AUTONOMY WITHOUT CAPACITY: THE ROLE OF HEALTH FACILITY GOVERNING COMMITTEES IN PLANNING AND BUDGETING IN TANZANIA

POLICY BRIEF NO: 01-2023

Introduction

Since the inception of health-sector reforms in Tanzania in the 1990s, health planning and implementation was decentralised to the Council Health Management Teams (CHMTs) headed by the District Medical Officer (DMO). This arrangement centralised the autonomy for planning, budgeting and resource allocation at the district level with very limited autonomy and authority at the health facility and community level. Since 2017/2018, the government of Tanzania has further transferred the autonomy to plan, budget and manage financial resources to health facilities. Under the current arrangements, each health facility prepares its comprehensive annual health plan and budget, and funds for the implementation of the plans are transferred directly from the Ministry of Finance and Planning (MoFP) to health facilities; the policy known as Direct Health Facility Financing (DHFF).

Each health facility is supposed to have a planning team responsible for preparing annual plans. The team is required to: (i) conduct a thorough assessment of the implementation of the previous year comprehensive health facility plans to guide preparation of subsequent annual plan; (ii) gather community opinions regarding priorities and challenges in accessing health care services to inform the planning process; (iii) conduct a robust situational analysis about the morbidity and mortality trends, underlying causes and health system bottlenecks hampering the delivery and uptake of interventions; (iv) prepare plans in accordance to existing guidelines; (v) provide feedback of the approved facility plan to Health Facility Governing Committee (HFGC), Village Development Committee (VDC) and Ward Development Committee (WDC); and (vi) ensure that the plans are responsive to local needs (facility and population).

The central government issues guidelines that steer the planning process at the district and health facility levels. The CHMTs and health facilities need to abide by these guidelines when preparing their annual health plans. Similarly, the central government supplies the budget making guidelines, which stipulate the ‘budget ceilings’ that every district and health facility has to adhere to.

All facility plans are at later stage consolidated into a Comprehensive Council Health Plan (CCHP) for the whole district. Similarly, the preparation of the CCHP is led by a guideline from the central government. The consolidation process is done by the CCHP planning team led by the District Medical Officers (DMOs). After endorsement at the Council level, the plan is submitted to the Regional Secretariat (RS) for assessment, approval and submission to the national level. At this level, the plan is assessed by assessors comprising members from the President’s Office-Regional Administration and Local Government (PORALG) – Health and MoH and recommended for funding.

Objectives

This study aimed to comprehensively investigate the functioning of the HFGCs and the health facility planning teams in the context of the current increased autonomy to plan, budget and manage financial resources in Tanzania.

Methodology

This three-year research project (2020- 2023) was conducted in 10 out of 26 regions in mainland Tanzania. These regions were purposively selected based on their performance in the 2018 Star Rating assessment conducted by the Ministry of Health. Three categories of regions were selected, namely high, medium and worst performing. Other criteria included geographical balancing of the regions in the zones as well as rural-urban districts. The involved regions are Kilimanjaro, Geita, Mbeya and Mwanza (high performing); Singida and Shinyanga (medium performing); and Ruvuma, Rukwa, Tanga and Morogoro (worst performing). In each region, two districts were selected taking into consideration their performance making a total of 20 out of 162 districts. Data were collected using in-depth interviews with district health managers, health workers and members of HFGCs. In addition, various documents including guidelines, circulars, and Comprehensive Council Health Plans were reviewed.

Key findings

Autonomy in planning and budgeting

Generally, respondents in the health facilities felt that they had autonomy in the planning process compared to previous years when this process was done at the district level. Health facilities had the view that they were now free to identify specific interventions within the broad 13 priority areas. However, there were concerns regarding budget ceilings since they failed to provide flexibility in the sense that they did not allow district and health facility managers to modify them.

Capacity in planning and budgeting

In almost all districts, there was no evidence of existence of planning teams in most of the health centres and dispensaries. In the majority of dispensaries, health plans were prepared by the persons-in-charge and submitted to the CHMT through DMOs for consolidation. This practice contradicts the planning guideline which requires health facility plans to be prepared by the planning teams and submitted to CHMT for consolidation.

Almost all members of HFGCs at the dispensary level were neither aware of the existence of the health facility planning team nor were they involved in the preparation of health facility plans. In addition, in the majority of districts, there was no evidence of official feedback from CHMTs to health facilities on consolidated CCHP.

At district hospitals, the majority of respondents confirmed the existence of health facility planning teams; and preparation of the plans was coordinated by the planning teams. However, in most of the districts, the final compilation of the plans was done by few members mainly technical experts instead of the planning team.

In almost all districts, members of HFGCs had not received training to enable them perform their roles and responsibilities, except a one-day orientation provided during launching of the committees and the Council Health Service Board (CHSB). However, they felt that the orientation was not enough to enable them understand their roles and responsibilities.

Furthermore, except for in-charges of health facilities, the vast majority of the HFGC members were not aware of the existence of the comprehensive health facility planning guidelines. Similarly, they had never been provided with any document which described their roles and responsibilities.

Conclusion

Health facilities have now been granted wide autonomy in the identification of priorities, planning, budgeting and management of financial resources. In addition, HFGCs are important for social accountability and can serve as a bridge between health facilities and the communities they serve. However, there has been little efforts to strengthen the capacity of health facilities and the community to handle the new responsibilities in the context of the current decentralisation. Consequently, priority setting, planning and budgeting process are mainly driven by health care workers, based on historical documents, and rarely informed by local evidence. Similarly, there are weak accountability mechanisms at the community and local levels.

Recommendations

* District health management teams should sensitize communities on the existence, roles and responsibilities of HFGC members.
* District health management teams should ensure that community members actively participate in the selection of members of HFGCs.
* District health management teams should build the capacity of HFGCs in planning, budgeting and management of health facility resources.
* District health management teams should ensure that all members of HFGCs have important documents to guide the planning and budgeting process; and the planning and budgeting guidelines should be in Kiswahili language.
* District health management teams should ensure that each health facility has an active planning team which participates in the preparation of the comprehensive health facility annual plans.
* District health management teams should ensure that HFGC members are actively engaged in the consolidation of health facility annual plans into comprehensive council health plans.
* District leaders need to strengthen relationships between HFGCs and health care providers, health managers and community leaders.

This policy brief is an output of a three-year (2020-2023) research project named: Examining effects of decision-making space and its practices on health systems performance in Tanzania (RIGHT) jointly funded by the Department for International Development (DFID), the Medical Research Council (MRC), and Wellcome in partnership with the Economic and Social Research Council (ESRC) Grant No: Grant Ref: MR/T023597/1.

Prof. Stephen O. Maluka (PI)[1,4]*, Prof. Peter Kamuzora[1], Prof. Anna-Karin Hurtig[2], Prof. Miguel San Sebastian[2], Dr. Lilian Mtasingwa[1] & Dr. Ntuli Kapologwe[3]

1. Institute of Development Studies, University of Dar es Salaam, Tanzania
2. Department of Epidemiology and Global Health, Umeå University, Sweden
3. President's Office-Regional Administration and Local Government, Tanzania
4. Dar es Salaam University College of Education, University of Dar es Salaam, Tanzania.

Contact: stephenmaluka@yahoo.co.uk