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RESEARCH ARTICLE

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Health sector decentralisation in Tanzania: How do institutional capacities influence use of decision space?

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Summary

While decentralisation of health systems has dominated political arena in the low-income and middle-income countries since the 1970s, there is scarcity of studies on how organisational capacities influence the ability of the decentralised local-level officials to use the available decision space. Using qualitative approach through in-depth interviews and focus group discussions in 4 districts in Tanzania, this study explored how organisational capacities influence the use of decision space available in the 5 broad categories namely planning, finance, human resources, service organisation, and governance. The findings of the study indicated that while the district health managers had authority in many health system functional areas, limited capacity of the local government in financial resources highly affected their capacity to make use of the available decision space. In addition, while the district health managers had skills, knowledge, and experiences in preparing district health plans, health facilities and community representatives had limited capacity. Most of the health facilities had critical shortage of skilled health providers. Similarly, health committees had limited capacity in knowledge and skills. This study concludes that decentralisation will only improve delivery of health services when an appropriate degree of discretion is combined with adequate institutional capacities to enable exercise of those authorities. The district councils and the Ministry of Health should strengthen the capacities of health service providers and members of health committees and boards.

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KEYWORDS

decentralisation, decision space, institutional capacities, Tanzania

1 | BACKGROUND AND CONTEXT

Decentralisation of health systems has dominated political arena in the low-income and middle-income countries since the 1970s. It is 1 of the most widely debated concept with many forms and dimensions and varies greatly within and among countries. Decentralisation broadly refers to the transfer of decision-making authority from the central government to agencies and actors at subnational levels.[1-3]

Decentralisation is often classified along political, fiscal, and administrative lines. Political decentralisation transfers authority to make decisions from the central government to the subnational levels including grassroots. Fiscal decentralisation refers to the ability of the decentralised local authorities to control financial resources, including generating and allocating funds. Administrative decentralisation deals with the relationships of authority between the central and local government authorities.[1,4] Dennis Rondinelli proposed 3 forms of decentralisation, namely deconcentration, delegation, and devolution.[1] Mills[5] further refined these forms of decentralisation to include privatisation as a fourth form of decentralisation. While this categorisation of decentralisation has been widely discussed, in practice, countries may use a combination of models to meet their specific needs.[2]

In the health sector, decentralisation and public services delivery continue to invite debate. The proponents of decentralisation argue that smaller organisations which have decision-making autonomy are closer to the people, and they are more active, innovative, and responsive to the needs of the people they serve.[6] Bringing services closer to the people, for instance, increases likelihood of responding to the local health priorities and therefore increases use of the services.[6] Other scholars add that decentralisation provide opportunity for community participation in planning and service delivery,[7,8] and improve quality, access, and equity.[4,7,8] On the other hand, opponents argue that the health sector is complex and involves numerous functions, and that greater local autonomy may undermine the performance of the health system.[9] They also argue that the skills and knowledge of the decision makers at the subnational levels are often too weak to make and implement good decisions about delivery and management of health services.[10]

Bossert[11] argues that decentralisation naturally grants decision-making space to the local-level authorities. The decision space is reflected in the different health system functional areas such as finance, human resources, service organisation, access rules, and governance.[11-13] Decision space is assessed by determining how much power for decision-making on different functions is granted to local-level authorities from the central government officially.[11-13] The decision space approach classifies the wide range of decision-making space as being *narrow*, *moderate*, or *wide*.[7,11-14] The wider the decision space in the functions, the better the performance of the decentralised local authorities in service delivery and vice versa.[11-15]

Besides what is written in official documents, the actual exercise of authorities in the decentralised contexts may be different from what is stated in the policies and thus may vary from 1 district to another. For example, decentralisation of revenue and expenditure may or may not occur together with decentralisation of administrative functions such as human resource management, governance, or the organisation of services.[11] The central government, for example, may attempt to maintain a tight command over local-level decisions by introducing red tape related to officially "local" decisions.[11-15] Similarly, the central government can use financial decision space to affect administrative decision space. For example, greater local-level authority by health officials over administrative functions such as recruitment and hiring of medical personnel may not be matched with greater authority over financial decisions needed to exercise those powers such as deciding on the number of employees to be recruited and budgeting for funded posts.[11-15]

While decentralisation of health systems has been on the policy agenda in LMICs including Tanzania for many years, earlier discussion on decision space did not take into account the differences in the capacities of those making decisions in personal skills and knowledge as well as organisational factors such as availability of financial and human resources.[16,17] Recently, many analysts have argued that decentralisation will only improve delivery of services when an appropriate degree of discretion is combined with adequate institutional capacities to make choices and accountability of those choices to local health needs and priorities.[15-18]

Unfortunately, very few empirical studies have been conducted in developing countries to understand the roles that local institutional capacities and accountability play in the implementation of the decentralisation reform. Furthermore, methodologically, most of the studies which have attempted to assess decentralisation, decision space, institutional capacities, and accountability mechanism have adopted quantitative approaches through the use of structured questionnaires; see for example Bossert et al,[14] Bossert et al,[15] and Bossert and Mitchell.[16] For example, Bossert and Mitchell reported a strong positive relationship between organisational capacities and accountability and between organisational capacities and decision space.[15,16] Although these studies provide insights of the synergies between decentralisation, institutional capacities and downward accountability mechanisms, context-specific studies which apply qualitative approaches to explore in-depth experiences of the authorities responsible for the implementation of the decentralisation process are needed. Using qualitative approach through in-depth interviews and focus group discussions in 4 districts in Tanzania, this study explored how organisational capacities influence the functional decision space available in the 5 broad categories namely planning, finance, human resources, service organisation, and governance.

2 | METHODOLOGY

2.1 | Study settings

This study was conducted in 4 district councils in Tanzania, namely Iramba (Central Tanzania), Kilolo (Southern Highlands), Rombo (Northern Tanzania), and Liwale (Southern Tanzania). Table 1 provides a summary of the key demographic and health indicators of the study districts.

2.2 | Study design

A descriptive case study design focusing on 4 districts was used. A case study design is suitable in investing a phenomenon in its real-life settings.[19] Stratified sampling technique was used to select districts for this study. In the first step, 4 health zones were selected purposively taking into consideration variation in geographical representation of

TABLE 1 Key characteristics of the study settings

	Iramba District	Kilolo District	Rombo District	Liwale District
Population	236 282	218 130	280 266	91 380
Public hospitals	1	0	0	1
Health centres	6	2	4	29
Dispensaries	60	56	37	32
Divisions	7	3	5	3
Wards	31	22	28	20
Villages	143	106	71	32
Health workers available	43%	61%	42%	40%
Shortage of health workers	57%	39%	58%	60%

Source: CCHP Iramba (2017); CCHP Kilolo (2017); CCHP Rombo (2017); CCHP Liwale (2017).

the zones. In Tanzania, there are 8 health zones namely Eastern Zone, Central Zone, Lake Zone, Southern Highland Zone, Southern Zone, Northern Zone, Southern West Highland, and Western Zone. In each zone, 1 district was randomly selected. In each district, 1 district hospital was selected purposively for in-depth analysis of the decision-making space. Furthermore, in each district, 2 health centres and 2 dispensaries were randomly selected.

2.3 | Data collection techniques

This study combined 3 different data collection techniques, namely in-depth interviews, focus group discussions (FGDs), and analysis of documents. The use of multiple data collection techniques made it possible to triangulate the findings of the study. The formal range of choices which have been granted to the local authorities was assessed through reviewing key legislations, previous literature, and interviews with the key informants. Interviews were conducted with the national, regional, district, and health facility staff. Respondents were selected because of their direct involvement in the formulation and overseeing of various policies and guidelines related to the health sector decentralisation process in Tanzania. Interview guides were developed based on the revised decision space framework. The interview guides were tailored to specific categories of respondents. Interviews were conducted by the first author (RK) from December 2015 to March 2016. Saturation point was reached when no new concepts were identified in successive interviews. Table 2 provides the summary of the key informants.

Focus group discussions were conducted with the ward councils (elected local officials), particularly heads of various committees of the councils. Participants for the FGDs were selected purposively based on their involvement in various committees related to the planning and budgeting in the districts. The FGDs were composed of 8 to 10 participants. A total of 4 FGDs were conducted in the 4 districts involved in this study, 1 FGD in each district.

Further, various policy documents related to decentralisation in the health sector in Tanzania were reviewed to assess the range of choices which the central government had granted district-level authorities. The key documents which were reviewed included health policies, health sector strategic plans, national-level planning, and resource allocation guidelines. The analysis of these documents provided a good opportunity to compare and triangulate the findings generated through in-depth interviews and FGDs on the actual decision space exercised by the district health managers and other local government official in the decentralised health system. The extraction of information from the documents was primarily guided by the framework used in this study.

2.4 | Data management and analysis

In-depth interviews, FGDs, and summaries from the review of documents were analysed using thematic approach.[20] First, both authors read the transcribed interviews and FGDs to familiarise themselves with the data set. Second, the

TABLE 2 Categories of the key informants at the district and local levels

Category of Respondent	Number of the KII			
	Iramba	Kilolo	Rombo	Liwale
Council health management team (CHMT)	3	3	3	3
District executive directors	1	1	1	1
District planning officer	1	1	1	1
Health service providers	4	4	4	4
Total respondents	9	9	9	9
National and regional-level key informants				
Ministry of Health, community development gender, elderly, and children (former Ministry of Health and Social Welfare)				2
President's Office for Regional Administration and Local Government (former Prime Minister's Office for Regional Administration and Local Government)				2
Regional health management teams				12
Total key informants				16

first author (RK) developed a code manual based on the objectives of the study and the conceptual framework which guided the study. Therefore, a list of initial codes was developed. Third, data were coded manually to the identified codes. Additional codes which emerged during the coding process were added along the way. Responses from the interviews and FGDs were coded into *narrow*, *moderate*, and *wide* decision space. Organisational capacities were coded into *low*, *medium*, and *high*. These responses were then compared across different types of respondents and across different districts of the study. Finally, data were summarised and synthesised, keeping the key expressions of respondents as illustrative cases.

2.5 | Ethical issues and consent to participate in the study

This study got approval from the University of Dar es Salaam. The study was also approved by the Regional Administrative Officers in each region of the study. Verbal informed consent was obtained from all prospective respondents and FGD participants. All respondents and participants of the FGDs were informed of their rights to withdraw from the interview and FGD any time they wished. Interviews and FGDs were audio-recorded after getting consent from the respondents. The transcripts were only accessible to the team members. During the presentation of the findings, no individual identification was attached to the findings. All quotes which were used to illustrate respondents' and participants' views had no personal identifiers.

3 | FINDINGS

3.1 | Analysis of the decision space in key functional areas

As reported in other papers, the decentralisation process in Tanzania has provided authorities with a range of decision-making space to be utilised at the local level.[21,22] The decentralisation process in Tanzania has provided decision space to district health managers, to health service providers, and to community members in identifying the needs of the communities and prepare plans and budgets as well as in the implementation of health plans and budgets. However, the ability of district health managers and health facilities to effectively prepare health plans was constrained by the centrally determined list of priorities stipulated in the National Essential Health and Social Welfare Intervention Package. For the district health plans to get approval from the central government, district health managers and health facilities were required to adhere to the centrally defined priorities. This means that the local governments, including health facilities and the communities, had little room to add other identified local priorities. Nevertheless, district health managers and the health facilities had wide decision space in identifying specific interventions and activities within the broader national-level priorities.[21]

The findings of the study indicated that local government authorities, including the health departments, had narrow decision space in the allocation and utilisation of financial resources provided by the central government to finance district health services.[21] The districts depended on the Health Basket Fund and Health Block Funds to finance district health services. The districts were required to adhere to the centrally defined budget ceilings while allocating resources to various priority areas. In addition, the central government provided cost centres to be used while allocating financial resources by type of expenditures. The districts, thus, had little room to allocate funds beyond these determined ceilings and cost centres. The districts, nevertheless, had wide decision-making space in mobilising and using locally generated financial resources.[21]

In human resource utilisation and management, services delivery, and governance, district health authorities had moderate decision-making space.[22] While the district councils had moderate decision space on promotion, motivation, and demotion of the health providers, they had limited decision-making space on the recruitment of skilled health providers. Recruitment for the decentralised institutions was done centrally by the Ministry of Health after getting approval from the Ministry of Finance. The budget ceilings determined by the central government in the Personnel Emolument (PE) constrained the decision space of the local governments in the recruitment of skilled health service

providers. Advertising, recruitment, and posting were done by the central government. However, the districts had moderate decision-making space on promotions, sanctions, and distribution of health service providers within their districts.[22]

Furthermore, decentralisation has provided moderate decision space for the decentralised local institutions and community to exercise some control through various governance structures. The governance of district health system was primarily through health committees and boards. However, the health committees and boards were predominantly engaged in activities with limited influence.

The remaining section, therefore, analyses organisational and contextual factors that facilitated or impeded the use of decision space granted by the central government to local-level authorities in the context of decentralised health system in Tanzania. The key factors which were assessed in this study were financial resource capacity of the district councils, human resource capacity, and management capacity of the district health managers (skills, knowledge, experiences).

3.2 | Financial resource capacities and decision space

The analysis of documents in all 4 districts reveals that the districts had limited capacity in financial resources. While policies permitted local government increased autonomy to mobilise financial resources and to determine how to use those resources, the sources of the local government revenues were limited. The main sources of funds for the districts were user fees, community health fund, and National Health Insurance, and local and international organisations. The district councils largely depended on the central government to finance district health plans and budgets. For example, the analysis of Comprehensive Council Health Plans in all the 4 districts revealed highest dependence of the local government budgets on the central government. Table 3 below indicates the approved budgets for financing district annual health plans for the 2015/2016 financial year.

While generally all districts had limited capacity to mobilise resources locally, as indicated in Table 3 above, there were some variations across the districts in their ability to mobilise resources from different sources. It is evident from the data that Iramba district performed relatively better compared to other districts. In addition to user fees,

TABLE 3 District councils' sources of revenue for the 2015/2016 financial year

			District Councils			
	Revenue Source		Liwale	Kilolo	Iramba	Rombo
Central	HBF	PE	1 662 966 792	1 337 193 000	3 018 382 600	3 282 426 900
		OC	212 102 000	244 972 000	207 319 000	282 013 000
	HBF		181 809 000	520 388 400	531 375 999.57	356 648 000
	CDGF		94 579 000	111 676 400	120 000 000	137 726 000
	CGV MSD		234 834 829	264 860 240	302 275 275.01	194 848 000
Local	Cost sharing and insurance fund	User fee	97 140 000	43 370 000	27 182 000	12 000 000
		NHIF	79 999 999	40 150 000	109 780 000	30 000 000
		DRF	52 000 000	84 480 000	12 250 000	20 000 000
		CHF	97 823 000	0	135 637 072	130 000 000
	Own source	Dev	33 000 000	7 267 000	52 749 000	84 328 000
		OC	0	0	0	30 000 000
	NGOs		0	259 911 600	0	
	Global fund		0		275 497 600	0
	Other gov dev grant		0	0	30 000 000	0
	Central gov other source		0	0	112 360 000	30 000 000
	Multi and bilateral partners		0	0	315 000 000	251 000 000
	Total		3 236 282 171	2 637 220 864	5 249 808 970	4 532 387 400

Source: 2015/2016 CCHPs for Liwale, KIlolo, Iramba, and Rombo districts.

Abbreviations: HBG, health block grants; CDGF, Capital Development Grant Fund; CGV MSD, Central Government Via MSD; OC, other charges; CHF, Community Health Fund; HBF, Health Basket Fund; PE, Personnel Emolument; MSD, Medical Stores Department; DRF, Drug Revolving Fund; NHIF, National Health Insurance Fund.

community health funds, and National Health Insurance, the district was able to mobilise resources from a number of national and international organisations. Conversely, Kilolo and Liwale districts had very little resources generated locally.

The analysis of interviews, FGDs, and documents revealed that the limited capacity of the local government to generate financial resources using their own sources of revenue largely affected their capacity to use the centrally granted range of choices (decision space) within the framework of decentralisation. The effects were reported in various areas including planning and priority setting, allocation of financial resources, implementation of the approved plans, human resource for health utilisation and management, service delivery, and leadership and governance. The effects are addressed in the specific subsections that follow.

3.2.1 | The effect of financial capacity on the choices in district planning and priority setting

Interviews and FGDs revealed that in some cases, the centrally controlled allocation of fund did not meet the needs of the community. While the district health managers and the local government officials had power to identify priorities and prepare plans for their respective districts, limited financial capacity largely compelled the districts to align their plans and budgets with the centrally determined priorities. Similarly, the centrally determined budget ceilings provided little flexibility for the district health managers and periphery staff to prepare plans and budgets based on the locally determined needs and priorities. A health manager in Kilolo District said in an interview that

> In determining the priorities, we first consider the ceiling set by the Central Government. Although health facilities bring their priorities to be incorporated in the plan, we should first consider the priorities of the Central Government. Often the priorities which do not match those of the nation are omitted *(IDI with district health manager, Kilolo)*.

Another respondent in Iramba District added that

> We reserve the power to plan our activities at the health facility in collaboration with the Department of Health with the Health Committee, and so we plan how to make use of the money in our bank account. However, despite the authority, the money happens to be very little. We have failed to implement a lot of activities because we have limited funds *(IDI Health worker, Iramba)*.

The findings from document analysis revealed that in all 4 districts, the budget ceilings provided by the central government limited the capacity of the districts to make wide choices in planning according to the needs of the population. In addition, it was reported that most often, ceiling allocation to priority areas was low compared to the actual costs to be encountered during the implementation of the planned activities.

3.2.2 | How financial capacity affected implementation of the district health plans

The main problem which respondents reported during implementation of district health plans was delay in the disbursement of funds from the central government. The district-level respondents reported that sometimes they received the first quota of the funds at the time they were supposed to get the third quota. The findings from document analysis in all the 4 districts revealed serious delays in disbursement of funds for both health block grants and health basket funds. The analysis of interviews revealed that delays in funding of health development projects in the districts significantly prevented interventions/activities being implemented according to the locally made plans. Similarly, respondents reported that, in most cases, the large amount of funds was disbursed to the districts during the last quarter and the districts had little time to complete the implementation of the planned activities. Consequently, in most cases, some of the planned activities were delayed or even deferred to other quarter of the year. A Liwale Health Manager illustrated that

> The major challenge is the delay of funds from the central level. We are supposed to receive funds every three months. In a year we expect to receive funds in four Quarters. But at the end of the day, we may wait for the first quarter, the second one, and the third one without any funds. And when the funds are released, we are supposed to implement all projects simultaneously within two weeks. So we always fail to cope; and if we use up all the money queries arise. Eventually the money is receipted and rolled back to the Ministry *(IDI with district health manager, Liwale)*.

Another respondent in Kilolo had a similar experience; thus

> In the first quarter the funds may not come out; and they come in the second quarter. Before the first quarter we may have stayed for three months without funds. In the third quarter we have received nothing, and we get funds in the final quarter. And the funds received in the final quarter were for the third quarter. Meanwhile, we have a lot of activities to implement within thirty (30) days and have all the money spent. Otherwise, the money should be receipted and sent back *(IDI with district health manager, Kilolo)*.

Similar finding was reported by the regional-level respondents. One respondent in Lindi Region narrated it this way:

> In the first quarter we may receive no fund, but in the second quarter. Therefore, with the money we receive in the second quarter, we do activities for the first quarter. As RHMT members we had planned to perform some supervisory activities but we failed because we had no funds. Where do we get fuel from? We have no vehicle. So finally we fail to do the supervision. We may also fail to purchase medicines because we lack funds *(IDI with regional health manager, Lindi)*.

The national-level respondents reported further that the central government depends on local revenue collections to provide health block grants to the district councils. If there are no adequate revenues collected, this will absolutely lead to delays in sending funds to the district councils. With regards to the health basket funds, respondents reported that this was totally dependent on contributions from development partners. Regularly, development partners did not release funds without receiving annual audited reports from the previous financial year. Therefore, most often, the delays were caused by this requirement by the development partners which led to late receipt of funds from these partners. A national-level respondent elaborated this way:

> You know the disbursement of basket funds to the councils is delayed by the very councils by delaying their financial reports since donors do not issue funds unless the reports are submitted. So the more they delay the reports, the more the donors delay the release of funds, and the later councils receive the funds

Another national-level respondent added:

> Basket Funds are from our donors; and so for the funds to come out, all councils should submit their financial technical reports for the previous year. Therefore, sometimes councils delay their reports; and this causes delays in the process of releasing funds to the councils *(IDI national-level respondents)*.

3.2.3 | How financial capacity affected choices in human resources management

As indicated above, within the ongoing framework of decentralisation, the district councils had moderate decision-making space in some aspects of human resource utilisation and management, including promotion, motivation, retention, and employing staff on contract basis. However, the analysis of all sources of data and in all districts revealed that the ability of the districts to make choices on the areas of human resource use and management was constrained by the availability of funds. For example, while the district councils had authority to employ skilled

health personnel on contract using locally generated resources, only in Liwale District did respondents report that they had employed a radiographer on contractual basis using locally generated funds. In the remaining districts, employment was largely done for the nontechnical staff because their salaries were relatively lower compared to the technical staff. One of the respondents exemplified this way:

> We are authorised to hire labour but we are limited by scarce financial resources, and so the Council has failed to hire medical professionals. The limited funds we have only allow us to hire drivers, security officers and other low cadre personnel *(IDI with district health manager, Iramba).*

Another respondent in Kilolo District had this to say:

> Although we have been authorised to hire labour using the Council funds, we fail to do so because of the meagre income of our Council. So we mostly hire supporting staff like security officers, drivers, cleaners and other low cadre workers. But more resourced councils like Kinondoni can even higher medical professionals since they can pay them handsomely *(IDI with a district health manager, Kilolo).*

Likewise, while the districts had moderate decision-making space in the areas of motivation, promotion, and retention of health workers, they were significantly constrained by the limited capacity of financial resources. The ability of the district councils to promote health service providers was contingent to the budget ceilings provided by the central government. Some promotions were delayed or even deferred to other financial years because of limited financial capacities. One of the respondents in Iramba District had the following elaboration:

> The council is fully mandated to promote personnel; heads of department and the Director can effect promotion but then the budget is the limitation; and the budget is approved by the Central Government *(IDI with a district health manager, Iramba).*

Another respondent in Liwale District explained that

> We depend on the funds for other charges (OC) to give motivation to our employees. But currently OC funds do not come out as they used to be. It thus proves difficult for us to motivate our personnel *(IDI with a district health manager, Liwale).*

Furthermore, limited financial capacity made it difficult for the districts to pay for basic requirements for the employees such as subsistence allowances, transport during vacations, supporting in-service training, housing allowances, and other retention schemes particularly for those in hard to reach areas. It was within the mandate of the district councils to provide different incentives and retention packages to health service providers in their respective districts. One of the respondents in Liwale contended that

> Due to the lack of funds for OC, we currently fail to pay our employees their dues including subsistence allowances, transport allowances, transfer allowances, motivation packages (especially for those who work in hard to reach areas) and other performance improvement issues *(IDI with District health manager, Liwale).*

3.2.4 | Limited capacity in financial resources and service delivery and governance

With regards to service delivery, the analysis of various policy documents, interviews with all categories of respondents, and FGDs with elected local-level officials indicated that as part of the implementation of the Primary Health Services Development Programme (2007-2017), the district councils have been given authority to build a health centre in every ward and a dispensary in every village. This is aimed at increasing access to primary health care services to all Tanzanians. While the central government provides support for final finishing of the building and equipping the

newly constructed health facility with human resources, equipment, and other facilities required, the districts have been granted power to mobilise local resources and initiate the construction of the facility up to a certain level. However, district-level respondents reported that they were largely constrained by limited financial resources. While there were some variations across the 4 districts, to a large extent, limited financial resources constrained the district's ability to make use of the granted power. One of the respondents in Kilolo reported this way:

> The Government has mandated us to build health centres and dispensaries as per policy directions that each village has to have a dispensary and each ward a health centre. The major challenge remains the funds to complete the projects. This is because the policy requires villagers to fund the projects to a certain level, and the Council to do the rest of the work. In some areas villagers have done their part, but since then everything has come to an end *(IDI district health manager, Kilolo).*

Participants in FGDs in Iramba District narrated that the policy requires each village to have a dispensary and each ward a health centre. They added that the same policy is also emphasised in the ruling party manifesto. In implementing the policy, they had mobilised the community to initiate the projects and take them to some levels, hoping that the government would complete the projects. They add, however, that things have turned out to be different now. The community had done their part but no finishing so far. It was further learnt in the FGDs that a number of wards including the 1 from which the Mayor came had initiated the projects and the community had done enough, only for the projects to end right there. The participants finally urged the government to finish up the projects (FGD with Councillors, Iramba).

The analysis of the district health plans confirmed this finding. For example, it was reported that in 2015/2016 financial year, communities had constructed 11 dispensaries in 10 villages and 2 health centres in 2 wards. However, because of limited financial capacity of the district, many of these buildings remained unroofed (Iramba District Council, 2016). Similar finding was reported in Kilolo District. The district annual health plan 2016/2017 indicated that the community members had constructed 17 dispensaries in various villages, but they remained uncompleted because the district government had limited financial resources (Kilolo District Council, 2016). This situation was reported to discourage community members who had been sensitised to mobilise resources to construct dispensaries and health centres in their areas.

In addition, within the ongoing decentralisation process, the Council Health Management Team (CHMT) members have been granted decision-making space to supervise delivery of primary health care services in their districts. Similarly, the Regional Health Management Teams (RHMTs) have been granted mandate to provide support and supervision to the CHMT. The district-level and regional-level respondents reported that they were required to conduct supportive supervision quarterly. The district health managers reported that they did not have adequate capacity to conduct supportive supervision in the hospitals, health centres, and dispensaries as planned. Similarly, regional-level respondents reported limited capacity to carry out supportive supervisions of the districts. This was mainly attributed to limited financial resources to cater for cars, fuels, and paying allowances to the members. One of the respondents in Lindi Region narrated that

> As RHMT we are supposed to supervise CHMT to follow up their operation and extend support to them. But due to lack of funds, we often don't do it. The major obstacle is the fund for fuel *(IDI with regional health manager, Lindi).*

A respondent in Kilolo District elaborated in an interview that

> Deficit of funds, especially for OC has made us fail even to repair vehicles which could help us to deliver health services. Without transport, it is very difficult to serve our clients. For example, in case of maternity emergence, the ambulance has to go for patients in distant dispensaries. We have instructed them in health centres that in case of any maternity emergency, they have to call directly to the maternity ward, and then arrangements can be made to get a driver and a doctor or

> a nurse to attend the case. However, fuel expenses may be high while vehicles breakdown regularly due to poor infrastructure, while maintenance funds are also a problem *(IDI with district health manger, Kilolo).*

The analysis of the district health plans confirmed this finding. In almost all districts, only half of the planned supportive supervision activities were conducted mainly because of limited financial resources for fuels and allowances for the district health managers. For example, in Rombo District, in the first 2 quarters, they only managed to achieve 58% of the planned supportive supervision. This was mainly attributed to lack of funds for fuel and allowances for the district health managers (Rombo District Council, 2016); all the 4 districts had similar pattern reported.

With regard to governance, the district councils had wide decision-making space in selecting and managing health facility committees and boards. For example, it was within the capacity of the district councils to pay allowances for the members of the health facility committees and boards. This would largely increase the functioning of the user committees and boards. One of the respondents put it this way:

> Allowances for the District Health Board have been fixed by the Central Government. But for health centre committees, it is the council that determines the amount to be paid to the members. In our District, health committees meet monthly. The Chair and the Secretary receive Tshs. 3,000/= and the rest Tshs 2,000/= per meeting. Currently, even the attendance is very poor; members question the rationale for receiving Tshs. 2,000/= claiming that it is as good as nothing. In fact, as CHMT we can see the situation but due to the limited funds, there is no way we can review the allowances *(IDI with district health manager, Iramba).*

3.3 | Analysis of human resource capacity and decision-making space

As with financial resources, the capacity of the decentralised institutions to use the range of choices granted by the central government depends on human resource capacity at the local and periphery levels. The key areas of the human resource capacity include availability of adequate and skilled personnel at the district and capacity of the district health management teams. In this study, 3 components of human resource capacities were assessed namely availability of skilled health providers to undertake planning and implementation of district health plans and budget, capacity of the district health managers in planning and implementation of district health plans, and capacity of the health committees and boards to actively participate in the development and implementation of health plans and budgets.

3.3.1 | Availability of skilled health providers

In all the 4 districts, district-level respondents reported that many of the health facilities did not have adequate number of skilled health personnel who are also able to prepare health facility plans and execute and supervise the implementation of the planned activities in their respective areas. Similar view was reported during FGDs with elected local government officials. Participants reported that most of the health facilities, particularly dispensaries had very few qualified health personnel.

In 1 of the FGDs in Kilolo District, participants insisted that health service delivery demands skilled personnel, and that they had quite few of them. They added that population growth was fast, and so, requirements also soared as they had a lot of activities to carry out. However, with the few skilled personnel, it was claimed that sometimes a single service provider could serve a lot of clients. This significantly hampered quality service delivery because patients had to wait for quite long to get the service. It was further revealed that sometimes a dispensary could have a single service provider, and so when she/he had an emergency including travelling, the facility closed down (FGDs with councillors, Kilolo District).

In Liwale District, FGD participants recounted that their health facilities were acutely shorthanded, arguing particularly that their dispensaries were mostly served by medical attendants. This was said to affect even planning and implementation of health plans in their dispensaries. Similarly, quality service delivery was said to be a challenge (FGD with ward councillors, Liwale).

Similar finding was reported by the regional and district health managers. All district health managers, in all 4 districts, said that health facilities were facing critical shortage of skilled health service providers. This situation significantly affected the ability of health facilities to prepare and implement their health plans effectively. In all the 4 districts, district health managers pointed out that most often the district did not receive the number of health employees who were posted by the central government. Some of the health providers who were posted to their districts did not report. It was evident that the rural and hard to reach districts such as Liwale faced significant challenges in attracting skilled health service providers. One of the district health managers in Liwale narrated this way:

> The availability of medical personnel is currently a problem. One can't believe that within three years we have succeeded to get only two medical doctors. But also every year we request for six clinical officers, only to receive one or none. It proves quite difficult for us to hire personnel. The government may allocate twenty nurses to us but they do not show up. Sometimes we may be allocated 12 or 13 nurses only to find that seven do not turn up. The situation is even more serious with medical doctors; in the whole district we have only three (3) medical doctors *(IDI with district health manager, Liwale).*

Another respondent from a different district exemplified this way:

> *Availability of health professionals is a critical problem. It is surprising that for the past three years we have been able to attract only two of the required number. But every year we we apply for the 6 clinical officers only to receive one or none. Employment has been very difficult. The government allocates us 20 nurses but they hardly turn up. The whole district has only three medical doctors.(IDI with district health manager Liwale)*

The analysis of district health plans also confirmed this finding. In all 4 districts, shortage of skilled health workers was above 50%. In all districts, the most affected cadres were clinical officers, clinical assistants, enrolled nurses, assistant health officers, health officers, and nursing officers. All the 4 district respondents reported that the critical shortage of skilled health personnel affected the ability of the district to make sound plans and implement the planned activities. This was also reported in the council health plans. In most cases, districts were not able to implement the planned interventions. This was attributed to inadequate funds and shortage of skilled health service providers.

3.3.2 | Capacity of the district health managers and use of decision space

District health managers in all 4 districts reported that a few members had received training on planning, budgeting, and reporting of the district health plans and budgets. The teams which received training have continued to provide support to other members who had not received the training. In addition, because many CHMT members have worked for long time in the health sector, they have gained extensive experiences and were able to effectively develop and implement district health plans and budgets. Looking at the qualifications, most of the district health managers had bachelor degrees and some had advanced diploma. Table 4 presents qualifications and experiences of the district health managers.

However, the findings indicated differences in the capacity of the CHMT members in the 4 districts. The CHMT members in Iramba and Rombo councils seemed to have better capacity in planning, budgeting, and reporting compared to the CHMT members of Kilolo and Liwale districts. It is not surprising that Iramba District received prize from the Ministry of Health and Social Welfare (MoHSW) during the 2014/2015 financial year because of high quality of the CCHPs.

Furthermore, the majority of the CHMT members in all the 4 districts reported that frequent changes in the Plan Rep versions affected the planning process. Council Health Management Team members were forced to spend most of their time to revise CCHPs based on the new release of updates of the Plan Rep (financial planning and budgeting software). Additionally, differences in reporting between Ministry of Health and Ministry of Finance affect the planning process. According to our respondents, health reports are normally provided based on the calendar year (January-December) while financial reporting is done based on the financial year (July-June). This makes it difficult to use accurate data during the planning process. In most cases, the districts are compelled to use data from previous year.

3.3.3 | Capacity of the health committees and boards and use of decision space

While decentralisation has created decision space for the participation of community members in planning and implementation of health activities, community participation was found to be generally low. The review of the district health planning guidelines indicated that health centres and dispensaries were required to prepare their plans which, in turn, were to be incorporated into the district annual health plans. Analysing the district annual health plans and the district-level interviews confirmed that the planning processes began at the community level through health committees. However, how community plans were incorporated into the district health plans was not clear. Respondents reported that the district health plans were largely prepared by the district health managers. One of the respondents in Rombo District elaborated it this way:

> Regarding the preparation of facility health plans, we just started this year. The first plan started only recently and we are still learning. But formerly we had no health plan for the facility. Budgets used to be prepared by the Office of the District Medical Officer *(IDI with health provider, Rombo District)*.

Another respondent in Liwale District added that

> We have just begun this year to prepare health plans and budgets. Formerly, we didn't do it ourselves *(IDI with committee member, Liwale District)*.

In addition, the analysis revealed that once the process of preparing district annual health plans had been completed, there was no mechanism to provide feedback to the health facilities. This means the dispensaries and health centres did not know which of their priorities had been accepted and which ones had not been accommodated into the district annual health plan.

The central problem that affected all health centres and dispensary committees was inadequate capacity of the health facility committee members. One of the respondents in Iramba District illustrated that

TABLE 4 Qualifications and experiences of the district health managers

District	Resp	Age	Years of Experience	Education	Years in Present Post
Liwale	1	36	7	Bachelor of Arts	4
	2	55	27	Advanced Diploma—Paediatric	14
	3	44	44	Bachelor of Medicine	5
Kilolo	1	58	36	Advanced Diploma—Public Health	10
	2	31	6	Bachelor of Arts	6
	3	44	7	Bachelor of Pharmacy	6
Iramba	1	41	14	Bachelor of Medicine	1
	2	42	20	Advanced Diploma (Mid wife)	9
	3	34	5	Advanced Diploma (Paediatric)	3
Rombo	1	34	3	Bachelor of Nursing	1
	2	27	3	Bachelor of Arts	3
	3	36	2	Bachelor of Pharmacy	2

Source: Field data, 2017.

> The major challenge facing the Committees is the limited understanding of their roles. For example, with exception of the Board whose majority are educated and retired officers, members from remote areas have very limited understanding due to low education. Therefore, even the community representation is lacking as they simply make friendship with service providers. So members may not present people's chaos for solution. In one of our operation areas we had to disband the committee after learning that the Chairperson and the Secretary were so close to service providers, and so it was very difficult for them to present the problems facing the community. They seemed to be so closely related and we had to find a way to dissolve the committee *(IDI with district health manager, Iramba).*

Another respondent in Liwale District had this to say:

> The major challenge facing these committees is that they lack capacity. They need some training. If they are trained they may be very supportive persons; but if they are not, they will just be there unknowingly. Basically, these committees are a very useful link between health facilities and the community. This is because when they go to village leaders, they report the challenges facing the facilities. So if they are given the understanding that the facilities belong to them, and that they are the in-charges while the service providers are under their control, then they will be very active *(IDI with district health manager, Liwale).*

4 | DISCUSSION OF FINDINGS

This study aimed to explore how organisation capacities within the decentralisation framework affected the use of decision-making space granted by the central government to the subnational levels. The findings of the study indicated that while the district health managers and local government officials had been granted authority in many health system functional areas, including planning and budgeting, human resources management, service delivery, and governance, limited capacity of local government to generate financial resources from local sources highly affected their capacity to make use of the available decision space. The local governments primarily depended on the central government funds, which were not only inadequate but also unpredictable. In addition, the findings indicated that while the district health managers had skills, knowledge, and experiences in preparing district health plans, health facilities and community representatives had limited capacity. Most of the health facilities in the study districts had critical shortage of skilled health providers who could effectively undertake planning and priority setting process. Similarly, the ability of health committees to effectively participate in planning and priority setting processes was constrained by limited capacity in knowledge and skills.

These findings resonate with the findings of the earlier studies on decentralisation in developing countries. Scholars have reported that in most cases, the increased responsibilities of local-level authorities do not go together with increased financial resources to act on them.[23-28] In most cases, while decision-making over budget allocations has been decentralised to the local authorities, the central government still controls the funding flows and allocations. Studies have reported that while policies may grant authority to the decentralised local authorities to mobilise financial resources and to determine how to use those resources, this new delegation becomes redundant if the sources of local revenue are limited.[9,23,28]

Recent studies in the health sector have demonstrated that decentralisation will only improve delivery of health services when an appropriate degree of discretion is combined with adequate institutional capacities to make choices and accountability of those choices to local health needs and priorities.[15-18] Providing local-level authorities with greater authority to provide or manage public sector services increases the likelihood for these local authorities to be more responsive to preferences, needs, and priorities of the communities. However, without adequate institutional capacities, the decentralised local-level officials may not be able to respond effectively to local needs and priorities.[15-17]

However, financial and human resource capacities alone are an insufficient condition for effective functioning of decision space in the decentralised health systems.[29] The ability of the local-level managers to better use the available decision space is depended on the local managers' capacity, knowledge, and skills to develop and implement local plans and budgets.[23] For example, in Tanzania, the district health management teams having been granted greater responsibilities in the decentralised health system felt that they lacked capacity to perform in the new roles adequately.[26] Lack of human resource with relevant skills and knowledge in priority setting, planning, as well as budgeting, for instance, may result in historical budgeting practices rather than the favoured strategic planning and budgeting process. Correspondingly, limited capacity to collect, compile, and analyse data might result in planning practices which do not reflect needs of the local communities. Studies conducted in Ghana have reported that merely having decision space did not guarantee good management but rather that decision space had to be accompanied by management capabilities and leadership skills.[30-33]

In addition to managerial knowledge and skills, recently studies have underlined the importance of personal initiatives of the key district health managers and local government officials in getting things done.[34-37] For example, Maluka and Bukagile[34] reported that the personal initiatives of the district-level officials contributed significantly in the variations in the uptake of the Community Health Fund. Similar findings were reported by Joseph and Maluka in a study on leadership and management practices and their influence on the performance of the CHF in Tanzania.[35] Another study also attributed the variation in the performance of the health facility governing committees to the efforts and initiatives of the top district-level leaders.[36] Furthermore, another study done in Indonesia on decentralisation and performance of district health systems also highlighted the importance of personal initiatives of the key district health leaders in getting things done.[37] The authors attributed the variations in the performance of the districts to the personal initiatives of the district health managers to get things done and fairness in handling staff disciplinary matters.[37]

5 | CONCLUSION

This study concludes that while decentralisation provided decision-making space in various health system functional areas, the ability of the district health managers to use the granted authority was constrained by the organisational capacities in financial resources, skilled health providers, and managerial skills. These findings underscore that decentralisation will only improve delivery of health services when an appropriate degree of discretion is combined with adequate institutional capacities to enable exercise of those authorities. Without adequate institutional capacities, the decentralised local-level officials may not be able to respond effectively to local needs and priorities. The central should increase institutional capacities through providing additional skilled personnel and managerial training programmes and providing additional financial resources. In addition, local government authorities should be capacitated to generate financial resources using different local sources. This would help ensure that the needs and priorities of the local communities are implemented effectively, and hence, objectives of the decentralisation are achieved. In addition, deliberate efforts should be made to capacitate health committees and boards.

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CONFLICT OF INTEREST

The authors declare that have no conflict of interest.

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