Received: 10 February 2018 | Accepted: 12 February 2018

DOI: 10.1002/hpm.2511

RESEARCH ARTICLE

WILEY

Decentralisation and health services delivery in Tanzania: Analysis of decision space in planning, allocation, and use of financial resources

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Funding information
Tanzania Higher Education Students Loan Board

Summary

While decentralisation of health systems has been on the policy agenda in low-income and middle-income countries since the 1970s, many studies have focused on understanding *who* has more decision-making powers but less attention is paid to understand *what* those powers encompass. Using the decision space approach, this study aimed to understand the amount of decision-making space transferred from the central government to institutions at the periphery in the decentralised health system in Tanzania. The findings of this study indicated that the decentralisation process in Tanzania has provided authorities with a range of decision-making space. In the areas of priority setting and planning, district health authorities had moderate decision space. However, in the financial resource allocation and expenditure of funds from the central government, the districts had narrow decision-making space. The districts, nevertheless, had wider decision-making space in mobilising and using locally generated financial resources. However, the ability of the districts to allocate and use locally generated resources was constrained by bureaucratic procedures of the central government. The study concludes that decentralisation by devolution which is being promoted in the policy documents in Tanzania is yet to be realised at the district and local levels. The study recommends that the central government should provide more space to the decentralised district health systems to incorporate locally defined priorities in the district health plans.

KEYWORDS

decentralisation, decision space, health services planning, Tanzania

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1 | BACKGROUND AND CONTEXT

Reforms in the public health sector in low and middle-income countries (LMICs) have been the major policy focus over the last 4 decades. One of the components of the health sector reforms is decentralisation. Decentralisation is defined as the transfer of power and resources from the central government to agencies and actors at lower levels.[1-3]

Denis Rondinelli proposed 3 forms of decentralisation, namely deconcentration, delegation, and devolution.[1] Mills[4] 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. On the one hand, there are scholars who see it as the panacea for reforming the health sector. They argue that decentralisation brings services closer to the people,[1,2,5] provide opportunity for community participation in planning and services delivery,[6,7] and improve quality, access, and equity.[1,5,8] 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 decentralisation local governments are less technically capable than the central government, and thus, decentralisation may lead to the poor delivery of the 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.[7,11,12] Decision space is assessed by determining how much power for decision-making on different functions such as planning and financial management is granted to local-level authorities from the central government officially.[11,12] However, in practice, decentralised officials may exercise a different degree of choice, which Bossert and Mitchelli refer to as de facto or informal decision space.[13,14] 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 district councils in service delivery and vice versa.[7,11-14]

While decentralisation of health systems has been on the policy agenda in LMICs including Tanzania for many years, many studies have focused on understanding *who* has more decision-making powers but less attention is paid to understand *what* those powers encompass.[13-17] A few studies, however, have examined decision-making space in the context of decentralisation in LMICs on one specific functional area such as human resource capacity or financial management. For example, Marchal and Kegels[18] assessed the availability of decision space on management and human resource capacities in Ghana. Tsofa et al[19] examined how decentralisation affects health sector planning and financial management in Kilifi County in Kenya and another study in the same country studied decentralisation by devolution and its effects on health workforce and commodities management.[20] In Tanzania, only one study assessed decentralisation and decision space in the decentralised district health system.[21] There is, therefore, paucity of studies that analyse the amount of choices transferred from the central government to institutions at the periphery in the decentralised health system in Tanzania.

2 | DECENTRALISATION INITIATIVES IN TANZANIA

After independence, Tanzania adopted decentralisation to improve social services which were mainly concentrated in urban areas following the colonial structures.[22] In 1962, the government abolished Local Government Ordinance of 1953 and established the democratically elected district councils.[22,23] However, local governments were treated as agents of the central government rather than governance organs which represent the needs of the local people.[24] As a result, local government authorities did not bear fruit because authority, resources, and power in decision-making were concentrated at the centre.[25] This resulted to local governments' failure to deliver public services, including health.

This paved the way to Decentralisation of Government Administration, through Act 1972 (Cap. 27) which established Deconcetration Policy in 1972. The 1972 Decentralisation Policy transferred planning, coordination, and management of rural development functions from the ministries to the regions and district councils.[24] However, weak institutional capacities undermined the objective of the 1972 deconcentration which was to increase people's participation in decision-making and enhance the performance in delivering public services.[23,24] Instead, the deconcentration system led to the deterioration of the economy and public services, including health within the country.[22,24] Consequently, in 1982, the Tanzania re-established local government authorities and were backed by local governments' legal framework.[26] The legal framework provided local governments the responsibility for service delivery in different areas including health. However, the legal framework for local government in Tanzania has been characterised by central government control.[27] Therefore, despite the 1982 Act providing more authority to the local governments, health service delivery continued to deteriorate because local governments were still under the control of the central government.[27]

The failure of the 1982 decentralisation to improve health service delivery compelled the government to undertake Local Government Reform Programme (LGRP) to devolve power, authority, and resources. The local government acts were, therefore, amended to enable the implementation of decentralisation by devolution (D-by-D). The D-by-D through LGRP intended to create good governance and remove the culture of centralised bureaucracy. It also aimed at improving the central-local government relations while redefining the power relations and devolving more decision-making power and resources to the district councils and people at large.[28] Administrative decentralisation aimed to delink local government authority staff from their respective ministries and grant ability to recruit their own staff and establish their own payroll according to the needs of each local government. Further, financial decentralisation intended to enable district councils to have enough discretional powers to collect financial resources through local taxes and other sources of revenues. At the same time, local governments would have the ability to prepare their own budgets which reflect their own priorities as well as ability to excise expenditure from the revenue they earn.[28]

3 | METHODOLOGY

3.1 | Theoretical framework

This study was guided by the decision space framework which was developed by Thomas Bossert.[11] The decision space framework (DSF) is based on a modified principal-agent approach. The principal-agent theory conceptualises a “principal” with specific objectives and “agents” who are charged with the responsibilities of implementing those objectives.[29]

In this study, the principal refers to the Ministry of Health, Community Development, Gender and Elderly and the President's Office Regional Administration Local Government. The agents refer to the decentralised local government authorities, particularly the district health managers. Other notable government agencies at the national level which influence decision-making in Tanzania are the Public Services Commission and the Ministry of Finance and Economic Affairs. As indicated in Table 1, the decision space (DS) was determined by assessing the involvement of the respondents and central level authorities in local decisions.

3.2 | 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 2 provides a summary of the key demographic and health indicators of the study districts.

TABLE 1 Assessment of decision space in decentralised planning and financial resources

Function/Indicator	Dimension	Level of Decision Space (DS)		
		Narrow	Moderate	Wide
Planning				
■ Local involvement in planning	DS	District health managers mainly defer to central planning norms/targets	District health managers make some local-level adaptations to central planning norms/targets	District health managers mainly include locally defined strategies and targets
Budgeting				
■ Preparation of regular budget	DS	Budget line items conform mainly to central norms	Local revisions made to budget line items but most allocative decisions made by higher authorities	Local revisions made to budget line items with minimal revisions made by higher authorities

Source: Modified from Bossert et al (2010).

TABLE 2 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).

3.3 | 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.[30] 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 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.

3.4 | 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 3 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. As for in-depth interviews, discussion guide was used to facilitate the discussion. A total of 4 FGDs were conducted in the 4 districts involved in this study, 1 FGD in each district.

3.5 | Data management and analysis

In-depth interviews, FGDs, and summaries from the review of documents were analysed using thematic approach.[31] First, both authors first read the transcribed interviews and FGDs to familiarise themselves with the data. Second, the 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 drawn up. 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 in-depth interviews and FGDs were coded into narrow, moderate, or wider DS. 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.

3.6 | Ethical issues and consent to participate in the study

This study got approval from the University of Dar es Salaam. The research clearance was then sent to the Regional Administrative Officers in each region of the study for approval in their administrative areas. 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.

TABLE 3 Categories of the key informants at the district and local levels

	Number of the KII			
Category of Respondent	**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 & 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**

4 | RESULTS

This section presents findings on the analysis of decision-making authority which has been granted by the central government to the district-level authorities and the actual DS exercised by the district-level managers following implementation of the decentralisation process. Quotes and expressions from the respondents and participants have been used to illustrate the key points.

4.1 | Planning and budgeting process

Within the framework of decentralisation, local government authorities have been granted authority to prepare annual health plans and budgets commonly known as Comprehensive Council Health Plans (CCHPs). The Ministry of Health and Social Welfare (MoHSW) and Prime Minister's Office Regional Administration and Local Government (PMO-RALG) designed the planning template that assists the health facility and district level to prepare their plans and budgets. The Council Health Management Team (CHMT) has been given mandate to collate and integrate the lower level plans and budgets into the overall CCHP. CHMT members are required to ensure that health facilities follow the template provided by the central government for developing their annual health plans. Similarly, the CCHP needs to follow the central-level defined priorities stipulated in the National Essential Health and Social Welfare Interventions Package (NEH&SWIP). The NEH&SWIP sets broad priority areas which need to be included in the CCHPs. This list of defined package is fairly used consistently across different districts nationwide. However, districts had decision-making space in determining specific interventions/activities to be implemented in their district to achieve the broader centrally determined priorities. Table 4 provides the list of priorities which are contained in the NEH&SWIP.

The district health managers felt that they had moderate DS over planning and budgeting process. There was consensus among the district health managers that they only had a small room to accommodate locally defined priorities and needs. According to our respondents, the districts did not have a different budget line for the locally defined priorities. One respondent illustrated this way:

> *"We set budgets every year but priority areas are determined by the central government. We are obliged to fix our priorities within the framework of the government-determined priorities, even if they may not fit in quite well. There is no space for the district to introduce priorities which do not reflect those already fixed by the central government"* (IDI with CHMT member in Iramba District).

TABLE 4 Priority areas contained in the National Essential Health and Social Welfare Intervention Package

S/N	Priority Area
1	Medicines, medical equipment, medical, and diagnostic supplies management system
2	Maternal, newborn, and child health
3	Communicable diseases
4	Noncommunicable disease control
5	Treatment and care of other common diseases of local priority within the council
6	Environmental health and sanitation
7	Strengthen social welfare and social protection services
8	Strengthen human resources for health and social welfare management capacity for improved health services delivery
9	Strengthen organizational structures and institutional management at all levels
10	Emergency preparedness and response
11	Health promotion/behaviour change communication (BCC)
12	Traditional medicine and alternative healing
13	Construction, rehabilitation, and planned preventive maintenance of physical infrastructures of health facilities

Source: URT (2014).

Similar views were recounted by district health managers from other districts.

> *"In planning our budgets, we closely observe guidelines from the Ministry of Health. The guidelines outline the priority areas which should be considered in the budget. If it happens that some aspects are not accommodated, we are instructed to rework the plan and include the missing aspects before we have the budget approved"* (IDI with CHMT member in Rombo District).

A Liwale district health manager had similar views as he stated that:

> *"We prepare our health plans every year but there is something called ceiling. This strictly sets limits to our priority areas. We may come up with a lot of things, only to find that our priorities are limited by the so called ceilings"* (IDI with district health manager, Liwale).

According to the national-level respondents, the guidelines are meant to ensure consistency and quality of the district health plans and budgets. The central-level officials further reported that districts have wider decision-making space in deciding specific interventions (activities) to be included in the district annual plan and budget. While broader priorities were the same countrywide, specific interventions within the broad priority areas could differ from 1 district to another. An official from the Ministry of Health had this to say:

> *"Councils come up with their health plans, but they have to follow guidelines from the central government. But also districts have some space to introduce their priorities so long as they align with the national priorities. For example, if the national target is to reduce maternal mortality, and we find that these aspects are ignored in the plan, we question them. But we do not determine for them the kind of activities that they may carry out to scale down maternal mortality"* (IDI with Ministry of Health official).

Respondents in all levels reported that district annual plans had to be approved by regions and the central government. During the assessment and approval process, both the regional and the central-level health secretariats had the power to check whether the district health plans had been prepared in line with the central level priorities. After the approval of the district annual plans, health facilities and the district health managers were responsible for implementing what they have planned. The district health managers have been given power to oversee the implementation of the planned activities in all health facilities in their districts.

4.2 | Financial resource allocation and utilisation

There were 2 major sources of funds provided by the central government to finance the delivery of health services. The first one is the Health Basket Fund (HBF) which mainly comes from donors' contribution. The second source is Health Block Grants which consist of Personnel Emoluments (PE)—salaries for the staff, Other Charges (OC), and Development Grants. The government also provides drug revolving fund via the Medical Stores Department (MSD). In addition to the central government funds, the local governments generate their own funds using different sources of revenues. These sources, therefore, vary from one district to another although the most common are user fees, National Health Insurance, and Community Health Fund (CHF). In addition, districts may get funds from other donors who do not contribute to the health sector basket funds. The next section provides an analysis of the DS in the allocation and use of the major sources of funds for financing district health plans.

4.2.1 | Health Block Grants and Health Basket Fund

In budgeting and spending of Health Block Grant and HBF resources, local government authorities were required to comply to the centrally defined guidelines. The annual allocation of Health Block Grants and HBFs from Central Government to the local government authorities was based on a formula that was determined by the central government. The funds are allocated based on the following criteria: population (70%), poverty count (10%), district medical vehicle route (10%), and under-5 mortality (10%). In addition, at the district level, allocation of funds is done through budget

ceiling which is also determined by the central government. Districts are not allowed to allocate funds beyond these determined ceilings. Table 5 below illustrates the cost centres which are taken into account when allocating funds in the annual health plans.

Further, the central government determines the formula for resources allocation by type of expenditure for the basket funds. Table 6 below indicates resource allocation formula to be used for allowance, transport, and maintenance.

District health managers and health workers felt that they had very little ability to allocate and spend Health Block Grants and HBF according to locally determined priorities. One of the Liwale District Health Managers had this to say:

> *"Although the district is mandated to plan, the Ministry has set the ceilings which have to be adhered to. So, these ceilings guide us as we do our planning. If we go beyond the guidelines, the plan cannot be approved of"* (IDI with Liwale District Health Manager).

The observation above was supported by one of Kilolo District Health Managers who added that:

> *"Often the government intervenes in the Basket Fund. For instance, we may decide that the funds shall be spent on one, two, three, four. The central government may decide that the funds should be spent on medical supplies because that is the number one government priority. So the government may authorize a hundred million shillings on the condition that 35 million be spent on medical supplies"* (IDI with Kilolo District Health Manager).

In all the four districts studied, health managers complained about the formula used by the central government to allocate Health Block Grants and HBFs to the districts. According to our respondents, the formula used favoured districts which have large population which were mostly those in urban areas like Dar es Salaam, Mwanza, and Mbeya cities. As a result, districts which are in hard to reach areas got small share though in the perspectives of our respondents these districts were facing significant challenges in the delivery of health services. The Liwale District Health Managers illustrated this way:

TABLE 5 Allocation ceiling for the health basket fund and block grant

Cost Centre	Ceiling Range for Allocation by Council
Office of DMO	15%-20%
Council hospital/CDH	25%-30%
Voluntary agency hospitals (VAH)	10%-15% (Health basket fund only)
Health centre	15%-20%
Dispensary	20%-25%
Community initiatives	2%-5%

Source: PMO-RALG, MOHSW (2011). *Comprehensive Council Health Planning Guidelines*.

TABLE 6 Resources allocation by type of expenditures

Ceilings for Basket Funds		
Type of Expenditure	**Allocation Ceilings/Range**	**Examples of Expenditure**
Allowances	Maximum 20%	Allowances for supervision and distribution activities only
Transport	Maximum 20%	Fuel and maintenance of vehicles
Minor repairs/maintenance	Range 10-20%	Planned preventive maintenance of technical, medical equipment and HF

Source: Comprehensive Council Health Planning Guidelines (2011).

> *"We really experience significant challenges in health service delivery because the amount of money we receive is so little. The major criterion in allocating funds is the population size. Meanwhile, the population of Liwale District is small but very scattered. So despite our small population size, our needs are so demanding given the distance from one point to another. This is quite different from the situation in urbanized districts like those in Dar es Salaam"* (IDI with district health manager, Liwale district).

In the utilisation of the Health Block Grants and HBFs, all respondents at the district level reported that the districts were required to use the allocated funds as per budget ceilings and the planned activities. There was very little possibility for re-allocating funds after the approval of the budget. One of the Iramba Health Managers reported this way:

> *"In the course of implementing our programmes, expenditure should match the government guidelines and not otherwise"* (IDI with district health manager, Iramba district).

The FGDs held with the Liwale District Councils' heads of various committees further illustrated that local governments do not have the mandate because more often than not we receive directions from the central government on the use of our funds. We may be instructed that the money should not be spent on 1, 2, 3. That is why we argue that we do not have total autonomy on expenditure.

Similar views were reported by respondents from different districts. A Liwale Health Manager illustrated that:

> *"There is no way you can spend Basket Fund beyond the given guidelines. If we attempt to go against the guidelines, we are sure to have a lot of questions to answer during auditing"* (IDI with district health manager, Liwale district).

However, a few respondents had the view that lack of central level guidelines would result into misuse of funds and allocating funds to areas which are not of high priority. A Kilolo Health Manager responded that:

> *"Without guidelines, money can be spent on quite unnecessary issues. For instance, some money could be spent on per diems, fuel and on other things that could create opportunity for personal gains. In that way, it is very possible to ignore issues that could be of more interest to the wider public"* (IDI with district health manager, Kilolo district).

The above views by Kilolo District Health Manager were similar to the views of the Liwale District Health Manager who commented that:

> *"Indeed, guidelines help us in designing priorities and allocating funds. In the absence of the guidelines, most funds could be allocated to per diems for some officials instead of serving the needy population"* (IDI with district health manager, Liwale).

Similar views were expressed by the ward-level councillors during focus group discussions. In one of the FGDs in Liwale District, participants had the opinion that in any expenditure, there have to be in place some guiding principles. Therefore, it is not a bad idea having guidelines from the central government on the use of financial resources.

4.2.2 | Ministry of Health funds for medicines, equipment, and supplies

The findings from document analysis indicate that the Ministry of Health provides funds for medicines and medical supplies through the MSD. Funds are allocated using the following formula: 70% council population, 15% council poverty index, and 15% council under 5-year mortality index. Allocation of funds to the health facilities (health centres and dispensaries) within each district council is based on the catchment population of the facility.

Health facilities had authority to apply for medicines and medical supplies to the MSD on a quarterly basis using Request and Report (R&R) form. Request forms are required to go through the district pharmacist, who then reviews and submits the forms to MSD. Upon receipt of the R&R form, MSD prepares a custom package for each facility based

on the amount requested in the R&R form as well as funds available for each facility. The MSD delivers orders placed directly to health centres and dispensaries.

Interviews with all health providers confirmed that health facilities had authority to forecast medicine needs in their health facilities and prepare request for medicines to MSD via district pharmacists. The process of preparing orders at the facility is coordinated by the head (in-charge) of the health facility. In most cases, some members of the health facility governing committees (user committees) were involved, particularly when CHF was used to purchase the medicines.

This finding was reinforced by the district health managers in all study districts. Respondents confirmed that they provided support to the health facilities in preparing their orders. However, the power to forecast and prepare orders was to a large extent within the health facilities. One of the Rombo District Health Managers explained that:

> *"Health centres outline their needs. They bring the outlines to us just for approval. The medical In- charge authorizes the request after scrutiny of the request and satisfaction that the request is correct. The In-charge may make necessary amendments to the request when he/she feels that some corrections are needed"* (IDI with district health manager, Rombo District).

The district health managers and health service providers reported that they had moderate decision-making space in the procurement of medicines and medical supplies. However, health providers reported that they had no control over funds which are allocated to their health facilities for medicines and medical supplies. The allocation of funds was done by the central government and was disbursed directly to the MSD's account. This implies that sometimes respondents prepared orders for medicines and medical supplies without knowing the amount of funds available.

In addition, health providers from all districts of the study reported that while they had wider DS in preparing orders and forecasting the needs for medicines and medical supplies in their respective health facilities, sometimes the MSD delivered medicines which were not ordered and the facilities had little authority to reject the medicines. A health worker in Liwale District said:

> *"Sometimes the MSD supplies medicines which have not been requested especially when they feel that some medicines are about to expire. Sometimes we receive medicines only to find that they will expire after one month. Likewise, we may order certain kinds of medicine only to receive quite different supplies"* (IDI with health worker, Liwale District).

4.2.3 | Mobilising, allocating, and using locally generated funds

In the framework of decentralisation, districts had authority to mobilise and use locally generated funds to finance different activities in their districts. Each health facility in the study district own bank accounts into which they deposit funds from user fees, health insurance, and community health fund. The bank accounts are managed by the members of the health facility governing committees, who are selected by the community members and names approved by the District Executive Director. The districts had wider authority in determining and modifying user fees rates as well as community health fund annual contribution rates in the health facilities. It was evident that the annual contribution rates for the CHF membership varied across districts, indicating variation in the use of decision-making space within the context of decentralisation. For example, in Rombo District, households were paying Tshs 30 000 annually while in Kilolo, Iramba, and Liwale districts, households were paying Tshs 10 000 annually. In addition, the district councils had power to modify user fee rates within their district.

This finding was also supported by health care providers. When asked who was responsible for determining user fees and the CHF annual contributions, one health service provider in Liwale reported this way:

> *"For instant charges, we initiate changes as the Hospital Management Committee, and propose to the ward councilors and the full council meetings. The rates have actually been approved and posted to the notice boards. But for other charges like CHF contribution, it is the District Council that approves. Formerly we*

charged Tshs. 5,000/= per household per year but it was later found to be too little, and now it is Tshs. 10,000/=" (IDI with in-charge of District Hospital, Liwale).

However, the ability of the local government to effectively use locally generated funds was constrained by the bureaucratic procedures of the central government, particularly in the procurement of medicines and medical supplies. The health service providers and district health managers expressed the challenges they were facing in getting medicines from the MSD. It was discovered in the findings that the health facilities were required to deposit funds to MSD before being assured of the availability of medicines. As a result, health facilities deposited funds to the MSD account while the supplier had no medicines to deliver. It was further found that when the MSD was out of stock, it did not return the funds to the health facilities to enable them purchase medicines from other vendors. A Health Manager in Iringa expressed that:

"More often than not, health facilities are told that the medicines they request are out of stock. When we go to the MSD, they tell us that 'out of stock'. However, the problem is that if they cannot get the supplies, they do not refund us. So we experience a lot of delays because of this chain" (IDI with Regional health manager, Iringa region).

Another respondent added that:

"The major challenge is that the health centre could deposit money to the MSD bank account only to find that between 60 and 70 percent of the ordered medicines are out of the MSD stock. It is really challenging to get back the money we deposited to the MSD bank account" (IDI with regional health manager, Kilimanjaro).

Similar views were reported during focus group discussions with the ward-level councilors in almost all districts. In 1 of the FGDs in Liwale, it was explained that a health centre raised funds from CHF and deposited Tshs. 35 000 000/= to the MSD, but they received medical supplies worth Tshs. 15 000 000/= only. However, they never received the rest of the consignment, and the money had never been rolled back to their bank account yet (FGDs with ward councilors in Liwale district).

5 | DISCUSSION OF THE FINDINGS

This study aimed to analyse the amount of choices which have been transferred from the central government to institutions at the periphery in the decentralised health system in Tanzania. The findings of the study indicate that decentralisation in the health sector in Tanzania has provided district authorities with a range of choices to be utilised at the local level. The findings indicated that while the districts had power to make decisions in some aspects, they had narrow decision-making space in other aspects. The subsequent section discusses the key findings of the study in the light of other studies in low-income and middle-income countries.

5.1 | Planning and priority setting

It was evident from the data that the district health managers, health facilities, and the communities participated in developing and implementing district health plans. The district annual health plans had some inputs from the communities as well as from the health facilities. Maluka and colleagues[32] and Frumence and fellows[21] also reported that decentralisation provided opportunities for the community members to participate in planning and priority setting process. Likewise, Massoi and Norman had earlier reported that D-by-D provided local government DS in planning and budgeting processes.[33]

However, this study indicated that the ability of the district health managers and the 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. In order for the district health plans to get approval from the central government, the district health managers and the health facilities were required to adhere to the centrally defined priorities. The local government, including health facilities and the communities, had little room to add other identified local priorities, but they had wider DS in identifying specific interventions and activities within the broader national-level priorities. This study suggests that while centrally defined priorities are important to ensure that national and international priorities and targets are achieved, the central government should provide more space to the decentralised district health systems to incorporate locally defined priorities in the district health plans.

5.2 | Allocation and use of financial resources

The findings indicated that, to a large extent, the districts depended on the HBF and Health Block Funds to finance district health services. These funds were allocated to the districts by the central government. While the district health management teams, hospitals, health centres, and dispensaries had authorities to prepare annual budgets, the budgeting process and allocation of expenditures were controlled by the central government. The districts had little room to allocate funds beyond these determined ceilings and cost centres.

These findings validate previous studies conducted in other settings. For example, a study conducted in Fiji reported that the decentralised local institutions had no specific budget allocation and these institutions had narrow decision-making regarding the centrally allocated budget.[34] Other studies in Tanzania have reported that the decentralised local government institutions are highly dependent on the central government funding to finance the delivery of health services in the districts.[21,35] Similarly, recent studies on decentralisation in Kenya also documented the same results. Despite the implementation of decentralisation by devolution, counties in Kenya highly depended on the central government funding to support delivery of health services.[19,20] The high dependency on the central government funding highly affected the implementation of the planned activities.[19,20,35]

This finding suggests that the D-by-D which is being promoted in the policy documents in Tanzania and elsewhere is yet to be realised at the district and local levels. The central government still has more control over budgeting process and allocation of expenditures at the district and local levels contrary to the policy documents that emphases the devolution of power and resources, including finances to the local government authorities. To achieve the objectives of the decentralisation process, the central government needs to give more authorities to the local government institution in the budgeting process. This would ensure that the needs and priorities of the local communities are implemented effectively, and hence, objectives of the decentralisation are achieved.

The findings of this study further revealed that the formula used by the central government to allocate health block funds and health basket funds to the district Councils paid very little attention to other factors such as local context and geographic conditions of the districts. The central government should consider the possibility of reviewing this formula to consider other factors such as geographic condition which have high influence on the delivery of health services. The current formula used to allocate financial resources to the districts seems to favour urban-based districts, which have high population compared to remote and hard-to-reach districts which, in most cases, have low population size. It should be taken into account that the urban districts have wider choices in accessing health services compared to the rural population, which faces significant challenges in accessing health services. In addition to limited capacity of financial resources, the rural populations are also constrained by lack of health facilities where they could access services.

5.3 | Procurement of medicines and medical supplies

The findings of this study indicated that while the district councils and health facilities in the study districts had wider DS in preparing requests for purchasing medicines and medical supplies from the MSD, they had narrow decision-making space on the funds which the central government allocated to the health facilities for medicines and medical supplies. The central government determined the criteria of allocating funds for medicines and medical supplies for

health facilities countrywide. In addition, the allocated funds were disbursed by the central government directly to the MSD. This was reported to have highly affected the decision-making space of the local government authorities and the health facilities on matters related to the acquisition of medicines and medical supplies. Consequently, health facilities were sometimes sending requests for medicines and medical supplies to MSD without knowing the amount of funds available in their account and how much has been disbursed to the MSD.

This study suggests a need for the central government to inform district health managers and health facilities well in advance about the amount of funds allocated and disbursed to the MSD for medicines and medical supplies. This would enable district health managers and health facilities to make a wiser request of medicines and medical supplies based on the actual amount of funds available and the needs of the communities they serve.

The finding of this study further revealed that while the district councils and health facilities had wider decision-making space in procuring medicines and medical supplies using locally generated funds, they were highly constrained by the limited capacity of MSD to deliver required medicines and medical supplies to the health facilities countrywide. The DS was also watered down by bureaucratic procedures which restricted health facilities to procure medicines and medical supplies outside the MSD. It was discovered from the findings that the major challenge facing the MSD was related to financial capacity, which led to frequent drug stock-out in the MSD warehouses. The limited financial capacity of the MSD coupled with bureaucratic red tapes of the central government which limited the space for the health facilities to procure medicines and medical supplies outside the MSD contributed significantly to the frequent and persistent stock-outs of essential medicines and medical supplies in the health facilities.

Similar findings have been reported in other settings. For example, the recent study in Kenya reported that significant delays in the procurement of essential medicines and medical supplies resulted to long stock-outs of drugs in the health facilities. Additionally, when the health facilities were given more decision-making space to procure medicines and medical supplies, facilities reported to have contained problems of persistent drug stock-outs.[20] Similarly, in Guatemala, the study on decentralisation and logistics systems reported that allowing local officials to procure medicines and medical supplies directly from producers for fixed low prices resulted into better performance.[13]

To improve the availability of essential medicines and medical supplies in the health facilities in Tanzania, the central government should capacitate MSD financially to enable them procure sufficient medicines and medical supplies. The central government should also reduce the bureaucratic procedures which restrict health facilities in Tanzania to procure medicines and medical supplies outside MSD, particularly when the MSD experiences drug stock-outs. This would provide more flexibility for the health facilities in the country to procure medicines and medical supplies and hence reduce frequent dug stock-out in health facilities.

6 | CONCLUSION

This study concludes that decentralisation in the health sector in Tanzania has provided district authorities with a range of decision-making space to be utilised at the local level. However, the decentralisation by devolution which is being promoted in the policy documents in Tanzania and elsewhere is yet to be realised at the district and local levels. The central government still has more control over budgeting process and allocation of expenditures at the district and local levels, contrary to the policy documents that emphasises devolution of power and resources, including finances to the local government authorities.

The study recommends that while centrally defined priorities are important to ensure that national and international priorities and targets are achieved, the central government should provide more space to the decentralised district health systems to incorporate locally defined priorities in the district health plans. Similarly, to achieve the objectives of the decentralisation process, there is dire need of the central government to give more authorities to the local government institutions in budgeting process. This would help ensure that the needs and priorities of the local communities are implemented effectively, and hence, objectives of the decentralisation are achieved. The central government should consider the possibility of reviewing the formula for allocating health basket funds, health block

funds, as well as funds for medicines and medical supplies. In particular, consideration should be more in addressing inequalities in the access to health services rather than the population size of the district. The central government should capacitate MSD financially to enable them procure sufficient medicines and medical supplies and should reduce the bureaucratic procedures which restrict health facilities in Tanzania to procure medicines and medical supplies outside MSD, particularly when the MSD experiences drug stock-outs.

ACKNOWLEDGEMENTS

This paper was part of the thesis of the first author (RK) for Doctor of Philosophy (PhD) in Development Studies submitted to the University of Dar es Salaam. We thank national, regional, and district health managers and other stakeholders who participated in the study. We are also grateful to the Tanzania Higher Education Students Loan Board through Dar es Salaam University College of Education (DUCE) for supporting this study financially.

CONFLICT OF INTEREST

The authors declare that have no conflict of interest.

FUNDING INFORMATION

The research was supported financially by the Tanzania Higher Education Students Loan Board through Dar es Salaam University College of Education (DUCE) as part of the PhD programme.

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How to cite this article: Kigume R, Maluka S, Kamuzora P. Decentralisation and health services delivery in Tanzania: Analysis of decision space in planning, allocation, and use of financial resources. *Int J Health Plann Mgmt*. 2018;1-15. https://doi.org/10.1002/hpm.2511