impact of fiscal decentralisation on health status using provincial panel datasets from 31 provinces of China from 2002 to 2006 showed that fiscal decentralisation is detrimental to health status, but good for health equality(Yan, 2009).

Robalino, Picazo and Voetberg (2001) developed a cross-country study focusing on the impact of fiscal decentralisation on infant mortality rates over the period 1970 to 1995, using panel data of low- and high-income countries. The analysis was based on how the local government spending on the central government transfers funds to child interventions. The study found that decentralisation was associated with lower infant mortality rates. Interestingly, the marginal benefit from decentralisation was found to be greater at low-income levels. However, they found that the share of the public expenditure managed by local authority correlated with their administrative capacity. Therefore, when local authorities have stronger administrative capacity, fiscal decentralisation is likely to improve health outcomes (Robalino et al., 2001).

The effectiveness of fiscal decentralisation depends on other factors, like local accountability. Evidence from Klemani's (2004) study of 30 local governments in Nigeria found that the design of the intergovernmental fiscal relations had an important effect on local accountability, and ultimately on health outcomes. It was found that the personnel of public health facilities were not paid, which led to poor quality of services due to high absenteeism and lower drug availability. Klemani (2004) further argues that the situation was not explained exclusively by the lack of financial resources available for local health services, but rather the lack of local accountability for those resources (Khemani, 2004). The key message in this study is that conditional transfers, which were the main source of local health spending, may damage local accountability, since the public do not hold local officials accountable for those resources.

Administrative decentralisation

Administrative decentralisation deals directly with the powers of local managers and officials who are responsible for delivering services. This includes issues such as personnel, service facilities, general management, and other discretionary administrative matters. Thus administrative decentralisation requires the least systemic change. The analysis of the administrative shift of power from central to local authorities is difficult, since a number of elements need to be taken into account (Saavedra, 2010). Bossert's (1998) is of the view that decision space model analyses a given range of power to the local government over various functions such as services organisation, civil services access, rules and governance. The difference about how local governments provide service is the autonomy given to manage its human resources for them to tailor services to respond to the local choices (Huff-Rousselle, 2001).

In most African countries, administrative performance is poor due to capacity limits. Bossert and Beauvais (2002) analyse effects of increased 'decision space' in Ghana, Zambia, Uganda and Philippines. They found that decentralisation allows moderate choices over expenditure, fees, contracting and targeting. In many countries, local government authorities are given some

administrative authority but central government usually controls personnel salaries. In Colombia, Bossert et al (2000) found that increased administrative decentralisation increased health expenditure per capita and the utilisation of health services.

Jacks's (2002) study in the Philippines found that increased administrative responsibility was not accompanied by adequate funding hence decentralisation led to deterioration of in the quality of service delivery. It is claimed that administrative decentralisation by itself may not be sufficient to generate the expected results. A study of Brazilian municipalities found that administrative decentralisation can lead to improved results when it is accompanied by good governance (Mobarak et al., 2006)

Political decentralisation

Political decentralisation, on the other hand, is known for its ability in improving health service delivery, since it brings local accountability. This takes place where citizens have the means to provide their input in local decision-making processes and the ability to hold decision makers accountable (Klemani, 2004). Any form of decentralisation introduces a new accountability relationship between central and local policy makers, while shifting existing relationships between citizens and politicians (Reich, 1995). Such accountability mechanisms are critical for improving local service delivery, as they affect the incentives facing service providers. It has been argued that the incentives for local authorities to improve service delivery are likely to improve if they can raise their own revenue through local taxes, rather than depending on central authority (Cabral, 2011). Central dependence undermines local government's accountability, and hence affects service provision. Therefore, for improved local accountability through the political process, local elections may be a useful tool for citizens to hold politicians to account. In Nigeria it was found that voters in local elections reward the politicians who bring local income growth and punish those who fail to do so (Khemani, 2001). In India it was found that an increase in the allocation of nurses in rural districts was associated with a higher turnout in local elections.

In African countries, Ndegwa (2002) found that political decentralisation is a widespread element of the decentralisation process, but not well renowned. Although many countries have elected local structures, the fairness and freedom of the electoral process are usually compromised. Likewise, participation beyond elections and downward accountability are low (Ndegwa, 2002). Ndegwa used indexes for measuring the degree of political, administrative and fiscal decentralisation in 30 African countries. His findings show that, although all countries have local governance structures, central authorities continue to dictate local affairs. He concludes by arguing that decentralisation in Africa has been widespread but not deep seated (Ndegwa, 2002)

Generally, there are very few cases documenting a positive link between decentralisation and health service delivery in Africa. Mehrotra's (2006) cross-country study indicated that the decentralisation of primary health services to locally elected heath committees in Benin, Guinea and Mali, and to local government in Mozambique, increased access to affordable health services, which contributed to improvements in immunisation rates and infant mortality. The impact was associated with the nature of decentralisation process where power and resources were truly transferred to the LGAs (Mehrotra, 2006). Conyers's (2007) analyse experience of decentralisation in sub-Saharan Africa. The results show that decentralisation has brought unsatisfactory and slight progress in improvement of quality of services provided through LGAs to local citizens. In Uganda decentralisation involve all government sectors, council managers assumed that health services were already funded, hence they allocated funds to other priorities (Hutchinson et al., 2001).

With respect to reproductive health, McIntyre and Klugman (2003) suggest that, under a given sufficient decision space, local health managers can be able to prioritise Sexual and Reproductive Health Services (SRH). Sri Lanka presents a successful story whereby of there was a decrease in maternal mortality and an improvement in women's health after decentralisation(McIntyre and Klugman, 2003). However, it took about forty years for the full decentralisation of power to the LGAs. In Latin America SRH was well established in local authorities due to technical support

for local decision making that was provided by SRH advocates. The participation of civil society organisations in decision-making in Bolivia, Mexico, Peru and Guatemala increased the visibility of SRH programs (Policy Project, 2000). Following the devolution of primary health services to municipalities in Chile, resources were made available for maternal health, which led to an increase in service coverage. In Bolivia, Maceira (2001, cited in Ravindran, 2005) found that decentralisation increased social participation in decision making, hence creating successful results for sexual and reproductive health. Noticeable was an increase in facility deliveries, from 13% to 57%, and in contraceptive prevalence from 1% to 27%. The positive experience in Latin America was driven by social movements geared to transform fragmented SRH (Ravindran, 2005).

In many African countries decentralisation of reproductive health services has not been successful. Zimbabwe's experience demonstrates that decentralisation can harm already well-functioning SRH programs. It has been noted that, in the early 1990s, Zimbabwe's National Family Planning Council (ZNFPC) was strong and had the best contraceptive logistics system in the world, giving Zimbabwe the highest contraceptive prevalence rate in Africa. When decentralisation was implemented in the 1990s, the role of ZNFPC, as being in charge of the entire family planning (FP) system, was taken over by local authorities. The process distracted attention from the FP and contraceptive management information systems (Rogers, 2000). In addition, supervision was disrupted, as experienced provincial nursing officers who were in charge of family planning logistics at the provincial level and supervisors of the district family planning workers were replaced by district health officers. It was observed that district health officers had other priorities; hence they were not able to carry out supervision of the family planning workers. As a result, the supervision of the family planning services was inadequate (Rogers, 2000) and resulted in poor quality of services. Stocks of family planning commodities also were not available locally. Thus the utilisation of ante-natal care did not increase as expected after decentralisation.

Decentralisation in itself does not improve the efficiency, equity and effectiveness of SRH (Lakshminarayanan, 2003a, Nanda, 2002, Langer et al., 2000, Ranjani and Barbara, 2004). In Ghana, decentralisation made mandatory the provision of SRH in all health departments but it did not improve SRH delivery due to inadequate supplies of equipment and service protocols'(Birungi et al., 2006:6). The Ghanaian experience suggests that decentralisation improves district decentralisation; however, before decentralisation, vertical loyalties were difficult to break down (Agyepong, 1999). In rural China, Jing (2004) found that RH was missing components of the health reforms (Jing, 2004). Lakshminarayanan's (2003) study in the Philippines shows that local authorities were not adequately prepared to deliver family planning services. Similarly, it was found that the poorest districts suffered more from decentralisation due to insufficient resources transferred and limitations to in the generation of their own income. In Mongolia, SRH lost momentum after the implementation of health reform due to reform tensions between national and local governments. This led to a reverse in the previous gains made in SRH (Hill et al., 2006). In Poland, the implementation of reform led to the elimination of contraceptive subsidies, the privatisation of health care and an increase in bribes to poorly paid healthcare providers, which created new challenges for women to access health services (Mishtal, 2010).

Overall, the impacts of decentralisation on service provision in terms of responsiveness and improvements in access to service delivery are inconclusive. Very few studies show positive outcomes of decentralised service delivery. Faguet's (2000) study in Bolivia found that as a result of decentralisation, these changes were strongly and positively related to real local needs, supporting the argument of allocative efficiency(Faguet, 2000). The findings of the World Bank (1995) study in Colombia suggest that the allocation of resources by local governments was more consistent with community preferences than allocations from the central government.

2.4 Framework for analysing decentralisation and its impact on service delivery

This section provides a framework for the relationship between decentralisation and service delivery by discussing its elements. It examines the process and implications of health services delivery at local levels. Different elements of decentralisation from previous sections are used to construct a simple framework that is used in analysing health sector decentralisation in Tanzania.

2.4.1 Principal-agent framework

One of the dominant frameworks used in analysing decentralisation is the principal-agent approach, sometimes known as agency theory. Bossert (1998) came out with the 'decision' space model to examine the relationship between forms of decentralisation, process and outcomes. The framework suggests a 'principal' hold specific objectives, and 'agents' who are required to execute activities to achieve the principals' objectives. It includes various functions and activities in which LGAs (the agents) have control and the degree of choice they are allowed by the central government (the principal).

The crucial element of the principal-agent theory is the 'agency relationship', which depends on power discretion and information flows between principals and agents (Hiskey, 2010). Mewes (2011) links the principal-agent theory to the top-down and bottom-up approaches. Local governments are agents, exercising power on behalf of the central government (principal). In the bottom-up model, the ultimate principals are the citizens or service users, while politicians, as the representatives of the policy makers, are agents. In turn, local government bureaucrats are responsible for executing service delivery functions as agents of local political leaders (Mewes, 2011). The challenge with this relationship is how central authorities can support the interests of the LGAs in such a way that they are in line with the national goals that wish to accomplish (Batley, 2004, Bossert and Beauvais, 2002, Bossert, 1998, Brinkerhoff and Azfar, 2006).

The performance of the LGAs in executing their new functions is dependent on how much discretion (decision space) is available and the powers actually exercised in practice. The model analyses various functions that are decentralised, such as finance, human resources, and governance and then ranks each function, the degree of decision space allowed at the local level as narrow, moderate or wide (Bossert, 1998). Thus, it allows an assessment of decision-making authority per function. For instance, some countries choose to decentralise health service delivery, but not the power to allocate resources. This selective transfer may impact on the LGAs' ability to deliver health services (Kawonga et al., 2005).

Hiskey (2010) supports the use of the principal-agent approach in analysing decentralisation to explain changes that have occurred. The argument is that, when decentralisation takes the form of devolution, there is an alteration of principal-agent relationships, where principals theoretically gain more leverage over agents who are directly responsible for service provision" (Hiskey, 2010:30). He stresses that using the principal-agent perspective in analysing decentralisation helps to explain the 'trade-offs' between different actors and the changes that decentralisation might carry with it, given the new responsibilities of the actors involved.

In this study the decision space as argued by Bossert (1998) was used to analyse the three most important elements of decentralisation which are (i) the amount of choice transferred from central government to LGAs, (ii) the choices local officials make with their increased choice and (iii) the effect these choices might have on the health system performance. Those elements are analysed through decision space mapping (table 2-5).

The public administration typologies were used to describe forms of decentralisation, while the principal-agent framework was used to examine the degree of power and choices that are given to the LGAs. The central ministries (principal) grant the agents (LGAs) power and resources to implement decentralisation. The principal believes that LGAs have a mandate from the central

government because they can obtain information about their local activities, which the principal does not have (Bossert and Beauvais, 2002).

The decision space also evaluates the LGAs' characteristics that influence policy decision-making and implementation. Thereafter, it determines whether LGA officials are innovative in making choices that are different from those directed by the CG, or those that have arisen from their locality. Finally, it evaluates whether local choices have improved decentralisation performance. The framework acknowledges that LGAs have their own preferences and choice of activities and expenditures to be undertaken to respond to the local needs, which differ from central needs. LGAs may not always make decisions in accordance with the central mandate, but seek to accomplish policy objectives through sets of strategies to control and influence their decisions (Bossert et al., 2000). Thus, the central authorities can impose incentives and sanctions, monitor, report; carry out inspections and performance reviews as mechanisms to influence local decisions (Bossert et al., 2003b, Bossert et al., 2000).

Table 2-5: Bossert's Framework for Mapping Decision Space

Category	Function	Indicators
Service organisation	• Prioritisation of service • Service package • Insurance plan	Defining priorities of local health needs Choice of service package Choice of how to design community insurance plans
Finance	• Source of revenues • Allocation expenditures • Income from the fees	Intergovernmental transfer as % of total health expenditure % of the LGAs spending as a total of public health spending Range of price that LGAs are allowed to set
Human resources	• Salaries • Civil services	Setting of personnel salaries Hiring and firing of the LGAs staffs
Governance	• Health boards • Facility committees • Community participation and accountability	Size and composition of the boards Size and composition of the health committees Means and role of communities participation

Source: Modified from the Bossert (1998) conceptualisation of decision space.

However, the framework has been criticised because of its focus on the vertical relationship between central and local government, which makes it difficult to analyse multiple principal-

agents at different levels of service delivery (Bossert, 1998; Batley, 2004). Nevertheless, the model can be modified to suit different contexts (Bossert and Mitchell, 2011, Bossert, 1998). The framework was used just to map decentralisation functions, as it cannot measure the final outcomes. The next sub-section provides details of other frameworks that are useful in measuring decentralisation outcomes.

2.4.2 Conceptualising the relationship between decentralisation and its impact

This section presents the analysis of the causal relationship between decentralisation and its impact on health services delivery based on the literature established in previous sections. The term impact refers to the immediate effect of a health programme, process or policy, while outcome refers to an ultimate effect (Scott-Samuel et al., 2005).The Oxford Advanced Learner's Dictionary defines impact as 'powerful effect' (Wehmeier, 2000:649), while outcome refers to 'results or effect' (Wehmeier, 2000:899). These definitions make the two terms interchangeable. However, usage varies among disciplines; those in health research tend to use the two terms namely impact and outcome in the evaluation of non-health matters (Green and Kreuter, 1991.).

However, Börzel (2000) distinguishes impact from outcome. Impact is the effect of the policy on the socio-economic environment, while outcome is the effect of the policy measures on the behaviour of the targeted actors (Börzel, 2000:3). As this study analyses decentralisation and its impact on health services delivery, Börzel (2003) definition is more useful. However, the meaning of outcome is modified to include the term impact. Thus, in this study, impact refers to the effect of decentralisation on the fiscal, administrative and political environment, which ultimately affects health services. This definition allows a focus on national and local levels to understand the dynamics of the three dimensions of decentralisation on service delivery.

Theoretically, the relationship between decentralisation and its impact can be understood by examining its dimensions and impact over selected health outcomes. Figure 2.1 shows an

upstream pipeline in the production of a certain health outcome. It starts with input, such as finance management and decision making (political power) in setting health service priorities. These inputs allow the production of services through hiring and managing personnel such as doctors and nurses, the purchasing of equipment and supplies that are needed for treatment, providing maintenance among others. These initial inputs directly help to provide some of the intermediate outputs of services, such as new family planning acceptance, access to facility delivery, antenatal and postnatal care, to mention but a few. At the end of the pipeline it leads to improved health status of the population, as shown in improved reproductive health indicators like reduced maternal deaths. The key assumption behind the traditional service pipeline model is that outcome is mainly determined by input. The assumption is that there is a linear relationship between input and outcomes. In reality it is not only the input that produces health outcomes. There is the important process, i.e. institutional or government processes, through which the input is processed. At the same time there are other factors that influence final outcomes, like the contextual factors (socio-economic and cultural structure). Institutional characteristics also influence service delivery.

This study proposes the use of intermediate outputs to measure access to reproductive health services rather than final outcomes. In most countries, including Tanzania, intermediate outputs are at the centre of the public health services problems. In this case of reproductive health care, access variables include availability of skilled personnel, and access to facilities for antenatal and postnatal care and birth attended by skilled personnel among others.

The inherent difficulty in this model lies in its assumption that the input-output relationship is linear. It assumes that a given cost of a certain amount of input will produce a certain amount of output. Since decentralisation is a political process, it does not follow the linear path. The relationship between input process and output are not step-wise, but rather continuous and intertwined.

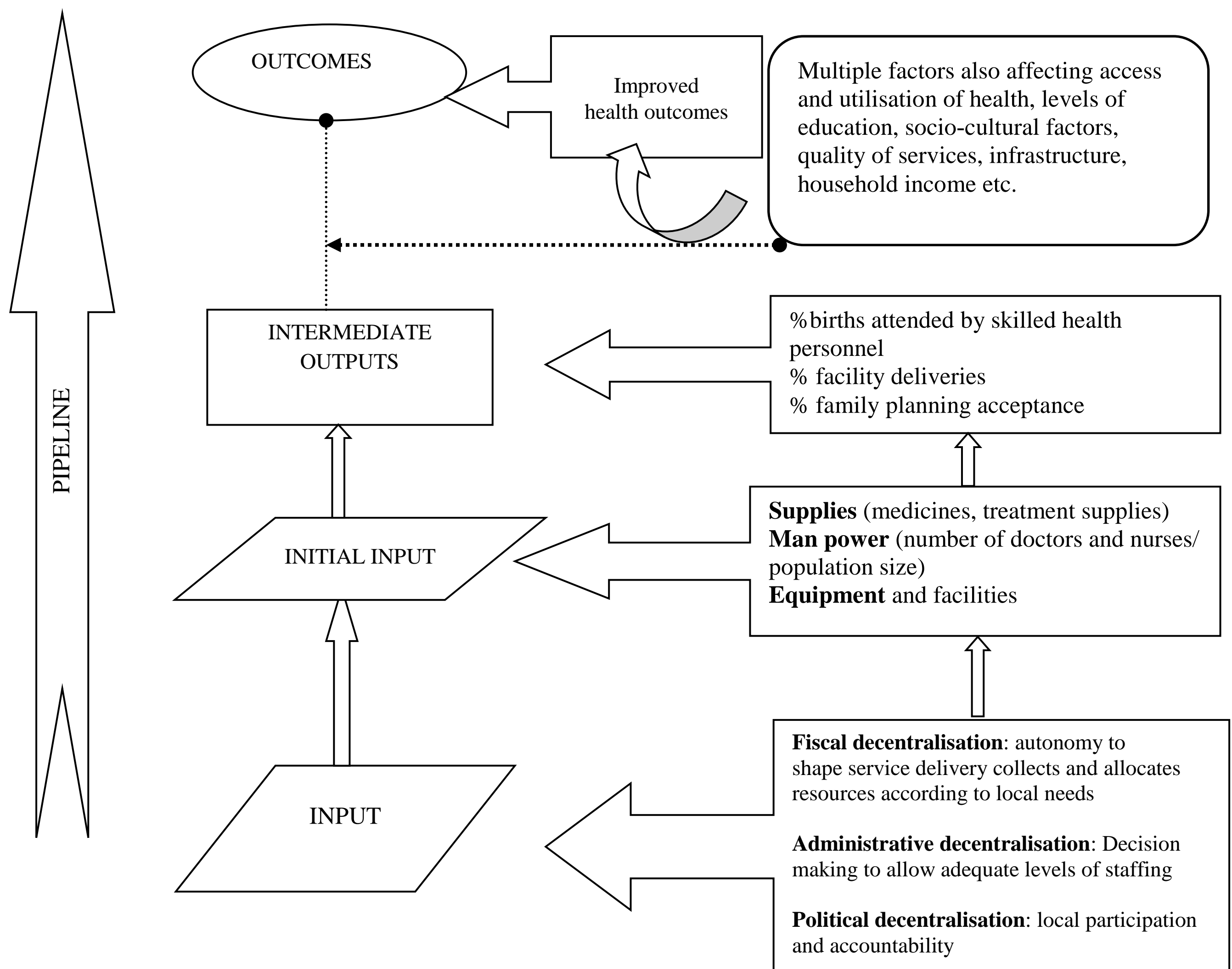


Figure 2-1: Traditional service delivery pipeline framework

Source: Adapted from the World Health Organisation and the World Bank, 2004

2.4.3 Accountability framework

Accountability in the health care system has emerged as a means to change the history of health system governance. Health systems were highly centralised; decisions on public health care planning were top down, driven by experts in the field, and lack input from the users (Brinkerhoff, 2003; Brinkerhoff, 2001). The aim of accountability in public health care delivery is to improve health system performance towards achieving quality and equitable health care

services. It intends to improve the performance of health care providers, management of public finances and democracy in the delivery of public health (Brinkerhoff 2004).

Goetz (2003) defines accountability as whether and how power holders answer for their actions and are sanctioned in case of abuses. She puts forward two aspects of accountability which are ‘answerability’ and ‘enforcement’ (Goetz, 2003). In the context of public service delivery, Caseley (2003) perceives accountability more broadly by linking the above two concepts with ‘engagement’ and ‘responsiveness’. Engagement is a mutual relationship between two actors in which demands are expressed by one actor in a transparent manner to the other. Responsiveness means the relationship between signals and outcomes. For Caseley (2003), responsiveness comprises three elements: (i) answerability- passing information and justifying decisions on the basis of demand expressed, (ii) enforcement-ensuring compliance with decisions, and (iii) organisational change- changing the way in which services are delivered (Caseley, 2003).

Understanding various actors, the realms in which they get and use their power, and to whom and how they are accountable are necessary to understand the impact of decentralisation (Ribot and Agrawal, 1999). Several frameworks have been identified to study actors, power and accountability in a decentralised setting (Olowu, 2001c, Crook and Sverrisson, 2001b, Crook and Manor, 1999, Crook and Manor, 1998, Ribot and Agrawal, 1999, Ribot, 2002, WB, 2000). In this study, accountability framework of the World Bank (2004) was adopted to understand the type of accountability relationship that exists between service providers and users, which in turn shapes health outcomes.

An actor(s) usually refers to the individuals, group of people or organisation in which their actions affect public policies(World-Bank, 2004). An actor has a particular identity, with a set of norms, values and practices that distinguishes one from another (Bovens, 2007). The difference between an actor and a non-actor lies in their action. If an entity is capable of influencing policy decisions either directly or indirectly, it can be named an actor (Buse et al., 2005). An actor can

be an organisation, such as state, a community, an individual, or a group of individuals such as professional, associations or a group of actors representing a large community that is organised for a certain interest or purpose. There is a mix-up between state and community actors because all are known as structures. When one individual acts on behalf of the state or community with that particular state or community then s/he becomes a state or community actor (Ramji, 2009).

The World Health Organisation (2000) has specified three sets of actors in health systems, namely state actors, service providers and service users. The state actors include politicians, policymakers and other government officials. The actors in the administration of the public health sector are central government agencies, where the Ministry of Health (MoH) is a central actor in accountability relationships. These actors are accountable in terms of holding providers accountable and being accountable to other government agencies, such as parliament, and also directly to citizens(WHO, 2000). The MoH exercises broader oversight over a number of health sector providers, both public health delivery at various levels (central, regional, local) and private sector providers. This can be through regulatory, monitoring and enforcement, budget, logistics, quality assurance, purchasing and contracting, policy planning and regulations, etc. This oversight role is usually accompanied by sanctions such as the right to award contracts, the ability to hire or fire, and the authority to set policy regulatory and performance standards. In most countries, the capacity of the MoH to take control over this mandate is limited (Brinkerhoff, 2004). Thus, health system reform aims to strengthen or restructure organisations that enable the MoH to exercise accountability more effectively (Travis et al., 2002).

The second set of actors is health service providers. In most countries, providers range from public to private, but in some countries, like Tanzania, public provision forms the largest part of the health care system. In developing countries, service providers, in particular insurance companies, pharmaceutical industries, equipment manufacturers and suppliers to mention a few are rarely held accountable by government, service users, professional associations or civil society (Mcnamara, 2006, Molyneux et al., 2012, Berlan and Shiffman, 2012).

The third set of actors includes service users/clients/citizens, the general public and organised civil society. This group can be differentiated by wealth, income, location, service or by disease pattern. Civil society includes professional associations, community-based groups and advocacy organisations (Walt and Tantivess, 2008). Service users are currently participating through user representation in health boards and facility health committees.

Other mechanisms used include public report cards and patients' rights charters, but these are rarely used in developing countries (Molyneux et al., 2012, Berlan and Shiffman, 2012). Boards and committees are used to organise participatory activities for health management. These committees and boards can be self-elected or appointed. They are typically managed and work under the supervision of the Ministry of Health. Decentralisation programmes usually work with these committees, despite the existence of the locally elected representative local governments. The governing committees and boards of health facilities may be self-elected or appointed. They are typically managed and work under the supervision of the Ministry of Health.

Accountability is a major responsibility of the MoH as a primary policy maker and overseer of the entire health system. However, decentralisation shifts the oversight from MoH to regional and local government authorities. It introduces a new relationship of accountability between national and local policy makers. Accountability is an important means for achieving quality and equitable health care services. It intends to improve the performance of health care providers, the management of public finance and democracy in the delivery of public health services (Brinkerhoff, 2004). In health systems, accountability is important for three main reasons which are first, accountability is claimed to mediate between citizens and their government on issues of cost, access, quality and distribution of health care services, second, since health care providers are granted significant powers over people's lives and well-being, accountability seeks to regulate for any possible abuses, and lastly health services delivery constitutes a major budgetary expenditure, and accountability seeks to ensure proper management, reduce corruption and

enhance the responsiveness of service providers and policy makers to citizens (Brinkerhoff, 2004).

Bahl et al. (2005) argues that decentralisation is introduced as a policy to offset problems caused by centralised governance. Thus, pressure for decentralisation can increase when the citizens are dissatisfied with the performance of public service delivery (Bahl et al., 2005). As argued elsewhere decentralisation has three dimensions, namely fiscal, administrative and political. Most studies have focused mainly on one dimension of decentralisation, in particular the fiscal, to be used as proxy for the overall process (Saavedra, 2010). On the other hand many studies seem to overlook the point that the political and administrative components of the decentralisation process are largely related to fiscal. The exclusion of one dimension from the analysis might lead to biased outcomes. This study assumes that each individual dimension of decentralisation might have a specific impact on service delivery, thus excluding one dimension might overstate/understate the effect of decentralisation. For example in Bolivia, municipalities were given more autonomy of financial resources, but all administrative decisions regarding personnel are taken by central authorities (World-Bank, 2005a). In Pakistan, local governments were given greater autonomy of administrative and political devolution, but not fiscal. Local governments are totally dependent on the federal government to finance social services including health (World-Bank, 2005b). In this situation it is difficult to judge whether Bolivia is more decentralised than Pakistan by considering only one dimension of decentralisation. Each dimension of decentralisation can have an independent impact on its own, although they can reinforce one other to produce an added significance. Thus, accounting for all three dimensions of decentralisation is important in establishing the impact of decentralisation on health service delivery.

In judging the impact of decentralisation on health service delivery, the study suggests using the World Bank's Accountability Framework (2004) as presented in Figure 2-2 below. The framework shows the relationships among key actors in a decentralised system. Ahmad et al. (2005) suggest that understanding the relationships between central policy and local government

policy makers, service providers and citizen policy makers can help fully understand why decentralisation reforms can, and sometimes cannot, lead to better service delivery. Successful service delivery for people materialises when actors are linked in relationships of power and accountability (World-Bank, 2004:47). Service delivery can be improved by strengthening and balancing the actors' relationships. Once one actor has more power than the other(s), the accountability mechanisms may be disrupted, which could lead to ineffectiveness of health service delivery.

The figure demonstrates the significance of each dimension of decentralisation in delivering public services. Three forms of decentralisation were identified by Rondinelli (1981) as follows; (i) de-concentration, (ii) delegation, and (iii) devolution which echo how policy makers, service providers and service users/citizens/beneficiaries are connected. Councils can have some degree of fiscal decentralisation, but if they do not have the autonomy to control human resources they cannot alter services to meet local needs more efficiently.

Furthermore, where local officials are not democratically elected by citizens, accountability to local residents can be weak, since appointed officials are accountable to the Centre. They track the interests of the centre while local choices are neglected or forgotten. Where there is political decentralisation but councils lack basic resources and administrative autonomy to make decisions, the Council might lose integrity. Hence, service users would not have influence over the user charges levied to improve local health services. As a result, theoretical justifications of allocative efficiency, technical efficiency and local knowledge of choices and needs arising from a decentralised framework may suffer (Saavedra, 2010).

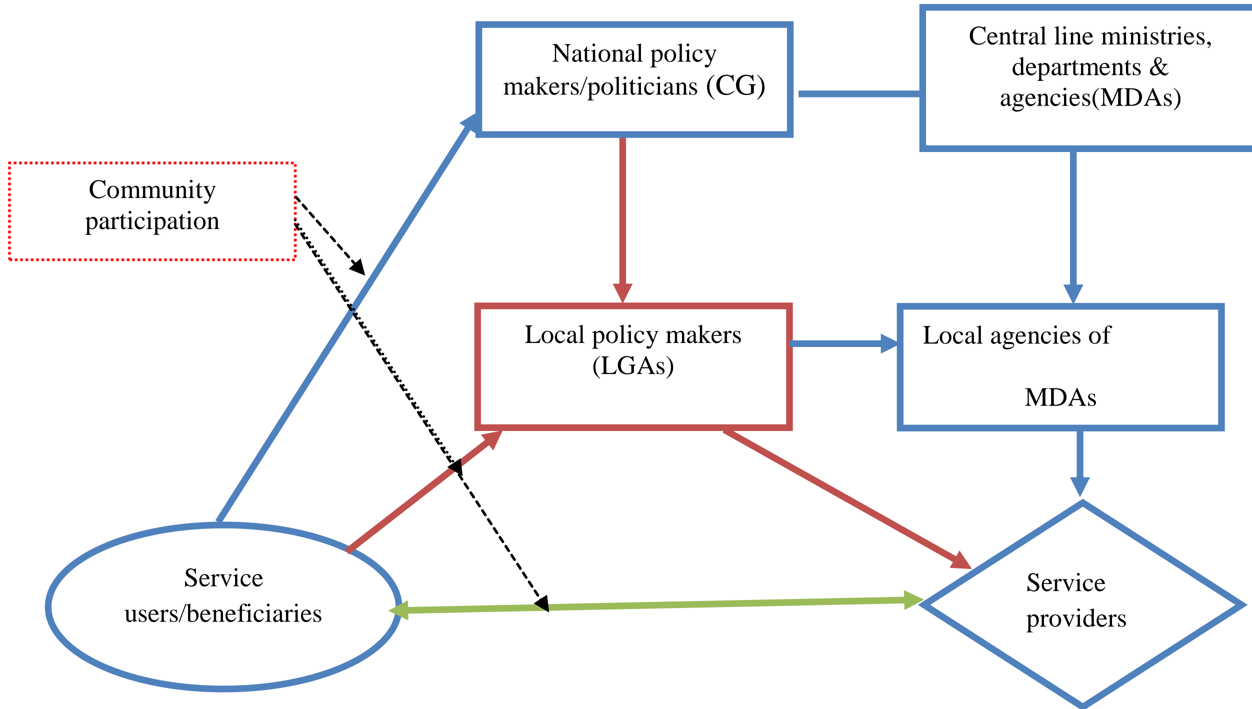


Figure 2 2-1: The framework of accountability in a decentralised system

Adapted from World Bank Service Delivery Framework (2004)

← Demonstrates long route of accountability in a de-concentrated system; LGAs are likely to have limited autonomies for fiscal and administrative decision making on local expenditure and staffing. Service users can have indirect influence on service providers through elected government.

← Demonstrates a short route of accountability in form of delegation or devolved system in which LGAs are likely to have higher fiscal, political and administrative autonomy

← Demonstrates a direct voice of service users/beneficiaries to the service providers

The relationship between central policy makers and service users as against local policy makers is that national constituencies represent a large population that is heterogeneous; thus local service users cannot hold national policymakers accountable. Similarly, central policy makers cannot tackle all the local needs and demands; as they usually follow policies that keep them in power. In a decentralised system of service provision, local policy makers are accountable to a

smaller population, which makes it easier for them to address locally perceived needs; that is, more direct accountability lines.

Bardhan and Mookherjee (1998; 2000a; 2000b) provide a caution in this regard. They argue that knowledge of local needs coupled with decentralisation powers might enable increased efficiency in service delivery if and only if LGAs want to use that discretion for improving services. Otherwise decentralisation is vulnerable to elite-capture as LGA officials can form an alliance with central officials to hinder the gains of decentralisation. Thus, even locally elected council may not realise the anticipated service delivery. Instead, they can choose to individually rent from resources received for delivering services (Bardhan, 2002, Bardhan and Mookherjee, 2000a, Bardhan and Mookherjee, 2000b, Bardhan and Mookherjee, 1998).

2.4.4 Framing the conceptual framework for the study

This thesis focuses more on the implementation of health decentralisation, than the initial stages of policy formulation. Usually, policy implementation begins after the formulation of the policy document, which includes the development of the working programmes by central government jointly with other actors that have an influence over government policies. Concentrating on policy implementation assists in raising questions about what happens to policies in practice after they have been formulated and how relationships among various policy actors shape policy outcomes. Figure 2-3 presents a simple framework that was developed to guide the study. It is deducted from the previously presented literature.

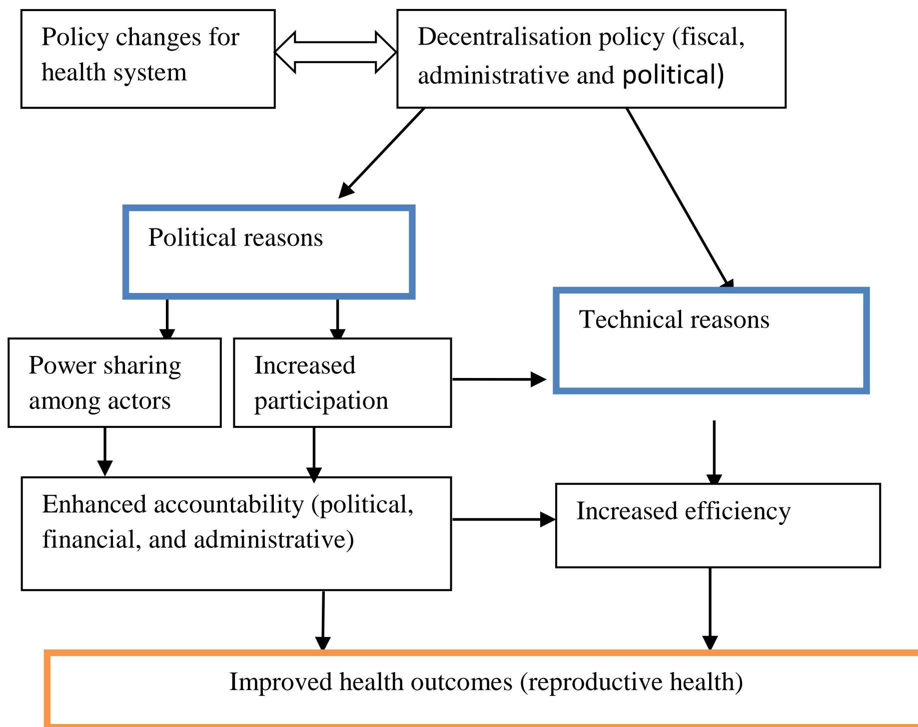


Figure 2-3: A simple framework for understanding decentralisation and its impact on health service delivery

Source: Developed by author, synthesised from the literature

The conceptual framework in Figure 2-3 illustrates the relationship between decentralisation and health outcomes. The said process includes changes in health policies that bring with them political, administrative and fiscal decentralisation. Decentralisation is frequently implemented for political and technical gains. It enhances power sharing between central and local actors, while improving community participation in health programs, which leads to improved local governance outcomes through (i) responding to the local reproductive health needs (ii) enhanced political, financial and administrative accountability, (iii) increasing local control over planning and decision-making, and (iv) strengthening accountability through greater citizen monitoring and observation. With regard to the framework the following are the arguments:

(i) Decentralisation grants LGAs fiscal, administrative, and political powers for local reproductive health service delivery. The decentralised power affects local decision

making process on issues such as resource allocation and prioritisation which ultimately affects resources needed to deliver reproductive health services delivery.

(ii) For decentralisation to improve health outcomes, effective accountability mechanisms are important to hold officials accountable. Within discretionary power, LGAs are more likely to be accountable to higher levels of government (upward accountability) than to the citizens (downward accountability). Citizen accountability mechanisms safeguard against the misuse and abuse of local discretion. Thus, citizens must have the ability and opportunity to claim accountability and LGAs have the means and stimuli to respond to citizen demands for better health service delivery, in this case reproductive health.

Therefore, it is against this background that this thesis attempts to generate empirical knowledge on how the implementation of decentralisation policy affects health care delivery by studying specific health interventions that is reproductive health. Comparatively little has been written regarding the relationship between decentralisation and the universal access to reproductive health by 2015. Those few studies reviewed above are inconclusive on the extent that decentralisation undermines or supports reproductive health services delivery.

Chapter conclusion

The literature review confirms that decentralisation has the potential to improve the functioning of the health system to deliver quality health service delivery. However, the reviewed literature shows that there is little convincing evidence to confirm that health outcomes have improved because of the implementation of decentralisation policy. In most studies from developing countries in Africa, Asia and Latin America, the quality of health services has either declined or remained unchanged after decentralisation. In particular the review suggests that decentralisation of health services has not improved access and quality of RHS. Decentralisation also worsens health inequities and inequalities among the councils as a result of discrepancies in administrative capacity and ability to raise local resources. From the evidence summarised by Cabral (2011), the experience and impact of service delivery decentralisation in Africa has been disappointing, with limited evidence of the improvement of quality of health services provided.

There is negative, positive and inconclusive evidence that health service delivery indicators have improved as a result of decentralisation. The aim of the study therefore was to answer the following question: how has decentralisation impacted on reproductive health service delivery in Tanzania? In this respect, the extent to which decentralisation has increased local autonomy over fiscal, administrative and political factors in the health sector in Tanzania was analysed in relation to access to and utilisation of reproductive health services by a rural population in Tanzania.

Analysing decentralisation’s impact is difficult because studies are not comparable. The evaluations do not measure the same things in part because the form of decentralisation being implemented differs greatly. In many cases, evaluation does not state specific reason(s) for the decentralisation process. Nor does it state goals that are the object of the programmatic change. This makes evaluation even more challenging; changes as a result of decentralisation cannot be expected to have only positive effects. Thus, a starting point of decentralisation evaluation would reasonably be to assess if it had the anticipated positive effect. Any expected or unexpected negative effects could be appraised as study proceeds.

Abbreviation for Chapter 3

ANC	Antenatal clinic
CFS	Consolidated fund for services
CHMT	Council health management teams
CHSB	Council health service boards
DDHs	District designated hospitals
DHS	District health system
DPs	Development partners
ESAP	Economic and Social Action Programme
FY	Financial year
HBF	Health basket funding
HFCs	Health facilities committees
HRH	Human resources for health
HSR	Health sector reform
HSSP	Health sector strategic plan
IPT	Intermittent preventive treatment
ITNs	Insecticide treated bed net.
LGAs	Local government authorities
LGRP	Government reform programme
MDAs	Ministries, departments and agencies
MDG	Millennium development goals
MKUKUTA	MkakatiwaKukuzaUchuminaKupunguzaUmaskini Tanzania
MMR	Maternal mortality ratio
MNCH	Maternal and new-born, child health
MoFEA	Ministry of Finance and Economic, Affairs
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
PER	Public expenditure review
PHC	Primary health care
PHSDP	Primary health service development programme

PMO-RALG	Prime Minister's Office for Regional and Local Government
PMTCT	Prevention of mother to child transmission
POPSM	President's Office-Public Service Management
RHMTs	Regional health management teams
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
TFR	Total fertility rate
URT	United Republic of Tanzania
US$	United States of America Dollar

CHAPTER 3

HEALTH SECTOR REFORMS AND DECENTRALISATION POLICY IN TANZANIA

3.0 Introduction

The chapter presents the important aspects of the health sector reforms which are central to the current study. Decentralisation reform being the major components of the HSR provides the context in in which the identified theoretical question can be examined. The goal of decentralisation in many countries is to improve health system performance and ultimately health outcomes. Thus, the formulation and implementation of decentralisation entails changes in the process of planning, resource allocation within the health sector and distribution of benefits to the different population groups. It is a highly political process involving policy makers, politicians, service providers and users, whose interests could be affected by the proposed policy changes (Glassman et al., 1999). These benefits are not equally shared; there are might be looser and winner of the decentralisation.

This chapter provides a foundation for a scientific inquiry into decentralisation in the real world in the subsequent chapters. The historical background of health system reform and how decentralisation fits into it is provided. The chapter is divided into three major sections: (i) a brief overview of the health sector reforms with a focus on the contextual factors that led to decentralisation of reforms, (ii) a brief overview policies that guiding health sector and (ii) selected health system performance indicators.

3.1 Health sector reform in developing countries

Health sector reforms (HSR) in this study refers to the new generation of reforms introduced in the 1990s, a widespread movement that affected the health systems of many developing countries including in Africa. However, health reforms were a result of the global macroeconomic and political changes that affected developing countries and can be dated back at least to the early 1980s. Health system refers to 'all the activities whose primary purpose is to

promote, restore or maintain health'(WHO, 2000). Generally, health sector reforms 'refer to significant, purposive effort to improve performance of the health care system'(Huntington, 2004). In a wide variety of policy literature, health forms are defined as a "package of policy measures affecting the organization, funding and management of health systems"(Zwi and Mills, 1995:314). Berman and Bossert (2000) cautioned that not all action to improve health sector performance should be labelled as health sector reform; to them, health sector reform should bring 'sustained, purposeful and fundamental changes' in the health system (Berman and Bossert, 2000).

However, this study acknowledges that health sector reform is not a concept that demands a single global definition but it is important to be aware "what is and what is not reform" (Cassels et al., 1996). Health sector reforms include numerous activities concerning health care delivery. Roberts et al., (2004), identified five areas of health care to be addressed under health reforms: financing, payment, organisation, regulation and behaviour (Roberts et al., 2004). Basically, reforms initiatives can be wide in scope and involve change within several areas of health system structures and operations while others are rather narrowly conceived and with a more limited scope of change (Berman, 2002). Whatever type of reforms is implemented, it creates an effect in the health care system hence necessitating alterations in their implementation. HSR is an incremental process reflecting the social values and political processes of a country (Gilson, 1997). It involves significant transformation of the health care systems and creation of actors who will defend their interests (Huntington 2004).

The World Bank has been an influential institution in shaping health reform policies in African countries (Zwi and Mills, 1995). It suggested a shift in elements of service provision from the public to the private under the justification of the greater technical efficiency of the private sector as it encourages competition to provide services delivery (World-Bank, 1987). In addition, in its influential 1993 World Development Report(WDR), "Investing in Health" and its 1994 publication, "Better Health for Africa", the Bank recommended to national governments to limit government actions in formulating policies, providing a limited package of public health

interventions and financing basic clinical services targeting groups, especially those who are incapable of paying for private care(Lee et al., 2002).Thus, HSR efforts are responding to resource constraints, arguing that scarce public health resources were not efficiently used (World-Bank, 1993).

Multilateral organisations of the United Nations such as World Health Organization (WHO), United Nations Children's Fund (UNICEF) and bilateral agencies including Danish International Development Agency (DANIDA), Europeans Union (EU), German Technical Cooperation (GTZ) to mention a few, promote HSR as part of their aid assistance. These organisations work with national government agencies which deliver health services (Meachan, 2001). In Tanzania for example, DANIDA has been a key supporter of the HSR through health sector program of work since 1996 through basket funding mechanisms. DANIDA has supported the implementation the recent HSSP III (2009-2014) with USD 163.1 million as well as five 5 technical advisors to MoHSW.

The driving force for the 1990s reform varied greatly according to the following contexts: (i) reforms that resulted from the major political, economic, and social changes associated with transition from socialist to market economies; (ii) changes resulting from social movements to reform of the state, and (iii) reforms that are part of the structural adjustment programmes (Leighton, 1999).

Thus, the reform packages adopted vary from one country to another and policies vary across and within countries themselves. Despite the variations, many countries adopted some aspects of the HSR as an attempt to use scarce resources more effectively in pursuit of improvements of the public health. The specific HSR policies implemented vary across countries but mostly include new methods of defining priorities, development of new financing mechanisms, delivery of basic health packages, integration of services and the decentralisation of decision-making (Berman, 1995). In African and Asian countries, HSR was a part of the structural adjustment programme caused by severe resource crisis (Berman and Bossert, 2000).

With reference to Tanzania, the current health sector reform program that took effect in 1994 aimed at improving efficiency and effectiveness in the delivery of services. Indeed, it was wide in scope, purposeful and fundamental. The HSR aim to transform the previously vertical program into integrated service delivery (Oliff et al., 2003) In countries like Tanzania, they introduced market principles into the reforms of the primary health care sector as a reaction to the government failure to fund health services, without any proof of their effectiveness (Zwi and Mills, 1995). Hsiao also raised explicit questions about the effectiveness of using free market principles to structure the health sector (Hsiao, 1995:134). He saw that many countries have defined and undertaken health reforms without considering the facts and context but had been influenced by ideology(Hsiao, 1995). I shall discuss the contextual aspects of health sector reform in the next section.

Health sector reform in Tanzania

The first HSR in Tanzania started with the introduction of Western health care by the German colonial government in 1881. During their administration (1980-1919) several hospitals were established in Dar es Salaam, Pwani and Tanga (Clyde, 1962, Nsekela and Nhonoli, 1976). The colonial administration established urban biased health facilities aiming at serving their civil servants, military personnel, settler farmers and plantation workers. In the country side, the health services were operated by missionaries and were targeted to serve the missionaries and a few natives(Mwaffisi, 1999).

A national health care system was introduced soon after gaining independence in 1961.The government adapted the colonial health system and this marks the beginning of the second wave of health reforms which was sustained up to 1972. This period overlapped with the formulation of the broader national development policy namely socialism guided by Arusha Declaration. The third health sector reform took place between 1972 and 1982, prompted by the failure of local government to provide social services including health (Semali et al., 2007, Semali et al., 2005, Semali, 2003). It also coincided with political strategies of implementing socialist political ideologies in which the central government assumed greater role in providing health services in all districts for free (Kopoka, 2000). Because of economic problems, the central government

failed to support district health services hence the service deteriorated (Kaijage and Tibaijuka, 1996, Wangwe et al., 1997). Thus, failure to finance district health services was the key reason for the fourth HSR that took place between 1983 and 1993. The fifth HSR, which is the concern of this study, was started in 1994

Tanzania began a PHC strategy after the Arusha Declaration in 1967 which emphasised rural development. The Government re-oriented national policies to increase resource allocation to rural areas compared to urban areas (Jonsson, 1986). These efforts were seen in 1970s with extensive networks of health facilities across the country. By 1980, about 90% of the rural population of Tanzania was living within 10 kilometres of a health facility(Gish, 1982). Yet, the World Health Organisation (WHO) report for the 2000, ranked Tanzania 176th out of 191 countries on level of health status, 140th in respect to responsiveness and 45th on fairness of financial contribution (WHO, 2000). Thus, the HSR were implemented to improve the sector performance to enhance the delivery the health services.

3.1.1 The reform content

HSR content is influenced by anticipated achievements. The driving force for the HSR differs from one setting to another. In developed countries HSR aimed at addressing the escalating costs of health care and meeting public expectations (Cassels, 1995). HSRs were aimed at increasing resources to provide health care. In Tanzania, the content of HSR entails significant changes in the systems, programs, organisations and institutions in which those reforms were to be implemented. Numerous policy documents including(MoH, 1994, MoH, 1995, URT, 1997b) identified the content of HSR as:

(i) **Ideological reforms** which involved changing the role of the central government to that of facilitator in the provision of health services and ending the free provision of health care services to all,

(ii) **Organisational reforms** which comprised changes in the administrative structures through the creation of autonomous LGAs and district health boards, support to community based

health care initiatives; review of the functional role of MoH with regard to planning and budgeting, training of workers and establishment of a new scheme of promotion,

(iii) **Managerial reforms** which called for the transfer of the management of health services and district hospitals to LGAs, changes in recruitment process of the DMOs and establishment of a separate council account for health funds,

(iv) **Financial reforms** which included introduction of new sources of health care financing, by establishing national and community health insurance scheme. Allocation of public health resources was based on cost-effectiveness analysis, population patterns, income distribution and utilisation of health services,

(i) **Public/private** reforms included legalisation of private practitioners as well as fostering the development of the private sector and

(ii) **Health systems research** reforms to generate information for evidence based practice,

The central theme of the health sector reform in Tanzania has been decentralisation which calls for transfer of power from central government to LGAs[1]. The assumption is that LGAs will determine priorities and allocate health funds, with technical assistance from the central levels (see details in section 3 1.2).

3.1.2 The Reform context

In sub-Saharan Africa, health sector reform has been driven by wider macroeconomic policy and the implementation of structural adjustment programmes which necessitate control of public expenditure and changes in public and private sector institutional structures (Sahn and Bemier, 1993). It can be argued that in SSA, HSR was promoted in a context of widespread poverty (Semali, 2003). In Tanzania for example, Household Budget Survey (HBS) data of 1991/92 shows that poverty was widespread and about 38.6% of the households were living below the basic needs poverty line (URT, 1992). In 2000/02 the figure was 35.7% (NBS, 2002). A World

[1]In this study it refers to district/ council which are the administrative and implementation units for public policies in Tanzania

Bank study carried out in Tanzania (2002) shows that between 15 and 18 million, out of 43.4 million were living below a poverty line of US$0.65 in a day of which about 12.5 million people were living in abject poverty(World-Bank, 2002). Yet, user fees were introduced in 1993 in a context where the majority of the population could not afford health care (Gilson and Mills, 1995).

(i) Economic context

The background above led to the poverty initiatives by African governments and donors in order to improve access to social services. The section below presents the state of the Tanzanian economy in which HSR was established. The review is divided into four timelines :(a) after independence (1961-1967, (b) the socialist regime (1968-1978) and (c) the home grown reform (1980 to 1985) and (d) the reform era (1986-1995).

(a) After independence 1961-1967

After independence in 1961, the Tanzanian Government under the leadership of President Nyerere committed to eliminate the three major enemies of national development; disease, poverty and hunger (Nyerere, 1968). The colonial economic structure was adopted and the revenue was derived mainly from exports of agriculture produce which contributed to more than 50% of the gross national product (GNP). Sisal, coffee, and cotton comprised 60% of total foreign earnings (Bevan et al., 1988). Per capita incomes increased by 2% per year (Table 3-1), and the economy experienced macroeconomic stability, low inflation and a reasonable balance of payments. Yet, inequalities increased as the economic growth failed to realise the expectations and demands of the population. President Nyerere by then and the ruling party named Tanganyika African Union (change the name to Chama cha Mapinduzi (CCM) after the union with Afro Shiras Party from Zanzibar in in 1977), leaders came with a proposal to speed up the national development through the socialist ideology (see Nyerere 1968 for details) implemented through the adoption of the Arusha Declaration in 1967.

Table 3-1: Table 3-1: Macro-economic data from 1961 to 1967

	1961	1962	1963	1964	1965	1966	1967
Per capita income growth %	-7.1	4.3	1.2	3.6	-0.2	9.9	1.8
Population growth %	2.8	2.8	2.9	2.9	2.9	3.0	3.0
Urbanisation %	4.8	4.9	5.1	5.2	5.3	5.6	5.9
Terms of trade (1987=100)	130	124	137	142	137	137	126
% of labour force in agriculture	92.4	92.1	91.9	91.7	91.4	91.2	90.9
Monetary growth %		21.7	25.6	-15.2	31.8	476.7	13.1
Inflation %	7.8	0.6	4.9	2.8	-2.4	9.3	11.5
Gross investment % of GDP	13.7	11.6	10.7	12.0	13.9	15.1	18.9

Sources: Bigsten, A. Danielsson, A. Is Tanzania an Emerging Economy*?* Data, adapted from the Income and investment data & World Development Indicators 1998**.**

(b)The Arusha Declaration and after 1968-1978

In 1967 the first national economic declaration were made, establishing the country's era of economic socialism. Leaders explicitly endorsed the socialist policy (known as *Ujamaa* in Swahili) to address inefficiencies in the country's economy (Nyerere, 1967). While embedded in Tanzanian traditional family structures. *Ujamaa* introduced a villagisation program whereby villagers from remote areas were relocated into *Ujamaa* villages. This was to enable them to access the means of production, as well as social services, including health and education, water, energy and improved communication. This was meant to increase the availability of productive inputs, the human capital and the sales prospects for agricultural production (Nyerere, 1968). The assumption was that national productivity and efficiency in agricultural production would increase, hence leading to a growth in per capita income which ultimately would increase national income distribution, and improved economic welfare (Wangwe, 1993).

Per capita income rose by 0.7% per year (table 3-2) but was not sustainable as the country experienced an oil crisis in 1973/74, the break-up of the East African Community and the war with Uganda. These crises consumed a large proportion of the national resources and reduced the ability of Government to meet its external obligations specifically servicing of the outside debt (Wenzel and Wiedemann, 1989). The Government suffered fiscal deficits, and started to borrow from local banks (Wangwe et al., 1997). Socialism was blamed for the worsening economy and the strategy was no longer sustainable. Financial support began to diminish as development

partners were hesitant to support what they saw had become an unattainable development model (Hyden and Karlstrom, 1993).

Table 3-2: Macro-economic from 1968-1978											
	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
Per capita growth %	2.1	-0.7	3.0	0.8	2.3	0.5	-0.5	2.9	2.3	-2.7	-1.9
Population growth %	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1
Urbanisation %	6.1	6.4	6.7	7.4	8.1	8.7	9.4	10.1	11.0	12.0	12.9
Terms of trade	126	126	137	123	128	146	174	142	152	182	152
External debt Million$			212	284	407	619	900	1170	1380	1700	1970
%labour force in agriculture	90.6	90.3	90.1	89.7	89.3	88.9	88.5	88.1	87.7	87.2	86.7
Inflation %	14.5	15.2	3.5	4.7	7.4	9.9	17.9	23.2	6.6	11.0	6.4
Monetary growth %	17.8	**9.2**	12.0	18.2	17.7	18.2	22.1	24.4	25.1	20.2	12.6
Gross investment, % of GDP	18.4	16.3	22.9	26.8	23.6	22.6	21.6	20.8	29.0	29.4	33.8

Sources: Bigsten, A. Danielsson, A. Is Tanzania an Emerging Economy*?* Data, adapted from the Income and investment data & World Development Indicators 1998**.**

(c) Recession period 1979-1985

In 1979, Tanzania experienced a fiscal deficit associated with the war with the Uganda. Thus, by the early 1980s, the economic performance deteriorated continuously, despite all efforts under the socialist policy (Mogedal S et al., 1995). Tanzanian products failed to access international markets because of poor quality which did not meet international standards. Therefore export earnings declined (Bevan et al. (1990). Due to collapsing world market prices, terms of trade deteriorated severely which led to an increase in the trade deficit, foreign capital inflows decreased, and overall indebtedness rose to critical levels (table 3-3).

President Nyerere negotiates with International monetary fund (IFM) on loan arrangement but the deal failed in 1979. This led to the formulation of the home grown National Economic Survival Program (NESP) in 1981-82, which did not succeed. As development partners were more critical about the negative effects of *Ujamaa* on economic efficiency. By 1983 most of the DPs had begun to pull out which went hand in hand with a fall in the imports. As foreign aid decreased, foreign savings also declined (Danielson, 1996) which, in turn, directly affected investments in the social sector. By the mid-1980s, the crisis was so acute and the external

support was so small that the government had no option but to shift, albeit reluctantly to reform (Bigsten and Danielsson, 1999).

Table 3-3: Macro-economic data from 1968 to 1978

	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
Per capita income %	2.1	-0.7	3.0	0.8	2.3	0.5	-0.5	2.9	2.3	-2.7	-1.9
Population growth %	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1
Urbanisation %	6.1	6.4	6.7	7.4	8.1	8.7	9.4	10.1	11.0	12.0	12.9
Terms of trade	126	126	137	123	128	146	174	142	152	182	152
External debt-Million $			212	284	407	619	900	1170	1380	1700	1970
% labour force in agriculture	90.6	90.3	90.1	89.7	89.3	88.9	88.5	88.1	87.7	87.2	86.7
Inflation %	14.5	15.2	3.5	4.7	7.4	9.9	17.9	23.2	6.6	11.0	6.4
Monetary growth %	17.8	9.2	12.0	18.2	17.7	18.2	22.1	24.4	25.1	20.2	12.6
Gross investment, % of GDP	18.4	16.3	22.9	26.8	23.6	22.6	21.6	20.8	29.0	29.4	33.8

Sources: Bigsten, A. Danielsson, A. Is Tanzania an Emerging Economy? Data, adapted from the Income and investment data & World Development Indicators 1998.

(d) The reform period 1986-1995

The new government adopted a three-year ERP (1987/88–1989/90), the aims of which were to create an economic recovery through reducing inflation, re-establishing a free market and improving the balance of payments (Kaijage and Tibaijuka, 1996). These aimed to reach a GDP target growth rate of 4.5%, an inflation rate below 10%, fiscal government deficit below 13% of GDP, an adjustment of the exchange rate, positive real interest rates by mid-1988, an increase of between 30 and 80 percent in nominal producer prices for cash crops, and decontrol of domestic prices over a period of three years. In August 1986, the Government received 18-month standby credit from the IMF. In November 1986, it obtained a Multi-sector Rehabilitation Credit from the IDA and Development partners (Wangwe et al., 1998).

In addition, Government qualified for loans under Paris Club, as it had heeded donor pressure by signing an agreement with the World Bank and International Monetary Fund (IMF) to implement radical reforms between 1986 and 1989 (Moshi, 1994). It was later noted that the state of social sectors was critical because of under-funding, poor management and inefficiency. Government, World Bank and other donors agreed to establish another reform namely Economic and Social Action Programme (ESAP) (World Bank, 1990). The ESAP aimed to reverse the poor

performance of the social sector, including health, consistent with economic development. The reform content of include trade liberalisation, liberalisation of medical practice and restructuring of public administration among others. The economy reverted positively with an average annual GDP growth rate of 4% between 1986 and 1994 (table 3-4). Per capita incomes grew by 0.6% per year. However, in 1990-1995, Government obligations to restructuring reforms were poor which led to weak donor support. This made the IMF, World Bank, and other DPs to reduce their support by suspending payments for development projects (Wangwe, 2003).

Table 3-4: Macro-economic data from 1986 to 1995

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Per capita income growth %	3.4	2.7	1.3	-0.6	3.1	-1.3	-4.1	-0.3	-0.1	0.6
Population growth %	3.2	3.2	3.1	3.1	3.1	3.1	3.1	3.0	3.0	2.9
Urbanisation %	18.2	18.9	19.5	20.2	20.8	21.5	22.2	22.8	23.5	24.2
Terms of trade	141	100	107	103	93	94	85	83		
External debt Million$	4610	5490	6010	5850	6410	6540	6620	6800	7260	743
Interest rate spread %	10.0	11.8	12.2	14.0	18.2					
%labour force in agriculture	85.0	84.8	84.7	84.5	84.4					
Current account % of GDP	-11.6	-15.5	-18.1	-17.2	-21.8	-24.5	-25.5	-24.		
Export % of GDP	9.8	14.6	13.2	8.5	8.4	15.2	18.5	20.5		
Import % of GDP	27.3	30.7	35.5	35.3	36.8	44.0	45.4	42.4		
Gross investment % of GDP official		23.5	17.4	19.3	28.2	28.5	28.9	26.7	26.4	21.2
Gross investment % of GDP (WB			18.2	17.0	22.3	25.9	26.5	25.8	24.6	21.7
Government Consumption % of GDP	16.8	16.3	17.0	18.4	19.3	19.5	18.1	16.1		
Domestic saving % of GDP			1.3	1.3	0.3	-0.6	-1.6	-2.8	-2.0	0.0
Manufacturing VA in GDP %			8.1	8.1	8.9	9.1	8.5	7.8	7.4	7.3
Inflation %	28.1	26.2	27.1	23.0	30.6	25.2	19.8	22.5	29.3	24.2
Monetary growth %	27.9	32.1	32.6	32.1	41.9	30.1	40.6	39.2	35.3	33.0

Sources: Bigsten, A. Danielsson,.

The data presented above shows that, in the post-independence period, 1961-1967, there was a rapid increase in per capita income of 2.0% per year. In the period before the recession, 1968-1978, there was an increase of 0.7% per year and, during the recession, 1979-1985, there was an annual decline of 1.5% per year. During the reform period, from 1986 onwards, per capita incomes increased by 0.6% per year. However, growth recovery could not be sustained due to infrastructural and institutional bottlenecks to support a free market economy. Regardless of liberalisation, it was noted by the mid-1990s that the macro-economic stabilisation policies did not succeed in improving social services (Wangwe et al., 1998). This is reflected in the health

system indicators presented in table 3-5. During the recession period only 3.1% of the GPD was allocated to the health sector

Table 3-5: Trends in the indicators of investment in health and health status in Tanzania				
	1923-62	**1961-722**	**1972-83**	**1983-92**
Health investment indicators				
Population/ Health Centre(1000s)	432	121.2	100.4	78.4
Population/Med/ Assistant (1000s)	9.7	7.9	9.4	6.4
Population/ Rural Medical Aid (1000s	42.5	35.8	17.1	10.8
GDP per capita in US dollars	12.3	25	132	74.8
Government Expenditure on health as percent of total expenditure	7.7	6.4	3.1	9.3
Health status indicators				
Life expectancy	35	45	52	50.6
Infant Mortality rate	160	150	135	88

Source: Semali, 2007

At the end of the 1990s, Government decided to focus programs on reducing poverty as the way of improvising the living conditions of Tanzanians. The idea coincided with the decision by international financial institutions to move to Poverty Reduction Strategies (PRS) which was obligatory for Highly Indebted Poor Countries (HIPCs) to access debt relief funds. The Government of Tanzania responded quickly by preparing a PRSP in order to gain access to the HIPC debt relief resources aiming at achieving the MDGs (Muganda, 2004).

From 1995 to 2005, substantial reforms were implemented by President Benjamin Mkapa and numerous measures to encourage private investment both from foreign and domestic sources were implemented. In addition,, numerous policies were put in place to lessen the budget deficit, remove price controls, and privatise of state-owned companies. These changes led to an increase in the export of goods and services from 24.1%, in 2006, to 30.2%, in 2012. Imports of goods and services also increased from 35.8% to 44.5% in the same period (MoFEA, 2013a). The GDP increased from 14 billion Tanzanian shillings in 1999/2000 to about 32 billion Tanzanian shillings in 2010/2011. This matches an average annual growth rate of 7.9%, which is high compared to other developing Sub-Saharan Africa countries (4.4%) and OECD countries (1.9%). Apparently per capita GDP is still at a very low level of 824,000 current Tanzanian shillings

(392 current US Dollars) .The percentage of people living in poverty was 43.5 % in 2011/12 (NBS, 2013).

(ii) Epidemiological context

Starting in the 1980s many developing countries started implementing intensive reforms in their health sectors in order to improve performance (Macrae et al., 1996). Health systems were under-performing and failing to reduce the burden of disease (BoD). In 1990s, the global burden of disease was quite high according to Disability Adjusted Life Years (DALY). Developing countries contributed a very high proportion of the DALY compared with their population size (Murray and Frenk, 2000). Sub-Saharan Africa, which had less than 9% of the world population, had about 21%t of BoD because of poor management, lack of resources and organizational failure (World Bank, 1993).

The current BoD in Tanzania was assessed by the latest Tanzania Demographic Health Survey (TDHS) of 2010/2011. According to TDHS data of 2009/2010 the MMR has declined to 454 deaths per 100 000 live births (NBS and Macro-ICF, 2005, NBS and ICF-Marco, 2011). This is a notable improvement, but maternal morbidity remains relatively high, requiring more effort to attain the MDG, which is 265 per 1 000 000 live births, similar to the goal used for MKUKUTA. HIV/AIDS still causes the highest amount of annual DALYs lost, compared to other diseases, with 3,276,000 of 18,189,000 total annual DALYs (URT, 2013). However, according to HIV/AIDS and Malaria Indicator Surveys 2010/2011, HIV prevalence slightly decreased from 6% in 2007/2008 to 5.7% (TACAIDS, 2013). The level of HIV infection is higher in urban compared to rural areas (7% and 4%, respectively). Access to and coverage of the prevention of mother-to-child transmission and antiretroviral drugs continue to increase. About 92.4% of HIV-positive women were receiving ARVs in 2010 an increase from 43% in 2009 (TACAIDS, 2013).

The estimates of the TDHS 2010 show that TFR is 5.4 and women with no education have high fertility rates (6.7) compared to women with other levels of education (3.1). Fertility declines have been associated with increase in women's health, earnings and participation in paid employment (Canning & Schultz, 2012).The TDHS (2010) indicated that 27% of married

women were using modern contraceptive methods. The increase relies heavily upon cross-sectoral investments in education, as evidenced by the way usage increases with education form 22% of married women, with no education, to 52 % of married women, with at least secondary education (NBS and Marco, 2010). However, this is still far from the goal of 60% contraceptive prevalence rate by 2015 specified in the Maternal Neonatal and Child Health (MNCH) Strategic Plan 2008-2015.

As maternal mortality rate stands at 454 which is still relatively high, requiring more effort to attain the MDGs, which is 265 per 1 000 000 live births, similar to the goal set by MKUKUTA. There is slow progress in the coverage of deliveries by skilled birth attendants in Tanzania, which increased from 43% to 51% from 2005 to 2010. Health management information system (HMIS) 2012 data show that 62% of deliveries took place in health facilities (MoHSW, 2013b). Not all health facility deliveries are attended by skilled birth attendants, despite the increase in the number of nurse-midwives in the country. 30% of health facilities still do not have a proper delivery room and adequate facilities (SARA, 2012). In rural areas, 42% of women delivered in a health facility, compared to 83% in urban areas. There also is a wealth gap in skilled birth attendance, as 93% of the women in the highest quintile had attended births, compared to only 33% in the lowest wealth quintile (NBS and ICF-Macro, 2011).

The prevalence of Malaria is the second largest cause of annual DALYs lost in Tanzania (1,644,000 DALYs). Efforts to reduce this burden of disease include the distribution of insecticide-treated bed nets (ITNs) and anti-malaria drugs. In 2010, three out of four Tanzanian households owned at least one mosquito net, but the percentage of households who owned an ITN was only 64. There is also an increasing distribution of intermittent preventive treatment (IPT) to protect pregnant women from malaria. The percentage of women who received the needed amount of IPTs (IPT-2) increased from 22%, in 2004/2005, to 30%, in 2007/2008. Nationwide, about 80% of pregnant women slept under mosquito nets at night but not all pregnant women receive IPT 2 due to low follow-up attendance in ANC (TACAIDS, 2013). Table 3-9 summarised key reproductive health indicators in Tanzania.

Table 3-6:Reproductive health indicators in Tanzania	
Total Population:	47.8 million
Annual Population Growth rate	2.7%
Maternal case fatality rate in health facilities	161
Total Fertility Rate (TFR)	5.2
ANC: pregnant women attending at least 4 times	36%)
ANC: first visit before 16 weeks of pregnancy	43%
Tetanus Toxoid coverage:% of pregnant women receiving 2nd dose of TT	88%
Institutional delivery rate	50%
Skilled birth attendance: births attended by trained personnel	51%
Emergency obstetrics care (EMOC): facilities that provide (%)	39% of health centres provides while hospitals 73%
HIV Prevalence, 15-49 years	5.3% (6.2% F, 3.9% M)
Postnatal care coverage	31%
Contraceptive prevalence rate	27%
ITN use among pregnant	71%

Source: Tanzania Demographic Health Survey (TDHS, 2010), health management information system (HMIS, 2012) National Bureau of Statistics (NBS, 2015), Tanzania Commission for AIDS (TACAIDS, 2012) Health Management Information System data , Service Availability Assessments (SARA, 2012),

(iii)Political context

Tanzania has been led by a single left wing party since gaining its independence, 54 years ago. Despite changing leadership in five times and the introduction of multi-party democracy in 1995 the same party *Chama cha Mapinduzi* has remained in power. In that respect the country has had no major political ideological shift and has always been promoting equity, fairness, justice and grassroots participation since the adoption of the Arusha Declaration.

The economic, political and epidemiological contexts that prevailed from the 1960s pushed for the current health sector reforms in Tanzania. Government proposed ambitious reforms in the sector to transform the roles and responsibilities in the provision and financing of health care services, in order to ensure a cost-effective use of resources and emphasise priorities towards outcomes rather than inputs. The Social Sector Strategy adopted in October 1994 aimed to increase resource allocation to social sectors, including health sector, promoting high quality service standards and higher private sector participation.

3 1.2 Decentralisation in Tanzania: historical background

The current decentralisation efforts originated from the adoption of the Local Government Reform Agenda in 1996. This is within the framework of the wider public service reforms and the liberalisation of Tanzanian economy. However, local government had undergone significant adjustments prior to the adoption of the local government reform paper in 1998. During the post-colonial period there were LGAs were established, then abolished of the LGAs in 1972, and reintroduced in 1982.

(i) Colonial era

This can be divided into the German era (1884-1917) and British era (1917-1961). During this period, the British colonial administration acted politically to give power to the natives to control their localities through a system known as "indirect rule" (Barkan et al., 1998). The British administration attempt to democratise the local government system by enactment of the Local Government Ordinance (Cap 333) of 1953 to replace the Native Authority Ordinance (Cap 72) of 1926 introduced electoral processes at the local level (Max, 1991:24).The 'native authorities' were established to collect local taxes and were responsible for limited services such as primary education, sanitation, dispensaries, and village roads. Rural health services were a legal responsibility of local authorities supervised by a District Medical Officer (DMO) as an agent of the central government. Services provided were mainly preventive health services like Maternal and Child Health (MCH) services.

(ii) The First Decade of Independence

Between 1962 and 1967, the new independent government undertook significant changes in local authorities by (i) replacing the administrative officers who previously head the provinces and districts with political appointees: regional and area commissioners; (ii) removing executive and judicial powers from the traditional chiefs and (iii) extending modern councils throughout the country to replace the native authority councils that were in place during the colonial

administration (Max, 1991). Besides these elected members the councils had also appointed members who were selected by the minister responsible for local government and did not exceed more than five (Max, 1991: 32). Another important landmark was the Arusha Declaration in 1967 which introduced centralised planning and management of health care and declared free health services to all.

(iii) Decentralisation through deconcentration (1972-1982)

In 1972, Local Government system which had existed for a decade was replaced by 'structural decentralisation' (Nyerere, 1972:1). Power and authority of the key functions of development planning, coordination, and management were consolidated at the grassroots through centrally appointed regional and district heads who were party appointees and/or civil servants(Oyugi, 1998, Max, 1991).The aim was to strengthen the role of regional and district administration as well as to implement the policy of socialism and self-reliance (Maro and Mlay, 1979). The new system was aimed at giving the people decision making powers over matters affecting their welfare. Participation was a rallying slogan. Hence village councils were established under the Village Act 1975 in order to enhance grassroots participation (JENNINGS, 2008:59-60). The deconcentrated administrative structure did not establish mechanisms that would enable meaningful citizen participation as the bureaucrats tended to make decisions on behalf of the people (Picard, 1980:40). It turned out to be bureaucratic organisations dominated by 'central government officials' (Maxi 1991:88), resulting to a nation of 'peasants and bureaucrats' with bureaucrats firmly in charge (Eriksen et al., 1999). There were overlapping central and local government functions, poor coordination at the all levels of government, communication breakdown between ministries and districts, plus limited resources (Warioba, 1999). However, villages managed to produce corporate plans, implemented through the top-down authority from the region to district, and to district functional officers, including DMOs.

Between 1976 and 1982, the ruling party recognised that the central government was no longer able to provide health services in rural areas. The Government started to re-introduce LGAs after the de-concentrated LGAs failed to deliver service. By 1983 the government had to decentralise in order to increase efficiency, community participation and management obligation(URT,

1983). The process was facilitated by the enactment of the two acts that was approved by the parliament in 1982. The aim was to provide the legitimacy to re-decentralise urban and rural councils(GoT, 1982a, GoT, 1982b).This was decentralisation by devolution to local government at district level. The Government re-established urban local authorities with less autonomy than the old ones since regions retained substantial influence. The power for raising local revenue was reduced. The CCM incorporated the re-introduction of LGAs in 1980 election manifesto. In 1982, Government enacted two new laws, the Local Government (District Authorities) Act No. 7 and Local Government (Urban Authorities) Act No. 8 which introduced a comprehensive system of local government authorities in rural and urban area (Steffensen and Mwaipopo, 2004). By 1984 a comprehensive LGA system at district and village levels in rural areas and at municipal and city levels in urban areas was formulated to empower LGAs to enact by-laws, collect revenues and determine local budgets and plans (Eriksen et al., 1999).

However, the revived local government system did not meet the expectations of the people in terms of efficient and effective service delivery. The local government agencies failed to organise participation and responsiveness to local needs. The Government commissioned studies to analyse government administration in all aspects including health services and to give suggestions regarding the best ways to achieve development goals (Ngware, 2005). One of the recommendations was to reform the local authorities through further decentralisation to respond to the existing socio-economic and global challenges. This laid down the basis for the Local Government Reform Programme (LGRP) in early 1990s. The process originated from the Civil Service Reform Program (CSRP) initiatives in 1994. The ruling party, CCM in their 1995 Election Manifesto promised that, if elected, it would extend decentralisation The noticeable political reforms were the first multiparty elections for parliamentarian seats and local government in 1995 and 1994 respectively (Oyugi, 1998). To date, yet majority of the seats in the parliament and the local councils are still controlled by the CCM.

(iv) Decentralisation devolution (1996+)

In 1996 the government announced a decision to restructure the intergovernmental system and local governments in order to make local governments more effective. The power of the regions was to be downsized. It was hoped that decentralising the intergovernmental and local

government systems would lead to improvements in service delivery (Steffensen and Mwaipopo, 2004). The government amended the Constitution to give LGAs more power. The Constitution states firmly that the purpose of having LGAs is "to transfer authority to the people." Article 146 of the Constitution states that the objectives of the LGAs is to "enhance the democratic process within its area of jurisdiction and to apply the democracy for facilitating the expeditious and faster development of the people"(URT, 1997a). The constitution requires of LGAs "to involve people in the planning and implementation of development programmes within their respective area"(URT, 1997a). The decentralisation process is therefore based on the solid foundation of the national constitution.

The local government reform agenda and policy in Tanzania is based on the Policy Paper on Local Government Reform of 1998. The policy paper sets out a comprehensive and ambitious agenda for local government reform through decentralisation by devolution. Specifically it envisaged decentralisation in four areas:

(i) **Political decentralisation:** to devolve powers to the LGAs, setting the rules for the councils and their organs of the LGAs and strengthening the local government system as the most important local political bodies within their areas of jurisdiction;

(ii) **Financial decentralisation:** to ensure LGAs has financial discretionary powers to levy taxes and raise local revenue, to make and approve their own budgets according to their own priorities reflecting local conditions and needs, while observing certain mandatory expenditure requirements to attain national goals and improving the inter-governmental fiscal transfer system for the LGAs to have adequate unconditional and other grants

(iii) **Administrative decentralisation:** to allow LGAs to hire, fire, pay and oversee their staff by delinking LGA staff from their corresponding ministries. This was intended to make LGAs personnel accountable to local council rather than central ministries,

(iv) **Central -local relations means** creating an enabling environment for the LGAs to deliver local services with full autonomy, whereas line ministries relinquished the role and functions of execution to take up the role of policy making, providing supportive services and capacity building to the LGAs, monitoring and quality assurance, and regulatory functions through legal control and audit of the LGAs (URT, 1998a).

The LGRP was launched in 2000, to enhance the implementation of decentralisation. The focus of LGRP was on building capacity of the LGAs, to allow them greater responsibilities to control their own resources and deliver public services more efficiently (URT, 2006). The intention was to limit the role of sector ministries so that they provide technical guidance on sectoral issues, set sector policies and legislative guidelines for LGAs, determine sector specific service delivery standards and monitor performance; and they were expected to reduce the extent to which they determined the composition and allocation of resources available to the LGAs (URT, 1996, URT, 1998a).

In addition, decentralisation also aimed to empower the lower tiers of LGAs to raise and manage revenue and expenditure. Village Councils can, for example, make by-laws to prescribe local fees, charges and tariffs for the licenses or permits they issue (Fjeldstad and Semboja, 2000). In Section 9 (1) of the revised Finance Act (1999), direct community involvement in controlling public revenue and expenditure through service user committees and boards has been provided. The linkage of the local level planning and budget processes and the central government's Strategic Budget Allocation System has been strengthened through the Plan-Rep system and introduction of formula-based grant systems in 2004 has made transfers more equitable, predictable and efficient. But, the government's commitment to formula-based allocations is weak, with some recurrent and development allocations deviating substantially from the formula (MoFEA, 2010).

The framework for decentralisation is well established within the legal framework of the Local Government Acts of 1982 and their amendments. This acts as a reference point for the decentralisation process which is defined in the local government reform policy of 1998. Some components have advanced further than others, and there are some discrepancies (JICA, 2008). Furthermore, reform policies have to take into consideration Tanzania's long-term development framework, Development Vision 2025 published in 1998, and the medium-term development framework, which is guided by Tanzania's poverty reduction strategy known as National Strategy for Growth and Reduction of Poverty (NSGRP). The implementation of the LGRP was

phased out in June 2008. The joint Government-Donor Reviews (2002; 2004 and 2006) have shown considerable progress towards LGRP but very little has been achieved in terms of fiscal and administrative decentralisation., Government executed Phase II of the LGRP, from July 2009 to June 2014.

3.2. The Structure of the public health in Tanzania

The public health sector in Tanzania is divided into central and local government levels. The central level comprises the ministerial and the regional administration. At the central level, the Ministry of Health and Social Welfare (MOHSW) is the major organ for coordination overall of the national health services working in collaborations with the Prime Minister's Office Regional Administration and Local Government (PMO-RALG). The PMO-RALG is responsible for the LGAs health services. At the regional level, Tanzania is divided into 26 administrative regions which is an administrative extension of the central government authority. The Regional Medical Officers (RMO) is accountable to the MoHSW and PMO-RALG. At this level, heath service is managed by a technical team called regional health management team (RHMTs). By 2014, the government owned 15 regional hospitals. The RHMTs oversee regional referral hospitals, and monitor CHMTs. RHMTs provide technical assistance to regional facilities and local councils (MoHSW, 2008a). They assist the LGAs in the production of the council health plans which is referred as Comprehensive Council Health Plan (CCHP). They also provide advice on construction and rehabilitation of health facilities; assess the distribution of health facilities within the councils to ensure equity in access and efficient in the use of the health resources (MoHSW, 2008a).RHMTs works along with the administrative team called Regional Administrative Secretaries (RAS) in providing regional health services and supervising the delivery of health services in their region.

At the local level there is a local government authority with 158 district-level (urban and rural) LGAs. An average LGA has about 250,000 residents and is managed by elected Council. This is the main government level responsible for the delivery of decentralised public health services in Tanzania. The most senior local official in the health sector is the District Medical Officer (DMO). The DMO is supported by the Council Health Management Team (CHMT) which is

comprised by the DMO and senior local public health administrators holding postgraduate degree.

The district health system is responsible for primary health service which is made up with council hospital, dispensaries and health centres. These are the primary facilities that are closer to the communities. By 2014, Government had 63 council hospitals, 5,819dispensaries and614 health centres(MoHSW, 2015). Dispensaries are limited to out-patient care while the health-centres are supposed to provide in-patient health services that are referred from the dispensaries(URT, 1998b). However, the distinction is less clear as dispensaries have been improved to provide child and maternal health services. The health centres and dispensaries are the frontline in providing primary curative and preventative health services and are the main source of health services for the majority of the population, mostly in rural areas. These facilities operate with some degree of autonomy; but they are supervised by and fully accountable to the DMO for all aspects of their operations(URT, 2001d).

As well as the district hospital fall under the direct responsibility of the DMO. The current assignment of functional responsibilities has resulted in a relatively decentralised assignment of health services to the district council. However, at the district council level, control of the planning and management of health services is somehow centralised. The DMO is the appointee post by the MoHSW and formally reports to the Council through the Executive Director plays a significant role in planning, coordinating and implementing the delivery of the district health services. The DMO is supported by the CHMTs and executed their task following central guidelines and instructions. In order to promise the coherent in the delivery of council health services, the DMO and the CHMT are required to prepare a Comprehensive Council Health Plan (CCHP) that guides the delivery of the local health services.

A system of health committees (at the district and primary health facility-level) has been set up to assure public participation, oversight and accountability over local health services. council

health services boards (CHSBs), and health facility committees (HFCs) at have been established as democratic organs with legal status to govern the provision of health services (URT, 2001b). The bylaws for their establishment specify roles of the HFCs and CHSBs. It is assumed that they will lead to an increase in user representation and accountability (URT, 2001c, URT, 2001b).

The MOHSW works jointly with other government institutions and development partners for resource mobilisation. The Ministry of Finance and Economic Affairs (MoFEA) manages the overall revenues. It allocates funds for salaries as per the approved vacancies, and releases funds upon the approval of health budgets. MoFEA provides the Government with advice on broad financial budget and defines expenditure allocations

The President's Office, Public Service Management (PO-PSM) assists in matters of human resource management pertaining to Public Service across the entire government system. This includes responsibilities for personnel policies, administration and coordination of training and recruitment. This office plays a crucial role in human resources for health by overseeing staff establishment, schemes of service and promotions, and the issuing of approvals of vacancies against the posts available. LGAs and MDAs are responsible for placing requests with the PO-PSM for the staff they require. The MOHSW has been assigned the role of posting staff in accordance with POPSM-approved vacancies(MoHSW, 2013b).

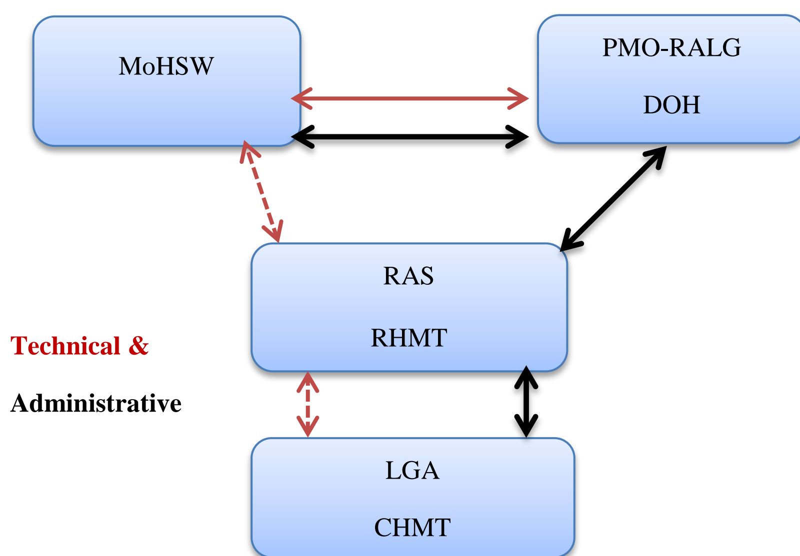


Figure 3-1: Technical and administrative relations in a decentralised health sector

Source: PER, 2013.

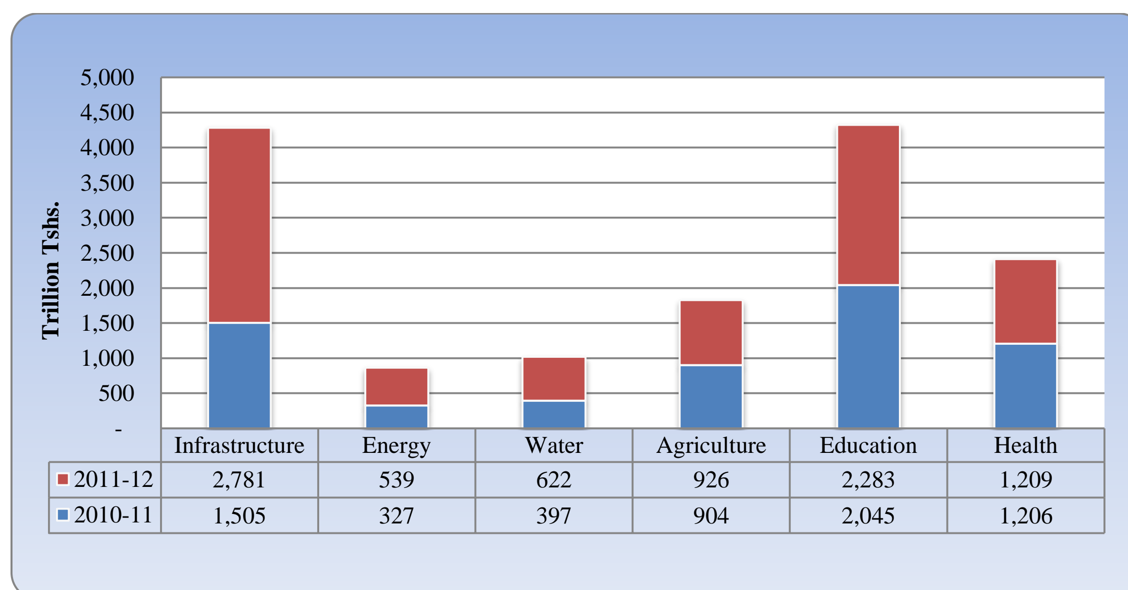
Although health governance structures are in place and CCHPs are developed annually, councils are not accountable to the public for spending within the health sector. This is mainly because the communities are often not aware of the money allocated to health care. As per government guidelines, community members should lodge their complaints about CHMT practices to the office of the DED (MoHSW, 2010). However, in practice, the DED are often not actively involved in enforcing CHMT roles and responsibilities (Masau et al., 2011).

3.3 Health system performance indicators

This section summarises health system performance indicators that are most relevant to this study based on MoHSW of the different documents. The review aims to point out financial human resources for health and health governance indicators.

3.3.1 Health financing

Government health expenditure data show that investments in the sector have stalled in the last few years. Figure 3-2 shows that the health sector lags behind to other priority sector; although, its budget has increased from Tsh1206 billion in 2010/2011 to Tsh1209 billion in 2011/12. However, there was an increase of 85% for infrastructure, 65% for energy, 12% for education and 2.5% for water while health was 3.1% (URT, 2011a).



	Infrastructure	Energy	Water	Agriculture	Education	Health
2011-12	2,781	539	622	926	2,283	1,209
2010-11	1,505	327	397	904	2,045	1,206

Figure 3-2 Allocation to priority sectors in Tanzania
Source: MoHSW, 2011

(a)Health budget trend

Financial trend to the health sector presented in figure 3-3 below shows that national allocation has increased between FY 2010/11 to FY 2011/12 then dropped in FY 2012/13 and increased in the FY 2013/14. However, per capita health spending as a percentage of GDP has increased from Tsh 11 298 (US$9.5) in 2005/2006 to Tsh 30 400 (US$19) in 2011/2012 (Masau et al., 2011).. However, this is below the 2011 WHO estimate of USD$40 needed for the Government to be able to provide a minimum package of health services to all Tanzanians. This amount is also less than the national target of US$33 and lower than the regional average of US$148 (MoHSW, 2013b).

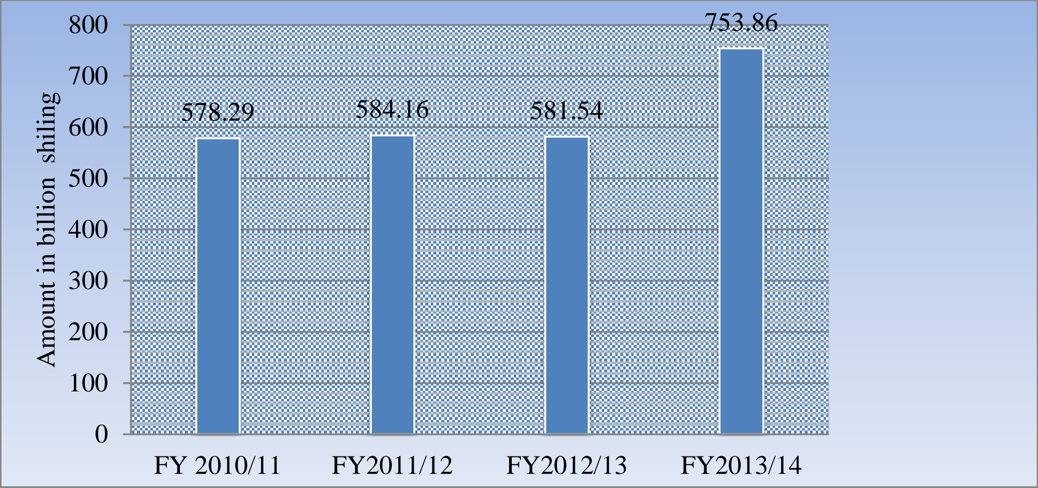


Figure 3-3: Overall national health budget trend from the FY 2010/11 to 2013/14

Source, MoHSW, 2014

(b) Sources of public health funds

The public health sector has two main sources of funding: internal and external resources. External resources are channelled to the health sector in three forms: general budget support, health basket funding and direct programme or project support. Internal sources account for 70% of the total health spending including tax revenues (28%), household revenues (25%) and private funds (3%). External sources (donors) are channelled to capital development, while recurrent expenditure comes from government sources (MoHSW, 2013b). Insurance funds contribute 3% of the total health care spending.

As shown in table 3-7, Government funding as a proportion of total public funding for health has been decreasing. In 2007/08 government funding as a share of total public funding was 66%, but decreased to 63% in 2009/10, and stands at 59%, as established in the 2011/12 budget (MOHSW, 2012a). However, public health budget has become increasingly reliant on external funds, which may not be sustainable in case they withdraw funding.

Table 3-7 Sources of public health funding										
	2007/06		**2008/09**		**2009/10**		**2010/11**		**2011/12**	
	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total
Gov Funds	378,114	66%	461,504	65%	578,793	63%	576,858	62%	710,096	67%
Foreign Funds										
Donor basket	80,957	14%	85,401	12%	128,796	14%	126,822	14%	151,013	14%
Non-basket	112,003	19%	154,168	22%	200,049	22%	213,979	23%	189,825	27%
Total Foreign Funds	192,960	33%	239,569	34%	328,845	36%	340,801	37%	340,839	32%
Off-budget	5,696	1%	5,858	1%	10,784	1%	14,212	2%	10,414	0%
GRAND TOTAL	**576,770**	**100%**	**706,931**	**100%**	**918,422**	**100%**	**931,871**	**100%**	**1,061,349**	**100%**

Source: PE, 2011

(c) Health expenditure as a share of total government expenditures

The health sector is one of the priority sectors in government allocation. Other sectors include education, electricity, water, transport and transportation infrastructure, agriculture, irrigation and job creation in the public and private sectors. The priority sectors were allocated more than 60% of the national budget in 2010/11 that equivalent to 17% of the GDP. However, total government expenditures, including all sectors (figure 3-4), increased by more than 10% during previous budget years. On average, the education sector received most of the allocated funds (19%), followed by health (9%), agriculture (4%), and water (3 %) (URT, 2011).

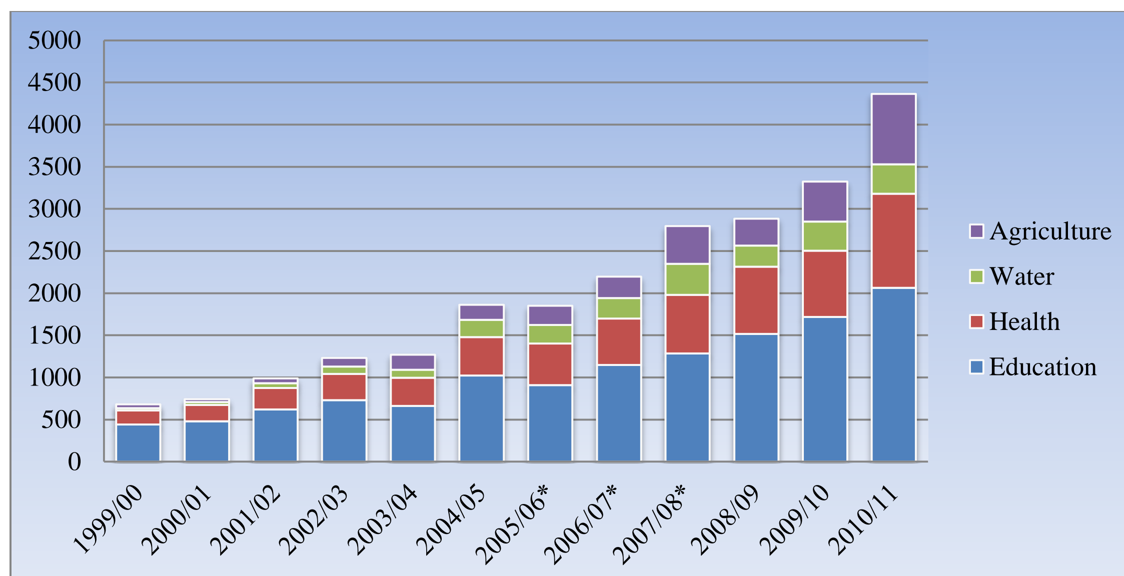


Figure 3-4: Government expenditure on major sectors in billion Tanzanian shilling

* Budget data available only (not actual expenditure)

Source: Ministry of Finance and Economic Affairs

Since 2001 Government intended to increase health expenditures in line with the Abuja goal of 15% of government budget devoted to the health sector. However, government data shows that the Abuja commitment has not been realised. Table 3-8 shows that 12.1% of government spending (excluding Consolidated Fund Service) was allocated to health in 2009/10, while only 10.4% of government budget was allocated in 2012/13. As a share of GDP, government health expenditures have declined from 3.0% in 2009/10 to 2.8% in 2011/12

Table 3-8. Health expenditure as share of total government expenditures

	2007/2008	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Health spending as share of gov budget excludes. CFS	12.3%	12.1%	13.1%	11.9%	12.1%
Health spending as share of gov budget Include. CFS	11.1%	10.8%	9.9%	9.5%	9.5%
Health spending as % of GDP	2.52%	2.67%	3.03%	2.63%	2.80%

Source: MOHSW, 2013

MKUKUTA allocation for cluster II, which included the health sector, receives fewer resources, as Table 3-4 shows. An analysis shows that, since their inception in 2005/2006, there has been uncertainty on allocations among the clusters. A larger proportion of resources are allocated to

support growth of the economy. Cluster II was allocated 31%, while Cluster I received 51% and Cluster III 8% of the total MKUKUTA funding. MKUKUTA budgets are restrictive to cost effective interventions thus, some components of reproductive health are not receiving any allocation. The HIV/AIDS and TB are prioritised which means that key reproductive health interventions, such as promotional services, are not favoured. The MKUKUTA focus has been mainly on economic growth, and the country has indeed experienced consistent growth of around 6%, (URT, 2009c).

General government financial resources to the health sector are decreasing and public health budget has become increasingly reliant on foreign funds. Thus, increasing resources for the RHS requires the expansion of the general health budget as at current level the health sector is already overstretched with other competing demands such as human resource for heath, expansion of the facilities to mention the few. The planned resource required to deliver health reform goals continues to diminish, signifying resource's for the RHS will also decline

3.3.2 Human resources for health

Health care personnel play a significant role in service delivery. Human resources in the health sector are inadequate in absolute numbers and relative to the size of the population (URT, 2009a). According to the human resources for health (HRH) profile for 2012, there were a total of 64 449 health workers which corresponds to 52% of the demand using 1999 staffing norms, or 36% of the demand using the new staffing norms (MoHSW, 2013a). Despite the national data on HRH showing improvements in certain cadres, the sector is facing a serious HRH crisis at all levels for all cadres. The shortage was significant during the 1990s following the retrenchment of the civil servants and the imposition of a freeze on employment which was a part of aid conditions. This led to the loss of one-third of the health workforce (Mæstad, 2006, CEGAA, 2009). The shortage was also worsened by the rapid increase of HIV/AIDS, malaria, and tuberculosis patients (URT, 2011b).

In responding to the crisis, the MOHSW formulated a strategic HRH plan (2008 to 2013). Included are an increase in the number of training institutions and government scholarships granted to students admitted to both public and private medical schools. This led to a significant increase in the number of graduates for different cadres (MoHSW, 2008b). Human resource management has been weak, with limited absorptive capacity in the system. The health sector can only take up some of the newly trained health workers, despite the huge shortage of health personnel. The workload is measured through the number of professionals per 10 000 people, as in Table 3-9. Generally there is an increase in all cadres expect for assistant medical officers.

Table 3-9: Human resource for health per population in Tanzania

Type of cadre*	2008	2012
Medical officer (MO)	0.3	0.5
Assistant medical officer (AMO)	0.4	0.4
AMO and MO	0.7	0.9
Nurse/midwife	2.6	4.8
Pharmacist/pharmacy technician	0.15	0.13

* Health worker per 10 000 population. Source: MoHSW, 2013

The national data shows that there is a huge deficit for specialist doctors (58.1%) compared to other cadres. The shortage is triggered by poor distribution, remuneration and infrastructure. As well, lack of the retention schemes and international migration after training (Mshana and Petit, 2011, Munga et al., 2014). Poor management affects the output of staff and ultimately the quality of services.

Regional data also show huge disparities between rural and urban (Figure 3-3). While urban facilities had, 77.5% of medical personnel, the remote regions had only 22.7% as Figure 3-6 shows. The regional averages reflect inequality in intraregional and intra-district distribution. The SIKIKA tracking study for the HRH (2011) found that 40% of the registered doctors were not practising. Only 43% were practising in public facilities while 17% are working with NGOs, 8% had emigrated. Country studies revealed that health workers are not attracted to work in remote areas. Factors that influence attraction and retention include provision of housing and

other essential items. The retention depends on the availability of the local resources which pose challenges for poor regions (Mshana and Petit, 2011). Inequitable distribution of HRH will persist until workable solutions are found to attract staffs to serve in less popular regions and councils.

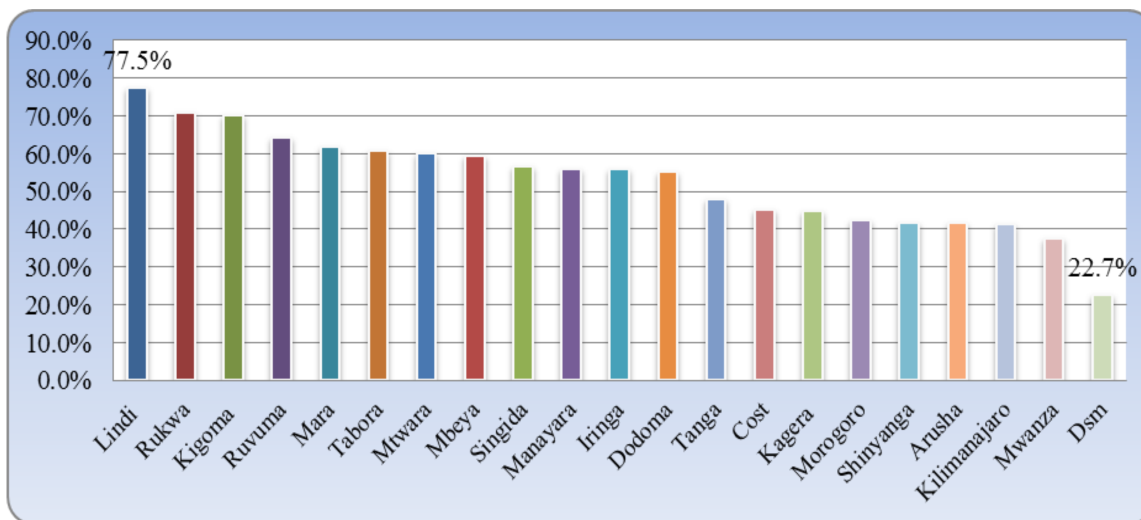


Figure 3-5 Deficit of human resources in health, by region

Source: PMO-LARG, 2011

LGAs HRH disparities are also huge in rural councils compared to urban ones, as shown in Figure 3-5. Urban councils have twice the number of health workers per capita compared to rural council. LGAs with a small number of HRH also had a small share of highly trained HRH. Figure 3-6 shows that LGAs lack specialist doctors, whose availability is 39%. Social welfare officers and assistant dental officers are far below the numbers required. Other cadres such as nurse-midwives, public health nurse, clinical officers, health officers, pharmacists/technicians and radiographers have increased by 50% but are below the 60% required. Assessments carried out in 2009 show that councils' HRH numbers are below 50% of the requirements (Munga and Maestad, 2009a). The health sector is facing a crisis of staff shortage which threatens operations to serve millions of clients in the nation. In order to prevent this, strenuous efforts by the government and other stakeholders in the health sector are needed to avert the current crisis.

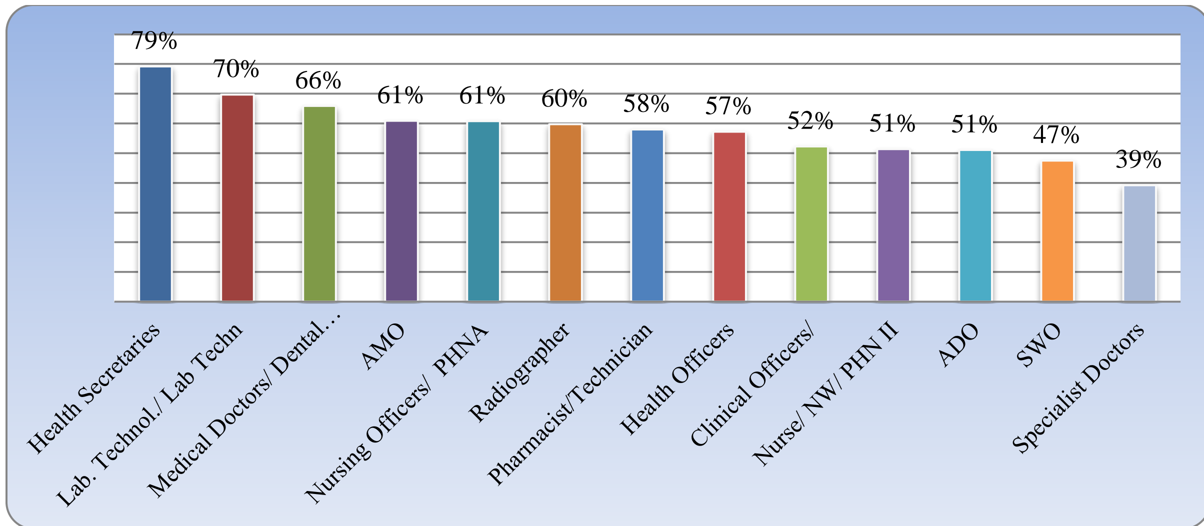


Figure 3-6: Percentage of the available healthcare personnel in LGAs

Source: MoHSW, 2011

3.3.3 Health governance

Governance is one of the political processes aiming at balancing of competing influences and demands (WHO, 2000). Governance in health systems is about developing and setting in place functioning rules in the institutional for policies, programmes, and activities related to fulfilling public health functions in order to achieve health sector objective. The rules define which actors play which roles, with what responsibilities, to achieve health system objectives (Brinkerhoff and Bossert, 2008).

Decentralisation by devolution in Tanzania plays a critical role in health governance. At national levels, MoHSW and PMO-RALG play a key role in management, but are not always sufficient to translate policy in practice. Generally, roles and responsibilities in the MoHSW and its departments are clear and well defined in the policy and strategy documents guiding the management (MoH, 2003) . The relationships with other ministries, DPs and private for and not-for-profit organisations are described in laws, regulations and other formal agreements. The challenge facing the MoHSW is the human resource problems, as many of the public servants have none of the necessary knowledge about policies and strategies; hence there is limited

capacity to translate concepts into practical programmes. Information is not always shared and collaboration between departments is not always optimum.

At the regional level, RHMTs oversee regional referral hospitals, and monitor CHMTs. RHMT members also provide technical assistance to the regional facilities and CHMTs (MoHSW, 2008a). They assist CHMTs in developing the Comprehensive Council Health Plans (CCHP) and managing health financing mechanisms within the council, as well as in developing health centre and dispensary plans. Specially, they provide advice on construction and rehabilitation of health facilities; assess the distribution of health facilities within the councils in order to avoid duplications and promote use of existing FBO facilities; monitor the distribution of and construction of additional health facilities within the councils to ensure equity of access and efficient use of available resources, which includes existing health facilities; and monitor the staffing and equipping of all health facilities (MoHSW, 2008a).

At council, CHMTs prepare the comprehensive council health plan (CCHP) on an annual basis. The plan holds the CHMTs and their councils accountable to the central health authority and their constituents. CHMTs are evaluated based on the quality of the CCHPs produced. The analysis of the 132 councils shows that 126 (95%) councils were recommended for funding, while six (5%) councils were not recommended. However, this is an improvement when compared to the preceding year, when 19 councils were not recommended for funding (MoHSW, 2011). This shows the importance of the RHMTs in assisting councils to improve planning and budgeting capacities. CHMTs, are supposed to perform both technical and administrative clinical supervisory duties within district hospitals, health centres and dispensaries(MoHSW, 2008a).

Governance structures have been established at communities to hold providers accountable in health services delivery. However, the functioning of this structure is still questioned, current as many of them are not performing their oversight role. Only half of governance structures are functional and few have approved CCHPs or annual hospital plans (Masau et al., 2011). These compromise the important role of voicing community interests in the management of health facilities.

Although the above-mentioned structures are in place and CCHPs are developed annually, councils are not accountable to the public for spending within the health sector. This is mainly because the communities often are not aware of the money that is allocated to health care. As per government guidelines, community members should lodge their complaints about the CHMT practices to the District Executive Director (DED) office (MoHSW, 2010). However, in practice, DED often are not actively involved in enforcing CHMT roles and responsibilities (Masau et al., 2011).

3.4 Reproductive health performance in Tanzania: A brief overview

Pregnancy and childbearing have been major causes of death and disability among women. In many parts of the world, women face a burden of ill-health linked to sexually transmitted infections. In low- and middle-income countries, unsafe sex is the leading risk factor for death and disability among women of reproductive age (20 to 49 years), which can lead to sexually transmitted infections, including HIV (WHO, 2014). Although many of these infections can be prevented and treated, women in the developing world have no access to appropriate information and services. Women are more vulnerable to infections for both biological and social reasons; they might lack the knowledge they need to protect themselves or may not be in a position to use it (Cook et al., 2003) Improved health outcomes have broader individual, family and societal benefits, including a healthier productive force and better access to resources for each child in smaller families (Canning and Schultz, 2012, Gribble and Voss, 2009, Cook et al., 2003). Hence, poor health outcomes affect opportunities for families to escape from poverty (Rights, 2012, Bernstein and Hansen, 2006).

Global data on reproductive health is not impressive, although there has been an improvement. The Adding It Up report by the World Health Organisation (WHO), United Nations Population Fund (UNFPA) and World Bank (WB) (Sing, Darroch & Ashford, 2014) shows that sexual and reproductive health needs are not met in developing regions. An estimated 225 million women

who want to avoid a pregnancy are not using an effective contraceptive method. Since the Adding It Up report for 2008, the number has been virtually unchanged. Out of the 125 million women who give birth each year, 54 million make fewer than the minimum of four antenatal visits recommended by the WHO; 43 million do not deliver their babies in a health facility; 21 million need but do not receive care for major obstetric complications; 33 million have new-borns who need but do not receive care for health complications; and 1.5 million are living with HIV, more than one-third of whom are not receiving the antiretroviral care they need to prevent the transmission of the virus to their new-borns and to protect their own health (Singh et al., 2014).

Although data on maternal deaths shows there it decreased by 45%, from 543 000 in 1990 to 289 000 in 2013, deaths in the developing world are still high. Of the 289 000 global maternal deaths, developing countries contributed 99% (286 000), compared to 2 300 deaths in the developed countries. Sub-Saharan Africa alone constitutes the majority of the deaths, namely 62% (179 000), followed by Southern Asia at 24% (69 000). These two regions account for 86% of the global maternal mortalities (WHO, 2014). The adult lifetime risk of maternal mortality for SSA women is the highest, at one in 38, in comparison to one in 140 in Oceania, one in 200 in Southern Asia, one in 310 in South-east Asia and one in 3 700 among women in developed countries. The contributing factor is the poor access to and poor quality of health service (WHO, 2014). Although the country data shows some improvements on RH indicators in particular maternal mortalities, yet, much of the target has not been achieved, including universal access to reproductive health care by 2015. The next section presents the available information against the selected reproductive health sector indicators. The aim is to understand the current RHS status in Tanzania.

3.4.1 Maternal mortality

Maternal mortality is any death reported during pregnancy, childbirth or within 42 day after the birth or termination of a pregnancy (MOHSW, 2008d). Maternal health has improved over the years, although the rate is still unacceptably high. According to the Tanzania Demographic and Health Surveys (TDHS), 2004/2005 estimates show that the maternal mortality ratio (MMR) at

578 maternal deaths per 100 000 live births. The TDHS results of 2009/2010 show that the MMR has declined to 454 deaths per 100 000 live births (NBS and Macro-ICF, 2005, NBS and ICF-Marco, 2011). This is a notable improvement, but maternal morbidities are still relatively high, requiring more effort to attain the MDGs, which is 265 per 1 000 000 live births, similar to the goal used for the MKUKUTA target.

3.4.2 Proportion of pregnant women starting ANC before 16 weeks' gestation age

Antenatal care can be most effective in avoiding adverse pregnancy outcomes when it is sought early in the pregnancy and continues through to delivery. Timely and consistent check-ups by trained providers are very important in assessing the physical status of women during pregnancy. In 2008 about a sixth (14%) of pregnant women started attending antenatal care (ANC) services before 16 weeks of gestation, whereas in 2009, slightly less than half (47%) attended ANC services before 16 weeks of gestation. The Reproductive Health Strategy 2005 to 2010 set a target of 60% of pregnant women starting to attend ANC services before 16 weeks of gestation by end of year (2010); the current performance is significantly behind the RCH target, which implies that more intervention is required.

3.4.3 Proportion of births attended in health facility

Proper medical attention and hygienic environment during delivery can decrease the risk of complications and infections that can cause the death or serious illness of the mother and/or the new-born baby. Hygiene is essential to reduce health risks to mothers and new born children. There is slow progress in the coverage of deliveries by skilled birth attendants, which increased from 43% to 51% from 2005 to 2010.Heath management information system (HMIS) 2012 data show that 62% of deliveries took place in health facilities (MoHSW, 2013b). Not all health facility deliveries are attended by skilled birth attendants, despite the increase in the number of nurse-midwives in the country. Still, 30% of health facilities do not have a proper delivery room and adequate facilities (SARA, 2012). In rural areas, 42% of women delivered in a health facility, compared to 83% in urban areas. There also is a wealth gap in skilled birth attendance,

as 93% of the women in the highest quintile had attended births, compared to only 33% in the lowest wealth quintile (NBS and ICF-Macro, 2011).

3.4.5 Proportion of births attended by skilled health personnel

The type of support a woman receives during childbirth has significant health consequences for the mother as well as the child. The proportion of births attended by skilled health personnel is measured by the number of deliveries conducted by skilled health personnel as a proportion of the projected number of births. The 2004/2005 TSDHS findings show that less than half (46%) of births or deliveries were attended by skilled attendants, whereas the 2010 TDHS reports that 51% of deliveries were attended by skilled attendants, indicating a slight increase.

3.4.4Contraceptive prevalence rate

The level of current contraceptive use methods is one of the indicators commonly used to assess the success of family planning programmes and the determinants of fertility. This indicator is measured as the number of contraceptive active users (including and excluding condoms) as a proportion of the total number of women of childbearing age. In 2010, data from facilities (HMIS) indicated that 46.7% of the women of reproductive age were using any modern family planning method. However, the 2004/2005 TDHS found that 20% of married women were using any modern contraceptive method, and this increased slightly to 27% according to the 2010 TDHS. These results show that there still is a big gap that needs to be filled when this realisation is linked to the 60% contraceptive prevalence rate by 2015 specified in the Maternal Neonatal and Child Health (MNCH) Strategic Plan 2008 to 2015.

3.4.5 Percentage of HIV-positive women receiving ARVs

This is an indicator that measures the number of HIV-positive women receiving antiretroviral (ARV) drugs for the prevention of mother-to-child transmission (PMTCT) as a proportion of the

total number of HIV-positive pregnant women per year. National Guidelines on PMTCT were developed in 2007 and integrated into ANC services (MOHSW, 2012b). Testing and counselling for HIV is offered to all mothers at ANC. Access to and coverage of PMTCT and ART continue to increase. About 92.4% of HIV-positive women were receiving ARVs in 2010 an increase from 43% in 2009 (TACAIDS, 2013).

3.4.7 Proportion of mothers who received two doses of intermittent treatment (IPT)

This is an indicator measured at household level and based on pregnant women aged 15 to 49 years who received at least two doses of intermittent preventive treatment (IPT) during their last pregnancy that led to a live birth within the last two years, out of a total number of surveyed women aged from 15 to 49 years who delivered a live baby within the same period outlined above. The malaria prevention has integrated into ANC and pregnant women receive two doses of Sulfadoxine/Pyrimethemane during the second and third trimesters to protect them from the adverse effects of malaria in pregnancy and low birth weight. Also, at ANC, pregnant women access subsidised insecticide-treated bed net (ITNs). Nationally, 80% of pregnant women slept under mosquito nets at night but not all pregnant women receive IPT 2 due to low follow-up attendance in ANC (TACAIDS, 2013).

3.4.8 Fertility trend

The World Fact Book data estimates for 2013 show that the annual population growth rate is 2.82% in Tanzania. This placed the country 17th in the world. The total fertility rate (TFR) is still high (5.4), although the TFR trend shows there are positive gains. When compared to previous TDHS, the 2010 TDHS estimates show that TFR is lower (5.4) than the 2004/2005 TDHS (5.7). Similar rates were identified in the 1996 TDHS (5.8) and in the 1999 Tanzania Reproductive and Child Health Survey (TRCHS) (5.6). When compared to some SSA countries like South Africa, with a TFR of 2.8, the Tanzanian TFR is very high, differs widely within the country and is associated with the background characteristics of women. Women with no education have high fertility rates (6.7) compared to women with secondary and/or other levels of education (3.1). This signifies an inadequate, low or unmet need for family planning. Review

studies have shown that fertility declines are associated with an increase in women's health, earnings and participation in paid employment (Canning & Schultz, 2012).

3.5 Chapter discussion and conclusion

The chapter looks at the contexts that led to health sector reforms in Tanzania. The poor performance of the economy and poor public administration led the government to solicit partnership with donors. The analysis reveals that in regard to the targets of health sector reforms to improve health system performance and local health service delivery, government had adopted deferent measures including centralising or decentralising depending on the time. For example during the socialist era government adopted deconcentration as form of decentralisation to consolidate development programs to grassroots like construction of dispensaries through both government and community efforts.

With regard to health reform there have been numerous changes. The foremost is the change in the role of central government from service provider to policy maker. Currently local authorities are in full of charge of local service delivery and citizens have been transformed from service recipients to clients/customers. Service providers are allowed to charge fees up to a certain amount and prices may vary depending on the level of service delivery Therefore, the relationship between the provider and receiver has changed into buyer and seller.

Since independence the government has pursued a distinct path of decentralisation with some approaches more meaningful than others. Government has concentrated on devolution to give meaningful authority to lower levels of government. However; their relative autonomy has not significantly changed despite a deliberate official policy of 'decentralisation by devolution'. The subsequent chapters which present field evidence, show that there are areas where the reforms have progressed and areas where they have had limited progress or even led to centralisation of the decentralised functions.

However, it is also widely recognised that the transitions of political and economic systems have been incomplete with lack of accountability and responsible governance. It is generally recognised that implementation of the decentralisation is influenced by values of the ruling party CCM with the patronage of the civil servants representing central government in local affairs. The opposition parties are becoming vibrant but CCM is still the majority party, with 98% and 70% of national and local parliaments respectively. Although, decentralisation was included in the CCM election manifesto; yet some of the party leaders have been supporting legislations which are against decentralisation. In an interview with the Prime Minister (PM) during the evaluation of the LGRP in 2007, he PM argued that some CCM leaders did not share the same vision of decentralisation. They felt that it was unrealistic for LGAs to employ and control their own staff. The existence of central appointees at the LGAs explains the interests of the CCM in strengthening local capacities for their political gains. Thus, unless central government decides to implement full decentralisation to enable LGAs decide upon their own matters, there is no hope further devolution would resolve service-delivery issues.

It has been obvious that health sector decentralisation is strongly influenced by the contextual factors surround general public reforms. In Tanzania, it is clear that decentralisation is strongly determined by historical, political, economic and international elements, as found in other studies elsewhere (Gilson and Mills, 1995, Mills et al., 1990, Collins et al., 2003, Collins et al., 2007). The chapter suggest decentralisation policy is to be understood within its historical, political context, the economic system of the country has an impact on the content and outcome of the policy.

Since adoption of the reform, development partners are playing key role for the initial push for reforms in the health sector following underperforming economies that were followed by broader national reforms i.e. ERP, SAPs. With resources from World Bank and other donors countries started analysing their specific situations, identified problems, designed reforms, planned them and started implementation. However, the ownership and willingness of the government to take

reform in its full package is not resolved Thus, the concern of the current study is to understand how a decentralised health system functions, with regard to political, fiscal and administrative aspects which are featured in the current local government reform and how it has impacted on reproductive health service delivery in rural Tanzania. The next chapter 5 presents views of national and local actors on the decentralisation policy in Tanzania

Abbreviations for Chapter 4

ALAT	Association of Local Government Authorities in Tanzania
CHMT	Council health management team
DC	District Commissioner
DED	District Executive Director
DMO	District Medical Officer
FGDs	Focus group discussions
HSR	Health sector reform
KI	Key informants
LGAs	Local government authorities
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
NIMR	National Institute for Medical Research
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PO-PS	President's Office – Public Service Management
PSI	Population Service International
RCH	Reproductive and Child Health Section
RCHCo	Reproductive and Child Health Care Coordinator
SOAS	School of Oriental and African Studies
SRH	Sexual and reproductive health
WHO	World Health Organization

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

There are three critical issues in the study of any social phenomenon: theoretical, conceptual and methodological (Classen, 1999). This chapter deals with methodological issues. This is an inductive explorative research which aimed at generating rather than testing hypotheses. The issues examined include, how the decentralisation processes were formulated and implemented, who are the key actors and sources of power to mention a few aspects. The study examines the impact of decentralisation on district health service delivery particularly reproductive health services. Being an inductive study the impact of decentralisation was critically examined in relation to the entire health system delivery system. The study further unveiled the interactions between actors and their working environment that produce health outcomes. The nature of the study is reflected in its methodological approach (Grodos and Mercenier, 2000). The current study embraces both analytical and health system research The analytical approach focuses on interactions of actors and their roles, while the health system research focuses on the whole system and interactions between actors and their working environment that produce health outcomes.

4.2 The research paradigm underpinning the study

A paradigm is ‘a set of assumptions about how a phenomenon should be studied’ (Henn et al., 2006:10). It is argued that every research paradigm has its epistemological foundations, which influence knowledge and methods that are appropriate for different settings (Patton, 1990, Patton, 2002). Thus, a research paradigm is important in the construction of theoretical concepts for revealing assumptions about social reality. Furthermore, it influences the research design at all stages, including the formulation of methods and analysis (Gray, 2004).

A number of research paradigms have been identified in the literature, the most common of which are the positivist, interpretive and critical paradigms (Cohen et al., 2000; Henn et al., 2006). These paradigms have their foundation in epistemology, ontology and methodology. The positivism paradigm is located within normative studies, whereby social reality exists ‘out there’ and is independent of the observer (Crotty, 1998, Guba and Lincoln, 2005).The Positivist studies aim at discovering a “set of laws to be used in predicting human behaviour”(Esterberg, 2002:10). In this line of argument the positivist paradigm is not appropriate for the achievement of the objectives of this study. On the other hand studies that are informed by the critical science paradigm aim at “exposing inequalities, malpractices, injustices and exploitation; give voice to the excluded and marginalised group and help explain generalised oppression in order to participate in the social change”(Henn et al., 2006:10). The critical paradigm central argument as explained before is not reflected in the main objective of this study which is to understand the impacts of decentralisation on health services delivery. Arguably due to the shortcomings of both positivism and critical paradigms this study adopts the interpretive paradigm whose foundation is laid in constructivist epistemology (Gray, 2004). The interpretive paradigm holds that social reality is created jointly over meaningful interaction between the researcher and participants in their social and cultural context (Yanow, 2000, Yanow et al., 2006). Social reality is experienced in different ways and interpreted "often in similar but not necessarily the same way”(Bessey, 1999:43).

The choice of interpretive paradigm was based on three reasons; first, it allows the researcher to access the experience and views of the participants in knowledge construction. Secondly, it is useful to understand the complex phenomena in a particular sociocultural context (Creswell, 1998:17).Lastly, the paradigm positions researchers as listeners to participants’ experiences and practices in their working environment. Then the information collected is pieced together as narrative. It is in this way that knowledge is generated in the area of interest, and findings are translated into a narrative layout (Kouritzin et al., 2009). Labonte and Robertson (1996) used constructivism approach in analysing community-based health promotion programmes and came out with convincing results. Their findings show that constructivism has the potential for knowledge generation (Labonte and Robertson, 1996).

From interpretive perspectives, national policy agendas, issues, problems and solutions are socially constructed by policy makers, government officials and other policy actors, including the public at large (Gamson and Lasch, 1983, Becker and Bryman, 2004). Constructivism calls for the attention to the manner in which policy makers and members of institutions are affected by policy and the way in which the general public makes sense of and constructs their own understandings (Yanow, 1996),decentralisation policy being the case. Actor's interpretation shapes the policy implementation, which at the end affect policy outcomes, in this case, reproductive health services. As argued before the paradigmatic position of the study is concerned with the two key aspects of policy process and outcomes. This involves how different categories of actors including but not limited to policy makers, health managers, providers and the service users construct realities from their own experiences with decentralisation policy and the outcome produced at the end.

4.3 Research approach: Case study

The research design depends on the central question and the theoretical background of the study. This study aimed at understanding and examining decentralisation and its impact on reproductive health services in rural Tanzania. Therefore, it is clear that the research question demanded a research design that could capture and explain a phenomenon that is rooted in its context. Based on the foregoing argument, this study adopts a qualitative research approach. Qualitative research is concerned with offering specialised techniques for obtaining in-depth responses about what people think and their experience with the implementation of the decentralisation policy either as policy makers, service providers or service users. It enables researchers to gain insights into attitudes, beliefs, motives and behaviours of the target population, and gain an overall better understanding of the underlying processes. By its very nature, qualitative research is subjective and exploratory. The basic principles of qualitative research are openness, research as communication, reflexivity of objects as well as flexibility (Denzin and Lincoln, 1994, Bryman, 2004).

The qualitative research design enabled the researcher to gain an in-depth understanding of the complex nature of the implementation of the decentralisation policy in the health sector and how it has impacted on reproductive health service delivery. Policy implementation issues are embedded in the complex socio-economic, political and cultural spheres of different layers of the governance. The study was not linear, neither did it aim at discovering or generalising the truth, nor did it look at causal-effects relationships, rather it describes, explains and evaluates decentralisation policy in relation to reproductive health delivery. It aimed at understanding the complexity of the implementation of decentralisation in the rural setting of Tanzania. To understand this complexity, the qualitative approach was applied to understand the realities of decentralisation. Qualitative studies aim at providing illumination and understanding of the complex issues and are most useful in answering 'how' and 'why' questions (King-Keohane and Verba, 1994). Thus, the improved understanding of a complex subject is more important than generalizability of the results as far as studying the outcomes of the decentralisation policy in reproductive health delivery system is concerned.

The qualitative approach covers many research approaches, including historical research,

phenomenological study, ethnographic study and case study. These approaches may have some related features, but different goal/s (Gall et al., 2007, King-Keohane and Verba, 1994). However, case study research is more holistic in conducting in-depth analysis of phenomena while accommodating both 'understanding' and 'analysing' dimensions(Yin, 2003b, Yin, 2009).(Yin, 2009, Yin, 2003a) The case study has used Yin's 'embedded design' to provide a deeper investigation of the actors which can be individuals institutions, communities and their relationships(Baxter and Jack, 2008). Furthermore, it supports the deconstruction and reconstruction of a phenomenon, in this case decentralisation. In relation to selecting the case study, Denscombe (2003) pointed out four reasons to justify its selection. Firstly, the case can be selected if it is an extreme instance, contrary to the norm. Secondly, an area is selected because of its suitability for either 'theory-building or testing'. Thirdly, a case might be selected to test the validity of a theory, and fourthly, a case can be selected because it is a typical instance. He stressed that "the logic being invoked is that, the particular case is similar in crucial respects with

others that might have been chosen and that the findings from the case-study are likely to apply elsewhere”(Denscombe, 2003:33).

The aim of this research was to understand decentralisation process and to examine its impact on reproductive health care delivery. In relation to the research questions, the focus has been on the ‘process’ and ‘impact of the process’ through which health outcomes can be achieved. The research is on the decentralisation of the health system which ultimately had an impact on the provision of RHS. Thus; the study recognises that policy actors (bureaucrats, politicians, service providers and users) construct their own meanings and reality from their experiences of decentralisation. Actors who are involved directly with community service delivery (downwards) construct knowledge through their views over reform content, new roles, responsibility, which informs policy makers (upwards). The upward actors (policy elites including politicians and bureaucrats) have an administrative role which influences and shapes the relationship between implementers and users. Thus, their views, perceptions, actions and interests provide a useful link in understanding the process. The interrelationships of the individuals in the process can change the content of that knowledge. However, meaning construction is experienced differently in a given setting (King, Keohane and Verba, 1994). Thus, in establishing a consensus of understanding the realities among policy actors, the study borrows from Mitra the idea of “engaging the actors and observers through focusing on the discourses that connect them”(Mitra, 2006:6). Health gains of decentralisation were analysed through users’ perceptions. To understand participants’ own experiences of the process, fieldwork was conducted over the course of six months in an attempt to capture the complex and unpredictable nature of the decentralisation process.

4.3.1 Study setting

Decentralisation is happening at both national and local levels. Therefore the study was organised at four different levels, namely the national, district council, facility and community levels. Political, fiscal and administrative decentralisation was studied in relation to the structures

that support the process and how they affect reproductive health services. At the national level the study aimed at understanding the roles of central government in the formulation of decentralisation policy and its subsequent role in the implementation of the reproductive health services. An understanding of institutional changes that resulted from implementation of decentralisation is important in understanding its effects at the lower levels, which in the end affect reproductive health service provision to various degrees. This was done at council and lower levels; the analysis covered the entire decentralisation policy. A decision space mapping table was used to map the degree of decentralisation. This was done to understand the authority of local government over fiscal, administrative and political decentralisation. The analysis at facility and community levels was to understand the impact of fiscal, administrative and political decentralisation on health service provision (outcomes).

Context of the council that formed the case study

The district council is the unit in which decentralisation reforms are implemented in Tanzania. It represents the geographical area within which Local Government functions. Therefore, in selecting the case study the researcher used the district council as the unit for understanding how decentralisation has been implemented. One district council was purposely selected in analysing how decentralisation policy has influenced the delivery of reproductive health services. The council is located on the central plateau of the country. According to district profile data 2011, the case district has a population of approximately 238 951 people, with an annual average growth rate of 2.3%. The people of the district are relatively homogenous in that they are of Bantu origin, with a few exceptions with Gogo forming the largest tribe.

Administratively, the council is made up of four divisions, 21 wards and 56 villages. It has a dry savannah climate and a very long dry season. Many parts of the council lack basic services such as electricity, safe water and transport systems. This provides a challenge in providing social services, in particular during the rainy season, when some areas are totally cut off from other areas, including council headquarters.

The main economic activities are animal husbandry and agriculture, which is mainly subsistence. The most important food crops are maize, beans, millet, sorghum, cassava and sweet potatoes. Sunflower seeds are the main cash crop but they are grown at subsistence levels. Seasonal unemployment is very prevalent in the council because of the short rainfall season, which is from December to March.

The 2010 comprehensive council health plan shows that the council had a total of four health centres and 39 dispensaries, of which 38 are publicly owned and one dispensary is privately owned. The council did not have a hospital, and the regional hospital served as a referral from the health centres. The council had a total of 175 health personnel as against the required number of 347 personnel. Therefore there is a shortage of 167 staff. In addition some of the available staff had inadequate skills, which has resulted in poor quality of services provided. Most health centres are a bit far from surrounding villages which require people to walk from 2 to 10 kilometres in seeking for health services including reproductive health services. The district's health system is linked with the council's administrative structure. At each division there is a health centre which serves up to fifty thousand people, while at lower levels there are dispensaries serving up to ten thousand people each. The council has four health centres and 39 dispensaries. Council's health secretary coordinates all public health activities in the council, and health services were delivered by the public system.

4.3.2 Ethical considerations

Ethics is of paramount importance in any research that involves human subjects. Since the signing of the Declaration of Helsinki in 1965, the World Medical Association has established international guidelines for health research that combine clinical and non-therapeutic care. Article 13 of the Declaration of Helsinki requires research proposals to be scrutinised by an independent committee to ensure that they conform to the laws and regulations of the country in which the research experiment is conducted (WHO, 2001). Crombie and Davies (1996) argue that ethics in health research is important since it employs patients. Thus, ethics are essential

Although some research might not involve a hazardous investigation, time can cause distress and anxiety (Crombie and Davies, 1996). Research into reproductive health carries with it ethical issues since it involves human affairs in the real life of the participants, thus there is an obligation to address ethical issues.

At first, research clearance was granted by the School of Oriental and African Studies (SOAS) research committee to conduct this study and the reference is appended at the end. In Tanzania, local clearance procedures were followed whereby the research proposal was submitted to the National Ethical Committee at the National Institute for Medical Research (NIMRI)[2] and ethical clearance was granted. A copy of the clearance letter was presented to the responsible heads of departments including the head of the reproductive and child health care, the health sector reform secretariat at the Ministry of Health, the directorate of local government at the Prime minister's Office's and the civil service department. Also at the regional and district level the clearance letter was presented and permission was granted Afterwards, a copy a research protocol was presented in advance to the relevant organisations and institutions that were involved in data collection (see Appendix ii). The organisations and institutions were contacted in advance of data collection, and the objective of the study was explained. The researcher also asked for permission from the Ministries of Health and Finance and the Prime Minister's Office, so that she is able to access, retrieve and read records on financial expenditure. Permission was also requested to access and retrieve records at the council and health facilities. The researcher was granted all the permissions she asked from the mentioned organisation and Ministries.

Seeking for informed consent from participants is one of the ethical issues in any given research, health research in particular. To adhere to ethical considerations the following were addressed in this study: (i) obtaining written informed consent from the participants before the interview, (ii) not exploring sensitive issues before a good relationship had been established with the participants and (iii) ensuring the confidentiality of the data collected. The tape recordings and transcriptions were handled with care and, when the thesis is accepted, all tapes and transcripts

[2]NIMRI is a regulatory authority for health studies in Tanzania.

will be destroyed. The participants were free to withdraw from the interview at any point. Also, to ensure confidentiality, the council studied is not named. Anonymity is ensured in the presentation of the research findings. On the other hand, at the national level, national key-informant interviews (NKI) are represented as NKI-01 and so on. These include representatives from central ministries, donors and civil society organisations. In addition, regional key-informant interviews (RKI) are represented as RKI-01 and so on while council key-informant interviews (CKI) are presented as CKI-01 and so on. For politicians, data were presented as politician key informant interview PKI-01 and so on. Facility key informant interviews were presented as FKI-01 and so on. For the focus group discussions (FGD), data were presented as FGD-01, FGD-02 and so on. In order to maintain anonymity personal names are not used in the thesis unless it was agreed by the respondents. In addition, photos used in the thesis were used after the given consent from the participants. And last but not least all sources are well acknowledged.

4.3.3 Piloting the research tools

It is argued that, when using interviews to collect data, bias can result from 'misconceptions on the part of the interviewer of what the respondent is saying and misunderstandings on the part of the respondents of what is being asked' (Cohen and Minion, 1994:282). Piloting is commonly used in testing research instruments as has been done in this study (Opie, 2004). Before piloting, questions were presented at a postgraduate seminar workshop at the SOAS whereby the workshop facilitator and research students gave their comments to modify some of the questions before they were used for field work in Tanzania. In Tanzania, the research interview and focus group guide were piloted in Rombo district to test their reliability. In consultation with the district medical officer, one village was selected for the exercise. This enabled the researcher to refine some of the research questions before the actual process.

4.3.4 Sampling procedures

This study employed non-probability (purposive) sampling. The power of the purposeful sampling is embedded in the selection of respondents with rich information on the given issue of interest to the researcher (Creswell, 2003). These were reached following the attainment of a theoretical closure[3]. Non-probability sampling usually involves the selection of participants due to their availability, convenience and those who have features that a researcher seeks for the study.

The study aimed at collecting information on decentralisation has impacted on reproductive health service delivery. Dodoma region was chosen purposively since it was a pilot region for the implementation of health reforms in Tanzania. One of the rural councils from Dodoma region was purposively selected to follow-up the decentralisation process in relation to reproductive health services. The selected council was in the first phase of the implementation due to the local government reforms which started in 2001, which went hand in hand with the health sector reforms. The selection was also based on its geographical location with good and reliable transport which enabled the researcher to easily collect data for the study. Also, the Prime Minister's Office, which coordinates the decentralisation process, is located in the region, making it easier for documentary review while collecting data. Additionally, there was no evidence of a similar study conducted in relation to decentralisation and its impact on delivery of the reproductive health service.

Although the study is not representative, the selected council involved in this study, its health facilities and district administrative structures are similar to those in other rural districts in the country in terms of the relevant characteristics, such as number of staff required per health facility, structure of health facilities and administrative division of wards and villages. The case study council has a total of four divisions, 21 wards and 156 villages, of which three wards and four villages were purposively selected for the study because of their accessibility during the actual

[3]Theoretical closure is when the researcher no longer gets new information from the respondents (Glazer and Strauss 1967)

process of data collection. Thus, statistical sampling procedures were not used in selecting study sites and participants.

Instead, purposive sampling in consultation with the district medical officer was used in selecting six health facilities. All four health centres were visited, as well as two dispensaries within the radius of each of the health centres. Based on the location of the health facilities selected, four villages were purposefully selected. Two villages were close to a health facility, and the other two villages were located far from the health facilities. In all the selected villages, pastoralism was the main form of livelihood. Data collection began in December 2010 and ended in July 2011. Data were collected from the following sites:

(i) National/central level:

- Representatives of the Ministry of Health and Social Welfare (MoHSW)
- Representatives of the Ministry of Finance and Economic Affairs (MoFEA)
- Representatives of the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG)
- Representative of the President's Office, Civil Service Department
- Representative of the Association of Local Government Authorities
- Representative of the civil society at national level
- Representative of the Parliamentary Committee for social services
- Representatives of the development partners

(ii) Regional level:

- Representatives of the Regional Secretariat, including regional medical officers, the regional coordinator for Reproductive and Child Health and the coordinator for local government services.

(iii) District Council level:

- Representatives of the district council administration: participants included the district director, district commissioner, planning officer, and human resource officer.
- Representatives of district health services: District Medical Officer (DMO), Council Health Management Team, council's health secretary, district nursing officer and the Reproductive and Child Health Care Coordinator (RCHCo).
- Representatives of civil society: Population Service International (PSI) was selected to participate in this study based on its long experience in the provision of reproductive health services.
- Representatives of the council health services board
- Representatives of the politicians, including the Member of Parliament of the case study council, council chairperson and councillors.

(iv) Facility level:

- The person in charge of the health facilities
- Reproductive health coordinators
- Members of the health facility committees

(v) Community level:

- Participants included representatives from various groups of different geographical locations (participants for the focus group discussions).

4.4 Methods of data collection and analysis

The study used a combination of methods including semi-structured interviews, focus group discussions, participant observation and documentary research as detailed below. Open-ended questions were used in both semi structured interviews and focus group discussions. The open-ended questions allowed the researcher to explore various issues in detail. The interviews were guided by a set of similar and different questions that were asked to different people purposively sampled in this study. The use of numerous interconnected methods in this research had the benefits of creating a better understanding of the research questions and reduced a 'tunnel vision' of truth by guaranteeing that each method contributes to reveal part of the truth (Verschuren

2003). The secondary data were collected from the selected literatures; institutions and health facilities to complement the primary data. The following are the methods used in this study.

4.4.1 In-depth interviews

This method is commonly used in qualitative policy studies as it allows the researcher to get rich and underlying reasons for many practical undertakings in relation to the policy under analysis. It also offers an opportunity for the researcher to clarify or probe and expand on interviewees' responses to ascertain their feelings (Wragg, 2002, Opie, 2004). In-depth interviews use a flexible approach by asking questions of a target group (Patton, 1990). Therefore, the selection of the correct participants, who are informed about the study topic, is important to obtain quality data. For the purpose of the study, an in-depth open-ended interview questionnaire was used (Appendix ii) and the participants were selected on the ground of their relevance. The final list is made up of 47 participants for the key informant interviewees (KIs), 12 at the national level, 20 at council level, six at facility level and nine politicians. The interview checklists were developed, covering the process, structures and outcomes of the reforms. Flexibility was applied in the use of the research guideline questions which reflected the key themes of the study. Two different sets of guidelines were used one, for the policy makers and the other for the service providers. The interviews were mainly carried out by the researcher herself and were tape-recorded after obtaining the consent of each participant, except for seven participants, who refused. The recorded information was verified with notes, corrected in the case of any missing points and validated through further clarification with the relevant participants. The aim of the key informant interviews was to collect first-hand information on the decentralisation policy, in particular on its formulation and implementation and its overall policy objectives, as well as its effect on health service organisation and management. Providers were encouraged to compare service provision and implementation status before and after decentralisation. The data obtained were used to complement information from policy documents. Figure 4.1 bellow summarises the distribution of the KIs at the various levels.

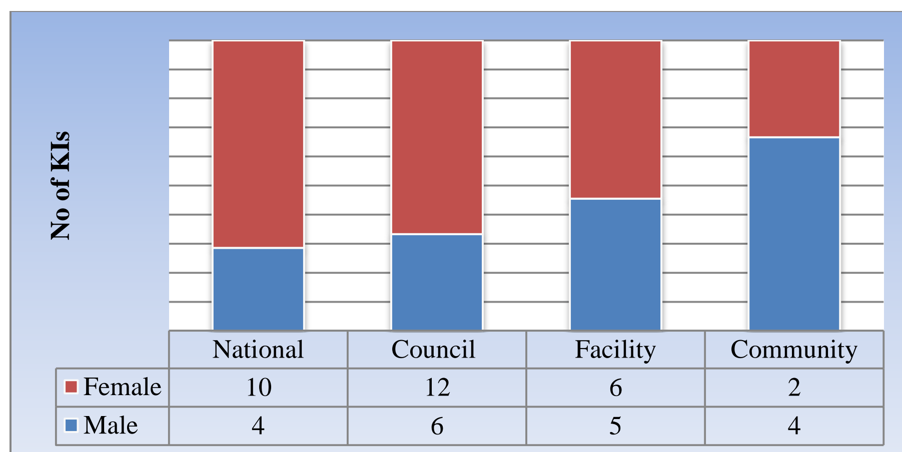


Figure 4-1: Distribution of the key informants by sex
Source: Field survey, 2011

4.4.2 Focus group discussions (FGDs)

A focus group discussion is one of the common participatory methods for qualitative data collection involving a small number of participants. A group of six to eight participants usually take part in the discussion by talk freely about the particular matter, while the researcher facilitates the discussion. The FGDs collected information on participant's views and perceptions on the implementation of decentralisation and its effect on reproductive health service delivery. During the discussion, participants were encouraged to identify changes in relation to health services after decentralisation. While selecting the FGD participants at the community level; priority was given to the same surroundings of the facilities that were selected for the KIs. This aided in triangulating information provided by the KIs. Generally, the FGDs were made up of four different sets:

The first set of FGDs was made up of the Regional Health Management Team (RHMT), and eight members participated. These came from different departments, including reproductive and child health. Of the eight participants, four were male and four were female, and they have been working in their current posts for more than two years.

The second set of FGDs was at the council level with the Council Health Management Team (CHMT) with a total of eight members, of whom five were males and three females. The group members shared their understanding, knowledge and experience with decentralisation processes. As discussed earlier, reality is socially constructed. Individuals perceive and understand different social economic process based on the position they hold in a certain social context. Therefore there were differences in term of understanding of the health sector decentralisation process and its variations. The differences were noted depending on the level of the participant's education. Despite divergences in understanding decentralisation, the participants showed their commitment to fulfilling their new roles and responsibilities under decentralisation.

The third set of FGDs was with the health committees which represent communities/service users. A total of four FGDs were conducted whereby each had an average of six to eight members. Of 26 participants, 15 were women and 11 were men. Of these, 9 women did not complete standard seven level of education which is the elementary level in Tanzania. FGD members were asked about their views on the way decentralisation has impacted reproductive health services delivery. They were also asked about community representation and service accountability. The collected data from the FGDs were used to complement information from the health facility KI interviews and the FGD with the regional and council health managers.

The fourth set of FGDs was held with communities in each of the visited villages, where three FGDs were conducted. In order to get appropriate FGDs participants, village leaders and village health workers assisted the researcher in recruiting participants. A total of eight FGDs (four villages) were conducted. Members included community leaders, men and, women below 30 years of age and those above 30 years. The decision to separate women into two groups with 30 years as a cut-off point was based on local experience, which has shown that younger women are not comfortable being involved in discussions with older women. Thus, the groups were deliberately separated to allow younger women an opportunity to participate actively in the

discussions. There were a maximum of eight participants in each group discussion. The FGDs with the communities focused on decentralisation, how it reached the communities and changes experienced to reproductive health service delivery.

FGD guidelines with key themes were used to collect the data (Appendix iii). The Swahili language, which is widely spoken and understood by the majority of Tanzanians, was used. Informed consent from participants was given verbally in advance of each session. The FGDs lasted between forty-five minutes and one hour. The discussions were tape-recorded after obtaining group consent and transcribed at the end of each day. The distribution of FGD participants is summarised in Figure 4-2 below.

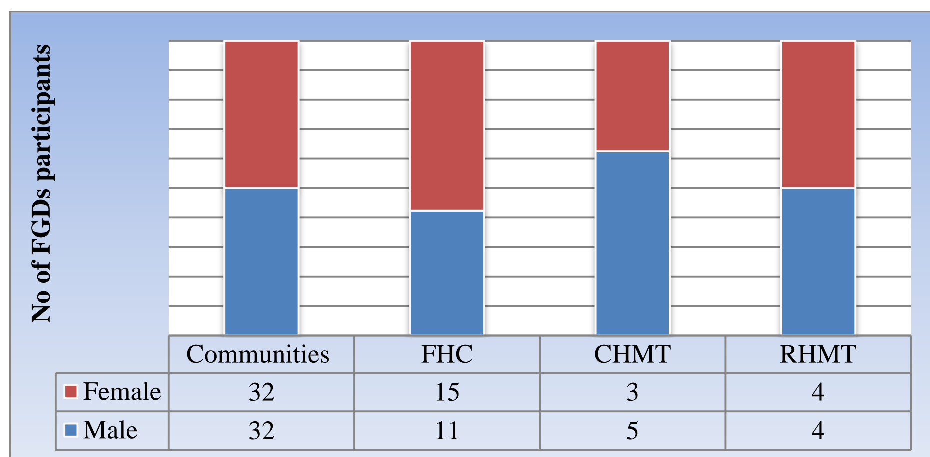


Figure 4-2: Distribution of the FGD participants at different levels
Source: Field survey, 2011

4.4.3 Observation

In this study, observation was used at two levels: at council and health facilities. The observation method was used to validate the information given by the key informants. The researcher attended two council meetings, observing the dynamics of planning and budget meetings .In addition, the researcher observed the way providers and clients interact at six health facilities. This helped the researcher to have a deeper understanding of the dynamics of reproductive health service delivery. The experiences were noted in a field diary. Observation method was used in different settings and contexts as described elsewhere in order to validate the data obtained

through other methods such as interviews and FGDs. To put it differently observation method helped the researcher to note some of the embodied messages arising out of the interaction especially between service providers and clients in relation to the provision of reproductive health service delivery.

4.4.4 Documentary review

In addition, the study used documentary review to collect information on the extent to which RHS issues are prioritised in broad development strategies and health policies. As well, to analyse the extent to which RH components that are identified in national policies re reflected in council health plans. The document reviewed included: national development vision 2025, five years development plan 2011/12 - 2015/16, national health policy, health sector strategic plan III, national road map for accelerating the reduction of maternal deaths, national family planning costed implementation program and national package of the essential reproductive health interventions. The policy analysis tool was used to analyse number of issues including policy reaction to international commitments to universal access to RH, prioritisation of the RHS at different levels as well budget document at national and council level were reviewed and analysed to gather information data on funding distribution from central to Council level, as well as allocation to reproductive health services. Additionally, council information of RHS utilisation in relation to family planning, antenatal and postnatal care and facility utilisation, were collected. However, the records obtained were from 2007, hence it was not easy to compare service trends before and after decentralisation.

Table 4-1: Summary of activities for the research project				
Phases of the research project	**Data and data collection methods**	**Method of analysis**	**Number of respondents**	**Reporting**
Stage 1: National level				
Decentralisation policy: formulation & implementation	Review of relevant policy documents and KIs with national actors	Gilson framework for policy analysis and thematic analysis of diaries	12 KIs at national level 20 at council level, six at the facilities and nine politicians (FGD with the CHMT and RHMT)	Chapters 1 & 5
Stage 2: Council and community/village level				
Development implementation of reproductive health polices	In-depth interviews with DMOs, DED, DC and villagers. FGDs with the CHMT and field observations	Gilson framework for policy analysis	20 KI interviews at the council, six at the facilities and nine politicians (FGD with the CHMT and RHMT)	Chapter 6
Decentralisation & its impact on health service	KI with health managers and providers. FGDs with communities and health management committees	Decision pace framework & accountability framework	20 at the council, six at the facilities and nine politicians (FGD with the CHMT and RHMT)	Chapter 7
Summary and conclusion of the thesis				Chapter 8

Source: Author, 2010

4.5 Data analysis and interpretation

Data analysis is about organising and interpreting the enormous amount of collected data to examine results against the research questions. Data collection and interpretation influence each other to establish an inter-subjective consensus on the interpretation of the reality logically and empirically (Miles and Huberman, 1994). The main concern of the research question is the process; recognising the way in which actors, either from the supply or the demand side, construct their reality from their own perspectives and experiences of decentralisation in relation to reproductive health service delivery. The way actors translate reform objectives, the way they manage to undertake new responsibilities, and their relationship with service beneficiaries, form one part of knowledge production. However, elite groups, particularly policy makers and

politicians, shape the relationship between providers and beneficiaries. Furthermore, their perceptions, actions and interests provide links to the outcomes.

This study deals with the bulk of qualitative data from the KIs, FGDs and observation. At the end of each day, data was supposed to be transcribed from the recorded interviews but this was not possible due to the large amount of information. Thus, some transcriptions were done in the two months after the fieldwork. Tapes were labelled to match the interviews. The organisation of the data was conducted through the following stages: (i) Preparatory stage, in which the responses to each interview were written on a separate sheet to make reading easier for conversion into a transcript, and then translated into English from Swahili. The interview data then were categorised into four types of responses – national, council, facility and community – for effective management. (ii) Intensive and repeated reading of data was carried out to determine analytical themes. The process was guided by the research questions. Themes were developed by both research objectives (deductive) and interpretation of the raw data (inductive). Codes containing short phrases expressed by the participants were developed (selective coding). To ensure that the quality of the information was not distorted, analysis was done in Swahili and then translated into English. The decision was used to analyse decentralised function against actual implementation. The findings on each question are presented in a separate chapter. In the discussions, references were made to detailed explanation and validation.

4.6 Trustworthiness, credibility and transferability

The criteria for examining rigour, both in qualitative and quantitative studies, have been internal and external validity and reliability (Punch, 2005). The origin of these concepts has been associated with positivist research, hence interpretive researchers have been unenthusiastic to consider them in their studies, as it would imply accepting positivism as the only absolute source of knowledge (Esterby-Smith et al., 1994). Brock-Utne (1996:612, cited in Bush, 2002:60) noted that the questions of validity and reliability within qualitative research are as important as within quantitative methods, although they may have to be treated somewhat differently. Gall et al.

(2007) noticed that validity and reliability in qualitative research are poorly applied when open-ended instruments are used to collect data. Likewise, Merriam (2002:27) argues that reliability is problematic in the social sciences simply because “human behaviour is never static, nor is what many experience necessarily more reliable than what one person experiences”.

Wolcott (1990) argues differently on the use of reliability and validity in social sciences. He stipulates that these criteria do not fulfil their research methodology because of differences existing between the axioms of interpretivism and positivism(Silverman, 2005). Guba (1992) suggests ‘trustworthiness criteria’ in judging the quality of a study that is positioned within interpretive paradigm. These elements include credibility, transferability and dependability (Guba, 1992), and were used, together with other strategies, to ensure the quality of this study.

The first strategy adopted to ensure the credibility of this study was triangulation (Gall et al., 2007). It comprises ‘the use of two or more methods of data collection in a study of some aspect of human behaviour’ (Cohen et al., 2000). Using this strategy helps researchers to balance the limitations connected with the use of one method to collect data (Creswell, 2003; Punch, 2005) and to determine the reliability of the information collected. The concept of triangulation is detailed elsewhere.

Apart from triangulation, peer examination was also used to ensure credibility of this study (Gall et al., 2007; Merriam, 2002). Regarding this strategy, colleagues at my working university were given the tentative findings to review and comment on in relation to the raw data. The comments increased the assurance of the findings of this study.

4.7 Triangulation

Triangulation refers to the process of observing a phenomenon in different ways rather than in one way only. Triangulation helps to improve the accuracy of data and is considered to be a fundamental principle in collecting data in case studies (Yin, 2009. It is an important strategy for establishing the internal validity of data and its interpretation(Bush, 2002). The purpose of triangulation is to merge the data and use the results to best understand the research problem

(Creswell, 2003:564). Two types of triangulation were incorporated into this study: method and respondent triangulation.

Method triangulation involves using multiple instruments to collect data for a study (Denscombe, 2002, Yin, 2003). Also, method triangulation enables researchers to compare and validate the outcomes in terms of one another (McFee, 1992). The use of multiple methods to collect data is an 'attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint' (Cohen &Manion, 1994:233). Method triangulation was obtained through the combination of semi-structured interviews, FGDs and observation for qualitative data collection. Documents were used to generate quantitative data, as already noted, but the data were analysed to add another perspective to the information collected.

Respondent triangulation involves using the same instrument to collect data from different participants (Bush, 2002). It is consistent with McFee's (1992:216) claim that the "reality of a situation is not to be captured from a single viewpoint. Thus it brings to bear two or more viewpoints on a particular occasion, with a view to characterising the occasion so as to accommodate, or account for, all these viewpoints". Respondent triangulation was achieved by using the same instruments to collect data with slight instrument changes to fit the purpose of the research at different levels. This strategy enabled similarities and differences in the views of the participants to be ascertained.

Figure 4-3 represents triangulation of the data at each level of analysis. While analysing the policy formulation process, triangulation was done between what participants were saying about what was set as organisational process and structure and what was written in a relevant document. This enables one to filter out 'noise' from the interview and construct a solid picture of the decentralisation policy process in Tanzania.

At the implementation level, triangulation was done between organisational documents and interviews with health managers, health committee members, politicians and providers and what was observed. Likewise, in analysing the impact, triangulation was done between the observed data, focus group discussions and in-depth interviews. These triangulations were finally used to

construct an understanding of the entire decentralisation process and what kind of impact it has on reproductive health services in rural Tanzania.

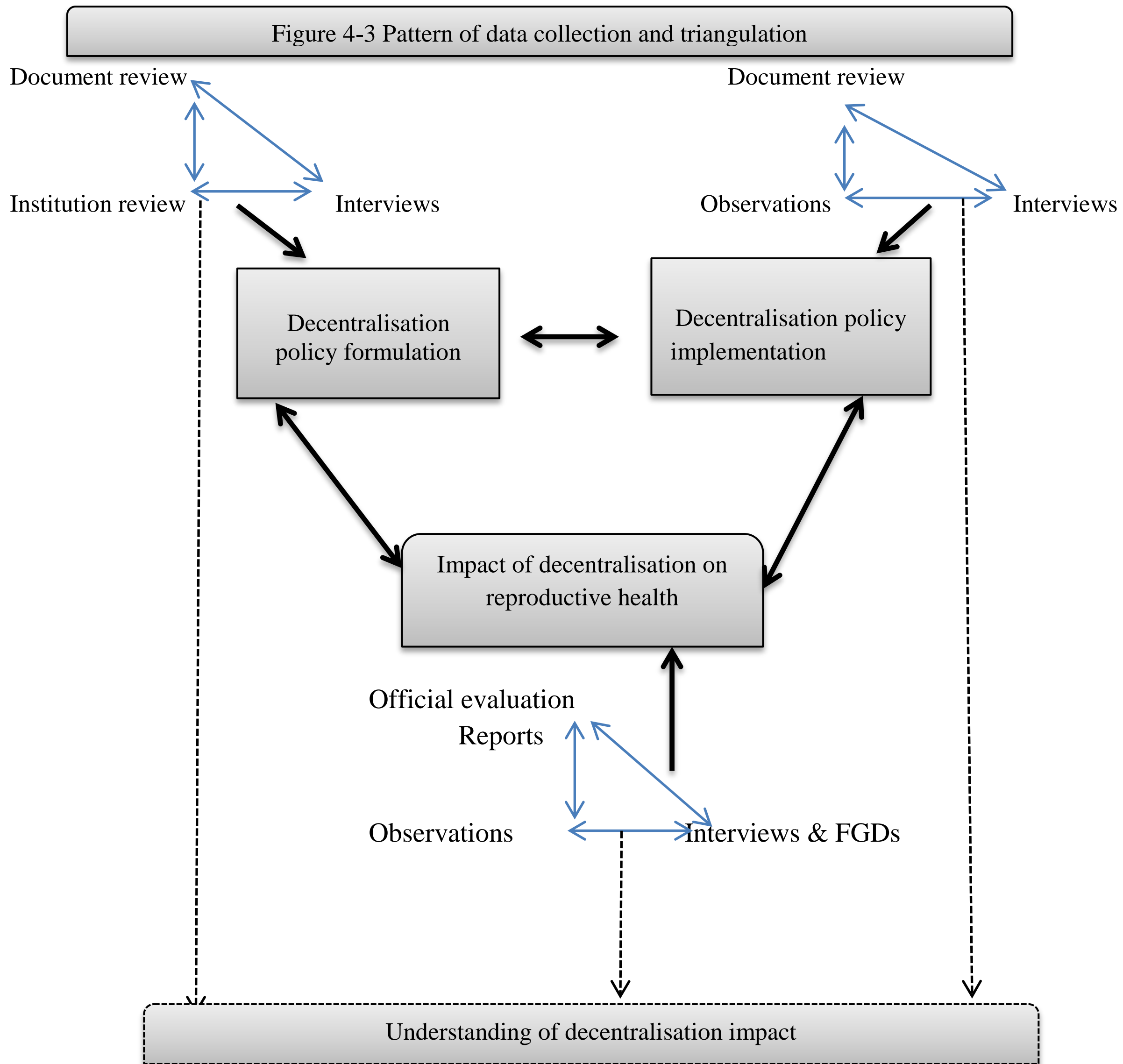


Figure 4-3 Pattern of data collection and triangulation

4.8 Limitations and challenges of the study

In the course of the fieldwork in Tanzania the researcher faced several difficulties and obstacles. The most serious one was power disruptions, followed by power rationing which sometimes lasted up to 48 hours. This affected the study in different ways. Lack of electricity was not the only problem (making it difficult to type and print the research clearance), but also some members of the research review committee at NIMRI were outside the country on other duties. This caused delays of up to three months before the actual process of data collection could commence. The researcher however made considerable effort to make sure that quality and reliable data were collected within the available time. In addition, some bureaucrats, particularly at national level, were not happy to be tape recorded. Their interviews took longer and, in some instances, interviews were stopped and continued on another day at their convenience

Data on reform outcomes were limited with regard to availability and precision. Because of the frequent transfer of government officials who were involved at the initial stage of decentralisation, it took time to find former key participants at their new offices. This was possible because some of the executives were transferred within government institutions. At council level, follow-up was not possible because staff members were transferred to other parts of the country. Thus, local experiences were somehow restricted, as many of the officials were new to the office and did not take part in the initial process of decentralisation reform even if they were implementing the same objectives.

Another important constraint experienced throughout the study was difficulties in separating reproductive health services from other services. Lack of specific data on the use of resources for reproductive health interventions was a problem at national, council and sub-council levels. Wherever possible, the researcher tried to gain specific data on reproductive health services as affected by decentralisation. Where this was not possible, the research used data on district health services in general, given that reproductive health services form the major part of primary health care services. Reproductive health services are funded via a comprehensive council health plan whereby a budget is allocated for integrated service provision along the cost centres.

Decentralisation is not the only reform policy in the health sector. There are a number of policy initiatives that are implemented within the health sector geared to improve health services. This causes difficulties in attribution the impact of decentralisation on reproductive health service delivery.

Abbreviations for Chapter 5

BFC	Basket Funding Committee
BNR	Big Result Now
CA	Central authorities
CCHP	Comprehensive council health planning
CFGD	Community focus group discussion
CHMT	Council health management teams
CHSBs	Council health services boards
CIDA	Canadian International Development Agency
CKI	Council key-informant interview
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHS	District health system
DLG	Directorate for Local Government
DPs	Development partners
FHCs	Facility health committees
FKI	Facility key-informant interview
HSPS	Health Sector Programme Support
HSRS	Health Sector Secretariat
IMTC	Inter-Ministerial Technical Committee
JICA	Japan International Cooperation Association
LGAs	Local government authorities
LGR	Local government reform
LGRP	Local Government Reform Programme
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MoFEA	Ministry of Finance and Economic Affairs

MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NEHP	National Essential Health Package
NKI	National key-informant interview
NSGRP	National Strategy for Growth and Reduction of Poverty
PMO-RALG	Prime Minister’s Office – Regional Administration and Local Government
PO-RALG	President’s Office – Regional Administration and Local Government
POW	Program of work
RCHS	Reproductive and Child Health Section
RHMT	Regional health management teams
RKI	Regional key-informant interview
SWAP	Sector-wide approach
TWG	Technical working group
UNAIDS	United Nations Agency for HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

CHAPTER 5

HEALTH SECTOR DECENTRALISATION IN TANZANIA: POLICY PROCESS AND VIEWS OF NATIONAL AND LOCAL ACTORS

5.1 Introduction

This chapter presents the policy process of decentralisation by looking at the policy actors, rationale and content. The chapter aims to first answer the research question, with regard to understanding policy processes involved in implementing health sector decentralisation. Thus, the chapter begins by reviewing policy documents to identify who are the key actors and the role they play in the decentralisation process. It was noted that the government policy formulation process is usually taken as a technical process, mainly with a high level of consultation with the key decision makers. Policy implementers and beneficiaries are rarely consulted at the formulation stage. They claim to be recipients of the central policies, rather than being part of the process.

The chapter also looks at the second question of the study, which aims at understanding the meaning attached to decentralisation and how it affects its implementation. The government policy thrust in Tanzania is fiscal, administrative and political devolution of functions to councils. At the national level, participants were aware of the decentralisation policy objectives, although some failed to articulate the meaning of decentralisation. At council level, most of the participants were not aware of the decentralisation policy objective. The majority defined decentralisation process based on the way they perceive the practical reality of decentralisation. Service providers and users are of the view that decentralisation process is has not grant them power to make autonomous decisions. The decentralisation process in terms of decision making concentrates at council level and not at the community level where services are delivered. The health care providers were found to have limited power; despite having institutional and social power that affects decentralisation objectives and reproductive health service delivery. As per the Tanzanian context health care providers are the ones who interact directly with communities; hence they have the role of executing decentralisation goals, including the engagement of

communities in health care planning. However, their roles are underestimated in the current policy reform process.

This chapter is organised into four sections. The first section is the introduction; the second part presents a review of the public policy process in Tanzania, followed by the presentation of data from the field findings on the actors' knowledge about the objectives and process of decentralisation. The final section contains the discussion and conclusions.

5.2 Policy-making processes in Tanzania[4]

This section reviews the process of public policy making in Tanzania. This is to enable the readers to link the two processes: formulation and implementation. The government of Tanzania has been striving to provide quality social services to its people. The primary objective is to improve service delivery in public institutions. This led the government to develop policies and give directions towards the achievement of the intended outcomes. Theoretically, policies are proposed as a response to deal with a particular recognised problem(s). The purpose is to ensure that the root causes of the problem are addressed in the design of the policy. The idea usually originates from actors, such as communities, public or private institutions, professionals and trade unions among others. The proposed ideas are then put into action to become a policy.

The suggested way of policy development in Tanzania is assumed to use a bottom-up approach and to be participatory, where consultations are undertaken with the interest groups to ensure their ideas are accommodated. The process is initiated after the recognition of a problem that needs to be tackled. Then actors likely to be affected are identified and their roles in the process are recognised. All key actors, including ministries and their agencies, regions, councils and communities are supposed to be involved. In the early stages, actors' participation is important to ensure that their ideas are taken on board. They can participate in different ways, such as workshops, round table meetings, interviews, policy dialogues with various people and interest

[4] United Republic of Tanzania (1997) Social Policy Formulation Process has been a source of the material presented in this section

groups. Also, the national media like radio and television can be involved for actors to engage themselves in discussions. This is to ensure that the policy papers are comprehensive and address the pressing needs.

Theoretically, participation should include key actors at all levels, since not all stakeholders can be fully involved. Consultation with actors is assumed to be an opportunity for the interested groups to air their voices and give their inputs into the process. The reality is that it is the government that chooses which actors to consult. Besides, consultations are mainly done to respond to what has already been proposed by the government. A draft of the proposed policy document is presented to actors in a stakeholders' workshop so that they can respond. The limitation of this approach is that there is no means of ensuring that stakeholder contributions are incorporated into the final document. In Tanzania there are two levels of policy making - the national and the council level.

5.2.1 National policy making

The national level involves macro-policies, sector policies and sub-sector policies. The macro-policies are those policies that are implemented by several ministries or cut across sectors. These include: National Vision 2025, National Strategy for Growth and Reduction of Poverty (NSGRP) and Big Results Now (BNR). These policies provide the overall framework for the formulation, implementation and monitoring and evaluation of the sector policies. The key actors in formulating these policies are the President's Office, the Vice-President's Office, the Prime Minister's Office, and the Ministry of Finance and Economic Empowerment, in particular the Policy Planning Division.

The design of the sector policies is the responsibility of the respective sector ministries and their agencies. They have the mandate to formulate, monitor and implement sector policies although they are supposed to formulate policies through a participatory approach. However, the

ministries can put together a task force, which is a technical team. Members are usually made up of ministry and other staff who possibly come from different implementation levels, such as local authorities, research and training institutions, civil society, etc. Usually, the team works closely under the supervision of the policy planning division. Their role is to review the performance of their sector and prepare the framework and policy declarations as well as to bridge the gap between policy makers and implementers. The task force solicits views from key stakeholders like ministries, institutions and NGOs and organises workshops to confirm their stand on the issue raised.

A series of workshops are organised for editing, finalising and preparation of the final policy document to be presented to the government for approval. This time there is a policy window that can be exploited by civil society organisations in presenting their inputs to the policy makers, either by being present in the workshops or by making formal submissions to the task force. A department within the sector can formulate sub-sector policy within the framework of the sector policy when the need arises.

After the ministerial level, sector and sub-sector policies are sent to the higher policy-making level organs, called the Cabinet Secretariat, where discussions are carried out in depth before being forwarded to the Inter-Ministerial Technical Committee (IMTC), which is made up of all permanent secretaries of all sectors. Their role is to ensure that the proposed policy is synchronised with the existing policies in other sectors. After the IMTC recommendations, the policy paper is submitted to Cabinet for approval.

Policy implementation follows the approval, referring to the transformation of policy choices into action. Often the delivering of the policy is the result of the interpretation of that policy and may lead to different outcomes than those originally planned. As a result, implementation is the critical part of the policy process. Engagement of the stakeholders is important for effective implementation. This is to establish ownership of the policy and to affect the outcomes.

Policy monitoring and evaluation follow in order to evaluate the policy outcomes to show the relationship between policy and outcomes. This is an intentional assessment of how policy has impacted the targeted population. This can be through policy dialogue via various research institutions and academia, some of which may have been involved during formulation of the policy (URT, 1997c).

5.2.2 Local Government-level policy process

Following decentralisation, local government authorities (LGAs) and village government are given legal mandates to formulate their own policies that may be passed into legally-binding by-laws to address a particular problem or to facilitate and/or regulate certain activities. For example, local authorities can make by-laws for facilitating the local collection of revenues from various sources in the form of levies and taxes.

The initial idea of formulating by-laws is raised by a village or ward development officer who is a member of the village assembly. The idea is then presented to the village government committee for further discussion and endorsement, before being submitted to the village assembly. The local by-laws should be approved by the Village Assembly. A draft of the village or ward by-law is presented to the Ward Development Committee so that amendments can be made before submission to the Full Council Meeting for final approval. Thereafter it may be functional for the village or ward concerned (URT, 2001d).

Similarly, at council or municipal levels, the proposed by-law may come from one of the technical departments of the council or from the communities through their councillors. The proposal has to be discussed by the relevant Council Committee before being presented to the full Council for approval. Minister responsible for Local Government has a legal mandate to pass the Council by-laws that may be applied to all or some of the LGAs.

Above all, government policies have to address a particular problem aimed at improving the welfare of Tanzanians. The changing of the environment and global process at large drive many countries to formulate different policies to address different socio-economic problems. Since 1986, the Government has been implemented reforms including Structural Adjustment Programme and Economic Reform Programme aimed at solving the socio-economic crisis through restricting the role of the state in the economy while giving greater flexibility to the market and the private sector. In the course of executing these reforms, concerns about their impact on social service provision have come to light. Thus, the Government has been formulating a number of public policies addressing different those needs. Despite the process of policy formulation, implementation and evaluation being somewhat participatory, yet the desired impact is far from the reality. As will be detailed later, during the implementation stage national actors have remained distant from policy implementers and from beneficiaries.

5.3 Health reform policy process

Decentralisation was implemented in the health sector as part of the broader government reforms. The Ministry of Health and Social Welfare (MoHSW) begun to reform the sector and later decentralisation was taken on board as a key component of the health sector reform (HSR). Following the announcement of HSR, a national joint workshop was chaired by the MoHSW, World Bank (WB) and development partners (DPs) for the approval of the formulation of the reform Technical Working Group (TWG). The TWG was composed of senior officials from the MOHSW and Planning Commission with the responsibility of coordinating the reform process and preparation of the HSR implementation plan. This provided an opportunity for the DPs to form a coalition of actors, working together to influence policy ideas. The WB provided technical support, such as acquainting policy makers with the TWG and cost-effectiveness as policy-making tools. The TWG came out with the health sector reform proposal. The proposal outlines several problems contributing to the poor performance of the health system (MoH, 1994). The HSR proposal and strategic health plan were approved by the cabinet in 1995. The MoHSW and the WB jointly prepared grounds for the implementation of the reforms. The part of the strategy was to increase the number of other DPs, since up to 80% of health expenditure was

financed by DPs(MoH, 1995). The government could only support one third of the financial expenditure required. This gave DPs a lot of influence in the process due to their high financial support to the sector as donor dependency means the country is far from being autonomous in policy formulation. DPs influence the process, since they contribute more than 50% to the sector survival.

However, government and the DPs did not keep their financial promises regarding funding for the HSR. The spending was less than what was pledged which therefore affected the execution of the reform. This was supported by the Public Expenditure Review of 1995, which showed that there was a variation between budgets and executions (MOH, 1997). The shortfalls were contributed by incomplete donor support, shortfalls from local counterparts and inaccurate projections. To get actors on board, the MoHSW created a supportive network of actors, which resulted in the formation of the Joint Ministry of Health and DPs Mission. The aim of the mission was to identify and prioritise key issues in preparation for the reform. In 1995 the first annual joint mission was held and its outcome was the commitment by both DPs and government to reform the health sector by providing financial and technical input.

The MoHSW conducted a number of pilot projects to learn from the experience. This included district capacity for planning and management, through which health boards receive training. The results showed that there was a need for close collaboration between health sector reform and local government reform (MOH, 1998b). Other pilot studies were undertaken in four other districts aiming at raising the quality, coverage and effectiveness of basic health services, which came with the recommendation for strengthening collaboration between the HSR and LGR. The other project was carried out in five districts, aimed at strengthening health management systems to improve accessibility to highly integrated reproductive health services at the district level. The lessons showed that this could be achieved through the enhancement of community participation, staff sensitisation, skills development and improving physical structure (MoH, 1998a).

Action plan 1996 to 1999

The DPs commissioned a consultant to prepare the Action Plan for implementing HSR 1996 to 1999. In April, both the MoHSW and a donor mission met to appraise the Action Plan. The aim was to identify areas than needed further refinement. These included strategies for involving communities, ensuring government commitment of resources to implement the reforms, donor coordination mechanisms and clarification of financing modalities. The appraisal defined the roles of various actors in the implementation. The emphasis was on community involvement as an important idea, since they were primary beneficiaries of the reforms. This was to ensure that the communities took an active role in the policy process. Yet their engagement depends on local institutional arrangements made available to them in the process.

During the process, government fund disbursement was poor, which discouraged the DPs from disbursing funds. The sector suffered from low financial support, which led to poor quality of services. The government requested financial assistance from DANIDA. In 1996 the government made an agreement with DANIDA for three years' funding. The support was known as Health Sector Programme Support (HSPS-I), and was extended from 1999 to 2003 as HSPS-II (DANIDA and MoFA, 1999). This support covered health system activities and part of health reform activities.

Reform actors

The actors in the reform process were the Ministry of Health (MoH), the Ministry of Finance (MoF), the President's Office – Regional Administration and Local Government (PO-RALG) and donor partners, including the International Development Agency (CIDA), the Department for International Development (DFID), the Danish International Development Agency (DANIDA), the Japan International Cooperation Association (JICA), German Technical Cooperation (GTZ), the United Nations Children's Fund (UNICEF), the United Nations Agency for HIV/AIDS (UNAIDS), the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the World Bank (WB), the World Health Organization (WHO), the Embassy of the Kingdom of Netherlands, and the Royal Norwegian

Embassy. The Program of Work (POW) 1998/2001 was revised and appraisal was carried out in 1998. A sector-wide approach (Swap) was also approved (MoH, 1998a).

Having Swap on board, the MoH had to re-orient its organisation, planning and resource allocation. This was implemented through a Programme of Work 1999/2001/2002, which was to begin from 1998/1999. However, the DPs requested further revisions and refinement of the HSR plans, and the POW was finalised and ready for implementation by 1999 (MoH, 1998a). The POW 1999 to 2001 carried eight interlinked strategies intended to achieve the following reform objectives: (i) district health services, (ii) secondary and tertiary hospital services, (iii) the role of the central ministry (MoH), (iv) human resource development (HRD), (v) central support system, (vi) healthcare financing, (vii) public–private partnerships and (viii) the MoH–donor relationship (MoH, 2003). It should be noted that district health services were the first priority that aligned with decentralisation reform aimed at transforming district health systems.

The development partners showed strong commitment in support of the process. However, at this stage there was little participation by other actors, viz. communities, academics, civil society, etc. Later, the Health Sector Strategic Plan (HSSP II) 2003 -2008 carried forward the eight strategies. The HSSP II was extended to June 2009 to incorporate the findings and recommendations of the Joint External Evaluation of the Health Sector, which was conducted in 2007. From July 2009 to June 2015, the MoHSW was guided by HSSP III. The HSSP III serves as the guiding document for the development of council and hospital strategic plans and for annual work plans.

5.3.1 Policy process of health sector decentralisation: Context and content

This section is concerned with the ways in which health sector decentralisation is being formulated and implemented. The discussions around the policy process cover an analysis of the

context of as well as the objectives of health sector decentralisation. The discussion then moves to analysing the way in which consultations with the key actors are being managed.

The current reform started to be implemented in the 1990s being driven by political and economic contexts. The political contexts included universal provision of health services as a right to all, and the government had the obligation to provide health services free of charge (Semali, 2003). The need for a decentralised sector is well rooted in the national legal framework, and the Local Government Act of 1982. The health sector decentralisation programme was reinforced by the adoption of the Local Government Reform Programme in 2000. However, by 1993, the MoHSW had started to devolve non-core health services to the local authorities, even before the launching of the LGRP in 2000. The early adoption of decentralisation was because the sector experienced management problems relating to planning that proved unresponsive to the health needs of Tanzania (MoHSW and PMO-RALG, 2007).

The reasons for the MoHSW to adopt decentralisation were to facilitate bottom-up planning and financing, the management of council health resources, procurement and purchasing of supplies and equipment, and addressing issues of access to services. Under health sector reforms, district health services were the first target to ensure that local service provision was accessible and of good quality (MoH, 2003). Government, jointly with the DPs, agreed that decentralisation should be devolution (MoH, 1995). This was launched officially in the health sector in 1999. The implementation initiative arose after the government announcement of the LGRP following approval of the decentralisation policy by parliament.

Progress towards the implementation of health sector decentralisation was disrupted by the local government reform programme in 1996. LGAs had to wait for local government reform to take place first. By 2001 there was meaningful decentralisation within the health sector, as explained by one of the participants:

> It was after the revisions of the local government policy of 1982 in 2000 when the LGRP was formally put into practice (NKI-02).

It was agreed that decentralisation should be implemented in a three phase approach. The first phase began in 2000, with 38 councils on board. The second phase took place in 2001 involving 45 councils and the last phase started in 2002, involving 31 councils. By 2003, all councils were ready to put the decentralisation policy into practice.

National participants had a different view on what and how much should be decentralised. Generally, senior officials at the national level did not support decentralisation, as they feared losing power. This was revealed during the interviews, when one of the participants insisted:

> .....if you decentralise you engage other government departments. There has always been disagreement on what should we devolved, especially from the central officials. The power struggle for control has always been the barrier to real decentralisation. For example, if I am with the Department of Finance and I agree that 70% of the functions should be devolved to councils, it means I will have only 30%. This implies that a larger portion of what has been coming to me from the national treasury as allocation will go directly to the local authorities. Thus decentralisation changes the roles and allocation from national to local … some of the officials are not ready to lose control over the councils, therefore for decentralisation to happen there is a long way to go (NKI-02).

He further insisted on the importance of a regional coordination plan for decentralisation to avoid sectors from either dumping functions on councils without resources or withholding other functions. The decentralisation task team at national, regional and council levels are no longer functioning. These teams were responsible for the coordination of the decentralisation of reforms and to ensure that local governments were well empowered to accept decentralisation. However, decentralisation teams were no longer in place due to budget deficits:

> … Government was not well prepared to roll out the devolution. Most of the funds were coming from donors. This led to implementation difficulties when donors delayed the disbursement of funds. For example, at present the established task team is no longer functioning due to lack of funds to pay for their activities. Also, the LGRP II has been delayed while waiting for donor funds. None of the planned activities has been implemented … we are still waiting. If donors decide not to release funds for the LGRP II, that will be the end of decentralisation (NKI-02).

At the MoHSW there was no proper division to coordinate decentralisation. The health sector reform secretariat works independently, mainly focusing on sector reforms. However, some consultations were done between the PMO-RALG and MoHSW with regard to council health

services. It was noted that MoHSW staff lack adequate experience of decentralisation. This is because decentralisation was not driven from within the MoHSW, but driven from outside the heath sector. The national and local roles of the decentralised sector also were not defined. The LGR just mentions that the role of the local authorities is to provide public services within their jurisdiction. The MoHSW was performing both planning and implementation roles. One of the participants claimed:

> … .We realised that MOHSW should not control both central level policy functions and the local authority implementation process; we have not been able to get out of this trap. May be we need to completely overhaul of the sector. It is confusing with both PMO-RALG and MoHSW working with councils at the same time (NKI- 02, -05, -06).

Decentralisation was stressed in strong inter-sectorial coordination between ministries, departments and agencies and the decentralised sector. At the national level, fairly good coordination between government and donors was in place during the joint annual review and planning. At council level, no functional sectorial coordination was set up to steer the decentralisation process. The necessary reform measures per policy requirement were not made available in the council structure. Doubts were raised about the capacity of the LGA to coordinate all functions related to decentralisation. LGA lacked technical and management specialists in the planning section to lead a decentralised planning process. However, some participants commented that:

> Council lacks planning officers to take down decentralisation objectives. For example, participatory planning needs knowledgeable planning officers to use those tools to engage communities in identifying their needs. But we did not perform bottom-up planning because we lack experts (CKI-02, -03, -06).

Similarly, participants pointed out the weakness of the national level for not taking an active role in the timely restructuring of the organisations that are involved. Failure to restructure the central authorities means that limited ranges of functions are transferred to the LGAs. They share the need for a proper restructuring of the PO-PSM office. The roles of the office were not restructured in line with decentralisation reform, and the roles of central managers were not re-defined. There was no systematic consultation with national programmes. International experience suggests that it is very important for consultation and discussion to be on the policy agenda (Collins et al., 2003, Dhakal and Singh, 2006).

In the council, no functional sectoral coordination was put in place to steer the process. The necessary reform measures as per policy requirements were not made according to council structure. This led to some confusion about the roles and some actors were not in agreement on some issues linked to decentralisation. This was expressed by one of the participants:

> We are not all going in the same direction of decentralisation within government itself. While other councils are concerned more with decentralisation, central authorities are concentrated on centralisation. Decentralisation should be a package that includes all responsible departments to think the same about change … for example civil servants are now concentrating on centralisation of civil service functions; it no longer seems to be the intention to carry out human resource decentralisation. Before 2004, council used to recruit their personnel, but the civil service department has reversed the process without our consultation (CKI-04).

The implementation of the LGRP ended in June 2008 with the limited achievement of the stated goals. Joint Government-Donor Reviews have consistently revealed that significant progress has been made at the local level. Little has been achieved in terms of fiscal and administrative decentralisation (MOHSW, 2008c, MOH, 2004, MOH, 2002). Building on the previous LGRP, government launched LGRP-II from July 2008 to July 2014, aimed at strengthening local government and mainstreaming the decentralisation policy to the central authorities and all sector ministries. The broader goal for LGRP II resembles the LGRP: to 'ensure effective and empowered LGAs to serve as principal and accountable actors for local socio-economic development, public service delivery and poverty reduction in their areas of jurisdiction'(URT, 2008a).

5.4 Objectives of health sector decentralisation

Defining a set of objectives for decentralisation policy is important, as it gives direction to the process, and facilitates the monitoring and evaluation of the changes. Participants were asked to express their views on how they perceived decentralisation and why government had been so interested in decentralisation. It is conceivable that a common understanding of decentralisation among policy makers, implementers and beneficiaries would have great significance in influencing its implementation and final policy outcomes. The responses are grouped according to different levels of governance, namely national, council, service providers and users.

Participants at the national level were somehow acquainted with the objectives and goals of the decentralisation policy. At the council level, decentralisation objectives were not known. Some of the key participants were not knowledgeable about the intentions of decentralisation policy. At the community level, discussion about health decentralisation concerned community participation in service delivery through enrolment in the community health insurance scheme. This looks more market driven decentralisation with privatisation. Generally, decentralisation was given its own meanings at different levels, which were not in line with the decentralisation policy goals. The finding supports the argument that states that 'decentralisation' means 'different things to different people'.

5.4.1 Objectives of health sector decentralisation: Views of national actors

At the national level, most of the participants, in particular those who were involved in policy formulation were familiar with the objective of health sector decentralisation. To them, decentralisation was very straightforward and they related decentralisation to changes in the organisation and management of delivering local services. This includes a number of processes geared to stimulating local development, and steering social, economic and political changes. Decentralisation was defined as a transfer of power and resources from the central ministries, departments and agencies to local governments to give them more autonomy for local service delivery. Local communities should be engaged in managing local services delivery within their localities with the oversight of their elected councillors. The following are the responses from national participants about the intentions of health sector decentralisation policy:

> … Give away power and resources to local government authorities to take full responsibility for local health service delivery (NKI-01).

A number of views were put forward by participants emphasising the importance of the community's involvement through decentralisation. It was felt by some participants that representatives of the local communities were more acquainted with local health problems than those who are at the centre. When communities are involved in identifying their needs, they can make priorities that reflect their local needs and make plans that are feasible. As one participant said:

> I am here at metropolitan city as a health manager … I cannot run health services in Dodoma from Dar es Salaam, it has to be done from the regions and local authorities (NKI-02).

Some participants saw decentralisation as a means for improving efficiency and effectiveness in the delivery of public goods such as health delivery:

> …objective of decentralisation is to build capacity at all levels of service delivery so as to increase efficiency through the devolution of authority. This is to enable communities to participate in defining the type of health services they need (NKI-03, NKI-04; NKI-05; NKI-09, NKI-12).

Some participants see decentralisation as an important way of strengthening district health services. For others, decentralisation was all about giving local authorities autonomy for planning and budgeting local service delivery to communities, as well as the execution of plans:

> ......decentralisation is the opposite of centralisation. It was adapted to facilitate bottom-up planning and financing, management of human resources, service delivery to communities (NKI-07; NKI- 10).

However, knowledge and experience of decentralisation differ among the national actors. Participants that were outside the DLG department were not very knowledgeable about the policy objectives, although they were responsible for monitoring the councils, such as council personnel management, finance and service delivery. The researcher was frequently referred to the DLG department when decentralisation questions were asked. One of the participants insisted that:

> … all the issues regarding decentralisation have been the role of the DLG department. The policy has not yet mainstreamed into other departments; maybe in the coming phase two of the LGRP. We are not aware of what is happening. Probably in the second phase of the reform all the departments will be taken on board (NKI-08).

Participants outside the DLG had a concern about government ministries, departments and agencies to mainstream decentralisation. There were notable delays in the implementation of decentralisation because of central authorities retains significant fiscal and human resource power. Decentralisation enhances implementation of programmes in more meaningful ways when local people are part of the process. With decentralisation, resources can be used more efficiently to benefit communities. Similarly, local participation is important for local resource mobilisation.

Another participant insisted that decentralisation was implemented without training and on the assumption that changes will happen automatically. Sharing his experience of coordinating council finances, he said:

> … Working with councils as a finance coordinator for the district health basket fund, more than fifteen years, I never received any training in decentralisation, only a one-week refresher course on fiscal decentralisation in America. Unfortunately, their system was different from ours; hence the course was not useful. I am working through my experience. I am not sure if things are in line with fiscal decentralisation goals. The DLG department focused more on councils and forgot some of the important managers who are working directly with councils (NKI-02).

At the MoHSW a similar situation was observed to that at the PMO-RALG office regarding the reform structure. A Health Sector Reform Secretariat (HSRS) was established to manage health reforms. The majority of the participants were acquainted with the intentions of the decentralisation policy. The following are some of the responses from the participants:

> Decentralisation means giving powers away from the ministry of health to the local authority to enable them to take responsibilities for local health care delivery (NKI-03).

> Decentralisation means yielding power to the community through health governing boards and committees to take responsibilities for planning and managing local health services (NKI-04).

It was further asserted that the goal of health boards and committees is to manage community health funds (CHF). The health boards and facility committees were established along with the introduction of the community health fund. One of the participant insisted:

> … the main reason for having governing boards and committees was to facilitate the establishment of the CHF. The aim of the CHF is to make communities more responsible, as well as to own their facilities. Otherwise they will keep the mentality that health service delivery is the responsibility of the government, although they have a role to play (NKI-04).

It was observed that there were different views among the participants within the central authorities. Participant from the Ministry of Finance and Economic Affairs (MoFEA) and the President's Office-Public Service Management (PO-PSM) are not supporting decentralisation process whereas the PMO-RALG was in favour of decentralisation. The planning team from the MoFEA, who provide budget ceilings for the health sector budget, were in favour of centralisation. This affects policy coherence during implementation. One of the participants argued that:

> … under the current arrangement we lack harmonisation of public policies. Everyone is busy within her/his departments executing their programmes without consultation. For example, in our department our reform concern is with integration of the previous vertical RH services into primary healthcare services to enable women to access all their health needs under one unit. While we are dealing with integration, other departments, like HIV/AIDS, are still implementing their programmes under the vertical arrangement (K1-03).

The above messages from the PMO-RALG and MoHSW show that participants had some common understanding of the overall purpose of decentralisation, namely that it was to improve service delivery. The official objective of health sector decentralisation is expressed in the National Health Policy, which states that: management and administration of health services has been devolved to district councils through their respective council authorities, council health service boards (CHSBs), facility committees and council health management teams (CHMTs)(MoHSW, 2003). It can be seen that some participants expressed views that matched more with this official view.

5.4.2 Objectives of health sector decentralisation: Views of council managers

At the council level, responses were not impressive, although this is the level where the policy goals are put into action. The knowledge of the actors at this level is important for the effective execution of policy at the grassroots level. There is a lack of common interpretation among the council actors about decentralisation. Participants, in particular councillors and administrative staff and health managers, had mixed views and experience with the decentralisation process. Some were aware of the decentralisation policy goals, while some were not. Some of the health managers were positive towards decentralisation, although the administrative staff, especially from human resources and finances department, felt that there still was a long way to go for real decentralisation to happen.

The locally elected leaders (councillors) were observed to lack a clear understanding of the decentralisation process. Six out of seven of the interviewees admitted that they did not have good knowledge of the policy itself, laws and/or regulations regarding decentralisation. They

were dissatisfied with the overall policy process, as they had not been consulted. When asked about their roles in decentralised governance their responses were not impressive. Some said they participated in council planning. This low level of understanding is not shocking because they did not receive any training. The majority acknowledged that they were given general training on how to participate and the procedures for council deliberations. When asked about their views and experience of the decentralisation process, the following were their responses:

> … definitely, I am aware of decentralisation. I understand the council has power over local affairs for planning for local service delivery (PKI-06, PKI-02).
>
> … I am familiar with decentralisation … it means that councils are granted powers, at least in theory, to manage their own matters without the interference of the central government with the oversight of the elected council (PKI-03).
>
> Decentralisation means power to the councillors to manage the council's staff to bring local development. This is through monitoring their actions and to sanction council staff members in the case of any abuse of council resources (PKI-01).

Some of the participants were not sure about decentralisation policy objectives.

> Although we know that government has shifted to a decentralised system, we have not officially been informed. We were just elected last November; we were never given any written document and/or training about decentralisation, we are not aware of its content. We only learn government by-laws and procedures for participating in council meetings (PKI-07).

Another participant also answered by assenting:

> … Yes … I heard about the decentralisation policy … I know that central government has decentralised some functions to allow the councils to take control of service delivery. But I cannot tell you exactly what it means (PKI-05).

One of the participants answered positively:

> … granting local authorities powers to plan and budget their plans with minimum control of the central government. The local governments are now free to plan by engaging local communities to prioritise their needs (PKI-01).

Under decentralisation, councillors are key actors in allocating council resources for the different functions. All five interviewed councillors admitted that they had access to council data. However, planning was not their role; the technical departments were responsible for planning. Thus, councillors were not able to identify the amount of money received by the council from the

central level. They admitted they had never participated in developing the comprehensive council health plan.

Low awareness of decentralisation among some of the participants was due to inadequate training. Some complained that they had never received any training since they had been elected, apart from training on local government meeting procedure and local by-laws. This was confirmed by one of the national participants, who argued that they did not have funds to conduct training:

> … government decided to cut off training due to lack of funds, as it is claimed, surprisingly, executives (council directors and commissioners) are provided with training on government policies soon after their appointments. However, even for them, official training covers national policy goals such as MKUKUTA and not decentralisation per se (NKI-03).

Health managers and elected leaders agreed that a significant element of the role of the councillors should be to set up health priorities of their communities; however, they were not yet performing this function. This was partly because they were not aware of their roles or because they did not know the planning process. The councillor's role is complex and difficult to grasp with their limited education and experience. In many instances, differences in educational level between councillors and council staff seemed to marginalise their roles. It sometimes also created tension with the council staff with their technical expertise. This poses a challenge for making decisions on health-planning priorities. Likewise, it affects decentralisation goals, since council deliberations are supposed to include community needs presented by councillors.

The council director was not familiar with the decentralisation policy, claiming that he was acting director since the director was on holiday. This is not an excuse, since he was heading a department in which decentralisation reform was being implemented. Unlike the acting council director, the District Commissioner was well informed about decentralisation:

> … decentralisation means having local authorities with autonomous powers and resources to deliver public goods and services through involving communities to have access to their basic social services including health, education, and water (PKI-02).

Some heads of departments said decentralisation was good, but they complained about the behaviour of central authorities to hold power for the council personnel and finances. Some asserted that 'decentralisation is just on paper' no real power has been given to us. The following were responses from some of them:

> Decentralisation means giving power to the local authority to recruit our own staff locally. In the past we had all this power, but the government decided to centralise the process. No more decentralisation, most of the key council personnel are posted to the councils from the central authorities (CKI-04).
>
> … having power to levy taxes and raise our own revenues locally. However, we never experience this since the central authority decided to stop some of our revenue. We totally depend on central transfers to fund council plans (CKI-07).
>
> We have never been involved in government policy formulation, not even consulted or even shared in the policy document; we are recipients of central policies. The decentralisation policy document is not available at the council. And we need policy documents to be printed in Swahili which we can all understand. If any policy has been written in English, it should be translated (FKI-02, FKI-04, FKI-06, FKI-08, FKI-09).

It was noted that council health managers were familiar with decentralisation to some extent. For them, decentralisation implies a change in roles at different levels of health service delivery. Some of the participants acknowledged that decentralisation had reduced central bureaucracy, since they can implement some of their plans more easily by consulting council health managers. This has been noted as an opportunity to improve local health service delivery, including that of reproductive health. With the DMO being accounting officer, with full authority to control council health resources, things are made easier than in the past, when there was little involvement of the council health managers. It was noted that the CHMTs were happy with the improvement in donor relationships. With their council health plans they can access donor resources directly and work together to ensure council health plans are executed:

> With decentralisation we have power to plan, budget, manage and implement council health services with no central interference. This enables me to achieve what I have planned since we planned according to the available resources. In the past we used to plan but we were not guaranteed an allocation, since funds were diverted to other activities for which they were not intended (CKI-01).

To others, decentralisation means additional managerial roles:

> More meetings and administrative roles compared to professional responsibilities. We are not sure what decentralisation means. But we produced a comprehensive council health plan which is a guide for health resource allocation at our council. Prior to the 1990s we did not plan, now we have an opportunity and communities are represented through health committees. Both private and NGO providers are now our partners in healthcare planning and healthcare delivery (FGD-01).

To others, decentralisation means more negotiations between politicians and bureaucrats:

> … now we are working with councillors who demand a number of meetings and negotiations. This takes much of our time to convince them of our plans. More of our time is spent on meetings than service delivery. Every councillor wants better services for their catchment, which means it sometimes takes time to compromise over health priorities (FGD-01).

There also were others who said that decentralisation meant:

> Running local health services by letting communities manage their facilities through health boards and committees (CKI-02).

Another participant asserted that:

> Yes, I know that central government has decentralised service delivery to allow CHMTs to plan and access health resources through comprehensive council health plans. Yet the MoHSW still control councils, through directives. We need a complete overhaul of the system (CKI-04).

The responses showed that council heath managers had at least heard about decentralisation. But relatively surprisingly, not all health managers were aware of the objectives of decentralisation policy. This perspective was clearly described by one participant, who said:

> I was not alerted about the decentralisation programme probably because I am not a member of the CHMTs, I also don't know the intentions of decentralisation; however, I know health resources and management of the council health service delivery are now the role of the CHMTs (CKI-05).

Despite the positive view of the health managers have of health sector decentralisation, the major challenge to the effectiveness of decentralisation to improve health outcomes was the inadequate and unqualified staff at the health facilities. Healthcare personnel are controlled by the central authorities, making it difficult to allocate health personnel according to needs. It was observed that most of the facilities were managed by unqualified personnel. Also, it was noted that medical attendants and nurse assistants, who are less trained, were the ones who were available in most of the facilities for delivering health services.

Councillors and council health managers lacked common understanding and interpretation of the decentralisation policy objectives. In particular, some council health managers said that the councillors did not give them the needed support for example with regard to allocation of council funds for health. They allocated these funds instead to other priorities such as roads. It was observed that councillors who are supposed to work with CHMTs in planning for the local health

service delivery were not actively involved in the planning, but only in the approval of the council health plan.

A key informant considered the problem of the conflict of interest between politicians and technical staff. The biggest challenge to health decentralisation was the tension created between the councillors and the technical people. The councillors thought they were in charge and that no decisions could be made without their consent, even if it was fine for the council:

> … they thought they should be involved in all decisions even on technical issues … I see this as the biggest challenge. Decentralisation is a good thing; the biggest challenge is that some people are using it wrongly to cause hassles in health service delivery. For example, councillors are more interested in physical infrastructure to please their voters, since it's a tangible outcome. If we don't budget for the construction or rehabilitation of the facilities it takes time to convince them and sometimes we change the plan to please them (CKI-04, CKI-05, CKI-06).

The CHMTs are not fully informed on health policies, programmes, or specific activities, let alone decentralisation policy. Their importance is not well appreciated at the current reform initiatives. The CHMT are important actors that translate policy goals into practice as health managers.

5.4.3 Objectives of health sector decentralisation: Views of services providers

Interviews with health providers in six selected health facilities indicated that there was a lack of clear understanding of decentralisation. They were not aware of what roles to play in the reform process; whether it involved resource allocation or priority setting. The majority of the health providers complained that they had never received any training on decentralisation. As a result, there were no significant changes in the re-organisation of services to reflect local health needs and priorities. Decentralisation was explained by emphasising on its characteristics, such as (i) community involvement in health planning and (ii) management of local health by the communities. The responses presented below are the interpretations of decentralisation by the service providers based on their experience of implementation of decentralisation reforms.

> I would also say that decentralisation has given powers and responsibilities to some people, in particular to the CHMTs and DMOs, regarding health matters. We cannot do something at the facility until we consult

> the management team (CHMT). We write to inform them about what we want to do for them to give directions and sometimes they might refuse (FKI-04, FKI-06).

Another participant observed that:

> There is a great change since the inception of the health reforms. Communities now play a key role in participating and contributing to the council health delivery. Through their health committees they are presented to the health facility meetings during planning. Also, communities are now paying for their services either through community insurance or through user fees. However, there are services that are provided for free when contraceptives are available (FKI-01, FKI-02).
>
> I have seen that decentralisation has helped the communities to initiate their own projects like health infrastructure, which has enhanced health delivery. For instance, through councillors we mobilise the communities to provide their labour to build a dispensary (FKI-05).

The shared view about health reform among the health care providers was that:

> Charging for the health services that we used to provide for free … the era of free service has passed. What we can see as a change is the pre-payment for healthcare service through community health insurance or user charges at the point of service delivery (FKI-01; FKI-02; FKI-03; FKI-04; FKI-05 & FKI-06).

Apart from the changes mentioned above, some of the participants claimed that there had not been substantial changes in the district health system since decentralisation implementation:

> I don't think there is any change so far, council health funds are from the central authorities. In planning and decision-making, there is no substantial change because the central authorities give us a budget ceiling for what they can fund and they approve our health plans before they release funds. This is to ensure the CHMT follows their instructions and sometimes they call to give directives. In some instances they hold the fund until the budget meets the stated criteria. Sometimes they command us to include interventions that are not our priority (FK1-01).
>
> I have not seen any changes since I have been working with this facility for the past ten years. There has been little improvement in facility planning and decision making, since CHMTs are now responsible for everything (FK1-03).

Theoretically, decentralisation reforms are aimed at empowering health providers; in practice the field findings do not portray a very positive picture. Health providers, both at the health centre and dispensary levels, felt that much power has been concentrated in the CHMT that operates at council level. Little power is given to the service providers, apart from planning and supervision of community health services. Service providers expressed dissatisfaction with the slow pace of decentralisation to the lower levels. Also, they complained about a lack of responsiveness and feedback from the CHMT. Inability to use funds collected through user fees and CHF was cited the most by health providers as an example of the limited power they hold.

Generally, the decentralisation by devolution has not reached health facility level, leaving health workers disempowered. Decision making is, to a large extent, concentrated in the district centres. This affects policy implementation, as it was found that in some facilities clients were being charged for reproductive health services, which were supposed to be provided for free A lack of common understanding and clear policy goals of decentralisation at different levels was due to a lack of dissemination of strategies from the responsible ministry to the lower levels. This was mentioned by the national and council participants as one of the obstacles to the decentralisation process. Policies were reported to be unfriendly, resulting in different interpretations by the key actors.

5.4.4 Objectives of health sector decentralisation: Views of the service users

Generally, the findings show that service users/communities, have limited knowledge and information about decentralisation. Majority of the community participants, decentralisation was a new concept. Furthermore, very few community leaders were able to identify the decentralisation policy goals and process. It was explained during the interview with the community leaders that, before the reforms, villages had health committees and ward development committees that operated from within their office with very little concern for the communities. They said little had changed because they never received any formal guidelines on what roles they should play. A lack of information regarding the reform process was the major complaint by the village leaders. Overall, local leaders lacked a clear understanding of decentralisation and its processes. Only one out of four village leaders interviewed were able to identify the process.

At the community level, all eight community FGDs revealed that the term decentralisation was not known. The question was altered by replacing it with other terms, such as health reforms, and/or other characteristics of decentralisation, like direct community involvement and/or user representation through facility health committees. There were mixed results concerning the meaning of the term decentralisation. Most of the participants linked decentralisation to finance

reforms. For them, health reform means community involvement in the payment of the CHF membership fee and user charges at the point of service delivery when they access public health facilities. Some participants identified the presence of facility health committees as the change brought by health sector decentralisation. The following quotations show the communities' views about health sector decentralisation:

> Decentralisation came with changes in which health service user's pay when they seek health care at public health facilities. In the past we used to receive free medication, but now things have changed, you either have to pay for the fees at the point of service delivery or enrol with community health insurance funds to access public health services (C-FGD-01-08).

The extent to which communities understood decentralisation varied slight from one village to another. Some participants identified reform in relation to the availability of supplies and equipment for health service delivery. For some, health reforms meant having enough health personnel, drugs, running water and electricity in their health facility. The following quotations give community opinions:

> Ten years ago there was no facility nearby. Health services, particularly maternal services, at least have been brought closer to the user. In this community, women used to be delivered by traditional birth attendants, now they access the service at the health facility. However, some still trust the traditional birth attendants (C-FGD–03).

> I really wonder why we pay insurance and user fees while we face the same problems as in the past. My experience in the colonial period was we paid for the service although it was not expensive, but we got better services than now. I am wondering what type of reform are these in the public sector (C-FGD-06).

A follow-up mechanism that is currently used at community level to ensure direct community participation in the identification of health priorities was found to be limited. The village health workers (member of village health committees) are supposed to work closely with communities. They form the first link between the communities and the facilities. They are nominated by their respective villages and receive some basic training in health services delivery from the nearby facilities. They are not paid, and usually work on a voluntary basis. Their responsibilities include setting health priorities based on their experience of working with the communities. Communities are informed when decisions are already made. In many instances, village

governments held a village meeting where people were given information on the deliberations of the village government.

Among the goals of health sector decentralisation in Tanzania is having the communities running their own health facilities. At present, there is no mechanism in place that ensures communities are taking charge in the management of health facilities in their vicinities. Health workers were sometimes invited to village meetings when health matters were reported on. However, due to insufficient time and huge workloads, they rarely get the chance to attend. In other cases, health care providers said they were not invited because village government failed to pay their allowance. One of the participants argued that:

> … the village government hesitated to invite us because they are supposed to pay for living expenses as we need to travel from our working stations. They are nevertheless reluctant to pay us even the sitting allowances while they pay themselves the same. So I never attend their meetings, if we are all civil servants we both deserve to be paid the stipulated allowances (FKI-04).

Some participants expressed concerns that some actors were opposed to decentralisation or were not enthusiastic about it:

> … central government officials do not want to delegate authority and responsibility to local governments. In reality these people do not have a desire for decentralisation. At most they may delegate some authority with the intention to snatch or take it away whenever they want (CKI–01, CKI-03, CKI-05).

The interviews exposed an ambiguity about whether participants opposed decentralisation or whether the process was more complex than simply identifying who is for or against it. This was stated by one of the participants, who did not see resistance but rather confusion and a lack of enthusiasm to implement decentralisation in its totality.

> Central authorities are in a state of confusion regarding decentralisation … it cannot openly deny decentralisation, neither does it show willingness to devolve authority and resources to LGAs.

The same participant criticised the lack of authority given to LGAs in managing their own staff:

> … no one opposes decentralisation, but some of the central authorities usually create an unfavourable environment for the implementation of decentralisation. Members of parliament and ministers usually make policies that are contrary to decentralisation … maybe it is not the right time to implement. It can be said there are people who are against decentralisation (CKI-03).

The complexity of the resistance to decentralisation is characterised by the opinion raised by one of the participants mentioning a lack of deliberation:

> … the theoretical part of decentralisation is well articulated in policy documents and has not been opposed by anyone. But there are those who oppose the practice. For instance there are those who do not explicitly oppose decentralisation but tend to dilute the definition to suit their own perspectives. In particular, central bureaucrats who are the ones who produce policy that favours decentralisation at the same time produce policy that contradicts it (NKI-06).

Communities felt disempowered with the current practice of decentralisation. This marginalises their responsibilities and obligation to participate in the decentralisation process. The data presented in Table 5-1 summarises the views on health sector decentralisation. Participants were asked to rate decentralisation policy. In replying to this question, some participants saw it as an opportunity to express their feelings. The responses are grouped under two headings, namely good and bad policy. About 64% of the participants viewed decentralisation as a good policy, while 34% of the participants viewed it as bad policy. Those who said it was good were the ones to whom decentralisation gave more power, while those whose power was taken from them feel that decentralisation is not good. Positive comments towards decentralisation emphasised the increase in the number of facilities, hence bringing the services closer to the users; improved availability of funds for local service delivery, i.e. each council can access health resources through their comprehensive council health plan, hence easier problem solving and improved service delivery. Those who said decentralisation was not good associated it with tension and confusion over the new roles and responsibilities. The participants commented on the poor dissemination of national policies and the lack of consultation during the formulation process. This was mentioned as a source of misunderstanding and delay in implementation.

According to the findings, the characteristic of decentralisation that was seen at national, council and community level was the establishment of governance structures to manage health facilities. However, the CHSB and FHCs were put in place to facilitate the financing of reforms and not to re-organise local health service delivery. Communities repeatedly mentioned that the key role of health boards and committees was to mobilise communities to join the community health insurance. This is contrary to the goals of decentralisation that aim to empower communities to

define and prioritise their health needs. The next section presents the discussion based on the research findings and other literature.

Table 5-1: Summary of the actors' opinions on health decentralisation

Opinion on decentralisation	Good	Not good
National n = 15	5 (11%)	9 (19%)
Regional n = 3	-	3 (6%)
Council n = 13	9 (19%)	4 (9%)
Providers n = 11	11 (23%)	-
Politicians n = 5	5 (11%)	-
Total = 47	30 (64%)	16 (34%)

Source: Field visits, 2010.

5.5 Chapter discussion and conclusion

The findings presented in this chapter confirm there is no universal form of decentralisation that applies to health systems. The decentralisation of the Tanzanian health sector is based on public administrative typology that defines decentralisation in terms of its components: deconcentration, delegation, devolution and privatisation. In each form of decentralisation, significant power and authority has remained with the central authorities despite government advocates for devolution. Similarly, the international experience shows that country health systems tend to approximate systems of deconcentration, devolution and delegation and sometimes combine all these forms (Mills et al., 19990).

The empirical evidence showed that the participants defined decentralisation differently, although there were common aspects shared among the participants. To some extent the evidence matches with what Rondinelli (1981) defines as decentralisation, as the transfer of planning and decision making to the sub-national level. Despite the fact that some of the participants, especially at the lower level, were not knowledgeable about the policy goals of decentralisation, they were observed to perform some activities that were identified in the decentralisation policy. These activities include decision making over local resources, organisation of service delivery, and internal transfer of health personnel within the council, which indicates that decentralisation, has taken place at the council level.

McLaughlin (1987) asserts that individual interpretation of policy meaning has a significant influence on how policy is implemented. Thus, meanings attached to policies affect policy implementation. Makinde (2005) contends that if policy is seen to favour the implementers, their attitudes towards implementation are very positive. But, when policies are likely to affect implementers negatively, their attitude towards implementation is poor. Similarly, Smithson et al. (1997), Mills et al. (2001) and Batley and Larbi (2004) studies show that the attitude of staff can be an obstacle to implementation.

This study argues that prior knowledge of policy objectives is the basic prerequisite for effective implementation. One participant insisted:

> …..LGAs leaders do not really understand what decentralisation means. It is then the role of government to train such people and other actors to play their part (NKI-07).

Thus, those who are responsible to execute policy decisions should have knowledge in order to communicate the policy goals effectively during implementation. The case of Tanzania has shown that central authorities usually produce policies but fail to communicate not only with the lower-level authorities, but even the higher authorities. This leads to difficulties in translating the decentralisation policy into practical outputs. The gap between policy formulation and implementation existed at all levels, and a policy can only get support if there is a clear understanding of its content. Likewise, the probability of getting support for implementation can be high if policies are decided upon among central government and local authorities (Ramji, 2009).

According to Sabatier (1991), the status of policy implementation is measured by the extent to which policy objectives are achieved. Thus, the process of implementation determines the success of a policy. Grindle and Thomas (1991) put forward evidence that policy outcomes are different from policy intention. Studies by Sakyi (2008) and Dhakal and Singh (2006) have shown that policy implementation is likely to suffer whenever there is misunderstanding and uncertainty over the policy objectives. This is because of the communication gap and the failure of central officials to share information because of the power struggle between them and local bureaucracies (Sakyi, 2008). This led to the discrepancies between the policy intentions and

implementation. Lower-level managers were not comfortable with the pace of decentralisation. Roles and responsibilities of the lower levels were not well articulated hence it is difficult for the facility managers to demand accountability of the council managers. It is alleged that the status of policy implementation is largely defined and shaped by the given conditions, objectives and characteristics (Grindle & Thomas, 1991). In the case of Tanzania, the policy characterised perception gaps between policy makers, implementers and users about the objective of the decentralisation policy. This has been one of the challenges for effective implementation. For example, providers perceive that decentralisation improves the mobilisation of resources, while service users perceive that services have not improved.

Decentralisation was reported to be complex and unclear, resulting in different interpretations among different parties involved in implementation. An example was the user fees policy which was interpreted differently by different actors. Despite the fact that a key component of the RHS direct health services is that they are provided free of charge, healthcare providers were charging the users. In addition, lack of a clear implementation strategy that specified the resources needed has also affected decentralisation as far as health delivery is concerned Likewise, the policy did not define the roles and functions of the decentralised sectors at the national level. This has led to the duplication of activities in the PMO-RALG and MoHSW.

Central structures are inadequate and inefficient to address decentralisation policy needs. The health sector decentralisation is not guided by sufficient communication from the MOHSW or the PMO-RALG, which is responsible for the administration of primary health facilities (MoH, 2002). This could be due to a lack of a clear decentralisation policy for the health sector. Decentralisation efforts are more politically motivated than technical efforts geared to address inefficiencies of the health care system (Watt et al., 2005, Jeppsson et al., 2003, Hanson et al., 2003).

Another challenge that was raised by the participants was lack of capacity at all levels. These included both financial and human resources. Mills et al. (2001) and Larbi (1998) questioned the capacity resources available in the health sector to implement decentralisation. They found that most of the district health management teams lack the technical knowledge to implement health reforms (Larbi, 1998). Additionally, a perception of losing power by central officials, along with the unclear roles of the actors and institutions involved in the implementation process, can lead to institutional divergences, which cause implementation gaps (Collins and Barker, 2001, Batley and Larbi, 2004). Successful implementation of decentralisation demands strong central-local relationships and inter-sectoral coordination (Collins et al., 2003, Green and Collins, 1994, Collins et al., 2007, Mills et al., 1990). This has been a challenge in Tanzania.

Capacity development should be a constant process before and after decentralisation, as demands for new skills emerge in the course of implementation (Gottret and Schieber, 2006). Health managers are basically clinicians who lack training in health related managerial structures. The significance of balancing capacity-building measures in management with technical skills was realised at all levels. Inability to balance these two skills prerequisites could lead to serious shortfalls in service delivery. In Namibia it was noted that health management teams were not trained in complementary public health skills and therefore focused more on management than on clinical skills, hence the public health programme became the victim (Bell et al., 2002, McPake et al., 1991).

Conclusion

Limited understanding of the decentralisation objective has emerged as one impediment to its effective implementation. The findings presented in this chapter acknowledge that effective policy communication among the actors and agencies involved is one of the important factors for effective implementation. The conclusion supports Jeppsson et al. (2005) on the importance of proper dissemination strategies to make policy available to the ultimate actors. It has been noted that policies that are not properly communicated to implementers, in particular the workforce, are usually left undone (Makinde, 2005). The case of Tanzania shows that local actors lag behind

in the decentralisation process (Jeppsson et al., 2003) . One of the reasons is lack of consultation during policy formulation and implementation stages. And after implementation, monitoring of the progress of sector decentralisation is rarely carried out by the Ministry of Health; whenever health sector evaluation is carried out decentralisation components are hardly included

Abbreviations for chapter 6

FKI	Facility key-informant interview
FY	Financial year
GPG	General-purpose grants
HFCs	Health facility committees
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
HRH	Human resources for health
HSBF	Health Sector Basket Fund
HSR	Health sector reforms
HSSP	Health Sector Strategic Plan
ICPD	International Conference for Population and Development
LGA	Local government authority
LGCDG	Local Government Capital Development Grant
LGRP	Local Government Reform Programme
MDAs	Ministries, departments and agencies
MDGs	Millennium Development Goals
MoFEA	Ministry of Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MPs	Members of Parliament
MSD	Medical Stores Department
MTEF	Medium-term expenditure framework
NGOs	Non-governmental organisation
NHIF	National Health Insurance
NKI	National key-informant interview
NPERCHI	National Package of Essential Reproductive and Child Health
NSGPR	National Strategy for Growth and Poverty Reduction
O&ODs	Opportunities and obstacles to development

OC	Other charges
OPRAS	Open performance review and appraisal system
PE	Personal emoluments
PER	Public expenditure review
PF	Policy Forum
PHSDP	Primary Health Sector Development Programme
PMO-RALG	Prime Minister's Office - Regional Administration and Local Government
PO-PSM	President's Office - Public Services Management
RCHCo	Reproductive and Child Health Coordinator
RH	Reproductive health
RHMT	Regional Health Management Team
RKI	Regional key-informant interview
RMO	Regional medical officer
Tsh	Tanzanian Shillings
US$	United States Dollar
WHO	World Health Organisation

CHAPTER 6

DECENTRALISATION AND REPRODUCTIVE HEALTH SERVICE DELVIERY IN RURAL TANZANIA

6.0 Introduction

This chapter analyses the three dimensions of decentralisation that is fiscal, administrative and political decentralisation and how they have impacted on reproductive health delivery. The findings presented indicate that fiscal, political and administrative decentralisation has taken place in the health sector. The most important effect of the fiscal decentralisation is that there is a notable increase in local health spending transferred from the central government (CG) to the local government authorities (LGAs). However, intergovernmental transfer has made the LGAs depend heavily on CG for local spending which is contrary to fiscal decentralisation goals which aim at strengthening LGAs to generate their own revenues to support their budget. Thus, the discretion of the LGAs to set local expenditure priorities continued to decline as has been reflected in field findings.

Administrative decentralisation has not been very successful much succeeded as the key authority and autonomy for the civil service regulations has been re-centralised since 2006. LGAs were found to have very limited power for their personnel. This made it difficult for LGAs to hold them to account in case of abuse. Therefore, LGAs should be granted more autonomy in order to hold their personnel accountable. In addition, LGA staff lack skills and qualifications and, currently, there is no system in place for in-service training let alone a strategy for local human resource development. It is difficult to attract skilled staff to LGAs. This compromise the quality of health services provided to the citizens.

Political decentralisation has led to the introduction of bottom-up planning, service user representation though council health services boards (CHB) and heath facility committees (HFCs) as a means for the community are heard. The findings challenge the assumption that

service user representation in such structures enables users to voice their needs. Since selection of the members is not democratic, representatives feel themselves as principally accountable to government and not to their communities.

At this point it is worth outlining the different definitions of decentralisation. There are three distinct elements of decentralisation that are applicable to this study:

- Fiscal decentralisation refers to the transfer of financial resources and granting the LGAs more financial discretionary powers to raise local revenue, to make and approve their own budgets according to their own priorities reflecting the local health needs. Three issues will be analysed: funding, budgeting and expenditure.
- Administrative decentralisation refers to the transfer of powers for human resource management to the LGAs in order to improve local service delivery and enhance accountability to the citizens. The study will therefore look at the relation between decentralisation, human resources and reproductive health service (RHS). It covers the following issues: public service arrangements and conditions of service, hiring and firing, supervision, and training and performance management.
- Political decentralisation refers to the transfer of power for decision-making regarding local health care planning and management to the citizens either directly on indirect through user representation. Political decentralisation is expected to provide a means to reflect local health needs and priorities. The section therefore, analyses the practices of community engagement and analyses how it has improved accountability for the provision of reproductive health services.

Basically, political, fiscal, and administrative decentralisation can be applied to any number of different functions in the health service delivery. For-instance, the ministry of health may control many of the health functions, including those relate to financing (such as expenditures allocation); service organisation (such as insurance payment mechanisms); governance (such as facility oversight committees); and human resources (Bossert, 1998). Yet, decentralisation of one function, such as financing for services through intergovernmental transfer grants, does not necessarily imply decentralisation within other functions, like autonomy to adjust centrally

defined program priorities. In Tanzania, for example, despite devolution of primary health care services delivery and delinking of health personnel from the Ministry of Health and Social welfare, human resource functions remain highly centralised (Munga et al., 2009).The next section analyses fiscal decentralisation in relation to council power to set local revenues and local autonomy over health care expenditures. Local own source revenues are very important to enhance local accountability between the council and local citizens.

6.1 Fiscal decentralisation

Fiscal decentralisation defines how and in what way expenditures and revenues are organised among different layers of government (UNDP, 2005).Section 10 of the Local Government Finance Act, No. 9 of 1982 spells out how central government should make fiscal transfers to LGAs. The overall intention of fiscal reforms is to give "local government wide discretionary powers and a strong financial base" and capacity to raise their own revenues (PMO-RALG, 2008:9).The highest degree of fiscal autonomy is determined by the ability of the LGAs to raise their own funds to support public services delivery(Boex and Martinez-Vazquez, 2003). Accordingly, fiscal decentralisation has expanded the amount of central grants allocated to the LGAs. Since the endorsement of the decentralisation policy in 1998, it was in 2004 when central transfers to LGAs were introduced. The Financial Act No. 6 of 1999 was amended to improve inter-governmental fiscal relations through fiscal devolution to ensure that LGAs' responsibilities are performed in the spirit of cooperation, equity and efficiency(URT, 2007b). Generally, intergovernmental transfers has been increased from 79% of total LGA revenues in 2001/02 to 93% in 2006/07 while own-source revenue decreased from 21% of total LGA revenues in 2001/02 to 7% in 2006/07 (URT, 2007b).Approximately 25% of the national budget is earmarked for intergovernmental transfers(MoFEA, 2013b). Table 6-1 shows local government budgets for the FY2010/11, FY 2011/12 and FY2012/13 in Tanzania. The transfers are allocated based on a formula-based mechanism, which takes into account socio-economic factors such as size of population, area, poverty, as well as access to health facilities (Boex and Martinez-Vazquez 2006).

Table 6-1: Overview of local government finances, (Tshs. billions)			
Fiscal Year *	**FY 2010/11**	**FY2011/12**	**FY2012/13**
Total Revenues	2,251	2,439	2,988
Intergovernmental Transfers	2,084	2,243	2,733
Own Revenues	158	195	240
Total Expenditures	1,987	2,708	2,619
Intergovernmental Transfers as % of Total Revenues	92.59%	91.97%	91.47%
Own Revenues as % of Total Revenues	7.03%	8.02%	8.06%

* Fiscal year starts on 1st July and ends on 30th June 30.

Source PMO, RALG, 2013.

6.1.1 Council health budget management and expenditure

Until 2003, LGAs in Tanzania had power over local revenue sources such as development levy and business fees. However, in 2004, Government came with a locked list of LGAs revenue sources and some other sources were abolished. The locked list includeproperty and land rent tax, sales taxes on crops, forest products and services, guest-house tax and various fees, fines and penalties. LGAs are not allowed to levy any tax outside of the locked list (PMO-RALG, 2007). This idea was imposed by central authorities without any inputs from parliament as "the ruling party CCM politicians fearing that the opposition would make use of unpopularity of local nuisance taxes" (Therkildsen and Mette, 2010).

At current, LGAs do not have full autonomy over locally generated revenues as the National Treasury Office imposes some restrictions. A proportion of locally generated revenues are remitted to the central government. For example, 80% of land taxes are remitted to central and the LGAs retain only 20%. Value added tax is centrally managed. LGAs' power to impose their own taxes was taken away, as explained by one of the participants:

> … since 2003, the local government has to get permission from the Ministry of Finance and Economic Affairs (MoFEA) when we want to increase local taxes and levies. The MoFEA has approved very limited increases in councils … it is a local tax but it is not really local tax because you have the MoFEA that has to approve it … that flies in the face of decentralisation because when you decentralise … you are giving the councils ability to raise revenues for them to deal with their new roles. … Generally, national treasury controls local levies (RKI-03).

The effect of removing local tax reforms made the LGAs lose substantial revenues which weakened their autonomy.This made LGAs to have limited control over local revenue sources (Cochran et al., 2009, URT, 2007a). LGA revenues from own sources comprised only 6.6% and 8% (table 6-1) of the total revenues for FY 2010/11 and FY 2011/12, respectively. This implies that LGAs depend on CG transfers for local spending. For example in financial year (FY) 2002/2003, CG was 81.0% but in FY 2011/12 the level has increased to 91%. This has a detrimental impact on local financial discretion and ultimately service delivery as it came with directives (URT, 2007b).

As an alternative to LGAs own revenues, CG established a system of the intergovernmental transfers to provide LGAs with financial resources to provide services. There are three main types of intergovernmental transfers that are found at the LGA level: (i) Formula-based recurrent block grants**:** cover block grants for the decentralised sectors (education, health, roads, agriculture, and water) and (ii) General Purpose Grant (GPG). The recurrent block grants contributed 68% of the total LGA funding for the FY 2011/12, (ii) other transfers (subventions): these are from Ministries, Departments and Agencies (MDAs) for recurrent purposes. For the FY 2010/11 and FY 2011/12 the subventions and funds accounted for 6.6% and 6.8% respectively of the total LGA funding and (iii) Local Government Capital Development Grant (LGCDG) serving as discretionary development grant transferred to the LGAs for capital investments such as new infrastructure construction and rehabilitation of health facilities.

The LGCDG is allocated according to a formula and annual assessment performance. LGAs that don't qualify are given a Capacity Building Grant (CBG) to enable them to qualify for LGCDG. DPs support LGCDG by combining project support, earmarked sector budget to fund the LGCDG activities, and the associated CBG (Mzumbe-Univeristy, 2010). Since its implementation in 2009/2010, at least 50% of the LGAs has claimed the grant (Tidemand and Sola, 2010a). The LGCDG funds are highly politicised, and grants are made available (more than 50%) in councils led by CCM. Basically revenue disbursements are used 'to protect party strongholds from decreasing vote shares' (Weinstein, 2010:53). Councils where opposition won are receiving 50% lower grants than average For FY 2010/11 and FY 2011/12 the development

grants (including funds under LGDG) constituted 17.2% and 17.4% respectively of the total LGA funding (Weinstein, 2010).

External sources of funds to LGAs comprise borrowing from financial institutions and other development partners that are not directly channelled through either Recurrent Block Grant or LGDG funding system. However, LGA borrowing has not been a preferred source of funding for LGAs. In the FY 2010/11, borrowing accounted for only 4.6% of LGA financing. In the FY2011/12, LGA borrowing has decreased to nearly zero (MoFEA, 2013b).

6.1.2 Source of council health funding

There are types of intergovernmental transfers from the CG to LGAs for the recurrent and development expenditures: The recurrent expenditure is referred to as the health block grant covering personnel emoluments which are mainly covered by government while development expenditure is known as Health Basket Funds (HBF) supported by donors which is mainly allocated for service delivery (Masau et al., 2011) Both health block grant and basket funds are allocated to councils through a needs-based formula which reflects four main factors: population (70%); poverty rate (10%); district vehicle route (distance), which is a proxy for the size of the area covered (10%); and mortality rate, for which under-five mortality is used as a proxy indicator (10%) (MoHSW, 2010).

At council level, funding of health services is fragmented and uncoordinated. There are at least 13 sources for LGAs health funding (table 6-2). Funds for drugs are from central government and donors in the form of Block Grants (BG) or Health Basket Funds (HBF). The allocation is made straight from the MoHSW to the Medical Store Department (MSD). Facilities request their supplies directly from the MSD on a quarterly basis as per their budget ceiling. There is little information on how cost sharing money is eventually distributed and used. Better coordination of the financial resources at the council level, and reporting systems that allow an overview across the country would help decision makers at all levels. Table 6-2 provides an overview of budgeted and actual expenditure for FY 2010/2011. Block grants from government constituted the largest share (57.4%), followed by donor basket funds (18%). The share of block grants increased from

52.2% in 2009/2010 to 57.4% in 2010/2011 due to the deployment of new health staff. The share of basket funds has declined from 21.3% in 2009/2010 to 18% in 2010/2011.

Table 6-2: Sources of health funds for 125 LGAs

	2010/2011		2011/2012	
Sources	**Approved budget**	**Actual expenditure**	**Actual expenditure (% of total)**	**Estimate**
Block grants	216 454 617 771	170 980 370 156	57.4%	275 144 699 103
Basket Fund	57 378 810 288	53 762 902 631	18.0%	65 992 031 177
Global Fund	4 788 370 409	844 741 984	0.3%	4 792 297 004
UNICEF	1 951 577 906	910 947 561	0.3%	10 721 692
CHF	3 519 419 856	2 627 257 173	0.9%	4 411 925 252
NHIF	1 657 255 399	1 036 486 116	0.3%	2 453 000 212
Cost sharing	9 497 199 609	7 156 968 446	2.4%	12 465 167 399
Own sources	6 439 655 159	2 703 534 631	0.9%	9 202 929 745
DRF	346 419 322	439 892 812	0.1%	459 369 100
In kind	19 884 711 219	24 020 575 605	8.1%	40 310 387 269
JRF	495 966 083	428 269 210	0.1%	388 804 735
LGCDG	2 297 364 394	1 128 398 612	0.4%	5 913 877 254
PHSDP	32 898 294 754	14 397 617 202	4.8%	37 039 790 240
Others	43 494 961 697	17 692 256 874	5.9%	44 571 021 795
TOTAL	**401,104,623,095**	**298 122,219, 013**	**100.0%**	**503, 156, 021, 977**

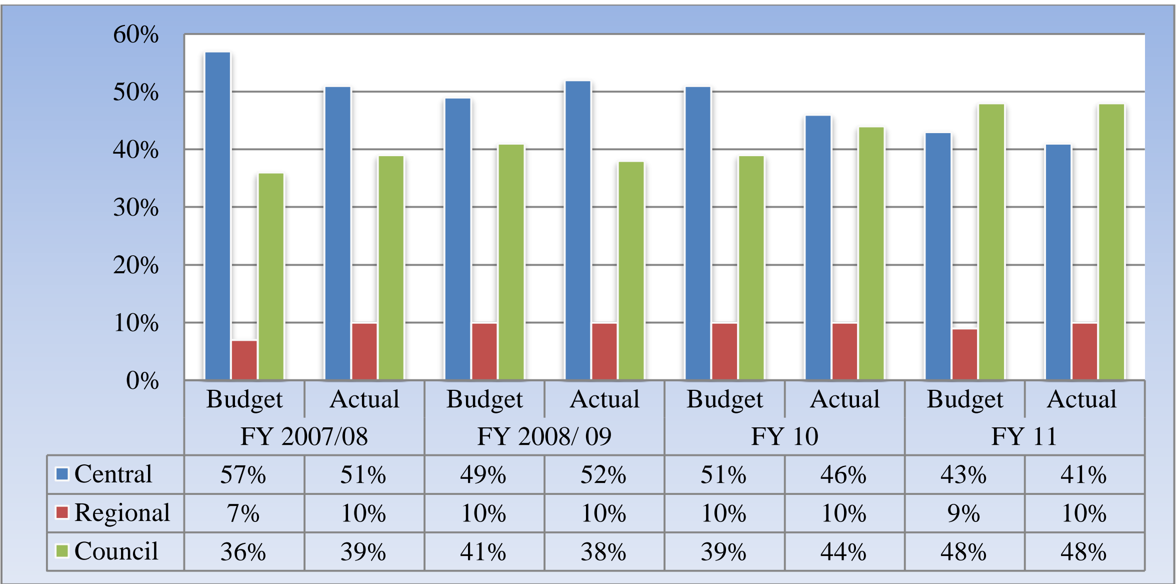
Source: URT, 2011. Note: DRF = Drug Revolving Fund; JRF = Joint Rehabilitation Fund; LGCDG = Local Government Development Grant; PHSDF = Primary Health Sector Development Programme

Generally, for the LGAs to provide health services, a combination of central-local transfers and local own source revenues are important. The average expenditure from councils' own resources for health spending accounted for only 1% in 2010/2011, which shows a declining trend, from 2% in 2009/2010. The low capacity of LGAs to sponsor their health budget threatens sustainability of council health service delivery if donors decided to withdraw funding. As well, it threatens local accountability between the LGA officials and the citizens.

(ii) Budget between layers of government

An analysis of the budget share between layers of government is presented in Figure 6-1. The data shows there is a significant variation in budget share over the three years. Central government has remained in possession of the largest share, followed by councils, with regions last. It was expected that councils would receive higher allocations under devolution. However,

the LGAs' shares are smaller than those of CG, despite a significant increase in their proportions. The percentage of public sector health resources allocated to councils' health services has slightly increased from 24% in 2005/06 to 34% in 2010/11. The allocation for the regional level increased from 4% to 6% in the same period. The increase in local spending was achieved through decreases in central allocation for tertiary services, from 72% to 60%, for the same period. It is argued that limited budgetary allocation from national level to LGAs has hampered the decentralisation process (MoHSW, 2013). Considering that the vast majority of the health care services are delivered by the LGAs; the proportional of LGAs spending suggests considerable underfunding of council health services. Despite government efforts towards fiscal transfers LGAs have limited fiscal discretion (URT, 2007b, Tidemand and Sola, 2010a, Kessy and McCourt, 2010, Braathen and Mwambe, 2007). This suggests central resistance to fiscal devolution.



	FY 2007/08		FY 2008/ 09		FY 10		FY 11	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Central	57%	51%	49%	52%	51%	46%	43%	41%
Regional	7%	10%	10%	10%	10%	10%	9%	10%
Council	36%	39%	41%	38%	39%	44%	48%	48%

Figure 6-1: Proportion of central and LGAs health budgets
Source: MoHSW, 2011

Council health funds are disbursed directly to council according to the council comprehensive plan. Usually, Government issues guidelines for production of the Comprehensive Council Health Plan (CCHP) before receiving central funds. The guideline directs the CCHP activities to be included in the CCHP. The plan should reflect the priority areas of the Tanzania Essential Health Package (TEHP) identified by the MOSHW. Under the TEHP, there are six priority areas

to be covered in the CCHP for central allocations. The TEHP aimed to ensure that health interventions address the high disease burden in Tanzania. The six priority areas, include reproductive and child health, communicable disease control, non-communicable disease control, treatment and care of other common diseases of local priority and community health promotion/disease prevention, and the establishment/strengthening of organisational structures and institutional capacities to improve health service management at all levels (MoHSW, 2010).

Funds are transferred directly from the MoFEA to council health account no 6 for the development expenditure after the approval of the CHHP. Implementation is monitored on a quarterly basis using the quarterly progress implementation and technical reports. The CHHP Planning Guidelines (2010) provide guidance on the distribution of the HBG among the council health cost centres as table 6-3 presents.

Table 6-3: Guidance on the use of Council health Resources

Cost centre	**Ceiling range for allocation by Council**
Office of DMO	15%–20%
Council Hospital	25%–30%
Voluntary agency hospitals (Health basket funds only)	10%–15%
Health Centre	15%–20%
Dispensary	20%–25%
Community Initiatives	2%–5%

Source: MOHSW CCHP Planning Guidelines (2011).

Although the guideline health centres and dispensaries are separate cost centres in the council budget, individual primary health facilities do not have their own sub-accounts (MoHSW, 2010). This implies that although council's health accounts can be used to identify how much funding goes to dispensaries and health centres overall, it is not possible to identity the resources that flow from the council to individual health facilities in the budget. The common practice that has been found in this study is that council officials manage all the health funds including user fee collections and community health insurance (CHF). This can be viewed as a limitation to fiscal decentralisation to the level below the council.

(iii) Council fiscal discretionary

The Public Financial Management Act has decentralised responsibility and accountability for expenditure to the council health managers. Funding for council health services are mainly transferred from central for the specific priorities, which make it difficult for the LGAs to respond to local health priorities. It is obvious that local expenditure is driven primarily by the nature of the intergovernmental fiscal transfer system, which limits local pinning and spending discretion for certain activities, such as PE, OC or capital development. In terms of discretionary funding as per (table 6-4) about 86% was utilised for personnel emoluments while OC is 14% which is used to cover administrative costs and the recurrent spending service delivery was 57%.

Table 6-4: Local government health spending

	2010/2011		**2011/2012**
Sources	**Approved budget**	**Actual expenditure**	**Estimate**
Government Fund (PE)	178 143 254 266	146 401 509 485	242 360 873 095
Government Fund (OC)	38 311 363 505	24 578 860 672	32 783 826 008
Recurrent	216 454 617 771	170 980 370 156	275 144 699 103
Development total	364 650 006 098	127 149 848 860	228 011 322 874
Grand total	**797,559,241,640**	**469,110,589,173,469**	**778,300,721,080**

Source: PER, 2013

Estimates of the Council budget for the year FY 2011/2012 were 9 984 180 554.Council's own source of revenue is very limited; hence council health services were financed through inter-governmental transfer. While locally generated revenues are an important source of funding at council level, of the total budget of Tsh 9.9 billion, the Council is planning to contribute Tsh 1 844 000 million only 0.02% of the total budget. Thus, the amount collected is insignificant to support local service delivery.

Table 6-5: Council allocation source for the FY2011/2012		
Source	**Approved budget**	**%**
Government block grants	1 320 453 510	13.22%
Basket fund	470 298 300	4.71%
Council own sources	1 848 000	0.02%
Cost sharing and CHF	492 192 700	4.93%
Receipt in kind	7 228 325 670	72.40%
PHSDP	59 094 000	0.59%
Other funding	411 968 374	4.13%
Total	**9 984 180 554**	**100%**

Source: DMO's Office, 2011

Fiscal decentralisation grants councils power to set a fee for insurance and user charges depending on the local economic context. An enrolment fee for the CHF was Tsh 5 000 and user fee minimum was Tsh 2 0000 charged for consultations and for basic treatment. Data presented in Table 6-6 shows that collection from the CHF was Tsh 44 399 500 million. Out of that only 3% was allocated for purchasing drugs, while 25% was allocated for community sensitisation and the remaining 72% was allocated for administrative costs.

Council health funds are usually transferred and controlled by the central government through budget ceilings, guidelines and approvals. This is to impose national priorities on local spending, which restricts local choices. The preparation of the CCHP should be done in accordance with the budget ceiling from the MoFEA, PMO-RALG and MOHSW. The Council cost centres were allocated the recommended proportional according to the budget ceiling (see table 6-6).

Table 6-6: Council budget allocation among the cost centres FY 2011	
Cost centres	Amount allocated
DMO's Office (20%)	94 263 136
Council (regional hospital) (25%)	116 047 700
Unallocated for VA (10%)	49 290 034
Health centres (20%)	96 184 636
Dispensaries (20%)	93 285 260
Communities (5%)	21 277 534
Total	**470 348 300**

Source: DMO's Office, 2011.

There were mixed opinions among health providers and council health mangers about fiscal decentralisation. One of the main financial benefits of the implementation of health service decentralisation within LGAs as reported by one of the participants is that decentralisation has

increased autonomy in the mobilisation of financial resources from local sources and the possibility of deciding on how to use them for the implementation of health services in the district. One participant insisted:

> Councils are now given power to mobilise local resources from different resources like own sources, including fundraising, community health fund and cost sharing (CKI, 4)

Other participants felt that decentralisation has enabled council to access the central funds directly with the CCHP. One of the participants insisted:

> ….in the past planning was theoretical as funding was not guaranteed during the execution; funds would somehow be diverted to other activities like roads. And no one questions, there was very little you could do about it…at least now there is some assurance that plans receive allocation (CK, 01).

While, theoretically, fiscal decentralisation is geared to empower health providers, in reality the field does not portray a very positive picture. Facility providers felt that much of the fiscal power was concentrated at the council level, with very little trickle down. They expressed dissatisfaction with the slow pace of fiscal autonomy as well as lack of responsiveness from health managers at the district level. Failure to use money collected at the facility level through CHF and cost sharing was cited as an example of the limited powers health facilities have been granted. These funds were managed at council level while providers cannot speak about their own budgets and they were not aware how much Council allocates for their budget. Participants claimed that:

> We never get feedback from councils on the approval of our budgets, thus we don't know how much we received (FKI-01, FKI-06).

With decentralisation it was expected that facilities would have power over utilisation of funds collected at their facilities. Staff in all the facilities visited complained that they did not have the power to utilise funds they collected. After the collection of the CHF contributions, providers deposited them at the district and later they were re-allocated upon request or as determined by the council. The allocation mechanism of the money does not follow a standard formula, but is instead based on observed need. Sometimes CHF is used as a pool fund at the council level and allocated to all health facilities. User fees are also allocated to the health facility which collected.

Providers felt discouraged by the fact that they are failing to meet the health needs of the communities.

Providers complained about difficulties in retrieving funds after they were deposited in the council account. This is contrary to CHF policy, which states that it is the facility and CHSB that have the mandate over the fund. Providers interviewed in this study were of the view that they would be more empowered if funds were reserved at the facility level. Lack of autonomy to use CHF creates a disincentive to mobilise more funds, since facility priority needs are not addressed.

Funding for reproductive health services

Budget for RHS was limited due to other competing demands of health priorities. National health resources are allocated based on health sector strategic plan (HSSP) III and broader national policies. At the council level, health resource allocation begins with the prioritisation process to identify which health interventions should receive funding. Most of the budgetary responsibilities for the RHS are centralised although councils are allowed to establish budgets for procurement of some items like contraceptives. Funding for RHS was channelled through budget or project support directly to councils. The experience with earmarking funds within the health sector is diverse. First, there is a sense among national programme managers that RHS is losing out under current implementation of SWAps, where development partners are pooling funds to support general budget rather than programs. For this reason earmarked funding for RHS should continue due to the delay in government disbursement and complicated procurement procedures. Secondly, national programme managers felt that earmarked funding for RHS did not influence priority setting; instead, it tends to alter funding arrangements and resource flows to LGAs. The feeling from the council managers was that RHS is benefiting from both earmarked and pooled funds.

The study struggled to find precise figures for RHS expenditures. The council allocates funds through primary healthcare services but there was no specified separate funding for RHS. However, HIV/AIDS does receive separate funding. Funds for RHS are allocated under the Maternal and Child Health (MNCH) interventions but the MNCH was allocated only 5% of the total health spending, (See table 6- 7). The largest proportion of the budget was spent on salaries (44%).

Table 6-7: Council allocation to health interventions

Priority Interventions	**Amount allocated (Tsh)**	%
Maternal, new-born and child health	150 004 100	5%
Communicable disease control	78 147 841	3%
Non-communicable diseases	15 194 359	1%
Treatment and care of local disease priority	22 455 450	1%
Environmental health and sanitation	44 785 624	2%
Strengthening social welfare and social protection services	17 054 650	1%
Strengthening human resources for health	1 246 766 040	44%
Strengthening organisation structure and institutional management	977 850 320	35%
Emergency preparedness and response	56 479 000	2%
Health promotion	199 897 500	7%
Traditional medicine and alternative healing	2 463 000	0.1%
TOTAL	**2 811 097 884**	**100 %**

Source: DMO's Office, 2011

Further analysis was carried out on MNCH allocations to identify the proportion allocated to different RHS components as table 6-8 presents. Only two components of RHS received funding. The CHMTs thought that RHS are funded by donors thus the council should concentrate on other pressing health needs. The Council allocated Tsh. 66 million to procure theatre equipment while family planning was allocated Tsh. 1 million from the basket fund, not council sources. The CHMTs were aware of other RH problems, like teen pregnancies, infertility and reproductive system cancers but because of inadequate funds they failed to make allocation to those interventions. Inadequate funding was contributed to by lack of reliable sources from local revenues. Almost 100% of the council health expenditure was from the intergovernmental transfer. This was not adequate to meet council health needs. The government usually provides a ceiling as a reference for the production of the CCHP and councils have to budget according to

that ceiling. This implies that council plans are aligned with was made available from the central authorities and they must adhere to the provided ceiling. The stated goal of decentralisation to enable the council to plan according to their local health needs is still a nightmare. A participant at the national level commented:

> ….council resources from own sources are extremely limited….they cannot plan according to their wishes, hence, they must obey the given budget ceiling….we understand health needs are many…but we cannot afford them all….the central resources are limited, hence, council plans should have a limit on what we can afford to fund. It cannot be for each council to plan and budget without ceilings. (NKI, 05)

The delays in disbursement of funds interrupt the implementation of health activities and some of the activities were not implemented at all. This was where participants highlighted the importance of local resources, although they were difficult to raised

> … When central government delays fund, council revenues can be used to fill in the gap. However, the total revenue allocated is very little and the amount received is not what we budgeted for. If you look at the performance of the budget for the health sector of this financial year, the Council did not release the amount requested (CKI-02, CKI-04)

Table 6-8 : Council Budget allocation for MNCH FY 2011/2012

Components	Allocations (Tsh)
Antenatal care	
Obstetric care, including emergency care	66 057 500
Post-natal care	
Sexually transmitted infections	
HIV, early infant diagnosis and PMTCT	
Post-abortion care	
Family planning	1 250 000
Peri-natal care	
Care of new-borns	2 520 000
Immunisation	34 305 000
Adolescent sexual reproductive health	
Other maternal conditions	
Reproductive system cancers	
Community-based healthcare services for MNCH	
Total	**104 132 500**

Source: PMO-RALG, 2011

Earmarked donor funds to support RHS were available through vertical programme as table 6-9 shows. These include support from Engender Health and Marie Stopes. Engender Health has been advocating for long-term family planning methods. Marie Stopes provides outreach services on long-term and permanent methods for FP, as well as community sensitisation of FP

methods. The UN-Joint Program (UNJP2) support since 2008 aimed to increase equitable access to comprehensive reproductive and child health interventions. UNJP2 funds were allocated for training and awareness campaigns on FP for community leaders. Global funds are targeted for HIV/AIDS, malaria and tuberculosis. Although these programmes have made significant contributions to improvements in RHS, they usually operate parallel to other programmes with technical supervisory staff to ensure that treatment guidelines and procedures are followed. The challenge to vertical programmes has been the competition for qualified health staff at Council level which is already in crisis.

Table 6-9: Council donor funding for MNCH FY 2011/2012

Sources	**Amount (Tsh)**
UN JP 2	11 989 000
Global Fund	12 020 000
Engender Health	13 452 100
Marie Stopes Tanzania	16 187 199
Total	**53 648 299**

Source: DMO's office, 2011.

It was also noted that vertical programmes take managers away from other priorities. As claimed by one district manager:

> …….. Vertical programmes influence priority setting; they come and marginalise other priorities as we want to catch donor funds (CKI-03).

It is important to note that vertical programmes have preferential support, which contributes to inequities within the health system. Usually these programmes are not distributed across the Council; hence some places are not served. Additionally, Council personnel that are working with vertical programmes, in particular HIV/AIDS are more motivated than other staff because of the incentives such as extra duty allowances, bonus and training. The output-oriented, results-based financing is realistic in vertical programmes, but does not occur within general health services programmes. Furthermore, despite integration of services at facility levels, there is very little coordination at the central level due to inadequate staff.

6.2 Administrative decentralisation

The aim of this section is to present research findings in relation to human resources. It will therefore look at the relation between decentralisation, human resources and RHS. Basically four issues will be analysed: public service arrangements on hiring and firing, supervision, training and performance management. In Tanzania administrative decentralisation aimed to enable the LGAs recruit and administer their human resources, but Public Service Act 2002 and subsequent regulations (2004) centralised management of all civil servants. Thus, LGAs must for example, obtain permission from the central government to recruit new staff. Besides, the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG), exercises unilateral control over the appointment, posting and transfer of council directors, Heads of Departments and other key LGA personnel. Although the Act allows for mobility of employees among employers; due to conditions of service are much better in the central government and other sectors, LGAs lose the staff they recruit and train at great cost to the central government, private sector.

The PO-PSM regulates the key conditions of civil service from national, regional and council levels. Although health workers have their specialised unions, like the Medical Association of Tanganyika, the Association of Nurses in Tanzania and the Pharmacy Council of Tanzania, but they are not represented in the civil service. Salaries and benefits, once set by the PO-PSM, are applied equally to civil servants. Councils have no authority to change conditions of service, but they can offer additional incentives such as housing to attract professional staff(Manzi et al., 2012).

LGA lodged requests to the PO-PSM office to fill health personnel demands. The MOHSW has been given the role of posting staff in accordance with PO-PSM-approved posts. The PMO-LARG approves health personnel transfers from one council to another. MoHSW or PMO-LARG can appoint DMOs, while approval of skilled health personnel is done by the MoHSW. LGAs can recruit lower skilled health personnel after securing recruitment permits from the PO-PSM. The MoFEA allocates funds for salaries as per the approved post by activating salaries that

are computerised. The reform process is poorly coordinated among the central agencies. The PO-PSM pursues its reforms without discussion with PMO-RALG. Likewise, the PMO-RALG implements LGRP without consulting PO-PSM.

6.2.1 Hiring and firing of council health personnel

LGAs remain in charge of hiring and firing health personnel whose salary scales are below Tanzania Government Salary scale number 2 (TGS-2). For personnel who are entitled to be above the TGS (2), special permission has to be sought from the PO-PSM. The council managers identify their need for staff and can proceed to fill the vacancy. The local level is involved in the whole procedure of appointing health personnel such as medical attendants. This includes setting selection criteria, skills required, advertising, short-listing, interviewing and final recruitment.

The LGAs recruitment goes together with budgeting processes. Regions and councils are mandated to identify and fill in the existing staff vacancies. The DMOs' offices assess the personnel needs, indicating the number of staff and skills required and the associated costs under local government recruitment committees then approve at the full council meeting. After agreement on the number of staff and type of skills required, councils forward their HRH plan to the PO-PSM for securing the recruitment permits. Thereafter, estimates and adjustments can be made, depending on the budget approved by the MoFEA for the MoHSW. At this stage, the recruitment permit is issued and the council is informed. DED informs the council employment board[5] of the existence of funded vacancies. After that, advertisements are placed locally and interviews are conducted to fill the vacancies.

It was noted that procedures for recruitment under the employment board are complicated. Securing permits from the PO-PSM is seen as an obstacle due to bureaucratic procedures, which means that such a process takes time, and the permits expire after three months. This makes it

[5]Members of the board include the chairperson (respected person from the council), one council member, the council administrative secretary, and a representative from the civil service department

difficult for remote councils to get enough time to recruit qualified staff within this short period. One participant noted:

> You can get those with required skills while short listing, they might show up for the interview but when we offer the posts most of the time they don't show up. Hence, you need to re-start the recruitment process again from the advertisement, invitations and interviewing, which doubles the cost. By the time you invite them for the interview, the permit has already expired (CKI-05).

To address the local hiring problems, the Government decided to centralise the process. Re-centralisation was seen as an effective means of equalising HRH in remote councils. It was seen that the MoHSW can easily access information from its own training institutions and universities; hence this would facilitate the placement of HRH to LGAs. However, this has never been the reality in Tanzania, and disparities across regions and councils are enormous. Lack of feedback from the LGAs hinders the MoHSW's efforts to fill vacancies in remote councils, since the majority of personnel do not report.

As other councils, the case council had a shortage of health personnel. The total number of posts that are not filled is 175, which is 51%, with only 176 (49%) of the required personnel in posts. The deficit was higher for nursing officers (21%) and clinical officers (13%). There remains, however, a shortage of professional staff such as doctors, pharmacists, midwives and obstetricians. As with many other managers, the DMO believes one of the main problems in the health sector is the lack of qualified staff:

> … I do think we are making progress at the moment, especially on professional skills like obstetricians … I think the biggest problem is staff scarcity and having the available professional midwives. I have clinics where I only have medical attendants who do everything (CKI-03).

Retention of well-trained medical doctors was observed to be a problem in rural settings. When trained at the degree level, health personnel move to urban centres for better career opportunities. Once appointed to work at the rural facilities, doctors then went for further university training but staying on the council payroll. When they returned they were saw themselves as too highly

qualified to work at the facilities and often go to work as hospital experts. One of the health managers had the following view:

> Once personnel have been recruited into the district health service, mostly they go for further training, without a replacement. But the problem is, when these doctors go for training, they still remain on our payroll and therefore we cannot recruit because they are still on the payroll. So that is a problem that we have experienced (CKI-03).

According to another participant at facility level claimed that:

> The main problem with the well trained health personnel especially doctors has been the high attrition rate. Mostly doctors don't stay in their working stations for long; may be 2 years, and then they leave. …… the reasons are varied, some go for further training. Some get better jobs in NGOs . So the rate has been high especially for the doctors (FKI, 02).

To improve retention of health personnel, council have decided to assist newly employed staff with resettling allowances. However, any such scheme has to be approved by the central authorities. This would appear to lead to a certain amount of tension between the centre and the LGAs given the shortage of staff and the difficulty in introducing policies of staff retention. One of the council participants noted:

> …the country in general has a severe human resources problem. …… we just don't have that enough clinicians and if we are not going to correct it we are going to run into severe problems. There are all these nice national strategies; you know recruitment and retention strategies of scarce resources, hardship allowances for those who are working in rural health facilities; but it doesn't get implemented (CKI, 02).

Disciplinary procedures are in place and CHMT are responsible for the providers. However, if the case is serious the HR office is involved. However, because of the shortage of personnel, procedures are not always followed. This means appeals take a long time, often up to three months. Labour union activities are not active at LGAs level. The health managers expressed their frustration in delays or completion of the process:

> …..sometimes it is difficult to fire personnel who are misbehaving due to procedures required to be followed even if s/he committed a serious offence which calls for dismissal. The person usually appeals and they know the loop holes of time which means the process goes beyond the three months. For the highly skilled personnel, the situation is worse. The process involves setting up a team from the central authorities which can take time, up to six months (CKI, 04).

Labour relations functions at the council level are not well established. The code of conduct is set by the central ministry of health and is expected to be applied across all councils:

> ....MoHSW provides us a code of conduct and sometimes professional organisations. If someone doesn't abide by the code of conduct a disciplinary action can be taken (CKI, 04).

6.2.2 Supervision

A system of dual supervision operates which combines the role of the clinic supervisors and visit the clinics on a regular basis and conduct the performance assessment of the facility and the programme managers who conduct visits to deal their own programme activities. The RHMTs are supposed to offer quarterly supportive supervision to CHMTs. In turn, CHMTs could provide clinical supervision to health facilities. Management style encourages sharing of knowledge and experience at each level. The national and regional level is responsible for ensuring that capacity is built at the lower levels. The councils are closer to the providers and, if they are not able to perform, the regional and higher managers are equally responsible. However, the process faces a number of challenges, mostly funding for fuel. Supervision is therefore, more administrative than technical. A lack of funds and transport were the most cited reasons for failure by CHMTs to conduct supervision as per the guidelines:

> Funds allocated by the central government are not enough to carry out supportive supervision. We are given responsibilities without resources; we need a budget for supervision. Decentralisation is bypassing the regional level; we are struggling with the little resources (6%) allocated to the total annual health budget, which is not enough for service delivery and other roles like council supervision (RKI-01).

Similar concerns were found at the council level:

> We rarely conduct supportive supervision, which is supposed to on a monthly basis. We are working under a constrained budget (FGD-01).

Lack of capacity hinders the RHMTs to execute their supervisory roles. In some instances, new guidelines were provided by the MoHSW without adequate capacity building for RHMTs before supervising the CHMTs. For example, new planning and reporting (PlanRep)[6] guidelines for the CCHPs were produced by PMO-RALG in 2010, with the view that RHMTs would use similar guidelines to support councils to develop CCHPs in the same year. This was not feasible, as one of the participants argued:

> … training is important particularly when new things are introduced to the sector. Our experience is only in medicine, now we are managers using different tools in planning and accounting systems. We cannot impart the skills to the CHMTs unless we are well trained (FGD-01).

[6] PlanRep is software used by CHMT while developing CCHP that enables them to compare expenditures with the actual disease burden.

CHMTs are supposed to provide technical and administrative as well as clinical supervision, to council hospitals, health centres and dispensaries. Supervision provides an opportunity for follow-up, improved performance and solving systemic problems that contribute to the poor service delivery. National guidelines recommend at least four supervisions are recommended per year; during planning and preparation, conducting actual supervision to access performance, immediate oral feedback to health staff, and final written feedback and follow-up actions. Although these guidelines are in place, it was found that supervision visits are not prioritised or planned accordingly. When supervision was conducted, facilities were visited once instead of four times per year as per the guidelines. Out of six facilities, two had not been visited at all. Of the few supervisions conducted, facilities were not provided with written feedback, only oral feedback while the CHMTs were at the facilities. This was described by the participants:

> Facilities are not receiving written feedback from supervisors. And now we are supposed to supervise the dispensaries. CHMTs are not carrying out their supervision role. They delegate it to us (FKI-01, FKI-02, FKI-03, FKI-04).

It was also commented by the national coordinators:

> providers are not monitored as frequently and as comprehensively as needed, which may lead to reduced motivation to improve the quality of care. Health facilities do not receive enough feedback and encouragement from supervisors. Individual performance appraisals are not established and are not connected to promotions or demotions (NKI-01, NKI-04, RKI-02, and RKI-03).

Reproductive health services supervision

Supervision is usually carried out by the CHMT. According to the CCHP guidelines, the council reproductive health coordinator is not a member of the CHMT. Although the CHMT in the case study council was flexible in involving the RH coordinator, supervision is not conducted as scheduled, which affects her participation. Usually, RH follow-up is carried out when there is an extreme case in the facilities. This limits supervision for RH activities, which has a negative impact on the quality of service provided. It was found that, in some facilities, women were charged Tsh 500 for antenatal clinic cards and for family planning pills, both of which services are supposed to be provided for free.

Likewise, at the council level, CHMTs lacks guidelines for the supervision of reproductive health and safe motherhood activities. Regarding their own supervision, only four out of ten CHMTs reported having been supervised by their respective facilities within the previous two months, and the rest less frequently. However, most of the visited facilities were those with serious problems, such as conflicts among the staff. Supervisory visit rosters were in place but not adhered to because funds were not available for supervision, as mentioned.

In the current situation, it is not possible to establish a linkage between facility performance and supervision conducted. There is a transition arrangement to use cascade supervision, whereby health centre staff supervise dispensary staff, while dispensary staff supervise village health workers. Cascading was opted for as a cost-effective method of supervision. It was mentioned by health managers that cascading has saved 25% of the total cost that would have been spent on ordinary supervision. However, cascading adds more responsibilities to providers who were already constrained. This has an impact on the quality of service delivery and clients queue up to four hours.

6.2.3 Training

Prior to decentralisation, the MoHSW was responsible for both pre and in-service training. With decentralisation; the councils have taken on in-service training although these roles are also carried out by central government and NGOs. The actual in-service training is usually done in association with the centre and particular programmes due to the lack of funds in the council for training. Training is a joint responsibility of the ministries and human resource division. The ministries focus on technical issues, while the latter focus on more general issues. In this study reference is made to in-service training. However, training can be organised outside the council and it is the responsibility of the district to select staff and make some contribution in terms of allowances. The LGAs can allocate specific funds for staff development. Otherwise it is organised in the central government through short courses.

There was a general view that there is more training conducted following decentralisation. For instance, LGAs can arrange in-service training according to locally available resources allocated under other charges (OC) subvention. Its proportion decreases from time and since 2010, the government banned allocations for local training. However, low skilled personnel do not benefit from these funds. Managers are the main beneficiaries of the fund, which pays for their participation in short training. Some of the health providers complained that they had never received any training since their appointment:

> I hear see a lot of training in HIV/AIDS, a lot of training in malaria, immunisation. But training is not meant for us with lower qualifications (medical attendants). I usually work alone. As you can see, today the nurse went for training, which she does frequently, but I have never been called for training in the five years since I have been working with this council (FKI-02).

The country faces a major challenge of having a large number of staff with low qualifications managing the health facilities, especially in rural areas. The government has introduced a policy to encourage existing staff to upgrade their skills and knowledge to improve their performance. The upgrade includes changing from one level to another, like from MCH aide to public health nurse, assistant clinical officer to clinical officer, and clinical officer to assistant medical officer. In-service training is usually undertaken as individual-level initiatives with support from the DMO; however, study leave has to be approved by the MoHSW. Costs for the courses are sometimes paid by the MoHSW and the staff members. Personnel retain their posts and salary during the training period. The negative effects of in-service training, as observed in this study, include the absenteeism of health care personnel, which increases the workload of the remaining staff hence compromising the quality of health services provided. This sometimes causing long delays and queues for the patients. And the mechanisms for replacement of staff that attended training were not in place.

During the facility visit, at least one of the personnel was away attending training at the regional level. This hinders access to the services as some of the facilities were closed. Two of the target facilities were closed during the visit and the two providers were absent. In interviews with Village Executive Officers they explained that the facility has only two providers; one was

supposed to submit a monthly report to the council while the other was on holiday. One of the participants asserted that:

> The situation happens as some of the facilities have two staff only. Facilities with one staff sometimes are closed for the staff to attend training. Another CHMT contended that: Some of the health staff has never attended any kind of training since their appointments. Imagine some have been working for more than 10 years without any training, and medical technology is changing fast (CKI-04).

Training programmes for the RHS have recently suffered as decentralisation and other health service reforms are not well synchronised. The council training guidelines do not support training of more than one week. Meanwhile, short training for FP is conducted for two weeks or more. There have been no funds from government to support in-training services for reproductive health, apart from donors under the 'off budget' expenditure.

It was observed that some of the reproductive health providers have never attended any SRH training, which is important for quality improvement. The lack of training was mentioned as a problem for them to provide quality services, especially when clients need more information. One of the providers articulated this clearly:

> I was employed 15 years ago and I have never attended any training on FP, this has made me feel incompetent especially when women in the FP programme come for more information regarding side effects. I don't know what to tell them other than introduce them to other methods. Even MCHAs who were trained to provide MCH services were complaining about training …
>
> We have never been called even for refresher courses for the past five years; we don't know what is happening now, as in the past we used to attend like four times per year. But our fellows in HIV/AIDS had the bulk of training (FKI-02).

The low-skilled personnel expressed unhappiness with the present selection process. Other complaints concerned short notice for training opportunities, with the information arriving too late for the providers to apply. This has become more of a problem due to the poor transport system in remote councils, where people rely on a single bus service on specific days. Providers were not happy about distribution of government funding for the advanced training and those who were given the opportunity never shared information to strengthen capacity of those who did not get the opportunity:

> … Some of us when we asked for government funding we never get the proper information. You have to pay for yourself, whereas the same people from the same council you hear have government funding. This is not fair at all (FKI-07).

Person in charge of the facilities feel that they are not adequately trained to manage a health facility. They are trained as clinicians rather than managers. The role of clinicians is now widened so that they are not only responsible for the medical services, but also act as facility managers. Their role extends to budgeting, control of stock such as drugs, supplies, etc. However, most of the managers complained about having to take new responsibilities without proper preparation. One of the participants claimed that:

> … In medical school we were trained as clinicians, either as nurses, clinical officers, etc. …. we never had any curriculum on management and our employer is not giving us an opportunity for management training (CKI-02).

Also, some of the CHMT members were not qualified to head the programmes. The majority of the posts were filled on an acting basis due to the lack of qualified professionals with the required skills. The CHMT believed that training improves motivation for the staff in their daily duties. Providers had a positive experience with training and it was seen as a path to increase personal knowledge and assist capacity building to others:

On other hand, in-service training was seen as a tool which enables council staff to acquire knowledge for the higher paying jobs with better working packages outside the civil services. This adds to staff turnover, especially in rural councils where retention is a challenge. Some of the participants thought that before allowing staff to go for higher training they should sign a bond to work with the council for a specified number of years.

Reproductive health training

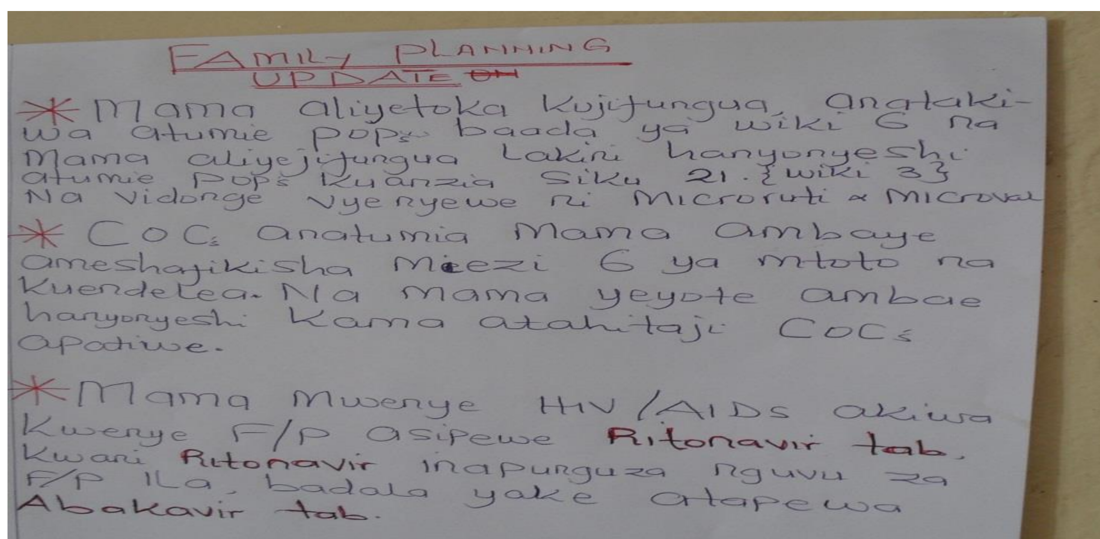
Training in reproductive health services that was provided by the NGO was disrupted by the donor shift to basket funding. Until 2002, UMATI coordinated the provision of long-term family

planning services on behalf of the ministry of health and supervised and provided programme support for capacity building, quality of care training and expendable supplies for 98 public and private sector locations. The USAID funds ended in 2003, which led to the reduction in the number of partners to support the national programme, including training. The transition while shifting oversight and training roles led to a disruption of services. UMATI has currently shifted to a broader reproductive agenda focusing on the youth.

There are no separate funds for training in RHS at all levels. Training is included in general council training programmes. However, funds for short training can be made available through DPs, if there is a new programme to be implemented. Regional office had a limited funding for RH training. But they were undertaking extensive training for specific purposes, like cervical cancer screening. The active involvement of regional programme managers was confirmed:

> … training for reproductive health is organised by the regional coordinator for reproductive health. But this is arranged when the coordinator has a donor project. Otherwise there are no funds allocated by the government for RH training. When there is national support for a certain service, government funds can be made available (CKI-05).

After training, participants are expected to share the new skills and knowledge with other Maternity and Child Health Aides (MCHA) and nurses in their facility. This was not always successful, since not everyone shares what they have learnt. Some put messages on the wall as a means of sharing the knowledge. The extract on (Photo 6-1) talks about things to consider while providing FP to mothers who are on antiretroviral therapy. The key message is to remember some of the FP methods interfere with ARV efficiency.



Source: Field survey, 2011

There were training gaps for reproductive health providers at the council level. For example, long-term family planning, such as the insertion of intrauterine devices was performed though the NGOs via outreach services. Training has a constructive effect on the level of skills, as expressed by some of the providers.

> Reproductive health technologies are changing so fast. There are new supplies like female condoms. Training is important … RH providers believe that such training would have helped them to improve service delivery … Training should be extended further (FKI-07, FKI-09).

Health managers had negative views on the training curriculum provided in medical schools in Tanzania. They complained that human resource management skills were not provided while they were studying at medical schools. Council health secretaries are the only ones trained in human resource management. CHMTs obtained support from the Council Human Resources Officer, who is responsible for the entire council staff. Even the DMOs are not trained in human resource management, while they control all the HRH at the council. Human resource management practices at council level are limited and practised poorly. As a result there are delays in staff promotions.

6.2.4 Human resource performance management

An open performance review and appraisal system (OPRAS) has been introduced as a means to motivate staff and improve health service delivery since 2008. OPRAS originated from the PO-PSM and is being implemented gradually in all government sectors, including among health personnel. In health sector the government has embarked on a reward system through payment for performance (P4P). This is a strategy focusing on performance management for health workers to improve maternal, new-born and child health. P4P is used as a motivational tool to health workers. Within the MoHSW there is broad commitment towards P4P as a means to motivate staff and improve service. At the Council, P4P had not yet been rolled out, although council had set aside a budget for it.

The possibility of improving performance through OPRAS system has not yet been realised as most of the government departments have not rolled out the system. Limited use of the OPRAS is contrary to the intention of the Public Service Pay and Incentive Policy (PO-PSM, 2010). In 2011 the MOHSW initiated a pilot project in the Coastal region. The results from this pilot study show that staff were inspired and proactive in solving health system problems through the OPRAS system (Mamdani et al., 2013, MoHSW, 2013c).

6.3 Political decentralisation

In this study the findings has found that government has taken bold initiatives to establish the mechanisms for community participation through management structures. However, the study challenges the assumption that user representation through HFCs enables users to voice their interests and makes services to respond to their health needs. It has been noted that because selection of the committee members is not democratic, representatives perceive themselves as primarily accountable to government and not to their communities. Lack of genuine political decentralisation as well as inadequate resources have compromised their roles. Health boards and facility health committees have an important role in monitoring the use of health resources and

the overall performance of the facilities, yet the majority of the members were not well aware of their roles.

In service delivery there was significant community involvement in support of prevention activities and community mobilisation for tasks such as building new facilities and other small work. Initially, the contact with the communities is through the village health worker, who plays a significant role in promoting local participation and the provision of information to communities. The effectiveness of community mobilisation for collective action depends also on the abilities of the councillor who is locally elected and holds the office for a period of four years. Their motivation and effectiveness vary greatly.

In relation to service accountability; the study challenges the assumption that political decentralisation enhance service user to hold providers to account and makes services more responsive to the local interests. It was found that HFCs members do not access information about the performance of the district health system, resources that government allocates and how those resources are used at their health facilities. Thus, community participation under political decentralisation has not strengthened accountability with respect to the delivery of local health services including those of reproductive health. The next section analyses the structure of the community participation.

6.3.1 Community participation

The formal process and structure for community participation in the council health system was through local village assembly and local management structures named council health service board (CHSB) and facility health committees (FHCs). Findings presented showed divergent views were presented by participants as to the effectiveness of these boards and committees. On the positive side they were seen as informing communities. In the three villages, the participants were not seen as a level for community involvement. Interpretations concerning the extent of community involvement varied according to the participants. Politicians tended to be more

positive about decentralisation. Health care providers tended to be more negative about the appropriateness of political decentralisation, viewing it as a form of control over technical people.

(i) Community participation through village assembly

Bottom-up planning is perceived as a means by which communities participate in decision making in their villages through 'Opportunity and Obstacles to Development' (O&OD) approach (PO-RALG, 2005). It aims to enhance local participation in making plans and priorities that communities perceive to be necessary to address their specific local needs and demands. Government policy documents stipulate clearly that:

> "O&OD is designed to promote community initiatives so as to accelerate achievement of national goals in the Tanzanian Development Vision 2025. In the O&OD planning process, the sub-goals in the Vision 2025 become direct basis of setting specific objectives, under which planning items are identified such as opportunities, obstacles, interventions, costs and so on. Besides, the O&OD is intended to promote effective and efficient allocation of Local Government Capital Development Grants (LGCDG) as clearly elaborated in the Planning Guidelines for villages, the O&OD is an essential methodology to identify community preferences for which the LGCDG is disbursed" (PO-RALG, 2004, PO-RALG, 2002).

Theoretically, bottom-up planning procedures start at the grassroots level. The O&OD planning concept is centred on the understanding that communities have different needs and resources. During the planning process, a facilitator who usually comes from the council is involved in initiating the planning process whereby all village members are invited. After the discussion with the villagers, they make suggestions of what they think to be their health priorities. The ideas are passed to the Village Development Committee, but if a higher decision is needed, the idea passes through the Ward Development Committee, and then to the Village Assembly for final adoption. The Village Assembly is open for ordinary citizens from 18 years to influence decisions and raise any question to the leaders. Being a legal meeting, the minutes are sent to the council office; for the council officials to understand what happening at the lower levels. In the case of

council, village assembly meetings were rarely conducted which is contrary to the practice of O&OD.

It was observed that communities were only involved after the decisions have been made by higher authorities. This was insisted on by some of the participants:

> Usually communities are given directives after the decision has been made. For example each village is supposed to build a dispensary with joint government and community efforts. The decision was made by central authorities without involving the communities during the initial stages of developing the idea. Hence communities are just recipients of the centrally decided programmes (WKI-01, WKI-02).

In many instances when communities were called, they did not show up because their experience of such meetings is negative. Their involvement was meaningless since local preferences were not taken into account. Therefore, attending community meetings was not a priority to the majority of the citizens. One of the village officers insisted:

> … in the past we used to mobilise the communities and the village assembly was powerful. But in many instances communities did not see the results of their contribution. They never get feedback, hence it is now very hard to call for a meeting and people show up (VKI-02).

Communities can be involved in planning specific projects, but they are not involved in identifying health priorities. They have been mobilised in providing in-kind support like labour, which does not require technical skills. Others activities included fetching water, and collecting stones and sand for the construction of dispensaries. Photos 6-1 and 6-2 below show a dispensary close to final construction and a maternity ward building to which communities contributed their labour. This indicates that when communities are well mobilised they participate effectively and can make a difference.

Photo 6-1 (l) and 7-2 (r): Constructed facilities through collaboration between local government and communities

Source: Field visit, 2010

Another challenge to roll out bottom up planning was the issue of resources needed from the LGAs. Under decentralisation, LGAs are supposed to transfer 20% of the own source revenues for each FY to lower level governments that is village level to be spent on priority needs of their own choice. However, this obligation has faced challenges as pointed out in the Annual Assessment Synthesis Report for FY 2011-12 which stated.

> *"*Sharing of own revenue still remains a challenge across a number of LGAs. A total of 53 LGAs (40%) shared less than 15% of collected revenue while 27% shared between 15-19% and 43(33%) met the minimum requirement of 20%. Non-remittance of local revenue to lower levels erodes the principles of devolution of power and finally thwarts the benefits of decentralization. Eventually, the communities become disinterested in participating in planning and budgeting for their localities*"*.

One of the key challenges facing LGAs is the inadequate revenues to fund the planning process. The transfer of funds to lower levels has remained limited as own sources are constrained and government's inconsistency in releasing general purpose grant (GPG) which was introduced to compensate for local revenue sources that were abolished in 2003. Unless the government ensures that the GPG funds are made available to councils and LGAs improve their own sources, lower level planning will remain problematic.

The structure for bottom up participatory planning does not provide space for communities to raise concerns regarding their local health needs and priorities. In this study it was found that

direct community participation was not executed for several reasons. The Council planning office complained over financial and capacity (skills for carrying out O &OD) to roll out the process. The village levels had very little direct responsibility in health service delivery and planning. Therefore, the CCHP is driven by CHMTs, with little or no inputs from wards or villages. When comparing the facility health plans with that of CCHP, few activities matched, in particular construction or rehabilitation of facilities. User representation through health boards and committees is a common practice in the health sector. The section below shows how people see the practice of user representation.

(ii) Community participation through user representation

Decentralisation reforms provide an institutional framework within which communities/ service users can participate. In the 1980s, Primary Health Care Committees were established throughout the country. This initiative did not achieve the expected results; therefore the health sector review of 1993 suggested that health committees be re-established at the village level to give communities more power and voice in the ownership of health facilities. Before introducing facility health committees; service users were represented through elected representatives. Because of their political influence; MoHSW found elected representation was not effective and proposed that a management structure namely council health service boards (CHSBs) and health facility committees (HFCs). They were established as democratic organs with legal status to oversee the provision of local health services (URT, 2000). It was thought that committees and boards would lead to an increase in service user representation and accountability (URT, 2003, URT, 2000). The guidelines for the establishment of the CHSBs and HFCs explicitly place them 'within the context of the local government reform which aims to improve service delivery through empowering councils, genuine community involvement, sensitising communities to take the initiative and advocates for alternative financing options like CHF and user fees' (URT, 2000:1).

Formal responsibilities of the health committees

The central authorities introduced health governance structures to align with the institutional framework of the overall decentralisation policy, supporting government commitment to the devolution of powers to LGAs and communities (URT, 2000:1). The CHSB is endowed with legal discretionary powers and council health managers are supposed to be accountable to the CHSB without 'jeopardising the board's autonomy (URT, 2000:5). In the case study council, it was found that CHMTs have more autonomy over the CHSB in discussing local health plans and expenditures. This is contrary to what the policy entails, where CHMTs are supposed to work under the CHBS.

Generally, the goal of the establishment of the HFCs is to act as an arm of central government at the local level. The HFCs are assumed to sensitise communities on government policies. In conjunction with the CHSB and HFCs guidelines, the government introduced the Community Health Fund Act in 2001. The objective of the fund is 'to mobilise financial resources from the communities for provision of health services to its members' (URT, 2000:1). Thus, the HFC structures were given four specified legal mandates: (i) approving facility plans and budgets, as well as a report prepared by the facility staff (health centres and dispensaries); (ii) submitting reports to the CHSB; (iii) liaising with other health providers and potential donors; and (iv) assisting facility staff in executing 'community based health initiatives' and ensuring 'affordable health care services' are provided to the communities (URT, 2000:1334). Thus, the main linkage between the communities and primary health facilities is through the HFCs.

Roles and functioning of the health committees in the case study council

The analysis of the structures between council and the lower level, that is. Health management committees took into consideration their division of functions and decision-making powers. This section gives that perspective by summarising the formal responsibilities of the four management committees. Out of six facilities visited, only four had established health committees. The section analyses the data from the group interviews and anecdotal evidence about the actual roles of the

committees by looking their meeting frequency and agendas. Then the reflections and feeling of the HFCs members on their success and challenges are presented.

Meeting frequency

At the council level, one of the participants insisted that all the facilities had HFCs and that they meet regularly. However, in practice, the person in charge of the facility reported that some of the HFCs had been inactive for a long time. During the visits it was found that no committees were established at two out of the six facilities visited. Only one HFC held a meeting with the community to discuss the construction of the village dispensaries. Another HFC conducted their meetings with the providers, but rarely held meetings in accordance with the guidelines. According to the guidelines, meetings are supposed to take place four times per year. The facility manager is the secretary of the meetings whiles the chairperson is a community representatives meetings. The meeting minutes are kept by the committee secretary. Sometimes secretaries are not consistent in fulfilling their role which means that meetings are conducted less frequently.

Meetings usually take place at the facility offices and there were delays and interruptions in meetings. It was observed in one of the visited facilities that the meeting was supposed to start at 9.00 am but it started at 11.50. The reason for the delay was that the secretary for the meeting (provider) was continuing with health service delivery. There was also a delay in the arrival of some HFC members who were coming from far away. All members were encouraged to participate in meetings. Individual contributions were treated equally and with respect. The meeting agenda was set by the secretary, who introduced the meeting, and then the members contributed ideas one after another.

There were inconsistencies in the HFC members attending meetings. In many instance fewer than 50% of the members attended the meetings. The person in charge of the facility of one of the facilities visited frequently cited lack of allowances as one of the key challenges for HFC

members to attend the meetings. Other reasons mentioned included limited awareness among the HFCs on their roles and distance from the facilities. By contrast, HFC members complained that some providers were hesitant to hold meetings because of CHF abuses:

> ….Providers misuse the CHF; instead of putting the funds in the facility account they use them … hence they won't hold the FHC meetings fearing that the committee will ask questions about the funds, which is true (CKI-06).

On the other hand, providers complained:

> … when we call the committee for the meeting the first question they asked is how much is the per diem? Unfortunately, we never had that budget; hence we did not manage to hold a committee meeting for quite some time (CKI-03).

The HFC members had the view that providers are abusing the CHF and user fees collected, hence they feared to be questioned during the HFCs meetings:

> When asked about the collected amount from CHF and user charges … providers are so furious and harsh. We just leave them to do what they want, because if they decide to leave, who will come to work in this remote village? (C-FGD-03).

An interview with council managers revealed that providers were resistant to collaborate with HFCs. One of the reasons mentioned was that providers want to have full control over the CHF and user charges, without interference from the HFCs:

> … some of the providers resisted giving away power to the HFCs, which might reveal their abuses. When the government introduced the user fees, providers were happy and supported the implementation …probably because they can access funds from the patients directly (CKI-03).

The formal responsibilities of the HFCs include planning and monitoring of health services delivery, financial planning, and accounting as well as reporting to the higher level. However, their roles vary depending on the members' understanding of their roles.

(i) Views about functioning of community participation structures (HFCs)

Different actors, including healthcare providers and communities, were able to identify some of the roles of the HFCs. Health managers, health providers and community members recognised the potential of the HFCs. The functionality and experience of the HFCs varies between councils and at different levels of the system. The categories of roles mentioned by the HFC committee members were related to health service delivery and resource mobilisation. Despite the official

role of the HFCs to mobilise community members to enrol in the CHF, evidence is lacking. It was noted that most of the sensitisation and mobilisation programmes were carried out by the providers, either at the facilities when patients seek care or through outreach services. The HFCs said they just discussed the CHF with communities when they had time, but there were no meetings reported to be held as part of their mobilisation. This was reflected during the community group discussion, when a significant number of the participants (35) said they did not know the roles of the HFCs. The remaining (17) commented that their roles were to mobilise the community to join the CHF and to control its expenditure. The responses in the case study council are discussed below.

Community knowledge about the roles of the HFCs was limited. However, in two out of eight villages visited, the community members were able to mention the function of the HFCs. This was an indication of their visibility and functioning. The mentioned activities were related to service delivery and control of CHF expenditure. What was frequently mentioned by both community members and village officers on the function of the HFCs was that it mobilised CHF contributions. However, in practice the facility providers were more in charge of mobilising communities to join the CHF:

> … the HFCs are supposed to mobilise the communities and to educate them about the CHF scheme. But usually providers do this role since the HFCs are not active … we must implement government policy directives given by the council office … we should abide by this (CKI-06).

Village officials thought that the only function of the HFCs was to mobilise contributions for the CHF. In some villages the HFC were referred to as the 'community health fund committee'. Generally, community awareness of the functionality of the HFCs was limited. The communities' FGDs (four) showed that participants that stayed near to the facilities were at least aware of the HFCs, compared to those who were far from the facilities (three) who had not heard about them. Only one group mentioned representation of the communities in various decision-making organs:

> … HFC members act as a link between the health providers and community members. We took information from the providers to the communities like on pandemics of diseases. And sometimes we took community claims to the facilities (CKI-03).

As has been explained elsewhere in this thesis, the HFCs were formulated along with the introduction of user fees and the CHF. They were expected to play a major role in community mobilisation to join the CHF, planning on how to use the user fees and CHF collections and giving feedback to the communities regarding the finances (URT, 2001:1). The contributions are collected from facilities and managed by HFCs. Councils decide on the disbursement of the funds based on the plans prepared in advance by the HFCs. The incentives packages –'top-ups' – are set by central government as financial support. HFCs were seen by health managers as a means of communication between the community and the facilities:

> Council health boards and facility committees are important structures that link communities with the facilities. However, members are not really elected by the communities (CKI-06).

> Decentralisation brought user representation through the boards and committees. They have power to take decisions; they also have the power to give a decree directly to the CHMTs (CKI-02).

However, communities did not view HFCs as a means by which they can air their complaints related to health services delivery. As one of the participants claimed:

> HFCs are supposed to mobilise the communities, to give them the knowledge about the potential of the CHF scheme and how they can benefit … they have to educate people, which is their role (RKI-01).

Arguably, community involvement is somehow outside what devolution policy entails. From the previous discussion, their engagement is linked to health finance reforms. The idea of devolution to empower local communities to respond to their own health preferences and needs is marginalised by financial reforms. This has been the result of decentralisation being part of the neoliberal economic reforms, where the role of provision by governments has been transferred to the citizens through user contributions. Some of the national participants contended that:

> … Introduction of the community health insurance increases the awareness of the users to feel more responsible and have ownership of their facilities. Otherwise they will keep on thinking the provision of health services is the responsibility of the government alone, while they have a role to play (NKI-01, NKI-02, NKI-04).

The council health management team was positive about the participation of the community through the HFCs:

> The role of the HFCs cannot be underestimated; they are the ones who stay closer to the communities. In case of any outbreak they bring the information to the facilities. They are our eye reporting on anything. It is a good service (FGD-02).

Some of the healthcare providers had a positive attitude towards HFCs, although some were ambivalent about the role of the committees. Some see them as overseers to which community members complain about services.

> … HFCs are good because they link the facilities with communities. Communities raise their complaints through the HFCs. But the challenge is that HFC is not motivated to perform their duties. They always complain about allowances which we don't have a budget for. Sometimes we call them for a meeting and they don't show up … we rarely get feedback from the communities via the HFC (FKI-05).

At one of the visited facilities, the health providers had managed to forge a close relationship with the community through the HFCs. In this facility the HFCs understood their roles and the health issues of their communities and were actively involved in meetings. There were positive suggestions for the improvement of the health services and they felt free to complain directly to the providers whenever the clinic was not functioning well. One of the participants explained that:

> HFC is there to monitor whether things have been done well, especially with the CHF fund. They were helpful to mobilise the communities. This year we managed to collect a substantial amount, 13 Tsh million, and with the top-up fund from the government we have 26 million. We are planning to renovate some of the health workers' houses and harvest rainwater and buy a solar panel. This will improve our working environment (FKK-04).

Only the people in charge of two out of six facilities appreciated the work of the HFCs, who were actively involved with the facilities and also with the communities. They said:

> … for each project and every activity for which we need the community's involvement we sit with HFCs in our meetings. We don't just impose on them and say what we want to do. We get them in and share what we need to do, and we plan how we can do it together (FKI-04, FKI-06).

There were some challenges regarding the HFC guidelines. The Community Health Fund Act (2001) stipulates that the roles of boards and committees are to monitor, mobilise and administer funds, but the roles of health facility committees are not mentioned in the Act (URT, 2001:8). Instead, both guidelines for the establishment of the governance structures and the CHF Act

mention that Ward Development Committees are responsible for the mobilisation of communities, supervising contributions, initiating and coordinating local health plans and organising meetings of CHF members. Thus, the comprehensive link between the community voice, payment for services and facility ownership is not well expressed. This is partly because of unclear power relations and concerns of common interest not being solved together. There is limited legitimacy over the selection of the community representatives and a lack of clear communication between the political structures, village and ward committees and health governance, which adds to the difficulties for HFCs to function properly.

6.3.2 Accountability in local health service delivery

Government reforms have put in place mechanisms for regulation of the health sector, with the scope for service users and other community members to complain about any misconduct or poor quality services. Both providers and service users have their complaints. Providers usually complain about low salaries, low motivation, poor working conditions, shortage of equipment and supplies. Service users largely complain about misconduct of the providers, which is manifested in corrupt practices, favouritism, substandard service and a shortage of medical supplies (Sikika, 2010).

At policy level the MoHSW has developed a Client Service Charter to be used with both healthcare providers and services users. The charter outlines the rights of citizens, providers and service users as well as, guiding principles and the complaint mechanism (URT, 2002). However, misconduct of healthcare providers is increasing. Corruption, abusive language, absenteeism, favouritism and drunkenness have been reported to be problems among healthcare providers (IHI, 2011). This is contributed to by ineffectiveness of the complaints system among health service users.

The study acknowledges that the existence and functioning of an accountability mechanism at any health service delivery point is one of the key fundamentals for the improvement of the quality of health services, including reproductive health. The non-existence of accountability mechanisms has a negative impact, not only on the service user, but also on the provider-user relationship. The improved quality of health service delivery reduces the chance of service users raising concerns about the betterment of health services. The study concentrates more on mechanisms for the service user's accountability.

(i) Types of accountability in the local health care system

There are two types of formal local accountability structures in local health service delivery. The first one is expected to receive complaints about health services provision, and the second concerns the roles communities can play in monitoring the flow of drugs and other resources through their representatives. The facility health committees are failing to hold providers to account. They are unable to withstand interference by the councillors which has negatively affected community accountability to be vague.

Services users' complaints can be made through the village health committees and facility health boards. The communities monitor the flow and use of drugs through the HFC members and village executive officers. When the drugs are delivered at the facilities, the providers are not supposed to open the consignment until some members of the HFCs are around. Their role is to countercheck and sign the 'kit box' delivered. This study did not obtain sufficient evidence to make an assessment of the effectiveness of this type of local monitoring.

(a)Accountability through elected representatives

At council level, councillors, who are the representatives of the communities, make decisions through full council (FC) meetings. This is the highest legal organ for local decision making that

is implemented by the council staff. The FC meets in each quarter of the financial year. The FC is supported by a number of committees: Finance and Planning Committee, Economic, Works and Environment Committee, and Social Services Committee. The membership of these committees is taken from the councillors and council technical staff. The function of the committee is to pass draft proposals, plans and budget from council departments before final presentation to the FC for their approval. The roles of the council standing committees under decentralisation have not been well established. Some of council personnel are the members of the standing committees while the same committees have the oversight roles over council staff. This endangers local accountability in the case of the misuse and abuse of a staff member who is a member of the committees.

Health services fall under the Social Services Committee. Among the CHSB members is a councillor who chairs the council's Social Services Committee. Clashes between committee meetings occur regularly, making impossible for some key members of the CHSB, including the representatives from the Social Services Committee and the RHMT, to participate effectively. For instance, during the production of the CCHP, the council planning officer and the council chairperson for the Social Services Committee were missing, as both were attending another important council meeting. Thus, oversight role during planning sessions is not satisfactory. The CHMT decided on behalf of the board members. Time therefore was a serious challenge for the committees to function properly.

On other hand, the council planning document is cumbersome, with up to 200 pages that are distributed to the members during the meeting or a day before the meeting. This makes it difficult for the councillors to work through it so that they can make a meaningful contribution. A lack of funds for transport makes it difficult to distribute the document in advance. The council is not able to provide a transport allowance for the councillors for them to attend the meeting. Likewise, the planning document is a technical document that some representatives cannot understand especially financial reports. This hinders their efficiency, as they cannot interpret the reports correctly and make use of the information to influence decisions:

> The role of councillors at current is not really practical; the majority have standard seven education and others never attended elementary education. These people are supposed to hold the bureaucrats accountable who are very knowledgeable within their expertise … this is not feasible at all (RKI-03).

Usually, council works through three standing committees, namely: (i) Finance, Planning and Administration; (ii) Heath, Water and Education; and (iii) Works, Economy and the Environment. The finance, administration and planning committee has the greatest authority to oversee council resources and the chair of this committee serves as Council Chairperson. The functions of these standing committees are to pass proposals, plans and budgets from council departments before a final presentation to council meetings for their approval. The roles of the council standing committees under decentralisation have not been well established. Some council workers are members of the standing committees, while the same committees had a role of oversight council staff. This threatens the local accountability of the council staff in the case of misconduct.

(b) Accountability through health committees

The HFCs were established as a mechanism for improving accountability between providers and service users. Guidelines for their establishment indicate that HFCs "shall be accountable to the council" (URT, 2001:33). The HFC regulations detail that the HFCs are expected to submit 'quarterly, biannual and annual reports to the CHSBs' which are ultimately accountable to the Council. The committee can be directed to perform any other relevant activity by the Ward Development Committees (WDC). But the regulation stipulates that a HFC "shall liaise with the community .to ensure that community health needs are adequately addressed and facilitate the two way flow of information" (URT, 2002:1334).

Every facility should have a HFC to manage the delivery of services and to hold providers accountable. Thus, services users can channel their complaints about any acts of the providers either through village health committees or HFCs. The assumption is that HFCs direct their acts of accountability towards the community which are represented. However the finding in this study indicates that the current structures promote the acts of accountability more upward than

downward. The next section presents analysis from the HFCs including appointment process, members and their potential for control within a management committee, role of the ex officio members such as the facility in-charge. The acts of accountability of the HFCs are analysed to understand the locus of HFC accountability (upward vs. downward). The findings were based on the group interviews (four) with the committee members and the community group discussions (eight).

Selection and election process

The HFCs guidelines (2001) specified clearly membership composition in two categories: five voting members and three ex officio members. The five voting members comprise three members from community service users, who apply individually after the WDC has advertised the post for user representation. The WDC makes a selection from the applicants and proposes the list of candidates to the Council for approval. The other two voting members should be representatives from the private health facilities in the area; one from a not-for-profit and one from a private clinic. However, there were no private for-profit clinics in this study (URT, 2001a). Thus, HFC members are from the communities. The three non-voting members of the HFC by virtue of their office are: a member from the WDC, a member from village council and the facility in-charge as the secretary (URT, 2001:1332).

In the facilities that were visited, the facility in-charge distributed the application forms for the HFC members. There was no information about the responsibilities, but the requirement that was presented was that 'an applicant should know how to write and read'. The applications were to be channelled to the village government. It was observed that, forms were distributed just to give the impression that the procedure was followed. The HFC members were nominated either by the WDC or by the person in-charge. The HFC members participating in discussion all more or less went through this process. The following was the response from some of the participants:

> … ward development officer received a letter from the district medical officer for the formulation of the HFCs. Then, the WDC directed the village government to select three people and proposed us to the ward

> development officer, who selected us. We never applied to be HFC members but feel privileged to be selected (FHC-03, FHC-04).

> …a letter from the district medical officer comes to the facilities to set up the HFC. Then I looked to see who from the community could can members, their names were sent to the council authorities for their approval. There has been a tendency to choose HFC members who live near to the health facilities (FKI-03, FKI-05).

Generally, it was found that FHCs were not selected according to government regulations. None of the HFCs members were elected through public meetings. Some of the HFC members (11) were selected without application letter. Another remark is that committees lack representatives from private organisations. This is due to the absence of private providers' representation in the case of rural councils. The HFCs members belong more to the local authority than to the communities. None of the members mentioned the role of representing their locality, as they saw themselves as a channel of information from the facilities to the communities. They feel that they serve the government and they had expected allowances for performing their duties. This confusion is caused by the selection process, where the local authority identified out some of the members. This makes HFC members to be accountable to the person in-charge rather than the community they represent.

The findings show that a key constraint on the activeness and effectiveness of the HFC members is the process of member selection. Communities were not involved in the selection of the HFC members. Thus, the HFCs are more answerable to the local authority than to the communities. The current working environment is failing to have an impact on holding government institutions accountable. The selection process results in individuals being selected with little interest in serving the community. It is because this would be considered an insult to those who nominated them:

> In some places, community members are active but in other places communities do not bother to have the committee. Providers usually pick those whom they think they can work with … but this endangers their working relationships. It is not easy for them to criticise providers in the case of misconduct (CKI-02).

In this study it was found that HFCs were unable to resist from the councillors and have failed to call them to account in the case of misuse. For example, on a field visit one of the councillors abused the construction funds for the dispensary, but no disciplinary action was taken by the committee members:

> … this councillor is very popular in the village … No one can touch him, even the council authorities. We report his abuses to the council but nothing is done (FKI-05).

By virtue of their positions, the chairperson and treasurer would have more direct control over resources within HFCs. More importantly, the person in charge of the facility, being an ex officio member, has more delegated power to control the facility resources. In fact, the HFCs have no direct control over the finances. The potential power for the HFCs is through the treasurer, who is the signatory when the facility wants to retrieved the CHF funds from their account. The person in charge can exert informal power over the HFCs in terms of status and knowledge. Also, the central sector ministries exert control over the HFCs and the flow of resources through the person in charge, which have a primary commitment to the government as their employer.

Arguably, if the providers as ex officio members had significant informal power, they would have been tempted to include friends among the HFC members. However, this study could not provide evidence for an informal local power dynamic. This offers an opportunity for further research on how informal power dynamics within health management committees affect health service delivery. The findings show clearly that the HFC members belong to the government that appointed/selected them. They served the government and expected allowances when performing their duties.

(ii) Acts of downward and upward accountability

An understanding of who controls local HFCs and the flow of resources can be one of the ways of understanding acts of accountability of the HFCs. The assumption made in this thesis is that HFCs will direct acts of accountability to those whom they believe are in control, despite the regulations which indicate that HFCs are supposed to be answerable to the communities. The

analysis of acts of accountability looks at the structure and its role in the accountability relationships for local health service delivery.

Figure 6-2 illustrates governance structures, with the lines of accountability relationship among the key actors. The line management arrangement for the service providers provides the most direct form of accountability. The main element of the hierarchy from the MoHSW are regional officials, district officials (DMO, CHMTs, CHSB) and the person in charge of the facility, either at the health centre or dispensary levels. Below the council there are a number of institutions that are responsible for planning and budgeting for health services. These institutions manage local resources and ensure the availability of health services.

The effectiveness of line management depends largely on the ability of the CHSB to oversee the activities of the CMHTs, and the HFCs to oversee the activities of the lower managers at the facility level, as well as the ability to apply sanctions and to provide incentives. With the current decentralisation arrangements, the CHMTs have dual reporting channels to the MoHSW and PMO-RALG. At the council level, the DMO reports to the District Director (DED) and District Commissioner (DC)-the extension branch of the ruling political party. The DED, in turn, is accountable to the elected Council Assembly.

HFCs theoretically act as a link between the communities and the facilities. There also are other structures, like WDC and Ward Health Committees, which are able to call meetings, but the legislation grants the WDC greater power than the WHC in the execution of health plans. Apparently there is a duplication of structures between those that are established under local government administration and those under the health sector. This makes the relationship to be complex and complicated and its impact remains uncertain. There also is a duplication of functions between the local governance structure, such as ward committees, and health governance structures. The WDC and WHC have some objective in common, and this leads to confusion and probably delays in implementation or bringing health problems to the higher level.

This was resolved by following the two lines of reporting directly to the district council office and to DMO's offices. This was noted by one of the participants:

> … we usually report to the council director and to the district medical officer … the director authorises the health budget and the DMO is in charge of the health-related activities. Both demand feedback on the executed activities (FKI- 01, FKI-03, and FKI-06).

At the council, CHMTs are supposed to be answerable to the CHSB. However, the lines of authority between the management teams and council health service boards are lacking. At all levels, there are medical personnel as heads: in the case of the health centre it is the person in charge of the health centre and the person in charge of the dispensary in the case of the dispensary. These officials were the overseers of the functioning of their respective facilities giving little room to CHSB and HFCs. There is no official link between WHC and HFC. The WDC and HFC had common objectives but officially report to different higher structures. The WDC is a more political organ that reports to the DC, while the HFC reports to the DMO.

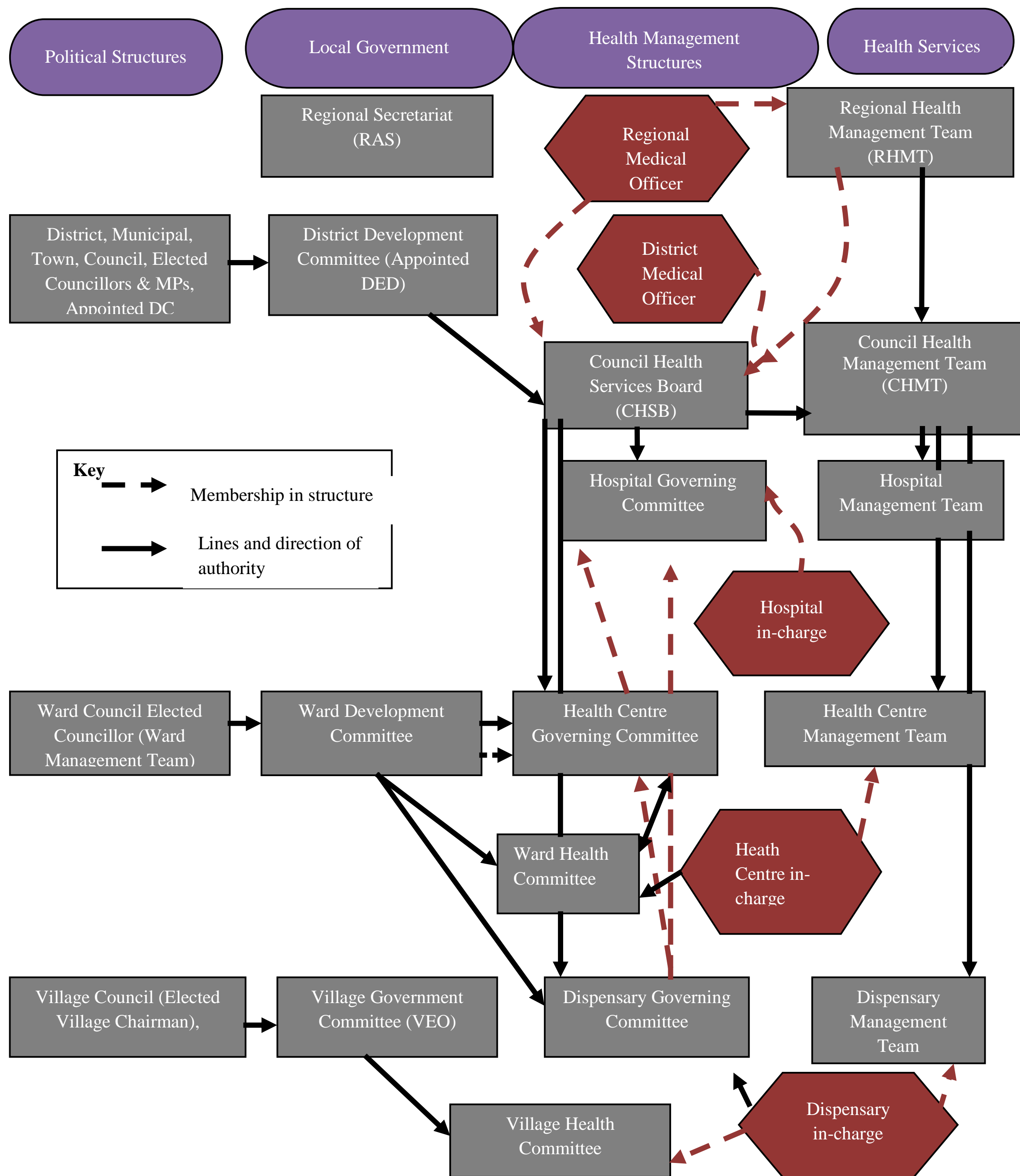


Figure 6-2: Relationship between health governance structure and local governmentn

Source: Ifakara Health Institute, 2011

From member's perspectives, the repeated role of the HFCs mentioned was to mobilise the communities to join community health insurance funds. In some facilities the HFC members can influence the collection of the CHF and its utilisation to purchase stock-out drugs:

> … as a member of the HFC, our role is to ensure that the funds that have been contributed by the service users are kept in the facility account. Also, to ensure that the amount collected has been retrieved for the facility to use (FHC-02).

However, the HFC members were not in a position to decide on how to spend the CHF and user fees revenues. A substantial amount of CHF was held in facility bank accounts at the council level, while the facilities are running out of stock. The health managers assert that the funds belong to facilities but the facilities do not request:

> … most of the facilities did not understand the procedures to request back their funds. They are supposed to plan and budget for the amount requested, then CHSB scrutinises their plan and, if feasible, they sign for the release of the fund. The majority just write a letter to request, rather than providing a plan (FCH-04).

Only two HFCs of the four interviewed committees had managed to mobilise communities to contribute their labour to construct a dispensary. However, they should ask permission from the village government since it is the village government that links communities with the facilities:

> … time to discuss some issues with the communities is minimal due to workloads. We convey the messages to the communities, like to provide their labour during construction, during the village meetings (FCH-01, FCH-03).

At the communities, HFCs were not seen as a structure through which they can present their views and grievances concerning health service delivery matters. The communities felt that HFCs were government officials enforcing their enrolment. Likewise, the HFC members felt that they are serving the government rather than communities. They assumed that they would be treated as other government civil servants with allowances when they assembled for meetings. Given this situation, the question is how far the HFCs can monitor the functioning of the providers and/or promote accountability to the service users. Similarly, the extent to which the representation of the elected government representatives was responsible to the primary

healthcare facilities was minimal. It seems to be important if the facilities are to mobilise additional resources from the citizens, such as the construction of facilities using local funds.

When asked about their roles, the HFC members frequently mentioned their role was to reinforce the implementation of the CHF policy. They did not see their role as promoting accountability to citizens, monitoring the work of the providers or monitoring access to health benefits by various groups. Some of the HFC members felt that their role was to improve infrastructure and not health services. The village health committee members argued that their role was to promote preventive health interventions, such as sanitation and hygiene in the village, and to call for an ambulance in case of emergency. The HFC and VHC visited were not performing accountability roles. The current structure doesn't promote policy accountability to citizens.

(a) Answerability of health facility committees

Regarding answerability, HFCs have more direct links to the councils than to the local communities they are supposed to represent. These structures are failing to hold government institutions to account in case of malpractices. In terms of resource mobilisation, committees can influence the use of CHF funds, especially in relation to supplies. In one of the health centres the HFC managed to collect enough funds to purchase drugs. Only two out of six facility HFCs had managed to retrieve the CHF. One decided to buy drugs and the other facility decided to buy cleaning equipment such as buckets, brooms, etc. In these facilities the HFCs at least know their roles:

> … is to ensure the collected funds from the CHF and user fees have been deposited in the bank by our cashier. Then, to ensure the amount contributed has been utilised for the benefit of our facilities (FKI-04, FKI-06).

Contrary, the HFCs did not mention about conveying the community messages to the providers to whom they can present their grievances concerning health service delivery. When asked about their roles; the HFCs members mentioned 'convincing communities on benefits of community

health insurance fund'. Four HFCs members said that their key role is to ensure the communities receive good health services by monitoring the provider's behaviour while dealing with the clients. The HFC in only one facility was involved to monitor the new drug kits delivered to check if the drugs that were procured are there. After cross-checking all powers are left to the providers. None of the members interviewed mentioned the role of representing the communities rather than convey the provider's messages to the communities.

(b) Scope and intensity of accountability

Both CHSB and HFCs were located inside government structures, with an element of external accountability through the inclusion of representatives from the communities and private health providers. However, the attachment to the accountability bodies within government led to questioning the decision-making powers of the CHSB and HFCS. The CHSBs were not seen to have a crucial role in decision making on health-related matters at the council. The CHTM had more power as stressed by one of the participant 'we seek blessings from the CHSB, just to follow the procedures'. The private sector representation is only seen in the budget meeting to share their plans for the preparation of the council health plan, but not as a part of the CHSB consultations. The capacity of the private sector to articulate accountability demands to government officials cannot be answered in this study.

Likewise, the HFCs cannot ensure proper representation of the service users, because they do not understand their roles. As a result, community inputs and membership in the CHF and user fees are likely to remain low. The informal chats with the facility providers revealed that the use of market incentives as one of the strategies to improve accountability has led to a number of patients seeking care from other sources, like traditional healers, or stay at home if they do not have sufficient funds.

From the findings presented a number of conclusions can be drawn on how service users' representation and accountability are organised through CHSB and HFCs. The intention of government to give service users a voice in and responsiveness to health service delivery has not had the desired impact. The selection process of the members of the committees and boards was dominated by the government. The views of the members on their role are mainly government focused to implement CHF policy. Community representation came out clearly as they do have a forum for consultations to raise their complaints and/or provide their ideas. However, private provider's representation was low. Usually, the HFCs members work as individuals rather than representatives of the service users.

It was found that acts of accountability were directed upward than downward accountability HFCs have not pledged to go to the community hence decisions were made without community consultations. Furthermore, lack of elections of HFC members questions their legality to be considered representative. In addition, the council has the power to dissolve the structure. It is obvious that councils have more control over health governance structures than the communities.

From the users' perspectives, contributions through CHF provide inspiration for providers to be accountable and responsive to service users. In some of the facilities visited, service users were ready to enrol in the CHF if the services were made available. The challenge has been in the representation and accountability structure, which does not provide sufficient incentives for the communities to question the service providers in the case of poor service delivery.

In relation to the short and long routes of accountability, the CHSB and HFCs are placed in between these routes. Both the CHSB and HFCs can reinforce the voice of service users and the responsiveness of the service providers and make policy makers and politicians more accountable to the service users and hold service providers accountable for the quality of service they provide to the communities. At present none of the two are working. The support of the

long route is lagging behind because the CHSB and HFCs are weak in decision-making powers and the members cannot facilitate the short route.

The ability of the HFC members to play their role effectively is also questionable under the current selection procedure, which is greatly influenced by the government. Is it possible for the government to choose individuals who will challenge the government? Government bureaucrats have a position that can influence CHF dynamics. On the basis of the findings, the study gives the following sets of messages: first, on the accountability to service users of any services; secondly on the accountability to service users of health services; and thirdly, on accountability to service users of reproductive health services.

Structures concerned with accountability cannot promote acts of accountability, since the service users are not aware of and do not mobilise around this structure; if the structures are headed by the service providers themselves and if capacities are not built into the HFCs with regard to the monitoring and accountability role. The HFCs, while strengthening service provision at facilities, their emphasis has been on community contributions and not holding providers to account for the services. The systems should be set up for committees to engage with communities in responding to their needs and to make service providers answerable to service users. At current such systems are absent. Thus, for service users to be able to push their accountability they need to know the services that they are entitled to. This could empower them to demand their rights (Loewenson et al., 2004)

Lessons on accountability

Above all, there are some lessons learned about community participation in accountability in health services delivery. Unlike other social services, such as sanitation, water and hygiene (to mention a few), there is a huge discrepancy in knowledge between service providers and the users on the technical issues of the healthcare service (George, 2003). This makes it difficult for

service users to push for accountability with regard to availability (they might not know what services are needed for their health problems) or quality of the health services (they might not be able to categorise what health services are of good quality). They might, though, push for affordable health services, in particular stopping the informal payments for health services meant to be provided for free. Unless adequate budget is allocated to the health sector, it is difficult to address the emerging needs from community demands. For example, one of the participants claimed that council should employ qualified pharmacists, for efficiency in procuring drugs and other supplies, but there was no budget for the same. On other hand, when council manages to allocate a budget, the qualified health professionals do not want to serve in rural settings.

6.4 Discussion and conclusion

The chapter has evaluated the effects of the three dimensions of decentralisation on health services delivery. Generally, the findings in this chapter support the importance of accounting for all dimensions of decentralisation while investigating its outcomes. As said previously, decentralisation reform that is executed only in one dimension may produce fewer positive results in improving service delivery than a multi-dimensional execution. However, current decentralisation efforts in Tanzania have remained theoretical policy designed by government to convince donors that they decentralise, while actually they have not. This was articulated by one of the national participants, who said that “decentralisation is a means to snatch donor grants but it is not really the intention of government to grant councils all powers”(NKI-02).

The evidence presented in this chapter shows that some aspects of decentralisation have progressed more significantly than others. When compared to the stated goals of devolution, the process of true devolution has been slow. However, LGAs have some discretionary power but little has been achieved with regard to fiscal and administrative decentralisation. This is due to the lack of enthusiasm of central government to allow full decentralisation to happen (Tidemand and Msami, 2008, Braathen and Mwambe, 2007, URT, 2007:4, Tidemand and Dege, 2010, Boex, 2008).

From the results presented, all three dimensions of decentralisation were seen as important, for improved health outcomes. However, additional value is added from interactions of the two forms of decentralisation dimensions on improving health system performance, which in the end improves reproductive health delivery. For the decentralisation to improve health outcomes, interaction of the three dimensions of decentralisation is important. For example, community engagement in construction of the facilities improves physical coverage, but this was not enough, as some of the constructed facilities lack personnel to render services. Thus, although one dimension of decentralisation can lead to a desirable output, on its own it is not enough to improve health outcomes. For this case administrative and fiscal decentralisation was needed to supplement community initiatives. Council still has to wait for the central government to post health care personnel as they don't have power to hire.

It was observed that interactions of the three dimensions of decentralisation are important. For example, administrative (autonomy to hire and fire personnel) and fiscal decentralisation was found that the large share of LGA are intergovernmental transfer mainly for the recurrent transfers for the personnel salaries. Staff recruitment and deployment have remained centralised functions. The process is not carried out for the benefit of the LGAs, and staff are transferred under the central directives without local consultation, leaving gaps in key positions (Manzi et al., 2012, Mshana and Petit, 2011). Also, it has not been possible to apply the formula-based allocations of recurrent grants in practice. As a consequence, financial allocations to LGAs are in many cases unequal and funds are released in places where health personnel have been posted. This leads to inequities in resource distribution, both in human and budget allocation. The urban councils receive higher allocations of funds than remote councils. The allocation for recurrent funding (personnel budget) is not allocated by need, but based on where personnel are stationed. This favours urban councils, because urban postings are more desirable and personnel posted in rural councils very often do not take up their posts. This affects both the quantity and quality of services provided in remote councils.

With regard to fiscal decentralisation, central control of LGAs, as shown by central government oversight, is necessary in ensuring that LGAs use financial and other resources in an efficient, effective and transparent way (Azfar et al., 1999). There is little local discretion over the recurrent budget, since the highest proportion is spent on salaries and central government determines both the quantity and structure of LGA personnel. With regard to the development budget, the discretionary fund, in particular LGCDG, which provides the council with more autonomy in budget prioritisation, comes with central instructions for the defined activities from the PMO-RALG. This undermines local autonomy and prioritisation. It was observed that funds under LGCDG were directed for the construction of a secondary school, which was not the role of the LGAs. This interference is not in the spirit of devolution. Similar studies have found that financial transfers to the LGAs are controlled by the centre through budget ceilings, guidelines and approvals (Mubyazi et al., 2004, COWI and EPOS, 2007, Yoshida, 2008). It was noted that local health plans have to comply with national priorities in order to receive fund allocations, (Maluka et al., 2010b).

In regard to administrative decentralisation, councils have very narrow choices as they can only employ less skilled staff. Government documents admit that “reluctance of central government to devolve autonomy for human resource management to local authorities is one of the bottlenecks in implementing decentralisation” (URT, 2009a:7). As a result, councils lack qualified technical health personnel. Shortage of skilled staff, inequitable distribution of the existing workforce, with more health personnel in urban than in rural areas and bureaucratic recruitment processes stand as major challenges to council health care delivery (URT, 2009b, COWI and EPOS, 2007). The re-centralisation procedures which aimed at assisting councils to have highly qualified personnel have failed to address the current crisis of health care personnel shortage particularly in rural councils (Munga et al., 2009). It is evident in this study that council has a shortage of more than 50% of the required personnel. This affects the quality and quantity of health services provided to the communities.

The study found little evidence that political decentralisation has increased local autonomy in prioritising, and planning of health care services according to local needs. The linkages and deliberations between communities and facility health committees were limited, bottom-up planning was typically viewed as wish lists by council health officials, and council priorities were typically set by the central government. In this study local health needs were not reflected in the CCHP. Similarly Mubyazi et al. (2004) found that ward and village leaders commonly complain about failure of the LGAs to respond to local priorities. Diseases that were identified by community members as major health problems were not reflected or were given a low priority in the CCHP. Similar studies as per (Per-Tidemand and Jamal, 2010, Chaligha, 2008, Odd-Helge et al., 2010, Molel, 2010) arrived with at the same conclusion observing that community involvement in local planning and delivery was limited, and council plans do not reflect identified community needs

According to Conyers (2007), the effectiveness of user committees depends on their structure, composition, motivation and the capacity of their members; and how they are linked to the local and national structures. In the case of Tanzania, the presence of service boards and committees does not appear to alter the existing power relations between technical staff and communities. Among the key challenge was the selection of HFC members: The absence of community involvement in the process has had a direct impact on HCF roles. In many instances, the member selection process has been carried out quickly and without following correct procedures. Members are often selected according to the discretion of people in-charge, instead of the community. This results in questions of legitimacy and accountability of the HFCs members. Other studies (Loewenson et al., 2004, Macha and Borghi, 2011, Kessy et al., 2008)have found that health committees were not functioning properly. Confusion about their roles and responsibilities also obstruct the full participation of HFCs in health related activities (Boon, 2008).

Generally, the current status of decentralisation shows that there is a principal-agent problem, whereby central government (principal) exercises more power over LGAs (the agents). As others

have stipulated, this problem is characteristic of decentralisation in many developing countries. Local institutions are frequently given power to make decisions but not control the resources needed to implement those decisions (Conyers, 2007; Ribot, 2002). Tanzanian health sector decentralisation is more top-down, and included all forms of decentralisation including deconcentration, delegation with limited devolution. Similar to (1990) Masanyiwa et al., (2013) all forms of decentralisation can be found in the health sector.

Conclusion

Government has not really given a fair trial to health sector decentralisation as it has failed to devolve significant powers to LGAs. Government hardly devolved the key functions of financial and human resources. The findings in this chapter support the claim that 'each dimension of decentralisation individually is highly relevant to produce health outcomes'. It has been observed that, inter-linkages between decentralisation dimensions generate additional benefits for improving health services. Thus, when one single dimension of decentralisation is implemented without applying all three dimensions some of its potential to improve health outcomes might be lost.

Abbreviations for Chapter 7

ANC	Antenatal clinic
C-FGD	Community focus group discussion
CHMT	Council health management teams
CKI	Council key-informant interview
FKI	Facility key-informant interview
FP	Family planning
ICPD	International Conference on Population and Development
ITNs	Insecticide-treated nets
IUD	Intrauterine devices
MCH	Maternal and child health
MMR	Maternal mortality rate
MNCH	Maternal and new-born child health
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NEHP	National Essential Health Package
NGOs	Non-governmental organisation
NKI	National key-informant interview
NPEHI	National Package of Essential Health Interventions
NPERCHI	National Package of Essential Reproductive and Child Health Interventions
PMTCT	Prevention of mother-to-child transmission
RCHS	Reproductive and Child Health Section
RHMTs	Regional health management teams
RHS	Reproductive and Health Services
RKI	Regional key-informant interview
STDs	Sexually transmitted diseases
URT	United Republic of Tanzania

CHAPTER 7

IMPLICATIONS OF DECENTRALISATION ON REPRODUCTIVE HEALTH CARE SERVICES IN RURAL TANZANIA

7.0 Introduction

This chapter presents findings on the council case based analysis, in understanding the impact of decentralisation on reproductive health service delivery. There are two main areas that were explored in an attempt to realise the implications of decentralisation on reproductive health service. This chapter also looks into how fiscal, administrative and political decentralisation empowered council health staff in deciding on health resource transferred from the central government for the council health service provision. Generally, there were mixed opinions to the effect that decentralisation has brought on the health care delivery. Some participants argue that there is a positive impact on the delivery of health care, while others felt that there is still a long way to go to actually say that decentralisation will improve the delivery of health services.

The chapter is divided into four sections: the first section gives a general overview of the of the reproductive health indicators of the case analysis council. The second section analyses administrative decentralisation looking on the number of health facilities and human resource situation of the case council. The third section presents the impact of fiscal decentralisation on health service delivery while the fourth section presents political decentralisation and the last section presents discussion and conclusion of the chapter

7.1 Council reproductive health services indicators

Analysing the effect of decentralisation on reproductive health (RH) brings to a question on how does RH indicators looks before and after implementation of decentralisation. However, this question was not achieved in the current study as data were not available. Thus, it was not easy for the study to track changes of RH indicators over time. The data presented are based on secondary data collected from District Medical Officer (DMO) offices and from the visited facilities.

Basically, National Package of Essential Health Interventions (NPEHI) of 2000 contain a list of priority health interventions that informed health planning at all levels (MOH, 2000b). Reproductive and child health services (RCH) is among the six priorities of the NPEHI. Specific components for RHS that are included covers services for family planning, maternal care-including antenatal care, provisional of basic and emergency obstetric care at all levels, post-natal care, gynaecological diseases, sexually transmitted diseases (STDs), post-abortion care and post-partum care, adolescent reproductive health care, other maternal health conditions, including infertility, rape and female genital mutilation and reproductive system cancer (MOH, 2000b).

The National Package of Essential Reproductive and Child Health Interventions (NPERCHI) were formulated in 2000 to give detailed guidelines for RCH component from national to facility levels (MOH, 2000a). The aim was to address the reproductive health needs of both women and men according to their needs. Regional health management teams (RHMTs) and council health management teams (CHMTs) were tasked to train staff at facility level on the utilisation of NPERCHI guidelines. It is assumed the RHMTs and the CHMTs should use the NPERCHI guidelines to plan for reproductive health training and supervision (MOH, 2000a). Unfortunately, during the field visit neither the RHMTs nor the CHMTs were found to have these guidelines.

The national reproductive health programs adopt the International Conference on Population and Development (ICPD) definition of reproductive health that defines reproductive health as "a state of complete physical, mental and social well-being in all matters relating to reproductive system, its function and process. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex, life and they have capability to reproduce and the freedom to decide when and how often to do so" (MOH, 2000a).

However, in this study it has been proved that there is a gap in terms of the existing policies to realise individual's rights to RHS. In particular, young people are marginalised in the current

polices and laws as the documents rarely talk about of them. For young people, documents mention about access to friendly services like information and education but not how to achieve the goal. This makes it more vagueness when it comes to implementation. In this study it was observed that young people were denied their access right to family planning services and providers were firm with this decision. The next section analysis the extent to which key RH elements that are stated in national policies are taken into council health plans.

The service mapping was done to identify the elements RHS that were readily available at the visited facilities. Table 7-1 present number of health facilities that are offering reproductive health. It was found that most of the health facilities had either fixed clinics, or mobile and/or outreach services, in which basic RHS were provided at free of charge. However, not all RHS that were identified at the national level were available at the Primary Health Care (PHC) facilities.

Table 7-1: Number of health facilities offering reproductive health services

RH component	Health centres n=6	Dispensaries n = 30
Family planning	6	30
Sexual transmitted diseases (STI/HIV/AIDS)-related services	6	30
Prevention of Mother-to-child Transmission (PMTCT) services	6	30
Antenatal care	6	30
Postnatal care	6	30
Delivery services	6	30
Post-abortion care	6	1
Basic obstetric care	6	30
Emergency obstetric care	1	-
Infertility treatment	-	-
Reproductive cancers (cervical & breast cancer screening)	-	-
Harmful traditional practices	-	-
Adolescent reproductive health	1	1

DMO's office, 2011

In each of the Council facilities at least some components of RHS were available. Services provided were related to ANC covering screening and treatment for syphilis, HIV counselling and testing, family planning, child delivery and referral for the risky pregnancies. Post-abortion services were available in all health centres, while at dispensary level post abortion services were

limited to one facility. Other services for short term family planning are more available than long-acting and permanent methods. The FDG discussion noted that pills are always available at the health facilities but this is not the case with implants, IUDs and injectables. However, the services were available through outreach arrangement with an international NGO called Population Services International (PSI). Services for infertility, menopause and management of reproductive system cancer were not available. Furthermore, programmes targeting adolescents were limited, being offered by one facility.

Services for STIs like HIV/AIDS were vertically managed. In Tanzania pregnant women are given a compulsory HIV test during their first visit to the ANC. Those who tested positive were enrolled in prevention mother to child transmission (PMTCT) services. Generally, RHS were provided for 9 hours from 8.00 am to 4.00 pm. It was noted that, some clinics were not providing services during the official time as the provider was sick and the other provider was called to submit the monthly report to the council. In addition, some of the clinics closed earlier than stipulated. This was revealed by service users during discussions:

> … Clinic services are supposed to start at 8.00 am but usually the nurse opens at 9.00 am. She usually finds us waiting for them. This has been a barrier to some women who come from far away. Long hours of waiting have made some women to seek traditional birth attendant rather than facility delivery (C-FGD-07).

> … one day we went to the facility for family planning around 2.00 pm. The provider told me I was late; she said 'Come back tomorrow, I am tired'. These are not good words … it discourages one a lot. For someone who walks a long distance to go back without having received services (C-FGD-09).

Some providers turn back family planning clients claiming that they came on the wrong day. This was expressed during community discussion as some of the participants argued:

> We are not satisfied with the services … some providers make their own arrangement like they set a day for pregnant women, a day for family planning, but they don't give us the information … so you have to come back on the right day … some might know, but for someone who doesn't know it is a problem (CF-FGD-07).

The next section below presents council reproductive health indicators since 2007 to 2011. The data relied on the available data at the facilities. As some of the services were not made available in many of the facilities thus the data is limited to safe motherhood indicators including maternal mortality, family planning services among others.

(i) Maternal mortality

Council data on maternal mortality indicates that there were 57 per 100 000 live births in 2010. But, maternal data in a case council should be treated carefully as deaths that occurred outside of the health facilities were not reported. The council has been using MMR as a RHS indicator to measure women's health status. The data indicates that MMR is one of the most alarming health problems, as shown in table 7-2.

Table 7-2: Case council –MMR from 2007 to 2011

Year	Maternal mortality rate
2007	197/100 000
2008	49/100 000
2009	27/100 000
2010	21/100 000
2011	57/100 000

Source: DMO's office, 2011

There is a decrease and at the same time an increase in the trend in maternal deaths as table 7-2 shows. Council health managers were aware of the trend and one of the Council's priorities is to have zero maternal death. As one of the participant insisted:

> Every life counts … the goal is to see that all women are receiving high quality maternal health services. It is my wish to see that all facilities are well equipped to provide basic and emergency obstetric care to ensure that all women are passing through safe delivery (CKI-04).

The construction of maternity waiting homes known as *Chigonella* was one of the initiatives taken by council to reduce MMR. Expectant mothers who live far from the facilities spent their last few weeks in these homes before delivery. This is to overcome geographical and/or transport barriers during the rainy season. However the availability of the maternity homes was said to be inadequate to meet the demands. Out of 39 council facilities only four had maternity waiting

homes. This implies that facility delivery is not accessible as during rainy season some part of the council can be disconnected up to three months. Some facilities were also located very far. This was revealed during the interviews:

> ….Some of the communities lives far away from the facility (approximately 50 Km). As it is a pastoralist community; the population is scattered and others live far away. They are accessed through outreach services particular once per month. The program aimed to provide mother and child services (FKI, 03).

The case council lacks hospital referral from the health centres and dispensaries and cases were referred directly to Regional hospital. Lack of transport and other associated costs affects access to RHS. One community group discussion noted that:

> The main issue that affects people in this locality and impacts on services including facility deliveries is the transport and distance from the facilities. …we don't have ambulance at our facilities if a patient needs emergency services we asked for the God's mercy (CFG-04).

(ii) Family planning services

Contraceptive counselling and services are part of primary health services and were available during post-natal and ante-natal visits. Short acting FP services are more readily available to all health centres and dispensaries. One of the key informants at the council stressed that:

> Most family planning services are available ……..if you want FP it is there at the RCH clinic. When you go the health facilities, you get pills and injectables but in the case of implants and IUDs one has to wait for the outreach services from PSI as our RH providers lack skills concerning them(CKI-05).

The type of FP services provided were injectables, pills and condoms. The Intrauterine Devices (IUD) insertions for women and male sterilisation were not available since providers lack skills on how to insert the IUDs and implants as well as perform sterilisation. Such services were available at the regional hospital since the council has no hospital. One of the participants claimed:

> I wouldn't say long term family planning methods like IUD or sterilisation are not provided to our clients. It's only that our communities are not well motivated about them. Today, as you see on this poster, one of our partners, PSI, came for IUD insertion for free as well as sterilisation for those who need it. Unfortunately no one came for the services, even though women asked for these services at the clinics (FKI-05).

The outreach services were advertised through posters, the local radio and announcements over loudspeakers around the village. Despite publicity for the services, no clients turned up. It was

noted that the use of loudspeaker spread the information to men as well. As a result they refused to let their wives attend. One of the providers claimed that:

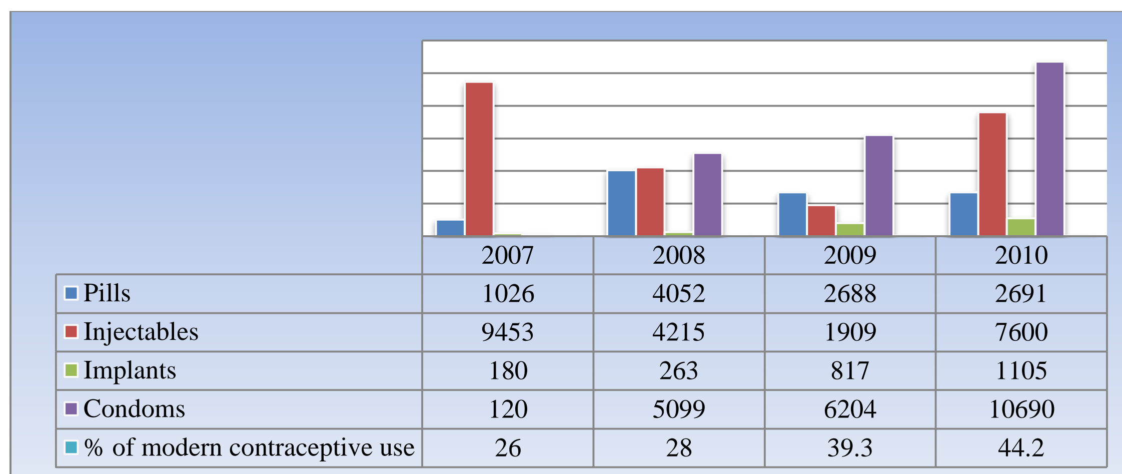
> … when men heard about the IUD services they refused to let women get out of their homes, some of the women were given duties outside the village, while others just remained indoors the whole day … you won't even see them fetching water as they usually do. The issue is not availability, but rather utilisation (FKI-05).

Male condoms were available but were not used as a family planning method. The reason was that men were hesitating to use them, the assumption being that, when you ask to use a condom in a union, it implies there is no trust between the partners. Asking for a condom breaks the supposed trust and intimacy. Participants argue that a spouse asking for condom use is unfaithful. Married couples were not in support of condom use, claiming that they were not meant for them. Frequently, women felt uncomfortable to talk about condoms use in the presence of men. This implies that they rarely negotiate for their use.

> …..using a condom with my wife? In marriage there is no need to use condoms, even though they claim that condoms can be used for the prevention of STIs including HIV (C-FGD-08).

> … We cannot argue with our men about the use of condoms … this can be a source of violence and of course we cannot negotiate even though we know they have extramarital relationships … we are very worried if we will survive in this battle of HIV/AIDS (C-FGD-10).

In-depth interviews with the RH providers revealed that availability of contraceptive methods was not a problem although stocks of specific methods like injectables were not available. All of the visited health facilities were able to provide some of the FP methods. Analysis of the council trend in contraceptive users as presented in Figure 7-1 indicates that condom use increased from time to time. There is overall increase in the contraceptive prevalence rate between 2007 and 2010, but a decrease in pills and injectables. Injectables were the preferred contraceptive method because of its conveniences. Lack of freedom from their partner made the women give up the pills. Women had to hide their pills under the mattresses and/or in kitchen lockers. In addition, injectables were not available in some of the facilities, which hindered their utilisation.



	2007	2008	2009	2010
Pills	1026	4052	2688	2691
Injectables	9453	4215	1909	7600
Implants	180	263	817	1105
Condoms	120	5099	6204	10690
% of modern contraceptive use	26	28	39.3	44.2

Figure 7-1: Council trends in contraceptives use from 2007 to 2010

Source DMO Office, 2011

Council unmet need for FP was high as women who want to postpone or to stop child bearing failed to do so. This was revealed during discussions with a group of women as some confessed they wished to be on FP but were not using any of the methods. Two myths and misconceptions about FP methods widespread among service users and providers were wrongly informed or misunderstood facts about FP commodities. They had a belief that the use of FP may cause infertility in the near future and cause giving birth to abnormal children. Other reason mentioned were the side effects associated such as over-bleeding and headaches. In some instances men do not allow their women to use FP methods. Injectables, is one of the desirable methods but were not readily available in some health facilities especially during the rainy season. FP services were appreciated by some of the community members, while others were against them. This was expressed in the community discussion groups:

> FP helps us with child spacing. They are available in our facilities. We like injections because they last three months before I have to come for it again. We don’t prefer pills because our partners don’t support the use of the contraceptives. They just want many babies to take care of their cattle (C-FGD-07).

One of the participants expressed her concern about provision of RHS as she compared it with her past experience:

> We used to have family planning cards with everything written there … We don’t have such cards now. You find women are just given pills…. or injections and it is noted on a piece of paper which method is

> prescribed … when the client goes, that is the end of it. So we cannot follow up the clients properly. We wouldn't even know how long this client has been on this pill. When was she diagnosed? You know, I'm really not happy (CKI-04).

To address unmet need, FP education to the wider community is important so that it should not remain women's business. In addition, it is important to deal with the attitudes of service providers as some were against the use of FP.

(iii) Ante-natal services

Ante-natal (ANC) services were available in all facilities while outreach services were provided once a month to the villages far from the health facilities. Women were given basic information related to delivery such as delivery preparations, pregnancy danger signs, nutrition and family planning. During their clinic visit they were also provided with safe delivery including tetanus toxoid, iron supplements, assessment of blood pressure, anti-malaria drugs, and de-worming tablets to prevent maternal anaemia. Laboratory tests were provided and this included urine test and screening for STIs. Women found to have risk pregnancies like high blood pressure were referred to the Regional hospital for specialised physicians.

Table 7-3 indicates a positive increase in the number of women attending ANC. However, the proportions were below the council's target of 78%, while, national coverage is 98%. This implies that ANC services were under-utilised. There were several reasons linked to low utilisation of ANC services. Women were dissatisfied with the attitudes and behaviour of providers as they faced verbal attack while seeking RHS.

The ANC services in the visited facilities were not satisfactory. Some laboratory tests for the pregnant mothers were not performed due to lack of test kits. The equipment required to provide assisted vaginal deliveries (forceps) were absent from all the surveyed facilities, and test kits for syphilis and HIV had not been available in some health facilities for the past three months. In

some facilities, laboratory technicians were not available; pregnant women were referred to the higher levels.

Table 7-3: Council antenatal clinic attendances from 2007 to 2010					
Year	**No of women expected**	**First visits**			**Overall attendance**
		< 16 weeks	> 16 weeks	Total	
2007	8 133	4 717	3 417	8 134 (58%)	60%
2008	8 267	5 042	3 224	8 266 (61%)	61%
2009	8 297	5 816	2 440	8 256 (70%)	70.1%
2010	8 170	5 882	2 275	8 157 (72%)	72%

Source: DMO's Office, 2011.

(vi) Facility delivery

Table 7-4 indicates positive trend towards facility delivery which increased from 54% in 2007 to 81% in 2010. Home delivery is increasing and poor transport system, providers attitude was mentioned to be a barrier. However, the data should be treated with care, as only 70% of women attended ANC.

Table 7-4: Council- Place of delivery 2007 -2010			
Year	**Total no of deliveries**	**Home deliveries**	**Facility deliveries**
2007	4 579	124 (1.5%)	4 423 (54%)
2008	6 614	386 (5%)	6 134 (74%)
2009	7 470	816 (10%)	6 590 (79.4%)
2010	7 062	433 (5.2%)	6 587 (81%)

Source: DMO's Office, 2011

A restriction to extending delivery services in some clinics was noted by some participants. The providers argued that reforms are not improving the working environment to provide quality services, especially at the PHC level. They complained about the lack of premises, which interfered with the privacy of the patients. In some facilities, only a single room partitioned by curtains was used as the outpatient section, and for counselling and drug dispensing. This

affected the client's confidentiality, in particular those who were coming for delivery and HIV/AIDS counselling and treatment services. The HIV-positive mothers had to wait until the outpatient clients had all been served. This was stressed by participants claiming that:

> … I have never delivered women at this facility during the day for the five years working in the facility. I came to realise that women fear to be heard during delivery, as some cry a lot. If they are heard, their fellow women will intimidate them as not being brave. Thus, those whose labour pain started during the day opt for TBA. Those who started their labour pain during the night come for facility delivery (FKI-03).

Absenteeism of personnel was noted during the facility survey, with some facilities having only one staff, even though they were supposed to have two or three. This led to delays in the provision of ANC services, which made the clients, wait for as long as four to five hours to get family planning. Some complained about this:

> …we don't have an option; we have to wait until the nurse is finished with other clients who come with serious conditions. We are waiting for the family planning services. Others have already left without services, fearing to be seen by their husbands. If we take too much time, husbands might follow us and we end up being beaten sometimes (C-FGD-07).

(iv) Sexually transmitted infections

All council facilities provided some services for STIs. However, facility data for STIs shows that there was a decrease in the number of new HIV infections among women while there was an increase in syphilis cases as data in table 7-5 indicates. HIV counselling and testing is now compulsory for all women during the first ANC visit. Women were tested without pre-test counselling, providers claiming that they had to attend to large number of women but they are few to perform all the duties for all women. Women who tested HIV positive were referred to the counselling and testing centre (CTC) where they received post-test counselling and other services including anti-retroviral drugs. One of the participants said the following about the services:

> Shortages of staff made us go for HIV testing without counselling, which is against the policy and guidelines. But what can we do? The government adds more programmes with the same number of people. Here we have out-patient clients, immunisation, family planning, deliveries and clinic. We are only two … How can we deliver full packages to those entire programmes? (FKI-02).

The CTCs were located outside the RCH clinics. This type of arrangement was not seen to be convenient to HIV positive women, fearing their HIV status will be disclosed. Others decided to change their clinic location. Nevertheless the HIV/AIDS data in 2010 should be taken with precaution because HIV test kits had not been available for the past six months. Data for 2010 could either increase or remain the same if HIV testing was conducted.

Table 7-5 Case study of council – pregnant women tested for STI infections 2007 to 2010

Year	No of women tested for HIV	HIV-positive women	No of women tested for syphilis	Syphilis-positive women
2007	604	136	3 299	11
2008	8 269	22	1 638	139
2009	8 412	20	3 485	67
2010	7 787	8	5 248	121

Source: DMO's Office, 2011

(v) Adolescent services

Young people are finding it difficult to access reproductive health services due to lack of youth friendly services as they fear to be seen by their parents at clinics. Providers were calling for the government to establish centres for young people to access their reproductive health needs. As one of the participants claimed:

> …Young girls and boys rarely come for the reproductive health services, as they are shy and fear to be seen by adults, including their parents. Unfortunately, most of the facilities don't have youth services to make services friendly and accessible to them. Maybe the government can think about having youth health centres (CKI-04).

Providers' attitudes influence decisions of young people to use modern contraceptives. They discouraged young people from using contraception as it might reduce their fertility. Participants from the community discussion were repeatedly quoted as saying:

> … nurses are biased towards young girls when we ask for contraceptives. Nurses are not cooperative, they tell us that we are prostitute … For instance when we ask for family planning … they laugh at us and ask why are you coming for contraceptives while you are not married? They forget we are sexually active and having sex doesn't mean you have a husband (C-FGD-07, C-FGD-08).

However, other community members believed that modern contraceptives services are for women who have children already and not for young people who don't have children. .One of the participants from the community discussion said:

> Family planning methods are good for people who have children already not for young girls. Pills and injectables are not for young people as they need to have children. Some of the family planning methods reduce fertility…we don't want barren girls in our community in the future (C-FGD, 04).

The findings presented in this section have shown that there is a low utilisation of the available services such as low uptake of modern contraceptive methods. This is contributed to by the erratic supply of contraceptives with limited range of choices, inadequate skills of providers and provider bias affecting informed choices especially for the young people, limited partner support for married women, lack of young people friendly health services and misconceptions about family planning methods. Low facility delivery was due to poor quality of services provided and mistreatment by some of the providers which discourages women from seeking to deliver in the facility. Other factors were associated with poor transportation which hinders access to health facilities. Postnatal services were not made available due to lack of premises. Women after delivery usually stayed up to six hours and were then discharged. Other services including abortion services were limited to few health facilities.

Although RHS are mandatory services at the health facilities, individual rights to access and use are not well established. This can be one of the reasons for the unmet need for the family planning as individual choices cannot be made available. During the interview some participants from MoHSW believed that there is a policy commitment towards RHS as implied in several policy documents. However, it has been noted that political leaders rarely advocate for RHS in their speeches. For-example, during the budget session 2012/13, the Parliamentarians Family Planning Club (PFPC) observed Government did not allocate any fund for family planning commodities. The PFPC signed a petition to the President, Prime Minister, Madam Speaker, Ministers for Finance and the Minister for Health to demand allocation for contraceptives. From this case it is evident that policy champions are important at all levels to ensure RHS receive funding. In the case of Tanzania, Council RHS coordinators indicated that they are not, by law members of the CHMT; this makes RHS invisible under decentralised health care.

7.2 Impact of decentralisation on reproductive health services

Before examining the link between decentralisation and RHS in Tanzania, there is a key issue that should be highlighted. The analysis of the association between decentralisation and RHS delivery should not be understood in isolated fashion. Decentralisation has a broader impact on the health care system so that it is likely to have an impact on RHS. It has been suggested that decentralisation should not be viewed as an end in itself, but as a means to enhancing health system performance and responsiveness to local health needs (Gilson and Mills, 1995, Bossert and Beauvais, 2002). Thus, the impact of decentralisation has to be viewed in the broader perspective of the health care system. This opinion will be taken up again below.

This section therefore explores the implications of the health sector decentralisation for RHS with respect to effects on: (i) human resources (administrative decentralisation), (ii) local finances availability for RH delivery (fiscal decentralisation) and (iii) local decision-making regarding use of resources and on community (political decentralisation). Some of the impacts are based on evidence, and others are premises based on the understanding that changes in health system performance would affect the delivery of health services, including those of reproductive health.

7.2.1 Implications on human resources

In provision of the health services availability of well trained and motivated personnel are the most significant. However, the scope of decentralisation of human resource for health (HRH) functions has been limited. Participants were asked to mention some specific administrative and managerial roles being evidence of the administrative decentralisation. Participants at the council managed to identify set of indicators as gesturing administrative decentralisation: decision making with regard to council health care planning, mobilisation of funds, human resource management, and control of finances.

The evidence shows that council health management team (CHMT) members assume more responsibility with regard to the council health care personnel. Some of the participants (four out

of nine) said that the CHMTs are now managing transfer of personnel, placing, appraisal and promotions of the council health personnel. Another important observation was that CHMTs were granted authority in the management and control of the council health funds and decision making powers regarding health services planning, design and execution of health interventions. These represent some progress towards administrative decentralisation although the key functional role for the civil services management is centrally controlled.

The effect of administrative decentralisation; it is noted to have aided to reduce bureaucracy in implementing health activities. It was explained that decentralisation has made it easier to implement a set of plans and objectives, because major decisions are currently made by the CHMTs at the council; they do not have to go through the bureaucracy of the MOHW and at the regional secretariat. This is noted to have given districts the opportunity to improve the quality of health services including reproductive health services. With the district health officer (DMO) being an accountable officer with full responsibility and control of health resources to run the council health services, resources are readily available and easy to secure. It was also noted that decentralisation has improved donor coordination, with a comprehensive district health plan, and donors operating in the council, all work together in ensuring what is set out in the plan is achieved:

> ….with decentralisation it has been ease for us (council health management team) to plan and realise council health plans…..if we want to go for supervision we now have our own transport …in the past we shared transport with other departments and it took long process before you could essentially get a car for supervision (CFG, 01).

The council was trying to improve reproductive health service delivery within the decentralised context, but inability to hire qualified staff at the health facility level. HRH allocation is still controlled by civil the service department under the President's office, making it difficult for councils to recruit trained personnel according to their needs. It was found that many health facilities are managed by medical attendants who are not trained to deliver health services, let alone reproductive health services.

A criticism from the council participants about administrative decentralisation was on filing the empty post. They perceive that decentralisation has had a negative impact on distribution of health personnel between urban and rural areas and unfairness in training decisions like prohibiting the use of council funds. It was noted that the council is currently facing a shortage of staff in the health sector. Available data showed that that overall the council has a deficit of 175 (51%) of the required HRH personnel. And the available staff had inadequate skills. The deficit was higher in the lower cadres where 21% of nursing officers and 13% of clinical officers were not available. The council lacks a pharmacist and the position was seconded with unqualified personnel (URT, 2011:6). The shortage is triggered by low output of qualified staff, poor distribution, poor remuneration, poor infrastructure, lack of attractive retention schemes with international migration after training and inter-sectoral movement and/or retraining to other disciplines (Musau et al., 2011). This huge deficit threatens the quality of health services provided to the communities. It was observed that for the past four years the district did not have the services of a gynaecologists and obstetricians. Some of the participants had a view that:

> … I am not against decentralisation, the idea is a good one, but how long does decentralisation take to happen? The process is taking a too long to materialise. There is some reversal of the process in terms of some council personnel … that's one typical example … central authorities claimed decentralisation of the human resource personnel was not the best thing for equitable distribution of health personnel. To date we have had the same crisis of health personnel, especially in rural councils (CKI–03).

Another participant commented on a similar issue:

> … Decentralisation came with changes in programs but they never took into consideration the existing capacity in terms of human resources. They never cared who is going to provide those services. Staffing is a problem as it imposes a heavy workload on the existing staff thereby compromising the quality of services provided (CKI-05).

Repeatedly, concerns of council health managers were related to inadequate competencies of the available health care personnel to provide quality of the RHS. Rarely professionals posted in remote areas hardly stay even for three months. This was stressed by one of the participants:

> …..the problem with decentralisation is it fails to address the problem of human resources for health crisis … the council personnel deficit is about 57%. This implies that existing personnel are overstretched. How we can deliver the quality services? (CKI, 04).

It was also noted that shortage of staff affect facility supervision. When the supervision is carried out, the CHMTs find it difficult to carry out their supervisory roles when they find the clinics are

busy served by one or two personnel. Some assisting the providers with the waiting queue of patients and thereafter do their supervision tasks. This decreases time available for the supervision and time spent with the providers. But, managers expressed the opposite opinion; that health care providers do not appreciate supervision as it is seen as policing activity. One of the participants insisted that:

> …..they do not value supervision at all. They see it as labelling, as the policing – they haven't seen it in a positive way… there is no need to change at all (CKI, 02).

The inability of council to recruits trained and competent personnel has affected the quantity and quality of health services provided. Health care providers argued that more investment in particular on skilled personnel is important to improve service delivery. Evidence indicates that the shortage of skilled staff in health facilities particularly at the dispensaries undermine the quality services provided. Health care providers complained understaffing as a fact and that they regularly work double shifts:

> There is a critical shortage of staff, for example in our dispensary, we are only two, medical attendant, and we have delivery services and other services. We are supposed to take care of all other units in the dispensary such as injection, antenatal care, children, and dressings. It is not easy to provide adequate care (FKI-07).

> Because of staffing shortages we are forced to work every day …..as well we have few trained experts in reproductive health. Really, it is hard work and you are forced to do everything by myself as I am the only trained nurse. It is too much work and you don't even have time to rest… (FKI-09).

> … Most of the clinics lack qualified staff and they are greatly understaffed … I think there is a need for more qualified nurses. Services are provided by attendants who in urban setting are just cleaners. Whom to blame in the case of emergency? Women opt for traditional deliveries rather than at facilities since they know the providers are not qualified. And at dispensaries there is one member of staff who usually takes all responsibility because there is not enough staff. … there is a big staff shortage and I think that makes them incompetent to handle all the responsibilities, from the outpatient to antenatal services (CKI-05).

Providers were unhappy with the quality of services they provide. Some of them complained bitterly over the poor working environment. They did not appreciate the current status of the service. Reproductive health providers at each of the four visited facilities complained about poor infrastructure and supporting services including water and electricity, space in the delivery room, beds in the maternity ward, sanitation and waste disposal facilities, and transport in case of emergency. All this were found to diminish the capacity of health workers to provide women

with safe delivery. Health staff revealed that the working space was too small to cope with any of the relative during delivery, and frequently referred to the lack of supplies including gloves, delivery kits, disinfectants, oxytocin and HIV/AIDS test kits, and family planning injections, chlorine and functioning latrines. The two photos below reflect a delivery room in one of the visited remote health facility (left), compared to another in a semi-rural facility in a council. Privacy and confidentiality of the services were not addressed in most of the facilities. Delivery room in a remote health facility (left) compared to another in a semi-rural facility in a case council. The following response reflects the providers' claims:

> Changing names is not enough, we are seeing new posters are brought from the ministry, this is not our claim. We need to be equipped with enough supplies to provide quality care to women. We don't have wards for post-natal services, delivery beds are of poor quality, water supplies and electricity are not available. All this is important for us to improve the quality of our services (FKI-07, FKI-09, and FKI-10).

Photo 7-1: Conditions in the delivery rooms of some of the facility visited

Source: Field survey, 2011

Communities viewed that health provider as uncaring and not providing quality of care. They felt services provided were inadequate and do not meet their health needs. For some, services were better in the past than present. There were several comments from community members expressing dissatisfaction, as the following narration cemented:

> … … services, like diagnostic services, are not available at our dispensaries … drugs usually are not available. Nurses give us prescriptions and direct you to their drug shops but the medicines … I think they

are stealing the medicine from the facilities and sell to us through their drug shop … there is nothing we can say is changing (C-FGD-03, C-FGD-08).

…..providers are prescribing without giving us drugs discourage many people from seeking formal health care. Spending your money on transport and ending up buying drugs from drug shops does not worth. We better serve time by buying drugs from pharmacies (C-FGD-04).

… Drugs are not available but I wonder why the same provider will direct you where you can buy the same drug from a private pharmacy. The government made a mistake to return to the policy of private provision of health care. Drugs are transferred from public to private hospitals and pharmacies (C-FGD-01).

7.2.2 Implications on council finance

The driving force for fiscal decentralisation is to grant council power over the transferred funds and raise their own revenues to be able to support their budgets including health. However, the findings from the council own sources were inadequate which contributed to less that 3% of the total council health spending. The sources of the council health services funding is through central transfer. And the finding has shown that resources allocated to supports councils' health needs have never been adequate. The government provides a ceiling point which the council's health plan has to budget within that limit. This implies that councils are given boundaries on how much they can budget for. They must abide to the ceiling points because this is one of the criteria for the assessment of their health plans before it is approved by the MoHSW. One participant commented that:

Basically councils might have more health care needs than those planned for. But our resources are constrained, and then there must be a limit on how much can be allocated to councils. MoHSW cannot allow each council to plant without budget ceiling points (NKI, 02).

Central transfers frequently come with delays in the disbursement of funds The CHMT were claimed that the implementation of health service activities sometimes delayed because of the excessive delays over funds from the central government, particularly basket funds:

It happens we receive the first quota of the funding at the time we were supposed to receive the second or the third quota. This affects very much the implementation of health service as some of the planned activities are delayed to start or shifted to following quarter of other the year (FGD, 02)

As well, there are some positive contribution of the fiscal decentralisation including increased autonomy in local resource mobilisation and utilisation, as illustrated by the council health mangers. The following quotations reflect their views:

> With decentralisation council can solicit funds to improve district health delivery. For example last year council held stakeholders meeting to solicit fund to construct council hospital. We secure some funds to start up the construction by 2013 e. The hospital shall reduce the distance barrier (CKI-06).

> council decided to allocate funds to build houses for health workers. We told the councillors if they don't have accommodation facilities for providers, it won't help since it is too remote in some villages with poor housing condition for providers to rent … I know one of the villages built a house for their providers through their own efforts … this is encouraging (CKI-08).

Some of the participants interviewed consider fiscal decentralisation of reproductive health services to be good. However, one of the council health managers expressed the opinion that the preventive and promotive aspects of reproductive health would be better managed centrally:

> Preventive services responsibilities should be re-centralised because out there is direct attention and therefore pull in resources…if you have somebody central that is now responsible for making sure that those programmes are going on and those programmes will go on irrespective of anything else that happens (FKI, 04).

Purchasing of contraceptives should remain centralised for better negations and to guarantee the availability of the service. If decentralised, council may persuaded to divert funds to purchase antibiotics that are needed for urgent use; following the thinking that contraceptives are not life-saving and the patient can come back for it:

> If purchasing of contraceptives left to the council…..they would rather buy antibiotics than to buy Depo Provera because they are in immediate use to serve lives. Whereas somebody comes in for contraceptive, they can still come back without any impact. If someone with fever misses the drugs means s/he is going to die next morning (FKI, 05)

In the community discussions, majority of the participants contended that the effect of the fiscal decentralisation was the introduction of the user while seeking public health care. Others appreciate improvement in health services delivery. The following quotations reflect their views:

> … we really see changes in our healthcare system. Health services are no longer free of charge; we are now paying for the services otherwise you must enrol to the community health insurance fund to access the public health services (C-FGD, 08).

> …I saw some changes related to the way we access services compared to the past. We now have our own facilities at our localities. Services are closer when compared to past, when we used to walk up to 40 kilometres to access health services (C-FGD-01, C-FGD-04).

The community views concluded that poor availability of medicines is a major problem in the health sector, thus, affecting accessibility. The poor quality of services can also explained by the low financial priority given to the health sector. Decentralisation affects local funding availability for health care spending as council own sources have been limited.

Funding for the reproductive health was included within essential health service packages, and inclusion is based on criteria driven by principles of cost effectiveness and disease burden rather than on need. It was found few components of the reproductive health were allocated funds. The assumption is that most of the RHS components such as family planning were funded through vertical program. Thus, CHMT did not allocate funds for the most of the reproductive health interventions. Detailed analysis of RHS funding has been provided in chapter 6.

7.2.3 Implications on local decision making and community participation

Political decentralisation was analysed based on its effects on local decision-making concerning priority setting while allocating resources and community participation. Findings show that some of the health managers did not feel empowered to set priorities according to local needs or to take autonomous management decisions. It was found that involvement of reproductive health coordinators were limited. It was found that observed council reproductive and child health coordinator (RCHCo) hardly participate in the district health planning and priority setting processes. Principally, they are not a member of councils' health planning they are neither represented in the council health planning team (CHPT). They are not invited into full council meetings where the council's health budget is decided. This limits their participation and opportunities to understand what has been approved for the RHS budget. Generally, RCHCo were facing restrictions on influencing priority setting procedures. One of the participants explained:

> RCHCo prepare plans and send them to CHMT to be included in the comprehensive council health plans. The CHMT passes through the suggested plan from RCHCo. Depending on how much money is available, some of the RHS interventions can be included and others will not. Very often, many of the RH interventions that are important like promotional services are not included in the final council health plan. The CHMT favours health plans that are coming from their unit (CKI, 06)..

The involvement of the communities to set their own health priorities was not very limited as the governance structures which are supposed to represent communities were not functioning. When functioning, their roles were to mobilise communities in the enrolment to the CHF than organisation forums for communities to air their voices. Thus, the assumptions that the council health priorities would be a reflection of community needs has not been realised in the case of Tanzania. The established health management structures has failed to facilitate the participation

of the local communities in setting health priorities and decision making related to health. And women who face the most serious reproductive health problems are not well represented in the council deliberations. Hence, decisions on which public health services should receive funding are mainly decided by the CHMTs.

Views about the impact of political decentralisation on RHS some participants appreciate the positive outcome while others criticised the process. There were those who believed that services were improving as communities are their partners in enhancing service delivery. Providers contented that communities were involvement with the patients care before and after discharging from the facilities. Providers encouraged traditional birth attendants to escort pregnant women to the facilities for delivery, especially those who stayed far from the clinics. This kind of participation was taken as a positive impact. The quotation below reflect some of their views:

> …….decentralisation has improved some areas of RHS including reduction of the maternal mortality. Communities are our partners; we encourage them to escort mothers to the facilities than past where women were taken to traditional birth attendants Without community support may be number of maternal deaths could be much higher (CKI-03, CKI-05).

> Some of the community members come and report at the facilities a health problem in their locality. For example, there was a man who used to provide services and was not a medical expert. They report and we followed up and we took the man to court (FKI-06).

> … In the case of women who need ambulance services, one of the community members calls us and asks for help. If we are in a position to help we help. If we don't have fuel we ask them to contribute for their patient to access the hospital (FKI-04).

In some instance providers, think that planning and management of the health service activities is sole responsibilities of health experts. Thus; communities cannot take part during planning process. One of the participants insisted that:

> Some of the health care providers are preoccupied with the idea that community members do not know their health needs and priorities because they are less skilled and knowledgeable about health issues (FKI, 03).

However, some of the providers appreciate the improved physical access to health services that has come with decentralisation. Government's goal of having a facility in each village brings health services closer to the communities:

> I think decentralisation brings services closer to the communities … People are coming in, they are no longer staying home. They are using the facilities more than in the past, when women used to deliver with traditional birth attendants … I can see those who can access the facilities use modern services (FKI-08).

In the community group discussions some members had mixed reactions about the changes in RHS as a result of decentralisation. Some had thought services are not improving, while others were supportive of the changes. Their views depended on the level in which service was accessed. Those who accessed the health centres said there are some improvements but those who accessed the dispensary level claims the service were poor. Those who appreciated the changes related that the improvement also came with the availability of drugs when they visited the facility. Those who complained about the services as only prescriptions were provided without medication. With regard to RHS, some participants claimed that women were charged fees for the ANC cards which were supposed to be free of charge. Some had decided on self-medication using traditional herbs or purchasing drugs from shops without consultations as they trust with the system has varnished. Table 7-6 summarised the views of the participants about the implications of decentralisation on RHS delivery in Tanzania.

7.3.3 Decentralisation and its impact on reproductive health services

In this study, communities were the key judges of the impact of decentralisation in relation to the health services that they have been received from the facilities. In group discussions, community members had mixed reactions about the changes in health services. Some thought they were worse off, while other were supportive of the changes. Their views differed depending on the level of access to care. Those who accessed health centres said there was some improvement, while those who accessed dispensaries claimed poor quality of the services. In many instances, communities referred to the introduction of the fee for service as a major change in service delivery. Those who appreciated the changes related the improvement in the quality of health services with the availability of drugs and the use of the revenues collected through the user fees for the rehabilitation of the facilities. In some villages, residents complained that they only got prescriptions from the facilities. Some participants added that, women were charged fees for the ANC cards. It was added that some of the villagers had decided on self-medication using traditional herbs or purchasing drugs from shops without consultations.

It was observed that all eight focus group discussions mentioned service charging as a major change in health services delivery. Although they appreciated the availability of services like antenatal clinics, they wanted these to be free of charge despite irregularities.

> … we really see changes in our healthcare system. Health services are no longer free of charge, we are now paying for the services (C-FGD, 08).

Other participants appreciated some of the changes:

> To be honest I saw some changes related to the way we access services compared to the past. We now have our own facilities at our localities. Services are closer when compared to past, when we used to walk up to 40 kilometres to access health services (C-FGD-01, C-FGD-04).

> At clinics we receive all the services under one roof unless you need to go for laboratory tests. This makes the services convenient to us. In the past we had a different unit for family planning (C-FGD-03).

There were some divergences in attitudes between health providers and communities. Service providers and facility managers felt that the community was often demanding from them what was beyond their capacities:

> We are just doing what we can within our capacities … the communities thought that we are selling their drugs … We are just workers and other functions are out of our control. For example, drugs stock-outs; we usually place the order at the national medical store, and they just deliver what they deliver without considering our needs. When the clients come and we tell them we don't have stock they think we hide the drugs (C-FGD-11).

Oppositely, communities viewed that health provider were uncaring and not providing quality of care. They felt services provided were not inadequate and do not meet their health needs. For some, services were better in the past than present. There were several comments from community members expressing dissatisfaction, as the following narration cemented:

> We walk long distances to the facilities with someone who is very sick and the providers will tell you go to the hospital. If you asked for the ambulance they will tell you that the ambulance is not there. In most of the clinics you always find that the drugs are not available. In the past drugs were available … we wonder what went wrong (C-FGD-14).

> …......usually the clinics open at eight, but they don't start right away and their closing time depends on who is on the roster that day, some providers turn people home and say the clinic is closed even though it is working hours. Others they close and go to do business at the local markets, as we meet them there (C-FGD-12).

> … some of the services, like diagnostic services, are not available at our dispensaries … drugs usually are not available. Nurses give us prescriptions and direct you to their drug shops but the medicines … I think they are stealing the medicine from the facilities and sell to us through their drug shop … there is nothing we can say – it is changing with regard to service delivery (C-FGD-03, C-FGD-08).

> I think this trend of doctors prescribing medication discourages many people from seeking health care. Spending the whole day and ending up buying drugs? People are buying drugs from the pharmacy without consulting healthcare providers (C-FGD-04).

> … Drugs are not available but I wonder why the same provider will direct you where you can buy the same drug from a private pharmacy. The government made a mistake to return to the policy of private provision of health care. Drugs are transferred from public to private hospitals and pharmacies (C-FGD-01).

In an emergency situation, ambulances were available; however, delays in response hindered the reliability of the services. The concern was to improve access to ambulance services:

> We can wait for an ambulance but in the end they say there is no fuel. Hence the women end up giving birth at home and sometimes if the traditional birth attendants cannot handle the case you hear she died (C-FGD-13).

Despite of the efforts in the expansion of services closer to communities, in some places services were not available. In rural communities, public transport is important to access health facilities. There was a concern about transportation, especially during rainy season, when roads were not passable. This hinders access to healthcare facilities despite having ambulance services. This was noted during discussions with the community group:

> … Most of us who are living in the rural areas have problems with transport, even the ambulance is not coming to our places because of the poor roads. We asked for the government to improve the roads for our communities to be accessible. Sometimes you might have money to hire a private car, but they won't come to places because of poor roads (FKI-05).

> To reach clinics one needs to use transport … and in our area transport is a problem. Our roads are so rough. The mobile clinic comes once per month … all other days, if a woman needs services she has to walk or hire a motor cycle to the nearest clinic. This costs money and some people don't have money and some women decide to walk … others give birth on the road (C-FGD-14).

The quality of services was not impressive, facilities lack basic supplies such as disinfectants gloves, test kits, anti-malaria drugs and some had only one delivery bed in poor conditions. One of women shared her delivery experience:

> I was in a labour room where there was only one nurse. And we were four expecting women and the labour pains started with two of us while the nurse was alone with one delivery bed. She assisted both of us at the same time. I thank God it went well. I don't know how she will manage if the case becomes complicated. Thus, since then I never go for facility delivery (C-FDG-06).

Access to hospital was mentioned to be a problem, especially in case of referral. The council lacks a district hospital; hence referral had to be made at the regional hospital, which is far from the users (75+ km). Community members said they would like to have a hospital closer:

> … we must travel to Dodoma regional hospital in the case of referral … it is better to have a hospital in our location. Transport cost is a problem to many of us … this has made some women opt for home deliveries when referral is given, especially teen mothers during their first birth, which they call a risky pregnancy (C-FGD-11).

There were disagreements regarding the improvement of the quality of services. Those who access health centres said there had been some improvements, while those who access the dispensary claimed services were still of poor quality. The FGDs (eight) agreed that quality had not yet been achieved, despite some improvements. The lack of drugs, test kits and injections were mentioned to affect service utilisation.

Table 7-6: Implications of decentralisation for reproductive health services in Tanzania		
Element of health systems	**Unintended consequences**	**Implication for the RHS**
Financing of services	•Resource allocation based on central transfers accompanied with delays in disbursement • Curative care bias of the council spending not addressed.	• Under funding of preventive reproductive health care; and • Council authority did not invest in RH priority areas such as family planning
Human resources	•Low motivation of health care personnel • More workload increased for the frontline personnel. •Inadequate training and supportive supervision	• Health care providers were unable to meet the RH care needs of the communities and • Quality of RHS adversely affected;
Local participation and accountability	• health committees Local representation for communities in decision-making and health planning was not functioning •Capacities of the health committees to influence health decisions and priorities is limited	• Limited voice from the communities in decisions taken on RHS •Limited voices form the reproductive health coordinator in council priority setting process
Quality of care	•Under funding of RHS, low personnel morale, increase in workload of the health care providers; •Cuts for training; and • Supervision by CHMT is inadequate •	• Negative implications for quality of health drugs, test kit are not available ; • Reproductive health care skills weakened; and • No clinical support for devolved health personnel

Source: Compiled by author

7.5 Chapter discussion and conclusion

The findings presented shows that, to some extent there are some linkages between dimensions of decentralisation process and health services delivery was evident in this chapter. Nevertheless the scarcity of evidence, in this chapter highlights that the numerous potential benefits posed by decentralisation may not always materialise. Interpreting the theoretical concepts of decentralisation into practice; presents a number of challenges to both central and local government levels. In the fulfilment of the ICPD promises in the context of decentralisation is an extra challenge, since the ICPD also necessitates RHS to undergo a particular re-orientation and restructuring.

Since reproductive health is concerned with access to high quality RHS care it is likely for decentralisation to advance these ideas by enhancing decision-making power at local level. In in this chapter it was possible to establish improved access to reproductive health services as a

result of local innovation as well as increased discretion over financing and use of resources at local level. For example, the case of construction of the maternity waiting homes as a result jointly efforts of the council and communities. This provides an opportunity for women to access facility delivery.

Though some of the experiences drawn in this chapter are not specific to reproductive health, it is reasonable to assume that decentralisation has the potential to enhance access to reproductive health services. But, this is only if mechanisms to ensure resource allocation are deliberately established, including improving on human resources and finances redistribution among the key health interventions as identified in national health package for essential service delivery. As well, in advancing the comprehensive package for RHS by expanding the scope of RHS that is defined in NPERCHI into primary health care package that include RH component is important. Allocation of fund to finance that package may be essential to safeguard provision of comprehensive RH at the facilities. The CHMTs are currently facing a challenge of harmonising a comprehensive definition of RH that is identified in national polices into the reality of selective intervention that is implemented at the facilities.

The fact is that reproductive health services have to compete for funding with other health intervention priorities at council level during planning. An excessive advocacy is required to ensure reproductive health issues are retained on the decision-making agenda. In this regard, reproductive health coordinators should be part of the planning team at all levels to ensure RH issues to reach the decision making organs.

Reproductive health indicators of the case council support the Richey (2008) argument that women's reproductive health in Tanzania is a "by-product of the state initiatives towards fulfilling the international agenda and not attempting to intervene in women's health and well-being" (Richey, 2008:12). The ideology attached to reproductive health has always been provision of family planning services to regulate population control than provision of comprehensive packages of RHS as advocated at the ICPD. This was reflected in council

reproductive health indicators mainly focused on safe motherhood initiatives. There is a gap between RHS components specified at policy documents and components available at facilities which compromise the individual choices in particular the long term family planning services.

In Tanzania, decentralisation has impacted on the supply chain of family planning delivery. Following decentralisation, it was found that authority and the roles and responsibilities for supply chain management were not clarified between different levels of government. Thus, facility managers and health management structures did not know who was responsible for overseeing the various supply functions. As well, skilled workers were not available at council and facility levels to manage the contraceptive supply chain. Thus, decentralisations disrupt contraceptive commodities and reduce visibility of family planning in council health plans. Thus contraceptive stock outs were not replaced following decentralisation (Pile and Simbakalia, 2006).

The premise of decentralisation, to make health packages more responsive to local needs and allow a greater sense of local ownership than centralised programmes, is far from the reality in the case of Tanzania. For decentralisation to be responsive to service RH needs, localities must be in a position to express their reproductive health needs directly through community participation or indirectly through councillors and/ or health committees. This is to ensure their RHS needs reach the council health managers during planning and to enhance accountability in service delivery. Additionally, local decision-makers lack reliable health information and knowledge of reproductive health. This impedes their ability to identify interventions that are urgently needed by communities. Thus, the contribution of decentralisation to reproductive health is the improvement of the health system performance that will enhance improvement of the RHS (Leslie et al., 2007), in case of Tanzania it looks like decentralisation has not able to do so.

Some of the participants at the communities expressed their doubts about the effectiveness and outcome of decentralisation. Whether communities could be judges of the health sector

decentralisation, it is fair to consider their opinions which are embedded into their conceptual feelings. This is important to be assessed systematically and critically so that measures can be taken to make daunting communities to cooperate toward making decentralisation policy success. Community willingness to participate through user fees and CHF was seen to be positive with regard to local resource mobilisation. Yet the communities lack control over those funds. This was reflected in the allegations against the CHF and user fee schemes that had failed to complement local health services delivery like purchasing of stocks out supplies. This made the communities to have low trust towards health care providers and health committees.

Basically, the quality of the reproductive health care in the many of the visited facilities in particular dispensaries are of poor quality. Both health providers and health care users experienced poor quality working environments and caring in the health facilities. This has made the women to bypass the primary facilities and to look for the care at higher levels. But the challenge has been to the majority of women who cannot afford even the transport cots to access the higher level services. This finding is similar to other studies which shows that women are not satisfied with the reproductive health services delivery care because of staff attitudes, lack of privacy and high costs for supplies, which women have to bring when delivering in a health facility(Mselle et al., 2013, Kruk et al., 2014, Kruk et al., 2009a, Kruk et al., 2009b, Duysburgh et al., 2013, Nyamtema et al., 2012). Investing in improved quality of care in primary care facilities may improve the efficiency and effectiveness of the health system in providing improved reproductive health services.

As well, the quality of reproductive health services provides also depended on availability of the skilled professionals to deliver the required services. As the case council had a deficit of 50% of the health care personnel it is obvious quality of care is severely compromised. Thus, more trained staff need to be deployed with a focus on expanding coverage in remote and underserved areas. Studies have documented that providing adequate salary and incentive packages attract and retain qualified health staff in rural facilities (Manzi et al., 2012, Djibuti et al., 2008, Gerein et al., 2006, WHO, 2009). Therefore, substantial improvements in reproductive health services in

rural council can be realised through improving health system performance. Addressing shortage of trained health care personnel through professional development including supervision and training could increase provider's self-confidence and self-esteem of and may contribute to retention of skilled professionals (Van Dormael et al., 2008). A review of decentralisation in Asia revealed that decentralisation failed as a result of inadequate training of professionals. This led to negative impact on human and technical skills for reproductive health services delivery (McIntyre and Klugman, 2003).

In Philippines by Lakshminarayanan's study in 2003 found that, following decentralisation local governments did not prioritise reproductive health hence decrease financial resources for the services. Local government were not prepared to deliver family planning. While contraceptives were provided by the central government; some of the local government denied family planning services due to religious beliefs. Furthermore, the poorest local government authorities suffered severely because of decentralisation. This was caused by inadequate finance resources allocated and their restricted ability to generate own income. Thus, economically better-off local authorities achieve better the increased responsibilities brought by decentralisation. While the poor local authorities were constrained by the new added demands of decentralisation (Lakshminarayanan, 2003b). Thus, there were different levels of RHS delivery among local authorities which adversely affected health equity. In Mexico, states health managers did not improve FP service provision and contraceptives as a priority (Beith et al., 2006). Many states did not allocate funds for the family planning commodities due to lack of commitments.

In conclusion, health sector decentralisation was designed to improve quality of the health service delivery, including reproductive health. However in this chapter, findings have shown that decentralisation do not always achieve its stated theoretical benefits. Service organisation reform has proved to be a failure when is implemented without prior training of the local government officials and health care providers. This slow implementation of the key reform components such as involving communities in identifying their health needs. The study calls for

understanding of the health sector decentralisation as a basic ingredient for the successful implementation.

Abbreviations for Chapter 8

CHMTs	Council health management teams
DPs	Development partners
HFCs	Health facility committees
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
ICPD	International Conference on Population and Development
LGAs	Local government authorities
MoHSW	Ministry of Health and Social Welfare
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PO-PSM	President's Office – Public Services Management
MoFEA	Ministry of Finance and Economic Affairs
RHMT	Regional Health Management Team
RH	Reproductive health
RHS	Reproductive health services
URT	United Republic of Tanzania
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organisation

CHAPTER 8

SUMMARY AND CONCLUSIONS

8.1 Introduction

This chapter provides an overview of the main points that have emerged from the research. The trend towards health sector decentralisation in Tanzania has been supported by donors as a key strategy to break the tendency of the central control on local public service provision, and as a response towards the neoliberal economic policies that encourage health system reforms since the 1980s. In Tanzania, the decentralisation of government/ public sector has led to the decentralisation of health service, with the aim of bringing greater efficiency in health care delivery. The national decentralisation policy of 1998 proposed significant institutional changes to support decentralisation changes which were expected to transfer fiscal and administrative powers to locally accountable local government authorities (LGAs) that could be sanctioned by the communities.

The aim of this study was to analyse the impact of the three dimensions of decentralisation on reproductive health services (RHS). The assumptions made were that (i) higher autonomy of LGAs in decision-making on council resources led to a better match of resources and local needs, and (ii) better matching of local health needs and local public spending increase accountability and hence improves RHS delivery. The findings in this thesis show that decentralisation is progressing, but not according to its vision. It was found out LGAs have limited local autonomy over fiscal and human resources. The thesis argues that all the three dimensions of decentralisation, that is, political, fiscal and administrative powers are essential for the successful implementation of decentralisation. Thus, in judging the impact of decentralisation LGAs should practice the assumed decentralised power.

The decentralised power was measured using a modified decision space (Table 8-1). The results indicate that the Tanzanian health sector is more centrally managed which limits the LGAs

decision space on the devolved functions. The allocations for financial resources and management of human resources are centrally controlled which resulted in no decision space for the decentralised agents (LGAs). Narrow decision space was created in the service organisation functions like priority setting process, with limited decision space created health governance.

The current trend of decentralisation in Tanzania reveals that, while the key responsibilities for health care delivery has shifted from the central Ministry of Health and Social Welfare to the LGAs and further to the health facilities, it has been done with limited transfer of administrative, and fiscal authority. This propose Tanzania is implementing a deconcentration form of decentralisation than the advocated for devolution, as the transfer of responsibilities of decision-making in the key functional areas has remained mostly centralised. Thus, the benefits of decentralisation like improved reproductive health outcomes are likely to be limited. This is elaborated in the next section which presents summaries of the key findings on the current status of the health sector decentralisation in Tanzania. Further analysis was carried out to see how decentralisation has impacted on the delivery of health services including reproductive health.

8.2 How much power has transferred to local government authorities?

The decision on what model of decentralisation the health sector should adopt depends on the country's contextual issues, objectives, political vision and the actual needs of the citizens. In defining the form of decentralisation which is found in practice, the key question is, who has more choices over the decentralised functions (Bossert, 2004). Is it the council health managers, or facility managers or services users? How much choice do they have/ how big is the decision space? Basically, the form of decentralisation found in practice influence decision space found at the level of implementation and therefore how LGAs can deliver their roles (Mills, 1990). For real decentralisation to be realised decentralised "functions are supposed to be performed by the council itself" and not otherwise (Mills, 1990:11).

Decentralisation basically implies expansion of local choices. Decision space defines various functions and activities in which LGAs have increased their choice through decentralisation. Table (8-1) presents a matrix map of decision space over devolved health functions. The vertical axis represents a series of functional areas in which expanded choice can occur and the horizontal axis represents an estimate of the range of choices or discretions, which are defined as narrow, moderate or wide for a given function. The assumption of decision space is that performance of LGAs in executing new functions depends on decision space open for each function. Thus, decision space is used to analyse three important elements of decentralisation, namely, (i) amount of choice transferred from central government to LGAs, (ii) decisions local officials make with their increased choices and (iii) the effects of the choices on the performance of the health system (Bossert, 1998).

Tanzania's health sector decentralisation policy is based on a public administrative approach that adopts four different forms of decentralisation: de-concentration, delegation, devolution and privatisation. In each forms of decentralisation significant authority and responsibilities remain at the national government. In some cases, a shift from less to more radical forms of decentralisation redefines the functional responsibilities in a way that the CG level retains policy making and monitoring roles and the LGAs advance operational responsibility and management.

A number of policy reform initiatives were undertaken by the government to improve health system performance. The current decentralisation policy was guided by sector devolution after the adoption of local government reform paper in 1998. The findings show that, at the very least, decentralisation has taken place although the LGAs power over the key functions for service delivery is limited. The deconcentrated system usually restricts decision space for the LGAs. The results suggest that the current decentralisation reforms do not fit well to the evaluation criteria of the well-designed decentralisation systems. Thus, the most important question is whether such limited decision space can produce the intended benefits of decentralisation of improving health outcomes such as reproductive health. The sections presented below summarise the key findings

from the documentary review, council key informant interview and community discussion about how much did they feel they had over decentralised functions.

Table 8-1: Decision space of Council decentralised functions

		Range of choices		
		Narrow	**Moderate**	**Wide**
Function	**No choice**			
Finance				
Source of revenues	CHMT and facilities depend entirely on central transfers	√		
Allocation expenditures	High % earmarked by MoHSW & MoFEA	√		
Income from the fees	Determine by legislation but the CHMT has power to set the fee prices according to their local context		√	
Human resources				
Salaries	Determine by PO-PSM	√		
Contracts	Determine by PO-PSM except for the lower cradles of personnel	√		
Civil services	Determine by PO-PSM	√		
Health governance				
Management structures -health boards and committees	Defined by legislation	√		
Community participation and accountability	Size and composition of the boards and committees are defined by the legislation	√		
Prioritisation of service	Centrally defined priority services		√	
Service package	Basic service package is centrally defined by the MoHSW but Flexibility is allowed to add local priority			

Source: Field survey, 2011.

8.2.1 Fiscal decentralisation and council health care delivery

The local government policy paper of 1998 states clearly that the goals fiscal decentralisation in Tanzania based on a definition of the principles of financial discretionary powers that gives authority to LGAs to raise local revenues, and that the central government has an obligation to supply LGAs with sufficient unconditional grants (URT, 1998a). However, the findings demonstrate that council do not sufficient and consistent own sources of revenues that could be used to support the delivery of reproductive health services. At current, LGAs are not permitted to have substantial own sources of revenues as well as autonomy to determine their health

expenditures. The permitted sources of revenue in particular rural councils cannot contribute significantly to supporting health service delivery (Masaki, 2015).

The evidence presented in chapter 6 revealed that there are some benefits of decentralisation, including increasing accessibility of central resources through intergovernmental transfer. The LGAs are often financially incapable of providing basic public services without support from the central government (Masaki, 2013). Thus, central transfer has improved the capacity of the LGAs to provide quality public services to their citizens (Caldeira and Rota-Graziosi 2014). In Tanzania LGAs own resources are less than 10% of the total spending which is insufficient to support public services delivery including health care. Under this condition, central transfer is important to provide quality public services. However, the challenge is that CG funding has been mainly for the personnel emoluments based on available number of staff employed in each LGA. This has led to very unequal resource allocation among councils as urban LGAs receive higher level of funding since they can attract more personnel than rural councils which also have high turnover of health care personnel (Sikika, 2010).

The current challenge to fiscal decentralisation make the LGAs health services entirely depend on inter-governmental transfer. These grants are inadequate to support local health needs and priorities. Councils are given budget conditions, including a ceiling point on the allocation of the health budget. Usually, central government delays to disburse the funds which make it difficult for LGAs to provide adequate health service on time. Such delays are partly attributed to the late submission of the LGAs technical and financial reports to donors before the realising of funds (PMO-RALG, 2008). At the facility level, no financial information exists and managers cannot speak about their budget. Similar findings have been noted in other studies in Tanzania which found that councils depend on central government grants for more than 90% of their budgets and that such grants are accompanied by strict and conditional guidelines, directives and instructions (Mollel, 2010, Frumence et al., 2014a, Venugopal and Yilmaz, 2010, Kessy and McCourt, 2010, Tidemand and Sola, 2010b).

The case of Tanzania is similar to other studies that have been carried in Africa. In Africa, most LGAs are highly dependent on financial support from the CG to perform their day-to-day activities including administrative and public service delivery (Masaki, 2013). Gideon and Alouis (2013: 234) highlight that “over reliance on external revenue sources increases the supremacy of the central government on local authority, reducing them to mere talking shops without finance to implement their decisions’ A study from the United Nations on fiscal decentralisation in Africa shares a similar view:

> The financial dependence of the Local authorities upon the centre...breeds an unhealthy reliance upon the government, forcing local authorities to look to the centre for advice and direction even on the smallest matters. It reverses the direction of accountability, making local authorities less responsive to the demands of their paymasters (United Nations Human Settlements Programme 2002, 6)

A study in Uganda found that, central government transferred insufficient funds for the districts to implement their health plans. At the same time districts lacked reliable local sources to generate resources to support the execution of the health plans (Jeppsson, 2001). A study carried out in Ghana on the barriers to the implementation of the health sector administrative decentralisation found out that the lack of adequate financial resources was the main challenge facing health decentralisation (Sakyi et al., 2011).

In other circumstances fiscal decentralisation has seen improving equity in the allocation of the healthcare funds (Bossert et al., 2003a, Bossert et al., 2003b, Bossert and Beauvais, 2002, Bossert and Mitchell, 2011). Faguet (2004) analysed the fiscal decentralisation reform in Bolivia in 1994. The findings show that decentralisation doubled the share of public revenues allocated to municipalities and expanded their expenditure responsibilities. In addition; decentralisation was associated with a high increase in local public investment in education and health. These investments were more responsive to the local needs (Faguet, 2004). Similarly, Kis-Katos& Sjahrir (2014) found that expenditure decentralisation to sub-governments in Indonesia has led to higher investments in public infrastructures in districts with lower levels of infrastructure. After decentralisation, large parts of education, health, and infrastructure exclusively became the obligation of the local authorities hence they started to invest more in these sectors (Kis-Katos

and Suharnoko Sjahrir, 2014). These results support the Oates (1972) and Besley & Coate (2003) arguments that suggest there are some opportunities from decentralisation.

In Tanzania fiscal decentralisation changes are targeted to improve equity in resource allocation by using a formula-based allocation for the recurrent grant and the local government capital development grant (LGCDG) (MoFEA, 2010). The ineffectiveness use of the formula was due more to its population criteria than the health needs. For instance, the population of a council has a weight of 70% in the formula for allocation of health sector block grant, (MoFEA, 2013b). As populations are not always homogenous, health needs differ from one locality to another. The efficiency use of the formula can be improved if the health needs of the localities could be included. One of the health manager participants insisted that:

> … Despite use of the formula, some LGAs are disadvantageous due to its geographical location and population. Having small population doesn't mean health needs are less. It's better to allocate resources according to the needs than population criteria (CKI-04).

A study on the use of the formula-based allocation of resources carried by Ministry of Finance (2013) in Tanzania shows that its use has been declined considerably. The mention reason is that, the formula is not well-known at the council level and does not reflect a rational and equitable allocation of resources. Another country study conducted by Sikika (2011) in 122 councils revealed that formula allocation for the health resources has not been applied efficiently. Furthermore, formula allocation of drugs to the health facilities has not been used. Facilities with a large numbers of clients received relatively fewer resources for drugs compared to those with smaller numbers of clients Another study done conducted by the National Audit Office on the application of the formula to the health sector revealed inefficiencies on its use. The formula fails to link to the actual workload or performance of each health facility or local burden of disease (BoD) or poverty indicators (URT, 2008b). Likewise the study conducted by Policy Forum in (2010), found out that allocation formula has not consistently been applied in the allocation of the health resources. This led to inequities in health funds allocation among the LGAs (PF, 2010, MoFEA, 2010).

Another challenge for the decentralisation is the untimely disbursement of funds from the CG and insufficient funds limiting LGAs' capacity to provide adequate public services. The same claim has been made by other country studies including (Frumence et al., 2012, Frumence et al., 2014a, Tidemand and Sola, 2010b, Per-Tidemand and Jamal, 2010). Likewise in Ghana, Kojo (2011) study observed that lack of adequate financial resources was among of the challenges to the effective implementation of the health sector decentralisation. In Uganda, Jeppsson and Okuonzi (2002) found that central government transferred insufficient funds to the districts to implement the health responsibilities that had been transferred to them, while the districts did not have adequate and reliable local sources to generate additional resources to support the execution of health services.

In Tanzania funding for the RHS is funded within the general public funding for primary health care services. The analysis of the policy documents shows that RHS is stated as a priority both at national and council levels. Yet, the proportional of national budget that is allocated for RHS has constantly remained at average of 1% of the total health expenditure in the FY 2011/12 (Mungure and Owaga, 2014). This limited number of RHS that are provided at the facilities. The council shows clearly that unmet needs for families were not addressed as many of the facilities could only offer limited services like dispensing pills. Women's preference was on injections and implants which were available during outreach services through mobile clinics. In summary two main factors influence the utilisation of the available RHS: namely that service users do not trust the reproductive health care providers due to in-competencies, and the quality of the services provided.

Inadequate funding impacted on the general supplies of the drugs and other commodities like test kits among others. There were community complains about persistent shortage of drugs and supplies have been reported from the facilities. Facility managers criticised the collection of funds through user fees. In addition community health insurance schemes are not well utilised to improve health services. They complained that that they did not have the power to utilise the funds they collected according to facility priority needs. This discouraged them as they are the ones who are collecting the money from the services users and which are then sent to the council headquarters. When funds are needed to address facility problems, the providers fail to retrieve

them back because of the bureaucratic procedures. This is similar to the previous studies that have been conducted in Tanzania which found that facility managers failed to retrieve back locally collected funds (Nanda et al., 2005, Frumence et al., 2014b). Therefore, fiscal decentralisation does not make sense where own-source revenue generation cannot fill the resource gap.

In addition, the budget allocated to the sector has remained below the 15% of target of the Abuja declaration. According to Society for International Development (SID) report on health care spending for the East African countries published in 2012, Tanzania lags behind other East African countries. Rwanda ranked number one with US$ 48 spent on health care per capita, whilst Uganda was the second highest with a per capita healthcare expenditure of US$43, followed by Kenya with $33, Tanzania fourth with US$25 and Burundi last with US$20 per capita health spending in 2009 (SID, 2012).

8.2.2 Administrative decentralisation and health care delivery

The intention of the administrative decentralisation in Tanzania is to de-link local authority human resources from their respective ministries and directly work under LGAs. This implies that LGAs are granted power to recruit their own personnel who will be accountable to the local residents, which at the end improve service delivery (URT, 1998a). It is assumed that by giving LGAs power to recruit, LGAs will ensure sufficient availability of competent staff according to their human resource demands.

The case of Tanzania shows that, the role of recruitment, distribution and remuneration of the skilled health personnel is centrally organised, leaving LGAs with a very narrow choice to employ and reward health care personnel. This is similar to Bossert and Beauvais (2002) who found that, LGAs in many developing countries have little or no control over human resource management (Bossert and Beauvais, 2002). Usually, CG practices restrictive policies by setting ceilings for central funding over LGAs personnel. This can be interpreted as part of government's restructuring macroeconomic policies. The study on the decentralisation-

centralisation dilemma and its implications on recruitment and distribution of health workers in remote districts of Tanzania; found that neither centralisation nor decentralisation of the human resources recruitment process has aided the LGAs to secure highly qualified health workers (Munga et al., 2009). But, the centralisation of the human resource for health (HRH) denies LGAs administrative power and authority that have transferred under devolution. LGAs have remained with a narrow choice over human resource management functions.

The issue of human resources issue has emerged as a barrier to the decentralisation process in various forms including lack and inadequate of the qualified personnel and lack of incentives to motivate council health workers. This findings confirmed by other country studies that has identified several factors that demotivate health workers in the implementation of the (Manzi et al., 2012, Munga and Maestad, 2009b, Munga et al., 2009, Sirili et al., 2014). A critical shortage of the skilled health personnel over the years together with the failure to fill established posts pleads the question of whether LGAs are in position to realise the benefits of decentralisation (Ramji, 2009). Lack of locally generated resources restricts local hiring as LGAs failed to hire to low skilled personnel. As well, Bartley and Labri, (2004) and Mills et al., (2001) have questioned the capacity of human resources available in the health sector to implement decentralisation.

Inadequate HRH affects other supporting services include supportive supervisor. Supervision was limited within the council and from the regional levels. Regional heath managers did not conduct supportive supervision to CHMTs. Likewise; the CHMTs are not conducting facility supervision, which is contrary to service delivery guidelines. Inadequate human and funding resources are the mentioned for poor supervision. This has been noted in other studies in Tanzania (Munga et al., 2009, Manzi et al., 2012, Mæstad, 2006)

8.2.3 Political decentralisation and community participation

Community participation has long been advocated as part of decentralisation in Tanzania (URT, 1998). The deconcentration form did not provide mechanisms for community participation. Each health care facility is supposed to have a health committee which has limited influence over key health care delivery decisions. The facility managers, not local communities usually, appoint members of the committees, thus, members are accountable to the managers (Boon, 2008, Kessy et al., 2008). Legislation empowers the committee's decision space over management of the health facility including planning, maintenance and repair of the facility to ensure that the health service delivery is of good quality (URT, 2001a). This gives the committees some degree of influence over the decisions that are made at each health facility

However, the current position of the health sector decentralisation has not flowed to expand community participation. There are mixed views about community participation through service user's committees. In many instances, participation is used as a means to mobilise resources from the services. Community participation in managing service delivery through health committees is very limited as other country studies confirmed (Frumence et al., 2012, Molel, 2010, Shayo et al., 2013). On other had the level and value of community participation through committees is questioned matter (Boon, 2008). As the result of the above limitations, community participation is hardly strengthened accountability with regard to provision of comprehensive reproductive health services. Similar findings were noted in community studies in Asia which found that limited gains has been achieved with regard to reproductive health service accountability.(Murthy et al., 2005, Murthy and Klugman, 2004)

The practice shows that the CHMT members are more active in health service planning, thus dominating the process with limited involvement from health care providers, communities or their representatives. Studies on decentralisation and the health care prioritisation process in Tanzania (Maluka et al., 2011, Chitama et al., 2011) jointly reported that health experts have a tendency to dominate priority settings for the council, making it difficult for management structures like HFCs and CHSB to make them accountable. Some of the country studies has found out that that most of the community members or their representatives, particularly in the

rural areas, cannot participate fully in the planning and prioritisation of the process at the grassroots because they lack formal training in planning skills and knowledge (Odd-Helge et al., 2010, Massoi and Norman, 2009). The findings from the current study has also noted that communities members had a view that health plans and prioritisation demands people with a professional skills to be able to participate in the process. However, this is contrary to what political decentralisation which advocated for the community participation in planning the matters that affect their lives including health (MoH, 1994).

However, there are some benefits of community participation in designing and assessing of primary health care is an ingredient for the successful implementation of health programmes (Preston et al., 2010, Gilson et al., 1994). But capacity building at all levels by equipping health care providers and service users with planning skills and knowledge, participation is important for its efficiency otherwise it will remained a vague process under decentralisation (Kilewo and Frumence, 2015). Otherwise, health care providers at the facilities and communities shall remain with a narrow choice in terms of making priorities and plans on health care services. More efforts has to be made to enhance the performance of the existing management structures for them to full participate fully in district health programmes (Mubyazi et al., 2007).

As national level priorities are council level priorities pointed to conclude that the thrust of activities at the council level is about building capacity to implement national priorities rather that selecting local driven priorities. This finding is similar to other country studies which found a number of shortfalls in the council's priority setting processes and criteria lead to inefficient and unfair priority setting decisions in RHS (Chitama et al., 2011, Maluka et al., 2010b, Mubyazi et al., 2007). In Ghana, Mayhew (2003) found that reproductive health was mentioned to be a priority at both the national and district levels but national level sets priorities and districts implement (Mayhew, 2003) . Thus, the health care priorities were not emanated from the districts per ser.

Nonetheless, the findings support the argument that states each dimension of decentralisation individually is very pertinent in its effect on healthcare service delivery. Furthermore, there is trust that inter-connections between two decentralisation dimensions generate more benefits for improving access to health services than one dimension. Thus, it looks as if those governments that are not applying all three dimensions comprehensively during the design of decentralisation reform would lose some of the prospects that decentralisation can offer with regard to the improvement of access to basic services such as health care. Admitting each individual dimension of decentralisation has its own impact on healthcare delivery, the following section summarises the findings on LGA discretionary power over revenue sources and expenditure (fiscal decentralisation); management of human resources (administrative decentralisation); and community participation and accountability and their impact on service delivery (political decentralisation).

8.2.4 Implications of decentralisation on reproductive health outcomes

Does decentralisation have resulted into health gains in particular reproductive health? The findings in this study observed that decentralisation is a complex process which is associated with several issues including local capacities. Decentralisation implementation in the case council did not show impressive changes in the health services indicators including outpatient's services among others. However, the implementation progress in priority health care services including safe motherhood, family planning, facility delivery, family planning in terms of centrally defined priorities through national essential health package.

The analysis of the data from 2008 to 2010 of the case council showed an increase trend of reproductive health service indicators (see table 8.2). The achievement could be attributed by both government and donor efforts to safe motherhood priorities. Linking decentralisation and its impact on reproductive health services was difficult as the improved RHS depends on several factors, including function of the basic supportive services at different levels of the health systems such as referral systems, quality of services, availability of commodities and supplies; available among others.

Table 8-2: Council health indicators			
Health Indicators	**2008**	**2009**	**2010**
Outpatient attendances (persons attending) (in %)	68%	73%	72.1%
ANC new attendance rate (in %)	61	70.1	72
ANC clients receiving Tetanus (%)	96.3%	98.6%	95.3%
Proportion of births attended at health facility	74%	79.4%	81%
Community delivery	6.1%	11%	6.2%
Proportion of FSB among reported births (in %)	0.1	0.05	2.2
Caesarean Sections per expected births (in %)	0	0	0
Number of maternal death per year (give full number)	3	2	4
Number of TB cases diagnosed in the last 12 months	285	225	211
Proportion of TB patient offered HIV testing	0.4	0.3	0.2
Proportion of People living with HIV screened for TB		0.6	0.7
Proportion of under 5 deaths due to malaria	0.01	0.01	0.01
Severe malnutrition rate (in %)	3%	2.3%	1.1%
Moderate malnutrition rate (in %)	20%	14.1%	14%
Proportion of low birth weight (in %)	1.4%	0.9%	0.7%
No. of PLHIV cases recorded	0	0	463
No of PLHIV patients on ARVs	0	0	201
HIV Prevalence among Pregnant women (PMTCT)	3.3	0.9	3.7
Prevalence of HIV among people tested through VCT	3.3	2.9	2.8

Source: Council District Primary Health Care reports of 2008, 2009 and 2010.

Inadequate financial and human resources were obstacles to council health service delivery. In this study council capacity was negligible; most of the health care funding came from central government and was not enough to fund all activities. In addition, central transfers, come with directives which hinder local autonomy. Funding for supervision and training was not made available and this compromises the quality of the service given. As well limited availability of data on reproductive health indicators has made impossible to analyse changing in RH indicators over time before and after decentralisation. It was noted that, context in which decentralisation and other policies is being introduced effects the ability of Councils to respond to the demands of a decentralised health services. This in turn seems to impact on the implementation of reproductive health policies and the outcomes for reproductive health. The findings illustrate the difficulties of attribution of the decentralisation on reproductive health outcomes. There is some insight into factors requiring consideration before and during implementation if there is to be a positive outcome from policy changes.

8.3 Conclusion of the study

Despite its limitations in terms of scope and depth, the findings of this study articulate several significant challenges to the current practice of health sector decentralisation and its impact on reproductive health service delivery. The main lesson of this study is that, implementation of changes resulting from the decentralisation policy, is likely to meet resistance from individuals and groups that have benefited from the centralised system. This means that the involvement of those who are likely to oppose the policy during designing is important. In Tanzania it has been very clearly there is more resistance from the central authorities to let decentralisation to pin down to the councils and then to the communities. Decentralisation involves significant changes in fiscal, administrative and political powers.

In the process of change, the following points are stressed by the study:

(i) Consultation during the policy processes is crucial

Decentralisation is hampered by the perception gap between the policy makers, service providers and services users. Policy makers recognised that decentralisation grants council more power over finances, i.e. improving local mobilisation and control of resources, and service providers believe that decentralisation has not improved their autonomy, while on the other hand, service users perceive that health services have not improved. The information gap is due partly to poor dissemination of central policies to all levels.

Extensive policy consultation is important and should be done at all levels across government, within health sector departments, with health sector staff and with local actors. The decision space of health sector decentralisation has to be monitored. A monitoring system of the impact of health sector decentralisation has to be set up, consisting of a network of institutions co-ordinated by the MoHSW and PMO-RALG and using input, output and outcome indicators, operating over the short term to the long term. This enables a process of learning in the implementation process.

(i) Inter-sectoral coordination

Decentralisation policy was developed and coordinated by the PMO-RALG but its implementation needs collaboration with other government institutions (MoHSW, PMO-RALG, MoFEA and PO-PSM) and LGAs. Communication of policy from central and line ministries to council is needed. Weak coordination between the central agencies and the councils has been observed to affect decentralisation implementation. A lack of consensus among the government agencies has been noticed in staffing and recruitment processes. For example, the PMO-RALG can recruit the DMO, similar to the MoHSW. Thus consensus and coordination between all responsible institutions are important in identifying common challenges, resolutions and actions.

Likewise, inconsistent timing of fund disbursements was partly caused by poor coordination and communication between the MoHSW, PMO-RALG, MoFEA and the councils. The council health managers often face situations where there are no funds to carry out planned activities for up to three months. This has an impact on the quality of health service delivery. However, improvement can be done to inter-sectoral collaboration through action learning, facilitated by the MoHSW and PMO-RALG.

(ii) Capacity

At policy level, the capacity of the key actors including ministries and agencies should be enhanced to have in-depth knowledge of the concept of decentralisation to facilitate its implementation and monitoring. At the implementation level, most key actors, in particular healthcare providers, have limited information on the on-going decentralisation reforms. As a result there were no significant changes in the ability of health personnel to relate service delivery to that of decentralisation. These constraints are in turn the result of the several factors. The government's own assessment of the successes and challenges regarding the implementation of decentralisation is instructive. It states in part that:

> Notable progress has been made in increasing the profile of D by D in government, best illustrated by the implementation of the strategy through the national planning and budgeting system beginning in 2007. Related activities in that direction include support for the Local Government Development Grant system, on-going restructuring and capacity building initiatives for LGAs and PMO-RALG. Implementation of D by D has, however, faced a few challenges mostly in the form of lack of progress on human resource decentralisation, incomplete legal harmonisation across sectors, LGAs revenue assignments and persistent governing by directives from the central government. It can therefore be concluded that the strategy to institutionalise D by D in the government was not adequately embedded across Ministries, Departments

> and Agencies and LGAs due to a number of reasons including lack of knowledge on vision, reluctance and fear of devolution and policy and legislative bottlenecks' (URT, 2008:10).

From the above statement, it appears that there are number of issues the government needs to address. These include harmonisation between the laws governing LGAs and CG governing by directives; and incomplete fiscal and human resource decentralisation. Critically, government should at the persistent denial of the central ministries and agencies to the vision of D by D.

(iii) Community participation and accountability

Community participation, both in the management and planning of healthcare services, is an important aspect of decentralisation. The case of health sector decentralisation has failed to create a participatory environment at the lower levels. The process is vague, health governance structures are disconnected from the community, and hence community voices do not reach the policy planning level. The case of the health sector shows that decentralisation has failed to bridge the gap between discretion and accountability. The findings show that the nature of accountability is more often upward towards the government than to the service users. The initiatives to strengthen service users' voices and participation ostensibly failed to open up space for service users' communities to monitor the provider's performance and provide feedback for better service delivery.

While the government has created a number of policies, guidelines and laws, the staff at the lower levels within the health system often is not aware of them. This was reflected in the answers to the first research question, which showed that a significant number of participants at the lower levels had failed to spot decentralisation policy goals. Participants recommended mass awareness about government policies, including decentralisation. If the providers and service users do not understand decentralisation, effective organisation and advocacy are a challenge. Communities do not know that they have a right to ask for better quality health services as well as the right to challenge unethical practices. They just feel comfortable with what is given to them since they do not have other options. For example, the findings have shown that it is common for providers to charge delivery fee for free services. Although the communities know

the practice is unethical, they do not believe that they have right to complain. Despite of those challenges that have been argued to be obstructing effective service delivery in Tanzania and in consideration of the benefits of decentralisation, the study concludes that, if such challenges could be addressed, decentralisation has possibilities for improving health services delivery. Attaining capacities and accountability would lead to the effective implementation of decentralisation and efficient service delivery. Thus, RHS can only progress if the entire health system improves.This study suggests that there is a need to draw lessons from existing initiatives in the area of community participation. In this study, some participants, in particular service users, were against the prioritisation of reproductive health needs. The argument put forward was that health needs need technical expertise, which they do not have. However, more studies are needed to find out what service users think about their participation in health-related activities, including the prioritisation of health needs.

Generally, the findings in this thesis show that decentralisation is progressing, but not according to its vision. There are two substantial constraints on LGAs autonomy that remain unsettled. Firstly, there is the persistent influence of central government's on local affairs through the regional structures. Secondly, there is council's greater dependence on central revenues with limited capacity to raise their own local revenue. The dependency on central government makes local authorities to lack motivation to collect their own revenues, and even when they collect there are no local accountability measures and this creates a sense of dilemma among the citizens who end up blaming the central government which is very far from them and having no clear grounds to make local leaders accountable. The central governments use their fiscal strength to influence decisions at the local level. This led to discrepancies between the decentralised functions stipulated in the policy and what has been implemented. Decentralisation has not matched with changes in the processes, guidelines and attitudes of central and local actors that would facilitate the implementation. While the role of CG is supposed to be limited to policy making, regulation, monitoring and quality assurance, (URT, 1998; 2008a; 2009), in practice there is a degree of central government involvement in LGAs' affairs (Kessy and McCourt, 2010; Venugopal and Yilmaz, 2010). This mirrors what Blair (2001:120) alludes to as 'distributed institutional monopoly' where CG decentralises authorities and responsibilities for

certain functions, but maintains control in the form of deconcentration or delegation. This hinders the benefit of decentralisation.

The study suggests that improving mechanisms through which policy makers and service providers could be held more accountable would lead to improved health service delivery. In the case of the health sector it is important to recognise that devolution, which is seen as a more democratic form of decentralisation, may not improve health system performance more than other forms, like deconcentration or delegation. Devolution may enhance responsiveness to local preferences more than deconcentration or delegation. However, deconcentration and/or delegation may be more responsive to the overall health sector priorities set by the national government. From the perspective of health system performance, policy makers therefore should critically consider the advantages and disadvantages of each form of decentralisation, i.e. fiscal, political or administrative or some combination that is best positioned to improve health system performance and ultimately improve health service delivery including reproductive health.

Bibliography

Books, Book Chapters, Journal Articles and Research Reports

AGYEPONG, I. A. 1999. Reforming health service delivery at district level in Ghana: the perspective of a district medical officer. Health Policy Plan, 14, 59-69.

AGYEPONG, I. A. & ADJEI, S. 2008. Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. Health Policy and Planning, 23, 150-160.

AHMAD, J., DEVARAJAN, S., KHEMANI, S. & SHAH, S. 2005. Decentralisation and service delivery. Washington, DC: World Bank Policy Research Working Paper 3603 May

AITKEN, I. 1998. Decentralization and Reproductive Health. Boston: Dept. of Population and International Health, Harvard School of Public Health.

AITKEN, I. W. 1999. Implementation and Integration of Reproductive Health Services in a Decentralized System. In: KOLEHMAINEN-AITKEN, R.-L. (ed.) Myths and realities about the decentralization of health systems. Boston, Mass: Management Science for Health.

AKIN, J. S., HUTCHINSON, P. L. & STRUMPT, K. 2004. Decentralization and Government Provision of Public and Private Goods: The Public Health Sector in Uganda. Journal of Development Studies.

ANDERSON, J. E. 2006. Public policymaking: an introduction, Boston, Mass., Houghton Mifflin.

AVELINO, G., BARBERIA, L. G. & BIDERMAN, C. 2013. Governance in managing public health resources in Brazilian municipalities. Health Policy and Planning.

AYUK, E. & MAROUA, M. A. 2007. The Policy Paradox in Africa: Strengthening Links Between Economic Research. Ottawa Africa World Press Inc and International Development Research Centre.

AZFAR, O., KÄHKÖNEN, S., LANYI, A., MEAGHER, P. & RUTHERFORD, D. 1999. Decentralisation, governance and public service the impact of institutional arrangements: A review of the Literature. IRIS Centre, University of Maryland, College Park.

BAHL, R., HEREDIA-ORTIZ, E., MARTINEZ-VAZQUEZ, J. & RIDER, M. 2005. India: Fiscal Condition of the States, International Experience, and Options for Reform. International Centre for Public Policy Working Paper Series, at AYSPS, GSU paper05142, International Centre for Public Policy, Andrew Young School of Policy Studies, Georgia State University.

BAKER, C. 1996. The health care policy process, London Sage.

BALTACI, M. & YILMAZ, S. 2006. Keeping an Eye on Subnational Governments. Internal Control and Audit at Local Levels. Washington DC: World Bank Institute Working paper 37257. World Bank.

BARDHAN, P. 2002. Decentralization of Governance and Development. Berkeley: University of California.

BARDHAN, P. & MOOKHERJEE, D. 1998. Expenditure Decentralization and the Delivery of Public Services in Developing Countries: Institute for Economic Development Paper No. 90. Boston: Institute for Economic Development, Boston University.

BARDHAN, P. & MOOKHERJEE, D. 2000a. Corruption and Decentralization of Infrastructure Delivery in Developing Countries. Berkeley: University of California.

BARDHAN, P. & MOOKHERJEE, D. 2000b. Decentralizing Anti-Poverty Program Delivery in Developing Countries. Berkeley University of California.

BARDHAN, P. K. & MOOKHERJEE, D. 2006. Decentralization and local governance in developing countries: a comparative perspective, Cambridge, Mass., MIT Press.

BARKAN, J. D., NG'ETHE, N., MUKANDALA, R. S., DDUNGU, E., GBOYEGA, A. & MAKUMBE, J. M. 1998. Five monographs on decentralization and democratization in Sub-Saharan Africa, Iowa City, Iowa, and Centre for International and Comparative Studies with The University of Iowa Libraries.

BATLEY, R. 2004. The Politics of Service Delivery Reform. Development and Change, 35, 31-56.

BATLEY, R. & LARBI, G. (eds.) 2004. Changing views of the role of the Government", The Changing Role of Government: The Reform of Public Services in Developing Countries, Basingstoke: Palgrave Macmillan.

BAXTER, P. & JACK, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers The Qualitative Report [Online], 13. Available: http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf.

BEALL, J. 2005. Decentralizing Government and Decentering Gender: Lessons from Local Government Reform in South Africa. Politics & Society, 33, 253-276.

BEALL, J. 2009. Decentralization and government and decentring gender: Lessons from local government reform in south Africa. In: GOETZ, A. M. (ed.) Governing women: women's political effectiveness in contexts of democratization and governance reform. New York: Rutledge.

BECKER, S. & BRYMAN, A. 2004. Understanding research for social policy and practice: themes, methods and approaches, Bristol, Policy Press.

BEITH, A., QUESADA, N., ABRAMSON, W., SÁNCHEZ, A. & OLSON, N. 2006. Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean, With Lessons Learned from Asia and Africa. Arlington: DELIVER, for the U.S. Agency for International Development.

BELL, R., ITHINDI, T. & LOW, A. 2002. Improving equity in the provision of primary health care: lessons from decentralized planning and management in Namibia. Bulletin of the World Health Organization, 80, 675-681.

BERER, M. 2002. Health sector reforms: implications for sexual and reproductive health services. Reprod Health Matters, 10, 6-15.

BERER, M. 2003. Integration of Sexual and Reproductive Health Services: A Health Sector Priority. Reproductive Health Matters, 11, 6-15.

BERLAN, D. & SHIFFMAN, J. 2012. Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. Health Policy and Planning, 27, 271-280.

BERMAN, P. 1995. Health sector reform: making health development sustainable. Health Policy, 32, 13-28.

BERMAN, P. A. & BOSSERT, T. J. 2000. A Decade of Health Sector Reform in Developing Countries: What Have We Learned? Data for Decision Making Project International Health Systems Group. DDM Symposium: "Appraising a Decade of Health Sector Reform in Developing Countries". Washington, D.C: Harvard School of Public Health.

BERNSTEIN, S. & HANSEN, J. H. 2006. Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. New York: UN Millennium Project.

BESSEY, M. 1999:43. Case Study Research in Educational Settings, Buckingham, Open University Press.

BEVAN, D., BIGSTEN, A., COLLIER, P. & GUNNING, J. 1988. The Decline in Tanzanian Incomes During the Nyerere Experiment: Evidence from Household Budget Surveys. In: GINNEKEN, W. V. (ed.) Trends in Employment and Labour Incomes. Case Studies on Developing Countries. Geneva: ILO.

BIGSTEN, A. & DANIELSSON, A. 1999. Is Tanzania an Emerging Economy? A Report for the OECD Project "Emerging Africa".

BIRUNGI, H., NYARKO, P., ASKEW, I., AJAYI, A., ADDAI, E. & JEHU-APPIAH, C. 2006. Priority Setting for Reproductive Health at the district level in the context of the reproductive health in Ghana. Population Council, Ministry of health Ghana & UNFPA-Ghana.

BIRUNGI, H., NYARKO, P., ASKEW, I., AJAYI, A., ADDAI, E., JEHU-APPIAH, C. & ADDICO, G. 2006:6. Priority Setting for Reproductive Health at the District Level in the context of Health Sector Reforms in Ghana. Accra: Ministry of Health, Ghana, Ghana Health Service, UNFPA/Ghana, Population Council, USAID and European Union

BLAIR, H. 2000. Participation and accountability at the Periphery: Democratic Local Government in six countries. World Development, 28, 21-39.

BOEX, J. 2003. The incidence of local government allocations in Tanzania. Public Administration and Development, 23, 381-391.

BOEX, J. 2008. Fiscal Decentralization and the Financing of Local Health Services in Tanzania. Dar es Salaam: Royal Netherlands Embassy.

BOEX, J. & MARTINEZ-VAZQUEZ, J. 2003. Local government reform in Tanzania: Considerations for the development of a system of formula-based grants. Working Paper 03-05, Georgia State University: Andrew Young School of Policy Studies.

BOON, S. 2008. How not to decentralise: Accountability and representation in health boards in Tanzania Dar es Salaam: Netherlands Development Organisation

BORGHI, J., MACHA, J. & MUSHI, H. P. 2011. Examining the links between accountability, trust and performance of the health service delivery in Tanzania Dar es Salam: Ifakara Health Institute

BÖRZEL, T. 2000:3. Private Actors on the Rise? The Role of Non-State Actor in Compliance with International Institutions. Working paper prepared for the group.

BOSSERT, T. 1998. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Social science & medicine, 47, 1513-27.

BOSSERT, T., BEAUVAIS, J. & BOWSER, D. 2000. Decentralization of Health Systems: Preliminary Review of Four Country Case Studies. Major Applied Research 6, Technical Report No. 1. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

BOSSERT, T., CHITAH, M. B. & BOWSER, D. 2003a. Decentralization in Zambia: resource allocation and district performance. Health Policy Plan, 18, 357-69.

BOSSERT, T. J. 2004. Objectives and framework for analysis Boston

BOSSERT, T. J. & BEAUVAIS, J. C. 2002. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. Health Policy and Planning, 17, 14-31.

BOSSERT, T. J., LARRANAGA, O., GIEDION, U., ARBELAEZ, J. J. & BOWSER, D. M. 2003b. Decentralization and equity of resource allocation: evidence from Colombia and Chile. Bull World Health Organ, 81, 95-100.

BOSSERT, T. J. & MITCHELL, A. D. 2011. Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan. Soc Sci Med, 72, 39-48.

BOVENS, M. 2007. Analysing and Assessing Accountability: A Conceptual Framework. European Law Journal, 13, 447-468.

BRAATHEN, E. & MWAMBE, G. 2007. Service Delivery in Tanzania: Finding from six Councils. Dar es Salaam: REPOA.

BRINKERHOFF, D. 2003. Accountability and Health Systems: Overview, Framework, and Strategies Bethesda: Partners for Health Reform plus.

BRINKERHOFF, D. & LEIGHTON, C. 2002. Insight for the implementers: Decentralisation and health system reforms. Partners for Health Reform plus.

BRINKERHOFF, D. W. 2004. Accountability and health systems: toward conceptual clarity and policy relevance. Health Policy and Planning, 19, 371-379.

BRINKERHOFF, D. W. & AZFAR, O. 2006. Decentralization and Community Empowerment: Does community empowerment deepen democracy and improve service delivery? Available: http://pdf.usaid.gov/pdf_docs/PNADH325.pdf.

BRINKERHOFF, D. W. & BOSSERT, T. J. 2008. Health Governance: Concepts, Experience and Programming Options. Washington, DC: USAID, Health Systems 20/20 project.

BRYMAN, A. 2004. Social research methods, Oxford, Oxford University Press.

BURGESS, C. 2004. Managing Policy Change and Navigating Sub-government Breakdown: The Case of the 1990 Independent Commission, Ohio State University.

BUSE, K., MAYS, N. & WALT, G. 2005. Making health policy, Maidenhead, Open University Press.

BUSH, T. 2002. Authenticity-Reliability, Validity and Triangulation In: COLEMAN, M. & BRIGGS, A. R. J. (eds.) Research Methods in Educational Leadership and Management. London: Paul Chapman Publishing Ltd.

CABRAL, L. 2011. Decentralisation in Africa: Scope, Motivations and Impact on Service Delivery and Poverty. London: Overseas Development Institute.

CAMPBELL WHITE, A., MERRICK, T. W. & YAZBECK, A. S. 2006. Reproductive Health—The Missing Millennium Development Goal: Poverty, Health, and Development in a Changing World. Washington, DC: World Bank.

CANNING, D. & SCHULTZ, T. 2012. The economic consequences of reproductive health and family planning. Lancet, 380(9837), 165-171.

CASELEY, J. 2003. Blocked drains and open minds: Multiple accountability relationship and improved delivery performance in Indian city. Brighton: Institute of Development Studies (IDS) Working paper 211.

CASSELS, A. 1995. Health sector reform: key issues in less developed countries. J Int Dev, 7, 329-47.

CASSELS, A. & JANOVSKY, K. 1996. Reform of the Health Sector in Ghana and Zambia: Commonalities and Contrasts, Geneva, World Health Organization - Division of Strengthening of Health Services.

CEGAA 2009. The IMF in Tanzania: Implications for health and development. Washington DC: Centre for Economic Governance and AIDS in Africa (CEGAA).

CHALIGHA, A. 2008. Local autonomy and citizen participation in Tanzania: from a local government reform perspective. Dar es Salaam: Special Paper No 8:26, REPOA.

CHEEMA, G. S., RONDINELLI, D. A. & UNITED NATIONS CENTRE FOR REGIONAL DEVELOPMENT. 1983. Implementing decentralization programmes in Asia: local capacity for rural development, Nagoya, Japan, United Nations Centre for Regional Development.

CHEN, Q. 2004. The Effect of Decentralization on Health: A Case of China. Available: http://www.paper.edu.cn.

CHITAMA, D., BALTUSSEN, R., KETTING, E., KAMAZIMA, S., NSWILLA, A. & MUJINJA, P. G. 2011. From papers to practices: district level priority setting processes and criteria for family planning, maternal, new-born and child health interventions in Tanzania. BMC Women's Health, 11, 46.

CLASSEN, J. 1999. Introduction. In: CLASSEN, J. (ed.) Comparative Social Policy: Concepts, Theories and Methods. Massachusetts: Blackwell

CLYDE, D. F. 1962. History of the medical services of Tanganyika, Dar es Salaam, Govt. Press.

COCHRAN, T., BOND, D., SHEPPARD, B. & SAMUELS, B. 2009. Financing Local Infrastructures: Part One Report: The Tanzania Environmental Scan. Report prepared for the United Nations Capital Development Fund.

COHEN, L., MANION, L. & MORRISON, K. 2000. Research methods in education (5th ed), London, New York, RoutledgeFalmer.

COLLINS, C., ARAUJO, J. & BARBOSA, J. 2000. Decentralising the health sector: issues in Brazil. Health Policy, 52, 113-27.

COLLINS, C. & BARKER, C. 2001. Health sector decentralization and management: developing a district general policy on management. Trop Doct, 31, 11-5.

COLLINS, C., OMAR, M., ADHIKARI, D., DHAKAL, R., EMMEL, N., DHAKAL, M. R., CHAND, P., THAPA, D. & SINGH, A. B. 2007. Health system decentralisation in Nepal: identifying the issues. J Health Organ Manag, 21, 535-45.

COLLINS, C., OMAR, M., DHAKAL, R., ADHIKARI, D., EMMEL, N., RAJ DHAKAL DHRUBA THAPA, M., DHAKAL, R., BAHADUR CHAND, P. & BAHADUR SINGH, A. 2003. Developing Health Sector Decentralisation in Nepal: Collaborative Policy Development Kathmandu: British Council.

COLLINS, C. D., OMAR, M. & TARIN, E. 2002. Decentralization, health care and policy process in the Punjab, Pakistan in the 1990s. Int J Health Plann Manage, 17, 123-46.

CONYERS, D. 1981. Decentralization for regional development: A comparative study of Tanzania, Zambia and Papua New Guinea. Public Administration and Development, 1, 107-120.

CONYERS, D. 2007a. ‘Decentralisation and service delivery: lessons from Sub-Saharan Africa. IDS Bulletin, 38, 18-32.

CONYERS, D. 2007b. Decentralisation and service delivery: lessons from Sub-Saharan Africa. IDS Bulletin, 38, 18-32.

COOK, R. J., DICKENS, B. M. & FATHALLA, M. F. 2003. Reproductive health and human rights: integrating medicine, ethics, and law, Oxford, Clarendon Press.

COWI 2007. Local Government Reform Programme -Embedding Decentralisation by Devolution Across Government. Assessment Report for the Ministry of Health and Social Welfare.

COWI & EPOS 2007. Joint External Evaluation of the Health Sector in Tanzania: Draft Report.: Online source. Dar es Salaam: COWI Management Consultants and EPOS Health Consultants.

CRESWELL, J. W. 1998:17. Qualitative inquiry and research design: choosing among five traditions, Thousand Oaks, Calif.; London, Sage Publications.

CRESWELL, J. W. 2003. Research Design: qualitative, quantitative, and mixed methods approaches (2nd ed), London, Sage Publications.

CROMBIE, I. K. & DAVIES, H. T. O. 1996. Research in health care: design, conduct and interpretation of health services research, Chichester, Wiley.

CROOK, C. R. & SVERRISSON, A. S. 2001a. Decentralisation and poverty alleviation in developing countries: A comparative analysis, or is West Bengal unique. Institute of Development Studies-Working Paper 130.

CROOK, R. C. & MANOR, J. 1998. Democracy and decentralisation in South Asia and West Africa: participation, accountability and performance, Cambridge, Cambridge University Press.

CROOK, R. C. & MANOR, J. 1999. Enhancing Participation and Institutional Performance: Democratic Decentralization in South Asia and West Africa Report to the Overseas

Development Administration, on Phase Two of a Two-Phase Research Project, January.

CROOK, R. C. & SVERRISSON, A. S. 2001b. Decentralization and Poverty-Alleviation in Developing Countries: A Comparative Analysis or, is West Bengal Unique? , IDS Working Paper 130. Available: http://www.ids.ac.uk/files/dmfile/Wp130.pdf.

CROTTY, M. 1998. The Foundations of Social Research: Meaning and Perspective in the Research Process, London, Sage Publication.

DANIDA & MOFA 1999. Health sector Programme support (HSPSII) Phase 2 (July 1999-June 2004) Appraisal Report

Dar es Salaam: DANIDA.

DANIELSON, A. 1996. Ten Years of Economic Reforms. Macroeconomic Report. Stockholm: Sida.

DEMELLO, L. 2004. Fiscal decentralisation and sub-national expenditure policy. Washington, DC: International Monetary Fund.

DENSCOMBE, M. 2003:33. A Good Research Guide for Small Scale Social Research Project, Buckingham Open University Press.

DENZIN, N. K. & LINCOLN, Y. S. 1994. Handbook of Qualitative Research, London, Sage Publications.

DHAKAL, R. & SINGH, A. 2006. Health sector decentralisation in Nepal: prospects and challenges. Nepal Public Health Association, 3, 26-34.

DIXON-MUELLER, R. 1993. Population Policy and Women's Rights: Transforming Reproductive Choice. Westport: Praeger.

DJIBUTI, M., GOTSADZE, G., MATARADZE, G. & MENABDE, G. 2008. Human resources for health challenges of public health system reform in Georgia. Human Resources for Health, 6, 8.

DUYSBURGH, E., ZHANG, W. H., YE, M., WILLIAMS, A., MASSAWE, S., SIÉ, A., WILLIAMS, J., MPEMBENI, R., LOUKANOVA, S. & TEMMERMAN, M. 2013. Quality of antenatal and childbirth care in selected rural health facilities in Burkina Faso, Ghana and Tanzania: similar finding. Tropical Medicine & International Health, 18, 534-547.

DYE, T. R. 2004. Understanding public policy, New Delhi, Pearson Education Inc.

ENSOR, T. & RONOH, J. 2005. Impact of organizational change on the delivery of reproductive services: a review of the literature. Int J Health Plann Manage, 20, 209-25.

ERIKSEN, S. S., JON, N. & ARILD, S. 1999. Decentralisation from Above: A Study of Local Government in Botswana, Ghana, Tanzania and Zimbabwe. Oslo: Norwegian Institute for Urban and Regional Research.

ESTERBERG, K. G. 2002:10. Qualitative Methods in Social Research, London, McGraw Hill.

ESTERBY-SMITH, M., THORPE, R. & LOWE, A. 1994. The Philosophy of Research Design. In: BENNETT, N., GLATTER, R. & LEVACIC, R. (eds.) Improving Educational Management through Research and Consultancy. London: Paul Chapman.

FAGUET, J.-P. 2000. Does Decentralization increase Government Responsiveness to Local Needs? Evidence from Bolivia. Washington DC: Working Paper World Bank.

FAGUET, J., PAUL 2004. Does decentralization increase government responsiveness to local needs? Evidence from Bolivia. Journal of Public Economics, 88, 867-893.

FALCONE, D. 1980. HEALTH POLICY ANALYSIS: SOME REFLECTIONS ON THE STATE OF THE ART. Policy Studies Journal, 9, 188-197.

FJELDSTAD, O.-H. & SEMBOJA, J. 2000. Dilemmas of Fiscal Decentralisation. A Study of Local Government Taxation in Tanzania. 27.

FJELDSTAD, O. 2004. To pay or not to pay? Citizens' views on taxation in local authorities in Tanzania.

FJELDSTAD, O., HENJEWELE, F., MWAMBE, G., E, N. & NYGAARD, K. 2004. Local government finances and financial management in Tanzania: Baseline data from six councils, 2000-2003. Available: http://bora.cmi.no/dspace/bitstream/10202/127/1/Working%20Paper%20WP%202004-7.pdf.

FRENK, J. 1995. Comprehensive policy analysis for health system reform. Health Policy, 32, 257-77.

FRUMENCE, G., NYAMHANGA, T., MWANGU, M. & HURTIG, A. K. 2012. Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. Glob Health Action, 6, 20983.

FRUMENCE, G., NYAMHANGA, T., MWANGU, M. & HURTIG, A. K. 2014a. The dependency on central government funding of decentralised health systems: experiences of the challenges and coping strategies in the Kongwa District, Tanzania. BMC Health Serv Res, 14, 39.

FRUMENCE, G., NYAMHANGA, T., MWANGU, M. & HURTIG, A. K. 2014b. Participation in health planning in a decentralised health system: Experiences from facility governing committees in the Kongwa district of Tanzania. Global public health, 9, 1125-38.

GALL, M. G., GALL, J. P. & BORG, W. R. 2007. Educational Research: an introduction (8th ed), Boston, Pearson International Edition.

GAMSON, W. & LASCH, K. 1983. The Political Culture of the social welfare policy. In: S.SPIRO & E.YAAR-YUCHTMAN (eds.) Evaluating social welfare state: Social and political. New York: Academic Press.

GEORGE, A. 2003. Accountability in Health Services: Transforming Relationship and Contexts: Working Paper Series Harvard Centre for Population and Development Studies.

GEREIN, N., GREEN, A. & PEARSON, S. 2006. The implications of shortages of health professionals for maternal health in Sub-Saharan Africa. Reproductive Health Matters, Human Resources for Sexual and Reproductive Health Care, 14, 40 - 50.

GILSON, L. 1997. Implementing and Evaluating Health Reform Processes: Lessons from the Literature Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

GILSON, L., KILIMA, P. & TANNER, M. 1994. Local government decentralization and the health sector in Tanzania. Public Administration and Development, 14, 451-477.

GILSON, L. & MILLS, A. 1995. Health sector reforms in sub-Saharan Africa: lessons of the last 10 years. Health Policy, 32, 215-43.

GILSON, L. & TRAVIS, P. 1997. Health system decentralization in Africa: An overview of experiences in eight countries. Paper prepared for WHO regional seminar on decentralization, Bamako, January 1997.

GILSON, L. & WALT, G. 1994. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, 9, 353-70.

GISH, O. 1982. Selective primary health care: old wine in new bottle. Social science and medicine, 16, 1049-1053.

GLASSMAN, A., REICH, M. R., LASERSON, K. & ROJAS, F. 1999. Political Analysis of Health Reform in the Dominican Republic. Health Policy and Planning, 14, 115-126.

GOETZ, A. 2003. Promoting accountability for implementing the MDG 3, UNIFEM Power point presentation made in the World Bank High -level Consultation: Promoting gender equality MDG: The implementation challenge. Washington, DC.

GOT 1982a. Local Government (District Authorities) Act, 1982. Dar es Salaam: Government Printers.

GOT 1982b. Local Government (Urban Authorities) Act, 1982. Dar es Salaam: Government Printers.

GOTTRET, P. & SCHIEBER, G. J. 2006. Health financing revisited: a practitioner's guide. Health affairs. 2007/07/17 ed. Washington, DC: World Bank.

GRAY, D. E. 2004. Doing research in the real world, London, SAGE.

GREEN, A., ALI, B., NAEEM, A. & VASSALL, A. 2001. Using costing as a district planning and management tool in Balochistan, Pakistan. Health Policy and Planning, 16, 180-186.

GREEN, A. & COLLINS, C. 1994. Decentralisation and primary Health Care: Some Negative Implication in Developing countries Internal Journal of Health Services, 24, 459-475.

GREEN, L. W. & KREUTER, M. W. 1991. Health promotion planning: An educational and environmental approach (2nd ed.), Mountain View, CA, Mayfield.

GREENE, E. M. & MERRICK, T. 2005. Poverty Reduction: Does Reproductive Health Matter? : Centre for Global Health, George Washington University School of Public Health and Health Services, Washington, DC, USA.

GRIBBLE, J. & VOSS, M. 2009. Family Planning and Economic Well-Being: New Evidence from Bangladesh Washington, DC: Population Reference Bureau.

GRINDLE, M. & THOMAS, J. 1991. Public Choices and Policy Change. The Political Economy of Reform in Developing Countries, Baltimore MD, Johns Hopkins University Press.

GRODOS, D. & MERCENIER, P. 2000. Health systems research: a clearer methodology for more effective action. Studies in Health Services Organisation & Policy. Antwerp: ITG Press.

GUBA, E. G. 1992. The Alternative Paradigm, London, Sage Publication.

GUBA, E. G. & LINCOLN, Y. S. 2005. Paradigmatic Controversies, Contradictions, and Emerging Confluences. In: DENZIN, N. K. & LINCOLN, Y. S. (eds.) Handbook of Qualitative Research. 3rd ed. Thousand Oaks Sage.

HAMMER, J. S. & BERMAN, P. 1995. Ends and means in public health policy in developing countries. Health Policy, 32, 29-45.

HANSON, K., RANSON, M. K., OLIVERIA, V. & MILLS, A. 2003. Constraints to expanding access to health interventions: an empirical analysis and country typology. Journal of International Development, 15, 15-39.

HARDEE & YOUNT, K. M. 1995. From Rhetoric to Reality: Delivering Reproductive Health Promises through Integrated Services. Research Triangle Park NC: Family Health International

HARDEE, K. & SMITH, J. 2000. Implementing Reproductive Health Services in an Era of Health Sector reform Washington, DC: POLICY Project, The Futures Group International

HENN, M., WEINSTEIN, M. & FOARD, N. 2006:10. A short introduction to social research, London, SAGE.

HILL, P. S., DODD, R. & DASHDORJ, K. 2006. Health Sector Reform and Sexual and Reproductive Health Services in Mongolia. Reproductive Health Matters, 14, 91-100.

HISKEY, J. T. 2010. The Promise of Decentralised Governance. In: CONNERLEY, E., EATON, K. & SMOKE, P. (eds.) Making decentralization work: democracy, development and security. Boulder London: Lynne Reiner Publishers.

HOGWOOD, B. & GUNN, A. 1984. Policy analysis for the real world, Oxford, Oxford University Press.

HOGWOOD, B. & PETERS, B. 1983. The Pathology of Public Policy, Oxford, Clarendon Press.

HSIAO, W. 1995. Abnormal economics of the Health Sector Health Policy, 32, 125-39.

HUFF-ROUSSELLE, M. 2001. Myths and realities about the decentralization of health systems. The International Journal of Health Planning and Management, 16, 172-174.

HUNTINGTON, D. 2004. Health Sector Reforms and Maternal Care Programs. Background Paper, Prepared for the Global Forum for Health Research. Background Paper, Prepared for the Global Forum for Health Research. Mexico City, Mexico.

HUTCHINSON, P. 2002. Decentralization in Tanzania: The View of District Health Management Teams: MEASURE Evaluation. Carolina Population Centre, University of North Carolina at Chapel Hill.

HUTCHINSON, P., AKIN, J. & STRUMPF, K. 2001. Decentralisation and Government Provision of Public Goods: The Public Health Sector in Uganda. Bethesda, MD: Abt. Associates: MEASURE Evaluation Project Working Paper 01-35.

HUTCHINSON, P. & LAFOND, A. K. 2004. Monitoring and Evaluation of Decentralization Reforms in Developing Country Health Sectors. Bethesda, MD: The Partners for Health Reform plus Project, Abt Associates, Inc.

HYDEN, G. & KARLSTROM, B. 1993. Structural adjustment as a policy process: The case of Tanzania. World Development, 21, 1395-1404.

IHI 2011. Health Facility Committees: Are they working? Spotlight Issue. Dar es Salaam: Ifakara Health Institute.

JENNINGS, M. 2008:59-60. Resettlement and Change: Centralization and Control:
Development Structures Surrogates of the state: NGOs, development, and Ujamaa in Tanzania
Bloomfield, CT, Kumarian Press.

JEPPSSON, A. 2001. Financial priorities under decentralization in Uganda. Health Policy and Planning, 16, 187-92.

JEPPSSON, A., OSTERGREN, P. O. & HAGSTROM, B. 2003. Restructuring a ministry of health - an issue of structure and process: a case study from Uganda. Health Policy and Planning, 18, 68-73.

JICA 2008. Local Level Service Delivery, Decentralisation and Governance A Comparative Study of Uganda, Kenya and Tanzania Education, Health and Agriculture Sectors: TANZANIA CASE REPORT. Institute for International Cooperation and Japan International Cooperation Agency.

JING, F. 2004. Health sector reform and reproductive health services in poor rural China. Health Policy Plan., 19, i40-49.

JUMA, C. & CLARK, N. 1995. Policy research in sub-Saharan Africa: An exploration. Public Administration and Development, 15, 121-137.

KAIJAGE, F. J. & TIBAIJUKA, A. K. 1996. Poverty and social exclusion in Tanzania, Geneva, International Institute for Labour Studies.

KAUFMAN, J. 2000. The impact of the health sector reforms on reproductive health: Arrows for change Women and Gender Perspectives in Health Policies and Programmes 6.

KAUFMAN, J. 2002. Privatisation of health services and the reproductive health of rural Chinese women. Reproductive Health Matters, 10, 108-16.

KAWONGA, M. 2005. Decentralisation--Africa Regional Paper: Initiative for Sexual and Reproductive Rights in Health Reform. Women's Health Project. Johannesburg. Witwatersrand University

KAWONGA, M., MACEIRA, D. & NUNN, A. 2005. Decentralisation of health systems. In: RAVINDRAN, T. & H, D. P. (eds.) The Right Reforms? Health Sector Reform and Sexual and Reproductive Health. . Johannesburg: Women's Health Project, School of Public Health, University of the Witwatersrand.

KESSY, A. T. & MCCOURT, W. 2010. Is Decentralization Still Recentralization? The Local Government Reform Programme in Tanzania. International Journal of Public Administration, 33, 689-697.

KESSY, F., DR. HONATHAN, M., KALIMA, M. & MBUYA., D. 2008. Technical Review of Council Health Service Boards and Health Facility Governing Committees in Tanzania.

KHEMANI, S. 2001. Decentralization and Accountability: Are voters more vigilant in local than in national elections? : World Bank Policy Research Working Paper No. 2557.

KHEMANI, S. 2004. Local government accountability for health service delivery in Nigeria Washington, DC: Development Research Working Group, World Bank.

KILEWO, E. G. & FRUMENCE, G. 2015. Factors that hinder community participation in developing and implementing comprehensive council health plans in Manyoni District, Tanzania. Glob Health Action, 8, 26461.

KIM, A. 2008. Decentralization and the Provision of Public Services: Framework and Implementation. SSRN eLibrary.

KING-KEOHANE, R. O. & VERBA, S. 1994. Designing social inquiry scientific inference in qualitative research, Princeton, Chichester, Princeton University Press.

KINGDON, J. 2003. Agendas, Alternatives and Public Policies 2nd edition, New York, Longman.

KINGDON, J. W. 1984. Agendas, alternatives, and public policies, Boston, Little, Brow.

KIS-KATOS, K. & SUHARNOKO SJAHRIR, B. 2014. The Impact of Fiscal and Political Decentralization on Local Public Investments in Indonesia. IZA Discussion Paper No. 7884. Available at SSRN: http://ssrn.com/abstract=2381136.

KOPOKA, A. Provision of health services in Tanzania in the twenty first century: lessons from the past. Paper presented at a workshop on Economic Policy environment in Tanzania in the twenty - first century: Lessons from the Nyerere legacy. 2000 Dar es Salaam. University of Dar es Salaam

KOURITZIN, S. G., PIQUEMAL, N. A. C. & NORMAN, R. 2009. Qualitative research: challenging the orthodoxies in standard academic discourse(s), London, Rutledge.

KRASOVEC, K. & SHAW, R. P. 2000. Reproductive Health and Health Sector Reform: Linking Outcomes to Action: Draft paper for Module 7, Core Course Adapting to Change. Washington, DC: Population, Reproductive Health and Health Sector Reform, World Bank Institute

KRUK, M. E., HERMOSILLA, S., LARSONA, E. & MBARUKUB, G. M. 2014. Bypassing primary care clinics for childbirth: a cross-sectional study in the Pwani region, United Republic of Tanzania. Bulletin of the World Health Organization, 92, 246-253.

KRUK, M. E., MBARUKU, G., MCCORD, C. W., MORAN, M., ROCKERS, P. C. & GALEA, S. 2009a. Bypassing primary care facilities for childbirth: a population-based study in rural Tanzania. Health Policy Plan, 24, 279-88.

KRUK, M. E., PACZKOWSKI, M., MBARUKU, G., DE PINHO, H. & GALEA, S. 2009b. Women's Preferences for Place of Delivery in Rural Tanzania: A Population-Based Discrete Choice Experiment. American Journal of Public Health, 99, 1666-1672.

LABONTE, R. & ROBERTSON, A. 1996. Delivering the goods, showing our stuff: the case for the constructivist paradigm for health promotion research and practice. In: THURSTON, W., SIEPPERT, J. & WIEBE, V. (eds.) Doing Health Promotion Research. Calgary: University of Calgary.

LAKSHMINARAYANAN, R. 2003a. Decentralisation and Its Implications for Reproductive Health: The Philippines Experience. Reproductive health matters, 11, 96-107.

LAKSHMINARAYANAN, R. 2003b. Decentralisation and its implications for reproductive health: the Philippines experience. Reprod Health Matters, 11, 96-107.

LANGER, A., NIGENDA, G. & CATINO, J. 2000. Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links. Bull World Health Organ, 78, 667-76.

LANGRAN, V. I. 2011. Decentralization, Democratization, and Health: The Philippine Experiment. Journal of Asian and African Studies, 46, 361-374.

LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) 2002. Health Policy in a Globalising World: Cambridge University Press.

LEE, K., LUSH, L., WALT, G. & CLELAND, J. 1998. Family planning policies and programmes in eight low-income countries: A comparative policy analysis. Social science & medicine, 47, 949-959.

LEIGHTON, C. 1996. Strategies for achieving health financing reforms in Africa. World Development, 24, 1511-1525.

LEIGHTON, C. 1999. Safe motherhood: reforming maternal and reproductive health care. Health reform and priority services / PHR, 3-6.

LESLIE, P., TIEN, M., ERIN, M. & ROSCHE, T. 2007. Tanzania: Contraceptive Security Assessment. Arlington: USAID/DELIVER PROJECT.

LITVACK, J., AHMAD, J. & BIRD, R. 1998. Rethinking Decentralization in Developing Countries. Washington, DC: World Bank.

LITVACK, J. & SEDDON, J. 1999. Decentralisation Briefing Notes. Washington, D.C: World Bank Institute-Working Papers: World Bank.

LOEWENSON, R., RUSIKE, I. & ZULU, M. 2004. The impact of health centre committees on health equity in Zimbabwe. EQUINET Conference; 9. Durban, South Africa.

LOZANO, R., NAGHAVI, M., FOREMAN, K., LIM, S., SHIBUYA, K., ABOYANS, V., ABRAHAM, J., ADAIR, T., AGGARWAL, R., AHN, S. Y., ALMAZROA, M. A., ALVARADO, M., ANDERSON, H. R., ANDERSON, L. M., ANDREWS, K. G., ATKINSON, C., BADDOUR, L. M., BARKER-COLLO, S., BARTELS, D. H., BELL, M. L., BENJAMIN, E. J., BENNETT, D., BHALLA, K., BIKBOV, B., ABDULHAK, A. B., BIRBECK, G., BLYTH, F., BOLLIGER, I., BOUFOUS, S., BUCELLO, C., BURCH, M., BURNEY, P., CARAPETIS, J., CHEN, H., CHOU, D., CHUGH, S. S., COFFENG, L. E., COLAN, S. D., COLQUHOUN, S., COLSON, K. E., CONDON, J., CONNOR, M. D., COOPER, L. T., CORRIERE, M., CORTINOVIS, M., DE VACCARO, K. C., COUSER, W., COWIE, B. C., CRIQUI, M. H., CROSS, M., DABHADKAR, K. C., DAHODWALA, N., DE LEO, D., DEGENHARDT, L., DELOSSANTOS, A., DENENBERG, J., DES JARLAIS, D. C., DHARMARATNE, S. D., DORSEY, E. R., DRISCOLL, T., DUBER, H., EBEL, B., ERWIN, P. J., ESPINDOLA, P., EZZATI, M., FEIGIN, V., FLAXMAN, A. D., FOROUZANFAR, M. H., FOWKES, F. G. R., FRANKLIN, R., FRANSEN, M., FREEMAN, M. K., GABRIEL, S. E., GAKIDOU, E., GASPARI, F., GILLUM, R. F., GONZALEZ-MEDINA, D., HALASA, Y. A., HARING, D.,

HARRISON, J. E., HAVMOELLER, R., HAY, R. J., HOEN, B., HOTEZ, P. J., HOY, D., JACOBSEN, K. H., JAMES, S. L., JASRASARIA, R., JAYARAMAN, S., JOHNS, N., KARTHIKEYAN, G., KASSEBAUM, N., KEREN, A., KHOO, J.-P., KNOWLTON, L. M., KOBUSINGYE, O., KORANTENG, A., KRISHNAMURTHI, R., LIPNICK, M., LIPSHULTZ, S. E., et al. 2012. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet, 380, 2095-2128.

LOZANO, R., WANG, H., FOREMAN, K. J., RAJARATNAM, J. K., NAGHAVI, M., MARCUS, J. R., DWYER-LINDGREN, L., LOFGREN, K. T., PHILLIPS, D., ATKINSON, C., LOPEZ, A. D. & MURRAY, C. J. L. 2011. Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. The Lancet, 378, 1139-1165.

LUBBEN, M., MAYHEW, S. H., COLLINS, C. & GREEN, A. 2002. Reproductive health and health sector reform in developing countries: establishing a framework for dialogue. Bulletin of the World Health Organization, 80, 667-74.

MACHA, J. & BORGHI, J. 2011. Health facility committees are they working? Dar es Salaam: Ifakara Health Institute.

MÆSTAD, O. 2006. Human resources for health in Tanzania: Challenges, policy options and knowledge gaps. Bergen: Chr. Michelsen Institute.

MAKINDE, T. 2005. Problem of policy implementation in developing nations: the Nigerian experience. Journal of Social Science, 11, 63-99.

MALUKA, S., HURTIQ, A.-K., SAN SEBASTIAN, M., SHAYO, E., BYSKOV, J. & KAMUZORA, P. 2011. Decentralization and health care prioritization process in Tanzania: From national rhetoric to local reality. Internal Journal of Health Planning and Management, 26, e55 - e73.

MALUKA, S., KAMUZORA, P., SAN SEBASTIAN, M., BYSKOV, J., NDAWI, B. & HURTIG, A.-K. 2010a. Improving district level health planning and priority setting in Tanzania through implementing accountability for reasonableness framework: Perceptions of stakeholders. BMC Health Services Research, 10, 322.

MALUKA, S., KAMUZORA, P., SANSEBASTIAN, M., BYSKOV, J., NDAWI, B., OLSEN, O. & HURTIG, A.-K. 2010b. Decentralized health care priority-setting in Tanzania: Evaluating against the accountability for reasonableness framework. Soc Sci Med, 71, 751 - 759.

MAMDANI, M., IDDY, M., IRENE, M. & IKUNDA, N. 2013. P4P Process Round Three Report. Dar es Salaam: Ifakara Health Institute.

MANOR, J. 1999. The Political Economy of Democratic Decentralisation: Directions in Development Series. Washington DC: World Bank.

MANZI, F., SCHELLENBERG, J. A., HUTTON, G., WYSS, K., MBUYA, C., SHIRIMA, K., MSHINDA, H., TANNER, M. & SCHELLENBERG, D. 2012. Human resources for health care delivery in Tanzania: a multifaceted problem. Human Resources for Health, 10, 3.

MARO, P. S. & MLAY, W. F. I. 1979. Decentralization and the Organization of Space in Tanzania. Africa: Journal of the International African Institute, 49, 291-301.

MARSH, D. 1998. The development of the policy network approach Cambridge Open University Press.

MASAKI, T. 2015. The Impact of Intergovernmental Grants on Local Revenues in Africa: Evidence from Tanzania. Department of Government, Cornell University.

MASAU, S., CHEE, G., PATSIKA, R., MALANGALILA, E., CHITAMA, D., PRAAG, E. V. & SCHTTLER, G. 2011. Tanzania Health System Assessment 2010 Bethesda, MD: Abt Associates Inc.

MASSOI, L. & NORMAN, A. S. 2009. Decentralisation by devolution in Tanzania: Reflections on community involvement in the planning process in Kizota Ward in Dodoma. Journal of Public Administration and Policy Research Available [Online], 1. Available: http://www.academicjournals.org/jpa.

MAX, M. A. O. 1991. The Development of Local Government in Tanzania, Dar es Salaam, Education Publishers and Distributors Ltd.

MAYEH, O. Undated. Health sector decentralisation in developing countries: Unique or Universal. Leeds: Nuffield Institute for Health

MAYHEW, S. 2003. The impact of decentralisation on sexual and reproductive health services in Ghana. Reprod Health Matters, 11, 74-87.

MCFEE, G. 1992. Triangulation in research: two confusions. Educational Research, 34, 215-219.

MCINTYRE, D. & KLUGMAN, B. 2003. The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa. Reproductive Health Matters, 11, 108-119.

MCNAMARA, P. 2006. Provider-specific report cards: a tool for health sector accountability in developing countries. Health Policy and Planning, 21, 101-109.

MCPAKE, B., HANSON, K. & MILLS, A. 1991. Evaluation of the Bamako Initiative: Background paper. London: London School of Hygiene and Tropical Medicine.

MEACHAN, D. (ed.) 2001. Globalization, Health Sector Reform, Gender and Reproductive Health, New York: Ford Foundation

MEHROTRA, S. 2006. Governance and basic social services: ensuring accountability in service delivery through deep democratic decentralisation. Journal of International Development, 18, 263-283.

MENON, S. 2006. Decentralization and health care in the former Yugoslav Republic of Macedonia. The International Journal of Health Planning and Management, 21, 3-21.

MERRICK, T. 1999. Delivering Reproductive Health Services in Health Reform Settings: Challenges and Opportunities. Washington DC: World Bank.

MEWES, K. 2011. Decentralization on the Example of the Yemeni Water Sector. Heidelberg: Springer Fachmedien Wiesbaden.

MILES, M. B. & HUBERMAN, A. M. 1994. Qualitative Data Analysis (2nd ed), London, Sage Publications.

MILLS, A. 1994. Decentralization and accountability in the health sector from an international perspective: What are the choices? Public Administration and Development, 14, 281-292.

MILLS, A., BENNETT, S. & RUSSELL, S. 2001. The challenge of health sector reform: what must governments do? Basingstoke, Palgrave.

MILLS, A., VAUGHAN, J. P., SMITH, D. L. & TABIBZADEH, I. 1990. Health system decentralization: concepts, issues and country experience, Geneva, World Health Organization.

MISHTAL, J. 2010. Neoliberal reforms and privatisation of reproductive health services in post-socialist Poland. Reproductive Health Matters, 18, 56-66.

MITRA, S. K. 2006:6. The Puzzles of India's Governance, Culture, Context and Comparative Theory, London, Rutledge.

MOBARAK, A., RAJKUMAR, A. & CROPPER, M. 2006. The political economy of health service provision in Brazil. Working Paper S3508. Boulder: University of Colorado.

MOFEA 2010. Assessment of the effectiveness of formula based budgetary allocation to local government authorities Morogoro: Mzumbe University

MOFEA 2013a. The Economic Survey 2012. Dar es Salaam: Ministry of Finance and Economic Affairs.

MOFEA 2013b. Study on Mapping of Transfer of Funds to Local Government Authorities (LGAs). Dar es Salaam: Directorate of Planning: Ministry of Finance

MOGEDAL S, HODNE STEEN, S. & MPELUMBE, G. 1995. Health Sector Reform and organisational issues at the local level: lessons from selected African countries. Journal of International Development, 7, 349-367.

MOH 1994. Proposal for health sector reform Dar es Salaam Ministry of Health.

MOH 1995. Strategic Health Plan 1995-1998. Dar es Salaam: Ministry of Health

MOH 1997. Report of Health Sector Reform Programme of Work 1998/99- 2000/01. Dar es Salaam: Ministry of Health

MOH 1998a. Health Sector Reform Plan of Action July 199 to June 2002. Dar es Salaam, Tanzania Ministry of Health.

MOH 1998b. Report of the Health Sector Reform Dissemination Workshop

Paradise Holiday Resort, Bagamoyo: Ministry of Health

MOH 2000a. National package of essential reproductive and child health interventions Dar es Salaam Ministry of Health.

MOH 2000b. National package of the essential health interventions in Tanzania. Dar es Salaam: Ministry of Health.

MOH 2002. Tanzania Joint Health Review 11-13 March 2002. Main Report. Dar es Salaam: Ministry of Health.

MOH 2003. Second Health Sector Strategic Plan (HSSP) II: July 2003-June 2008. Dar es Salaam Ministry of Health.

MOH 2004. Report of the Tanzania Joint Annual Health Sector Review: 15th – 17th March 2004 Golden Tulip Hotel. Dar es Salaam: Ministry of Health.

MOHSW 2003. National Health Policy. Dar es Salaam: Government Printers.

MOHSW 2008a. Functions of Regional Health Management System. Dar es Salaam: Ministry of Health and Social Welfare.

MOHSW 2008b. Human resource for health strategic plan 2008-2013. Dar es Salaam: MoHSW.

MOHSW 2008c. Joint Annual Health Sector Review 2008. Dar es Salaam: Ministry of Health and Social Welfare.

MOHSW 2008d. The National Road Map Strategic Plan to Accelerate Reduction of Maternal, New-born and Child Deaths in Tanzania 2008 - 2015. Dar es Salaam: Ministry of Health and Social Welfare.

MOHSW 2010. Comprehensive Council Health Planning Guidelines. Dar es Salaam: Ministry of Health and Social Welfare and Prime Minister's Office Regional Administration and Local Government.

MOHSW 2011. Summary and analysis of comprehensive council health plans: 2011/12 report. Dar es Salaam: MoHSW and PMO-RALG.

MOHSW 2012a. Health Sector Public Expenditure Review 2010/11. Dar es Salaam: Government Printers.

MOHSW 2012b. National Operational Guidelines for Integration of Maternal New-born and Child Health and HIV/AIDS Service in Tanzania. Dar es Salaam: Ministry of Health and Social Welfare.

MOHSW 2013a. Annual Health Sector Performance Profile 2011/12-Final Draft. Dar es Salaam: Ministry of Health and Social Welfare.

MOHSW 2013b. Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Main Report, Ministry of Health and Social Welfare. Dar es Salaam: United Republic of Tanzania.

MOHSW 2013c. Tanzania P4P Assessment Report (Draft). Dar es Salaam: Ministry of Health and Social Welfare

MOHSW 2015. Health Sector Strategic Plan July 2015 – June 2020 (HSSP IV) Reaching all Households with Quality Health Care. Dar es Salaam: Ministry of Health and Social welfare.

MOHSW & PMO-RALG 2007. Local Government Reform Programme – Embedding Decentralisation by Devolution Across Government. Dar es Salaam: Government Printers.

MOLEL, A. 2010. Participation for local development: the reality of decentralization in Tanzania, Leiden, African Studies Centre.

MOLLEL, H. A. 2010. Participation for local development: The reality of decentralization in Tanzania. African Studies Collection, vol. 29 Leiden African Studies Centre- University of Leiden.

MOLYNEUX, S., ATELA, M., ANGWENYI, V. & GOODMAN, C. 2012. Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. Health Policy and Planning, 27, 541-554.

MOSHI, H. P. B. 1994. Privatization and Indigenization: An Assessment. In: MSAMBICHAKA, E. B. & MOSHI, H. P. B. (eds.) Development Challenges and Strategies for Tanzania. Dar es Salaam: Dar es Salaam University Press.

MSELLE, L., MOLAND, K., MVUNGI, A., EVJEN-OLSEN, B. & KOHI, T. 2013. Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. BMC Health Services Research, 13, 174.

MSHANA, E. & PETIT 2011. Synthesis of Human Resources for Health Studies conducted 2000-2011. Dar es Salaam: Pemba Consultants.

MSHANA, S., SHEMILU, H. & NDAWI, B. 2007. What do District Health Planners in Tanzania think about improving priority setting using 'Accountability for Reasonableness'? BMC Health Services Research, 7, 180.

MUBYAZI, G., KAMUGISHA, M., MUSHI, A. & BLAS, E. 2004. Implications of decentralization for the control of tropical diseases in Tanzania: A case study of four districts. International Journal of Health Planning and Management, 19, 167-S185.

MUBYAZI, G. M., MUSHI, A., KAMUGISHA, M., MASSAGA, J., MDIRA, K. Y., SEGEJA, M. & NJUNWA, K. J. 2007. Community views on health sector reform and their participation in health priority setting: case of Lushoto and Muheza districts, Tanzania. Journal of public health (Oxford, England), 29, 147-156.

MUGANDA, A. 2004. Tanzania's Economic Reforms- and Lessons Learned. Reducing Poverty, Sustaining Growth-What Works, What Doesn't, and Why A Global Exchange for Scaling Up Success Scaling Up Poverty Reduction: A Global Learning Process and Conference. Shanghai: World Bank.

MUKANDALA, R. S. 1992. Bureaucracy and Agricultural Policy: The Experience in Tanzania. In: ASMERSON, H. K., HOPPE, R. & JAIN, R. B. (eds.) Bureaucracy and Development Policies in the Third World. Amsterdam: VU University Press.

MUNGA, M. & MAESTAD, O. 2009a. Measuring inequalities in the distribution of health workers: the case of Tanzania. Human Resources for Health, 7, 4.

MUNGA, M. A. & MAESTAD, O. 2009b. Measuring inequalities in the distribution of health workers: the case of Tanzania. Human Resources for Health, 7, 4.

MUNGA, M. A., SONGSTAD, N. G., BLYSTAD, A. & MAESTAD, O. 2009. The decentralisation-centralisation dilemma: recruitment and distribution of health workers in remote districts of Tanzania. BMC Int Health Hum Rights, 9, 9.

MUNGA, M. A., TORSVIK, G. & MAESTAD, O. 2014. Using incentives to attract nurses to remote areas of Tanzania: a contingent valuation study. Health Policy Plan, 29, 227-36.

MUNGURE, E. & OWAGA, P. 2014. Family Planning in Tanzania: A Review of National and District Policies and Budgets. Arusha: Deutsche Stiftung Weltbevoelkerung.

MURRAY, C. J. & FRENK, J. 2000. A framework for assessing the performance of health systems. Bull World Health Organ, 78, 717-31.

MURTHY, R., KLUGMAN, B., WELLER, S. & AIZENBERG, L. 2005. Service accountability and community participation. In: TKS, R. & H, D. P. (eds.) The Right Reforms? Health Sector Reform and Sexual and Reproductive Health. Johannesburg: Women's Health Project, School of Public Health, University of the Witwatersrand.

MURTHY, R. K. & KLUGMAN, B. 2004. Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. Health Policy and Planning, 19, i78-i86.

MUSAU, S., GRACE, C., REBECCA, P., EMMANUEL, M., DERECK, C., ERIC, V. P. & GRETA, S. 2011. Tanzania Health System Assessment Bethesda, MD, Health Systems 20/20 project, Abt Associates Inc.

MWAFFISI, M. 1999. Corruption in the health sector. Global Integrity: 2000 and Beyond Developing Anti-Corruption Strategies in a Changing World. Durban-South Africa: The 9th International Anti-Corruption Conference.

MZUMBE-UNIVERISTY 2010. Assessment of the effectiveness of formula based Budgetary Allocation to Local Government Authorities Dar es Salaam: MoFEA

NANDA, P. 2002. Health sector reforms in Zambia: implications for reproductive health and rights: Working Paper. Tacoma Park, Maryland: Centre for Health and Gender Equity.

NANDA, P., NYONI, J. & MAKUNDI, E. A. 2005. The Implications of Health Sector Reforms on Reproductive Health Services: The Case of Bukoba District – Kagera Region, Tanzania Study.

NBS 2002. Household Budget Survey (HBS 2000/01). Dar es Salaam: Government Printers.

NBS 2013. Household Budget Survey: Key Findings. Dar es Salaam: National Bureau of Statistics.

NBS & ICF-MACRO 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania. Dar es Salaam: NBS and ICF Macro

NBS & ICF-MARCO 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam: National Bureau of Statistics and ICF Macro.

NBS & MACRO-ICF 2005. Tanzania Demographic and Health Survey 2004/2005. Dar es Salaam: National Bureau of Statistics and Macro-ICF.

NBS & MARCO, I. 2010. Tanzania Demographic and Health Survey Dar es Salaam: National Bureau of Statistics and ICF Macro.

NDAVI, P. M., OGOLA, S., KIZITO, P. M. & JOHNSON., K. 2009. Decentralizing Kenya's Health Management System: An Evaluation. Kenya Working Papers No. 1. Calverton, Maryland, USA: Macro International Inc.

NDEGWA, S. N. 2002. Decentralisation in Africa: a stock taking survey. Africa Region Working Paper Series 40. Washington, DC: World Bank.

NGWARE, S. 2000. Characteristics of Governance at the Grassroots Level. Identify Issues and Design a Research Programme to Support Local Government Reform in Tanzania, 3-4 May 2000 paper presented at a workshop organized by REPOA, NIBR and CMI. Dar es Salaam.

NGWARE, S. 2005. Is the Local Government Reform Programme Impacting Positively on the lives of Tanzanians? ESRF Policy Dialogue Seminar. Dar es Salaam: Economic and Social Research Foundation.

NSEKELA, A. J. & NHONOLI, A. M. J. A. 1976. The development of health services and society in mainland Tanzania: (a historical overview--tumetoka mbali), Kampala, East African Literature Bureau.

NYAMTEMA, A. S., JONG, A. B.-D., URASSA, D. P., HAGEN, J. P. & VAN ROOSMALEN, J. 2012. The quality of antenatal care in rural Tanzania: what is behind the number of visits? BMC pregnancy and childbirth, 12, 70-70.

NYERERE, J. K. 1967. The Arusha Declaration and TANU'S policy on socialism and self-reliance, [Arusha.

NYERERE, J. K. 1968. Socialism in Tanzania, Uppsala, Nordiska Afrikainstitutet.

NYERERE, J. K. 1972:1. Decentralisation, Dar es Salaam, Mpigachapa mkuu wa serikali.

OATES, W. 1972. Fiscal Federalism, Harcourt Brace Jovanovich, Inc. New York.

ODD-HELGE, F., KATERA, L. & NGALEWA, E. 2010. Planning in Local Government Authorities in Tanzania: Bottom-up Meets Top-down. Dar es Salaam: Paper no 8/210, REPOA.

OLIFF, M., MAYAUD, P., BRUGHA, R. & SEMAKAFU, A. M. 2003. Integrating Reproductive Health Services in a Reforming Health Sector: The Case of Tanzania. Reproductive Health Matters, 11, 37-48.

OLOWU, D. 2001a. Decentralisation Policies and Practices Under Structural Adjustment and Democratisation in Africa. Governance and Human Rights Programme Paper 4. Geneva: United Nations Research Institute for Social Development

OLOWU, D. 2001b. Local Political and Institutional Structures and Processes. Paper for the Participatory Symposium, Cape Town. South Africa: United Nations Capital Development Fund.

OLOWU, D. Local Political and Institutional Structures and Processes. Paper for the Participatory Symposium, Cape Town, 2001c South Africa, 26-30 March 2001. United Nations Capital Development Fund.

OLOWU, D. & WUNSCH, J. S. 2004. Local governance in Africa: the challenges of democratic decentralization, Boulder Colo, Lynne Reiner Publishers.

OPIE, C. 2004. Research Approaches In: OPIE, C. (ed.) Doing Educational Research: a guide to first time researchers. London: Sage Publications.

OYUGI, O. W. 1998. Bureaucracy and Democracy in Africa, Nairobi, and Heinemann Educational books Inc. University of Nairobi.

PATTON, M. Q. 1990. Qualitative evaluation and research methods, Newbury Park; London, Sage.

PATTON, M. Q. 2002. Qualitative research & evaluation methods, Thousand Oaks, Calif.; London, Sage.

PER-TIDEMAND & JAMAL, M. 2010. The impact of the local government reforms in Tanzania 1998-2008. Dar es Salaam: Special paper no 10/1, REPOA

PF 2010. Our Resources: Whose Decisions: Social Accountability Monitoring Report 2008/09. Dar es Salaam.

PICARD, L. A. 1980:40. Socialism and the Field Administrator: Decentralization in Tanzania. Comparative Politics, 12, 439-457.

PILE, J. M. & SIMBAKALIA, C. 2006. Tanzania Case Study: A Successful Program Loses Momentum A Repositioning Family Planning Case Study 2006. Available: www.acquireproject.org.

PMO-RALG 2007. Local Government Fiscal Review. Dodoma: Prime Minister’s Office Regional Administration and Local Government.

PMO-RALG. The Status of Implementation of Decentralization by Devolution on Mainland Tanzania & The Way Forward. National Convention on Public Sector Reforms 17th -18th June, 2008 Ubungo Plaza, Dar Es Salaam.

PO-PSM 2010. Public Service Pay and Incentive Policy. Dar es Salaam: President's Office-Public Service Management.

PO-RALG 2002. National Framework on Participatory Planning and Budgeting. Dodoma: President's Office-Regional Administration and Local Government.

PO-RALG 2004. Planning guidelines for villages and mitaa. Dodoma: President's Office-Regional and Local Government.

PRESTON, R., WAUGH, H., LARKINS, S. & TAYLOR, J. 2010. Community participation in rural primary health care: intervention or approach? Aust J Prim Health, 16, 4-16.

PUNCH, K. 2005. Introduction to social research : quantitative and qualitative approaches, London ; Thousand Oaks, Calif., SAGE Publications.

RAMANATHAN, M., VIJAYAN, A. & VARATHARAJAN, D. 2004. Political decentralisation and the primary health care system: examining the potential for improving women's reproductive health care in Kerala. Kerala: Trivandrum: Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology,.

RAMJI, P. D. 2009. Analysis of the Implementation Challenges of Health Sector Decentralization Policy in Nepal. Doctor of Philosophy Chulalongkorn

RANJANI, K. M. & BARBARA, K. 2004. Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. Health Policy Plan, 19 Suppl 1, i78-i86.

RATANAWIJITRASIN, S., SOUMERAI, S. B. & WEERASURIYA, K. 2001. Do national medicinal drug policies and essential drug programs improve drug use?: a review of experiences in developing countries. Social science & medicine, 53, 831-44.

RAVINDRAN, T. K. S. 2005. Understanding Health Sector Reforms and Sexual and Reproductive Health Services: A Preliminary Framework. Reproductive Health Matters, 10, 16-18.

RAVINDRAN, T. S. & HELEN, D. P. (eds.) 2005. The Right reforms? Health Sector Reforms and Sexual and Reproductive Health, South Africa: Women's Health Project , School of Public Health, University of the Witwatersrand.

REICH, M. R. 1995. The politics of health sector reform in developing countries: three cases of pharmaceutical policy. Health Policy, 32, 47-77.

REICHENBACH, L. 2002. The Politics of Priority Setting for Reproductive Health: Breast and Cervical Cancer in Ghana. Reproductive Health Matters, 10, 47-58.

RIBOT, J. C. 2002. African Decentralization: Local Actors, Powers and Accountability. United Nations Research Institute for Social Development

RIBOT, J. C. & AGRAWAL, A. 1999. Accountability in decentralization: A framework with South Asian and African cases. Journal of Developing Areas, 33 Summer, 473-502.

RIGHTS, C. F. R. 2012. Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Mainland Tanzania. New York.

ROBALINO, D., PICAZO, O. & VOETBERG, A. 2001. Does fiscal decentralization improve health outcomes? Evidence from a cross-country analysis". Policy Research Working Paper 2565. Washington DC: World Bank.

ROBERTS, M., HSIAO, W., BERMAN, P. & REICH, M. 2004. Getting health reform right: A guide to improving performance and equity, New York, Oxford University Press.

ROBINSON, M. 2007. Does Decentralisation Improve Equity and Efficiency in Public Service Delivery Provision? IDS Bulletin, 38, 7-17.

ROGERS, R. 2000. Impact of health care reform on contraceptives logistics. Washington DC, USAID.

RONDINELLI, D. A. 1981. Government Decentralization in Comparative Perspective: Theory and Practice in Developing Countries. International Review of Administrative Sciences, 47, 133-145.

RONDINELLI, D. A., CHEEMA, G. S., NELLIS, J. R. & WORLD BANK 1983. Decentralization in developing countries : a review of recent experience, Washington, D.C, World Bank.

RONDINELLI, D. A., MCCULLOUGH, J. S. & JOHNSON, R. W. 1989. Analysing Decentralization Policies in Developing Countries: a Political-Economy Framework. Development and Change, 20, 57-87.

RONDINELLI, D. A. & NELLIS, J. R. 1986. Assessing Decentralization Policies in Developing Countries: The Case for Cautious Optimism1. Development Policy Review, 4, 3-23.

SAAVEDRA, P. A. 2010. A Study of the Impact of Decentralization on Access to Service Delivery Dissertations -Paper 40, Georgia State University-Department of Public Management and Policy.

SABATIER, P. A. 1986. Top-Down and Bottom-Up Approaches to Implementation Research: a Critical Analysis and Suggested Synthesis. Journal of Public Policy, 6, 21-48.

SABATIER, P. A. 1990. Public Policy: Toward better theories of the policy process, Evanston Illinois, North-western University Press.

SABATIER, P. A. 1991. Toward better themes of the policy process. Political Science and Politics, 24, 144-156.

SABATIER, P. A. 1999. Theories of the policy process, Boulder, Colo. ; Oxford, Westview.

SABATIER, P. A. & JENKINS-SMITH, H. C. 1993. Policy change and learning :An advocacy coalition approach, Boulder Colo, Westview Press.

SAHN, D. E. & BEMIER, R. 1993. Has structural adjustment led to health sector reform in Africa? Health sector reform in developing countries: Issues for the 199Os. Durham, New Hampshire.

SAKYI, E. K. 2008. A retrospective content analysis of studies on factors constraining the implementation of health sector reform in Ghana. The International Journal of Health Planning and Management, 23, 259-285.

SAKYI, E. K., AWOONOR-WILLIAMS, J. K. & ADZEI, F. A. 2011. Barriers to implementing health sector administrative decentralisation in Ghana: a study of the Nkwanta district health management team. J Health Organ Manag, 25, 400-19.

SALTMAN, R. B. 1997. The context for health reform in the United Kingdom, Sweden, Germany, and the United States. Health Policy, 41, Supplement, S9-S26.

SALTMAN, R. B. 2008. Decentralization, re-centralization and future European health policy. European journal of public health, 18, 104-6.

SALTMAN, R. B. & BANKAUSKAITE, V. 2006. Conceptualizing decentralization in European health systems: a functional perspective. Health economics, policy, and law, 1, 127-47.

SALTMAN, R. B., BANKAUSKAITE, V., VRANGBÆK, K. & EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES. 2007. Decentralization in health care : strategies and outcomes, Maidenhead, McGraw-Hill/Open University Press.

SAPRU, R. K. 2004. Public Policy: Formulation, Implementation and Evaluation, New-Delhi, Sterling.

SARA 2012. Tanzania Service Availability and Readiness Assessment (SARA) 2012 – final report submitted for review. Dar es Salaam: Ministry of Health and Social Welfare.

SCOTT-SAMUEL, A., BAMBRA, C. & FOX, D. 2005. Towards a politics of health promotion. Health Promotion International, , 20, 186 -193.

SEMALI, I., DE SAVIGNY, D. & TANNER, M. 2005. Health Sector Reform And Decentralization In Tanzania: The Case Of The Expanded Programme On Immunization At District. Journal of Health & Population in Developing Countries, 1 - 14.

SEMALI, I. A. J. 2003. Understanding Stakeholders Roles in Health Sector Reform process in Tanzania: The Case of Decentralizing the Immunization Program. Doctor of Philosophy, Basel.

SEMALI, I. A. J., TANNER, M. & SAVIGNY, D. D. 2007. Health Reform Cycles in Tanzania:1924-1994. Tanzania Journal of Development Studies, 7, 89-102.

SHAH, A. 1998. Balance, Accountability, and Responsiveness: Lessons about Decentralization. Washington, D.C: World Bank.

SHAYO, E., MBOERA, L. & BLYSTAD, A. 2013. Stakeholders' participation in planning and priority setting in the context of a decentralised health care system: the case of prevention of mother to child transmission of HIV programme in Tanzania. BMC Health Services Research, 13, 273.

SHIFFMAN, J. & WU, Y. 2003. Norms in tension: democracy and efficiency in Bangladeshi health and population sector reform. Soc Sci Med, 57, 1547-57.

SID 2012. The State of East Africa 2012. Deepening Integration, Intensifying Challenges. April, 2012 ed.: Society for International Development (SID), and Trademark East Africa (TMEA).

SILVERMAN, D. 2005. Doing Qualitative Research (2nd ed), London, Sage Publications Limited.

SINGH, S., DARROCH, J. E. & ASHFORD, S. L. 2014. Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014. New York: Guttmacher Institute.

SIRILI, N., KIWARA, A., NYONGOLE, O., FRUMENCE, G., SEMAKAFU, A. & HURTIG, A. K. 2014. Addressing the human resource for health crisis in Tanzania: the lost in transition syndrome. Tanzan J Health Res, 16, 104-11.

STANDING, H. 2002. An overview of changing agendas in health sector reforms. Reproductive health matters, 10, 19-28.

STEFFENSEN, T. & MWAIPOPO, J. 2004. A Comparative Analysis of decentralization in Kenya, Tanzania and Uganda, Tanzania Country Study.

SUTTON, R. 1990. The policy process: An overview. London (ODI working paper No. 118): Overseas Development Institute.

TACAIDS 2013. Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam: Tanzania Commission for AIDS.

THERKILDSEN, O. & METTE, K. 2010. Elections and Landmark policies in Tanzania and Uganda. Seminar in Political Science department Århus University Danish Institute for International Studies and Department of Political Science

TIDEMAND, P. & DEGE, N. S. 2010. Comparative assessment of decentralization in Africa: Tanzania desk study. Washington DC: USAID

TIDEMAND, P. & MSAMI, J. 2008. The impact of local government reforms in Tanzania 1998-2008 Special paper 10/1 [Online]. Available: http://www.repoa.or.tz/documents/10-1_SP_lr.pdf [Accessed 12.3.2012].

TIDEMAND, P. & SOLA, N. 2010a. Comparative Assessment of Decentralization in Africa: Tanzania Desk Study Washington DC: United States Agency for International Development.

TIDEMAND, P. & SOLA, N. 2010b. Comparative Assessment of Decentralization in Africa: Tanzania Desk Study. Washington DC: USAID.

TRAVIS, P., DOMINIQUE, E., PHILIP, D. & ABDELHAY, M. 2002. Towards better stewardship: concepts and critical issues. Geneva: World Health Organization, WHO/EIP/DP 02.4.

TREISMAN, D. 2000. Decentralization and the Quality of Government. Department of Political Science Working Paper. University of California, Los Angeles.

UCHIMURA, H. & JÜTTING, J. 2007. Fiscal decentralization, Chinese Style: good for health outcomes? : OECD Development Centre Working Paper.

UNDP. 2005. Population, Reproductive Health and the Millennium Development Goal: Messages from the UN Millennium Project Reports. Available: http://www.unmillenniumproject.org/documents/SRHbooklet080105.pdf.

URT 1983. Taarifa ya Kamati Maalum ya Kuchunguza Uhusiano Kati ya Wizara na Mikoa Baada ya Kuanzishwa kwa Halmashauri za Wilaya.

URT 1992. Household Budget Survey 1990/1991 Dar es Salaam: Government Printers.

URT 1996. Local government reform agenda. Dar es Salaam: Ministry of Regional Administration and Local Government.

URT 1997a. The Constitution of the United Republic of Tanzania Dar es Salaam: Government Printers.

URT 1997b. Health Sector Reform Support Project. Dar es Salaam: Ministry of Health

URT 1997c. Socio Policy Formulation Process, Dar es Salaam, Government Printers

URT 1998a. The Local Government Reform Policy. Ministry of Regional Administration and Local Governments. .

URT 1998b. National District Health Planning Guidelines. Dar es Salaam: Ministry of Health.

URT 1998c. Policy Paper on Local Government Reform. Dar es Salaam: Ministry of Regional Administration and Local Government

URT 2000. Guidelines for the establishment and operations of Council Health Board and Health Facility Committees. Dar es Salaam: Ministry of Health and Ministry of Regional Administration and Local Government.

URT 2001a. Establishment of Bylaw for Council Health Service Board. Dar es Salaam: MOH & PORALG.

URT 2001b. Government of Tanzania, Acts Supplement to the Gazette of the United Republic of Tanzania No. 14 Vol. 82 dated 6th April. Dar es Salaam: Government printer.

URT 2001c. Guidelines for the establishment and operations of Council Health Board and Health Facility Committees. Dar es Salaam: Ministry of Health and Ministry of Regional Administration and Local Government.

URT 2001d. National Framework on Participatory District Planning and Budgeting in Tanzania. Dar es Salaam: President's Office Regional Administration and Local Government.

URT 2003. Second Health Sector Strategic Plan (HSSP) II : July 2003-June 2008. Dar es Salaam Ministry of Health and Social Welfare.

URT 2006. The Local Government System in Tanzania http://www.dpwg-lgd.org/cms/upload/pdf/HAin_the_field_of_Local_Governace_and_Decentralization.pdf. Ministry of Local Government

URT 2007a. Evaluation of Local Government Reform Program (LGRP). Dar es Salaam: PMO-RALG.

URT 2007b. Local government fiscal review 2007: Measuring progress on decentralization by devolution. Dodoma: Prime Minister's Office-Regional Administration and Local Government.

URT 2007:4. Local Government Fiscal Review: Measuring Progress on Decentralization by Devolution Dar es Salaam Central Printing Works Limited.

URT 2008a. The Local Government Reform Programme II (Decentralization by Devolution) Vision, Goals and Strategy July 2009 – June 2014. Dar es Salaam: Prime Minister's office Regional Administration and Local Government.

URT 2008b. A performance audit report on the management of primary health care: a case study of health centres Dar es Salaam: National Audit Office

URT 2009a. Annual Health Statistical Tables and Figures : United Republic of Tanzania. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.

URT 2009b. Local Government Reform Programme II (Decentralization by Devolution): Vision, Goals and obstacles to delivering services to the poor. Dar es Salaam: PMO-RALG.

URT 2009c. Poverty and Human Development Report. In: MKUKUTA SECRETARIAT, P. E. D., MINISTRY OF PLANNING, ECONOMY AND EMPOWERMENT (ed.). Dar es Salaam: Research on Poverty Alleviation

URT 2011a. The budget speech for the financial year 2011/12 by the minister for Finance and Economic Affairs: honourable Mustapha Mkulo (MP). Dar es Salaam: Ministry of Finance and Economic Affairs.

URT 2011b. Summary and analysis of comprehensive council health plans: 2011/12 report. Dar es Salaam: MoHSW and PMO-RALG.

URT 2011:6. Comprehensive Council planning for 2011/2012. Dodoma Bahi district council

URT 2013. Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam: National Bureau of Statistics.

VAN DORMAEL, M., DUGAS, S., KONE, Y., COULIBALY, S., SY, M., MARCHAL, B. & DESPLATS, D. 2008. Appropriate training and retention of community doctors in rural areas: a case study from Mali. Human Resources for Health, 6, 25.

VENUGOPAL, V. & YILMAZ, S. 2010. Decentralization in Tanzania: An assessment of local government discretion and accountability. Public Administration and Development, 30, 215-231.

WALT, G. 1996. Health Policy: An Introduction to Process and Power, London, Zed Books.

WALT, G. & GILSON, L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, 9, 353-70.

WALT, G. & TANTIVESS, S. 2008. The role of state and non-state actors in the policy process: the contribution of policy networks to the scale-up of antiretroviral therapy in Thailand. Health Policy and Planning, 23, 328-338.

WANGWE, S., SEMBOJA, H. & TIBANDABAGE, T. (eds.) 1998. Transitional Economic and Policy Options in Tanzania. Tanzania Political Economic Series, 1, Dar es Salaam: Mkuki na Nyota Publishers.

WANGWE, S. M., MUSONDA, F. M. & KWEKA, J. P. 1997. An Assessment of the Economic and Social Implications of the Economic Reform Programme. Dar es Salaam: Economic and Social Research Foundation.

WARIOBA, M. 1999. Some profiles in the Tanzania decentralization systems before1976:Concepts and trends.

WATT, S., SWORD, W. & KRUEGER, P. 2005. Implementation of a health care policy: an analysis of barriers and facilitators to practice change. BMC Health Services Research, 5, 53.

WB 2000. World Development Report 1999/2000: Entering the 21st Century: The Changing Development Landscape, Oxford. Oxford University Press.

WEINSTEIN, L. 2010:53. The Politics of Government Expenditures in Tanzania: 1999-2007 Working Group in African Political Economy. Pomona College.

WENZEL, H. D. & WIEDEMANN, R. 1989. Tanzania's economic performance in the eighties. Studies in Applied Economics and Rural Development, 20.

WHO 1998a. The Challenge of Implementation: District Health Systems for Primary Health Care, Geneva, World Health Organisation.

WHO 1998b. Health for All Renewal: Building Sustainable Health Systems-From Policy to Action Geneva: World Health Organization.

WHO 2000. The World Health Report: Health Systems: Improving Performance. Geneva: World Health Organization

WHO. 2001. World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. 79.

WHO 2004. Health sector reform and reproductive health: report of a technical consultation. Geneva, Switzerland: World Health Organization, Department of Reproductive Health and Research.

WHO 2009. Monitoring and Evaluation of Human Resources for Health: With special applications for low- and middle-income countries. In: MARIO R, D. P., GUPTA, N., QUAIN, E. & SOUCAT, A. L. (eds.). Geneva: World Health Organization.

WHO 2014. Trends in Maternal Mortality: 1990 to 2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division Geneva: World Health Organisation.

WORLD-BANK 1987. Financing health services in developing countries: an agenda for reform: A World Bank Policy Study. Washington DC: World Bank

WORLD-BANK 1993. Investing in health, Oxford University Press for the World bank.

WORLD-BANK 2000a. Decentralization: rethinking government. World Development Report 1999/2000. Washington DC: World Bank.

WORLD-BANK 2000b. World Development Report 1999/2000: Entering the 21st Century: The Changing Development Landscape, Oxford, and Oxford University Press.

WORLD-BANK 2001. Decentralisation and governance :does decentralisation improve public service delivery Washington Dc: World Bank.

WORLD-BANK 2002. Tanzania at the Turn of the Century: Background Papers and Statistics. A World Bank country study. Washington, D.C: World Bank.

WORLD-BANK 2004. World Development Report: Making services work for the poor. Washington DC: World Bank.

WORLD-BANK 2005a. Bolivia Country Assistance Strategy Evaluation Washington Dc: World Bank.

WORLD-BANK 2005b. Devolution in Pakistan. Washington Dc: World Bank.

WORLD BANK. 2004. Health sector reform in Bolivia : a decentralization case study, Washington, D.C., World Bank.

WRAGG, T. 2002. Interviewing. In: COLEMAN, M. & BRIGGS, A. R. J. (eds.) Research Methods in Educational Leadership and Management. London: Paul Chapman Publishing.

WUNCH, J. 2001. Why decentralisation has failed in Africa. Public Administration and Development, 21, 277-288.

YAN, Q. 2009. Fiscal Decentralization and Health Outcomes.

YANOW, D. 1996. How does a policy mean? : interpreting policy and organizational actions, Washington, D.C., Georgetown University Press.

YANOW, D. 2000. Conducting interpretive policy analysis, Thousand Oaks, Calif. ; London, Sage.

YANOW, D., SCHWARTZ-SHEA, P. & NETLIBRARY INC. 2006. Interpretation and method empirical research methods and the interpretive turn. Armonk, N.Y.: M.E. Sharpe.

YEE, E. 2001. The Effects of Fiscal Decentralisation on Health Care in China. Undergraduate Journal of Economics, 5.

YIN, R., K 2003a. Case study research: design and methods: Applied social research methods series, Thousand Oaks, California, Sage Publications.

YIN, R. K. 2003b. Applications of case study research, Thousand Oaks ; London, Sage Publications.

YIN, R. K. 2009. Case study research : design and methods, London, SAGE.

YOSHIDA, M. 2008. Decentralized service delivery in Tanzania. Regional Development Dialogue, 29, 117-133.

ZWI, A. B. & MILLS, A. 1995. Health policy in less developed countries: past trends and future directions. Journal of International Development, 7, 299-328.

List of Annexes

Annex i: SOAS clearance letter

Dear Cresencia

Re: **Application for Registered Overseas Fieldwork**

Thank you for forwarding to the Registry your completed application for Overseas Fieldwork.

You should note that the Registry must be informed in writing of any proposed changes to your period of Overseas Fieldwork. SOAS records changes of status and corresponding fees on a termly basis. As your period of Overseas Fieldwork will begin on 15 July 2010 and extend until 15 June 2011, our records will note that you are on Overseas Fieldwork for Terms 1 and 2 of the 2010/11 sessions. Therefore, your pattern of study for the 2010/2011 session will be as follows.

2010-2011

Term 1	Fieldwork
Term 2	Fieldwork
Term 3	Full-time

Information regarding your 2010-11 tuition fees will be sent to you over the summer. Please note that fees are due before 27 September 2010. The 2010/2011 academic session commences on 27 September 2010. The Registry will forward information about the 2010/2011 session enrolment procedure in the summer of 2010. As you will be on Fieldwork during the beginning of the academic session you do not need to come to enrolment but should come to the Registry when you return from fieldwork, to complete enrolment formalities.

I wish you every success in your Fieldwork.

Kind regards

Lauren Malley (Ms)

Assistant Manager: Postgraduate Research Registry

School of Oriental and African Studies: University of London

Local clearance letter

UNITED REPUBLIC OF TANZANIA

Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

22nd November 2010

National Institute for Medical Research
P.O. Box 9653
Dar es Salaam
Tel: 255 22 2121400/390
Fax: 255 22 2121380/2121360
E-mail: headquarters
(w.nimr.or.tz

*NIMRlHQ/R.8aNol.*IXIl035

Cresencia A Masawe
Dar es Salaam University College of Education
University of Dar es Salaam
P.O. Box 2329
DAR ES SALAAM

CLEARANCE CERTIFICATE FOR CONDUCTING
MEDICAL RESEARCH IN TANZANIA

This is to certify that the research entitled: Health Sector Reform and Women's Reproductive Health Services in Rural Tanzania, (Masawe C A *et al),* has been granted ethics clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1.Progress report is submitted to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.

2.Permission to publish the results is obtained from National Institute for Medical Research.

3.Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.

4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).

5. Approval is for one year: 22nd November 2010 to 21st November 2011.

Name: Dr. Mwelecele N Malecela
ACTING CHAIRPERSON MEDICAL RESEARCH COORDINATING COMMITTEE

Name: Dr. Doe M Mtasiwa
CHIEF MEDICAL OFFICER

cc RMO
cc DMO

Annex ii: Research protocol

A consent form

Title of the Research: **health sector decentralisation and its impact reproductive health services in Tanzania**

Hello, my name is Cresencia Masawe, and I am conducting research towards a doctoral degree. I am researching on the women's reproductive health services in rural Tanzania under decentralisation reform policy and would like to invite you to participate in the project.

Brief information on the study
This is an academic study. I am interested in studying how reform policy has been implemented in Tanzania and its impact on reproductive health care delivery. The key question is to investigate policy and practice on the reform process. I want to understand whether the reform impact positively or negatively on women's reproductive health care delivery in rural settings. You are selected to participate in this study because you are among the stakeholders in the reform process.

Mode of Participation
Please understand that your participation in this study is voluntary. The choice to participate is yours alone. If you choose not to participate, there will be no negative consequence. If you choose to participate, but wish to withdraw at any time, you will be free to do so without negative consequence. However, I would be grateful if you assist me by allowing me to interview you.

You will answer some questions which will take you a maximum of 40 minutes. I would also like to tape-record this interview. Should you have no objection to this, please tick in the box below. Please understand that you may choose not to be tape-recorded.

I agree

Reimbursement, Costs and possible harm
Kindly understand that this is just an academic study, you will not receive any payment for your participation. Please also understand that you will not directly benefit by taking part in this research. I do not anticipate that you will suffer any kind of harm or incur any cost for participating in this study.

Anonymity and confidentiality

Information collected shall be kept with high secrecy and accessed by the researcher only. Your personal particulars will not be used in the report without your consent. Please understand, you have no obligation to provide your personal particulars (name, occupation, title). However, if you have no objection, your personal particulars will be recorded on a separate sheet which will be kept separately. Please kindly note that information collected from you will be used only in compiling the final report and discarded after the production of the final draft.

I regret it may not be possible to give you the final report. However, I will deposit copies at the library of the University of Dar es Salaam, and National Institute for Medical research and the Ministry of Health. As well the Regional and council library shall receive a copy.

Signature of Participant: ________________________Date: __________________

Key Informant interview guide

Objective of the study: To understand the implementation of health sector decentralisation and its impact on reproductive health care delivery in ruralTanzania

<table>
<tr><td></td><td>Interview check list</td><td>Coding</td></tr>
<tr><td></td><td>Date and place of the interview</td><td></td></tr>
<tr><td>1</td><td>Policy formulation
Who formulated the decentralisation policy? Probe on consultation
Why did the government decide to decentralise health sector decentralisation? Probe on: availability of services according to the local needs, better management of health resources at the local , community participation of the local communities in local health plans and accountability on service delivery
What are the features of decentralised health care delivery?
How does policy formulation process proceed?</td><td>Context, Actors knowledge and objective of decentralisation</td></tr>
<tr><td>2</td><td>Policy implementation
What changes were made in the organisational structure to implement decentralisation? probe on the functional of facility health committees or councillors
How do changes in decentralisation influence the implementation of reproductive health programs?</td><td>Organisational structure</td></tr>
<tr><td>3</td><td>What are the changes made in community participation and accountability
How does local health plan take place? Who participate? What is the basis of planning? Who set the service targets for the health programs? What are the differences do you noticed in planning practices? Does the local plan gives any special focus to reproductive health?</td><td>Decision space for the political decentralisation</td></tr>
<tr><td>4</td><td>What are changes made in health financing and expenditure? Probe on budget guidelines, source of local health funds, expenditure patterns ,funding for RH programs, health facilities responsibilities for their budget, timely release of fund, council decision to allocate funds according to the local needs</td><td>Decision space for the fiscal decentralisation</td></tr>
<tr><td>5</td><td>What are the changes made in human resources management in the council? Probe on: civil services arrangement , council authority on hiring staff according to the need, authority to approve and transfer staffs</td><td>Decision space for administrative decentralisation</td></tr>
<tr><td>6</td><td>Decentralisation and its implication on reproductive health
What are the changes of reproductive health programs brought by the implementation of decentralisation policy?
To what extent are the key changes of health care decentralisation has impacted on the implementation of the reproductive health programs?
Which features of health system decentralisation are beneficial and or not beneficial to sexual and reproductive health?
What is your opinion regarding decentralisation and it impact on RH programs? (probe on service organization, priority setting , community participation and accountability, human resources, funding)
Comment over general changes of decentralisation in relation to RH programs</td><td>Decentralisation outcomes on reproductive health</td></tr>
</table>

Decision space mapping table for the health managers and LGAs officials

Decision space mapping			
Selected functions	Range of choice		
	Narrow	Moderate	Wide
Finance • Source of revenue • Allocation of expenditure • Income from fees			
Service organization • Health facility autonomy • Insurance plans • Payment mechanism			
Human resources • Recruitment and contracts • Salaries • Transfer			
Governance • Facility boards • Community participation in planning • Local accountability • Prioritisation of local health needs			

Focus group discussion guidelines

Focus Group Discussion guidelines with the RHMTs and CHMTs

1. What are your group's views about health sector decentralisation policy? Probe on their understanding, availability of policy documents)

2. What strategies were taken to implement decentralisation policy?

3. How does council health panning take place? Who are involved in the process? (Structures, criteria for participation, service users representation)

4. What is the group opinion with regard to the status of implementation of health sector decentralisation?

5. What is your opinion regarding decentralisation and provision of reproductive health services? (probe on changes on services delviery)

6. How facility health committees do works? (Look on formulation process and its functionality, and the acts of accountability as service users representatives)

7. What is the group's suggestion for decentralisation to be more effective?

Focus Group Discussion guidelines with the Facility committees and facility managers

1 What are your group's views about health sector decentralisation policy? Probe on their understanding, availability of policy documents and implementation viability)
2 How facility health committees do works? (Look on formulation process and its functionality, and the acts of accountability as service users representatives)
3 How does council health panning take place? Does council health plan address local needs? (A copy of facility plan if available)
4 What role did the HFCs played to address health matters? (look on meeting agendas, answerability mechanism)
5 What is the group opinion with regard to the status of implementation of health sector decentralisation? Is there any difference in practises before and after decentralisation?
6 What is your opinion regarding decentralisation in relation to sexual and reproductive health?
7 Is there anything further you would like to discuss? (recommendations)

Focus Group Discussion guidelines with men services users

1. What is the group view about decentralisation objectives. (Probe about understanding of objectives for health sector decentralisation)

2. What have been the changes on the decentralised health service delivery (in planning process, resource allocation/mobilization and formation of health facility committee)

3. Have there been any significant changes on reproductive health care services after introducing the decentralisation?

4. How would you describe the quality of health care services provided by the health facility? (probe on privacy, drugs, contraceptives availability)

5. What is your opinion regarding decentralisation in relation to services delivery?

6. Is there anything further you would like to discuss?

Focus Group Discussion guidelines with women services users

1. What is the group view about decentralisation objectives. (Probe about understanding of objectives for health sector decentralisation)

2. What are the changes that have been noted with respect to decentralisation /health reforms? Probe on participation in planning process

3. What are the reproductive health problems in your community?

4. Have there been any significant changes on the quality of reproductive health care services after decentralisation/health reforms?

5. How would you describe the quality of reproductive health care provided in your local health facility? (Privacy, drugs, contraceptives availability)

6. What is your opinion regarding decentralisation in relation to sexual and reproductive health?

7. Is there anything further you would like to discuss?

Annex iii: List of persons interviewed

Name of the title	Organization Affiliation
1) District health coordinator	Ministry of health
2) Basket fund coordinator	-Ministry of health
3) Reproductive health coordinator	-Ministry of health
4) Communication officer	-Ministry of health
5) Health sector secretariat representative	-Ministry of health
6) Human resource director	-Public service management
7) Public policy director	-President's office
8) Council health services coordinator	-Prime Minister's office
9) Social services coordinator	-Prime Minister's office
10) ALAT representative	-Prime Minister's Office
11) Gender director	-Ministry of Gender
12) NGO's representatives	-SIKIKA &TGNP
13) Donor representatives	-UNFPA& USAID
14) Regional Medical officer	-Region
15) Reproductive health coordinator	-Region
16) Local government secretariat	-Region
17) District director	-Council
18) District commissioner	-Council
19) Council Administrator and human resource officer	-Council
20) District medical officer	Council
21) District health secretary	-Council
22) Council reproductive health coordinator	-Council
23) Council member of the Parliament	-Parliament
24) Women member of the Parliament representative	-Parliament
25) Council chairperson	-Council
26) Women councillors (2)	-Council
27) Men councillors(2)	-Service Providers
28) Facility in-in charge (6)	-Service Providers
29) Reproductive health coordinator at facility level (4)	-Service Providers
30) Ward executive officer	- Ward
31) Village executive director	-Village
LIST OF FOCUS GROUPS	
1) Regional health management team (1)	
2) Council health management team (1)	
3) Facility health committees (4)	
4) Community level (8)	

Annex iv: List of the documents reviewed

1. Community health fund operations and guidelines 2001
2. DANIDA- Joint External Evaluation of the Health Sector in Tanzania 1999-2006
3. Government of Tanzania Local Government Reform Agenda 1996-2000
4. Government of Tanzania Local Government District Authority Act, 1982
5. Government of Tanzania -Local Government Laws (Miscellaneous Amendments) Act, 2006
6. Government of Tanzania-National Development Vision 2025
7. Government of Tanzania Public service reform program 2000
8. Government of Tanzania- The Constitutional of the United Republic of Tanzania 1977
9. Government of Tanzania-Community Health Fund Act 2001
10. Government of Tanzania-Five Year Development Plan 2011/12-2015/16:Unleash Tanzania's latent growth potentials
11. Government of Tanzania-Policy Paper on Local Government reform 1998
12. Integrating reproductive health services in a reforming health sector: the case of Tanzania Ollif, 2003
13. Local government District Authorities Act 1982
14. Ministry of Finance and Economic Empowerment National Strategy for Growth and Poverty Reduction
15. Ministry of Finance and Economic Empowerment: Five years Development planning 2011/12-2015/16
16. Ministry of Finance and Economic Empowerment: National annual budget speech for 2012/2013

17. Ministry of Finance and Economic Affairs-Assessment of the effectiveness of formula based budgetary allocation to local government authorities 2010

18. Ministry of Health and Prime Minister's Office-Regional Administration and local Government -Comprehensive Council Health Plan Guidelines 2010

19. Ministry of Health and Prime Minister's Office-Regional Administration and local Government -Primary Health Sector Development Program 2007-2017

20. Ministry of Health and Prime Minister's Office-Regional Administration and local Government-Joint Field Visits 19th- 23rd September, 2011 Summary Findings

21. Ministry of Health and Prime Minister's Office-Regional Administration and local Government-Summary and analysis of comprehensive council health plans: 2011/12 report

22. Ministry of Health and Social Welfare Annual Budget speech for 2012/2013

23. Ministry of Health and Social Welfare - Human Resource, for Health Strategic Plan (2008–2013)

24. Ministry of Health and Social Welfare Health- National Family Planning Costed Implementation Program (2010–2015), and the National Plan of Action for Orphans Vulnerable Children

25. Ministry of Health and Social Welfare Health- National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child deaths in Tanzania ("One Plan") (2008–2015)

26. Ministry of Health and Social Welfare Health-Technical Review Meeting: Public Expenditure Review

27. Ministry of Health and Social Welfare -Summary and Analysis of CCHPs 2012/13and Progress Report

28. Ministry of Health and Social Welfare-12th Joint Annual Health Sector Review 2011 Main Meeting, 3 November 2011

29. Ministry of Health and Social Welfare-Health sector performance profile :Mainland Tanzania July 2009 to June 2010

30. Ministry of Health and Social Welfare-Health Sector Performance Profile Report 2011

31. Ministry of Health and Social Welfare-Health Sector Public Expenditure Review 2010/11

32. Ministry of Health and Social Welfare-Public Expenditure Review for Human Resources for Health 2011

33. Ministry of Health and Social Welfare-12th Joint Annual Health Sector Review 2011 Main Meeting, 3 November 2011

34. Ministry of Health and Social Welfare-Technical Review Meeting: Public Expenditure Review 2012

35. Ministry of Health and Social Welfare- Summary and analysis of comprehensive council health plans 2011/12

36. Ministry of Health- health Sector Reform Plan of Action July 199 to June 2002

37. Ministry of Health -Health sector reform program of work 1998

38. Ministry of Health -Health sector strategic plan ii (2003-2008)

39. Ministry of Health -Health sector strategic plan iii (2009-2015)

40. Ministry of Health -National Health policy 1990 last revised 2007

41. Ministry of Health -National Package of Essential Reproductive and Child Health Interventions 2003

42. Ministry of Health- National policy guidelines for reproductive and child health services, 2003

43. Ministry of Health- Report on health sector reform dissemination workshop 1998

44. Ministry of Health-Guidelines for the establishment and operations of Council Health Board and Health Facility Committees 2001

45. Ministry of Health-health sector reform Plan of Action 1996-1999

46. Ministry of Health-National District Health Planning Guidelines 1998

47. Ministry of Health-National Package of Essential Health Interventions 2000

48. Ministry of Health-priority activities to be implemented by MoH July 1999- June 2000

49. Ministry of Health-Proposal for health sector reform 1994

50. Ministry of Health-Strategic Plan for Integration of Health Services in Tanzania, 2003

51. National Audit Office- Annual General Report of the Controller and Audit General. 2013

52. National Audit Office- Report of the Controller and Auditor General on Special Audit on Drugs Availability at Medical Stores Department (MSD), 2012

53. President's Office, Public Service Management -Public Service Pay and Incentive Policy2010

54. Prime Minister's Office-Regional Administration and local Government-Local Government Reforms Programme II, Decentralisation by Devolution, Vision Goals and Strategy 2009

55. Guidelines for the establishment and operations of Council Health Board and Health Facility Committees 2000

56. Government of Tanzania-Public Service reform programme 2000

57. Government of Tanzania-Social Policy Formulation Process 1997

58. Government of Tanzania-Evaluation of Local Government Reform Program 2007

59. Government of Tanzania -Constitution of the United Republic of Tanzania 1977