

**The Relationships between Central Organizations and Local  
Government and Their Influence on Local Planning Process:  
A Case of Council Health Management Team Planning in  
Tanzania.**

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## Executive Summary

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### Introduction

Decentralisation was intended to promote local decision-making and make district health plans more responsive to local needs. However, there are factors hindering these achievements. Among these is confusion about accountability, local government capacity limitations, and infringement of local decisions space. This study aimed to gather new evidence and gain a theoretical understanding of how the relationships between central organisations and Council Health Management Teams (CHMT) influence Tanzania's local health planning process. The study was conducted in Ilala Municipal Council and Morogoro District Council in Tanzania. An exploratory, descriptive qualitative approach was employed where Policy triangle, Decision space, and decentralisation typology were used to inform the study conceptual framework. Document review and Key Informants Interviews were used to collect data, and framework analysis was employed.

### Findings

Objective 1: To describe the context of local health planning including decentralisation

The study found for main factors shape both the planning process and relationships between actor of central level and those are at local level. These factors include finance, hierachy, information availability, legal frameworks and roles politicians. Tanzania is amongst the fast-growing economies in Africa. However, the budget allocated to health is about 10% of total government expenditure which is still below Abuja declaration. Planning levels is aligned to administrative hierarchy hence drawing very thin line between administrative accountability and planning responsibilities between levels hence influence the utilization of granted decision space by a local planner. Employees who are lower in the chain of command may tend to consider themselves inferior to those who are higher in the hierarchy. Furthermore, information for planning is another factor that influences capacity of local planners to back their decisions with evidence.

The constitution did not clearly demarcate the limitations of central government powers. Hence making the central actor to overpower local actors

Objective 2: To describe and analyse the health planning process in decentralised settings health sector decentralisation

According to the policy documents health planning is decentralised with clearly stipulated roles. A mix of bottom-up and top-down decisions experience was found. Generally health planning was found to be deconcentrated than devolved. The stages exposed to central influences are priority settings and resource allocation. This is because what is prioritised depends highly on finance availability and whether the priority is within allowable expenditure. It was found that all councils follow a standardized health planning process. The process is set to ensure is aligned with planning guidelines issued by Ministry of Health, Presidents' Office Ministry of Health and Local Government and Ministry of Finance. The allocation of resources to councils is guided by resource allocation formula that takes into account several factors such as population, the burden of disease and health systems constraints of the councils. To avoid misappropriation of funds, expenditure ceilings were set. Several alterations were made in expenditure ceilings which they sometimes broadened and sometimes narrowed local decisions space. Changes in restriction on expenditure ceiling were aggravated by variety of reasons, these include addressing equity, addressing health commodities shortage or controlling expenditure on items that are easily prone to abuse. Poor adherence to procedures as provided in the guidelines connotes poor performance in the assessment of plans. Capacity limitations have been the reasons leading to re-centralisation either formally or informally.

Furthermore, it was found that financially and structurally central government is more powerful than the local government. Hence the findings suggest unequal space between central and local governments concerning decision-making hence during planning process. Administrators were found like an extended arm of the Centre. Administrators consider decision space is broad-based on written policies and not actually what is happening in practice. Majority of local planners expressed

realities in how the decentralisation is practised and considered the decision space is narrow in some aspects and broad in some aspects.

The study findings suggest that, less has been done to make planners acquire planning skills, but a lot has been done to orient planners with required format, regulations and policies that they have to adhere to during planning. Therefore, planners capacity on planning techniques is watered down which negatively influence the analytic and reasoning capacity of local planners

Objective 3: To describe and analyse the central –local relations in local health planning

The central-local planning relationships were mainly formal, no significant informal relationships were identified. Central – local relations in the process of developing local health plans were found not static. Main actors in central-local planning relationships were government (central and local government administrators and technocrats) donors and politicians. Three types of planning relationships were identified– administrative, technical, and political. Types of health planning relationships were found to be highly linked to actors' mandates and accountability demands which are formal and complex in nature and they overlap. MOHSW has multiple accountability responsibilities: Political, Hierarchical, Financial and Technical. Central government use its mandates and resource power to gain local compliance in addressing the central agenda in local health planning. The power of central government was derived from constitutional and ministerial roles and functions, political stance and fiscal policies. Implementation of decentralisation in health planning was found to differ between ministries who actively engage in the planning process.

The study found that decentralization of the planning process is faster than the pace at which actors' roles and responsibilities are changing in the entire central-local management arrangements. Some actors were reported to still act in a centralised manner despite the adoption of decentralisation policy. Some ministries were said to lag behind. For example, health sector implements decentralization while the ministry of finance is operating in a centralized manner.

Consequently, they influence sectoral ministries like MoH to also retain some of its power which ideally, they would have decentralised

Objective 4: To explore the influences of central- local planning relationships and their implications on local health planning process

Three primary forms of influences of central-local relations on health planning were identified. Political, technical and administrative relationships. The influence on the responsiveness of local health plans to local needs, infringement of local decisions space, and influence on altering central arrangement leading to deviations between written intentions of decentralisation in the health planning process and the practice. Central level technocrats were found to have a great influence on planning decisions than lower-level technocrats for matters of central priorities as well as those of local priorities and were the custodian of policies and strategic directions of the country. Central control of LGA budget by setting revenue collection structure were noted which aimed at ensuring funds are not misappropriated and plans address national priorities. . Central level politicians have greater say than both technocrats and local politicians when it comes to decision making in planning. The avenues of influence reported were through parliamentary committees and budget sessions during parliamentary meetings. It was mentioned that rural council were likely to be affected more by central influence on planning compared to urban because the urban council have advantage of having a broader revenue base than rural.

### **Conclusions and Recommendations**

In relation to the overall aim and objectives of the study, three main conclusions have emerged from the above findings. Firstly, central-local relationships have a varying influence on local health planners' decision space in which some contradict decentralisation intentions. Secondly, council and national level respondents consider local health planning process a mix of bottom-up and top-down approach. And thirdly, there is misalignment between the constitutions, ministerial responsibility and decentralisation policy regarding central-local planning

relationships. The following recommendations are made to improve the central-local relationships in the local health planning process.

- i. Ministry of Health and Social welfare in collaboration with other sectors to prepare a national guiding document for implementing decentralised health planning containing resolutions to reduce mismatches between regulatory frameworks, specifically between the Ministry of Health and Ministry of Local Government.
- ii. Adapting a structured mechanism for communication, transparency, and regulation of the peripheral units without interfering with local autonomy is recommended, such as performance contracting.
- iii. Building capacity of Health Facility Governing Committees and Health Service Boards to promote local agenda in the local health planning process



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## Abbreviations

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AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretrovirals
BRN	Big Results Now
CCHP	Comprehensive Council Health Plans
CHMTs	Council Health Management Team
CHSB	Council Health Service Board
COSTECH	Commission for science and technology
CSO	Civil Societies organisation
CSOs	Civil Society Organization's
D by D	Decentralisation by devolution
DANIDA	Danish International Development Agency.
DFID	Department for International Development
DG	Director-General
DHFF	Direct Health Facility Financing
DHIS2	District Health Information systems
DMO	District Medical Officer
DPG	Development Partners Group
DPs	Development Partners
GDP	Gross Domestic Product
GoT	Government of Tanzania
HBS	Household Budget Survey
HFGC	Health Facility Governing Committee
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
ICT	Information Communication Technology
JFV	Joint Field visit



JICA	Japanese International Cooperation Agency
LGAs	Local Government Authorities
MMAM –PHSD	Primary Health Service Development Program
MOFP	Ministry of Finance and Planning
MOH	Ministry of Health
MOH&SW	Ministry of Health and Social Welfare
MOHCDGEC	Ministry of Health Community Development Elderly and Children
MOU	Memorandum of Understanding
MRALG	Ministry of Regional Administration and Local Government
MTEF	Medium Term Expenditure Framework
MTUHA	Health Management Information System
NEHCIP	National Essential Health Care Interventions Package
NGOs	Non-Governmental Organizations
NIMR	National Institutes for Medical Research
NPEHSWI	National Package of Essential Health and Social Welfare Interventions
NTD	Neglected Tropical Disease
ODA	Official Development Assistance
P4P	Pay for Performance
PORALG	President Office Regional Administration and Local Government
PS	Private Sector
RDD	Regional Development Department
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RS	Regional Secretary
SWAP	Sector Wide Approach
TB	Tuberculosis
TC- SWAP	Technical Committee-Sector Wider Approach

TEHIP	Tanzania Essential Health Intervention Project
TRA	Tanzania Revenue Authority
UN	United Nations
UNICEF	United Nations International Children's Emergency Funds
USAID	United States Agency for International Development
WHO	World Health Organization

## Chapter 1. Introduction to Thesis

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### 1.1 Introduction

This study aims at gathering new evidence and gaining a further theoretical understanding of how central-local relations influence local health planning in Tanzania. This chapter outlines the background and rationale of the study, identifies the existing knowledge gap in the current literature and highlights the focus of the study. Further, the chapter presents the study objectives and research questions. Lastly, it provides an overview of the thesis

### 1.2 Background and Rationale

Despite its increased relevance to improving population health and health systems, the record of health planning is debatable, with plans failing to be implemented, or implemented but failing to meet the stated objectives (Green., 2007). The poor record of health planning is attributed to many factors including the functionality of decentralisation and imbalanced power between central and local level actors (Green., 2007; Ramani, Mavalankar and Govil, 2008). Decentralisation is thought to be a remedy for addressing some of the failures of health planning especially increasing its responsiveness to local needs. However, there are several factors that affect the achievements of this outcome (Atkinson *et al.*, 2005). Among these factors are the differences in actors' mandates, resource access, accountability, and capacity of local authorities which influence bureaucratic reorientation and increase central level involvement in local government matter (Bossert, 1998a; Rhodes, 2018; Rhodes, 1981a; Rhodes, 1999a; Wright, 1982)

Existing evidence highlights that the level of autonomy to make decisions of the local authority is narrowed in most cases for several reasons (Bossert, 1998b; Bossert, 1998a; Berman and Bossert, 2000; Bossert and Mitchell, 2011; Liwanag and Wyss, 2019; Homedes and Ugalde, 2005). The reasons include shifting of priorities in instances where the allocation decisions were left to local authorities (Homedes and Ugalde, 2005). Poor performance of centrally funded services such as immunization and breakdown of referral systems-*ibid*

The researcher feels that, challenges affecting health planning in a decentralised setting are the product of two assumptions. The first underlying assumption about decentralised planning is that, local planners will make good plans that are responsive to local needs if they are granted responsibilities and authority to allocate available resources. This assumes the neutrality of the process and the planners themselves. It assumes that, Central government is a neutral actor and fully trusts local government to the extent it may leave its interest on the mercy of local government. However, there are records where discretion is granted and the grantees misuse the expanded autonomy opportunities (Homedes and Ugalde, 2005). Furthermore, literature provides that, in decentralising decision making central government employs variety of tools that enable it to use its power and resources to call for local compliance for matters of central interest (Rhodes, 1981a; Rhodes, 1999b). This means planning process is somehow shaped by the central-local relations process and in some cases, control is maintained by the central level.

Academic backing on the reasons why local decision space is narrowed unveils the synergies between decision space, accountability and capacity (Bossert, 1998b; Berman and Bossert, 2000; Bossert, 2016; Bossert and Mitchell, 2011; Liwanag and Wyss, 2019). On the other hand, the literature on central-local relations also indicates that, the autonomy granted to local government is not complete (Loughlin, 1996; Brewer and Selden, 2000; Morgan and Trinh, 2016; Rhodes, 1981a; Rhodes, 1999b). Bossert 1998 points out some limitations of the study as quoted below

*“[...] First, our analyses are associative in nature and do not account for many factors which may affect relationships between dimensions of decentralisation. Our cross-sectional design precludes causal inference for the relationships we find between decision space, capacity and accountability in decentralisation.” (1998:47)*

This justifies the need for a thorough understanding of how the government system is structured and the existing patterns of relationships between central and local level which may have impact on the local planning process. Tanzania is among the countries implementing health sector decentralisation. Local studies have indicated challenges regarding decentralised health planning at district level (Semali, deSavigny and Tanner, 2005; Kessy, 2018; Kessy and McCourt, 2010; Venugopal and Yilmaz, 2009). However, little is known in Tanzania on how the synergy between capacity, decision space and accountability relate to central-local relations practices in health planning. Therefore, the interest of this study was to explore how central-local relations in health planning influence the process of formulation of comprehensive council health plan. However, there are limited studies at least in Tanzania exploring the influence of central-local relations in health planning in particular at council level. In order to strengthen local health planning, there is a need to understand factors influencing the process of formulation of health plans. The development of council health systems and its responsiveness to health needs depends much on its planning process strengths. It is my hope that this study will contribute to increased understanding of the influences of central-local relations practices on local health planning process, and potentially may lead to the improvement of overall design and management of local health planning process in Tanzania.

### **1.3 The Focus of the Study**

This thesis explores the influence of central-local relations in formulation of council health plan. The broad aim is to gain a better understanding of central-local relations in local health planning. Specifically, this will be achieved by gathering new evidence and gain theoretical knowledge regarding the factors influencing the central-local planning relationships and how the relationships affect the formulating local health plan and the implications of such influences. Studying local health planning process was chosen because Tanzania implemented decentralised health planning since 2000. Decentralised district health planning in Tanzania did not receive emphasis and political support until 1999 when the country introduced health sector reform (Mapunda, 2003). One of the milestones

of the reform was coordination of health budget support through a standard basket called Basket Fund<sup>1</sup>(MOH&SW, 2004). Since 2000, councils were enrolled in phases to get basket funding budget support and they were trained to develop Comprehensive Council Health Plans (CCHP). There have been achievements and challenges. Achievements since 1999, include:

- Integration of services at local level, alignment of district health plans to macro strategies such as poverty reduction;
- Inclusion of community structures as approvers of health plans;
- Improved coordination of health providers; and
- Improvement in availability of supplies and drugs.

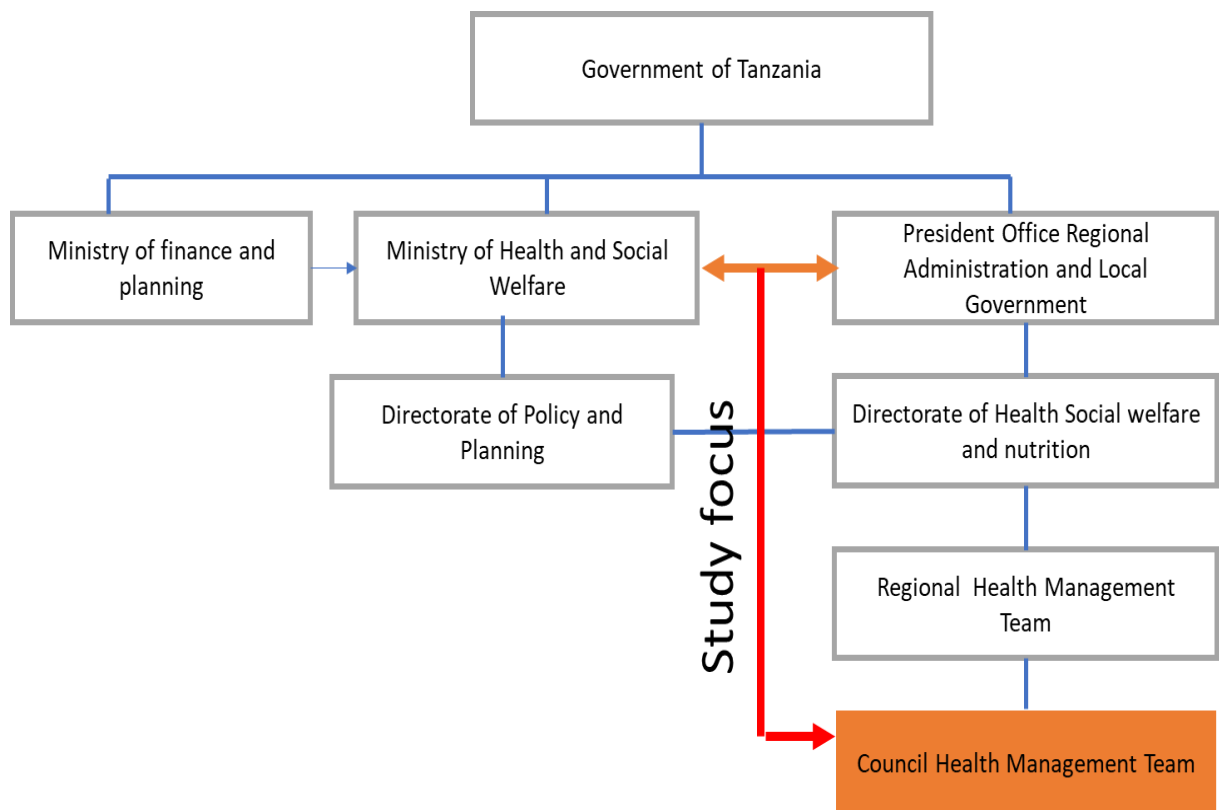
The following challenges existed, MOH&SW (2007):

- Rigidities of the 'basket funds' guidelines can make it difficult for councils to plan effectively. For example, 7 of 16 districts' self-assessment done during the health sector evaluation of 2007 reported that their autonomy is restricted by Ministry of Health and Social Welfare.
- The guideline is more of a budgeting tool than a dynamic planning tool.
- The CCHP development process is complex and time-consuming.
- Health planning at district level is dominated by local health system managers and has not been truly participatory.
- Dual structure of authority has potential conflict. CHMT technically report to MoH&SW but administratively to Ministry of Local Government.
- Weaknesses in community representative structures such as health service boards. The boards were found to meet infrequently. It was also found that cost sharing money is accumulated at the district level because the proposals on how funds should be used are expected to come from the boards and they are incapable of doing so (MOH&SW 2008).

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<sup>1</sup> Basket Fund is the arrangement where all donors put together resources in one basket and the funds are used to implement Ministry's plans

The interest of this study is to understand the influences of relationship between central (Ministry of Health and Social Welfare) and Council Health Management Team (CHMT) on the process of developing annual health plans – called- Comprehensive Health Plans (CCHP). The two entities are linked by the organisation structure that explains formal relationships between the two levels- Figure 1.1. The researcher acknowledges the existence of other important units which in one way or the other interact with the focal units of assessment.



*Figure 1.1: The focal unit of assessment of the study*

#### **1.4 Study Objectives and research questions**

The study aim was achieved by addressing four specific objectives and corresponding research questions presented in Table 1.1

Table 1.1: Study Objectives and Research Questions

Study Objectives	Research Questions
1. To describe the context of local health planning including decentralisation •	1.1. What is the context of local health local planning process? 1.2. What is the context of local health planning relationships?
2. To describe and analyse the health planning process in decentralised settings health sector decentralisation	2.1. How Tanzania health planning is organised 2.2. How the local health plans are developed (includes problem identification, priority setting and resource allocation)? 2.3. Who is involved in the development of local health plans and how 2.4. How the local health planning process is guided and why?
3. To describe and analyse the central –local relations in local health planning	3.1. What types of central-local planning relationships exist? 3.2. What are the roles of actors in the relationships? 3.3. How central and local actors interact in the relationship 3.4. What powers central -local actors possess and how it is applied in the local health planning process in the relationship?
4. To explore the influences of central- local planning relationships and their	4.1. What are the influences of central-local health planning relationships in the local health planning process? 4.2. What are the Implications of the influences to the planning process (on planning priorities, available options of appraised, quality of end product)? 4.3 How can central-local relations be improved to support local health planning process as aimed by decentralisation objectives?
	4.3.
5.	5.1.
6.	6.1.1.



7.	
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These questions were examined within Ilala Municipal and Morogoro District Councils. The former represented urban settings and the later represented rural settings. The study used policy triangle(Walt and Gilson, 1994) decision space approach(Bossert, 1998a) and decentralisation typology(Mills *et al.*, 1990a) to explore central-local relations influences in health planning. This is an exploratory descriptive qualitative approach of inquiry. According to Hansen (2020), a qualitative approach is best suited to research problems that need to be understood in relation to wider social, cultural, political, and economic contexts that involve exploration into the processes of how these factors relate and interact, through which generalizing about the problem would “*not give an accurate picture of the situation*” (Ward, Comer and Stone, 2018; Hansen, 2020)

### **1.5 Thesis Overview**

This chapter provides the background of the study where the rationale, objectives and research questions are presented. Literature review is presented in two chapters (2 and 3). Chapter two presents health planning literature and chapter three presents literature on central-local relations and describes the study conceptual framework which informed the overall study’s design –objectives, research questions, data collection and analysis. Chapter four describes the research methodology used to answer the research questions. Chapter five sets the scene of the overall study findings where relevant contextual factors characterizing the planning process and the central-local relations are explored and analysed. Chapter six outlines and analyses the health planning process including how the local health planning process is guided. chapter presents and analyses types of central-local relations in local health planning process and how local health planning process is influenced by central- local relations. Chapter eight analyses the implications of central-local relations influences on local health planning. Chapter nine concludes with a discussion of the implications of the findings for management of decentralised local health planning process and lastly

recommends on improvement of central-local relations to support the health planning process.

## Chapter 2: Literature Review -Health Planning

### 2.1 Introduction

The previous chapter provided the background of this study, rationale, research aim, objectives and research questions. This chapter presents the review of literature on health planning. Section one presents the methods used in the review including the databases. Section two defines health planning, Section three discusses actors and their roles. In section four health planning process described and discussed. Section five present types and levels of plans. Section six describes and discussed the planning approaches. Outline of effective planning is presented in section seven. This is followed by chapter summary.

### 2.2 Defining Health Planning

There are several definitions of health planning as outlined in table 2.1.

Table 2. 1: Health Planning Definitions

Authors	Definitions
WHO Health Systems Strengthening Glossary of Terms	<i>"The orderly process of defining health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action, concerned not only with the adequacy, efficacy and efficiency of health services but also with those factors of ecology and of social and individual behaviour that affect the health of the individual and the community". Pg. 8</i>
Green (2007)	<i>- "a systematic approach to attaining explicit objectives for the future through the efficient and appropriate use of resources, available now and in the future" pg. 3</i>

EPHTI (2004) <sup>2</sup>	<i>Defines health planning as “Is the process of defining community health problems, identifying needs and resources, establishing priority goals, and setting out the administrative action needed to reach those goals”.pg 9</i>
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There is no one single definition that describes health planning. The definitions provide several concepts that collectively provide insights to important attributes of health planning, thereby expanding the scope of understanding health planning- Table 2.2.

Table 2.2: Health planning attributes derived from literature on health planning definitions

Attributes	Descriptions
Factual	Careful, intelligent and orderly process of defining and interpreting health problems and identifying unmet health needs.
Future orientation	Aiming at attaining explicit objectives for the future.
Relevance	Broad and narrowed focus of the targeted beneficiaries by targeting the general population, vulnerable groups as well as vulnerable groups with added vulnerability focuses also on those factors of ecology and of social and individual behaviour that affect the health of the individual and the community.
Realistic	Establishing priority goals that are realistic and feasible, concerned not only with the adequacy, efficiency and effectiveness of health services but also with projecting administrative and political actions influencing the priorities.
Adapts existing technology and knowledge	Takes into account innovations in terms of technology, interventions and strategies in addressing health problems of the population.

<sup>2</sup> [http://pdf.usaid.gov/pdf\\_docs/pnaec412.pdf](http://pdf.usaid.gov/pdf_docs/pnaec412.pdf)

Health planning is considered as a system and not a mere activity conducted by health planners (Green., 2007). Planning defines the journey, a road map and timeline for getting to the desired destination, taking into consideration available resources, the competition for these resources, and the contextual factors within which resource allocation and prioritization occur (Tsofa, Molyneux and Goodman, 2016). The targeted destination is set while balancing the desire to get there and the reality of the resources available and the context within which these resources are allocated and managed *ibid.*

From the attributes listed above the following operational definitions are made and will be applied in the context of this study:

- a) Local health planning is the process whereby local health department coordinates the process of identification of health needs, choosing best alternatives and allocate resources coming from central government, development partners and those which are generated from local level revenue sources to address national health priorities as well as specific health needs of their localities.
- b) A planning system, in this study, is considered as a collection of components that are relevant for consideration in planning in a country this include guidelines, rules, regulation, tools and technology, actors, structures and relationships, financing systems and procedures as well as oversight and accountability systems. These components are considered interdependent and interconnected.
- c) Health planner is defined as an individual or group of individuals who create plans. (In the case of this study, local health planner is a Council Health Management Team (CHMT)).

### **2.3 Health Planning Actors**

Literature provide health planning is done in an environment where several there are several actors with different interests (Akbar and Zaidi, 1994). Health planning actors range from international agencies, government officials, pharmaceutical companies, health personnel and community and citizen's groups *ibid.*. Accord to Zaidi (1994), the roles of actors mostly dwell within broader social, economic and

ideological framework which determine the operationalisation of the existing model of health care. Shifting landscape on engagement between the State and Local levels were evidenced in 1990s. It placed health planning in dilemma of need to achieve equitable access to health services (centrally) in an resource constrained context (Akbar and Zaidi, 1994; Green, 1995).

The obligations of the State in providing health services can be traced since 1948 where the United Nations adopted the Universal Declaration of Human Rights. The declaration states:

*“Everyone has the right to a standard of living for the health and wellbeing for himself and his family, including food, clothing, housing and medical care and necessary services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. (UN 2015 pg. 52)*

In addition, WHO constitution of 1949 article (1), sets the objective of the World Health Organisation being to:

*“Attainment by all peoples of the highest possible level of health” WHO constitution (1949:2)*

WHO Basic Documents, Forty-fifth edition, Supplement, October 2006 indicates responsibilities of government as quoted below

*“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures”.*  
(2006: 1)

The roles of the States in health development include; policy formulation, dedicating units mandated for health planning, resource mobilisation, capacity building, provision of guidelines, regulation, coordination of provision of health care services- curative and preventive(Green., 2007). Unlike other sectors, the market forces fail to address health needs of populations<sup>3</sup>. This increase government

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<sup>3</sup> [https://applications.emro.who.int/docs/em\\_rc53\\_tech.disc.1\\_en.pdf](https://applications.emro.who.int/docs/em_rc53_tech.disc.1_en.pdf)

responsibilities to engage in health planning and provision of services to enhance both equity and access to quality health services in an efficient and effective manner (Green, 1995).

Green (2007) identifies determinants of a good planning system. These include the overall financing of the health sector, technical resources for planning, management of external and internal resources, information availability (technical and administrative), balanced analysis (technical and political), stakeholders' participation, adequate capacity and guidance for planning.

## 2.4 Health Planning Process

As mentioned earlier planning is a systematic process. Different writers outline the planning process in almost the same way. The stages include analysing the current situation, defining the desired future objectives, identifying existing alternatives, appraising the identified alternatives, choosing the best alternatives, implementation, monitoring progress and evaluation (Green., 2007; Lawrie *et al.*, 2006). Table 2.3 outlines the planning process from the perspectives of three authors.

Table 2.3: Stages of the planning process - example from Lynne et all (2006), Green (2007) and EPHTI

EPHTI (2004)		Lynn et all (2006)		Green (2007)	
Stages	Activities	Stages	Activities	Stages	Activities
1	Situation analysis	1	Surveying the environment (What is)	1	Situation analysis
		2	Problems and challenges (Differences between what is and what ought to be)		
2	Analysing and selecting	3	Best solution(s) (Preferred ways to	2	Priority setting

	critical (priority) problems		get to what ought to be)		
3	Setting objectives and targets	4	Range of solutions (Ways to get from what is, to what ought to be)	3	Optional Appraisal
4	Identifying potential obstacles	5		4	
5	Designing the strategies	6	Setting directions (what ought to be)	5	Programming
6	Writing up the plan	7	Implementation & monitor (Putting in place the best solutions)	6	Implementation and monitoring
		8	Evaluation (Did we get from what is to what ought to be?)	7	Evaluation

The health planning process is an interactive one, linking actors vertically and horizontally within health care system and is subjected into variety influences. Health planning is both a technical and political process (Green., 2007). Therefore, planning and budgeting take into account technical considerations to rationalise the use of resources in selected priority areas (Green, 2001) and respond to other factors, such as donor requirements, political interests, planning and budgeting institutional arrangements and society's social values (Tsofa, Molyneux and Goodman, 2016). Therefore, it is influenced by interests of different stakeholders, groups and individuals (Tsofa, Molyneux and Goodman, 2016; Green., 2007). As a process with various stages that are chronologically linked to one another, in each stage of the planning process there are different activities involved adding to the complexity of the process.

In the next section, realities of the planning environment are discussed. The justifications about where resources are to be allocated are derived from varieties of methods and techniques that generate rationale behind decisions made by planners. These are referred to as planning models.



## 2.5 Types of Plans and Planning levels

Planning happens at different levels, from national to sub-national levels, with the higher level providing broad strategic direction, whereas the lower levels plans are more specific and focused on the needs of the local population and health system (Green, 2007). Common types of health plans include: The long-term plan (five year or longer strategic plans), The medium terms plans (usually three years), short term plans which usually are one-year operational plans and budget (Bryson, Edwards and Van Slyke, 2018; Tsofa, Molyneux and Goodman, 2016). Strategic plans carry fundamental decisions of the whole government or part of the government ( a specific ministry) shaping and guiding an organization (or other entity), what it does, and why it is designed and usually goes beyond three years(Bryson, Edwards and Van Slyke, 2018). Medium Term Expenditure Framework (as an example of a medium- term plan) is a “*planning and budgeting tool designed to link public sector priority policy objectives and activities identified during planning with budget vote heads, in a concept referred to as “output-based budgeting”*”<sup>4</sup>. The operational plan is described by Tsofa et al (2016) as a day-to-day management tool for operationalization of policies through short-term operational plans.

The literature indicates that planning is a process of translating policy(Green, 2007). Planning is an avenue for translating policies into actions by setting long-term sector strategic visioning and through short-term operational plans(Tsofa, Molyneux and Goodman, 2016). This study focusses on exploring the influences of central-local relations in the development of local health planning process in Tanzania. The local health plans are called Comprehensive Council Health Plans (CCHP)

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<sup>4</sup> <https://www.pempal.org/sites/pempal/files/attachments/OPMMTEFReview.pdf>

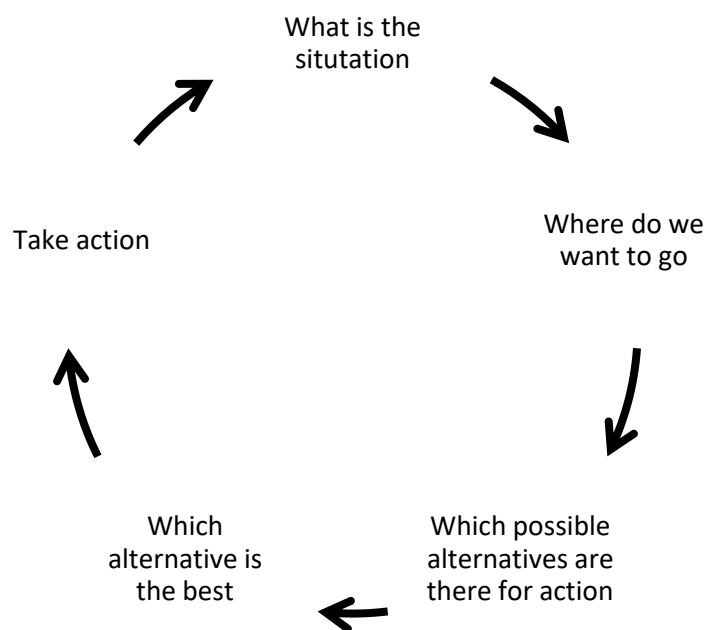
## **2.6 The Planning Approaches**

Several models to planning are outlined in the literature to include: comprehensive rationalism; incrementalism; and mixed scanning (Green., 2007). The variations between the three models are caused by the feasibility of attaining a certain degree of preciseness in the existing information for analysing the problem and its alternative solutions in order to guide resources allocation decisions. The models are discussed in details in the following sub-sections:

### **2.6.1 Comprehensive Rationalism Model**

In this model planning is viewed as a scientific process with techniques to rationally justify planning decisions. It consists of series of steps that systematise the planning process into sequential stages and each stage informing the other (Green, 1999). It includes an assessment of factors, other than health, and requires that, decisions should be made based on rationality, after all possible cause of actions have been thoroughly evaluated (Berry, 1974). This approach is criticised as a cumbersome process requiring volumes of data in which it is costly to collect and sometimes even challenging to analyse (Berry, 1974; Nutt, 1984; Green., 2007). On the other hand, the approach assumes that people are convinced with facts and all decisions are made based on scientific rationality. In practice there are other factors that influence people's choices such as structure, relative power of the groups within the organization, the political ideology and relationships between the providers and user of health services. Therefore, decisions to allocate resources are not always based on rational arguments backed up with scientific data. It concludes that decision making is a technical as well a political process. This is because planning is carried out in an environment where there are variety of factors (Lustick, 1980). What is rational depends on who, where, when and why the decision is made and its impact on other essential elements like technical, economic, political or social writers (Green., 2007; Berry, 1974) have pointed out the importance of looking at actors in the process within and outside the organization. The essence of formulating competitive strategies is to relate an organization to its environment. Therefore, planning cannot be a purely technical activity. Value judgments among planners are also significant (Green 2007). However, there are arguments that rational planning is impossible.

However, the planning academics still think that whatever the goals of a society, they would be more likely reached if members analysed problems rationally (Baum, 1996). Rationality is also described as being intentional or calculative (Etzioni, 1986b) and embraces the use of planning standards (Pissourios, 2014). Rational planning involves several activities as illustrated in figure 2.1. derived from Green (2007) and table 2.4 presents stages of comprehensive rationalism



*Figure 2.1: Steps in Rational Planning*

Source: Green (2007)

Table 2.4: Comprehensive rationalisms stages

Planning Stages	Activities involved
What is the situation?	This stage is meant to enable planners understand the problem as well as decision making situation. This stage analyses the current position in terms of the problem and the capacity to address the problem.
Where Do we want to go?	This involves the identification of alternatives and their appraisal to determine the feasibility and their capability to achieve the aim.
Which possible alternatives are there for action	This involves assessing several alternative and selecting the best one.
Which alternative is the best	This involves making decision on which alternative actions to take.
Taking action	After decision regarding the appropriate alternative, then the alternatives are implemented.
Reassessment of the situation	Reassessment and the evaluation of the situation in a second round to establish whether the problems identified earlier have been addressed.

There have been several arguments that justify impossibility of the having decisions derived systematically as claimed by the rational approach. Several reasons are mentioned contributing to this impossibility. One is feasibility; conducting such comprehensive assessment may not be feasible due to cost of gathering information and the analysis. This may be not be rational if the price is higher and the decisions reached also are expensive to implement. Information challenges include difficulties in accessing quality information due to costs and their availability. Also, the skills to analyse, interpret and draw proper conclusion from it, is another limitation (Etzioni, 1986b). Rationality is not only be anchored by evidence alone but also by position and interest of participating actors. Actors may participate as resources providers or those that their needs to be met by

resulting planning decisions.(Green., 2007; Etzioni, 1986b; Tsofa, Molyneux and Goodman, 2016)

### **2.6.2 Incrementalism**

Lindblom (1959) describes the planning as a process of 'muddling. Incrementalism suggests the following planning stages Etzioni (1986):

1. Assessment of only those policies which differ incrementally from existing policies rather than conducting a comprehensive assessment.
2. Consideration of small number of policy alternatives to appraise.
3. Restrict number of "important" consequences to be evaluated.
4. Analyses and evaluates alternatives in a sequence of steps, such that choices are continuously amended over time, rather than made at a single point prior to action.
5. Continuously remedying existing social problems, rather than solve problems completely at one point in time.
6. Share responsibility for analysis and evaluation with many groups in society, so that the process of making policy choices is fragmented or disjointed.

The approach does not emphasise on extensive analysis but rather a marginal analysis in order to specify ways of moving away from problems. This is done by comparing the previous attacks on the problem and depends much on consensus building(Berry, 1974). This is done with the recognition that decisions are made by people or groups with interests (Green., 2007). Thus, the journey from conceptualising the problem to devising a solution is not linear. It is affected by many factors both technical and political (ibid). There are series of disjointed steps towards a goal (Nutt, 1984; Green., 2007; Atkinson, 2011; Lustick, 1980). Moving from one step to the other is not a straight forward event. This highly depends on the political context. The political context as explained in this model include issues such as ideologies, politics, actions, nature and effects of the interest groups (religious, trade unions, professional associations or ethnic groups), gender, and class. These issues determine individual values, loyalty, judgments and actions.

Groups may include community and users, nongovernmental health providers and others, private firms, government technocrats and politicians and the external partners. The planning system therefore needs to take into account what groups are there, how will they affect or are affected by the plan. Although plans are technical documents, the planning process wears two hats- *Political and technical* (Pissourios, 2014).

The advantage of incremental changes is big losses are avoided when the solutions do not work, simple to work on and easy to reach consensus. However, the model has its limitations. For simplicity only good enough solutions are considered. Therefore, not suitable for situation needing radical change. However, the model suits the government institutions as for government it is safe to work with incremental changes to avoid big failures.

The critiques of this approach are based on the challenges of power dynamics within the society. It is difficult to guarantee that the overall decision-making process will gain consensus easily as individuals have different values and interests and there are power differences in the society (Lustick, 1980). Its short-term nature may lead to the stagnation of innovation as it seeks no more than limited variations from past policies. The model also does not fit in making "large" or fundamental decisions. It is hard to use this model when budget procedure does not allow for trial-and-error (Lustick, 1980; Etzioni, 1986a). Lindblom work after 1959 continued to acknowledge the need to expand the model to encompass the issues pluralism and competition. The key issue coming out of the academic discussions of this model is that, what constrain planners is their task environment (Atkinson, 2011; Lustick, 1980). Especially the situation where power differentials exist and they influence decisions making process. The model takes into account the limitations of the actors but underplays basic societal innovations (Etzioni, 1986a)

### **2.6.3 Mixed Scanning**

Mixed scanning is an approach that tries to address the major limitations of incrementalism and rational models and is seen as half-way point between the two models previously described. The model seeks to improve the rational model by

limiting the details required in fundamental decisions. The model suggests instead of conducting a detailed analysis of the whole sector, a broader scan is proposed in order to select priority areas of interests. Areas needing attention are then scanned further or zoomed in (Etzioni, 1986a). The approach was first published in 1967 (Etzioni, 1986a). Unlike the rationalistic model which tends to posit a high degree of control over the decision-making situation on the part of the decision-maker, this model involves both the ideas of incrementalism and rationalism in a more practical way<sup>5</sup>. The model is built on the premise that, it is rational to be selective and systematic about deciding on number of alternatives but flexible on the requirement to examine all factors in a greater detail due to cost, time availability and skill. It is built on the basis of progressive innovation, accommodating in its design, actors' behaviour and the power distribution. The model suggests four stages of planning process each with several steps Etzioni (1986).

Table2. 5: of Mixed Scanning by Etzioni (1986)

Stage	Activities involved
1: Strategic Occasion	<ul style="list-style-type: none"> <li>a) Brainstorming and listing of all possible alternatives these include alternatives which have been considered in the previous plans and the ones which were not considered.</li> <li>b) This is followed by examining the alternatives and neglecting the ones which reveal potential for being objected because of the any of the following reasons.               <ul style="list-style-type: none"> <li>i) Utilitarian Reasons: Alternatives whose means are not available.</li> <li>ii) Normative reasons: Alternatives violating the values of the decision maker</li> </ul> </li> </ul>

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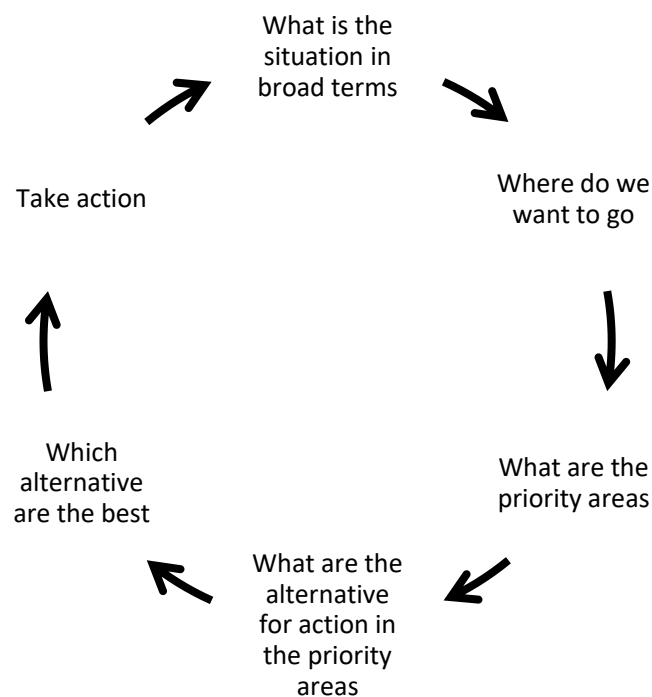
<sup>5</sup> <http://0-www.ijstor.org.wam.leeds.ac.uk/stable/pdf/973394.pdf>

Stage	Activities involved
	<ul style="list-style-type: none"> <li>iii) Political reasons: Alternatives are not favored by other actors whose support is essential for decision making or for the implementation of the decisions made</li> <li>c) Further assessment of the alternatives that are considered having no crippling objections</li> </ul>
2: Implementation stage	<p>This stage involves the implementation considerations of the selected alternatives which may be in terms of the following:</p> <ol style="list-style-type: none"> <li>1. Administrative rule: This Involves sequencing the implementation process steps.</li> <li>2. Political rule: Involves division of commitments to implement into several steps- referred to as political commitment</li> <li>3. Utilitarian rule: Sequencing the implementation while maintaining the strategic reserve</li> <li>4. Sequencing the implementation in a manner that the costly decision come at the end than those which are reversible</li> <li>5. Scheduling time for continuous collection of information to ensure that information is available when it is needed</li> </ol>
3: Review of implementation	<p>This stage involved gathering information of implementation at midpoint and at a longer period. Reviews are done even if things go right. This is because there are potentials of encountering new objections or emergence of new alternative which is better.</p>
4: Formulation of the resource allocation rule	<p>This stage involves the formulation of resource allocation criteria/rule and also setting time in which various scanning will be conducted. It involves the following:</p> <ol style="list-style-type: none"> <li>a) Setting system for routine information collection</li> <li>b) Setting timing for overall reviews</li> <li>c) Setting time for initial reviews – when the initial problem is considered</li> </ol>



Stage	Activities involved
	d) Setting time trigger- setting intervals in which the reviews will be initiated without waiting for crisis e) Setting mechanisms for occasional review of resource allocation rule and establishing of the pattern of allocation in the strategic review

Figure 2.2 illustrates the mixed scanning cycle



*Figure:2. 2: Mixed Scanning Cycle*

Source: Green (2007)

The limitation of this model is rested on the arguments that deciding areas of focus is subjective. This is because human actions are not driven by the existing information only but rather there are personal values that influence their positions. Although the presentation of planning process may seem sequential, in reality there are several shifts from one stage to the other (Green., 2007). This is because health planning process occurs in an environment that comprise of several

influences such as changes in political direction, health expectations as well as realisation of new evidence about outcomes (Lawrie *et al.*, 2006). Table 2.6. provides a summary of all the models

*Table 2.6. Features of Rational, Incremental and Mixed Scanning models*

<b>Planning Approach</b>	<b>Underlying belief</b>	<b>Plan Development</b>	<b>Limitations</b>
<b>Rationalism</b>	<ul style="list-style-type: none"> <li>• Decision making is a rational process thus should be based on facts and logic</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive analysis of all factors</li> <li>• Master plan</li> <li>• Emphasis on maximizing means –end achievement</li> <li>• The projects are compared to how they fit the masterplan</li> <li>• Future orientation</li> </ul>	<ul style="list-style-type: none"> <li>• Frequently, the decision maker has neither the time, nor the capacity, nor the information necessary to make the in-depth study that this method requires.</li> <li>• The planning environment is uncertain</li> <li>• It needs much time to gather, analyze information and use it to decide-</li> </ul>
<b>incrementalism</b>	<ul style="list-style-type: none"> <li>• Planners have limited cognitive capacity and the decision-making environment is unpredictable thus decisions should be made in an</li> </ul>	<ul style="list-style-type: none"> <li>• Marginal analysis</li> <li>• Specification of ways to move out of the current problems</li> <li>• Seeks to involve interest of</li> </ul>	<ul style="list-style-type: none"> <li>• No hierarchical arrangement of goals or means</li> <li>• Imperfect and limited information</li> <li>• Elevation of cost as an important consideration emerge</li> </ul>

Planning Approach	Underlying belief	Plan Development	Limitations
	<p>incremental and disjointed manner-</p>	<p>multiple actors for the purpose of building consensus</p> <ul style="list-style-type: none"> <li>• Focuses on remedial solutions</li> </ul>	<ul style="list-style-type: none"> <li>• Not suitable for making fundamental decisions- is focused on short term</li> </ul>
<p><b>Mixed Scanning</b></p>	<ul style="list-style-type: none"> <li>• It is rational to be selective and systematic about deciding on number of alternatives but irrational to examine all in a greater detail due to cost, time availability and skill.</li> <li>• The model accommodates in its design the opportunities for radical departure from what is expected as well as it is doubtful about human capacity to know and act sensibly</li> </ul>	<ul style="list-style-type: none"> <li>• Employees two cameras- Broad scanning of the overall sector and focused scanning on specific problems</li> <li>• Consensus building</li> <li>• Logical and factual</li> <li>• Long term orientation</li> </ul>	<ul style="list-style-type: none"> <li>• Less time on information collection and consensus building</li> <li>• Deciding areas of focus is subjective. This is because human actions are not driven by the existing information only but rather there are personal values that influence their positions</li> </ul>

## 2.7 Determinants of effective Health Planning System

### 2.7.1 The Financing of health plans

Health care provision is influenced by the perspectives of a state on what health or health care is (Green., 2007). The perspectives include health as a right, or health care as a right, investment or consumption good (Green, 1995). This perspective determines the degree of the State's involvement in health care provision (Green, 2007). Resources allocation in public sector is multi-staged. There is first the allocation by Ministry of Finance and Planning to sectoral ministries, then sectoral ministries to functional departments and downward to the regions, districts. In April 2001, Heads of State of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. This regional commitment was set as a catalyst to increase internal resources for health however, the majority of the countries were below this target by 2011<sup>6</sup>. In meeting the target<sup>7</sup> there is evidence that increased financing contributes to the achievement of the planning outcomes such availability of supplies, equipment and finance to support health service delivery. For example, Tanzania Essential Health Intervention Project's experience shows that where per capita health-care spending is raised and resources allocation made on the basis of evidence (disease burden and evidence based interventions) mortality is likely to drop as for an addition of just \$12 per citizen per year the child mortality was brought down by 25% (deSavigny *et al.*, 2004).

Important for health planning is the appropriate management of development assistance. Health planners are expected to manage external and internal resources to ensure that the programs are in line with the overall national strategic direction (Green *et al.*, 2007; Green., 2007). Official Development Assistance (ODA) is one of the major sources of health financing for many developing countries (Kwete *et al.*, 2021). There is an array of actors in decision making for development assistance for the health sector. These actors have unique powers

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<sup>6</sup> [https://www.who.int/healthsystems/publications/abuja\\_report\\_aug\\_2011.pdf](https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf)

<sup>7</sup> <https://www.who.int/healthsystems/publications/Abuja10.pdf>

and priorities (Akbar Zaidi, 1994). Experience with ODA indicate mixed results with regards to their impact and management at country level. Fragmentation leading to high transaction costs, divergence from national policies and lack of coherence between development partners are some of challenges affect management of ODA<sup>8</sup>. A planning system need to spell out how internal and external health resources will be managed in a manner that enhance equity and avoids duplication. In Zambia budget execution did not improve with the SWAp, and funding levels for hospitals declined (Chansa *et al.*, 2008). Cassels (1996) concluded that it does not worth to debate about which form of development assistance is better than the another as the two seem to complement. The important thing is to ensure that development assistance is in line with the national development objectives and are well coordinated and managed

### **2.7.2 Adequate guidance for planning**

As mentioned earlier that, one of the issues cause recentralisation by central government is doubts about local government capacity to plan. Moreover, the political nature of health planning, makes it the role of everyone in the organisation. Since non-planning specialists also do plan, availability of standard tools that guide planning from national to lower levels is important. It is important that planning team is reasonably skilled with techniques to different stages of the planning process coupled with optimal autonomy to allocate resources. For example, TEHIP found that larger proportion of funding was directed on comparably insignificant diseases. In 1996, for example, malaria was responsible for 30% of years lost, but received just 5% of the districts' budgets. Top childhood diseases such as diarrhoea, pneumonia, and malnutrition were responsible for 28% of the years lost, but got just 13% of the budget while tuberculosis was responsible for 4% of the burden of disease, got 22% of the money (deSavigny *et al.*, 2004).

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<sup>8</sup> <https://www.scielosp.org/article/bwho/2009.v87n12/930-939/>

### **2.7.3 Environment and tools supporting Balanced and Informed analysis**

Utilising resources where results can be achieved is one of the reasons why planners have to make choices of where the scarce resources will be spent. Information is needed in conducting situation analysis, priority setting, and option appraisal. Information is needed in implementation, monitoring and evaluation of plans. It is important that reliable information is available, analysed and utilised to guide resource allocation (deSavigny *et al.*, 2004; Green., 2007). In addition, planners also need timely information about the availability of resources such as budget ceilings from both the government and development partners supporting specific program areas.

Lack of information negatively affects the resource allocation process. Health planning faces challenges of availability of accurate and adequate information for planning. This is made more difficult due to absence of a framework to organise that information and to make information accessible to guide decision-making. (Gudes *et al.*, 2010). As indicated in the discussions on the planning models, health planning decisions are a mixed of evidence and stakeholders' values and interests. One of the reasons associated with planning failure is attributed to the inability of the planning system to balance technical and political analysis (WHO, 1971; Gish, 1977). The political requirements and tensions may influence changes in priorities and thus affecting health planning process.

### **2.7.4 Community Participation**

Community participations is one of the key objectives of decentralisation and requires that a planning system need to set mechanism for enhancing community participation (Maluka and Bukagile, 2016a). Several studies have mentioned diverted intentions of community participation due to power difference among stakeholders. "Elite hijack" was mentioned in many papers(Zaidi *et al.*, 2019; Prinsen and Titeca, 2008). For example, elite hijack of the community participatory endeavours has been associated with hidden motives such as, resource stealing and non-empowerment of the actual beneficiaries(Shah, Inamullah and Khayyam, 2017). In areas where participation is achieved through defined structures such community committees (as found in Tanzania), inadequate capacity, by the

community, was reported to hamper meaningful engagement (Maluka and Bukagile, 2016b). In the instances where community were engaged and identifies their priorities, it has been reported that, chances of getting engaged the financing locally generated priorities was not always guaranteed (Mollel and Tollenaar, 2013; Henriksson *et al.*, 2017; Kipiriri, Norheim and Heggenhougen, 2003).

It is important for health planning system to provide how citizens are going to participate in health planning process. In most cases participation happens in an ad hoc manner this is due to either less emphasis or cost that is associated with involving partners in terms of finance and time. Literature provides that ad hoc participation is less successful to enable power shifts (Katz, Cheff and O'Campo, 2015). Involvement is less emphasised by the health planning team. For example, in the instances where the participation process is hijacked by few individuals with either resource, political or expertise power decisions made may benefit certain groups in the society and alienate others. Where privatisation is adapted as a mechanisms for decentralisation, allocation decisions are inclined towards ability to pay rather than on the basis of equity (Green, 1995). The role of health planning as a means to address equity issues is reduced (Collins, 1989; Collins and Green, 1994; Smoke, 2003; Green., 2007). As mentioned earlier it is not enough to create channels for participation because the process of interaction may be manipulative, (Gonzalez, 1996).

### **2.7.5 Appropriate Balance between central and local decisions making**

In many organisations, the mandate for decision making may be concentrated at the centre or delegated to lower levels through decentralisation. Decentralisation is associated with a bottom-up planning approach as because it increases the ability of central government officials to obtain better understand local problems and hence lead to responsive plans (Rondinelli, Nellis and Cheema, 1983). Decentralisation refers to the transfer of authority or dispersal of power in public planning, management and the objectives of decentralisation are to improve government efficiency in service delivery, increase service access, empowerment, improve democracy and governance (Bossert, Chitah and Bowser, 2003). It has

also been used to reduce state interference into the economic activities and to liberalize market by privatization and deregulation (Green, 1995; Homedes and Ugalde, 2005; Collins and Green, 1994).

The literature provides mixed results with regards to implementation of decentralisation which sometimes called for a top-down approach. Experiences of decentralisation have been problematic in many countries. For example, in areas where countries have devolved powers for decision making, there was a failure to meet health financing costs as this relies mostly on local government revenue that has a narrower revenue base. To solve the financing problems some countries increased a cost of recovery that affected utilization of health care (Berman and Bossert, 2000; Homedes and Ugalde, 2005). In Peru for example, the Board of Directors of primary health centres decided to increase cost of recovery fee to finance the construction of hospital (ibid). To avoid increased fees for health services and vigorous cost recovery efforts by decentralised units which might contribute to low utilization of health services the central government has to be a major contributor in health financing (Mills *et al.*, 1990a).

Other experiences from Latin America show dramatic deterioration of quantity and quality as a result of decentralisation. For example, services in primary care programs in Mexico were unavailable to many as central government did not provide resources. In Columbia, resources were directed to building hospitals in Municipalities which according to the infrastructure plan were not needed. Experience from developed countries like Finland show that it is feasible to devolve but still this requires states investment in financing, capacity building and cooperation with local authorities to provide specialized care (Mills *et al.*, 1990a).

In Costa Rica where the cooperatives were used for the provision of health services through capitation payments evaluation showed patient satisfaction was high due to short waiting hours but indicated existence of more referrals not because of medical need but as a way of reducing expenditure to the cooperatives and physicians workloads (Homedes and Ugalde, 2005). In Brazil, it was found that the private for-profit sector provided the services which in turn the central government reimbursed them. The process of claiming for reimbursement was



chaotic, irrational and corrupt as the bills were inflated (Homedes and Ugalde, 2005).

Several studies have gone further to assess why central governments interfere with autonomy of the local government in planning and implementation. Factors identified include; local dependency on central financing, low capacity of local government to plan, manage central grants and accountability concerns (Liwanag and Wyss, 2019; Bossert and Mitchell, 2011; Bossert, 2016; Bossert and Beauvais, 2002a; Bossert, 1998b; Zaidi *et al.*, 2019; Kigume, 2018; Tsofa *et al.*, 2017; Kessy, 2018; Harrison, Rafiq and Medcalf, 2018; Koranteng and Larbi, 2008).

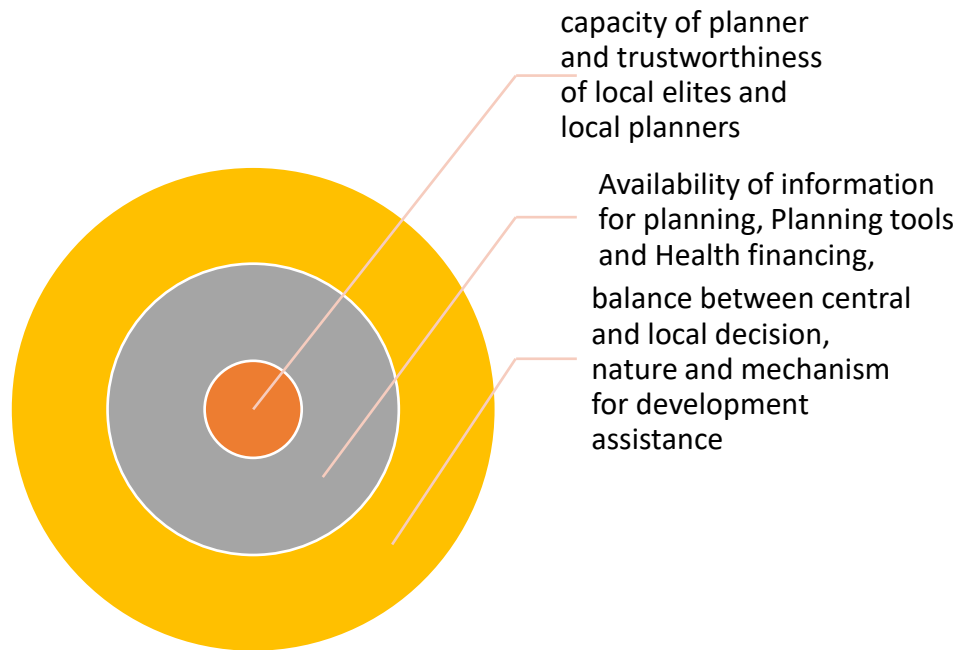
## **2.8 Planning models that apply to Tanzania**

Tanzania health planning seems to follow a mixed scanning approach. According to the guideline the guideline the decisions to consider a planning problem inclusion in Comprehensive Council Health Plan must be based on the following criteria which basically indicate an application of a mixed scanning model

## **2.9 Health planning Literature Summary**

From the literature on health planning five key messages emerged

- i. As a process health planning is exposed to influences within and outside. The influences are summarized in figure 2.
- ii. Planning decisions are derived from technical facts (the health systems needs and the needs of the population) and political and administrative requirements which also represent stakeholders' interests and values.
- iii. What government subscribe to do in the planning process is determined by social, economic and ideological factors.
- iv. Effective planning system is the one with clear mechanism to manage development assistance, coordinate stakeholders, generation and processing of information for planning, build capacity of planners, promote local participation
- v. Lastly planning is continuous process as indicated by Green (2007) – on the planning spiral



*Figure 2.4: Health Planning Process Influences*

The next section presents the central-local planning relations as presented in the literature including the study conceptual framework.

## **Chapter 3: Local Relations literature and the study conceptual framework**

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### **3.1 Introduction**

The previous chapter summarises literature on health planning definition, process and approaches. This chapter outlines theories and empirical facts of central-local relations. The section starts by a description of ways of political organisation. This is followed by description of central local relations which include, definition and features of central local relations, types of relationships and legitimisation of central – local relations. This is followed by description of the objectives of central-local relations and triggers of alteration of relationships. The last part presents frameworks for analysing Central - local planning relationships.

Prior to 1970s health planning was considered autocratic, controlled by few individuals (Green, 1995). The thinking then, was towards formalising and strengthening health planning to make it a more open process started. Although currently health planning may be considered as a more open, rational and systematic process, there are some snags that make the original challenges to still exist invisibly. In the last two decades a number of developing countries implemented decentralisation policy which was intended to promote local decision-making, and to make district health planning more responsive to local needs. However, there are factors hindering these achievements. Among these are confusion about accountability; local and central level capacity gaps; as well as political, social, epidemiological and economic influences on planning (Berman and Bossert, 2000; Bossert, 1998b; Cassels and Janovsky, 1992). However, little research attention has been given to the influences of relationships between various levels of government and their effect in making planning decisions at local level.

### 3.1. Definition of Central- Local Relationships

Central-local relations are the relationships between central and local government. The term central and local governments broadly denotes two levels of government whose power and behaviour are mainly determined by their different political resources and constitutional norms (John, 1996). They are the set up within the legal framework that determines the relationship between them. In this study the two levels are considered as one entity separated by the coverage of authority and scope of operation. In this case the Tanzanian Ministry of Health and Social Welfare is considered as a central government and health department at local authority is considered as local government (governed by the Ministry of Local Government). Rhode (1999) provides a distinction between inter-governmental relations and central-local relations. He describes inter-governmental relations as interactions between government units of all types and levels; and central–local relations refer to the interactions between central government department and local authority. According to Rhode the interactions happen when there is an exchange between the two levels (Rhodes, 1981c). These exchanges happen between public officials (elected and administrative) in all types and levels of governmental units "(Agranoff, 2004; Agranoff and McGuire, 2004).

Laffin (2009) describes 'Central–local relations' to include not just the direct governmental relations between central departments and local authorities, but also those interactions involving non-governmental actors at central and local level. Basically, this brings into the attention of this study the horizontal relationships. The exploration of planning relationships was based on how the horizontal relationships acted as a driver for creating or altering relationships.

Saunders (1982) argues that it is important for research on central-local relations to conceptualize central-local relations beyond the internal organisation environment management or institutional analysis to include underlying processes. These processes may lead to the understanding of relationships manifestations and the resultant tensions and conflicts between the two levels of government (Saunders, 1982). A central-local relation involves complex combinations of inter-dependencies and influences among actors. The discretion

of each is influenced by the goals, decision and relative power potential of the other. This power potential is the product of resources, rules of the game and a process of exchange. The process exchange is shaped by the resources of the participants, their strategies, personalities and number of units(Rhodes, 1981b).

From the description of central-local relations three key issues are gathered. One is a relationship within one entity. Second each level has horizontal linkages influencing their interactions with the focal unit. Third there are exchanges between the levels and important area for understanding the relationships to explore and analyse the processes as they determine how relationships manifests.

### **3.2 Features of central local relationships**

The following are the features of central-local relations.

*(a) Has legal backing (constitutional*

The relationship between the center and the local first are regarded as a legal relationship which is stipulated in the constitutions of the national governments. The constitution provides the roles of various organs starting from the ministry level to local authority level(Dunsire, 1981b).

*(b) Operationalized by individuals*

The relationships between the two units are executed by the individual occupying offices in various levels of the hierarchy. Thus the relationships between the two levels are the product of human perceptions, affiliations, attitudes and egotistic reactions of public officials and politicians(Agranoff and Radin, March 14, 2014).

*(c) Involves exchanges between organization- resources and information*

The organizations are dependent on each other to fulfil their goals(Rhodes, 1999b).

*(d) Operates with a regulatory framework*

The exchange between the organizations are happening within formalized regulatory frameworks that govern the behaviours of the interacting parties (Agranoff and Radin, March 14, 2014)

The features of central-local relations occur within particular model or frameworks. These are discussed in the next subsection

### **3.2. Types of relationships**

Central - local relationships can be formal or informal (Wang and Ahmed, 2002; Dery, 2002), as set out next.

#### **3.2.1. Formal Relationships**

The formal relationships are open interaction between central-local actors that are written and presented in the organisation structure (Smiddy and Naum, 1954; Wehrich and Koontz, 1993; Mintzberg, 1980). The organisation structures are the means of formalizing relationship between levels of the organisation (Mintzberg, 1980; Smiddy and Naum, 1954; Wehrich and Koontz, 1993; Thompson *et al.*, 1982). They determine which level is superior or less superior (Thompson *et al.*, 1982; Mintzberg, 1980). They involve the hard components of the organisation structure namely hierarchical alignment, functional divisions, chain of commands and departments (Thompson *et al.*, 1982; Wang and Ahmed, 2002).

Since the formal organisation structure categorizes the superior and less superior actor, it also entrust power to superiors to decide issues over less superior and this influence relative power position of the structurally inferior groups (Thompson *et al.*, 1982). The division of power involves complex combinations of interdependencies and influences among actors of the two levels (Wright, 1982; Chandler, 2005 ). This study adapts a definition of power by Dahl (1957)<sup>9</sup> stating that

*“Power is defined in terms of a relation between people, and is expressed in simple symbolic notation. From this definition power is developed a statement of power comparability, or the relative degree of power held by two or more persons”* pg 1

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<sup>9</sup> [https://fbaum.unc.edu/teaching/articles/Dahl\\_Power\\_1957.pdf](https://fbaum.unc.edu/teaching/articles/Dahl_Power_1957.pdf)

Power is ability of individuals, groups or institutions to influence decisions. Rhodes (1999) considers discretion as a product of power, rules of the game and a process of exchange. The process of exchange determines the degree of interdependency between the two levels. The interdependency is influenced by the types of power possessed by local or central levels of government. The process exchange is shaped by the resources of the participants, their strategies, personalities and mandates.

### **3.2.2. Informal Relationships**

Informal relationships are hidden interactions developed by individuals of central and local governments that are not formal. They can be the products of reactions of individuals in trying to survive the formal bureaucratic process. Informal relations can develop where formal relations are unclear or not set up. The formal lines are not the only ways with which actors interact (Saunders, 1982). There are hidden or not commonly agreed lines that influence the relationship among actors within an organisation. Informal relationships can also develop out of social networks between actors (e.g. family, political, professional, friendships, cultural- along ethnic or cultural groupings) (Dunsire, 1981a; Conyers, 1983). They refer to interactions between individuals or persons, departments or organisations that is not clearly stipulated in the structure (Dery, 2002; Wang and Ahmed, 2002). The drivers for this relationship are peoples' perceptions, judgments, bonds and emotions. They are not hierarchical but may map another completely different patterns of linkages(Wang and Ahmed, 2002). They may be powerful and highly influential. They can influence decisions, degree of enforcement of rules and regulations and communication channels underground (Wang and Ahmed, 2002; Smiddy and Naum, 1954; Wehrich and Koontz, 1993). They reflect the channels by which staff may operate beyond or instead of the formal organisation structure.

It is clear that there are limitations to faithful compliance and restrictions (Dery, 2002). When the written rules are inadequate and changing them is not possible human beings in most cases generate certain behaviours which may lead into bending some of the rules, getting away with some of the rules, or beating the system openly or in a hidden manner (Guston, 1996; DeHart-Davis, 2009). Such

reactions may lead into establishment of informal relationships. Table 3.1 outlines differences between formal and informal relationship.

Table 3.1: Formal and Informal relations

<b>Comparison factors</b>	<b>Formal</b>	<b>Informal</b>
Legal backing	Constitutional	Appear when the formal system seems ineffective
Visibility	Stipulated in the organisation structures	They are hidden social networks
Communication	Clear reporting channels that make formal interaction to happen.	Not visible, are embedded within the formal structures
Decision making influence	Influence decisions through clearly stipulated structures, policies	Influence decisions through individual interactions, or sub-groups

### **3.3. The objectives of central-local relations**

The central-local relations have different objectives. This is dependent on the perspectives of key actors in the system (Saunders, 1982). The actors include the ruling government and the general public (*ibid*). The objectives of the former may be to push central policies and the latter may be to counteract the central policies that are against electoral and principal commitments (*ibid*). Thus, the intention of the central-local relations is multifaceted. It may seek i) to control ii) to provide flexibility and iii) or to create a balance. This is described more by two commonly used dichotomy called centralization and decentralisation where within decentralisation there are several types that indicate varied degrees of central level involvement (Collins, 1989; Mills, 1994; Zannetos, 1965).



### **3.4. Origin and Triggers of alteration of central-local relationships**

Relationships between central and local government are at first constitutional. Local governments are legitimate bodies established by Act of Parliaments. The Act that legitimizes establishment of local government also entrusts the authority to the central government minister to monitor the way local government exercise the granted powers (Dunsire, 1981a). These are described as Authority model, where the constitution stipulates distinct boundaries that separate National, Regions/Province and the Districts. Local governments are considered as subordinate units of central government. Most of these were governed by the utilitarian framework which suggests that – the authority that is most competent with the principles should be supreme over principles and the ones competent over details should have details left to it-(Chandler, 2005). The constitutional relationships remain as a legal mandate. The changes into relationship may be derived from need to improve the functioning of the different section of public sector as an organisation. For example changes that were instituted during the introduction of public sector reforms in 1990s.(Rondinelli, Nellis and Cheema, 1983). Experience indicates that the administration may change from centralisation to decentralisation or may apply both if they are prompted to do so. In this study these are referred to as triggers of alteration.

Triggers of alterations of relationships are factors that lead to changes in relationships, for example, from centralisation to decentralisation and vis versa. The relationship between central-local governments may be altered after its outset. These create a certain state of affair for example they may lead to expanded or constrained local autonomy (Wang and Ahmed, 2002; Thompson *et al.*, 1982; Zannetos, 1965; Mintzberg, 1980; Smiddy and Naum, 1954; Weihrich and Koontz, 1993). A trigger in this study is considered as an event or circumstance that causes alterations in operational procedures that were defined in the legal framework. They constitute formalized changes (Wang and Ahmed, 2002; Zannetos, 1965). There are several reasons leading to alteration of central-local relations. Literature provides examples of several triggers on central-local relations.

Relationships between central and local government may be altered for the purpose of improving government's operations. The delegation of roles from the central government to local government the same as that of a principal and agent (Guston, 1996; Bossert, 1998b). Central government encounter two challenges in this relationship: a) challenge of selecting a capable agent and b) the difficulties to know whether the agent can achieve the goals of the principal to the expectation. This is because delegation by Principal not only triggers agent's motivation to execute the tasks but also create an incentive to cheat in some instances (Guston, 1996). For example, in Brazil it was found that the private for-profit sector provided the services which in turn the central government reimbursed them. The process of claiming for reimbursement was chaotic, irrational and corrupt as the billings were not honest (Homedes and Ugalde, 2005). In order to be able to influence the behaviours of local authorities' central government can do the following

- Enacting legislation concerning local authority functions (Rhodes, 1999a):
- Limiting certain kind of expenditure to central approval
- Monitoring performance regularly (Mills *et al.*, 1990a)
- Engaging on joint articulation of goals and evaluation

Other examples of reasons for alterations include challenges regarding the management of central grants by the local authorities (Rhodes, 1999a). For example, in Bolivia health and education fund was spent for constructions of roads and caused a breakdown of services such as immunization (Mills *et al.*, 1990a; Homedes and Ugalde, 2005; Bossert and Beauvais, 2002b).

Further alterations to central-local relations were experienced with increased weakening of government ability to manage social services. African countries in late 1980s especially have struggled with worsening economic conditions and reduced public finance for health services. In Latin America dramatic deterioration of quantity and quality of services of the primary care programs in Mexico was experienced as the result of failure of central government to provide resources to these units. The problem was addressed in different ways where some governments responded in a piecemeal fashion, reacting to internal and external pressures. Others have embarked on major reforms of various aspects of their health systems (Okunzi and Macrae, 1995; Gilson and Mills, 1995; Segal, 1997;

Gilson *et al.*, 2003). For example, Tanzania faced problems such as fragmentation through multiple vertical health projects coupled with lack of integrated planning and evaluation; limitation of the public sector in terms of capacity to manage resources, maintenance and sustainability of the already existing health care system to meet the ever- rising needs of the people; increased Burden Of Disease including emerging and re-emerging diseases; lack of community ownership and participation, obviously pressurized the Government to propose ambitious reforms in the health sector that would focus on cost effective interventions, transform financing management, emphasize quality, empowerment of local authorities and the community and greater involvement and use of the private sector. The adoption of decentralisation is an example of changes in the central –local relations where the need for local participation in policy making and steering for economic development expanded. Hence financial linkages including distribution and resource allocations emerged as amongst features for central – local relationships(Brans, 1992 ).

### **3.5. Frameworks for analysing Central-local relationship**

The existing academic discussions on central – local relations outline the development of understanding what it entails (Chandler, 2005 ; Weissert, 1994; Hupe and Hill, 2007; Chandler, 2010; Raelin, 1982). The existing literature also appreciates the complexities in the influences of the relationships as it includes many interrelated and interdependent variables that affect the features of relationships (Raelin, 1982; Walt *et al.*, 2008; Gilson and Mills, 1995; Gilson, 2008). Furthermore, apart from organizational relationships, capacity, values, interests, perceptions of the individuals inside and outside the formal structures have their contributions to generations of, and or alterations to the relationships between the two levels (Walt *et al.*, 2008; Gilson and Mills, 1995; Gilson, 2008). Hence the need to include various disciplines such as political science and organizational studies in conceptualizing central-local relations and their influences such organizational theories, political economy and public administration. Although there has been a growing interest to understand the nature and structure of central –local relations (Chandler, 2005), the academic backing as to how it influences local health planning is limited. The literature on

the topic is still confined to relatively few studies at least from Tanzania. Appreciating that there are contextual differences in different localities of the same country, unveiling such similarities and differences is important. Framework describing central-local environment, structures and defines the powers of central and local government.

### **3.5.1. The Systems Model**

System model consider the organizations as open systems. The organisations are influenced by their internal and external environments. In the context of central-local relations, organization links with the environment in two ways 1: resources exchanges (raw materials and finances) and 2: information exchange (Koontz, 1993; Rhodes, 1999b). The contribution of this concept in understanding central-local relations is the fact that, the organization are not closed systems, there are interactions between themselves and they are not self-sufficient they depend on each other in terms of resources and information. For the sake of understanding central-local relations- it is important to identify a focal organization which will then be taken as a point. This thinking concurs with Walt and Gilson (1994)- where the authors highlighted key issues to consider in policy formulation. The authors considered the policy formulation environment to consist of actors and the context which directly or indirectly influence the process and ultimately the content of the policy. Rhode (1999) argues that the relationship between central government and local authorities always vary. However, the limitation of this focus is that there are several influences emanating from an array of actors when assessing the relationships between central and local government. For the purpose of focused analysis, first it is important to consider central – local relations as a single relationship between central government entity and a local government entity (Rhodes, 1999b). If the influence of other entities dictates the direction of the relationship, then it is important to focus on network or patterns of relationships rather than individual actors.

### **3.5.2. Organizational Models**

Centralisation and decentralisations were considered as relevant frameworks to enhance the understanding of the structure and power distribution between central

and local governments. The models include centralised inclusive model, decentralised models, and power dependency models.

### **A. Centralized Inclusive Model**

In 1920s the experiences from developed countries indicated a centralized model of government where the local governments were considered as junior partners of the centre (Chandler, 2005 ; Chandler, 2010). For example, up to the end of the 1970s Swedish education policy and governance was highly centralized and regulated (Lundah, 2002). Structures of the school systems started from the central level, implementation was governed by the state through national curricula, state subsidies and regulations concerning resources, organization, staffing and the control of work in education. Although it is efficient and economical to use local government in implementation, it is detrimental leaving them uncontrolled (ibid). There are justifications for controlling the local governments such as enhancing national standards, equity, maintaining sovereignty(Raelin, 1982; Chandler, 2005 ). Key characteristics of this model as gathered from (Chandler, 2005 ; Chandler, 2010; Raelin, 1982) are:

- Use of rules and regulations to gain local compliance gain rather than fiscal incentives;
- Established national standard of welfare and growth;
- Members of parliaments serve as national representatives rather than representatives of local constituents;
- Directing policy of the state to locality; and
- Tight controls over local government expenditure and taxation sources.

The features of this model include the mandating of local authorities to implement centrally inspired policies coupled with the use of rules and regulations to enhance compliance rather than financial incentives(Rhodes, 1999b). However, the functionality of centralized model is affected by increasing complexities in the government operations. The complexities are the product of challenges in meeting electoral expectations, pressures from interest groups, scarcity of resources, and need to increase efficiency in operations and improved oversight. For example, in 1970s and 1980s Sweden experienced a growing dissatisfaction because the

community felt schools did not meet the expectations in removing social differences. Therefore, government had to revisit the system. It was believed that resources were better used and the task of creating good quality and more equal education better addressed if means and methods were chosen at the local level rather than by the central state (Lundah, 2002). Public Administration scholars for example have highlighted the challenges of ineffective rules and regulations such as, such as reduced services to clients (Scott and Pandey, 2005) and managerial inefficiency and unfriendliness (DeHart-Davis and Pandey, 2009). Again this does not rule out the importance of guiding principles and control but in a balanced manner (Wehrich and Koontz, 1993; Green., 2007).

### **The principal – Agent model**

This model resembles centralised inclusive model. In order to describe the principal –agent theory I will start by first describing agent. An agent is a person who acts in the name of and on behalf of another, having been given and assumed some degree of authority to do so (Mayer *et al.*, 2002). A Principal is the one whose work is performed by the Agent. This theory is used to explain the relationship between central and local governments assuming the central government being principal and the agent being local authority. The key assumption is that the goal of principal and that of the agent converge. Agents are able to maximize their interest at the expense of principal's aim. This is because agent has better information than a principal. The principal remains liable with what local authorities do. The key to determining whether a principal is liable for acts of his agent is authority that the principal has provided to the agent (*ibid*). This is because at the end of the day the central government remains accountable to the public. The principal seeks to increase its control to the agent in order to achieve the intended aims. Therefore, the range of choices given to agents is limited to ensure that the principal carries calculated risks by engaging the agent.

The contribution of Principal Agent Approach in understanding central-local planning relationships is derived from the use of innovative map. Thomas Bossert developed a framework for analysing the relationships process and types of

decentralisation using principal –agent theory and innovative maps of ‘decision space’ to explore the range of choice for different functions that is transferred from the centre to periphery (Bossert, 1998b). The author found different degrees of choices available for periphery staffs in Philippines as compared to Ghana, whereas Uganda and Zambia displayed variations between these extremes.

There are several reasons explaining such variations. The principal is accountable for the actions of the agent. There are four levels of government administrative accountability(Ward, 2007):

- i) Hierarchical Accountability: Based on rules and regulations and legal mandates.
- ii) Administrative accountability: based on professional norms, ethics and work procedures.
- iii) Legal Accountability: Spells out the specific relationship that exists between the administrator and the elected or appointed official—often referred to as the principal-agent level of accountability.
- iv) Political Accountability: Recognizes the citizen’s interests in decisions made by the agency.

The need of gaining public acceptance is an important component for any stable central and local government. Acceptance is gained when government is seen to be accountable and responsive. Institutional responsiveness has been defined as the achievement of ‘congruence between community preferences and public policies’ such that activities of the institution are valued by the public (Crook, 2003).

The principal-agent problem develops when a principal creates an environment in which an agent's incentives don't align with its own. Generally, the obligation is on the principal to create incentives for the agent to ensure they act as the principal wants. This includes everything from financial incentives to avoidance of information asymmetry. Central government uses tools such as devising mechanisms for control to curb discretion and cramp implementation, whereas the local government may act in a way that frustrates the central government(Jones, 1982). As an attempt to counteract the dangers of agent

unacceptable performance principals apply various mediation strategies such as policies, rules, guidelines, prototypes and procedures to guide and monitor agent's performance (Dery, 2002; Guston, 1996)

Limitations of Principal –Agent Approach are several. It is not possible to assess the relationships only using one dimension. There are several linkages which arise from the possessions of the organizations in terms of power or resources. The organization need each other to perform(Jones, 1982).

### **B. Decentralised Model**

There are several definitions of decentralisation. Mills et al. 1990). define decentralisation as a transfer of authority or dispersal of power in public planning, management and decision making from national level to sub-national level(Mills *et al.*, 1990a). Whereas Mawood (1983) and Smith (1985) define decentralisation as any act in which a central government formally cedes powers to actors and institutions at lower levels in a political-administrative and territorial hierarchy. Decentralisation is practiced in a variety of ways famously known as forms of decentralisation. It may involve the transfer of power to execute administrative function, to management of public services or political or democratic activities. Mills et al (1999) have classified decentralisation into four types; deconcentration, devolution, delegation and privatisation. However, this study will only focus on deconcentration and devolution because they present political and administrative decentralisation(Turner, 2002) which suit more the objectives of understanding central – local relations

#### *Deconcentration model*

The term **deconcentration** is applied to handing over of some administrative authority to the local based office of the central ministries(Bossert, 1998b; Mills *et al.*, 1990a; Turner, 2002). This may in most cases mean only a shift of authority but the responsibility remains to the person who is constitutionally or legally responsible at the centre. Therefore, for the Ministry of Health, it implies the establishment of a management unit with clearly defined administrative duties and



power that enable it to function without constant reference to the ministry of health (Mills *et al.*, 1990a).

The centre may deconcentrate power to the lower levels either vertical or in integrated manner (Mills *et al.*, 1990a). In the former type, the local staffs of each ministry are responsible to their own ministries both technically and administratively. In the later form which sometimes referred to as prefectorial, a representative of local government who is accountable to central government is made accountable of all local government performance in the area of his or her jurisdiction (*ibid*). The line ministries local staffs are responsible to their mother ministries technically. The integrated deconcentration is practiced in Tanzania where at council level there is a Council Executive Director who is responsible for all local government performance and each line ministry is having an officer in charge at local level. For example, in Tanzania for the health sector there is a District Medical Officer (DMO) who is in-charge of all health sector activities and reports to the Council Director (in the Ministry of Local Government) but is technically responsible to the Ministry of Health and Social Welfare structures. The services provided at the decentralised level include primary and secondary care where the referral and specialized services remains under the central government (Mills *et al.*, 1990a). In health planning perspectives, given that the Ministry of Health and Social Welfare is technically accountable for health matters of the population, the tendency is always to deconcentrate and ensuring appropriate follow ups and supervision.

### *Devolution*

Means the transfer of powers, resources and responsibility (for planning and delivery of services) from the central government to local governments with aim of creating and strengthening lower level governments to provide services effectively (Golooba-Mutebi, 2003). The decentralised units normally have legal status, clear geographical boundary, defined functions and statutory authority to raise revenue and make expenditure out of the revenues raised. Not completely autonomous but largely independent of the national government in their areas of responsibilities (Mills *et al.*, 1990a). Although previously devolution was mainly

associated with political decentralisation. Incrementally scholars consider devolution being a true mode of decentralisation that is associated with potentials to enhance community participation in development and participation in development and good governance(Turner, 2002).

Experiences of devolution in health planning are mixed. In Kenya it was found that devolution was effective in promoting local level prioritisation and community involvement. However, the local levels were not utilising the decision space availed to them because of inadequate capacity(Tsofa *et al.*, 2017). It was also found that the implementation of devolution created an opportunity for local level prioritisation and community involvement in health sector planning and budgeting hence increasing opportunities for equity in local level resource allocation. However, this opportunity was not harnessed due to accelerated transfer of functions to counties before county level capacity had been established to undertake the decentralised functions. Experiences from other countries as well indicate both positive and negative results. Positive results include: increased accountability and reduced bureaucracy in decision making in other counties. The negative effects include inequities, weakened local commitment to priority health issues, and interfered with service delivery by disrupting referral chains (Bossert and Beauvais 2002, Homedes and Ugalde 2005, Bossert 2016, Thapa, Bam et al. 2019). In most cases the outcome is increased central involvement on the planning through rules, regulations, controls and supervision (Elander, 1991). Mills and colleagues (1990) presented the likelihood of certain functions may be decentralised in each typology. Table 2.8 selected few functions which were considered relevant for local health planning. The authors considered deconcentration for the health sector and devolution being mostly autonomous to the entire local government system. This piece work has shaded light on how the typologies of decentralisation could be applied in understanding central-local relations of planning. Because health planning is about decision making, authority over resource allocation and revenue raising are important.

Table 3.2: Planning and planning related functions devolution and or deconcentration

Function	Deconcentration to the MOH field Office	Devolution to local government
Revenue raising	No responsibility	Some responsibilities
Planning and resource allocation	Limited responsibility	Some responsibilities
Personnel	Limited responsibility	Some responsibilities
Intersectoral collaboration	Limited responsibility	Extensive responsibility

The typologies are helpful in identifying the institutional location of the newly transferred power. However they tell very little about the range of choices to the decision makers at decentralised units (Bossert, 1998b). They help to understand ways in which power is retained or transferred between central and local government (Bossert and Beauvais, 2002b). In addition, they bring the structural arrangement issues that are important in understanding central-local relations origins and alterations. Therefore, they introduce important elements of hierarchical and administrative accountability which are issues in understanding relationships between the centre and the local. However, they are limited in revealing the range of choices that is granted to the decentralised units which is the interest in studying decentralised planning (ibid). Neither does it account for the variations that occur in the process of decentralisations in terms of relationships between the centre and the local whether formal or informal (ibid). Therefore, using only, the decentralisation approaches in analysing central – local relations in health planning may limit the inclusion of other important factors that are not structural but are equally important to understanding the alterations to the original relationships such as compatibility of goals, capabilities of local authorities and power of actors.

### **C. Power- Dependency model**

Although the analysis of central-local relations is focused on the two entities of concern, it will be a serious omission if the relationship between them is assessed

without acknowledging the horizontal interactions happening at both central and local level. These horizontal interactions are the ones which create complexities of the central – local relations because they influence the behaviours of the interacting organizations. Rhode (1999) describes ‘complexities’ as a number of other organizations and scale of interaction. For example, MOH may be considered as a central organization that interacts with the local authority, the type of relationship might be altered by the horizontal interactions with donors at national level (figure 1). In assessing the environment of the interacting organizations Rhode (1999) highlights the importance of considering only those other organizations in which the focal organizations interact with. This is because the relationship between these levels has a balance of power which is unpredictable. In his concept of ‘extended enterprises’ Tillquit (2002) argues that organizations create relationship with outside organizations for the purpose of gaining critical resources such as finance, raw materials, labour, skills or knowledge (Tillquit, 2002).

Organizational interactions are simply described as network of exchange (Cook, Staniforth and Stewart, 1997). The relationship between the centre and local actors is explained in terms of exchanges (interactions) that happens between central government and local authorities (Chandler, 2005). Organizational relationships as the exchange of the roles, goals, and activities within inter-organizational settings and the accompanying governance and control systems that set the rules of the game in the process of exchange (Tillquist, 2002). The relationships are influenced by resources interdependency. Various authors have explained the dependency between organizations being the reasons as to why organizations link (Rhodes, 1999a; Chandler, 2005; Tillquit, 2002). Organizations depend on each other for their survival and this is why they link. Most of the organizations relationships are resource based (Tillquit, 2002). Tillquit calls these organizations as “extended enterprises”. The organization resources include labour, access to consumers, specialized skills and knowledge (Tillquit, 2002). In order to strategically tap the potentials of other organizations, these entities structure their internal processes, organizations, and policies to ensure that they

access the critical resources required. Rhodes (1999) propagated the “Power-dependency’ model of intergovernmental relations.

Local authorities would take resources from central government without minding the degree of control the central government exerts on it because it is not possible to get such resources somewhere else. Thus, the central government can increase its power at the expense of local authority. This model considers the reasons for linkages between central government and local government is reciprocal. Central governments need the local authority to implement its policies and local authorities expect resources for implementation of policies from central government(Rhodes, 1999a; COOK, 1977). Interaction is induced either by powerful or dependent actors (Chandler, 2010; Chandler, 2005 ; Gilson, 2008). The dependency between actors is influenced by the availability, distribution and substitutability of resources. Resources is broadly defined to encompass all those means for supplying the needs of public sector organization(Rhodes, 1999a). In his resource framework he describes two components important to understand organisation power which are functional divisions of roles and the five elements’ sources of organisation powers(Elander, 1991).

- i. **Constitutional-legal resource:** This resource provided the interacting organizations with the mandatory and discretionary powers. This is a legal mandate provided by constitution and statutes. This element marks the establishment of the relationship between interacting organization and it changes when the constitutions change. It describes roles devolved by the constitutions or parliamentary Act. In addition, it describes local autonomy. However, central government sometimes restricts the local autonomy through supervision and tight controls. This power is drawn from their legitimate power. Legal powers and duties shape resource allocation and imposes restriction (Loughlin, 1996)
- ii. **Hierarchical resources:** This is the power entrusted to interacting organization structurally. Is obtained through the formally stipulated chains of command. They constitute the accountability, reporting and supervisory elements of central local relations. This creates operational relationships

and they are more visible than the constitutional relationships. They change and more powerful than constitutional roles in practical terms. Circulars issued to provide clarification on the interactions and accountability channels are sometimes seen as a legitimate intervention

- iii. **Financial Resource:** Means both money available and ability to raise money.
- iv. **Political resources:** The role of political structures in decision making. The power of professional's vis a vis that of the elected.
- v. **Informational Resources:** This includes informational and expertise resources possessed by actors

#### Limitations of power dependency Model

- The model assumes that always there is a room for bargaining and that the various kinds of power may play part in negotiations.
- The model underplays the importance of constitutional integrity of central governments and values favoring the separation of power. Therefore, resisting control or gaining autonomy have to be assessed taking into account values at national and subnational level supporting the existing framework for local autonomy.

#### **D. Bargaining Model**

The ability of central government to raise more resources than the local government enables the central government to buy compliance of local authorities by providing them with the grants that in normal circumstances it is difficult for the local authority to refuse (Rhodes, 1999b). The grants are used within the framework of the national standards. This model was prominent in USA in 1980s (Chandler, 2005). The grants are used to implement centrally inspired policies. This model increases the involvement of state in the local matters. The autonomy of the local government is lost by increased central government dominance (Chandler, 2005). The national governments use regulations rather than fiscal incentives to control local policies. This is done to ensure there is common fairness between fortune and less fortune local authorities (Rhodes,

1999b). The role of political electorates is fused within the promotion of national interests rather than that of their constituencies. The contribution of the model to the understanding of central-local relations in health planning is that:

- The financing of local authorities through central grants enables the center to buy compliance of central governments. Therefore, the central policies supersede local ones
- Categorical grants distributed by the center for implementing central government policies

### **3.5.3. Classifications of key elements for analysing central-local relations**

The models described in this section seem not mutually exclusive and that each model contributes elements for understanding the structure of central – local relations, power and tools used to regulate or de-regulate the actors. From the models discussed above lists of elements in understanding central local relations have highlighted. For the purpose of easing exploration and analysis, the elements have been groups into four i) assumed mandates ii) reasons for interaction iii) Organisational exchanges iv) influences of interactions v) outcomes of interactions

#### Assumed Mandates

- Explore to which extent actors in the system accept that a particular level of government has a mandate to undertake particular policies without interference
- Clear lines of authority are not always important-what is important is the complex understanding of actors about which policy area is comparatively better dealt with by which tier of the government.
- Another important consideration is how conflicts are dealt with

#### Reasons for interactions

- Organization is dependent upon other organizations for resources
- Organization operates in open system: Interact with environment for resources and information.
- Interaction with outside organization does not include everything but rather multiple linkages of networks of focal organization with other relevant organizations

#### Process of exchange

- The process of exchange: Involves exchanges between organization-resources and information. As mentioned earlier the organizations are dependent on each other to fulfil their goals. The exchanges between the organizations are happening within formalized regulatory frameworks that govern the behaviours of the interacting parties
- The process of interactions; Include the ways the two levels interact whether a top-down dominance or bottom dominance or the hybrid mode.
- Tools for interactions include guidelines, rules, regulations supervisions, circulars, laws, policies and strategies.

#### Influences of interactions

- Decision making of organizations are constrained by other organization
- Actors in the decision-making process have different spaces in influencing decisions- there is a dominant coalition and weak coalition
- Dominance is acquired by the use of various strategies to influence decisions
- Dominance is the product of resources: Constitutional, Hierarchical, financial, Political and informational resources
- Goals determines resource need: Goal setting is constrained dominant coalition and the process of consensus building

#### Outcomes of the interactions

- Discretion: The room for decision maneuver possessed by decision maker in the broader context of the power of bureaucracy

### **3.6. Models in application in Tanzania local health planning process**

Centralisation and decentralisations were considered as relevant frameworks to enhance the understanding of the structure and power distribution between central and local governments. Although the policies categorise Tanzania practicing decentralisation by devolution the practice in local health planning process demonstrates an application of features of other organisational models to support



health planning more significantly than the features of devolution. These are outlined in the table 3.2, below:

Table 3.2 The Application of features of various organisational models in the Tanzania local health planning process

Features of central-local relations in health planning in the context of Tanzania	Corresponding model	Experience in Practice		
		Significant	Medium	Low
Use of rules and regulations to gain local compliance rather than fiscal incentives	Centralised model	✓		
Members of parliaments serve as national representatives rather than representatives of local constituents	Centralised model		✓	
Directing policy of the state to locality	Centralised model	✓		
Tight controls over local government expenditure and taxation sources	Centralised model		✓	
The principal is accountable for the actions of the agent. MOH technically accountable for the actions of local authority	Principal- Agent	✓		
The line ministries local staffs are responsible to their mother ministries technically	Deconcentration	✓		
The decentralised units normally have legal status and clear geographical boundary	Devolution	✓		
The decentralised units normally have defined functions	Devolution	✓		
The decentralised units normally have statutory authority to raise revenue and make expenditure out of the revenues raised.	Devolution		✓	
Local government Not completely autonomous but largely independent of the national government in their areas of responsibilities	Devolution			✓

Source: Features of central-local relations used in this table were extracted from literature on central-local relation (Rhodes, 1999b) principal- agent approach (Bossert, 1998a) and decentralisation typology (Mills *et al.*, 1990a)

The design of decentralisation somehow differs from what actually happens in practice. The practice is influenced by inherent position of the local government in

the reform design. The local government reform policy paper of 1998<sup>10</sup>. stipulated the features of central-local relations which by default empowers central government with variety of tools and instruments that shape the operations of local governments in the country. The discretion that local government have must be exercised with the existing policy and legal framework

Table 3.3: Features of Tanzania central-local government relations

Issue	Parliament	Central Government	Local Government
Legislation and policy	<ul style="list-style-type: none"> <li>□ Supreme political body in the devolved system</li> <li>□ Provides for roles of Minister and others in the devolved system</li> </ul>	<ul style="list-style-type: none"> <li>□ Powers to make policy within framework of the Constitution and legislation</li> <li>□ In consultation with LAs develop and manage appropriate policy framework for LAs</li> <li>□ Obligation to negotiate and consult with LA</li> <li>□ Ascertain application and legality of LAs by-laws</li> <li>□ Minister may assume executive powers of a LA under specific circumstances and upon approval by Parliament</li> </ul>	<ul style="list-style-type: none"> <li>□ Discretionary general powers and flexibility to make policy, legislation and operational decisions consistent with national legislation and government policy</li> <li>□ Council accountable to the residents of its jurisdiction in the exercise of these powers</li> <li>□ Obligation to negotiate with and the right to be consulted by CG on specific issues</li> <li>□ Make and issue by-laws</li> </ul>
Local government structures and committees	<ul style="list-style-type: none"> <li>□ Provides for mandatory and permissive powers</li> <li>□ Oversees government operations</li> </ul>	<ul style="list-style-type: none"> <li>□ Advises LAs on structures and committees within the framework of the law</li> </ul>	<ul style="list-style-type: none"> <li>□ Decides on structures and committees according to own priorities within the framework of the law</li> </ul>

<sup>10</sup> <https://www.tamisemi.go.tz/storage/app/uploads/public/5b6/ff2/9e3/5b6ff29e34417145911620.pdf>

Issue	Parliament	Central Government	Local Government
Functions	<ul style="list-style-type: none"> <li>□ Enacts appropriate legislation</li> <li>□ Oversees government operations</li> </ul>	<ul style="list-style-type: none"> <li>□ Functions as prescribed by law (Ministries to remain with very few limited and specific implementation powers)</li> <li>□ Co-ordination of policies</li> <li>□ Negotiate and agree with LAs about implementation of specific national policies</li> </ul>	<ul style="list-style-type: none"> <li>□ Main government implementor of important public services not reserved for central government</li> <li>□ Discretionary general powers to operate according to own priorities within the law</li> <li>□ Negotiate and agree with CG on implementation of national policies</li> </ul>
Finances	<ul style="list-style-type: none"> <li>□ Enacts appropriate legislation</li> <li>□ Oversees government operations including those of local government</li> </ul>	<ul style="list-style-type: none"> <li>□ Powers to tax</li> <li>□ Specified obligations to provide adequate grants to LAs</li> <li>□ Right to audit and monitor LA finances</li> <li>□ Apply measures against LAs contravening the law</li> </ul>	<ul style="list-style-type: none"> <li>□ Powers to tax;</li> <li>□ Specified rights to grants;</li> <li>□ Right to formulate, approve, execute budgets and plans within the law</li> <li>□ Obligations to provide information to CG on financial administration and decision making</li> </ul>
Staff	<ul style="list-style-type: none"> <li>□ Enacts appropriate legislation</li> <li>□ Oversees government operations</li> </ul>	<ul style="list-style-type: none"> <li>□ Establish appropriate mechanism for recruitment and disciplinary matters</li> <li>□ Serves as appellate body for LA staff</li> <li>□ Provides certain types of training for LA staff</li> <li>□ Apply measures against LAs contravening the</li> </ul>	<ul style="list-style-type: none"> <li>□ Appoints all staff</li> <li>□ Employs all staff</li> <li>□ Manages all staff</li> <li>□ Staff accountable to council</li> <li>□ Obligations to adhere to labour laws and regulations in staff relations</li> <li>□ Responsible for on-the-job training, etc.</li> </ul>

Issue	Parliament	Central Government	Local Government
		law	
Performance & Service delivery	<ul style="list-style-type: none"> <li>□ Enacts appropriate legislation</li> <li>□ Oversees government operations</li> </ul>	<ul style="list-style-type: none"> <li>□ Sets national standards (including service delivery standards)</li> <li>□ Inspects LA operations</li> <li>□ Conducts performance audits and service delivery surveys</li> <li>□ Advises LAs on service delivery</li> <li>□ Facilitates capacity building for LAs</li> <li>□ Apply measures against LAs that contravene the law</li> </ul>	<ul style="list-style-type: none"> <li>□ Deliver services in accordance with national policies and standards</li> <li>□ Obligation to operate in an efficient and effective manner</li> </ul>
Monitoring	<ul style="list-style-type: none"> <li>□ Enacts appropriate legislation</li> <li>□ Receives reports on local government finance and performance</li> </ul>	<ul style="list-style-type: none"> <li>□ Monitors LA service delivery performance</li> <li>□ Provides information to LAs and the public about LA performance</li> </ul>	<ul style="list-style-type: none"> <li>□ □ Obligation to provide information and reports needed for appropriate performance audits</li> </ul>

Source: Local government reform paper<sup>11</sup>

<sup>11</sup> <https://www.tamisemi.go.tz/storage/app/uploads/public/5b6/ff2/9e3/5b6ff29e34417145911620.pdf>

### 3.7. The Study Conceptual Framework

To develop the study conceptual framework relevant theory and empirical research that help to organize the conceptual framework were reviewed to establish overlaps, limitations, refinements, or new development in the study of central –local relations. The literature review and conceptual and theoretical frameworks share five functions: (a) to build a foundation, (b) to demonstrate how a study advances knowledge, (c) to conceptualize the study, (d) to assess research design and instrumentation, and (e) to provide a reference point for interpretation of findings (Rocco and Plakhotnik, 2009). Literature and the conceptual framework in this study is used to achieve the following:

- i) To get a general conceptual understanding of the features and influences of central – local relations from theories and empirical studies;
- ii) To build foundation of the study; and
- iii) Get reference points for exploration and interpretation of the findings.

Given the literature on planning and central local relations four components emerge. The first component constitutes: The context describing access to resources and mandates of actors and regulations guiding the planning process including local participation. Second component focuses on actors' traits (explained by roles and their relative power). The third component focuses on the practice of relationship in the planning process. The fourth component presents outcomes of interaction between the planning process and relations process with regards intentions of decentralisation which local participation and responsiveness of plans to local need as well as discretion availed to planners in terms of decisions space. Given the four components policy triangle (Walt and Gilson, 1994), power dependency/ resource framework (Rhodes, 1981a; Rhodes, 1999b), decision space framework (Bossert, 1998b) and decentralisation typology (Mills *et al.*, 1990b) were used. Their application is summarised in table 9

Table 3.4: Models Informing the study conceptual framework

Model	Application
Policy Triangle	This model is chosen because it the basis for studying the key factors influencing health planning. The authors have categorized four factors that influence policy process –Context, Actors, Process and Content. Other frameworks will be used to enrich the analysis.
Decision Space	Decision space was used to understand the way the centre grants power and influences the local actions.
Decentralisation typology	The decentralisation typologies (Mills et al 1990) were used to understand the institutional home of transferred power within the organizational structure and the forms of decentralisation.
Resource Framework	Was used to understand the sources of actors' powers and their interactions and tools for interaction

The study conceptual framework is informed by the policy triangle (Walt and Gilson, 1994) (see figure 3.1. These are Bossert's (1998) and Mill's decentralisation typology (Mills et al 1990). Bossert (1998)

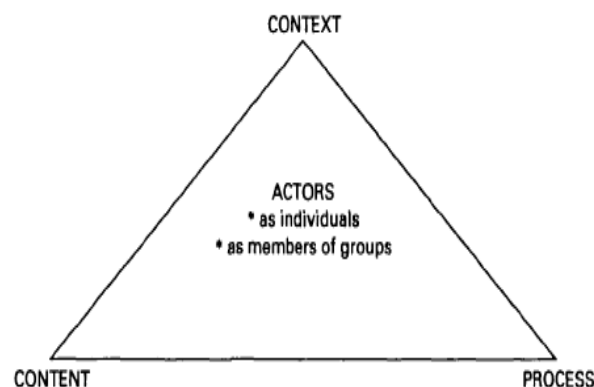


Figure 3.1: Policy Triangle Walt and Gilson (1994)

#### *The Context*

The context is conceptualized to include international, national and local factors that characterize the national and local environments. These include health

financing, policy, guidelines, rules, regulations, ideology, structure, power structures and socio-economic situation at national and Local Authority Level. There is increased recognition of how politics influence relationships.

### *Actors*

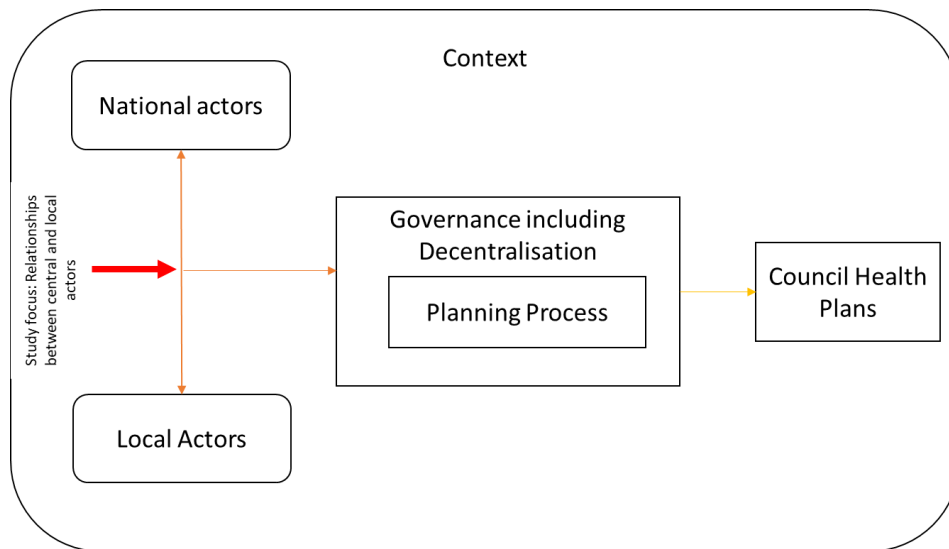
Actors are conceptualized to include: local government employees within the health department and other departments; local community; government officials at regional and national level, politicians, other health providers (NGOs, private providers and donors) at local and national level. There is a relationship between power of the actors and decision making (Verhoest *et al.*, 2004; Walt, 1994). Ability to make or not make decisions is influenced by the existence or absence of power (Buse, Mays and Walt, 2005). Sources of power in political settings include social standing, access to cash, credit and wealth, legal trappings associated with holding official posts (Verhoest *et al.*, 2004; Walt, 1994).

### *Process*

The planning process in this study will constitute stages itemised in Green (2007) planning spiral. The method of developing the health plan will not take a single approach but rather apply important facts from each approach. The planning process is a continuous process as indicated by Green (2007). The planning spiral indicate that the end point of each cycle is the beginning of next round of planning process. The planning spiral identifies six stages

### *Content*

Content in this study is conceptualized to include the contents of Comprehensive Council Health Plans. figure 3.2. provides the detailed conceptualisation that will guide the study to explore/analyse central-local health planning relationships in Tanzania.



*Figure 3.2: The Study Conceptual Framework*

### **3.8. Application of the conceptual framework**

The above conceptual framework was used to guide development of tools for data collection and its subsequent analysis. The conceptual framework and subsequent modifications done to it, was used in update the objectives and study question. The concepts from central local relations helped in exploring actors' relationships in both data collection and analysis. It helped in identifying who are the actors, what legitimises their existence, how they interact and tools they use to interact. In addition, it supported the process of investigating where actors originate, how power is utilised in the process and how the central-local relationships are influenced, manifested, triggered, and changed during the planning process. The planning process part of the conceptual framework was used in framing the objective regarding the health planning process and also understanding the planning environment and its influences to inform tools development, data collection and analysis. The analysis of governance including an exploration of decentralisation as part the context in framing the questions during data collections and analysis. It was also useful in gathering information on the design of decentralisation, its features and its practice in local health planning. The plan content part of the conceptual framework, was useful in exploring what is the ultimate objective of decentralised planning in terms of content and how central-local relations in local health planning process influence the outcomes. The context



was useful to explain the design and objectives of the overall health planning system and the design of central local relations including the power differences of the local and central government.

Following learning from the data collection and analysis, revisions were made to better understanding central-local relations features and practice. The new framework is presented in chapter 8, including a discussion for potential use. Although the framework was applied on studying influences of central local relations in health planning, I hope it could as well be applied to understand influences of central – local relation on implementation of health plans.

### **3.9. Chapter Summary**

This chapter explored literature in relation central-local relations. The chapter begun with a review of the literature on central-local relations. Various frameworks for understanding local – central relations were discussed. Given the focus of the study, the policy triangle, decentralisation typology and decision space approach were integrated to inform the formulation of the conceptual framework. The chapter concluded with a discussion of the study's conceptual framework that informed the study design, data collection, and analysis. Key issues gathered from health planning and central local relations are summarised in the table below.

Table 3.5: Summary of key issues in health planning and central - local relations in literature

Health Planning	Central-local relation in health planning
<p>a) Health planning formalisation is gaining recognition especially due to increased demands on quality.</p> <p>b) The history indicate improvement and shifts to decentralised health planning especially in Africa and other developing countries following introduction of health sector reforms.</p> <p>c) Despite the increasing significance and shift to decentralisation, health planners experience is mixed of positive and negative. The positive part presents that, decentralisation has increased local ownership of health planning process and engagement of local technocrats, politicians and citizens.</p> <p>d) Negative part, the local decision space especially on matters relating to priority setting and resources allocation is in most cases narrow. Several studies unveiled synergies between decision space, capacity and accountability.</p> <p>e) The planning process is non-linear it is influenced by internal and external factors</p>	<p>studies on central local relation revealed that</p> <p>a) central-local relations in most cases are between a powerful and less powerful actor.</p> <p>b) Furthermore, central government is concerned with political and wellbeing of the population.</p> <p>c) Central government uses policy to provide overall direction</p> <p>d) Central government uses its mandate and resources to gain compliance of local authorities over central policies.</p>

From the literature on health planning and that of central-local relations, it is evident that the planning process and central-local relations processes converge somewhere and it is important to explore their contribution to existing challenges

on decentralised health planning and make recommendations for improvement. The next chapter presents research methodology.

## Chapter 4: Research Methodology

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### 4.1 Introduction

This chapter provides a detailed elaboration of the research methodology used to address the overall research aim, objectives, and questions, which were presented in Chapter 1. The chapter starts with discussion of overall research methodology which includes study design; sampling strategy used to select the region, councils and respondents; data collection methods and analysis. It further explains ethical considerations, methods used to ensure rigour and study limitation.

The study was conducted in Dar es Salaam and Morogoro regions, Tanzania with some interviews that were conducted from national level stakeholders in Dar es salaam and Dodoma. Two districts were included in the study – Ilala in Dar es salaam and Morogoro District council in Morogoro. A brief overview of councils is presented in chapter six. This research used an exploratory, qualitative study approach. Ethical approval was granted from the University of Leeds Institute of Health Sciences Ethics Committee and the Institutional Review Board of Ifakara Health Institute. Data collection included semi-structured interviews and document review. In total 44 interviews were conducted.

### 4.2 Study Design

This section describes the study design, which includes the study approach, how the case study selection was done, sampling strategy, data collection methods and how data was analysed.

#### 4.2.1 Research Approach

This is an exploratory descriptive qualitative study. According to Hansen, a qualitative approach is best suited to research problems that need to be understood in relation to wider social, cultural, political, and economic contexts that involve exploration into the processes of how these factors relate and interact, through which generalizing about the problem would “not give an accurate picture of the situation”(Hansen, 2020; Ward, Comer and Stone, 2018). This contrasts with quantitative research approaches which assume there is an independent reality, or truth, unrelated to context, that can be explored, measured, and

replicated through deductive reasoning. There is several importance of exploratory qualitative research design. These would include the following

- i. it provided opportunity for exploring how a phenomenon is manifested, allows the researcher to explore a topic with limited coverage within the (Hunter, McCallum and Howes, 2019).
- ii. The nature of the study required an understanding of variety of contexts and processes to be able to explain the nature and influences of central-local planning relationships including factors explaining the variations. The approach was useful in exploring and explaining relationships between levels both the written relationships and what happens in practice including power dynamics leading to incidents of collaborations or conflicts in practice. Something that would have not been achieved through quantitative design achieved.

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- iv. The nature of the study required an understanding of variety of contexts and processes to be able to explain the nature and influences of central-local planning relationships including factors explaining the variations. The approach was useful in exploring and explaining relationships between levels both the written relationships and what happens in practice including

power dynamics leading to incidents of collaborations or conflicts in practice. Something that would have not been achieved through quantitative design achieved.

Literature provides six common qualitative study designs. These include qualitative designs phenomenological, ethnographic, grounded theory, historical, case study, and action research(Maxwell, 2010; Denscombe, 2007b; Denscombe, 2002). The brief description of each method, strengths and limitations are summarised in Table 4.1.

Table 4.1: Summary of Qualitative research designs, strengths and limitations

Data Analysis Methods	Description	Advantages	Limitations
Grounded theory <sup>12</sup>	<p>A systematic exploration of data in an open-minded, comparative and rigorous manner for developing a novel theory that is purely grounded within the data</p> <p>Data is extracted through a coding process.</p> <ol style="list-style-type: none"> <li>I. Open coding involving breaking down, analysis, comparison, and categorization of data where events or incidents are labelled and grouped through constant comparisons to form categories and properties</li> <li>II. Axial coding, represents the description of imaginary relationships between categories and subcategories,</li> <li>III. Selective coding can be described as the process by which categories are related to the core category ultimately becoming the basis for the grounded theory.</li> </ol>	<ul style="list-style-type: none"> <li>• offers opportunities to the researchers to use their values and understanding in order to generate a new theory for a very complex phenomenon</li> <li>• Grounded theory permits researchers to have a glance at the studied phenomena with new angles and construct new perspectives without restriction on extant theories.</li> <li>• Thus, grounded theorists are able to understand the studied phenomena holistically, explains why the cause of action evolved the way it did</li> <li>• Investigates those experiences of people and their responses</li> </ul>	<ul style="list-style-type: none"> <li>• No standard rules to follow in identifying categories</li> <li>• risk that grounded theorists fail to develop a solid theory after interpreting data</li> <li>• One of the key features of grounded theory is a grounded theorist has the right not to refer back to the participants if the participants agree with the data analysis that did by the grounded theorist</li> <li>• In this point of view, the generated theory might be contaminated by researcher's bias,</li> <li>• It requires skillful</li> </ul>

<sup>12</sup> <https://files.eric.ed.gov/fulltext/ED477391.pdf#page=18>

Data Analysis Methods	Description	Advantages	Limitations
			researcher to use
Narrative Analysis	<p>Built on the premise that people understand and give meaning to their lives through the stories they tell The approach comprises two elements.</p> <ol style="list-style-type: none"> <li>I. In the analysis of the narrative, the researcher tracks sequences, chronology, stories, or processes in the data, acknowledging that most narratives have backward and forward nature that ought to be unravelled in the analysis</li> <li>II. Narrative interpretation is concerned with meaning-making and construction. It seeks to understand social action in which people attach subjective meaning</li> <li>III. Data analysis in narrative research includes four stages: (1) preparing the data, (2) identifying basic units of data, (3) organizing data, and (4) interpretation of data</li> </ol>	<ol style="list-style-type: none"> <li>IV. Participants' account of a particular experience and the exploration of meaning embedded in the participants 'stories.</li> <li>V. The focus on particular experiences is from the presumption that lives are bounded by events which vary in significance to the people involved. Exploration of personal meaning refers to the fact that meanings are evolving and persons may recognize some meanings and not others.</li> </ol>	Time consuming
Framework Analysis	<ol style="list-style-type: none"> <li>1. objective of framework analysis</li> </ol>	suitable for studies that are:	<ol style="list-style-type: none"> <li>1. Framework Method is</li> </ol>



Data Analysis Methods	Description	Advantages	Limitations
	<p>is to identify, describe, and interpret key patterns within and across cases of and themes within the phenomenon of interest.</p> <ol style="list-style-type: none"> <li>2. Consists of two major components: creating an analytic framework and applying this analytic framework.</li> <li>3. These two major components occur through five steps: (1) data familiarization; (2) identifying a thematic framework; (3) indexing all study data against the framework; (4) charting to summarize the indexed data; and (5) mapping and interpretation of patterns found within the charts</li> <li>4. Data types used in framework analysis have included in-depth individual interviews, focus groups, observational data, policy documents, online discussion board posts, photographs, and case studies (</li> </ol>	<ol style="list-style-type: none"> <li>1. short term, start deductively with pre-set aims and objectives, and have more structured data collection, which is the case of this study.</li> <li>2. Framework analysis suits researches aiming at meeting specific information needs and providing recommendations within a short time scale</li> <li>3. The advantage of frameworks analysis is that, it provides systematic and visible stages to the analysis process which makes it clear to other people who will use the research as to how results have been obtained from the data</li> <li>4. Allows the use of both priori and emerging concepts. This broadens an understanding of the phenomenon in question.</li> <li>5. Creates a new structure for the data (rather than the full original</li> </ol>	<ol style="list-style-type: none"> <li>time consuming</li> <li>2. resource-intensive. When involving multiple stakeholders , multiple disciplines in the analysis and interpretation of the data,</li> </ol>

Data Analysis Methods	Description	Advantages	Limitations
		accounts given by participants) that is helpful to summarize the data in a way that can support answering the research questions	

For this study a framework approach by Ritchie and Spencer (1993) was used. This approach was chosen because it is suitable for studies that are: short term, start deductively with pre-set aims and objectives, and have more structured data collection, which is the case of this study. Framework analysis suits researches aiming at meeting specific information needs and providing recommendations within a short time scale (Lacey and Luff, 2009; Furber, 2010). The advantage of frameworks analysis is that, it provides systematic and visible stages to the analysis process which makes it clear to other people who will use the research as to how results have been obtained from the data (ibid). The framework allows the use of both *priori* and emerging concepts. This broadens an understanding of the phenomenon in question. The framework creates a new structure for the data (rather than the full original accounts given by participants) that is helpful to summarize the data in a way that can support answering the research questions (Gale *et al.*, 2013).

The approach provides five stages in the analysis described below, this includes familiarization, identifying thematic framework, indexing, charting and mapping and interpretation. The stages are interconnected and thus enables the researcher to move back and forth across the data until a coherent account emerges (Ritchie and Lewis, 2003). A brief description of what each stage entails is provided in this sections and how the approach was applied in the study is presented section 4.7

**Familiarization:** included Listening to audios, studying field notes and reading transcripts. This was done first to familiarise with data sets and also identifying recurring themes

**Identifying thematic framework:** This stage involved identification of key issues, concepts and theme by which data was examined and referenced. This was done while aligning the data set with the aim and objectives of the study, issues raised by respondents and recurring issues. The objective was to come up with a detailed index of data that labels data into manageable groupings for sequential retrieval and exploration

**Indexing:** Bloor and Wood (2006) describe indexing as “*an activity by which data is broken down, conceptualized and then re-formulated*”. Indexing is sometimes used interchangeably with coding. There is a slight difference between the two. Coding refers to the allocation of an exclusive code to a particular section of either field notes or interview transcript, while indexing allows the same piece of text to be allocated multiple codes. So indexing is simply unpacking coded text by giving meaning to raw data. This is done by assigning key words. These key words then act as signposts to themes within the data (Bloor and Wood, 2006). or phrases. The term indexing in qualitative research is distinctly different from its use within quantitative research. In quantitative research it refers to the combining of a number of variables into a single composite measure or index- *ibid*

**Charting:** In this stage data is rearranged according to the main themes and sub-themes from the thematic framework, so that it can be easily read across the dataset. The process requires a considerable amount of synthesis so that summaries of views and experiences are produced. Data from each respondent is synthesized within the appropriate section of the matrix, using the main themes and sub-themes (*ibid.*)

**Mapping and interpretation:** This stage is influenced by the original research objectives and emergent concepts. At this stage data is explored across rows and themes produced during charting stage.

### **4.3 Study Location**

The research was conducted in Tanzania as previously stated. Research was conducted in Tanzania because Tanzania implemented decentralised health planning since 2000. Decentralised district health planning in Tanzania did not receive emphasis and political support until 1999 when the country introduced

health sector reform (Mapunda 2003). One of the milestones of the reform was coordination of health budget support through a common basket called Basket Fund (MOH&SW 2004). Since 2000, councils were enrolled in phases to get basket funding budget support and they were trained to develop Comprehensive Council Health Plans (CCHP). Several initiatives were taken to improve decentralised health planning arrangement but several challenges were reported: rigidities of the 'basket funds' guidelines, complaints on reduced district autonomy, the guideline were found as more of a budgeting tool than a dynamic planning and CCHP development process was considered complex and time consuming (MOH&SW, 2007).

#### **4.4 Case study selection**

Case studies are prone to criticisms about the extent to which the findings can be generalised (Yin, 2009a; Creswell, 2009b; Denscombe, 2007a). Literature on case studies rules out random selection in this strategy; instead, it suggests deliberate choice by a researcher on the basis of known attributes that are relevant to the research problem and the theory behind the topic (ibid). Since settings, within which CHMTs plan, differ in terms of physical location, organizational arrangements and political situation, the inclusion of urban and a rural district was considered in this line. Furthermore on the two districts had significant attributes that provided understanding of what happens in what setting and also the attributes identified in these two districts had potential in which comparisons with others might be made. The study was conducted in two districts one The following were the important attributes that made Ilala Municipal and Morogoro District council suitable study locations

- *Case study boundary:* The case study boundary is the District Health System (DHS) where the local health department is situated. Usually, the borders of the DHS are identical with the administrative borders of the local government authority's area of jurisdiction (MOH&SW, 2000).
- *Age of local Authority:* The choice of local authorities within which the case study is located was based on their age. A local authority that has existed since 2000 and have been part of phase one health sector

reforms which were introduced in 2000. This is because new local authorities are always formed for example when the health sector reform was introduced there were 119 councils and these have been increased to have been constantly increased. To answer the research questions, councils that must be in existence since 2000 were better placed to provide the information required.

- *Local authority capacity*: The local authority capacity in planning and perceived broader revenue base were considered as local authority capacity parameters. With regard to planning, specifically being a TEHIP pilot district Morogoro District council was selected which also represented the criterion of being rural. Dar es salaam was selected based on being urban but with perceived capacity in terms of planning and also broad revenue base
- *Physical Location (rural-urban)*. This criterion focuses on the contextual factors that may influence the local planning process such as social groupings (ethnicity and power structures, capacity of CHMT in planning), urbanisation, economic status, distance from the centre and political situation. These factors may potentially influence may local authority power over the central government
- *Practical Consideration*: All factors being equal practical consideration (Costs, accessibility etc.) were taken into account to choose between districts that have similar qualities in terms of the above criteria.

#### **4.5 Sampling strategy and inclusion criteria**

Data were collected from the following respondents who were purposively selected Purposive sampling strategy was chosen because the samples in this kind of studies need to relate to the information sought(Denscombe, 2002; Denscombe, 2007b). Therefore, in the context of the study, the respondent's selection was done considering their engagement in health planning these include

- i. **Role of respondent**: A Council Health Management Team member, member of district management team, a national level official dealing with

- council health planning (coordinating the planning process, participate in approval, responsible for developing planning capacity, provision of guideline or work reform secretariat). The officials enrolled were the one who worked in the area related to the study focus for more than five years
- ii. **Position held at community** – Councilor, member of health facility governing committee and member of Council Health Service Board- The officials enrolled were the one who worked in the area related to the study focus for about two years
  - iii. **Development partner:** Member of basket funding group, dealing with local level health planning capacity development. The officials enrolled were the one who worked in the area related to the study focus for about two years

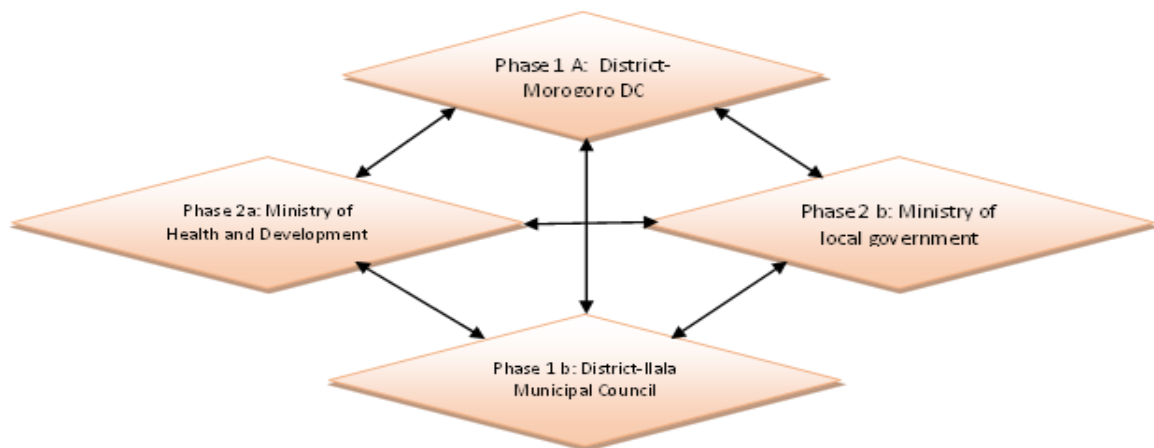
#### **4.5.1 Methods of Recruitment within Case Studies**

The recruitment of key informants within case studies was done purposively through organizations' head in this case, District Medical Officer (DMO). DMOs introduced the researcher to heads of sections. In both case study districts, before the start of interviews the DMOs introduced the researcher to the council director where she presented the aim of the research and shared the permission to conduct research from Institutional Review Board of Ifakara Health Institute. At health department DMO called a short meeting where the researcher introduced herself and explained the aim of the study and whom would be of interest to talk to. The DMO identified a person who supported in facilitating getting respondents at health departments, council and at facility levels. The same identified official facilitated the arrangement of meeting with politicians and health facility governing committees and council health services board. In the instances where the required key informants were not around DMOs or identified person helped the researcher with getting key informants contacts and the researcher contacted them by phone to discuss their participation in the study and we agreed on the convenient place and time to meet. As stated earlier all key informants were purposively selected based their engagement in health planning. Their experience was judged by position key informants held. In addition, key informants outside the health department of the selected districts with possible direct influence over the planning

process were identified through snow balling approach. First by assuring the respondent that participation is voluntary in front of the person who helped to secure respondents. Second, by reiterating that participation is voluntary during consenting process. I also provided time for respondents to read participants information sheet (Appendix G) and I allowed questions regarding participation prior the interviews and during interview where there was a need to do so

#### 4.6 Data Collection Methods

Data collection took place in two phases as illustrated in figure 4.1. Phase one was April 2015- June 2015 which focused only at district level. Phase one was aimed to understand district level perspectives on central-local planning relationships and their influences to local health planning process. Whereas, phase two involved data collection at national level. It took place from August 2015 – December 2015 with the aim of understanding national perspectives on planning relationships and their influences to local health planning process



*Figure 4.1: The Data collection phases*

There are several methods of data collection for qualitative case studies such as observations, textual or visual analysis (e.g., from books or videos) and interviews (individual or group). In most cases, particularly in healthcare research, in-depth interviews and focus groups discussion are mostly used (Hansen, 2006; Corbin and Strauss, 2008; Creswell, 2009b; Denscombe, 2007a). This study used interviews and document review. Observation although was listed as one of data collection methods it was later dropped. This is because practically it proved

impossible to participate in planning process because their decisions are made several meetings which was not possible for the researcher to be part of it. There were several meetings which also included non-health planners. This proved practically impossible because of the time and financial requirements. Focus group discussion was not conducted because it was a bit challenging. Information gathered through interviews were found to be rich enough and it reached a point where the same information was coming again in subsequent interviews- “saturation”. The justification of choice of each method is discussed in greater detail below.

#### 4.6.1 Key Informants Interviews

Though interviews are laborious and need skills in conducting them, they provide a more in-depth understanding of participants’ point of views than any other methods (Hansen, 2006; Corbin and Strauss, 2008). Interviews are useful when the focus is on exploring complex issues (Denscombe, 2007a). Key informants’ interviews were chosen because they are suitable for the exploration of more complex and subtle phenomena (Hunter, McCallum and Howes, 2019; Ward, Comer and Stone, 2018; Erasmus *et al.*, 2009; Creswell, 2009a). Semi structured interviews provide opportunity for gathering in-depth information that provide insight on experiences, feelings, values, opinions and knowledge. In total sixty-three interviews were conducted- 15 at national level, 6 at regional level, and 41 at district level

Table 4.2: Interviews conducted

Level	Category of Key Informants	Total interviews
National level	MOHSW	8
	PMORALG	2
	Planning commission	1
	Donors	2
	Politician	1
	Programs	2
Regional level	RHMT	6



District level	CHMT	30 (Ilala 14 and Morogoro District council16)
	NGOs	4
	Politicians	2
	CHSB	2
	HFGC	3
Total		63

Duration of interviews ranged from fifty minutes to one hour and 20 minutes. Majority of interviews were completed within one hour. The amount of time used in interviews depended much on availability of time respondents had, the experience in the area and their willingness. Interviews conducted in Kiswahili took longer time than the English ones as respondents were found more comfortable expressing themselves in Kiswahili than in English. An interview guide was developed prior field work, this was based on identified themes, objectives and the conceptual framework. The guide was modified at the middle of data collection to accommodate issues arose from preliminary analysis. It was realized that there is a limited coverage of questions in earlier interview guide about central-local relations; this led to further re-thinking of the conceptual framework. This limitation was informed by the pilot interviews conducted in Arumeru district in Arusha Tanzania and further informed by interviews conducted in Morogoro District council. Separate guides were used for different categories of respondents (national level key informants, CHMTs, RHMTs and Councillors and Health facilities including Health facility governing committees and council health service boards- the guides are presented in Appendix E. For all other informants, individual interviews were conducted but for health facilities a group interview was conducted because at this level planning is done in collaboration with health facility governing committees

All interviews conducted at national level and few at district level were conducted in English, as respondents were capable and comfortable to use English. The majority of district level interviews were conducted in Kiswahili and in some

interviews, respondents used both languages. Research assistant helped in monitoring the recorder and in taking notes which we compared at the end of each day to reflect on what was gathered. Research assistant also helped with collecting documents necessary to explain important things about organizations, ministries or concerned districts. Interviewees were given consent forms (Appendix ) and participant information sheet. Ethical considerations observed are discussed in later sections of this chapter.

All respondents and corresponding interviews were given identities and they were stored separately from their identities (Target group/Position/Respondent number/location number) to maintain anonymity. All documents were sorted by case studies and those presenting contextual issues were filed separately. All material was kept within a locked filing cabinet or in case of PCs within password protected folders.

#### **4.6.1.1 Interview Challenges**

Several challenges were encountered in interviews. There were instances where interview location was not conducive for calm and relaxed discussions. In some interviews frequent knocking of the door affected the flow of discussions. The researcher had to stop interview and start again. This happened in few interviews but it did not affect the interview quality.

I lost the data after the robbery incident which led to redoing the data collection. In the second round I met majority of respondents which I interviewed them earlier. The challenge was the respondents sometimes instead of explaining they referred to what they told me in the previous interview This distracted the flow of interview. The situation happened in four interviews only.

Literature on interviews highlights the influence of interviewer's age, sex, ethnic origins, social status, and educational qualifications on the information provided (Denscombe, 2007). As some respondents at national level were former colleagues who were personally known to me this had both advantage and disadvantage. The disadvantage was on the fact that they said you were here you

know these things. They felt that the interviewer was asking them about issues she knows. This needed more probing and creating an environment of free conversation. The good part is that because I knew them it was easy to get appointment and also easy to discuss sensitive issues more freely and openly.

Although it is advisable to start interview with general questions such as name and designation. It proved hard when interviewing National level respondents. The lesson learned here is that, setting the scene in the start of interview is dependent on the existing situation and researcher's relationship with the respondents. Some of the questions with known answers like designation may be omitted but recorded in the interview notes for reference.

#### **4.6.2 Documents**

Documents cover wide and inclusive data that brings things up to date(Denscombe, 2007a). They are the sources of information for triangulation as they validate information gathered from interviews. They provide information that are very relevant to the context as they have been produced within the local context. Documents were collected from case study districts which were mainly plans and reports on the assessment of health plans, evaluations of the health sector that had issues on planning. Other documents collected were the ones providing overall national guidance on health planning. They included national constitution, Acts of parliaments, policies, planning and strategic frameworks. This study also consulted reports, proposals, research and evaluation documents focusing on health planning, decentralisation and health sector reform implementation. In total 30 documents were reviewed from both districts and national level, which are provided in Appendix - F. Documents were identified before the start of field work and others were identified through references provided by key informants. Majority of documents were accessed except Ministry of Health Social Welfare and Local government coordination meetings report that focused on structural arrangements discussions. A pro forma was developed and used to guide the documents review, A document pro forma for reviewing

documents in NGOTU<sup>13</sup> study was adapted for this study – Presented in Appendix-E. The pro forma included

- Identifier: Title, Author, Date of Publication and Type of documents
- Thematic area (s) of the research a document refers to
- Conclusions which were the researchers' opinion on the relevance of document in grounding the findings of the study

The proforma was used to keep records of which documents were consulted and also what was gathered in each document. Documents applied in this study are of two categories. Category one constitutes literature from academic journals and books that set theoretical background of the research. Second category includes policies, reports, plans and guidelines from organization interviewed or those which were acquired after getting references from interviewees

#### **4.7 Literature Search Method**

The literature search was a continuous process, and was carried out at various stages of the research process. The first part was the literature search conducted to identify the gaps and develop the research proposal and tools. This was done between 2009 and 2010. Second literature search was conducted in 2015 when I was redoing data collection to help update the literature on the area to inform the data collection and rechecking whether the gaps identified in 2010 still existed as it was conceptualised. and the third part was done during analysis and reporting in 2019/20. The search in 2019/20 was done to establish any new literature relevant to the study findings.

##### **4.7.1 Search strategy**

The strategies applied included the use of possible search terms, keywords and phrases, subject headings as well as using Boolean logic. The search terms used

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<sup>13</sup> NGOTU is the Joint Research Project that focused on the involvement of NGOs in Policy making process in Tanzania and Uganda and which the researcher participated

were developed in line with the two main thematic areas of the study and important stages of the research such as methodology and analysis.

#### 4.7.2 Inclusion and Exclusion criteria

Inclusion and exclusion criteria used included Date of publication, topic related exclusion, type of materials or content (health planning, central-local relations, decentralisation, decision space) and peer reviewed journal. Figure 4.2 summarise the time frames of literature searches

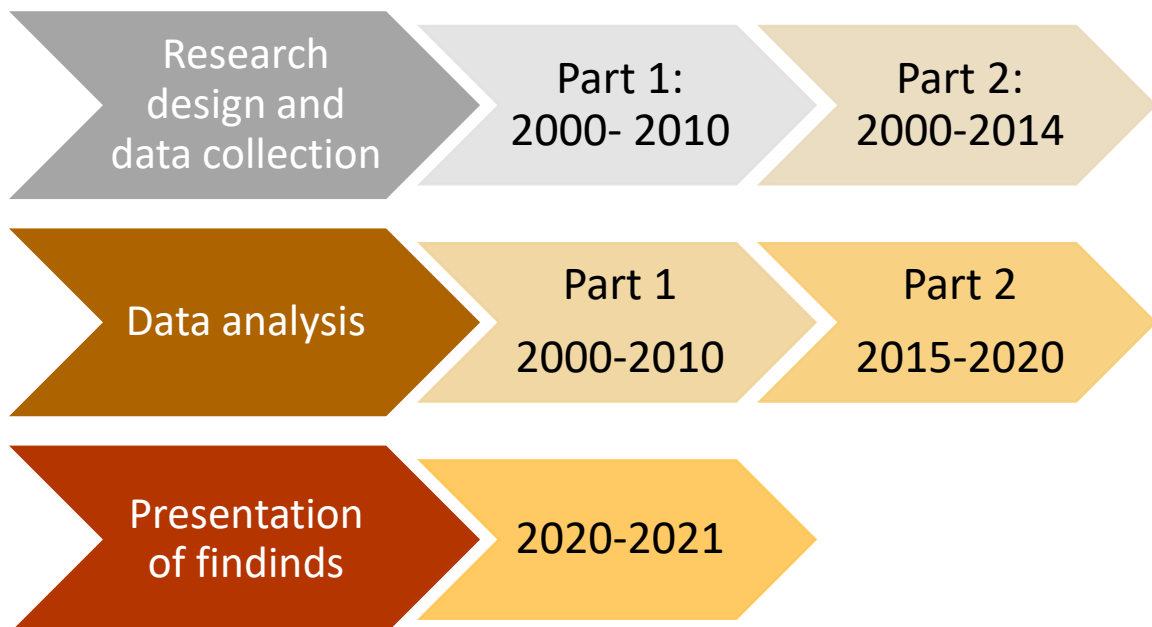


Figure 4.2: Stages of literature search

The University of Leeds library catalogue, keywords search on multiple databases, cited reference, and citation tracing was done to gather relevant articles and books informing the study an example of keywords used to search for literature is presented in appendix A. The following is the list of data base used

- Science Direct
- Web of knowledge
- Science Direct
- Google Scholar
- OVID Medline

## **4.8 Data Analysis**

This section discusses data analysis process. There is no rule of thumb for how qualitative data should be analysed (Hansen, 2006). The section presents the data preparation, analysis framework chosen and its rationale. It presents detailed description of analysis processes applied for each of datasets in this case documents and interviews. Furthermore, it highlights the different data sources that were integrated in the analysis including how they were used (in sequence or parallel).

### **4.8.1.1 Data Preparation and Management**

As stated above, most of the interviews were collected in Kiswahili and some in a mix of Kiswahili and English. The first step was to transcribe the interviews in Kiswahili and translate them into English after transcription, which proved to be time consuming and cumbersome. To ensure accuracy both Kiswahili and English transcripts were used when coding. 60% of interviews were transcribed by the researcher and other 40% by research assistant. To ensure accuracy of transcription, the researcher had to sample 5 transcripts from each location and read while listening the audio file to establish coverage of contents and whether there were paraphrased or written as they were spoken by respondents. Few paraphrasing was identified and corrected.

### **4.8.2 Analysis of Interviews**

A framework analysis was used to analyse the data. Coding the first stage of data analysis was preparation for coding the data. In order to be able to code the data familiarisation with the data took place. This was done by reading transcripts and also field notes. From written transcripts key phrases were highlighted and comments were inserted. A coding framework was then developed which included themes as well as coding categories in each theme by considering each line, phrase or paragraph of the transcript this was compared with the original themes from literature review and research questions. In the course of reading new themes and codes emerged and these were also jotted down. The original themes and priori codes were further expanded or regrouped as new codes emerged. As

part of ensuring rigour the coding frame and transcripts from which it was derived were reviewed by two experienced researchers. Few coding was done on the printed transcripts to ensure understanding of the codes and checking variations of interpretations between coders where inconsistencies between coders were checked and clarified. There were few codes that there was disagreement. The sources of disagreement were the understanding of the scope of the study. This coder applying the same code to the same piece of text but with less understanding of the context. The disagreement was handled by providing the scope of the study and discussing the reasons for the differences

Transcripts were then imported to NVIVO 11 to be coded. Developed code book contained identified coding categories and themes, The purpose of this process was to systematically group text data into fewer content-related themes that share the same meaning

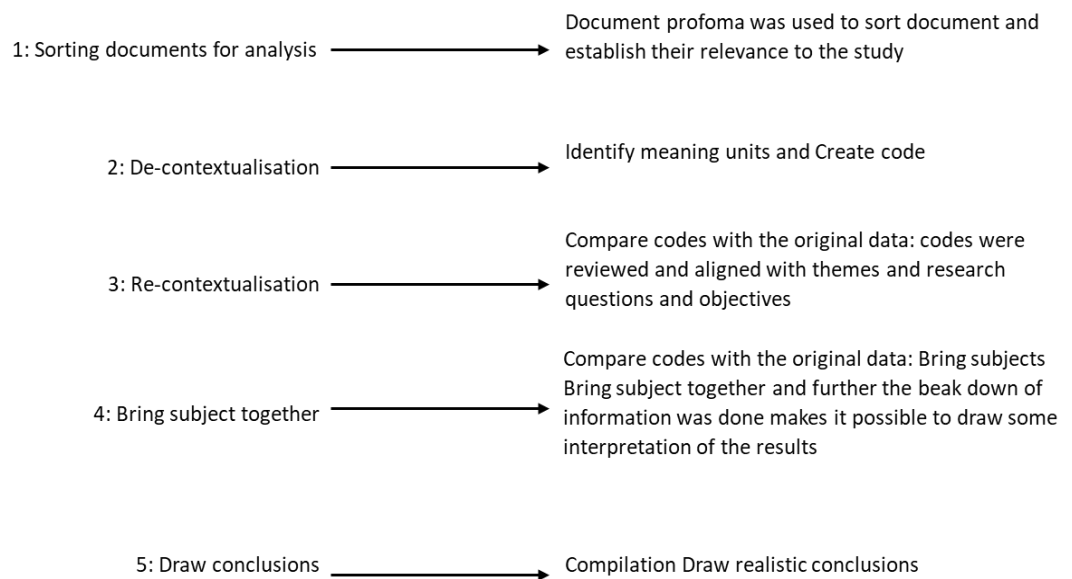
Further the phrases were broken down to unpack kinds of information emerging in the texts within themes and also identifying overlaps between themes. Modification was made as key issues and themes that emerged in course of the analysis process. During the charting stage synthesis was done to identify links between codes and categories, and links between categories and themes this was done by constantly referring back to the original transcripts and checking meaning across interviews using search functions in in-vivo. Data was examined to identify similarities, variations, association and emerging concepts and how they are explained by participants. This kind of analysis was done to examine variations, similarities, key concepts and associations. The process was guided by research questions presented in chapter one and emerging themes.

In addition to framework analysis, document analysis was used to analyse relevant national and district level documents.

#### **4.8.3 Document Analysis**

Document analysis is another way of gathering new information or triangulating information gathered from other sources. Document analysis is used to interpret

documents in order to give meanings with reference to assessment topic. Documents were analysed according to their context and contents. The contents of documents were explored through contents analysis which considers each document as an independent source (Bengtsson, 2016). The documents context was established through identification of timing and the overall political, social and economic history that related to the documents. In addition, also in establishing the context of documents also actors were included. This means the supporters of the documents or initiators and this are linked to contextual factors. The process of a qualitative content analysis from planning to presentation presented by Bengtsson (2016) was used as illustrated in figure 4.2. There are no specific rules that must be followed (Bengtsson, 2016). To systematise the process, the following was done



Apart from being used to sort documents by research themes, document pro-forma was also used to record information from each document. The document pro-forma helped me in contextualizing the results from the document in relation to findings from other sources. Documents were useful to add areas of inquiry in interviews; they were source of information on their own right but also help to triangulate with what was said by the respondents



## **4.9 Ensuring rigour**

Qualitative research is prone to criticism of lacking scientific rigour (Pope, Ziebland and Mays, 2000; Hansen, 2006). The criticisms are partly contributed by i) qualitative researchers' act of neglecting the importance of creating an account of methods and data which can enhance its application by another researcher in the same way to come up with the same conclusions and ii) the mind-set of the researchers influenced by their perception of what makes a piece of knowledge scientific (Mays and Pope, 1995). There is always a relationship between the piece of research and the presumed underlying truth (Seale and Silverman, 1997). This may be the source of bias in the overall research process. Applying techniques that improve rigour is important in increasing validity (Noble and Smith, 2015). Validity of research is not only influenced by methods but also interpretations and implications drawn from it (Maxwell, 2010). In this study deliberate efforts were made to ensure rigour throughout the process where triangulation, transparency of methods and analysis and researcher reflexivity techniques were applied. These techniques are discussed below

### **4.9.1 Triangulation**

Triangulation is a technique to analyse results of the same study using different methods of data collection (Nightingale, 2020). Triangulation was done through reaching multiple methods as well as asking multiple respondents on the same issue. The study reached multiple respondents. These include: Council Health Management Teams, Regional Health Management Teams, Council Executive Director, planning officers, health facility governing committee and Council Health Service Board members, Ministry of Health and Ministry of Local government officials, politicians, donors and NGOs. In addition, the study employed two data collection methods (Key informants' interviews and document review). This was done to provide a deep understanding of influences of central-local relations in health planning and unveil the complex interrelationships between different aspects under the study. Literature consider triangulation as both mechanism for collecting primary information and also means for validating findings (Maxwell,

2010; Jones and Bugge, 2006; Tobin and Begley, 2004; Creswell and Miller, 2000; Nightingale, 2020). Furthermore, during analysis, the findings from framework and document analysis were also triangulated in order to inform the interpretations. Literature presents challenges regarding the application of triangulation in qualitative studies especially if the aim is to confirm results (Tobin and Begley 2004, Jones and Bugge 2006). This is because qualitative research does not always aim at establishing truth but rather a recognition of multiple realities (ibid). Therefore, the use of triangulation in this study was aimed at enlarging the scope of inquiry in order to get a deeper understanding and a more comprehensive picture

#### **4.9.2 Researcher Reflexivity**

Reflexivity is described by Haynes (2012)

*“As awareness of the researcher’s role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research processes and outcomes” (2012. P. 2)*

Reflexivity constitute the act of reflecting and making a reflection of how the researcher and the object of the study affect each other (Carolan, 2003). Reflexivity involves self-evaluation of the researcher on how the research idea was conceived, what researcher new before about the phenomenon and how it influences the uptake of new understanding or how it affected the research (Haynes, 2012). It involves thinking about our experiences and questioning our ways of doing things if had influenced the way we engaged with the data. At the start of this study, I tried to recognise how my previous experience regarding local health planning, my perceptions and expectations of the benefits of decentralisation in health planning may influence my interpretation of the results. I had difficulties in seeing that despite adoption of decentralisation the councils experience rigidities from centre on many aspects of their decision-making process. My belief was built around strengthening primary health care systems where, giving the local autonomy to plan was one of the key issues. In most of the time I did understand that central government would foster its own policies and decentralisation being one of its policies – then I believed that central government

will foster it. I previously considered neutrality of central government in the whole process. As I continued to engage in research process, I was able to bracket my previous understanding and took a more open mind to interact with information gathered with less biased manner.

### **Strategies to minimise influence of personal experience**

In order to avoid the challenge of influence of my personal experience in most of the findings I presented I tried to clearly and accurately present respondents' perspectives and in addition I supported with quotes. During analysis I validated the coding and interpretation by asking another researcher to code the same transcript. Therefore, my interpretation of findings is then grounded on my own experience, the world view and the emerging new and perspective of the respondent

### **4.9.3 Transparency of methods and analysis**

Transparency is concerned with the obligations of the researcher to share, data, analysis, methods and their interpretations regarding the findings. In this chapter sampling, the methods used in data collection and analysis are fully elaborated. Quotes have been provided in support argument where it was appropriate. Quotation allow the readers of this study to interpret the data in relation to the interpretation presented in this report(Maxwell, 2010). Making the process visible allows the readers of this report to do similar research in other councils in Tanzania or in countries with similar context to Tanzania.

### **4.10 Ethical Consideration**

Ethical consideration was done at two levels- institutional and respondent level – ethical considerations.

#### **4.10.1 Level 1: Research ethics clearance and Permission from participating organizations**

At institutional level ethical approval was sought from the University of Leeds and in Tanzania through the Institutional Review Board of Ifakara to make sure that all approval requirements have been adhered to. Apart from the ethical clearance

permission to collect data was sought in council where data was collected in this case ilala and Morogoro districts.

#### **4.10.2 Level 2: Individual level consenting**

At individual level the following were ensured

##### Getting an informed consent

All respondents were given study information sheet that indicated the rationale relevance and the fact that their responses will be kept confidential (Appendix G). This information sheet was provided to respondents during appointments. During interviews respondents were provided with a consent form to sign and in addition the interviewer explained the contents of the consent form (Appendix I) and assured respondents that their participation is voluntary and their responses will be kept confidential. Permission to record interview was asked prior and a liberty was provided to respondents to request treating some of their information as off records when that was requested.

Although the study was carried with no direct risk to the participants, some of the discussions regarding central-local relations issues proved to have perceived professional risk to participants. When respondents felt uncomfortable with answering any question after several rephrasing of the question to ensure that their reluctance is not due to clarity of questions, they were clearly told that they may chose not to respond to the question they did not like to respond to. They were told if they felt uncomfortable for any reason during the interview process, they may ask for a stop and interview will be terminated. Participants were assured that their comments will remain confidential and the researcher ensured that interviews were conducted in places where respondents felt secured to respond. With regard to the management of data they were assured that their responses will be kept safely

##### Confidentiality

All responses were kept confidential. To ensure frank contribution by the research participants, this was communicated at the start of interviews and also reiterated at the end.

### Anonymity

Gray (2009) defines anonymity as an assurance that data will not be traceable to participants in a research project. Careful consideration was made when writing the results to avoid the disclosure of personal identifiers. This was helpful, especially when data was stolen no one could identify where or from whom information was provided as transcripts had a code rather than a name of the key informant. 'anonymity' has commonly been used either interchangeably with, or conflated with, 'confidentiality (Saunders, Kitzinger and Kitzinger, 2015)

The following was done

- Personal data were kept in a secured manner in closed lockers
- Interview transcripts were given another identifier rather than a name of interviewee; files that have the identifier and the respective names were kept under locked storage and will be destroyed three years after the completion of the PhD project

### Reciprocity and Dissemination

Although there were prior plans to disseminate the research findings to stakeholders, the need was further established when respondents and head of organizations asked for the feedback. Since the nature of the study unveils strengths and limitation of certain standard organizational practices, it was thought relevant first to feedback the overall picture to the respondents to validate the findings and also amplify some of the results. Secondly since one of the objectives of the study is to recommend improvements dissemination to various existing forums will continue including publication in peer reviewed journals. In addition, a summary of the results, will be disseminated through post and e-mail to each of the organizations that participated in the study. In addition, the final thesis, all published papers, and a summary of the results will be sent to Ifakara Health Institute, MOHSW planning department, NIMR and COSTECH, as stipulated within the research clearance documents. Municipal will also get summary of the results. In data collection no monetary incentives were given to the participants

this was purposively done to ensure voluntary participation and objective responses. Where participants had to travel, their expenses were reimbursed.

#### **4.11 Chapter Summary**

This chapter presented the study methodology. The study applied explorative descriptive qualitative case study approach where information was collected through interviews and documents review and updated and validated in a workshop with representatives of respondents. A framework analysis was used to analyse transcripts whereas content analysis was applied in analysing documents. Data was collected from CHMTs, Council management teams, NGOs, national level staff of Ministry of Health and staff from ministry of Local Government; as well as donor supporting councils through basket financing. Other methodological considerations such as the methods applied to ensure rigour in data collection and analysis, ethical considerations applied in the study including study limitation were discussed. The following chapter provides a detailed description of the national and district contexts that will be referenced in future discussion chapters when results are interpreted.

## **Chapter 5: The Context of Health Planning in Tanzania**

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### **5.1 Introduction**

This chapter situates the study within Tanzania's national health planning and central-local relations context. The chapter address objective one of the study. The aim of this chapter is to explore the environment within which the local health planning process is conducted in order to identify factors shaping the orientation of different stages of health planning process. The contextual factors described in this chapter are those which were found relevant to the study focus. The chapter starts by providing an overview of the country. Followed by description of health planning organization. Chapter concludes with discussions of key contextual factors shaping the local health planning.

### **5.2 Country Overview**

This section presents an overview of the country in terms location, population, economic status, as well as key health indicators. It further provides highlights on status of key health systems components such as health financing, human resources, service delivery and health information system.

#### **5.2.1 Location**

The United Republic of Tanzania is a union of Tanganyika (Tanzania Mainland) and Zanzibar (Tanzania Zanzibar). Tanganyika became independent on 9th December 1961 (from UK administered- UN trusteeship) and united with Zanzibar in 26th April 1964 to form the United Republic of Tanzania 29 October 1964. Tanzania is located in East Africa covering 945,454 Sq.KM. It has 30 regions.

The country shares its borders with Kenya, Uganda, Rwanda, Zambia, Malawi, Mozambique, Burundi and the Democratic Republic of the Congo.





*Figure 5. 1 Map of the United Republic of Tanzania*

### **5.2.2 Population**

Tanzania has 61,498,438 people according to 2012 Population and Housing Census projections. This indicates more than four times increase since 1967 (12.3 million in 1967 to 55.9 million in 2019). The average annual growth rate according to the 2012 Population and Housing Census is 3.1 percent. The country is still sparsely populated. 76.9. % Of the population lives in rural, and percentage of urban population is increasing. The current fertility rate for Tanzania in 2021 is 4.747 births per woman. Life expectancy at birth for Tanzanians is 62 years (NBS, (NBS 2019). Key demographic indicators are presented in table 4.1 There is a recorded progress in key health indicators as per the HSSP IV midterm review. In child survival, good progress is recorded in under five mortalities, infant mortality and improvement in life expectancy at birth. However, little progress is still recorded in neonatal mortality. As per the DHS 2015/16, childhood mortality declined from 40 deaths per 1,000 live births in 1999 to 25 deaths per 1,000 live births in 2015-2016. The infant and under-5 mortality rates decreased from 99 deaths to 43 deaths per 1,000 live births and from 147 to 67 deaths per 1,000 live births, respectively. Inequalities in mortality between the poorest and richest children were decreasing during 2005-2016, and the urban children had no survival advantage over rural children. Urban neonatal mortality rates were high, especially in Dar es Salaam. Such improvements are attributed to the increases on coverage of intervention (MOHCDGEC 2019). The HSSP IV Mid-term review analytical report of 2019, indicated major increases in the coverage of antenatal, delivery and postnatal care: ANC four or more visits increased from 37% to 59%,

institutional delivery care from 66% to 78% and postnatal visit within 2 days after delivery from 42% to 68%. The increases occurred in all regions during the period of 2015-2018. This is attributed to the national initiative called “Big Results Now” (BRN). The increases were recorded in 2017 and 2018 and were vivid in the BRN regions than elsewhere even before the introduction of new decentralised financing schemes Ibid.

Table 5.1: Key demographic indicators

<b>Indicator</b>	<b>Values</b>
<b>Maternal Mortality ratio</b>	556/100000 live birth
<b>Under fiver mortality</b>	67/1000 live birth
<b>Infant mortality</b>	43/1000 live birth
<b>Life expectancy at birth male</b>	63.2
<b>Life expectancy at birth female</b>	67.8
<b>Neonatal mortality</b>	32/1000 live birth
<b>Total Fertility Rate</b>	5.7
<b>Adult mortality</b>	4.6/1000 population

Source (Ministry of Health *et al.*, 2016)The economic status and health sector financing

### 5.2.3 Rationale of district selection and Description of study areas

#### i) Rationale of selecting Ilala and Morogoro District Council

As mentioned earlier this study was conducted in Ilala Municipal in Dar es salaam region and Morogoro district council of Morogoro region. The two councils were purposively selected. The rationale for the selection of districts was based on three criteria i) rural-urban ii) potential of having CHMT with planning capacity iii Potential for attracting local revenue.

*Table 5.2: District Selection criteria*

Councils	Criteria for district selection		
	rural-urban	potential of having CHMT with planning capacity	Potential for attracting local revenue
Ilala	Rural	Urban – had qualified staff	Urban with several sources of revenue
Morogoro DC	Urban	Was a TEHIP district potential of having staff with planning skills	Rural limited revenue base

The CHMT planning capacity was considered as a factor that may increase or minimise central interference to the planning process and also a factor that may increase confidence of local planners in engaging with central actors. Revenue base was also considered as a factor that may expand chances for local planners to be less dependent on central government financing and hence focus on making the health plans responsive to local needs. The two districts are not far from one another hence practically feasible in terms of cost and time

## ii) Description of Ilala Municipal

Ilala municipal council is in Dar es salaam region. It was established in 2000 under the government notice number 2 of 21st January 2000. Ilala is part of Dar es Salaam City, bordering by Indian Ocean for a distance of about 10 kilometers to the east. On the southern part it is bordered by Temeke and Kigamboni Municipality, whereas on its western part it is bordered by Kisarawe district and on its Northern part it is bordered by Kinondoni and Ubungo Municipality. At the time of data collection, Ilala municipal council comprised of three divisions, 26 wards and 159 streets. Ilala Municipality had a population of 1,195,936. According to 2018 health facility registry statistics, the Municipal council had 261 health facilities where 73% were private health facilities. Ilala Municipal council is an urban council with 261 health facilities as presented in Table 5.2

Table 5.2: Distribution of Health Facilities by type and ownership of Ilala District Council

TYPE OF FACILITY	OWNERSHIP				Total
	Government	FBO	Parastatal	Private	
District Hospital	1	4	0	5	10
Health centres	3	8	0	11	22
Dispensaries	22	15	6	116	159
Police/military	10	0	0	0	10
Clinics	1	0	1	57	59
Maternity and Nursing Home	0	0	0	1	1
<b>Total</b>	<b>37</b>	<b>27</b>	<b>7</b>	<b>190</b>	<b>261</b>

**Source: Health Facility Registry, 2018**

In Ilala Municipal, majority of facilities are owned by the private sector for example from Table 5.2. fifty percent of hospitals and health centers, seventy three percent of Dispensaries and 97% of clinics are owned by the private sector. Meaning majority of Ilala population is served by the private sector. This calls more

engagement of this sector in health planning. The practice indicates limited engagement.

Ilala is a busy urban centre with several revenue sources in 2017/18 for example internal collections were 56,801,000,000.00 compare to Morogoro which was 2,201,584,000.00. All 10 core members of the CHMT were qualified staff for the position. In 2018 the proportion of health facilities without skilled health workers was 0% meaning that the council is better off in terms of human resources availability

### **iii) Description of Morogoro**

Morogoro district council is one of five districts in Morogoro Region. Morogoro district is located at North East of Morogoro Region between 6°00' and 8°00' Latitudes South of Equator also between Longitudes 36°00' and 38° East of Greenwich. It is bordered by Bagamoyo and Kisarawe districts (Coast region) to the east, Kilombero district to the south and Mvomero district to the north and west. The council is divided into 6 Divisions, 31 Wards, 151 Villages. Morogoro district typical rural population 89% (234,179) while peri-urban population is 11% of the population that is (29,741) people. 82% of the adult population in Morogoro Rural earns their livelihood from Agriculture though mainly at subsistence level, 6% in Business Operation, 6% in Elementary Occupations, 4% in Office Work and 1.3% in Livestock Keeping. (Source: Census 2002). The Average individual annual income (Per Capital Income) in 2005/2006 for Morogoro Rural District is approximately US \$ 72 annually, (250 per day) – (O&OD- Opportunities and Obstacles to Development Process Source 2005.) While, Morogoro Regional Per Capital GDP at current prices is Tshs. 418,850/= (Regional Socio-Economic Profile 2006)

Table 5.3: Distribution of Health Facilities by type and ownership of Morogoro District Council

TYPE OF FACILITY	OWNERSHIP				Total
	Government	FBO	Parastatal	Private	
District Hospital	1	0	0	0	1
Health centres	5	1	1	0	7
Dispensaries	56	7	3	2	67
Clinics	0	0	0	0	0
Maternity and Nursing Home	0	0	0	0	0
<b>Total</b>					<b>75</b>

Roles of the district or municipal councils include: ensuring that people access social services hence responsible for planning and implementation of social services. It also Has a role of regulating business undertakings including issuing of business license. It is responsible for collection of public funds such as taxes, levies, government subvention and external assistance to finance council's development. The council health department is managed by Council Health Management Team. All 10 core members of the CHMT were qualified staff for the position and 6 participated in TEHIP project. The council revenue collection come from various sources and in 2017/18 the council collected 2,201,584,000.00 from the local sources which 5.2 of the council budgets. In Morogoro government is the main provider of health services. Shortage of human resources for health is 60% according to the district health profile of 2018

### 5.3 Tanzania GDP and Health sector financing

According to National Bureau of Statistics Tanzania's real GDP growth in terms of annual percent change was 6.5% in 2012. According to the 2017-18 Household Budget Survey (HBS) revealed that average consumption per household per month in Tanzania Mainland was TZS 416,927. The basic needs poverty has declined from 28.2 percent in 2011-12 HBS to 26.4 percent in the 2017-18 HBS. The food poverty declined from 9.7 percent in 2011-12 to 8.0 percent in 2017-18 proportion of Tanzanians who are extremely poor and cannot afford to buy basic foodstuffs to meet their minimum nutritional requirements of 2,200 kilocalories (Kcal) per adult per day declined from about 12 to 8 percent. The poverty incidence

is higher in the rural areas (31.3%) than their urban counterparts (15.8%)- Dar es salaam records the lowest poverty incidence- *ibid*. In July 2020, the World Bank reported an increase in Tanzania's gross national income (GNI) per capita from \$1,020 in 2018 to \$1,080 in 2019, exceeding the threshold for lower-middle income status despite the period being outside data collection period of this study.

Despite the increase GDP growth rate, the health spending per capita from financial years 2013/2014 to FY 2017/2018 was below the Abuja target of 15 per cent. United Republic of Tanzania general government expenditure on health as a share of general government expenditure was at level of 9.4 % in 2018, down from 9.5 % previous year the health sector is financed through government sources, grants, loan and pre-paid schemes and out-of-pocket payments. The share of public spending on health in terms of total public spending and GDP has been declining. For financial year 2017/18 according to UNICEF budget analysis Global Fund and the Health Basket Fund were responsible for major increases to the MOHSW and the development spending administered by LGAs and Regional Administrations decreased.

The health basket fund which was established since 1999/2000 remained prominent source of funding. It is managed through a sector-wide approach arrangement. The utilization of this funding is by councils through Comprehensive Council Health Plan and Comprehensive Health Plans. Funds disbursement is done after mutual agreement between Health Basket Financing partners and the Government of Tanzania managed under the 5-year Memorandum of Understanding. According to the report on 19th Annual Health Sector Review conducted in 2018, health financing was reported to be improving. According to NHA 2015/16 the insurance coverage has increase from 16% (2012) to 34% (2016) with Community Health Insurance accounting for 24% of all. The increase in CHF coverage is the product of joint efforts between government and development partners in addressing enrolment bottlenecks. Donor financing has fluctuated from 44% to 39% in 2014 and rose again to 41% in 2015. Out of Pocket was still contributing significant amount ranging at 22% in 2015-*ibid*. Total health expenditure has been stable since 2009 at US\$ 35 per capita, which does not

suffice for basic health services. The councils own source contribution to health has always been a challenge due to limited revenue base. The availability of human resources, health infrastructure and commodities are critical components in improving access to health care services. Several efforts have been made to improve supply chain management and to increase the budget for health commodities (GoT/MO HCDGEC 2019). HSSP IV midterm review report indicate improvements in availability of basic amenities and tracer medicines, and the star-rating assessment of all health facilities showed better results in 2017/18 than in 2015/16 in all regions, suggesting improved quality of care.

#### **5.4 Human Resources for Health planning**

Human resources for health are still a challenge where the country has only 44% of its requirement despite several efforts to address barriers of attraction and retention of health workforce (GoT/MOH-CDGEC 2019). The shortage was aggravated by the removal of ghost workers in 2016 and slow pace of replacement. According to the Health Sector Strategic Plan IV Mid term review, there were modest increases in the numbers of health workers, but major gaps remained and the core health professionals' density per 10,000 populations hardly increased. Regional disparities still exist *ibid*. Availability of skilled personnel is among capacity element critical for the success of decentralisation. Council health Management Team is responsible for development of Comprehensive Council Health Plans. Due to shortage of human resources not all councils have their CHMTs posts filled by individuals with required qualifications. For example, in regions visited during Health Sector Strategic Plan IV midterm review, only 60% of the CHMTs had required qualifications and only 40% of posts were held by CHMT with less qualification (MOHCDGEC, 2019)

#### **5.5 The Primary Care levels and its Governance structures**

Primary health care service delivery system is aligned to administrative hierarchies. Health service delivery is provided through layers of referral systems starting from communities to district hospitals. The first level is a community where outreach services and community-based services take place. Each village has two village health workers. The second level is comprised of dispensaries and health



centres. Dispensaries provide outpatient service and health centres are designed as first level referral points for any conditions that require in-patient care at primary level. Dispensaries cater for between 6,000 to 10,000 people whereas health centres cater for 50,000 people which is approximately the population of one administrative division. These facilities serve majority of populations and are supervised by the office of District Medical Officer. Ideally each district is supposed to have a district hospital. In areas where there is no government hospital at district level, Government normally negotiates with faith-based organizations to designate voluntary hospitals and get subventions from the Government to provide services. Health service delivery in Tanzania is provided by several actors, government being the main provider of service owning 74% of health facilities, followed by Faith based Organisations and the private for profit 12% of health facilities. The private for-profit own majority of dispensaries (NBS 2019). The population living within 5 km from health facilities was 65.9% in 2017 (WHO 2017).

Health plans are developed from dispensaries, health centres, council hospitals as well as CHMT level. CHMT plan constitutes budget for coordination and supervision activities. Which they are later amalgamated into CCHP. At each level there is a corresponding governing structure that links supply side with demand side. One of the key features in health sector decentralisation in Tanzania is the inclusion of structures that link communities with the supply side in planning and implementation of health plans at primary care levels. These are Health Facility Governing Committees and Councils Health Service Boards. These structures were meant to improve community empowerment (MOHCDGEC 2019). On the other hand, there is a clearly stipulated mechanism for engagement of private sector in health service delivery. Their engagement in planning is through Health Facility Governing Committees and Councils Health Service Boards. These are established by law

*“The council health service board, below we develop the health facility government committees which are for each facility, then again help to overlook the health facility under that decentralisation area, and these are*

*formulated legally because they were mandated under the instruments and bylaws to support the health sector” Government official national level*

For more than two decades, health facilities roles in planning were limited to identification of lists of wishes and the actual planning was done by Council Health Management Teams (Mollel and Tollenaar, 2013). For example, the 2007 health sector evaluation identified several limitations in terms of local health planning and the fact that it was not involving health facilities as expected (MOH&SW, 2007). Most of remote facilities ended up being dilapidated in 2015-star rating exercise (Kapologwe *et al.*, 2020; Yahya and Mohamed, 2018)

### **5.5.1 Health information system**

Health information system is one of the important components for health planning. There is growing concerns that plans need to be evidenced based. The identification of health problems needs evidence both facility based and population based. Tanzania records a growth in improvement of health information system especially the efforts to digitise health information with DHIS2 being the main health data warehouse (MOHCDGEC 2019). Since the introduction of health sector reforms efforts have been underway to ensure health management information system provides a minimum set of information that will inform health sector performance at all levels. This went in tandem with the improvement of quality of data in terms of timeliness and accuracy. Further efforts to integrate information systems into the DHIS2 has been one of the country's goals. Several information systems have been integrated into DHIS2 such as TB, HIV and Malaria. The aim has always been to improve interoperability between information system to ensure ease information access. Not all information systems are integrated for example there is a still a challenge of integrating human resources information system due to issues related to interoperability. With regards to information for planning, improvements have been seen in terms of enabling councils to access data. Since 2015 USAID supported the production of district profiles that were meant to make councils access key information relevant for planning. Again, equity analysis was made easy by having scorecards that indicate who is covered and who is not. There is an improvement in data quality. However,

there are no new data to assess trends in hypertension or raised blood glucose which affects efforts in addressing non-communicable diseases.

It is useful to have ready and quality data from HMIS to support planning. However, in DHIS2 not all program indicators are covered. This led to proliferation of information systems and databases that always add workload to health providers and also impact access of important information through routine system. For example, there are challenges in accessing data on Neglected Tropical Disease (NTD) but the same was available at program data. CHMTs cannot always access program specific data because the programmes manage some of their data parallel from the national system and this influences decision making during local health plan development

## **5.6 Health planning in Tanzania in the context of decentralisation**

In this section types and levels of plans are presented. This is followed by the historical perspective of decentralisation and that of health planning. The description of the historical perspectives is presented because the level of decentralisation determines the orientation of health planning and decisions space accorded to local authorities.

### **5.6.1 Types and levels of health plan**

In Tanzania health planning is conducted at national, regional and council levels. At national level the health sector prepares strategic plan which is long term normally covers three years. This is translated into three years medium term expenditure framework. Councils are also expected to have their own strategic plans that covers all sectors. The strategic plans are aligned with five years development vision as well as poverty reduction strategy. CCHP translates both the health sector strategic plan as well as the councils strategic plan on annual basis.

### **5.6.2 Historical background of decentralisation in Tanzania**

Decentralisation is presented in this section because planning is one of the governance activities. Whether health planning is top down or bottom up is determined by the governance orientation. It is therefore, worth understanding the

development of decentralisation in Tanzania since independence to explore causes of alterations and resultant central – local actors' relationships. Tanzania's central-local relations are defined by her constitution of 1977 which was amended in 1984 to incorporate changes instituted in public service in mid 80s reforms. The country has been changing its mode of governance between centralization and decentralisation since independence. The changes were attributed into larger extent to the inefficiencies of decentralised units. The following paragraphs outline the governance orientation since independence and their reasons.

Between 1961 and 1972 two shifts occurred with regards to the local government authorities. In 1961 immediately after independence, the government of Tanganyika (by then) abolished the Native Authorities established in 1926 and established new structure of Councils composed of elected Councillors and few appointed members. The native authorities were not efficient as expected. There was gross mismanagement of the funds collected and granted by Central Government. This was attributed to local authorities capacity limitations such as lack of qualified staff, limited experience of councillors to run and manage the affairs of local authorities. There was also Conflict between local authority staff and councillors because councillors refused to take part in campaigns for tax collection, fight over sitting allowances, demands for special treatment such offices and vehicles for personal use and high influence when awarding contracts (Roman, Cleary and McIntyre, 2017; Kessy and McCourt, 2010; Boex, 2003). This led to regionalisation where the regions were given mandate to manage councils in 1972

In 1978 vide Act No. 11 of 1978 the urban authorities were re-established following the recommendation of the investigation team which recommended reinstatement of urban local authorities because the standards of living of the population dropped. Government expenditure increased tremendously due to the extension of bureaucracy to villages. The rural region's development stagnated. Re-introduction of LGAs again faced some challenges such as limited capacity of urban authorities to raise revenue of their own. Town and Municipal Councils depended solely on the Central Government for their finances which in most cases

the funds were insufficient and municipal councils could not continue with development projects hence limited funds to finance locally generated project. Shortage of human resources at LGA level, weak leadership and management capacity, over employment within the councils, weak accountability and lack of transparency in the operations of council's work

In 1982 Tanzania formalized decentralisation by devolution (D by D). This took a series of process that included setting mechanisms, laws and regulation including amendment of the 1977 constitution. The amendments of the constitution were followed by several amendments in existing laws hence the following Acts were enacted.

The enactment of The *Local Government Laws (Miscellaneous Amendments) Act, 1999*, No. 6 of 1999 – This was amended to make better provisions for, and to consolidate laws relating to, local government, to repeal the Local Government Ordinance, to repeal certain other written laws and to provide for other matters connected with or incidental to the organization of local government in Mainland Tanzania in order to align the thinking of decentralisation with supporting laws. This meant to better define also roles in social development planning in which health is part of it. Subsequent amendments were made since the introduction of the Local Government (District Authorities) Act, 1982, No. 7 of 1982. Act number 7 provided clearly the role of local authorities in developing plans. The Local Government (Urban Authorities) Act, 1982, No. 8 of 1982 was enacted establish urban authorities and stipulate their functions. The Local Government Finances Act, 1982, No. 9 of 1982; make provisions for sources of revenue and the management of funds and resources of local government authorities.

To ensure the public sector improves its operations during the implementation of D by D, other reforms were established. In the interest of this study two will be discussed. Health sector reforms and local government reforms. The Local Government Reforms are one of the major reforms in Tanzania which aimed at restructuring the local government authorities to enable them to respond effectively to the needs of the population. The major component of these reforms

is the implementation of Decentralisation by Devolution known as D-By-D. The aim of D-By-D is to make LGAs- deliver service efficiently and effectively. To achieve this the following were done:

- Increasing the LGA autonomy, expanding the LGAs revenue base and providing LGAs with hiring and firing mandate so that they can attract qualified human resources.
- Decentralisation of planning and implementation roles to local authorities in order to increase the responsiveness of plans to needs of the citizen and increase of quality services provided.
- Setting mechanisms in which LGAs can be accountable to the citizens by expanding users' engagement and provision of space for users to have a voice on how services are managed and delivered.
- Promoting and expanding partnership between the CSO, private sector and other stakeholders (ibid).

Under the decentralisation settings, health service management fall directly under two key ministries, the Ministry of Health and Social Welfare (MOHSW) as a technical ministry, and Presidents' Office Regional Administration and Local Government (PORALG) as the ministry responsible for the management and administration of health planning and health services delivery at local authority level. The two ministries have been established by the President of the United Republic of Tanzania vide Government Notice No. 494 of 17 December, 2010. The roles of the two ministries identifies their jurisdictions which is very important to understand in assessing planning relationships between two levels in the two sectors

Table 5.4: Roles of Government Ministries in decentralised settings

Ministry of Health Mandates	President's Office Regional Administration and Local Government Mandates
MOHCDGEC is mandated for:	In the said Instrument, the President created the President's Office-Regional Administration and

- formulation of health and social welfare policies and monitoring and evaluating their implementation
- ensuring that all Tanzanians access quality health and social welfare services
- Local Government (PO-RALG) which is mandated for
- Formulation, monitoring and evaluation of Decentralisation by Devolution (D-by-D), Rural and Urban development policies and their implementation.
- Regional Administration and management of Local Government Authorities to provide quality services to their respective communities
- Administration of Social, Economic and Productive Sectors.
- Administering good governance and accountability that will contribute to poverty reduction and National economic growth.

The constitution clearly stipulated the functions of local authorities in general as: i) to perform the functions of local government within its area ii) to ensure the enforcement of law and public safety of the people and ii) to consolidate democracy within its area and to apply it to accelerate development of the people. The section 146 (1) of the constitution provides the purpose of having local government. Article 146 (1) identifies as local authority as the legitimate organ for engaging people in local health planning

*“146 (1) The purpose of having local government authorities is to transfer authority to the people. Local government authorities shall have the right and power to participate, and to involve the people, in the planning and implementation of development programmes within their respective areas and generally throughout the country” URT 1977 Constitution)*

In 1992 government started to implement the public Service Reforms. The reforms dealt with improving government efficiency by re-defining government roles and functions so that the public sector remains focused by concentrating on core

functions. The process involved restructuring and launching of decentralisation program. The aim of this reform being reorientation of central government's role towards policy making, regulation, monitoring and performance assessment, leaving the service provision roles to local governments in collaboration with civil society's agencies and the private sector (Burki 2001). The respondents also identified the roles of central government and local government as quoted below

*“Actually, before we come to the councils, we had to do the review of the whole sector to find different levels of actions and who does what. The centre was to focus more on the health policies, strategies and regulatory framework, supervision and quality assurance while the regional level was even mandated to support the district level in terms of planning and supervision of day-to-day activities and support the councils to develop their health plans” Retired ministry of health official*

### **5.6.3 Historical background**

The Tanzania's health planning history can be traced since 1964 where the country had its first health plan chapter within the five-year development framework immediately after her independence 1964 -1969(Gish 1975). The evolution of local health planning. Gish 1975 and other national documents (MOH&SW, 2008; MOH&SW, 2007; MOH&SW, 2004) including interviews presents series of political or professional influences that altered either the focus or scope of local health planning since Tanzania got her independence

Although Tanzania established new structure of councils in the first decade after independence, but health planning was not conducted by councils. The role of health planning was entrusted to medical committee that seated at national level. During this period health plans were centrally managed(Gish, 1977). There was no exactly a health plan but rather a section in 1964-1969 five-year plan. The focus was mainly curative. This led to construction of five hospitals in urban areas and 300 dispensaries were constructed which catered for rural areas. Also, it included the training of paramedics. In 1970 -1975 plan there was a slight improvement in recognising health planning and during this period health was more vivid in the



overall development plan and had a clear objective that extended to issues related to prevention. Health planning was centrally managed. Generally, the success of this plan was limited compared to the expectations. The main challenge was souring international relations following the breaking out of the diplomatic relationship with United Kingdom and Federal Republic of Germany. This meant no foreign aid from these countries- *ibid*.

In 1970-1975 Tanzania wanted to address the development challenges while taking into account limitations experienced in previous health plans. In this period unlike the previous more power was given to the regions with the expectation of improving efficiency and reducing regional disparities. Health planning was managed through Regional Development Department (RDD) following the 1972 decentralisation. The plan considered both curative and preventive and also the need to address geographical inequities. The focus of this plan was shaped by the 1971 Musoma resolution that gave priority to water, schools and health services in the rural areas which was followed by decentralisation to the regions in 1972. However, there were several challenges that were encountered during this period. First inequalities between rural and urban areas increase as most of expenditures went to hospitals. For example, 84% of approved expenditure were for Dar- es – Salaam projects.. It was also hard to create a balance between districts within the regions. Although the country implemented decentralisation the plan was still top down as most of the decisions were centrally driven.

1975 -1985 was even more chaotic in the history of health planning in Tanzania. This was the period when management of development cooperation was uncoordinated and the relationship between donor community and government was shaky. Donors accused government of diverting budgets to other activities which were not agreed upon and poor coordination and management of development project. Government accused donors of diverting the government system and working more with NGOs. This was the period of increased verticality. Donors' involvement in resource management through vertical programs was the major mechanism for channelling development assistance. Literature with regards to vertical programmes vis a vis integrated programmes suggest several

limitations of the former. Duplication of services, lead to ineffective use and limited evidence exist on whether they have positive spill over effects in improving health systems(WHO, 2008). This affects planning because in most cases resources within the vertical programs are controlled centrally by the program hence making planning difficult. Key role when planning is to avoid duplication and ensure equity. with donors working with NGOs directly, services had the potential to overlap as the Ministry of health and NGOs could provide similar services or in some instances the Government could decide not to provide service that NGOs were providing but then this result in some areas missing out as not all areas are covered by NGO services

1999 Tanzania introduced health sector reform. One of the features was decentralisation of planning and implementation of primary health care services to councils. The health sector reforms were rested in enabling the local authorities discharge their primary functions as stipulated in Local Government Authorities Act of 1982. Section 118. -(1) states thatIn addition, to the functions and duties conferred or imposed on local government authorities under section 111, the following shall be the function of every district council,

(a) to formulate, co-ordinate and supervise the implementation of all plans of the economic, commercial, industrial and social development in its area of jurisdiction.

... I

(b) to monitor and control the performance of the duties and functions of the council it and its officer and staff by departments of the council and

(c) to ensure the collection and proper utilization of the revenues of the council – to make by-laws applicable throughout its area of jurisdiction, and to consider and approve by-laws made by village councils within its area of jurisdiction;

(d) to consider, regulate and co-ordinate development plans, projects and programmes of villages and township authorities within its area of jurisdiction, so as to ensure the more beneficial development and mobilization of productive forces in the village and township authorities and their application towards i)

- the enhancement of productivity; (ii) the acceleration of social and economic development of villages; and (iii) the amelioration of rural life;
- (e) to regulate and monitor the collection and utilization of revenue of village councils and township authorities;
- (f) subject to laws in force, to do all such acts and things as may be done by a people's government at the district level.

It is worth noting that since independence there was no council health planning until in 2000 where the country started to implement health sector reform. Being in its infancy several developments were recorded in shaping council health planning in Tanzania especially in the context of decentralisation. The introduction was done in phases. The reason why the rollout was not country wide basically is because the health sector reforms was ahead of local government reform. For health sector reforms to work well, local government systems needed strengthening. The health sector reforms started in 1993 and was gaining momentum in 1996 through 1999 when basket funding and the Sector-Wide Approach was introduced. Decentralisation within the health sector started while local government authorities were not ready for the reforms

*“We started SWAP and basket fund approach and the local government reforms had not started, in a way we were moving into the decentralisation of the health services while the local government itself, the councils were not ready for the reforms” MOH official.*

The process of institutionalising decentralised council health planning had several milestones during the implementation of health sector reforms. First was introduction of Sector Wide Approach and basket financing. The most prominent financing was basket funding arrangements. This was followed by the development of allocation formula that guided disbursement of resources. The first resource allocation criteria were 0.5\$ per capita as basis for allocation. There have been several improvements in resource allocation formula. The improvements were based on addition dollar per capita, additional vulnerability considerations were also included to enhance equitable allocation of resources. Further in 1998

the first planning guideline for councils' health planning was developed and underwent several reviews dependent on emerging need for improvement. This was followed by capacity building initiatives for councils in planning under DANIDA support where all CHMTs were oriented on health planning and specifically how to develop Comprehensive Council Health Plans (CCHPs).

*“There has been formulation of financing modalities and also development of the national district health planning guidelines in 1995. This was then included into CCHP guideline in 1998 and underwent several reviews” MOH official*

The first years of implementation of basket funding mechanisms, councils were having troubles in adhering to conditions and following the planning prototype. Annual assessment of plans and implementation reports were introduced. Councils plans approval indicated that not all were able to get cleared on the first round. This has been a persisting problem for several years. The assessment criteria included checks: i) whether the presentation of the plan is done in accordance to proposed format in the CCHP guideline ii) whether data presenting current situation are consistent in all sections that use the situation analysis data iii) whether the objectives are set to address issues identified as priorities and that there is a logical link between objectives and activities iv) whether targets are specifics, measurable, attainable, realistic and indicate specific period in which they will be achieved v) budget allocation have been done in accordance to priorities and high impact interventions specified in Essential Health Intervention Package and they adhere to sources of funding conditionality.

Under the decentralisation preparation of local health planning is the responsibility of Council Health Management Team. However, the overall process brings in an array of actors who in one way or the other engage with the local health planning process. It is noted that it is hard to disentangle planning from the administrative chain of command within the health systems. This is because health planning also includes the implementation of national policies and strategic frameworks. Thus,

calls for follow ups by higher authorities. This study only focused on the development of local health plans and did include issues related to the implementation of the plans. In the history of health planning in Tanzania I presented how political orientation and focus determines the orientation of health planning and roles of central and local actors. Likewise, the national frameworks and policies also determine the focus and orientation of local health planning.

*“The main role of the central is to formulate the health sector policies, the health sector implementation guidelines, regulations on quality delivery of the services, technical guidelines to guide the decentralisation in health sectors down there” Ministry official*

The health planning in Tanzania has been part of the overall development vision since independence (Gish 1975). Currently the national health planning agenda is guided by the long-term national vision in this case the vision 2025<sup>14</sup>. The Vision 2025 was formulated to promote local ownership of reforms and enhancing their sustainability. With regards to the health sector, vision 2025 aimed at increasing access to primary health care and reduction of infants and mortality by three quarter. There are five levels at which visions 2025 is translated into action. First the national long term development agenda divided into five years planning timeframes aligned to the national elections promises. Secondly the five-years national plan is translated into National Poverty Reduction Strategy. Thirdly each sector prepares a strategic plan aligning it with the national five-year plan as well as National Poverty Reduction Strategy. Fourthly in order to ensure that the five-year sectoral plans are executed, they are then further broken down into Medium Term Framework- MTEF that sets three-year integrated estimates for recurrent and development expenditure capturing all sources of finance<sup>15</sup>. The MTEF is aligned to the performance indicators set out in the strategic plans of all Ministries

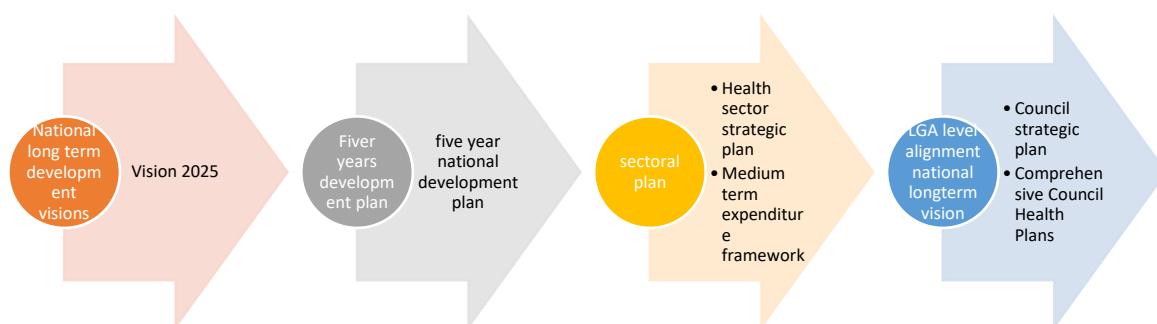
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[http://www.mof.go.tz/mofdocs/budget/Guideline/PBG%202011\\_12%20TRH%2018\\_MARCH%20%20FINAL.pdf](http://www.mof.go.tz/mofdocs/budget/Guideline/PBG%202011_12%20TRH%2018_MARCH%20%20FINAL.pdf)

<sup>15</sup>[http://www.policyforum-tz.org/files/EnglishUnderstandingtheBudgetProcessinTanzaniaCSOGuide\\_0.pdf](http://www.policyforum-tz.org/files/EnglishUnderstandingtheBudgetProcessinTanzaniaCSOGuide_0.pdf)

and Departmental agencies in the national five years plan and the poverty reduction strategy. Fifthly, annually each sector prepares a sector plan which is incorporated into the national budget by the Ministry of Finance. These plans comprise of priorities from all departments, agencies and local authorities. Figure-5.2 illustrates the linkages between various plans by levels.



*Figure 5. 2 Types and levels of planning in Tanzania*

Annual plans are aligned to the national overall focus through centrally agreed set of objectives. There are six objectives within which the activities of local health planners need to address their planning issues around them. The objectives are i) Improve services and reduce HIV/AIDS infection, ii) Enhance, Sustain and effective implementation of the National anti-Corruption Strategy, iii) Improve access, quality and equitable social services delivery iv) Increase Quantity and Quality of social services and infrastructure v) Improve social welfare, gender and community empowerment, vi) Improve Emergency and Disaster Management.

### **5.7 The local health planning Development and approval process**

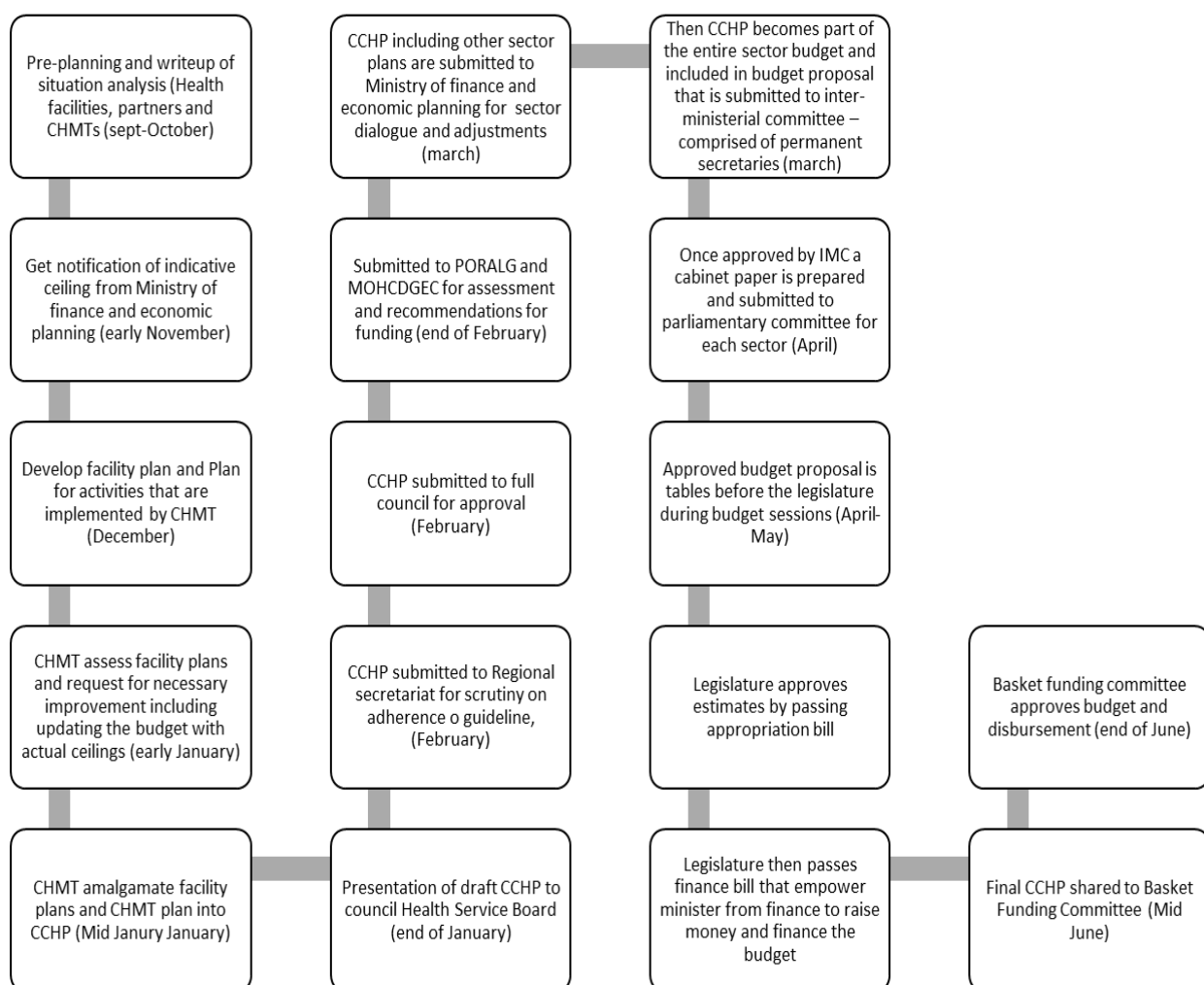
The local health plan is prepared annually and it is called Comprehensive Council Health Plan (CCHP). According to the Fifth Edition Comprehensive Council Health Planning Guideline it is defined as

*“Annual Council health plan which entails a consolidation of Council Health Management Team and health facility plans prepared in accordance to the guiding frameworks. The ultimate aim of CCHP is to maintain and improve the health status of Tanzanians to be achieved through the provision of*

*Promotive, Preventive, Curative and Rehabilitative health services which are accessible, affordable, effective, equitable and of good quality p.2*

CCHP development process and approval system is divided into two. It involves an array of actors who influence local health plan from development stage to the approval of final plan that is endorsed for execution in that particular year. Not all actors interact with local health planners directly but their decisions may lead to replanning. The first part is the approval within the health sector that looks at both technical and adherence to financial regulations. This part involves, Council Health Service Boards, Regional Health Management Team, MOHSW and PORALG. The second part is at Ministry of finance and planning level where the focus here is on adhering to ceiling and adjustments to fit into the actual ceiling. At this level the plans sometimes go back to CHMTs for adjustments of the budget according to the overall sector ceiling.

At council level, each head of department is provided with the Medium-Term Expenditure Format to feed the plan of their respective sector. After this all heads of departments meet and discuss and agree on the council plan of that year. After that, the plan is consolidated in a PlanRep tool where, both CCHP and MTEF for the council can be accessed. From the PlaRep tool one can print MTEF or CCHP. In MTEF not all aspects that appear in CCHP are included. The focus is mainly on the budget and service output only Figure 5.3 illustrated the process



*Figure: 5. 3 CCHP Development and Approval process*

## 5.8 The Chapter Summary

This chapter presented the Context of the local health planning process in Tanzania. Local health planning is influenced by several factors. The study found for main contextual factors shaping both the planning process and relationships between actor of central level and those are at local level. These factors include finance, hierarchy, information availability, legal frameworks and roles politicians. Tanzania is amongst the fast-growing economies in Africa. However, the budget allocated to health is about 10% of total government expenditure which is still below Abuja declaration. Planning levels is aligned to administrative hierarchy hence drawing very thin line between administrative accountability and planning responsibilities between levels hence influence the utilization of granted decision space by a local planner.



Employees who are lower in the chain of command may tend to consider themselves inferior to those who are higher in the hierarchy. Furthermore, information for planning is another factor that influences capacity of local planners to back their decisions with evidence. The constitution did not clearly demarcate the limitations of central government powers. Hence making the central actor to overpower local actors. Chapter six will discuss in detail the process of developing Comprehensive Council Health Plan (CCHP)

## **Chapter 6: The Council Health Planning Process in Tanzania**

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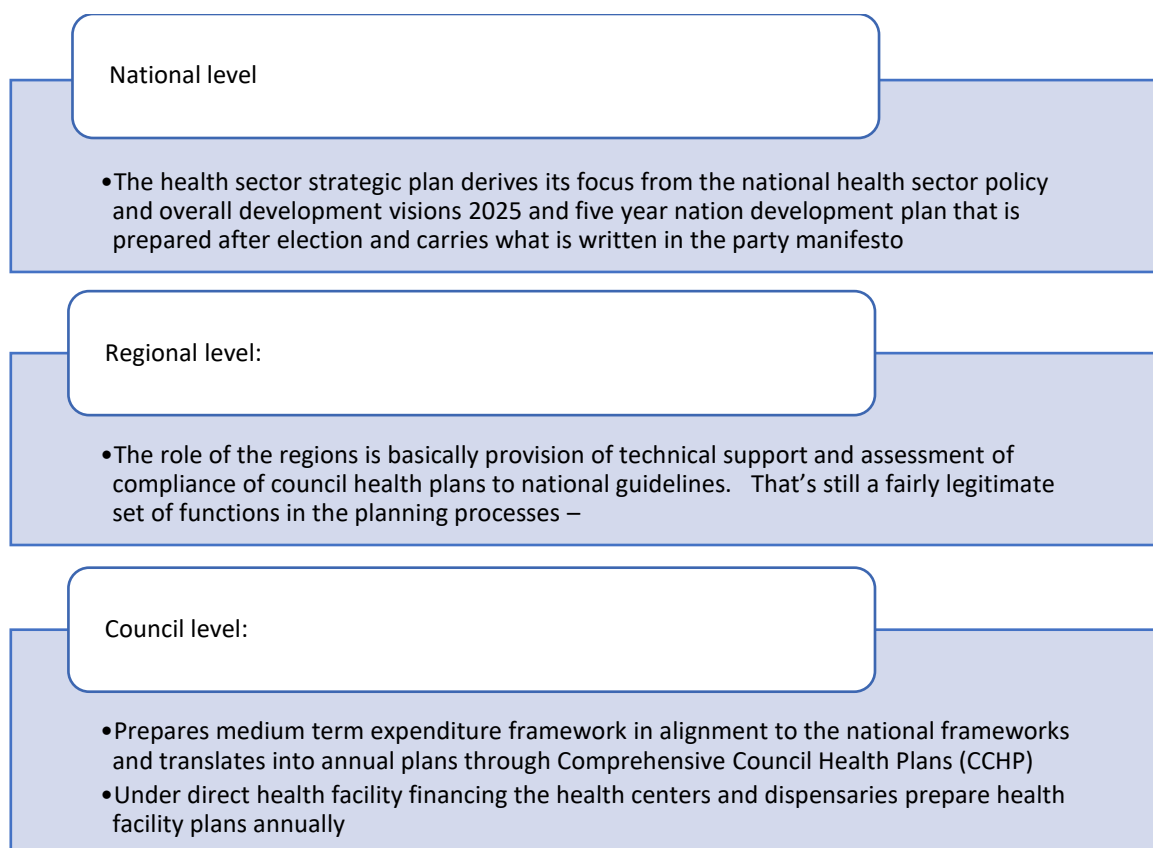
### **6.1 Introduction**

Chapter four outlined the data collection and analysis process used and applied in this study. The fifth chapter explored the context of health planning process. This chapter elaborates and discusses the local health planning process gathered from Ilala Municipal Council and Morogoro District Council in the United Republic of Tanzania. The chapter responds to objective two of the study reading “To describe the local health planning process in decentralised settings”. The chapter begins by describing the planning levels followed the proposed members of the local health planning team. The third part presents the process of formulating Comprehensive Council Health Plan using planning spiral. In the fourth sections explores the roles of actors involved in the formulation of local health plans. This is followed by a section analysing how planning capacity is developed. Lastly, a chapter summary is presented. The results presented in this chapter apply to both Ilala and Morogoro District Council

### **6.2 Levels of health planning**

The health planning in Tanzania is decentralised. As described in chapter two, different countries implementing decentralisation in sub-Saharan Africa have almost similar levels of health planning commencing from national level to the lowest level within the hierarchy of health sector management. According to the respondents, Tanzania’s local health planning translates both health and health related policies as well as the development frameworks through the health sectors strategic plan (HSSP). The Health Sector Strategic Plan provides strategic direction for the health sector in almost all aspects of the health system. In addition, it provides list of indicators that define the envisaged results that each level of health planning need to focus on. During this study, the health sector was implementing strategic plan IV which ended in 2020. The health sector strategic plans are operationalized by medium term expenditure framework which is a three-year plan informing the annual operational plans of all levels. The health planning levels are set to ensure there is good alignment and linkages of the plans with the overall national development frameworks as illustrated in figure 6.1. Understanding the levels of planning is important as they broaden the

understanding of the expected interactions between actors within these levels and the power each actor has in making or influencing choices. The levels were found hierarchical aligned with the levels of decentralisation as will be discussed in the next section.



*Figure 6.1: key planning functions across the three levels*

It should be noted that, the role of the regions is basically provision of technical support and assessment of compliance of council health plans to national guidelines. It serves as an overseer and a channel to communicating policies and ministerial directives to councils as illustrated in the following quotes:

*“RHMT is responsible to oversee all councils. Whatever is announced by the ministry the region must be aware so you cannot do anything without informing the region and get an approval before submitting to the ministerial level. The ministry communicates with the region on what to be done according to the policy and the region communicate with the district and feedback is given through the same channel” (CHMT Member Morogoro).*

There was a similar view from other study area, quotation indicates that the role of the region in health planning is to ensure the planners adhere to national frameworks and guidelines this aligns to the written functions of RHMT.

### **6.3 The Council Health Planning Team**

According to the 2011 the following members should form the planning team-

1. Council Health Management Team Members (Managerial and Technical members)
2. Council Planning Officer
3. Council Health Accountant
4. Council ICT Officer
5. Representative from the Private Sector
6. Representative from NGOs
7. Representative of Faith based service providers (religious organizations, voluntary agencies)
8. Representative of the RHMT
9. Council Community Development Officer
10. Any other members whose involvement will prove relevant

Private sector and professional association is a group of actor relevant for health planning. The former is important as it plays part in service delivery as well as supplies of health commodities and the latter is relevant for ensuring quality of health professionals. The findings of suggest lack or very minimal engagement of professional association as important actor in health planning process

One respondent mentioned the inclusion of other sectors in planning for health. This indicates the broadening of health beyond what can be done by medical practitioners.

*Among the participants are community representatives and health workers. We also involve other department compared to the past where the ministry of health was involved but now even community development department*

*person and planning officer[.] this has been helpful (CHMT Morogoro district Council)*

At national level the MOH has introduced Health in all Policy initiative the health sector is promoting participation of central ministries, Ministry of Finance and Planning (MOFP) and President's Office – Public Service Management and Good Governance (PO-PSMGG) and other sectoral ministries including but not limited to those responsible for water, agriculture, livestock, fisheries, infrastructure, ICT and others that have impact in the health sector in planning for health. Cross-sector collaboration is promoted under the guidance of the Prime Minister's Office to ensure that the Health in All Policies (HiAP) approach is effectively implemented. However, when the data was collected this initiative did not cascade to council level

#### **6.4 The Process of formulation of Comprehensive Council Health Plan**

The local health planning process in Tanzania, is implemented under the context of Decentralisation by Devolution which sets councils as focal point for health planning and implementation. The planning process emphasizes a bottom-up planning approach. Figure 6.2 illustrates the three major phases of the Tanzania's local health planning process. Descriptions and activities implemented in each are described in the following section. The phases were identified from the data. However, this study focused on pre-planning and actual planning only.

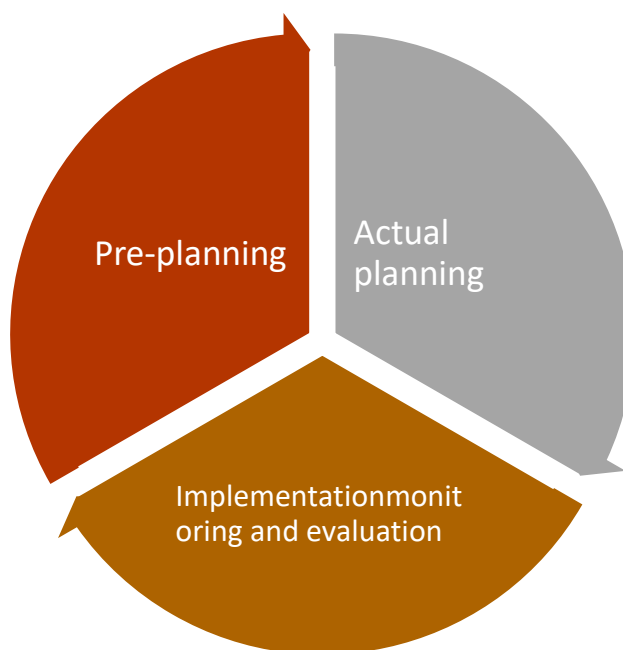


Figure 6.2: phases of the Tanzania's local health planning process

#### 6.4.1 Phase one: Pre-planning

The development of CCHP is informed by the performance of implementation of previous plans, community priorities, and the party manifesto (U.R.T, 2011; URT, 2017). The pre-planning stage was mentioned to be an overly critical stage in council health planning. It is in this stage where community priorities are identified. The planning process begins with community engagement where village/street leaders hold public meetings to identify development priorities.

*“In the planning issues our process begins at mtaa [street] level where mitaa leaders hold public meetings in order to identify their priorities areas...and if health sector is their priority, they are approved at ward level and submitted to the district council where even other ward have proposed their priorities for instance construction of RCH clinic, health centre or even hospital. Therefore, we start planning according to our budget by involving our experts. Is our budget enough to build a health center? Can we build by phases or can we focus on something else and build the health centre next year? We used to work in collaboration with our experts” (CMT Ilala).*

At pre-planning stage, the previous plan performance is assessed.

*we have CCHP evaluation meeting where we invite stakeholders to come and evaluate our previous plan and ask them what they think we should put in the future (CHMT Ilala).*

This stage constitutes several consultative meetings between CHMTs and facilities and between facilities, civil societies, and communities within the catchment areas (*CHMT Morogoro District Council*)

*“Initially only health workers were involved in planning and before planning but after reforms we now involve other stake holders including the community.”*

However, it was mentioned that the assessment of performance is watered down by lack of implementation of some activities due to delayed disbursement of funds.

*“.. we have to depend on grants from central government which sometimes the flow of the funds is not so smooth we get funds very late for instance for this financial year for the funds which were to be received from the central government we have received less than fifty percent for the development purposes you see! Until the end of the financial year we received less than fifty percent. In that way it means the activities which were planned to be executed during that financial year some have been implemented partly and some couldn't start at all a few could have been completed but most of the activities you see fifty percent it matters a lot “(CMT Ilala)*

*“The main challenge is delay of funds. For instance, the plan was presented in Dodoma since July last year but we received the first instalment in either November or December. Meanwhile there are so many activities which are not implemented while you are supposed to make new plan and fail to understand if the previous activities will get funds or I should proceed with new activities” (CHMT Morogoro district Council).*

#### **6.4.2 Phase two: Actual Planning: CCHP development process**

In this part the description and analysis of the CCHP formulation process is discussed (U.R.T, 2011). The analysis of the CCHP development process was done using Green (2007) planning spiral. The reasons why planning spiral was

used were discussed in chapter three. The stages applied in the analysis include: Situational analysis, priority setting, option appraisal and programming. Other stages such as implementation and monitoring, evaluation, and situation analysis two of the planning spiral were excluded in the analysis and in data collection because the scope of this study ends at the finalization of the planning document. It did not include the implementation of the plan as mentioned in chapter three.

The actual planning phase is planning write up phase. It is in this stage where the local health planners start the development of the planning document. The write up is done by a planning team chaired by Council Medical Officer.

#### **6.4.2.1 Situational analysis**

The situational analysis is the stage where relevant synthesis of information is conducted to inform the local health planners on the health needs. This analysis is done during planning workshop. This was said to include the identification of main causes of morbidity and mortality as well as coverage of services for some selected indicators that are nationally agreed. The main source of information was the District Health Information systems version two (DHIS2) and community meetings. However, respondents raised several factors that affect this phase. These include limited availability of quality data,, human resources shortage, limited digitization and multiple data demand from various actors that increase workload were mentioned as contributing factors.

*“In a facility sometime, you find you have only one clinician who is expected to do everything and then record patients. In most cases they do the work and start filling registers after work hour. You end up with guess work” (MOH official).*

At facility level still information was filled in Health Management Information System (MTUHA in Swahili) registers. They were referred to as “Vitabu vya MTUHA” meaning HMIS books. In most cases due to shortage of staff, health providers provide services first and fill the registers afterwards. The impact of not filling registers on time was mentioned to reduce reliability of data. For example, it was reported that in some instance there are inconsistencies of records from clinicians and the pharmacy or laboratory data. This was said to happen because



of lack of data use culture. Several reasons were brought forward about what leads to inaccuracy of data. Therefore, in most cases there are challenges of data reliability which makes difficulties in making decisions

*“In a facility sometime, you find you have only one clinician who is expected to do everything and then record patients. In most cases they do the work and start filling registers after work hour. You end up with guess work (CHMT ilala)*

the evidence provided illustrate that guidelines are intrinsic to the health sector in comparison to other sectors. The guidance on the situation analysis part, focuses on operational issues such as, ongoing program administrative requirements (Health Facilities planned for rehabilitation, construction under Primary Health Service Development Program (PHSD) and Summary of P4P Annual performance report Jan. – Dec), morbidity and mortality data, Status of Health Facilities (Dispensaries, Health Centres, and Hospitals). Less emphasis was found in the guidelines in terms of analysis of coverage of interventions and equity. This may contribute to narrowing the situational analysis scope.

Apart from the availability of quality data, analytical skills and interpretation were mentioned as another challenge in conducting good situation analysis.

*“First of all, we have to understand that most of our professional, data analysis and interpretation course was minor at a certain level of education. So, you can just see their level of education and the process of recording and processing them it is not an easy task. Basically, there is lack of awareness on why they should process those data so that they can be used for planning” (CHMT Morogoro district Council).*

*“Firstly, I think at facility level it is due to lack of knowledge and capacity to do analysis.” (CHMT Morogoro district Council)*

Firstly, situation analysis is affected by capacity of local planners to analyse and interpret the data. Secondly Although the electronic data system (DHIS2) was expected to ease data access and understanding of the dashboards in terms of visualization, this was not always the case because of frequent changes into the

system that shy away users. It was mentioned that features are changed frequently making it hard for users to interact with information.

#### **6.4.2.2 Priority Setting**

The priority setting was assessed in terms of how the process is guided, what considerations are included in priority setting and how community views are gathered and fostered. According to 2011 CCHP guideline the council health planners are directed to prioritize problems to be addressed given resource scarcity. In the guideline the section on priority setting is referred to as “problem prioritisation”. The guideline emphasizes the inclusion of national priorities outlined in national development frameworks. It also directs CCHP to also include Councils Strategic Plan priorities. There was a mixed opinions in terms of who sets the priority. According to the central level, the priority setting is done at the council level but within the framework of the national guidance. Therefore, the centre ensures that the local health plans align with policies, guidelines and procedures that are issued by the ministry of health as the technical sector.

*“The other thing is, to see into it that the process of planning is in line with the policies of the nation, which are issued by the ministry of health and social welfare and they also abide with whatever instructions provided by the ministry of health and social welfare because whatever guidelines we issue, whatever policies we issue, whatever instructions that we issue are actually intended to ensure quality health services to the people. So, the ministry of health is still responsible to oversee the expenditures done under the health issues, that are in line with our own guidelines” (MOH official)*

*“The technical things must be overseen by the technical sectors, so in a way, in terms of planning, yes, as the ministry of health, we are responsible of ensuring that the health sector plans, actually, are according to, coming from the local authorities, are in line with the policies, guidelines and procedures that are issued by the ministry of health as the technical sector” (MOH official).*

Alternatively, there was a feeling that the national level sometimes interferes with the local level priority setting. This happens when there is an emergency such as disease outbreak or when there is a new directive or sometimes when there is feeling that councils do not adhere to central government regulations.

*“And sometimes there are interference during planning, for example we expect the councils to come up with their own priorities but sometimes the central level interferes by issuing directives coming from the parliament” (CMT Ilala)*

*“Yes, critical examples are like when they say this year you have to plan for family planning, most of money should go for family planning it is not our problem or they can say this year you should plan for BBB (Baby Birth Breath) you have to plan for the babes only and most of the money should go to that part. But if you look at it is not our problem. You should not plan for construction using basket funds, no basket funds should be used in perishable goods, medical supplies, and medicine. You should not put things like development project for example in rehabilitation or major rehabilitation of the facility you are told no the basket funds should not be used like that one. So, something like that”. (CHMT Ilala)*

There were mixed opinions with regards to guidelines and instructions on what to do and what not to do. Some respondents thought it is contrary to the overall notion of decentralisation and hence interferes with the priority setting process. While the national level respondents thought it is an important tool to ensure that important aspects are integrated into the council health plan. For example, one council level respondent considered guidelines are means of controlling the local authorities. He felt decentralisation should be implemented with minimum central interference to enable the decentralised unit use the decision space as intended. The respondent considered guidelines restrict utilisation of the intended autonomy. He compares that act with giving someone food while squeezing his neck

*“[...] You decentralised power and give directives to a person. It is like giving a person food and while he is eating you squeeze his neck, so it is another*

*way of telling this person not to swallow the food because you have held tight his neck” (politician Morogoro)*

The guidelines were sometimes considered impractical. This because they are prepared at the ministry level with less involvement of the users.

*“[..]they just stay in their offices their office and draft guidelines and bring them here to be implemented, mind you, the community is not involved in the drafting of these guidelines. In that case they want things to be done according to their own interests. You cannot implement something which has been prepared by someone who was in the office and make decision because it becomes difficult when it comes to application practically. Other guidelines bring about unnecessary conflicts subsequently destroy everything” Politician Ilala)*

According to the above quotations local health plan priorities are on greater extent guided centrally, especially for things that must be included by all councils such as immunization while the scope of implementation is decided at council level. There is an implied imbalanced attention between the inclusion of nation priorities and that of the local level. The data indicates two major explanations for this. One, given the nature of the health sector there are issues related to prevention or curative services that have to be managed centrally. This will need instructions for the councils to abide to.

*“Okay, the central level provides guidance by giving guidelines, specifically, because the central level is looking at the national level issues, means that they have to guide things which are nationally required but must be implemented by the individual councils.” (MOH official)*

According to a council level respondent, the centrally proposed priorities do not differ much with the grassroots needs.

*“Actually, the priorities that are coming from the Centre they come as guidelines for us to base on... also setting our priorities. Yes, we normally*

*getting national priorities which in fact also address the priorities that are found at the grass root level. So, we base on that and it is not so difficult because when we say we want to improve the health status in our country it means when planning at the bottom we also refer to that” (CMT Ilala).*

### **6.4.2.3 Option Appraisal**

It was noted that option appraisal is not really done at council level despite it being stipulated in the guideline. This is attributable to capacity to analyse different available options. That is why the level of specification in the CCHP guideline is too detailed with examples on how to approach the planning process stages and what to include. Therefore, the options selected are based on the existing guidance. Respondents mentioned that the priority focus also comes with the instruction on the percentage of funds that need to be allocated to the specified priorities. The guidelines may specify even further, it sometimes provide instruction on allocations to a certain budget item.

*“Or you have to prepare a budget for HIV health provider’s allowances and training” (CMT Ilala)*

According to the 2011 guideline, the focus of the local health plan should be developed within centrally pre-determined council objectives. The following is council objectives as stipulated in CCHP guideline 2011 pg. 44

- Objective A: Improve services and reduce HIV/AIDS infection
- Objective B: Enhance, Sustain and effective implementation of the National anti-Corruption Strategy.
- Objective C: Improve access, quality and equitable social services delivery.
- Objective D: Increase Quantity and Quality of social services and infrastructure.
- Objective F: Improve social welfare, gender and community empowerment.
- Objective G: Improve Emergency and Disaster Management

For example, according to PORALG official CCHP is a tool for integration of health plan at council level. It cannot be made in a silo where it stands alone.

*“[...] I mean the, because they develop the plans, and if the ministry has something, it has to integrate the work. At the central level we can see that the decentralisation is not at that level of decentralisation, especially at the integration part, because at the district level it is purely integrated and all of the things are being integrated and formed within the comprehensive health council plans” Ministry Official*

#### **6.4.2.4 Programming**

Programming is the stage that was perceived easy and difficult at the same time for many reasons. Respondents mentioned local authorities depend on central grants in a greater extent. This is because resource capacity of local authorities is always low due to poor revenue collection. This makes programming challenging, specifically the component of revenue generation. Planning needs are many and internally generated resources are scarce.

*“Well, I could say most of the components of the reform program process are working but there are some which are not very adequately functional. I could say for instance the financial part I could see there still gaps especially in enabling the local government authorities to plan for revenue from their own sources. Most of the sources are not easy going I could say some are difficult you have to struggle hard...you must chase people...yes you must chase people in the street so that you can get the taxes you see! (CMT Ilala)*

*We need revenue to run our activity... to run our business we cannot collect enough revenues from our own sources it means we have to depend on the central government, grants from the central government and other development partners. When we depend much on sources from outside it erodes certain power... certain autonomy, you see the council can't plan its activities...it functions comfortably ..... but if it could raise enough funds from its own sources such bottleneck couldn't have happened because we could have been collecting our revenue and decide on what to do using our*

*own money at any time and that couldn't affect our action plan. So, depending on funds from central government or other development partners I could say it affects our capacity to exercise our roles freely (CMT Ilala).*

The central government is considered less challenged in terms of revenue collection in comparisons to what their counterpart are facing. The local government must chase taxpayers while for the central government, taxpayers normally go by themselves due to legal backing. Given such challenges it is difficult for local authority to continue with the identified priorities to programming as they are unable to finance them using locally generated revenue and central grants are not always enough.

*"It is unlikely the central government system whereby the taxpayers normally they go by themselves for instance the TRA are strong in collecting taxes. People...they go themselves to TRA but for the case of local government authority the collectors must follow the taxpayers which is sometimes difficult. Most of the businesspeople try as much as they can to avoid paying taxes especially to local government authorities. So sometimes we must apply extra force so that we can get the taxes. So, I think what is lacking I could say is the capacity to plan for alternative sources of revenue and the capacity to make follow up for collection of taxes. That is why I feel there is gap there "CMT Ilala.*

Respondents perceived the local government revenue base narrower as majority of sources are collected by central government.

*"For instance, the income tax we could share. Part could be collected the central government while partly can be collected by local government authority. I think there are some levies which normally go to the central government authority and they could be left to the local government authority. Also, the land rent is collected by the central government that could also left to the local government authority" (CMT Ilala).*

Another issue affecting revenue generation is exemption policies. The policy is focused on groups without stratifying them according to their ability to pay. Hence leading to challenges in generating internal revenue which ideally would lead to ability to meet the costs for things that are not centrally financed.

*“When you say a pregnant woman is not supposed to contribute maybe she is wealthy business woman, and her pregnancy has not denied her from contributing. These are directives which are meaningless because there are pregnant women who are even financially capable of running a school, has a child and can provide a huge support to the community. ...At least they would consider poverty. They should bring this matter to the lower level and be discussed so that we can tell them who can be given excuse but when they just decide pregnant women off course it is okay but for instance my wife is pregnant, but she has everything. It is just an example she can afford everything if you tell her not to contribute, she will be surprised” (Morogoro politician)*

The planning process is rendered cumbersome due to delays in provision of budget ceiling.

*If the central government issue the funds less than our plans it becomes trouble because we must cancel some of the activities to be in line with the ceiling. Off course no one would like his/her activities to be cancelled, then internal team conflict starts” (CMT Ilala)*

*“We are told to use the previous ceiling and a month before submission we are told that ceiling is released so we must sit and adjust. So that is the main challenge” (Morogoro CHMT)*

Given such situation the 2011 CCHP guidelines states that: i) The preparation of the CCHP should not wait for the budget ceiling, Councils should use previous years' ceilings as the basis for planning ii) It is essential for the respective authorities; MoH, PORALG, National programmes, NGOs and other partners working in the Councils to provide the planning team with reliable financial figures



in time. But it is also the responsibility of the CHMT to actively request for this information.

### 6.5 Health Planning Process Actors

According to the 2011 CCHP guidelines and responses from respondents, health planning process actors are several ranging from national level to community level. The national level actors include: Ministries: Ministry of Health and Social Welfare, Ministry of Finance and Economic Planning, Presidents Office Regional Administration and Local Government and development partners(URT, 2017). The regional level actor is a Regional Health Management Team. Council level actors include: Council Health Management Teams, Council Health Service Board and Full council. Community level: Health Facility Governing Committee. Figure 6.3 presents actors of local health planning process. Structures such as national assembly and full council these political structures approving the plans in alignment to the pledges made during the election.

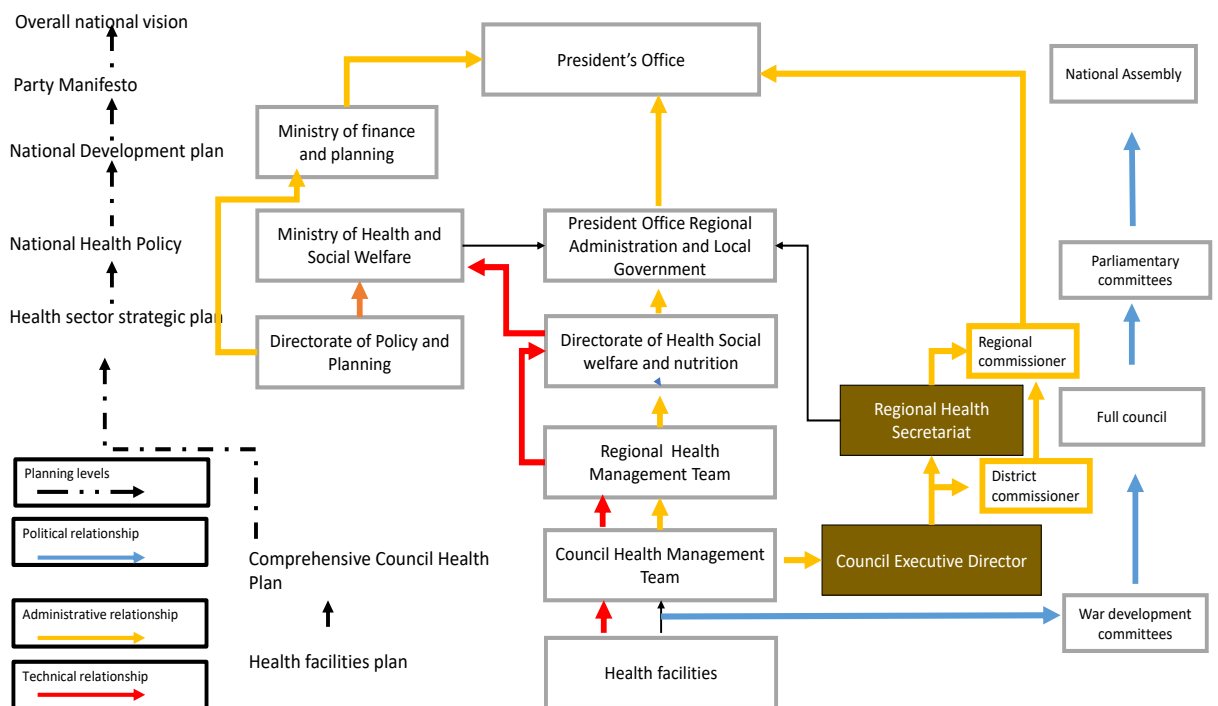


Figure 6.3: Actors in the formulation of local health plans

## **6.6 Roles of actors in the preparations of local health plans**

This section presents roles of national, regional, council and community level actors in the local health planning process.

### **6.6.1 Roles of National level actors in local health planning**

The national level in the context of decentralised health planning in Tanzania is comprised of i) Ministry of Health and Social Welfare, ii) the President' Office Regional Administration and Local Government (PORALG) and iii) Ministry of Finance and Planning. The planning levels that are discussed here have been identified from the interviews and from documents reviewed.

#### **6.6.1.1 Roles of Ministry of Finance**

The roles of Ministry of Finance and Planning includes among others the provision of budget guidelines as well as annual budget ceilings.

*“one thing is that the government through the ministry of finance gives guideline on the budget and ceilings this guideline doesn't mean that the money is in the basket, it is an assumption that the money will be collected through taxation it will be available it is also an assumption that the partners who have pledged to support the health sector, will disburse the money which they have pledged in time to be able to implement the plans which were all agreed in the health sector” (MOH official national level) (MOH, official national level)*

*“Apart from PORALG and MOHSW there is also ministry of Finance which used to give us their guidelines” (CHMT Ilala)*

As the above quotations highlight, the local authorities' budget is dependent on financing from MOHCDGEC. Therefore, councils will set their plans in accordance with what they receive from the centre. The plans are developed based on proposed ceilings. In most cases the ceilings are not provided on time. The planning seasons start while the official budget ceilings are not ready. To make the process going, the councils are advised to use the previous year's budget. In most cases the ceilings that are provided do not always remain the same as they

are based on the tax collection predictions and pledges by development partners who are part of the basket funding arrangements where the actuals do not always tally with the predictions. This was reported to be disturbing to the local authorities.

*“For instance, you can make a budget but when the ceiling comes is below the budget, so they want us to reduce the ceiling and the challenge arise on reducing some activities” CHMT member Ilala*

#### **6.6.1.2 Roles of Ministry of Health and Social Welfare**

The Ministry of Health and Social Welfare is mandated to be a technical ministry through government notice issued by the president of the United Republic of Tanzania<sup>1</sup>. The president issued a Notice on the assignment of Ministerial responsibilities (Instrument) vide Government Notice No.144 of 22<sup>nd</sup> April 2016. In that Instrument, the President has created a Ministry of Health and Social Welfare which is mandated for the formulation of;

- (a) Policies on Health,
- (b) Preventive and Curative Services.
- (c) Chemical Management Services.
- (d) Medical Laboratory Services.
- (e) Medical Research and Nutrition.
- (f) Food and Drug Quality Services.
- (g) Medical Supplies.
- (h) Promotion of Traditional and Alternative Medicine.
- (i) Health Services Inspection.
- (j) Family Planning.
- (k) International Health and Medical Organizations.
- (l) Coordination of NGO dealing with the functions under this sector.
- (m) Coordination of International Organisation under this sector.

Furthermore, the comprehensive council health planning guideline of 2011, identifies the following roles of Ministry of Health and Social Welfare.

Table 6.1: Ministry of Health and Social Welfare Roles in Local Health Planning

According to 2011 CCHP Guideline	Roles as mentioned by respondents
<ul style="list-style-type: none"> <li>• Scrutinize the Regions' assessment reports and recommendations to ensure that the Regions and Councils have correctly utilized the allocated funds, progress towards planned targets and status of implementation in line with the Council, Regional and MOHSW priorities guidelines.</li> <li>• Scrutinize the reports for compliance with financial regulations</li> <li>• Prepare the consolidated report to be submitted to the Basket Fund Committee. The report contains the following: <ul style="list-style-type: none"> <li>✓ A summary of health sector accounting returns including a recommendation for each Council</li> <li>✓ Summary of Regional and Councils' main achievements and challenges derived directly from collated Councils quarterly financial and technical reports by the RS.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Formulation of health sector policies, guidelines and regulations on quality</li> <li>• Resource mobilization and coordination</li> <li>• capacity building to CHMT and RHMT</li> <li>• Assess the plans</li> <li>• coordination of actors at national level</li> </ul>

✓ The means of overcoming the challenges.	
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The roles of MOH as presented in the CCHP guideline of 2011, appear to be more of oversight to ensure compliance to standards. Secondly indicate that MOHSW is the accountable organ to donor financing given to councils. However, in practice respondents

mentioned several roles that MOHSW play in the development of local health plans. The roles include i) Formulation of health sector policies, guidelines and regulations on quality ii) resource mobilization iii) coordination of actors iv) capacity building to CHMT and RHMT v) assessment and approval of plans. The details are presented below

*i. Formulation of health sector policies, guidelines and regulations on quality*

The main tool for which MOHSW communicates policies is through the planning guideline. The planning guideline illustrates priorities and also the linkage between CCHP with national strategic frameworks and sections guidelines. For example, in 2011 CCHP guideline the ministry stipulates the priority areas and sub areas of focus within the priorities including the set of selected high impact interventions. The 2011 CCHP guideline refers the local health planners to the National Package of Essential Health and Social Welfare Interventions (NPEHSWI). The National Package of Essential Health and Social Welfare Interventions (NPEHSWI) contains priority areas that must be covered in the CCHPs and includes the main diseases and health conditions responsible for the Burden of Disease in Tanzania as may be revised from time to time (Comprehensive Council Health Planning Guidelines, 2011-pg 24). In addition, respondents mentioned that, the guideline directs local health planners to also align their priorities with ruling party manifesto and the global priorities. The guideline also provides expenditures ceilings for levels of care within the councils and for sometimes goes further to specific budgets line as illustrated below:

*“Yes, we do receive guideline from the government and one of them is ceiling as we are told not to exceed a certain amount in this year and priorities should be included, if not the plan won’t be approved unless you re-plan.” (CHMT Morogoro district Council)*

*“Each fund for instance basket fund or block fund is allocated to its activities and we are not allowed to use for paying salaries, leave allowances, major construction and transfer allowances. we are only allowed to do rehabilitations.” (Morogoro CHMT)*

According to the PORALG official, resource allocation formular was managed by Ministry of finance and it was uniform for all sectors until 2004 when the need for a different consideration arose. The consideration was targeting education, health, agriculture, water and road sector. On the part of health sector in 2004 the resource allocation formular was based on population where the allocation set was 0.5\$ per capita. This was implemented until 2006. In 2007 the health sector evaluation noted limitations

in using only population as a basis. Councils have different context so achieving equitable distribution of resources other parameters were brought in. The annual allocation of funds to the Councils was based on a resource allocation formula, which took into accounts the following allocation factors:

- 70% in proportion to population
- 10% in proportion to poverty
- 10% in proportion to Under Five Mortality
- 10% in proportion to medical vehicle route

At implementation level, the fund was divided into cost centres. The allocation per cost centre guides the allocation of resources at Council level by type of provider or level of the health system. This form of allocation was for all sources of funds including cost sharing funds. With exception of Health Block Grants (OC) which was to be allocated to DMOs' Office. Health Basket Funds was allocated to six different cost centres. The cost centres were:

1. Office of the DMO
2. Council Hospital (Including Council Designated Hospital – CDH, Regional Hospital, which serve as Council Hospitals)
3. Voluntary Agency Hospitals (VAH)
4. Health centres ( Public and VA owned)
5. Dispensaries (Public and VA owned)
6. Communities

To each cost centre a certain percentage allocation range was provided as illustrated in Table 6.2

*Table 6.2 2007 Resource Allocation formular*

<b>Cost center</b>	<b>Allocation Ceiling Range within allocation to Council</b>
Office of DMO	15% - 20%
Council Hospital /CDH /Regional Hospital serving as a Council hospital	25% - 35%
Voluntary Agency Hospitals (VAH) / if none exists, this should be allocated to other priority health interventions in the Council	15% - 20%
Health centre (Public & VA owned	15% - 20%
Dispensaries Health centre (Public & VA owned	15% - 20%
Communities Initiatives in Health	5% - 10%

In 2011 the allocation formular was again adjusted as indicated in the following table

Table 6.3 Allocation formular Revised in 2011

<b>Cost center</b>	<b>Allocation Ceiling Range within allocation to Council</b>
Office of DMO	15% - 20%
Council Hospital /CDH	25% - 30%
Voluntary Agency Hospitals (VAH)	10% - 15% ( Service Agreement or None)
Health centre (Public & VA owned	15% - 20%
Dispensaries Health centre (Public & VA owned	15% - 20%
Communities Initiatives in Health	2% - 5%

The Planning team had a discretion to allocate within the range given range. The guideline provides that, allocation given to each cost centre should not be less than the minimum percentage or more than the maximum percentage provided for within that cost centre range. DMO office allocation included distribution and supervision related costs and cost for running the Council Health Service Board activities, while the Health centres and dispensary allocation included costs for operation of facility governing committees. For any Council specific peculiarities necessitating major changes to ceiling range given. Council are allowed to put a written justifiable proposal through RHMT/RS/PORALG for approval by HBFC before finalization of the Comprehensive Council Health Plan. According to the CHMT this option was available but was hard to implement as the process was cumbersome. In addition, there were restrictions by type of expenditure aimed at maximizing expenditure on actual service provision targeted to the clients. The expenditure is illustrated in table 6.4.

*Table 6.4.: Ranges and guidelines on resources allocation by type of expenditure*

<b>Type of Expenditure</b>	<b>Allocation Ceiling/ Range</b>	<b>Examples of Expenditure</b>
Allowances	Maximum 25%	Allowance for supervision, distribution, outreach, short trainings
Transport	Maximum 20%	Fuel for supervision, and maintenance of vehicles and fares
Minor repairs/ Maintenance	10 -20%	Planned preventive maintenance of technical , medical equipment and health facilities



*ii. Resource mobilization and coordination*

Another role MOHSW plays is to mobilise resources from donors to offset budget deficit within the health sector and ensure proper coordination of development assistance. This is done through Sector-Wide Approach (SWAp). It is the mechanism that has been adapted since the introduction of health sector reforms in 2000. It is the platform that brings together Government, Development Partners (DPs), the Private Sector (PS) and Civil Society Organisations (CSOs) to coordinate, harmonise and align resources for the common goal. The objectives are to reduce duplication, lowers transaction costs, increases equity and sustainability, and improve aid effectiveness and health sector efficiency (MOHSW 2019). The approach focuses government leadership towards:

- A sustained partnership of all main sector partners;
- Developing and implementing a single sector policy that addresses public and private sector issues and is supported by all significant sector partners;
- A common, realistic expenditure program which supports the sector policy;
- (MOHSW 2019) Broadening policy dialogue through defining clear mechanisms for policy dialogue and consensus building;
- Defining common monitoring and review arrangements;
- Greater reliance on government financial and accountability systems.

*iii. Council Health Plans assessment*

Respondents indicated the role of assessing the plans and recommending them for approval for funding as amongst roles of MOH and PORALG. This is done using the CCHP assessment criteria. The aim of the assessment is to ensure the plans comply with Health policies and technical and financial guidelines. Then the plans are presented to the ministry of finance for further scrutiny

*the guideline instructs you to follow the criteria. After finishing your plan, you do self-assessment to see if you have followed the required criteria, if*

*you are satisfied you submit it and are ranked. If you score below the pass mark, they send it back to you so that you can make changes (CHMT Ilala)*

However, some respondents seemed unaware of the criteria used for assessing the plans because the team knowledge about what is required in terms of assessments lies with few individuals who are set to finalize the plan.

*“You know when we finalise the draft another team finalize the planning process, but we don’t know the assessment criteria though I know they rank according to the arrangement and preparation. (Morogoro CHMT)*

It was reported that there are instances where the CCHP additional criteria are created which were not indicated in the guideline. For example, the 2011 guideline did not provide which percent of money should be allocated to medicines and consumables. Due to the complaints of out of stock in public facilities, a deliberation was made that there should be earmarked percentage of funding for medicine and consumables. This was sent as planning directive to the councils. This illustrates that the centre can guide the planning process at any point and through other means of issuing directives.

*“...they can ask you how much you have allocated for medicine but there is no place where it is written that you should put let’s say 30%. You can’t be awarded five points simply because you didn’t fill the medicine component.”  
(Morogoro CHMT member)*

Such instructions in a way affect the extent to which local priorities survive throughout the planning process.

The respondent’s perception with regards to guidelines was mixed. Some thought the guidelines will be considered good if they provide an opportunity to include local priorities.

*“In most cases we accept them because there is room for local priorities”  
(ilala CHMT)*

Another respondent thought it is a must to observe the instructions stipulated in the guideline so it is not something that one may debate against it.

*For example, we receive budget guidelines from the central government through the ministry of health and PMORALG, so in planning process we must observe the instructions which come with the budget guidelines (CHMT Ilala)*

Another respondent thought so long there is a national priority, the centre has to provide guidance and instructions to ensure that local level include national priorities in local health plans.

*“The central level provide guideline specifically...because the central level looks at national level which means they have to guide the things which are nationally a priority, but it is being implemented by individual councils, which is the same (Morogoro CHMT)*

Some respondents thought it somehow interfered with local priorities.

*“But when you look at it deeply it seems as if it is not really the bottom-up approach type of planning many of the things they do come from the top. For example, you can have your health problem, priorities and what, we discuss as a team but there are things that do come from the centre. No, this year you should not plan for this you should plan for this, so most of your budget should go to this thing and not that one which you have planned so that is the problem I think.” (CHMT Ilala)*

According to the central officials the role of the ministry is to ensure control of the local affairs and this is done through issuing policies, guideline and standardization of tools.

*“So, I would say that, the centre, in this case the Ministry of health and social welfare and PMORALG because we cooperate with them, sets the policies according to the national health policies, guidelines and looks upon the standardization of the tools that the regions and the councils are using. So, in short, the council level is the implementing level, and the Ministry is the controlling level in terms of guidelines and policies” (MOH official)*

### 6.6.1.3 The roles of President' Office, Regional Administration and Local Government (PORALG)

Before stipulating the roles of PORALG in local health planning, a brief description of the ministry is provided including its roles, functions and power according to the 1977 constitution of the United Republic of Tanzania and according to the Act establishing local government.. It is important to describe where PORALG derives its legitimacy to assume the decentralised roles. PO-RALG gets its mandates for Article 8 (1) 145 and 146 in the 1977 Constitution of the United Republic of Tanzania page 77.

1. There shall be established local government authorities in each region, district, urban area and village in the United Republic, which shall be of the type and designation prescribed by law to be enacted by Parliament or by the House of Representatives.
2. Parliament or the House of Representatives, as the case may be, shall enact a law providing for the establishment of local government authorities, their structure and composition, sources of revenue and procedure for the conduct of their business.

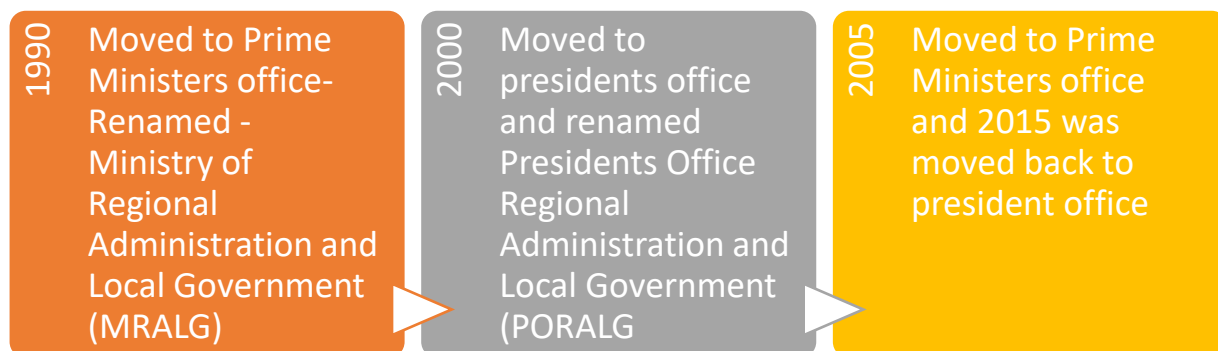
However, the provisions of the constitutions are vague in terms of their functions, composition, roles, responsibilities and entitlements<sup>1</sup>. Their roles and functions were itemised in 1982, when the Parliament of the United Republic of Tanzania enacted Local Government No 7 (Cap 287) Act and the City Authorities Act No. 8 (Cap 288), giving the Minister dealing with regional and local government authority over the establishment of District, Village, Street, and Local Authorities. With regards to health, the Acts stipulate broad and specific responsibility of local government-table 6.5.

Table 6.5: Broad and Specific roles of local government

Broad	Specific
<ul style="list-style-type: none"> <li>▪ Maintaining peace, order and good governance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Basic health care. Local governments are responsible for promoting public health and the establishment and maintenance of hospitals, health</li> </ul>

<ul style="list-style-type: none"> <li>▪ Promoting social welfare and economic well-being</li> <li>▪ Subject to national policy, promoting economic and social development</li> </ul>	centres, maternity clinics, and dispensaries.
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There are challenges of where exactly this ministry will be placed and different regime positioned it differently as illustrated in figure 6.5.



*Figure 6.4: Shifts of Management of Ministry of Local government since 1990s*

PORALG roles in local health planning is to a larger extent coordination of preparation of the annual plans and communication of central directive regarding planning. In practice sometimes PORALG break the line. Some respondents thought there are overlaps between the roles of MOHSW and that of PORALG following the implementation of decentralisation especially in guiding plan. According to the respondents this has been a persistent challenge to the CHMT team. Several instructions coming from two different ministries sometimes confuse the local health planners.

*“What I can say is, now I am responsible to two different ministries: [...]. For me it becomes somehow difficult because everybody has different policies which I must implement them. So, they bring the policy from the ministry of health as a District Medical Officer I have to implement. Local Government also bring the policy which I must implement (CHMT Ilala).*

One respondent mentioned that there was poor communication between ministries sometime involved in local health planning. This happened when councils were implementing Pay for Performance (P4P) initiative. Due to donors needing government to take over some of the costs, Councils were instructed to budget the payment from their block grant allocations. It seemed Ministry of Finance was unaware of this arrangement. Councils were to reallocate the P4P budget to medicine so it is a redo of the plan.

*“When we sent it to the treasury they were surprised because they were not aware of it So treasury told us we are not aware of P4P and since we don't have and directives so you can't get this money otherwise you have to reduce it. That was a challenge. That means there was no communication between the ministry of finance and treasury- (CHMT Ilala)*

Another challenge of several instructions coming from the centre was the instance where Ministry of Finance wanted all councils to use PlanRep while Ministry of Health and Social Welfare was not comfortable with the system. PlanRep is an electronic tool set to support councils to plan and report.

*another thing regarding guidelines is that; we also face challenge when plan REP II was introduced because the ministry of health refused us to prepare budget according to plan REP II by then. So, we faced a lot of challenges in preparing plans because treasury wants plan REP, ministry of health wants excels just imagine all the inputs you included into plan REP III you have to do them in excel. So, we face those kinds of challenges a (CHMT Ilala)*

#### 6.6.1.4 Roles of Donors Group

It was found that donors' engagement in health planning process in several ways such as provision of resources, capacity building for planning, supporting review and preparations of guideline through technical or financial assistance, oversight of alignment of plans with priorities as well as adherence to financing conditions

*"We are a donor to the health sector here in Tanzania. We provide funding to the government health basket fund (Member of DPG-Health*

*"We also support various partners to the health system. So, our role is a donor and also technical support... policy support at national level"*  
(Member of DPG-Health

It was found that roles of donors especially the bilateral is situated mostly at the central level where they participate in review of guidelines and policies

*"Okay as a donor most of our work is absolutely national level not at the district and regional level. We participated in the review of the CCHP guidelines back in 2010. So, we input that into CCHP guidelines particularly how the health basket funds will be used. Obviously, it has to go into the planning process at district level"* (Member of DPG-Health).

Another way in which donors engage in local health planning is indirectly by shaping policies. The respondent report, this is done through Joint Annual Health Sector Review. In this meeting it was reported that donors shape annual policy priorities for the coming year and the priorities are forwarded to councils and regions for actions

*"We also participate through the joint annual health sector review in identifying, shaping policy priorities for the coming year and they are translated downward to the districts and regions. translated downwards to councils and regions"* (Member of DPG-Health).

Furthermore, donors also support MOHSW in analysis of district level data to establish inequality which inform funding distribution decisions.

*I was very happy in looking at how districts are spending their money and making recommendations on that. Again, through the joint sector annual review, for example last year work very close with Dr. Anna in helping her prepare her presentation for joint annual sector review which was very well received it and showed a lot of inequities across districts (Member of DPG-Health).*

Furthermore, through district analysis shifts on how districts should be financed occur as quoted below

*“[ ....]and it led to increase focus on financial resources and most recently because of health basket fund and the new MOU and the implications to districts and regions we are developing communications to be delivered to the districts and regions. First of all, we prepared a presentation to RMO and DMO conference which highlighted the implications and changes that the districts would have to make into their plan so that they could achieve the results and priorities of the basket funds that will trigger the release of funds. So that was it. That is how we are more directly influencing planning at the districts and regional” (Member of DPG-Health).*

#### **6.6.1.5 Roles of council level actors in local health planning**

Actors at council level include: i) Council Health Management Team (CHMT) as technical organ ii) Council Health Service Board (CHSB) as the representative of community and the Council Management Team (CMT) as the managerial organ overseeing activities of all departments within the council.

### **6.7 Roles of Council Health Management Team**

The roles of councils were the same. The main role is to develop the Comprehensive Council Health Plan and ensure comprehensiveness. In doing so according to 2011 CCHP guideline they are expected to prepare CCHP, support health facilities during planning, submit CCHP for approval and respond to comments related to assessment of plans. These are discussed as follows



### **1: Prepare Council Comprehensive Health Plans (CCHP).**

Respondents reported that decentralisation created a shift from top-down instruction to bottom-up planning. One respondent said

*“Initially they were just instructed do this and we were not planning on our own but now we are planning on our own because we know our problems in our district. If you don’t have medicine, you can order according to your demand and types of diseases such as malaria.”*  
(CHMT Morogoro).

Another respondent recalled the previous experience where they would receive boxes of medicines that actually they did not need them. The central decision was guided by assumption that certain seasons are associated with outbreaks and bring medicines responding to those assumptions

*“Government used to pack boxes of medicines and bring to you without knowing what kind of medicines you want. for instance, during rainy season the government think there will be outbreak of diseases so they may bring you medicine while you are not in need of that but now medicines are ordered by respective facilities according to their needs”* (CHMT Morogoro district Council).

In assuming this role, CHMT are required to coordinate and actually engage in the analysis of previous year’s implementation of the CCHP to guide discussions of the next year’s plan. Also, CHMT are supposed to gather community opinions regarding priorities and challenges in accessing health care services to inform planning process

### **2: Support Health Facility teams in developing Health Facility plans**

Health facility plans are prepared by health facility management teams in collaboration with health facility governing committees.

### 6.7.1.1 Roles of Council Health Service Board (CHSB)

The sections 4 and 5 of Council Health Service Board Establishment Instruments of 2001, established and stipulates the members of the board. The CHSB comprise of ten members. Four members are drawn from service users (two females and two males), two members are drawn from the nongovernment health service providers (one from voluntary agencies and one from private for profit), one council who heads the department of social services and three technical members (planning officer, District Medical Officer and one member from Regional Health Management Team). The roles of Council Health Service Board include:

- To ensure population receive appropriate and affordable promotive, curative, preventive and rehabilitative health services.
- Discuss and amend health plans and budget and submit to council.
- Receive and analyse implementation reports from Council Health Management Teams.
- Identify, mobilise and solicit financial resources for running council health services
- Support Council Health Management Teams in managing and running of health service.
- Prepare and recommend a council wide health plan and budget to the committee responsible for health services.
- Promote sustainable infrastructure and reliable logistics and supply system.

According to respondents the Council Health Service Boards are less active and the roles stipulated in the instrument were perceived very far from what they do. One respondent mentioned that the Board is not planning but rather receives the already set priorities from the central level. Their role is to see if the community priorities have been included as illustrated in the following quote:

*“Health board is not the implementers so they are brought what is prepared by the officers and they do compare with the original ones. If they are similar.” (CHSB member Morogoro).*

This finding concurs with other studies which found that the roles of CHSB is limited and basically is rubber stamping the plans. The weaknesses of CHSB were

associated to limited capacity building on their roles and functions (Mollel and Tollenaar 2013, Maluka and Bukagile 2016).

#### **6.7.1.2 Roles of health facility level actors in local health planning**

At ward and village levels actors responsible for health planning are Health Facility Governing Committee (HFGC). Membership in these committees is drawn from different stakeholders, including community members who receive health services from these facilities, ward and village leaders and representatives of health service providers for both profit and non-profit health facilities operating in the area served by the facility.

*“Below council health service board, we have the health facility government committees which are for each facility, then again they help to oversee the health facility under that decentralisation arrangements, and these are formulated legally because they were mandated under the instruments and bylaws to support the health sector” (MOH official)*

The key roles mentioned by respondents include gathering community priorities and participating at facility planning. The committee members mentioned that because they are staying in the same community, they gather community needs both formally in meetings or in the informal gatherings

*“We come from the community and we interact with them in the meetings in the streets where problems are being discussed, the head of street government is one of the members in our committee, he takes those problems and discuss them in the committee meetings then we set strategies and eventually to the implementation” (Health facility governing committee member Ilala)*

*Despite sorting out and prioritizing needs from the community we also conduct meetings with facility in-charges and those meeting are our opportunity to talk to our municipal leaders especially the District Medical*

*Office to tell them the most disturbing chaos and which should first be addressed. Therefore, they sit and discuss their financial capability and according to their position they tell us which chaos they will start to implement and which one should follow later. (Health facility governing committee member Ilala)*

Health Facility Governing Committees have several encounters with health facility management teams. This increases their interactions with the health facility and hence with the planning process. HFGC are involved to verify medicines and supplies, they are the ones to handle community complaints and also to link health facilities with the community. Unlike CHSB, which has limited encounter with the health facilities as they are not tied to any health facility. This limits their interactions with district health department although they are expected to participate in health planning. Literature and also findings of this study indicated limited capacity of this structure which make their participation in the planning process less effective. It was also noted that, the effect of HFGC's activeness in the local health planning process did not necessarily translate into improvements on how local priorities were considered or attended. This is because it all depended on the availability of funds. As discussed earlier local authorities depended much on central grants for financing of local health plans. It will be interesting to know if the situation is different in the context of Direct Health Facility Financing. This could be one a future research area

## **6.8 Capacity Building for Planning**

It was found that developing local capacity for planning is not a systematic process among all CHMTs. It happens in an ad hoc manner responding to new format, new program or updates. Few international and local NGOs reported to provide training on health planning. Some respondents mentioned that they had planning training as part of their degrees and also were oriented on the formats, guidelines and tools used in formulating council health plan. Furthermore, CHMT members participate in the planning process but the finalisation of plans is left to those who are conversant with the formats such as health secretaries. Ilala had a dedicated

member of CHMT who had a role of coordinating planning activities. The planning training was provided to selected few CHMT members with the aim that, the trained ones will capacitate those who did not get the opportunity.

## **6.9 Chapter summary**

According to the policy documents health planning is decentralised with clearly stipulated roles. A mix of bottom-up and top-down decisions experience was found. Generally, health planning was found to be deconcentrated than devolved. In chapter three - table 3.2, I presented literature regarding the responsibilities that are deconcentrated and devolved. The findings of this study, indicate that, the responsibilities entrusted to local authorities is a mix of deconcentration and devolution. It was found that in some aspects, especially those of national concern, the responsibilities are deconcentrated. Majority of the must plan aspects are included in the priority areas discussed earlier. The stages exposed to central influences are priority settings and resource allocation. This is because what is prioritised depends highly on finance availability and whether the priority is within allowable expenditure. It was found that all councils follow a standardized health planning process. The process is set to ensure is aligned with planning guidelines issued by Ministry of Health, Presidents' Office Ministry of Health and Local Government and Ministry of Finance. The allocation of resources to councils is guided by resource allocation formula that takes into account several factors such as population, the burden of disease and health systems constraints of the councils. To avoid misappropriation of funds, expenditure ceilings were set. Several alterations were made in expenditure ceilings which they sometimes broadened and sometimes narrowed local decisions space. Changes in restriction on expenditure ceiling were aggravated by variety of reasons, these include addressing equity, addressing health commodities shortage or controlling expenditure on items that are easily prone to abuse. Poor adherence to procedures as provided in the guidelines connotes poor performance in the assessment of plans. Capacity limitations have been the reasons leading to re-centralisation either formally or informally.

Furthermore, it was found that financially and structurally central government is more powerful than the local government. Hence the findings suggest unequal space between central and local governments concerning decision-making hence during planning process. Administrators were found like an extended arm of the Centre. Administrators consider decision space is broad-based on written policies and not actually what is happening in practice. Majority of local planners expressed realities in how the decentralisation is practised and considered the decision space is narrow in some aspects and broad in some aspects.

The study findings suggest that, less has been done to make planners acquire planning skills, but a lot has been done to orient planners with required format, regulations and policies that they have to adhere to during planning. Therefore, planners' capacity on planning techniques is watered down which negatively influence the analytic and reasoning capacity of local planners. The next chapter provides an in-depth analysis of how the relationship between the centre and council health management team influences local health planning process.

## **Chapter 7: The Central local Relations in the Formulation of Comprehensive Council Health Planning in Tanzania**

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### **7.1 Introduction**

Chapter six presented the process of formulation of Comprehensive Council Health Plans. This chapter presents the central-local relations in the development of Comprehensive Council Health Plans in Tanzania. The chapter responds to objective three of the study reading “To understand and explore the central –local relations in local health planning”. The quotations used are based on interviews with respondents and extractions from documents. There are six sections in this chapter. Section one classifies central level and local level actors and illustrates their mandates. The second section presents the objective of central-local relations in the process of formulation of Comprehensive Council health plans. The third section presents types of relationships in the process of formulation of Comprehensive Council health plans and analyses their application, as the main findings of the study. The fourth section outlines factors influencing central-local relations during development of local health plans. The fifth section provides the summary of key findings of the chapter. The results presented in this chapter apply to both Ilala and Morogoro District Council

Chapter two identified the features of central-local relations to include legal backing, operationalised by individuals with hierarchies and involves exchange of resources and information and the exchanges are happening within formalize regulatory frameworks that govern the behaviours of the interacting parties (Dunsire 1981, Rhodes 1999, Agranoff and Radin 2015). The analysis of actors was based on these features.

### **7.2 Classification of Actors and their mandate**

In chapter two, central-local relations were defined as the relationships between central and local government. It was further mentioned that the term central and local governments broadly denote two levels of government whose power and

behaviour are mainly determined by their different power derived from access to resources and constitutional norms. This section identified the central government and local governments actors and establishes the origin of mandates and power they have. In chapter two the features of central and local governments were identified and one of it is the legal backing.

### **6.1.1. The Central Level Actors and their Mandates**

The central – local relations actors who interact during the formulation of Comprehensive Council Health plans include government ministries, the parliament and donors, their mandates, roles and interactions are discussed below.

#### **A: Mandates of central actors (legal backing)**

The constitution of the United Republic of Tanzania of 1977, section 4 (2) provides that,

*“(2) The organs vested with executive powers shall be the Government of the United Republic and the Revolutionary Government of Zanzibar; the organs vested with judicial powers shall be the Judiciary of the United Republic and the Judiciary of the Revolutionary Government of Zanzibar; and the organs vested with legislative and supervisory powers over public affairs shall be the Parliament of the United Republic and the House of Representatives”.*

This means that, Ministries and individuals within central and local government have the hierarchical power in the areas of their jurisdiction. Furthermore, the 1977 constitution of Tanzania in section six defines government as

*“6. In this Part of this Chapter, unless the context requires otherwise: - the Government includes the Government of the United Republic, the Revolutionary Government of Zanzibar, local government authorities and any person who exercises power or authority on behalf of either “Government”.*

Furthermore, the planning guideline stipulated who are the government actors and who are the political actors. The government actors include: government



ministries, regional administration and local authority level. At regional and local authority level organs such as Regional Health Management Team, Council Health Management Team, Health facility Management Team, Health Facility Governing Committees and Council Health Service Board who have been legally established fall in this part as any person who exercises power or authority on behalf of either government in local health planning process. Figure 6.1 identifies actors responsible in the planning process as conceptualised from the provision of the 1977 constitution of URT and from planning guideline. In chapter six actors in the local health planning system were identified and their roles were presented. In this chapter I will deal in identifying their mandates, power and also their interactions during the formulation of Comprehensive Council Health Plan. Figure 7.1 presents local health planning Actors as conceptualised from the 1977 Constitution of the URT and Planning guideline

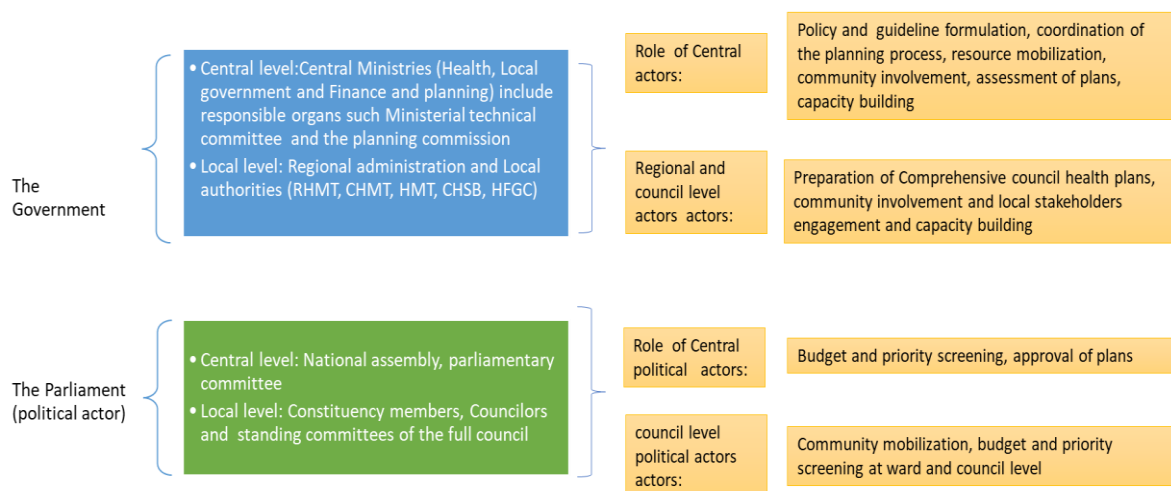


Figure 7.1: Central-local relations actors

Development partners such as the international donor agencies, known as development partners such as (but not limited to this) Irish Aid, USAID, DANIDA, JICA and UN agencies and Civil Societies supporting the local health plans in terms of financing and or other forms of capacity building was another category of local health planning actors. In this study this group is termed secondary actors. It

was found that the government reports to development partners about council health plans and also report the expenditure on implementation of local health plans. DPs are provided with an overview of where the investments have been directed in that planning period as illustrated in the following quote:

*“The other one is, we do report to our development partners where we have different meetings, we have the technical working group, where we have to report the matters of local government authority in the decentralisation system, the plans, the implementations, the reports, and the expenditures”- PORALG official.*

The engagement of the development partners in local health planning is not direct. It is through the central government. Sector- Wide Approach as defined in the Tanzania Health Sector Wide Approach (SWAP) code of conduct between the Government of Tanzania and the Cooperating partners in the health sectors as of 2020 as;

*“An approach to international development that "brings together governments, donors and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities” pg. 3*

One respondent mentioned that SWAP is operated through technical forums, such technical committee abbreviated as TC-SWAP. SWAP bring together Development Partners who support the health sector through basket and outside basket financing mechanism. The roles of TC-SWAP serve as a joint monitoring body of the goals and activities of the health sector as outlined in the Health Sector Strategic Plan, Medium Term Expenditure Framework and Comprehensive Council Health Plans. Plays an advisory role on planning and implementation of health services. Other mechanisms include Basket Financing Committee and Joint Annual Health Sector Review as illustrated in the following quote

*“Again, we have to report to the basket financing committee, it is another forum, we have the TC SWAP forum which takes all DPs not only the basket financing but other health Development Partners Group (DPG-Health)- under the TC SWAP. We have again, the joint health sector annual review,*

*where we still report the implementation of the local authorities at the central level, reporting the accountability on behalf of the local government”*  
*PORALG Official*

### **7.3 The objective of central – local relations in local health planning process**

The analysis of the ministerial functions and responsibilities stipulated in the Government Notice No.144 of 22nd April, 2016, indicates that, the focal Ministries in local health planning are Ministry of Health and Social Welfare (MOHSW), President Office Regional Administration and Local Government (PORALG) and Ministry of Finance and Planning (MOFP). These are central level government actors who have technical and administrative linkages with lower-level structures. The roles of these ministries are to fulfil the main objectives of the government as stipulated in 1977 constitution of the United Republic of Tanzania - section 8:1 (b) which states that

*“The primary objective of the Government shall be the welfare of the people”*  
 URT 1977 constitution pg. 13

This role is translated into action through formulation of long-term national vision, five years development plans and health policies which is translated into sector strategic plans as well operationalised through annual ministry departmental plans and annual council health plans.

The constitution further stipulates in section 8:1 (b) that the Government shall be accountable to the people. Accountability to people mean on variety of aspects through planning and accounting of expenditure. In chapter two section 2.2.4 it was discussed the central-local relations objectives differ depending on the level of governance. The central levels perspective varied in terms of the objectives. One ministry of health official said the objectives of central-local level relations is to devolve decision making power to local authorities so that they can address their local needs. The respondents further mentioned the intentions of decentralising planning. The councils have different problems so addressing

everything from above is not possible. So, planning has to be bottom up as indicated in the following quotes

*“The goal was bottom-up planning. You can’t plan centrally and yet to have effective of planning. Bottom-up planning objective is to accommodate or to allow the district to plan according to their needs under proper guidance because the districts context differ, each district has its own needs and the profile of health problem is different from one another. So that is the reason we thought probably let’s give a room for a district specific needs to be included rather than prescribing from above. By so doing the will plan for intervention that are properly targeted to the locality in other words you can’t have the solution from outside. The solution always can be generated where it starts” [Ministry of Health Official]*

*“The aim was devolving the power and resources to the local authorities which is devolution of power. The aim was to make capacity of the lower level to plan, to budget to monitor and implement intervention at that level. And the muscles come from the point of providing them resources and devolution without resources may not even work you need to devolve with the resources. Number of failures because they don’t devolve resources” [Ministry of health Official]*

The findings indicate that, achievement of the bottom-up planning is highly dependent on planning and management capacity of the councils in assuming decentralised roles. Ministry official mentioned several interventions to ensure that councils are capable of handling the roles. This includes preparation of guiding tools such as planning guidelines and assessment tools. According to the ministry of health official these tools help in managing the process of fiscal decentralisation as illustrated in the following quote

*“So, in Tanzania 1999 we started devolving the power with resources so the district could have their planning capacity. central level will only be responsible for producing guidelines, policies and guidance while the region should be able to translate those policies and guidelines for the district to be able to plan implement, evaluate and monitor their intervention. To*

*support this at the lower level we were able to develop the planning tools for the district one of them was the minimum package or minimum services. The other one was the development of comprehensive health planning tool to guide the district to be able to plan both resources as well as intervention”*  
*[Ministry of Health Official]*

The same notion was presented by the CHMTs and Council Health Facility committees and Council Health Boards where they consider the benefits of decentralisation being a chance for them to plan according to their needs. However, it was found that the local priorities that went into council health plans were those aligning to central priority areas. The planning guideline provides list of priority focus and also the assessment of plans are also aligned to those priority areas including adherence to budget conditions. So basically, it was found that, the objective of central government is to ensure that, central priorities are included in local health plans. The local government was found to also focus on central priorities than local priorities. It was found that in many cases when it comes to planning for health services the councils base their plans on priorities area which are presented in essential health intervention package and also emphasised in the planning guidelines(U.R.T, 2011). In additional the plans are also aligned to development visions and party manifesto(URT, 2017).

Furthermore, in chapter six various ways in which the centre engages with local government were discussed. The models included bargaining, power dependency, principal agent and organisational model (centralisation vs decentralisations). It was found that the main objective of the centre is to ensure health planning is leading to implementation of health sector policy (defined at the MoH) and is in line with election promises. It was further found that since the centre has more access to generated revenue it is financially stronger than local government. Hence the framework of engaging the local level is more of a principal – agent relationship. For example, one respondent MOH official divided the two levels into two functioning bodies. Central being “*controlling*” level and local being “*implementing*” level. The respondent further was asked to elaborated why the relationship was considered being “*implementer-controller relationships*”. The

response was because policies and guidelines are being set by the central level. The implementation is done by the lower level as per the policies and guidelines. This is illustrated in following quote:

*“So, in short the council level is the implementing level and the Ministry is the controlling level in terms of guidelines and policies” [---] It is Yes in such a way that the policies and guidelines and all that are being controlled by the central level”. MOHCDGEC Official*

When the respondent was asked if such relationship interferes with local decision making, the answer was both Yes and No. Yes, is when the centre controls the policies and guidelines. No is when the locals plan on their own. Sometimes the centre may interfere with local decision making when there is epidemics, emergencies or when there is a directive from parliament. This is illustrated in the following quote

*“It is. Yes in such a way that the policies and guidelines and all that are being controlled by the central level. The implementation is ought to be done by the lower level. But again, you have some issues whereby there is direct interference from the central to the implementation side on issues that are sometimes basics, such as if there is epidemics, urgencies, ... but sometimes the central level interferes depending on the directives coming from the parliament.” MOHCDGEC official*

The local health department's interest is basically to fulfil its roles and ensure that the plans are within the acceptable format and all considerations in the guidelines were adhered to in the process. This include assessing the previous plan performance, and develop the annual plans taking into accounts allocation and technical guidelines. Staff at local authorities consider themselves as implementers of policies. For example, local staff identified their role to be conducting localised analysis of the centrally directed priorities and address them in planning

*“You know in the national plan priorities have already been set for example the priority is the maternal and new-born. What is important is how do they*

*manage to analyse the problem for the maternal and new-born and health? I think we have about twelve or eleven priority areas. So, we follow those priority areas. It is a kind of national set". RHMT Morogoro*

It was further noted that the local actors were willing to accept what was proposed by the centre. Some respondents mentioned having national interests does not mean the centre interferes on local matters. Ideally the interest determined centrally constitutes issues affecting the country in general. However, planners at local level still have to prioritise on solution and issues to address priorities dependent on their local environment.

*"...let's say, if you talk about maternal health, it is a national problem...but the council may differ from one another in terms of the magnitude and the contributing factors. Therefore, in the choices of interventions they may have to prioritise solutions suiting them most -- that doesn't interfere council in addressing their priorities" RHMT member Morogoro*

The fact that the planning process is centrally guided technically was considered okay. One respondent mentioned that having guidance on what to include is a good mechanism for ensuring the meagre resources are used wisely as illustrated in the following quote

*"There is no point you are left free do whatever you want because everywhere there are targets as I told you earlier that there are objectives, target and interventions. For instance, at your home you have problems like school fees for your child, food and others want money for buying soda etc. Should you buy soda instead of food for the family? It is not impossible. So, you will prioritize and start with the most important one. The same apply to the government though you are given money but you are not left to do whatever you want. For instant now we are talking of maternal and child death you can't allocate funds for other things and leave this out because you won't reach the target. We plan according to level of problems." CHMT member Ilala*

## **7.4 Type of Central-Local Relations**

In chapter two, relationships between central – local actors were categorised into two, formal and informal relationships. The formal relationships were described as open interactions between actors vertically or horizontally (Laffin, 2009). The basis for their interactions is written mandates or roles entrusted to individuals in different levels of the organisation structure. In the same chapter it was mentioned that structures are means of formalising relationships and they determine superiority because various levels are hierarchically aligned and stipulates the chain of command. Informal relationships were described as hidden interactions developed by individuals of central and local governments that are not formal. Informal relations can develop where formal relations are unclear or not set up. The following sub sections discuss types of relationships in local health planning.

### **7.4.1 Formal Relationships**

The types of the relationships according to the data may be categorised into three -technical, administrative and political relationships. It was found that an actor can play more than one role in different stages of the planning process. For example, the Ministry of Health can play a technical role when guiding on priorities and health interventions. At the same time, it can also play an administrative role when overseeing and enforcing adherence to financial procedures. This section presents how the three forms of relationships are exercised and how they overlap along the stages of the planning process.

#### **7.4.1.1 Technical Relationships**

Technical relationships involve interactions between the parent ministry in this case MOHSW and the technical departments at PORALG, Region (RHMT), and Council (CHMT, Health Facility Management Team) as illustrated in figure 6.2. Central level actors involved in these relationships include: Policy and Planning Directorate (MOHSW) as custodian of plans, functional departments and Health Directorate at PORALG. At local level there is the Regional Health Management Teams, Council Health Management Team, and Health Facility Management Team. Other actors include Council Health Service Board and Health Facility Governing Committees.



Councils Health Service Boards and Health Facility Governing Committees are considered as intermediaries because they have duo roles. They help technocrats to link with communities and they are established to foster community priorities in the planning process as illustrated in the following quotes:

*“What we see which has been decentralised to us is the establishment of health facility board at dispensaries, health centres and hospital level. Initially these board were not there and we were just working as government official only”. CHMT member Ilala*

*“First of all, the board is legally established and its main role is to manage available resources within the district they might be from the central government or within the district itself, different stakeholders from within and outside of the district. Therefore, our main objective is to use those resources effectively and manage them accordingly.” CHSB Ilala*

*“These board have been very helpful because they act as a link between health facilities and the community, they have mandate to give their opinion firstly they involve in the planning because they are part of the community. They are able to talk to the community through their meetings at street level. When we call them during our quarterly meeting, they give us feedback from the community so we compile issues which have been raised in the community and facility and come up with one plan.” HFGC Member Morogoro*

One respondent considers Ministry of Health and Social Welfare as technical ministry. The respondent mentioned that according to the government organisation each ministry has its own written responsibilities as illustrated in the following quote:

*“Every ministry has its own responsibilities but in terms of technical we refer to the ministry of health because they are the one who guide the CHMT in making their plans according to health procedures.” CHMT member Ilala*

The research findings identify the technical relationships during local health planning constitutes capacity building and provision of technical guidance. With

regards to developing planning capacity, one respondent mentioned training and provisions of planning tools as examples of capacity building elements. This was said to happen through training, mentorship and coaching as demonstrated in the following quote

*“..because one thing is to support them technically in terms of mentoring, coaching if it is especially a new thing, but mainly what the central does is to support the councils improving their services, working within their system, because they have a system where the central cannot go directly until it passes through to support them” PORALG Official*

Provision of planning tools and orientation on how to use them was also mentioned. One respondent reported the existence of training on planning and on how to use planning tools such as PlanRep. PlanRep is a planning and reporting database used by Local Government Authorities (LGAs) and designed to incorporate the Strategic Plan (Medium-Term Expenditure Framework), revenue projection, budgets, funds received, and track expenditure and physical implementation. It uses indicators under each objective from the Local Government Monitoring Database. Each sector has a customised PlanRep. The centre improved the software following experiences gathered from implementation. Health planners were oriented as illustrated in the following quote

*“During my first appointment in 2007 I attended health planning training on REP and also recently when plan REP II changed to PlanRep III, I also attended another training I think it was two years ago I am not mistaken and I attended twice” CHMT Morogoro District Council*

*“Yes in some cases for example...the main issue is the budget guideline for example at the end of the planning session, end stages, you receive instructions like from the coming financial year you will have to do one, two and three of which in those issues which in those issues we have to do should be budgeted for...should be included in the plan. Sometimes there is no extra funds to support such activities. That is one which I at least I can mention somehow it constrain us. CHMT member Morogoro*

The majority of respondents mentioned policy and guidelines formulation as the main mandate of the MOHSW. Where it was mentioned that the centre formulates and disseminates health sector policy and technical guidelines as illustrated in the following quotes:

*“The main role of the centre is to formulate the health sector policies, guidelines, regulations on quality delivery of the services, technical guidelines to guide the decentralisation in health sectors down there, supporting supervision, even to look for the resources to support the decentralised health system down there” MOHCDGEC official*

*“So, the relationship between the Ministry and the council is that, the ministry is looking upon the policies, guidelines and standardization of the tools that are being used by the council”. MOHSW Official*

*“For example, we receive the budget guideline from the central government through ministry of health and PO-RALG. So, in planning process we have to observe the instructions which come with the budget guideline” RHMT member ilala*

Both local and central government actors have a general consensus that MOHSW as the technical ministry has the technical responsibility when it comes to health and thus, they are to guide the planning process. Deriving and communicating national priorities was mentioned as one of the technical relationships between MOHSW, PORALG, RHMTs, CHMTs and health facilities management teams. The centre generates annual health priorities from various forms. These priorities go to councils as annual policy commitments. The planning guidelines stipulated the process of generating annual policy commitments. The commitments originate from an annual health sector performance review under Sector Wide Approach (SWAp). The review is conducted to determine Sector’s performance against health sector strategic plan targets. Several activities inform the annual health sector annual health performance review. This includes: Annual Regional Medical Officers and District Medical Officers conference, Joint Field visit (JFV) and the Joint Annual Health Sector Technical Review Meeting. Outputs of these three activities lead to formulation of annual policy commitments on areas where the

sector has not been able to meet set targets and areas needing special focus and emphasis. These commitments are disseminated to the Council for inclusion in CCHP this process is summarised in figure 7.2. The process indicates inclusiveness of key actors, central government, regional authorities and local government as well as development partners. JFV include both governments, CSOs and bilateral agencies.



Figure 7. 2: Process of generating annual health sector priorities

Source: Government reports

One respondent explained that the centre provides national priorities which are communicated through provision of guidelines and that in most cases the priorities align to local needs, as illustrated in the following quotes:

*“Yes we are normally getting national priorities which in fact also address the priorities that are found at the grass root level. So, we base on that and it is not so difficult because when we say we want to improve the health status in our country it means when planning at the bottom we also refer to that. That flows up to the lower level but what is important we normally involve people at grass root level during the O and OD when we conduct the Opportunities and obstacles to the development at the grass root level. We have the O and OD participatory team at street level”.* CMT Ilala

The quote from Council Management Team member indicates that there are chances that the goal of principal (central) and that of the agent (local authority) converge. PORALG’s role of enhancing community participation at least in health planning although it is in written documents in practice the outcome of participation is dependent on how the identified priorities align with the national priorities. For

example, one respondent further explained that planners at local level prioritise on solution and issues to address central priorities in line to their local environment. The key assumption in this quote is that the goal of principal and that of the agent converge.

Provision of list of interventions with high impact is another example of technical relationship between the centre and local health planners. For example, in CCHP guideline it is indicated that, The National Essential Health Care Interventions Package (NEHCIP) is the reference document when it comes to selecting interventions to address morbidity and mortality. This is traced since the implementation of Tanzania Essential Health Intervention Project where information from the Demographic Surveillance Systems makes it possible for planners to determine spending priorities. Lessons from this project shaped how health planning is guided centrally to enable local health planners to make strategic decisions. Tanzania Essential Health Intervention Project (TEHIP) experience was centred into creating ability to allocate health resource in strategic ways that target real and prevailing needs. The experience of this project indicates the need to direct health resources to interventions with high impact<sup>1</sup>.

Another respondent identified the roles of local level being to conduct localised analysis of the centrally directed priorities and address them in planning. This presents a deconcentration mode of decentralisation as illustrated in the following quote:

*“You know in the national plan priorities have already been set for example the priority is the maternal and new-born. What is important is how do they manage to analyse the problem for the maternal and new-born and health? I think we have about twelve or eleven priority areas. So, we follow those priority areas. It is a kind of national set”. RHMT Morogoro*

#### **7.4.1.2 Administrative relationships**

Planning involves allocation of financial resources that have different expenditure conditions. Apart from ensuring that technically plans consider right intervention and address the public needs, also was found that their administrative accountability between actors involving adherence to budget guidelines. The

administrative relationships are the relationships of actors that defines their roles in hierarchy that can call for compliance on budgetary issues during development of health plan.

Administrative roles include: Setting resource allocation criteria, informing councils on budget ceilings and ensuring compliance to financing conditions stipulates in various sources of funds as illustrated in the following quotes.

*“When the ministry put those ceilings it takes into consideration the population, poverty, distance and things like that” CHMT member Morogoro*

*“Each fund for instance basket fund or block fund is allocated to its activities and we are not allowed to use for paying salaries, leave allowances, major construction and transfer allowances we are only allowed to do rehabilitations.” CHMT Ilala*

Apart from setting allocation criteria and ceilings, the centre also ensures compliance by councils. One respondent mentioned that the resource allocation criteria sometimes have its own limitation because a council may have low population but geographical configuration may be so hard making it so costly to provide health service

*“...but I think in some of the areas it could be better if they use the evidence-based planning. For instance, you can’t compare the real situation of Mvomero with the municipal. So, they should consider the evidence-based planning instead of generalizing as they are doing now. So somehow it has shortcomings but it does not hinder us from planning.” CHMT member Morogoro*

Administrative relationships according to the findings discussed above looks hierarchical. Thus, making actors higher in the hierarchy superior than those lower in hierarchy. Although the concept behind decentralised health planning would mean power to make decisions by the local, the hierarchies within the system silently influence the planning relationships. The hierarchies supersede the expected bottom-up planning relationships.

Respondents had mixed feelings with regards to centrally pushed priorities. According to some district respondents, having central priorities is fine but should not be at the expense of the ones that are locally pertinent. They mentioned that not all what is sent from the centre covers what is locally needed. There are instances where the local issues which do not fall within the central priorities were not included due financial constraints. The major challenge mentioned was limited revenue. The central government seemed to have a bigger control over the allocation and collection of resources. Making local government highly dependent on central government grants. This is illustrated in the following quotes:

*“For instance, the income tax could be shared, part of it could be collected by the central government and part being collected by the local authorities. Because with the income tax, the TRA are comfortable in collecting the income tax. And I think there are some levies which normally go the central government, even those levies could be left to the local government authorities. There are levies from certain designated hotels which go to the central government, it is very important that they should be left to the local government authorities. Also, the land rent, I think the land rent is being collected by the central government, that could also be left to the local authorities. These is what I think could help the local government authorities” Ilala CMT.*

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It was found that the central – local relations are complicated by multiple accountability lines. Respondents explained that a shift in local accountability is one thing that created both opportunities and obstacles in planning. That is, being accountable to the Council Director is an efficient way of administration and move forward their interactions. Some said that the Council was brought as an additional line while previous lines remained active as they were. Hence leading to multiple accountability lines. Another respondent thought there should a clear division of roles between Ministry of Health and Social Welfare and President's Office Regional Administration and Local Government to avoid conflicting roles and resultant dual accountability at local level.

*“My opinion is that there should be one ministry which supervise the health system in every district. If it is Regional Administrative and Local Government, they should be given all the power of supervising the health system. If it is the ministry of health, they should have all powers of supervising the health system in the country instead of having two ministries with different views. It is difficult to reach the millennium development goals because the ministry of health says this and the Local Government says that. So, for us it becomes difficult if it was me I could say let the ministry be one and will be answerable to only one ministry” DMO*

#### **7.4.1.3 Political Relationships**

Political relationships represent planning relationships that occur between the technocrats and the representatives of the people both at central and local levels. At central level it involves interactions between core MoHSW technical staff and Parliamentary Committee. At the Council level it involves interactions between Member of Parliament, Local Councillors with Council Health Management Teams, and Health Facility Management Teams. Figure 7.3 illustrates political relationship actors.



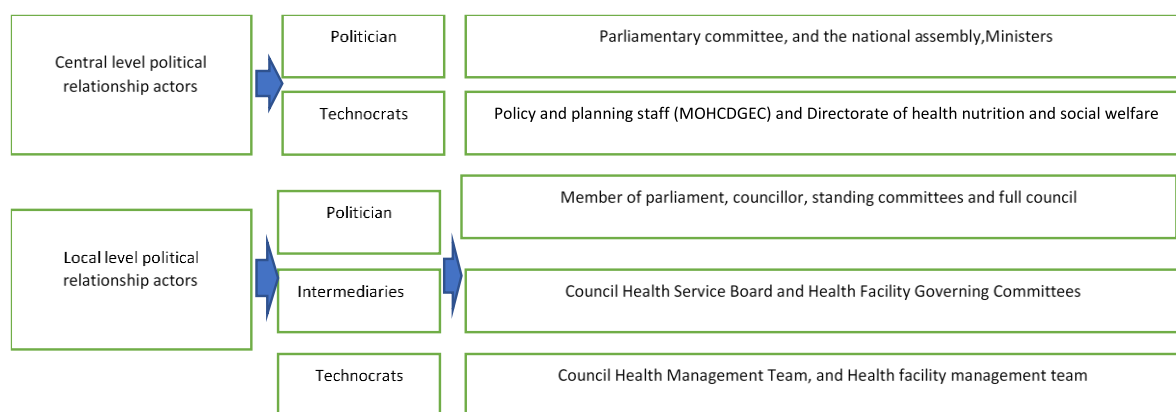


Figure 7.3 illustrates technocrats and political actors in the political relationship for central and local levels.

Source: URT Constitution of 1977 and CCHP guideline

One respondent identified local actors to include Local Councillors as political actors. The respondents mentioned that, Councils work through full council forum or through standing committees as illustrated in the following quotes:

*“Now after decentralisation in 1982 and district authorities’ act, number seven of 1982 and urban authority act, number 8 of 1982 now we can see the creation of the councillors and the departments, we can see the creation of the full council. A full council means it is a meeting which is held once in every three months to see everything which is done in the district under the chairmanship of the chairperson of the council and the full council constitute all the councillors those elected from each ward and those from special seats including the head of departments. And then we have the committees under this law, we have the standing committees which are three; the finance committee, economic committee and social activities committee. These committees meet as well once in every three months” Council Executive Director Ilala*

At constituency level this group’s interest was found to be mixed. , All members of the ruling party foster adherence to the party manifesto. It was found that politicians saw health services as of great priority. Specifically what matters most to politicians was said to be the “*steady availability of medicine*”. It was found that

value attached to health by politician is high and some thought more investment should go to health.

*“I would say that, everybody knows the importance of health, because even if they decide to approve investment in other areas like road, no matter how good the road is, if people are not healthy, no one will go through that road and even the engineers will not be able to construct it if the health is not good. So, for us, we have put health matters in the forefront and the other things follow” Councillor Ilala*

It was found that politicians engage in the planning process in several ways. First, they engage in identifying health needs, secondly in approving the plans and third in advocating for the plan in higher forums at council level. Local politicians engage at street, ward and council level where health needs as per local perspectives are identified. Politicians crosscheck if the village priorities have been included in the list that is presented at ward level. Furthermore, at council level, politicians engage with experts to include the priorities identified at lower levels. This is done taking into account the budget available, as illustrated in the following quote:

*“In the planning process, we start at the street level where we conduct meetings with citizens in order to determine their priorities. When it comes at the ward level we cross check again to know if their priority is in health and we bring the matter to the municipal. At the municipal level we will meet with many wards whose priorities are in health, either a mother and children centre, or simply the health centre or the hospital so we begin planning from there by involving our experts, looking whether the budget we have is enough to construct that health centre as a whole, or in phases, or we postpone it till the following year. So, by involving our experts is when we are able to do our jobs” Politician Ilala*

Another way in which local politician engage in local health planning was through approval of plans. This is done at committee levels. Health falls under the Education, Health and Social Services Committee. One respondent mentioned that each department falling under this committee category prepare plans and submit to this committee for approval as mentioned in the following quote:

*“Each department bring to us its own plans, for instance health department brings its plans, education department also brings its plans. So, when we finally approve health plan, we send it directly to the municipal plans, from there is when they decide to use either funds from the central government, local government or donors” Politician Ilala*

As stated earlier, technocrats serve as an organ to implement the ruling party’s interest with regards to planning for socio-development activities. For example, it was mentioned by one respondent that the Parliamentary Committee have power to direct national level technocrats to make changes on some of the priorities at council level. This could include the technocrats asking for more funds to be allocated in some budget items which are thought they are public concern. The following quote illustrates the point.

*“Parliamentary committee but these people have power to direct us to ask the councils change some of the priorities are setting. So, these are some of the examples they may tell you let’s say to allocate thirty percent for medicines if you go down to the council some of the councils might have not arranged for that percentage as along as it comes direct from the centre, they have to follow issues like that..” Ministry Official*

Respondents mentioned that within the politician not all have the same interests. There are instances where their interests differ. The difference may occur as between sub-groups or between a group with individual politicians. Also, individual politicians have their own local interest. For example, it was found that individuals within the group may differ on where should the project be implemented or may differ on where the investments should be directed, as illustrated in the following quotes:

*“For example, someone may say he wants to upgrade road in his/her locality to have tarmac while at the moment the cars are moving properly and while there are some areas where they do not have dispensaries and have to travel more than 5 km to look for dispensary, this makes it difficult” Councillor Ilala*

*“For instance, we plan to renovate a dispensary but we find out there is another one which is in worst condition and funds are not sufficient so when we say we can’t renovate yours instead we will renovate this one first they would say, no give me a little amount of funds” we tell him yours is in better condition than this one so let us renovate this in this year and yours will be done next year. Still, he refuses even though he is aware that funds are insufficient he will insist that, “No you have to give me even a small amount of funds because my people won’t understand me” CHMT Morogoro*

#### **7.4.2 Informal Relationship**

The drivers of informal relationship are peoples’ perceptions, judgments, bonds and emotions. From the data, one example of informal relationship was identified. One respondent mentioned that sometimes when the District Medical Officer faces challenge with his or her staff they use politicians to push for better behaviour. Politicians are used to support the full council meeting, as illustrated in the following quote:

*“.. because when my DMO faced obstacles he had to use me as a politician so that I could push his staff to act immediately. To be honest they use different techniques to approve something I am not saying in order to create conflicts between them. When they use us a politician actually it works out because when I go there, I ask and when I get no answers I go and rise that issue in the meeting. So, since, they afraid of councillor to go and say something in the meeting so they find solution immediately. So, they use this technique but I don’t know why should government officials wait to be pushed by a politician” Politician Ilala*

## **7.5 Tools for managing formal central-local relation in local health planning process**

### **7.5.1 Formalised assessment mechanisms of local health plans**

The MOHSW was found to apply constitutional/legal, hierarchical and resources power to induce compliance to centrally set priorities. As mentioned earlier MOHSW technically was considered accountable for quality of health service provision due to its legal mandate. MOHSW ensures that local planners adhere to priority areas and budget guidelines. The tool used is plan assessment tool as mentioned in the following quote:

*“They have assessment criteria they start from the cover page, allocation of funds, if you follow the ceiling that dispensaries, health centres have specific ceiling for basket and block if it is not there mhhh...and also there is if you have put enough money for buying kits for family planning if it is not enough they put - O. There are many things...” CHMT member Morogoro*

It was found that the CHMT does not always comply with central advice. This is not done openly. One respondent mentioned, CHMT may do this in their own ways in order receive central grants. This may either lead to genuine compliance or made to fit compliance with hidden motives that will be handled during implementation. This is illustrated in the following quote:

*“We plan for our priorities and relate them with the guidelines. Let’s, say we are looking at mother and child health, that the ministry looks at non-communicable diseases, but we look at it from our perspective and see how we can manage fit into it” CHMT Ilala*

The application of power to promote central priorities was said has a potential of narrowing chances for locally thought priorities. This may somehow water down the overall intention of decentralisation and may disappoint the local planners. Respondents said overemphasis of centrally proposed priorities sometimes make the local planners to feel that the centre is planning for them as mentioned in the following quotes:

*“Of course, it has a very big impact to them, because sometimes some of the council loose interest because they feel that the centre is planning for them. But some understand because we have to continue explaining to them the reasons as to why this happens. Yeah, but it is not good and we want to reach a point where what they have planned and once it is approved by the regional secretariate to remain and be implemented accordingly” Ministry of health Official*

*“Yes, in some cases for example...the main issue is the budget guideline for example at the end of the planning session, end stages, you receive instructions like form the coming financial year you will have to do one, two and three of which should be budgeted for...should be included in the plan. Sometimes there is no extra funds to support such activities. That is one which I at least I can mention somehow it constrain us”. CHMT Ilala*

The major issue leading to strict follow up on “Must Plan for” issues as per the findings were two. One was scarcity of resources that compels the centre to make sure everything that is of national interest is budgeted. In this case, the centre uses both legitimate and resource powers.

*“The instructions we are putting out don't want to give them a free room. Resources are very scarce if you don't give strong guidance. There could be areas where it could be marginalized, there could be areas where there is a lot of expenditure. For example, the area of procurement if you are not strict each council will like to procure that is the area where you can have a number of issues” Ministry official*

### **7.5.2 Provision of budget guidelines**

To ensure that the scarce resources are effectively allocated, the centre use variety of mechanisms. One is to set allocation formula for allocating funding to councils and also manage councils' allocations to activities through provision of ceilings. The ceiling guide national allocations to councils and also allocations within councils.

*“So, ... we even went further saying the formula of distributing resources we said for the council we considered the population of that council which carries around 70% of the total population per resources they get then we say the root they supervise 10% there is a variation, then we say poverty level 10%, then the epidemiology of the disease 10% so it comes 100” Ministry Official*

Furthermore, it was found that the centre also sets ceilings to avoid misuse of resources in fuel, medicine and allowances.

*“We limited even the fuel to avoid unnecessary misuse of resources and it is working very well. I believe so and it attracted a lot of donors now they are funding. We started with DFID then they went out from the basket now there are numbers of development partners now they are supporting the basket because of that process which we develop so it is useful and we restricted the procurement of some of the drugs for examples which they have special program for example TB, HIV so if we give a room the cost of HIV drugs is very expensive it will compromise others” Ministry official*

Another respondent mentioned governance as one of the reasons why full devolution in planning was not possible. This is because councils have competing priorities in a resource constrained setting and there are chances where services may be compromised. Also, the centre sometimes fear that resources will be abused as mentioned in the following quote.

*“In an area where a good governance is not completely implemented you need to have a lock somewhere otherwise you leave loose in expense of that giving them freeness you will compromise a number of services... They can invest in one area while living in other areas... If you don't do that, then the district or health centre will be pushed out of the system planning.” PORALG official*

With regards to respondents' perception of resource allocation formular, one respondent felt the criteria do not fit all the context. Although resource allocation

formula was made to address equity it proved disadvantageous to Ilala especially the criteria of population. According to population census has fewer people than the population it actually serves. Many people from Dar es Salaam live in the nearby municipals and do business in Ilala during the day whereby receive service in this municipal., as indicated in the following quote:

*“... But when you come to the allocation of funds they say that 70% of the people who sleep in that municipal so you find that many people during the day are in Ilala, all the business are in Ilala and when they are coming to Ilala also the services are getting here in Ilala. We tried to argue and they say no if they come there also the revenue becomes higher in your area but it is not true. If you find the collection of waste or production of waste is in our municipal is higher than what we are getting from...do you understand what I am saying?” CHMT member Ilala*

#### **7.6. Main relationships between stakeholders and their influences to health planning process**

Although planning actors are many the findings suggests their relationships influences are not the same. There are those with higher influence than the others. This is because the types of relationships identified in a way presents the power an actor has in the process. The main relationships which were identified include technical, administrative and political relationships. The relationships were found to align to actors mandates and accountability vested to an actor in the process. Basically, political and administrative relationships were found to be influential to the planning process than technical because they are tied with hierarchical, political and resource power. Table 7.6 illustrates the relationships and influences



Table 7.6 Relationships and influences of stakeholders in the planning process

Stakeholders	Influence on Priority Setting			Influence on budgeting		
	Technical	Administrative(resources and administrative compliance)	Political	Technical	Administrative	Political
PORALG	Medium	Low	Low	Low	Medium	Low
MOH	High	Medium	No	High	Low	No
Parliament	Low	High	High	Low	High	High
Ministry of finance	Low	High	No	High	High	High
Donors	High	High	No	High	High	Low
Local Politicians	No	No	Medium	No	No	Medium

### 7.7. Chapter Summary

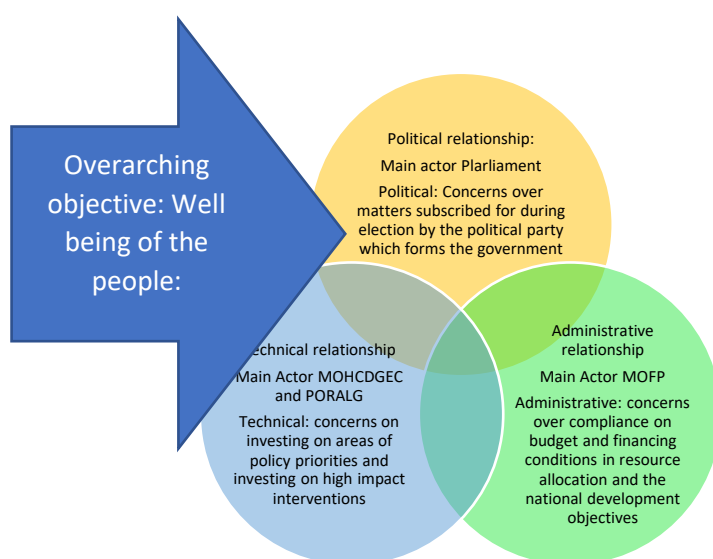
The central-local planning relationships were mainly formal, no significant informal relationships were identified. Central – local relations in the process of developing local health plans were found not static. Main actors in central-local planning relationships were government (central and local government administrators and technocrats) donors and politicians. Three types of planning relationships were identified– administrative, technical, and political. Types of health planning relationships were found to be highly linked to actors' mandates and accountability demands which are formal and complex in nature and they overlap. MOHSW has multiple accountability responsibilities: Political, Hierarchical, Financial and Technical. Central government use its mandates and resource power to gain local compliance in addressing the central agenda in local health planning. The power of central government was derived from constitutional and ministerial roles and functions, political stance and fiscal policies. Implementation of decentralisation in health planning was found to differ between ministries who actively engage in the planning process.

The study found that decentralization of the planning process is faster than the pace at which actors' roles and responsibilities are changing in the entire central-local management arrangements. Some actors were reported to still act in a centralised manner despite the adoption of decentralisation policy. Some

ministries were said to lag behind. For example, health sector implements decentralization while the ministry of finance is operating in a centralized manner. Consequently, they influence sectoral ministries like MoH to also retain some of its power which ideally, they would have decentralised

The following are the key findings in this chapter

- Planning relationships were found to be mostly formal. This is attributed to several factors including: Actors' mandate, formal nature of health planning, decentralisation design, accountability concerns and financial constraints.
- The key actors to central- local relations in local health planning process constitute two major groups. First is the government both central and local government as one group and the parliament as the second group. The two categories have representation at national level and local level. Their interactions during local health planning process happens in three forms, technical, administrative or political
- Due to accountability concerns application of types of relationships overlaps in the practice of central-local relations during planning as summarized in figure 7.7.



*Figure 7.7: Overlaps in forms of relationships*

## **Chapter 8: The influences and Implications of central-local relations on local health planning Process**

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### **8.1 Introduction**

Chapter seven presented the types of central-local relations in the local health planning process. This chapter identifies and analyses central – local relations influence on local health planning, specifically in the formulation of Comprehensive Council Health Plans (CCHP). This chapter address objective four of the study, “To determine the influences of existing central-local relationship in local health planning”. The first section identifies and analyses the central -local relations influences and each influence where feasible its implications to the local health planning process. The last section presents the chapter summary. The results presented in this chapter apply to both Ilala and Morogoro District Council

### **8.2 Forms of central-local relations influences in health planning**

The data illustrated four forms of Central – Local relations influences on formulation of Comprehensive Council Health Plans. These include:

- hierarchical;
- central resource control;
- donor financial management; and
- political influences.

The following sections describe the forms of influence and their implications in the local health planning process.

### **8.3 Hierarchy influence**

Local technocrats administratively and technically are accountable to central government. It was found that local technocrats are basically employees of central government either openly or impliedly. For example, the powers to constitute and abolish offices in the public service are vested in the President under Article 36(1) of the Constitution which in most cases is delegated to the Permanent Secretary (U.R.T 1977). Central government also appoints Council Directors and the Heads

of Departments are appointed by Minister (URT 1982). By default, the central government is considered higher in hierarchy than local government and there is an upward accountability relationship. It is difficult to consider local government technocrats representing local government but more answering to the central level. This is because of the nature of their appointments and answerability requirement is by design inclined to the central government than to local authorities.

When respondents were asked about to whom they are accountable, two dimensions of accountability were revealed. Vertical accountability and horizontal accountability. Some respondents mentioned that CHMTs are accountable to Council Executive Director (horizontal accountability) and the Director is accountable to central government (vertical accountability). The Council Executive Director works in accordance to rules and regulations, as illustrate in the following quote:

*“The government has a very good system of communication because when the Council Executive Director sits in his office with his experts from respective departments, they have all the government guidelines and policies. So, we as the council we work in accordance to the government guidelines and policies. We can’t go against them”. [ Local planners]*

The accountability originated from the policy formulation roles where central government is considered a policy maker and local government implementer. Translation of policies happen at each administrative level. This led to the planning levels to align with administrative levels. One respondent mentioned that within the practice of central-local relations in local health planning, there is a clear and good communication systems between the centre and the local levels. This happens through the Executive Director at the local level. In practice, local technocrats have all the central requirements through either a policy or guidelines presented to them by the Council Executive Director. Therefore, the technocrats work in accordance to the central directives and cannot go against these guidelines, as presented in the following quote:

*“The government has a very good system of communication because when the Director sits in his office with his experts from respective departments, they have all the government guidelines and policies. So, we as the council we work in accordance to the government guidelines and policies. We can’t go against that because we are serving the same population and we can...” [Local planners]*

This led to the central level technocrats having a greater say than lower-level technocrats when it comes to planning and decision making in planning. Some respondents mentioned that CHMTs are accountable to the District Council, which is the ideal arrangement of decentralisation, as illustrated in the following quotes:

*“We are now directly accountable to the district council so the council must be aware of everything you are doing.” CHMT member Morogoro*

*“Initially council was direct accountable to the ministry but now you can’t go straight to the ministry before passing to the region so RHMT is responsible to oversee all councils. Whatever is announced by the ministry the region must be aware so you can’t do anything without informing the region and get an approval before submitting to the ministerial level” CHMT member Morogoro*

Furthermore, it was noted that administrative accountability presents both horizontal and vertical accountability. However technical accountability is mainly vertical and involved Ministry of Health and Social Welfare directly, as illustrated in the following quotes:

*“Initially council was direct accountable to the ministry but now you can’t go straight to the ministry before passing to the region so RHMT is responsible to oversee all councils. Whatever is announced by the ministry the region must be aware so you can’t do anything without informing the region and get an approval before submitting to the ministerial level” [CHMT member Morogoro]*

*“So long as health is the technical ministry, they also allow some advice from the central much as we appreciate that they have the autonomy to decide but when it comes to technical issues, they have to also listen to us” [Ministry of Health Official]*

Although the local health planning process is expected to work bottom-up in terms of needs identification, there is a counteracting force between planning process and accountability process. According to one respondent, accountability concerns are somehow products of misconception of what decentralisation constitutes and hesitation to relinquish some of the authorities. The respondent mentioned there are challenges that sectoral ministries like the Ministry of Health and Social Welfare encounter when dealing with the State House, the Ministry of Finance, the Prime Minister's Office and Ministry responsible for Public Service Management. These ministries have authority over sectoral ministries. According to the respondents these ministries have not reformed fully in their practice although according to written documents they are implementing decentralisation. In practice, they have not decentralised some of the decision-making authorities over to the local level. Consequently, the technical sectors (at the central level) behave the same to local authorities, as illustrated in the following quote:

*"In the government machinery, from what I see, this is my personal view, in the government we still have most of the authorities being held by the central government and this comes straight from the system that we have. We have the so-called central government which includes the state house, the ministry of finance, the prime minister's office, the public health management, and these are the ministries that are having authority over the sectors. For me, this has not reformed the way we wanted it to reform. If they had reformed then they would have relinquished their authorities, their decision-making authorities over the sectors so that the sectors would have relinquished the same to the local government"* MOHSW official

According to this respondent, there is limited understanding on how local government operated. This because most of them do not have enough background knowledge of the local government authorities, operations. The respondent mentioned that awareness creation on reforms and decentralisation was not good enough, as indicated in the following quote:

*"I think this is an understanding problem, I don't think that we did enough work to ensure that the central ministries understood the reform process and again,*

*I don't think that we did very good even in ensuring that even the local government itself did understand the decentralisation process and this gives us a lot of problems, because even the appointment of the staffs, most of them don't have background on the local government system, most of them are accountants, most of them are engineers, most of them are agricultural officers, they don't have any background of the local government system, how the local government system works. Therefore, the issue of decentralisation to them is a problem, and this is what gives us problems" MOHSW official*

This was also the opinion of another respondents that decentralisation of planning has happened while the local authorities especially at village and ward levels need resources, orientation and more technical staff to assume responsibilities, as mentioned in the following quote:

*"I am saying that we were not prepared for decentralisation so we need to provide financial education to village executive officers, health facility in charges, head teachers of primary and secondary schools to educate them, for instance, we send all the funds direct to the people but there is no any accountant in the village office so we expect the village executive officer to be the accountant and has no any background of accounts. The same applies to the health facilities; facility in charges is our secretaries and the same person is an accountant" Politician Morogoro*

### **8.3.1 The implications of hierarchy influence to planning process**

The findings indicate that, local government technocrats are weak in fostering local government interests despite having roles to do so under decentralisation arrangements. This is because central government emphasise on central policies priorities and sometimes disregards the local priorities and capacities. This intervenes with written decision space as the hierarchical relationships overshadow decentralisation arrangement. Respondents presented varied perceptions with regards to decisions making space. In the context of this study decision space refers to the authority granted to local health planning department to prioritise for local and national needs and allocate resources to them.



Administrators who are mostly central government appointees, consider decision making space to be broad compared to the perceptions of politicians and CHMTs. The administrators mentioned that with the existing laws, local governments have broad decisions making space, as indicated in the following quotes:

*“I think the law I mentioned before, Act number 7 of 1982 gives us much room to decide and I don’t see serious interventions from the ministry or from the region their main work is just to advise but on the matter of deciding it is entirely under us under the district so there is much room I think” Council Executive Director Morogoro*

*“What I can say is that everything now is under the district all the decisions are done by the district itself but the region and ministry are just doing supervisory work” Council Executive Director*

*“Before that during centralization all the plans were done at the top but from there we started planning on our own. Our plans are basing on data collected hence we say they are evidenced based planning” [CHMT member Morogoro]*

However, some studies in Tanzania indicated weaknesses in the existing local government legal frameworks, especially on central-local relations aspects. (Kessy, 2018; Kessy and McCourt, 2010; Kigume, Maluka and Kamuzora, 2018; Kigume and Maluka, 2019). Generally, neither legal frameworks nor the constitution guarantees local government protection from interference by the central government. Politician perception was different. One respondent considered decision making space is narrowed because the existing guidelines restrict the local authorities to exercise their power as stipulated in the decentralisation framework. The respondent reported there were many restrictions in the guidelines making contributing to poor performance of council.

*“There are so many guidelines I can’t remember them all and this is the reason why most of the councils in Tanzania fail to deliver because there are so many things which contradict each other” local Politician*

Another local politician equated the small decision space as if one is given food and while he or she is swallowing, the neck is squeezed.

*“It is like giving a person food and while he is eating, you squeeze his neck so it is another way of telling this person not to swallow the food because you have held his neck tightly” [local Politician]*

It was perceived that the existence of guidelines was a way of making the process operate within existing standards. Another respondent considered central-local relationships in local health planning as a collaborative nature and guidelines do not infringe decision making space but rather they regulate behaviour of actors and align them to guiding principles.

*“I take relationship as collaborative of course it is collaborative ... I think they provide guidelines because if others are given a broad decision-making space, they will misuse it. So, it is better for the guidelines to be there” CHMT Morogoro*

*“For instance, if the guideline directs us to allocate a big percentage of funds for mother and child prevention while in your facility that is not a major problem and you would like to use more funds in addressing other problems hence we can't implement our priorities”. CHMT member Morogoro*

Although some respondents had varied opinions with regards to decision making space, it was generally found that local level decision space is narrow. This is because of both constitution and ministerial responsibility instruments provides more power to central government. Councils have liberty to allocate resources for only priorities that align with central government priorities of that year. It is difficult for local planners to include locally generated priorities because of limited local revenue and limited chance to manoeuvre in central grants as they are sent with guidelines for utilisation. The local government is operated under the Ministry of Local Government. This is a central government principle because it is placed either under the Prime Minister's Office or President's Office. Basically, PORALG advance the central priorities in local settings.

#### **8.4 Influences on access and control of resources**

Another influence of central local relations to local health planning is central government financial control. One respondent explained that they embraced centralisation as opposed to decentralisation. This is because decentralisation is accompanied by so many policies and so many demand especially on resource allocation. The demands come in forms of policies or guidelines from both MoHSW and donors as mentioned in the following quote. In chapter two, it was indicated central government employs all its sources of power to ensure that the local authorities comply. Although local governments derive the legitimacy from constitution which may provide them with local autonomy, central government may interfere with autonomy through supervision, tight controls and imposes restriction. This power is drawn from their legitimate power (Loughlin, 1996).

*“The good thing in centralization were by you get command from the central government and everything goes through the central government you get one instruction; you get instruction from the ministry through the ministry through the DG to the district or to the whatever department. But in decentralisation especially after forming this local government we have so many policies and so many demands” Municipal Management team member - Ilala*

Another respondent added that in the decentralised settings the central governments provide regulations on how to go with the budget, provides the national ceilings and policy guidelines, thereby demonstrating its control on resources. This includes accountability on expenditure and sometimes it takes action against local authorities in case they violate the guidelines, as illustrated in the following quote.

*“Yeah, the decentralisation is very supportive. First of all, it gives us regulations on how we go on with the budget, what is the national budget, what is the national policy guideline. Then they give ratios which has to be followed. Second, they control the funds, we have to report (...) central government is*

*keen on that sometimes it takes actions where we violated the financing provisions and so on” CMT ilala*

According to the respondent, municipal and district councils are also allowed to have their own financial guidelines for utilisation of the internally generated revenues. Sometimes the central government guidelines come into conflict with local government budget policies. For example, the budget regulation was said to stress that, a part of the revenue collected by the Council about 45% should be allocated to local development projects while the Municipal Council has laid down a policy where by the part which is to go to the development should be 60% of the internal revenue, as illustrated in the following quote:

*“ ..Therefore. you can see the chain of commands, the central government issues guidelines to control the budget, to control the expenditures and to control everything. Municipal Management team member - Ilala*

This is attributable to limitations of the legal framework under which local governments are established. The 1977 constitution of the United Republic of Tanzania does not clearly define the boundaries between the central government and local governments (Babeiya, 2016).

In chapter two, section 2.3.2 (c) Rhode (1999) argues that local authorities would take resources from central government without minding the degree of control the central government exerts on them because, it is not possible to get such resources somewhere else. Application of resource power by MOHSW was found as one of the mechanisms that enhances voluntary compliance by local actors.

*“.... the ministry of health is to give power for us to decide what to do but following the guideline of the ministry of health using the planning guide. But when you look at it deeply it seems as if it is not really the bottom-up approach type of planning many of the things they do come from the top. For example, you can have your health problem, priorities and what, we discuss as a team but there are things do come from the centre.” CHMT member Ilala*

It was found that the application of both hierarchical and resource power by MOHSW to ensure “*must plan item*” are included in local health plans. If councils fail to comply, the plans are returned to CHMTs to be redone.

*“So, we have those thirteen priority areas in the CCHP but you have meagre resources so the central level may look for what is the priority for this year as I told you. So, what they normally do is to send back the CCHP to council and ask them for example to put more money to purchase medicines. The councils are the ones who sit down and reallocate to adjust to that budget. The centre does not adjust the budget for the councils. But we send them back, we advise them and they make adjustments” Ministry of Health Official*

Although both central and local level acknowledges the change of roles in planning that in a way give local health planners mandate to plan for local matters, the efforts to safeguard local government interest over the central interest has been a challenge. This happens because central government uses its powers derived from technical mandates, resource access and control to ensure it gains local authorities’ compliance. Since the role of ensuring that population health is safeguarded is the primary responsibility of ministry of health, therefore the planning function is in some areas deconcentrated and not devolved.

*“You see the set up in this country the councils are autonomous so the final decision is the full council but now so long as health is the technical ministry, they also allow some advice from the central much as we appreciate that they have the autonomy to decide but when it comes to technical issues, they have to also listen to us” Ministry Official*

#### **8.4.1 Implication of resource control in local health planning**

##### **8.4.1.1 Frequent regulation, de-regulation of planning process**

Respondents outlined experiences where the restrictions are imposed or lifted. This happen when there is a requirement from Parliament or donors. For example, one respondent mentioned that in the previous year, basket funding conditions did allow payment of extra duty allowance but this condition was lifted. Another respondent also reported of expenditures that were allowed by MoHSW but were rejected after parliament stressed on more allocation for medical supplies. Another

respondents mentioned the challenge of delayed communication of new instructions. For example, the permission to budget for extra duty allowance in the basket fund was not communicated earlier to Councils. When the plans were submitted were rejected and councils were asked to go and budget for extra duty allowance. The same happen when new restrictions are imposed sometime the communication is delayed and hence councils are forced to start reallocating the funds to allowable investments

#### **8.4.1.2 Challenge of balancing between local and central priorities**

There is a challenge of balancing between local and central priorities especially for needs emanating from grassroot level that do not converge with national policy priorities. The relationships between central actors and local actors were found to be that of superior and subordinate. This concurs with what was found by Babeiya (2016) where he argued that while local governments in Tanzania have existed for more than a century, but still their relationship with the central government has been one-sided; with the latter surviving at the mercy of the former. As mentioned earlier local authorities have limited funding and are mostly dependent to central government for financing health projects. For example, one respondent indicated that, there is a mechanism of identifying needs at grassroot level, but the chances in which those needs to are accommodated is dependent on available resources. To prioritize issues for funding they must ensure that their priorities align with central government priorities. It was found that due to such focus, what MOHSW consider a priority is also stressed by PORALG as a priority and the same emphasis prevails at council level.

*“[...] the plans we receive from the grassroots is not the one which will come to implementation, because the resources are scarce, we don't have enough resources to implement all of the needs we get from the lower level. So, when you come to the municipal level, some of the problems are now rearranged and now sector priorities are prevailed according to the available resources. In that case you find that some of the issues which are supposed to be solved at the grassroot they are not solved as they are*

*anticipated, what they anticipate is not the actual implementation. [CHMT member Ilala]*

*“When we prepare ward action plan normally all villages bring their plans from all sectors... Normally not all priorities survive because during compilation of priorities they look at the ones which appear in most facilities” [member of Health Facility Governing committee Morogoro]*

A CHMT member explained that the District or Municipal Council is supposed to bridge the gap of financing from its internal financing. This is expected to happen to most of previous centrally financed activities. Normally shifting of such responsibilities come without discussions as to whether local authority is prepared to handle such investments through their internal revenues. Even if sometimes internally the CHMT members may find feasible to include some activities to be financed centrally, there is no room for negotiating such possibilities. For example, one respondent mentioned that, in ARV program there was a challenge of lost to follow. Addressing this challenge needed information from community because the data were missing from DHIS2. The Council decided to budget for community data collection but the budget was rejected by the central level and they were told to reallocate the fund to supervision and medical supplies.

*“The issue was for example this year we had almost two topics or two activities which are supposed to be implemented in the next financial year. But what happens we have taken only one into consideration because of the financial crisis. The first issue was lost of follow up on ARV. It was observed that this is a critical point compared to the other one. For the budget now this has been the issue of...I don't know what will happen but even this one the budget was supposed to be eight million to do this work but it was allocated only three million and yet when they went to Dodoma it was cancelled--- they said some money or certain percentage of money should be allocated to supervision and medical supplies” [Ilala CHMT member]*

It was further discovered that neither technical staff nor local politicians can enhance consideration of local priorities when they are not aligned with national priorities. Funding from NGOs were mostly found to be geared to locally raised

priorities. Again, also NGOs have their conditions and procedures to finance local priorities. One politician explained that, by constitution local governments have authority and power. The power is watered down when central government provide guidelines to local technocrats on what is allowable and what is not.

*“Yes, it is true there is a challenge there because according to the law we have a full authority and can’t be interfered pursuant to the constitution and law. But some of the guidelines from the central government bring about confusion and make the Local government fail to fulfil their duties as stipulated by the law.  
Politician Ilala*

The technical and political requirements were found to be one of the major justifications for enforcing central policies over the local priorities and gaining local compliance. The 1982 laws establishing local government do not disentangle the affairs of local government with that of central government. This makes it difficult for local government to plan for the local priorities without approval from the central level. Previous studies in Tanzania indicated overlap between local governance and ruling party administration hence making local governments not strictly autonomous and only partially participatory (Kessy and McCourt, 2010; Babeiya, 2016).

Moreover, it was found that financing from partners, local and international NGOs were found as complementing sources for addressing local matters that were not addressed through central financing. One NGO respondent indicate what funds they have and CHMT incorporate the activities into their plans. However, there are rare instances where Councils ask NGOs to funds things that they do not have funds for. For example, the NGO in Morogoro had funds for renovations of dispensary but when they communicated to the councils, they were told to construct a new building and this posed a problem to that NGO.

*“...for instance, we have been allowed to do renovations but the council say they want a building to be constructed so that is very difficult because donor allocated his funds for renovations only and it is not allowed for constructions of new building” [NGO Morogoro].*



### 7.1.1.3. Influences on community participation

Several influences, both positive and negative, of central local relations on community participation were identified. The recognition of community engagement in Ministry of Health policies, strategic plans and planning guidelines is considered a positive influence. Community participation is considered as one of the requirements for the council health planning process (U.R.T, 2011; URT, 1982). One respondent explained that local level was getting involved in planning for health issues in their locality through variety of mechanisms such as village assembly and ward meetings following implementation of decentralisation policy. In addition, community involvement in the CCHP planning guidelines community priorities is included in the resource allocation formular where community is given its own cost centre. The allocation to this cost centre is 5% of basket financing (U.R.T, 2011). Also, respondents identified the shift of power to lower level and use of bottom-up planning. The following limitation were identified with regards to local participation in planning:

- a) Incompleteness of the process of participation. Respondents mentioned the process of participation is incomplete. As mentioned, participation is highly formalized through community representation structure like health facility governing committees. The process is lacking a feedback loop. Therefore, it is hard for committees to know if what they proposed is included in the plan as illustrated in the following quote. However, it should be noted that this was reported before introduction of direct health facility financing mechanism, probably the situation is now different

*“As a health committee we also prepare our proposal and submit to the ward executive officer because the councilor attend every meeting and used to take the proposal with him. Normally when we discuss and send our proposal, they usually discuss them but we never receive any feedback. So, it becomes a challenge to the extent we even spend funds for medicines for other things” [Health Facility Governing Committee – Ilala]*

- b) Earmarked central priorities: One situation hampering genuine community participation is earmarked central priorities and financing. So, it was

reported that it is always hard to get community participation more genuinely. Therefore, the committees bless the proposed the proposed priorities rather generating them. It was mentioned that due to financial constraints, some of locally generated priorities get omitted as quoted from one respondent.

- c) Technocrats highly affiliated to central government: The process of local participation is taken superficially even by the local technocrats because to them what is brought by the centre broadly constitute their priorities.

There are instances where communities do not take the roles as prescribed in the decentralisation policy. They would depend on central government for everything. One respondent mentioned this, and according to him the challenge is probably awareness of the community about what roles they have in decentralised settings.

*“I think because this decentralisation policy has been introduced and people are not yet aware of their roles and responsibilities. I am telling you with evidences, for instance, in my ward, as a counsellor, I am trying my level best to go to the people and call for meetings and whenever I go people are complaining though you give them directives, do this and that because you are the one with authorities. If it is the case of land, you are the one with authority. If there are officials who are not performing their duties you have the authority but the turn up is low” Politician*

Although local participation is indicated as one of mechanisms for engaging communities in the formulation of comprehensive council health plans, the practice indicated that, the process ended at the identification of local needs only. Furthermore, community representative would not always get feedback of what has been incorporated in the final plan. The system for providing feedback exist but it does not function well,:

*“The system of communicating back the feedback has challenges because the way health centre and local government execute their responsibilities, the relationship between them is not that proper. We were thinking in the meetings we expect the officers responsible to give the feedbacks, since*

*they are not being involved in the process, it becomes difficult to communicate the feedbacks back to the community” Health facility governing committee member*

#### **8.4.1.3 Influences on investing on local planning capacity**

Central government interventions on local health planning capacity influence local health department performance in the formulation of local health plans. It was further established from the assessment of CCHPs report, that a slight increase in councils performance if councils receive orientation on new guidelines and capacity building in planning. This is the period where PlanRep<sup>1</sup> training was rolled out and both PORALG in collaboration with MOHSW were conducting workshop to orient councils on PlanRep and planning guidelines. A slight improvement was noted for both councils. in 2016/17 when new arrangement of direct health facility financing commenced there was decrease in performance for both Ilala and Morogoro district Council. - Table 8.1. in 2017 the PlanRep training phased out.

Table 8.1: Trends of CCHP Assessment Performance of Morogoro and Ilala (2013-2017)

Year	Ilala	Morogoro	Overall national average
2012/13	58%	70%.	74%
2013/14	76%	76%	78%
2014/15	87%	78%	90%
2015/16	81%	79%	87%
2016/17	69%	69%	85%

Source: summary analysis report of annual comprehensive council health plans (CCHPS) 2016/2017

Capacity building on health planning for councils was not institutionalised and highly donor dependent. It happens in ad hoc manner responding to new format or new electronic program or updates as illustrated in the quote below.

*“When we started planning, we were oriented on the planning guidelines and procedures so that plans which are going to be produced are evidence based”  
[CHMT member Morogoro]*

International and local NGOs were reported to provide planning training. Some respondents mentioned that they had planning training as part of their degrees. The focus of training it was not based on planning techniques but much on populating the planning documents format, as illustrated in the following quote:

*“Yah, we were given but now it’s that it changes, implementation changes you may find that what you know is not that you will find it, it just resembles” CHMT Morogoro*

Another respondent mentioned that central efforts to build planning capacity is sometimes hampered by transfers of employees.

*“[...] Its strength is that it builds our capacity and updates us in planning but the challenge is the for training is short, sometimes you may find that you train eight people but in doing the work you find you only have two or three people. Some of them are transferred so it weakens the working team” CHMT member Morogoro*

### **8.5 Donor Financial Management Concerns influences**

Donor financing influences to local health planning process was also mentioned.

Donor financing influence on local health planning process is on planning/budget regulations for local authorities. It was mentioned sometimes due to need for increased financial accountability donors work together with government to prepare guidelines.

*“The preparation of the MOU involves both parties, the development partners and the ministry people. Once the decision is made on the planning guideline and the MOU, the councils have to plan according to the available guideline” MOHSW official.*

The guidelines may have conditions that support local authorities in budget allocating. For example, one respondent mentioned that, basket funding has ceilings on allocation which work as a reminder for them. They make local planners to remember all important aspects for consideration during budget. Also, it provides a limit for allocation and this help local planners to put investment in important issues.

*“Cost centre ceilings are okay perhaps if we plan without the ceilings sometimes people can forget to allocate enough resources to some of the basic component’s [...] this is just a remainder but you could be more flexible in planning with the local issues. The issue of allowance is also... if you can’t standardize the ceiling you may end up paying a lot of allowances instead of addressing important issues for health provision”*  
 CHMT member Ilala

### **8.6 Politicians’ influences**

It was discovered that, technocrats at local level are caught up into two lines of accountability. Accountability to politicians through their local authority’s machinery and technical and administrative accountability effected through the organisation structure. Respondents explained that sometimes Councillors may insist on things that technically are not correct. If the professional refuses to abide with the politician requirements they might end up into disagreement which may result in a threat to the technocrat’s position. This practice was similar for both Ilala Municipal and Morogoro District Councils, as illustrated in the following quotes:

*“. For instance, a councillor might tell you don’t do this while you are professional and s/he doesn’t know anything about that thing. So, the current system allows politicians to interfere professional and it might reach a point where you completely disagree each other.... Sometimes they might say, “We don’t want this person” for instance DMO, simply because he doesn’t want to do what they want”. [CHMT Ilala]*

*“The current system allows politicians to interfere professional and it might reach a point where you completely disagree each other. Therefore, I would recommend these people to be empowered even if they are politicians so that when you are being advised at least you understand because sometimes you even show them the instruction from the guideline still, they don’t agree and say, “I want you to do this way” and disagree.”*  
 [CHMT member Morogoro]

Political power was found to influence the approval stage at local level and at national level. Political power is derived from political mandate and that application

of political power by Parliamentary Committee may sometimes influence the Ministry of Health to apply legitimate power over local planners. For example, it was reported that there were instances where the Parliamentary Committee responsible for health advised the Ministry of Health to exclude the training activities from CCHP of 2014 and to reprogram the money allocated for training to purchase medicines.

*“...if you are talking about planning, we expect the councils to come up with their own priorities but sometimes the central government just interferes depending on the directives coming from the parliament (...) for example. the previous year the parliamentary committee responsible for health advised the ministry of health to exclude the training activities from all plans. They were saying that because the allocated funds were very little and we thought the councils should focus on purchase of medicines” [Ministry official]*

The findings indicate differences of influences between local politicians and national level politicians. The local politicians influence is medium in both resource allocation and priority settings. The national level politicians have higher influence on resource allocation and priority settings. This is because the role of politicians is to ensure that party manifesto is taken care of in priority settings and resource allocations. The national level politicians have two avenues to influence planning at national level. The first avenue is through parliamentary committees which scrutinise sector budget before they are presented in National Assembly and during budget presentation at National Assembly

Administrative and political relationships were found to go together. This is because the Minister for Health and the Minister for Local Government are all members of Parliament from the ruling party.

## **8.7 Chapter Summary**

This chapter presented influences of central – local relations on local health planning and their implications in the process.

Three primary forms of influences of central-local relations on health planning were identified. Political, technical and administrative relationships. The influence on the responsiveness of local health plans to local needs, infringement of local decisions space, and influence on altering central arrangement leading to deviations between written intentions of decentralisation in the health planning process and the practice. Central level technocrats were found to have a great influence on planning decisions than lower-level technocrats for matters of central priorities as well as those of local priorities and were the custodian of policies and strategic directions of the country. Central control of LGA budget by setting revenue collection structure were noted which aimed at ensuring funds are not misappropriated and plans address national priorities. . Central level politicians have greater say than both technocrats and local politicians when it comes to decision making in planning. The avenues of influence reported were through parliamentary committees and budget sessions during parliamentary meetings. It was mentioned that rural council were likely to be affected more by central influence on planning compared to urban because the urban council have advantage of having a broader revenue base than rural.





## Chapter 9: Discussions, Conclusion and Recommendations

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### 9.1 Introduction

This chapter presents a discussion of the findings and conclusion of this study. The discussions are based on four results chapters (chapters 5,6,7, and 8). The results chapters were prepared in accordance with study conceptual framework and there are four sections in this chapter. Section one summarises and interprets the key findings of the study, provides conclusion and highlights the coverage of research objectives. Section two presents the implications of the findings within previous research and theories. Section three outlines the limitations of the study. Section four presents' recommendations on how to increase local planners' decisions space, responsiveness to local needs and on how to improve mode of interactions. The last section highlights areas for further exploration.

This study aimed at gathering new evidence and gaining theoretical understanding of how the relationships between central organisations and Council Health Management Teams (CHMT) influence the local health planning process in Tanzania, in order to develop ideas to improve local health planning. The study used an exploratory qualitative approach of inquiry. This study had five objectives which were to:

- i) describe the context of local health planning including decentralisation;
- ii) outline the health planning process in decentralised settings;
- iii) explore the central –local relations in local health planning;
- iv) analyse the influences of existing central-local relationship in local health planning; and
- v) identify options for improving central-local relationship in local health planning.

All objectives were covered and their findings are included. However, some of the recommendations such as those seeking provision of feedback to facilities on what was included in CCHP after the approval process were dropped because they

were already out of context. In 2015 Tanzania introduced Direct Health Facility Financing whose implementation started in 2016. DHFF is a fiscal decentralisation mechanism where the health basket financing is directly disbursed to health centres and dispensaries. This arrangement is different from the one which existed when data was collected. Therefore, the researcher is unsure that recommendations to support basket funding would be relevant following these changes.

## 9.2 Key Findings in Each research objectives

### 9.3 Discussion of key Findings

Key findings are presented under four main subheadings representing the study objectives and aligned with the study conceptual framework- figure 9.2. The key findings are summarised in table 9.1

Table 9.1: Key Findings

Study main themes	Key Findings
Context of local health planning and of local health planning relationship	<ol style="list-style-type: none"> <li>1. Financing of health plans. Tanzania is amongst the fast-growing economies in Africa. However, the budget allocated to health is about 10% of total government expenditure which is still below Abuja declaration.</li> <li>2. Planning levels is aligned to administrative hierarchy hence drawing very thin line between administrative accountability and planning responsibilities between levels. This may influence utilisation of granted decision space by local planner. Employees who are lower in the chain of command may tend to consider themselves inferior than those who are higher in the hierarchy.</li> <li>3. Information availability. Information for planning is another factor that influence capacity of local planners to back their decisions with evidence.</li> </ol>

Study main themes	Key Findings
	4. Legal framework verge in demarcating the limitations of central government powers.
The health planning process	<ol style="list-style-type: none"> <li>1. According to the policy documents the health planning is decentralised with clearly stipulated roles.</li> <li>2. A mix of bottom up and top-down decisions are experienced. The stages exposed to central influences are priority settings and resources allocation.</li> <li>3. The planning process: All councils follow standardised health planning process that has to align with planning guidelines issued by MOHSW and PORALG as well as budget guidelines issued by Ministry of Finance.</li> <li>4. The resource allocation: The resource allocation is guided by a formular that takes into account several factors such as population, burden of disease and health systems constraints of the councils.</li> <li>5. Financially and structurally central government is powerful than the local government.</li> </ol>
Central – local relations in local health planning	<ol style="list-style-type: none"> <li>1. The central-local relationships were mainly formal main actors being government (central and local government administrator and technocrats) donors and politicians.</li> <li>2. Actors interact on technical, political and administrative matters.</li> <li>3. Central – local relations in the process of developing local health plans were found not static.</li> <li>4. The power of central government was derived from constitutional and ministerial roles and functions, political stance and fiscal policies. Central government use its mandates and resource power to gain local compliance in addressing central agenda in local health planning.</li> </ol>

Study main themes	Key Findings
	<p>5. Central level technocrats have great influence on planning decision than lower-level technocrats for matters of central priorities as well as those of local priorities and they are the custodian of policies and strategic directions of the country.</p> <p>6. Central control LGA budget by setting revenue collection structure and allowable ceilings to be collected by LGA leading to limited revenue base for LGAs.</p> <p>7. Central level politicians have greater say than both technocrats and local politicians when it comes to decision making in planning.</p> <p>8. Rural council is likely to be affected more by central influence on planning compared to urban because urban council has broader revenue base than rural.</p>
Influences of central-local relation on local health planning	<p>Three major influences of central-local relations in local health planning were identified:</p> <ul style="list-style-type: none"> <li>• influences on local planners' decision space;</li> <li>• Influence on local plan responsiveness to local needs; and</li> <li>• Influences on actors' mode of interactions.</li> </ul>

In relation to the overall aim and objectives of the study, three main conclusions have emerged from the above findings. Firstly, central-local relationships have a varying influence on local health planners' decision space in which some contradict decentralisation intentions. Secondly, council and national level respondents consider local health planning process a mix of bottom-up and top-down approach. And thirdly, there is misalignment between the constitutions, ministerial responsibility and decentralisation policy regarding central-local planning relationships. Each of these conclusions is discussed below in relation to the above findings and recommendations are provided.

### **9.3.1 Central – local relations influence on local planners' decisions space**

The study findings indicate that, decisions space is interfered because of three factors. One is accountability concerns, two central government perception of local authority capacity and third fear that local government will abuse granted autonomy. This section discusses decision space and factors influencing it.

#### Decision Space

The study found that decentralisation of planning process is faster than the pace in which actors' roles and responsibilities is changing in the entire central-local management arrangements. Hence decision space availed to local planners is sometimes interfered. This study found a mixed perceptions with regard to decision space availed to local planners. Some respondents though it is completely narrow and some thought it is broad in some aspects and narrow for some aspects. The district administrators who are appointees of central government considered the decision space availed is broad. They were basing their argument on the existence of policy and acts that establish local authorities. For those who were saying the decision space is narrow in some aspect and broad in some aspect in which majority were CHMTs based on their experience in interacting with central government during formulation of local health plans.

The reasons why for example, MOH i broadens or narrows local decision space was explained to originate from their horizontal relationships with other central government ministries like Ministry of Finance. For example, it was stated by one central level respondents that, some central government ministries are reluctant to decentralise powers consequently they influence sectoral ministries like MoH to also retain some of its power which ideally, they were supposed to decentralise under decentralise arrangements. Therefore, although the ministry in its policy talks about decentralised health planning, in practice it also ensures that the local planers do not create serious problems that will create accountability liability to the ministry. In ensuring the local planners are accountable and their choices are within central government requirement, the centre provides preconditions that guide local planners' resources allocations decisions which sometimes was reported to narrow local decision space. As mentioned earlier the study found

three factors that is attributed to interference in local decision space; accountability, capacity and autonomy, as discussed below.

### **Accountability concerns**

Central government actors specifically Ministry of Finance and MOHSW are both accountable to the president and to the parliament(U.R.T, 1977). Their accountability concerns collectively influence local health planners' decisions space in terms of content and scope of local health plans. The planning guidelines and procedures for local health planning process indicate clearly that roles of the councils are to develop plans. Local planners report the process is not a straight forward one. Council respondents report several instances of revisions triggered by emergence of new items from the centre to be included in the plans or new financing conditions to be adhered to. Literature on health planning provides that, the planning process is not linear process and it is both political and technical process(Atkinson, 2011; Lindblom, 1959; Lindblom, 1979).

### **Central government perception about local capacity**

Capacity is defined as the "ability of local governments to perform their assigned functions (Steiner, 2010). In this study capacity constitutes the planning functions as stipulated in various government documents such as ministerial roles and responsibilities as well as planning guidelines. To establish the local government planning capacity, CCHP assessment criteria for local health plan was taken to present the expectations of the centre from local planning during development of local health plan. The assessment criteria present three groups of capacity elements:

- i) local capacity to analyse local health needs and involving community in the process;
- ii) local capacity to take into account national level guidance in the planning process (which include understanding central policy priorities and adhering to technical guidance in terms of health interventions to be invested); and

- iii) capacity to generate local resources and to allocate central grants in areas of national concerns and in alignment of various central grants conditions.

As mentioned in chapter six, central government took several steps to build local capacity. This includes, training, provision of planning templates and tools, issuing planning guidelines, indicating mechanisms to assess and approve local health plans. The focus of planning capacity building was inclined on ensuring the local health planners are aware of the dos and don'ts. This formed the major part of planning capacity building. For example, in chapter six it was reported that, assessment of councils' performance with regard to planning dropped in 2017 because there were no trainings conducted. It is in the same period where Direct Health Facility Financing (DHFF) was being implemented. In this period new directives continued to flow from the centre. This was catalysed by central government fears regarding local capacity limitation given the new arrangements. Consequently, leading to local health planning process to be deconcentrated than devolved in some aspects. Capacity limitations have been the reasons leading to re-centralisation either formally or informally. This finding also relates to findings from Kenya (Tsofa *et al.*, 2017).

### **Fear of abuse of granted autonomy**

One respondent mentioned that, decentralising resources is always the hardest part of decentralisation. He mentioned, it is hard to relax the rules because MOH is accountable for the resources and also accountable for service delivery. For example, the respondents mentioned that, it was very challenging during early years of health sector reform to relax rules because PORALG did not prepare the grounds ready for taking up roles. Very crucial regulations were not set and it was hard to think of decentralising resources in such unregulated environment. So, to ensure that, resources are decentralised in a secured arrangements MoH insisted on formulation acts of law, circulars and guidelines that reduce abuse avenues.

*“So, by the time we were moving forward, by the time we were issuing the guidelines there were danger, because were issuing guidelines for them to spend money without any legal backing, in case anything happened we*

*were not able to enforce the debts. So, in a way it was very risky, we issued the guidelines while the law was not there...” [ MOH official]*

The outcome of regulation may narrow decision space formally but also the translation of such tools in practice by individual bureaucrat may narrow local decision space informally. Incidence of abuse of granted autonomy were reported in other studies as well (Homedes and Ugalde, 2005). In some countries poor performance of centrally funded services such as immunization and breakdown of referral systems due to abuse of granted power by local actors were experienced.

### **9.3.1.1 Central – local relations influence on local participation**

The expectations of decentralised health planning are to promote community participation. Study findings suggest weak community representation in the planning process. To enhance participation a more formalised approach is adapted which basically has been in adequate. Local involvement is promoted through structures such as Health Facility Governing Committees and Council Health Boards. The role of these committees is to bring community priorities into planning sessions. However, the process is hampered by several factors. This includes low capacity of committees and centrally earmarked priorities which limit the committee’s roles as mainly to bless the priorities rather than generating them. This finding concurs to other studies in Tanzania (Frumence *et al.*, 2013; Frumence *et al.*, 2014; Maluka and Bukagile, 2016b). Venugopal and Yilmaz (2010) found that in the planning and budgeting process, the role of the community representation structures was simply rubber stamping the plans and budgets prepared by sector heads (Venugopal and Yilmaz, 2010).

### **9.3.1.2 Central – local relations influence on responsiveness of plans to local needs**

The study found more ownership of local health planning process by technocrats and their administrators. However, local bureaucrats were found less vibrant in ensuring local priorities are included in the plan especially those not aligned with central priorities. The local government staff who are in leadership positions are appointees of central government and hence safeguard the interests of central government.



This study found that in Tanzania, both constitution and ministerial responsibility instruments provides different mandate and power between local government and central government where central government is more powerful than the local government. Babeiya (2016) attributes continued imbalanced power between local government and central government to faulty take-off where the author mentions the main faulty line is attributed to challenges of their creation. The powers of central government were derived from the structure as well as the existing fiscal policies. Local government in Tanzania are managed through the President's Office Regional Administration and Local Government Ministry that structurally is located under the Presidents' Office with deconcentrated roles than devolved. The management of planning process was found to be linked with provision of tools to enhance the central government to oversee local authorities' affairs during planning. The overemphasis on regulating the planner's action somehow overshadowed efforts to empower local authorities to handle decentralised planning effectively. The same situation was reported in Pakistan(Zaidi *et al.*, 2019).

Generally, the study findings suggests that, less has been done make planners acquire planning skills, but a lot has been done to orient planners with required format, regulations and policies that they have to adhere to during planning. Hence watering down the contribution of planning techniques in expand knowledge of the problem and leading to appropriate solutions for local health problems.

Three types of planning relationships were identified– administrative, technical, and political. Types of health planning relationships were found to be highly linked to actors' mandates and accountability demands which are formal and complex in nature. The central-local relations are complex because the behaviour of central government over local government in the planning process is sometimes unpredictable. Rhode (1981) describes 'complexities' in central-local relations being contributed by number of other actors taking part in the process and scale of their interactions (Rhodes 1981). MOHCDGEC is interacting with more than one actor in the process. For example, council level respondents report alterations on resource allocation or additional demands from central. In some instances, these

were found to originate from MOHCDGEC interactions with donors and politicians at national level. In some cases, MOHSW proved less powerful.

#### **9.4 Revised Conceptual Framework**

In the course of analysis, it was realised that the original conceptual framework could be refined further based on improvement in literature as well as from the study findings. As stated in Chapter 2, decentralisation typology, decision space and policy triangle, informed the study conceptual framework. The three frameworks were used to complement on each other in order to prepare a single framework that provided insight on variety of aspects in understanding central-local relations in health planning. This includes first understanding the process, actors, content and context of central – local relations. Second understanding the modalities in which power is transferred as well as how much power is granted and how much is retained. Third to understand what determines the granting and utilisation of decision space. The policy triangle was used to analyse policy at national level but in this study, it was used to understand the design of central-local planning relations in terms of content, context, process and actors. The decentralisation typology was used to understand modality of decentralisation and decision space was used to understand perception of respondents on local decision space in health planning process.

After the analysis and further readings on the area, the conceptual framework was revised from the original framework presented in Chapter 2 to better reflect the study's findings and new development in the area. Several studies have indicated challenges of achieving decentralisation intentions. There are several reasons contributing to this such as: capacity limitations, abuse of granted authorities and influence of local elites on local participation. Elite hijacking local participation process was found in Philippine, Uganda and Pakistan (Kapiriri, Norheim and Heggenhougen, 2003; Zaidi *et al.*, 2019; Akbar and Zaidi, 1994) Capacity includes human resources capacity who are capable to utilise the granted decision space effectively. Another capacity element is financial capacity to address local matters without too much dependency on central financing (Bulthuis *et al.*, 2021; Kapiriri, Norheim and Heggenhougen, 2003). Also, decentralisation intentions are impeded

by the misuse of granted autonomy and hence the accountable authorities increase oversight consequently jeopardising the overall intention of decentralisation. These studies and many others indicated important synergies between capacity, decision space and accountability (Liwanag and Wyss, 2019; Bossert, 2016; Bossert and Mitchell, 2011).

This study amplifies these findings by demonstrating how capacity and accountability concerns, shape the practice of central – local relations in the planning process. The study confirms the need for an expanded analysis of decision space beyond establishing whether decision space is narrow or broad (difference between de jure and de facto decision spaces) to explore what leads to weakening of decentralisation intention in practice. This study adds additional dimension in exploring decision space during development of health plans which is the central-local relations aspect of health planning specifically the policy context of central-local planning relations determining actors' power or vulnerability. It is important to explore actor's power and their vulnerability because they influence the granting and application of decision space during planning. Sources of actor's power/vulnerability include resources access, technical, administrative and political mandates, skills and position in the organisation structure. The following section describes the revised conceptual framework presented in Figure 9.1

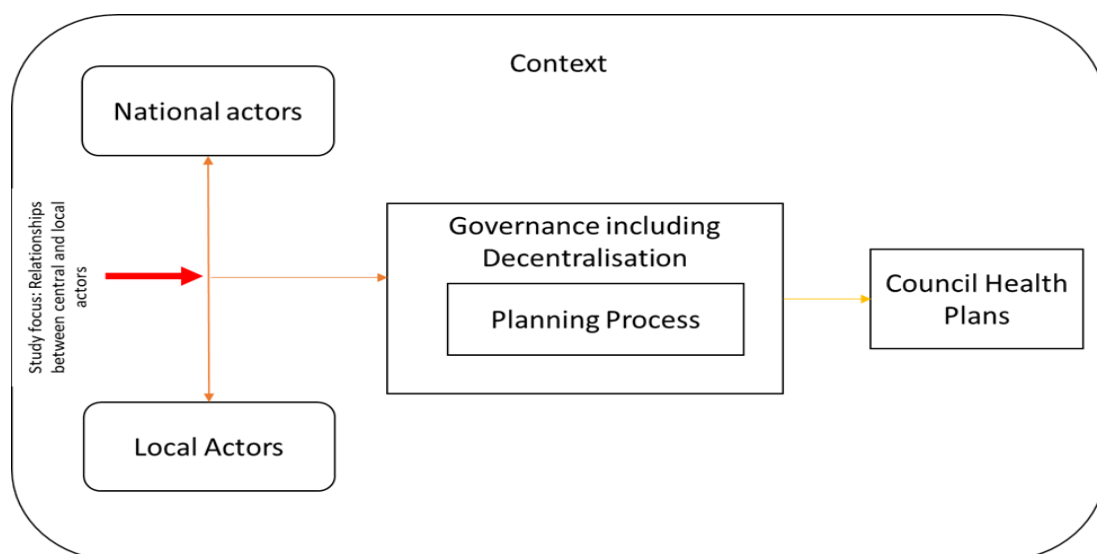


Figure 9.1: Original Conceptual Framework

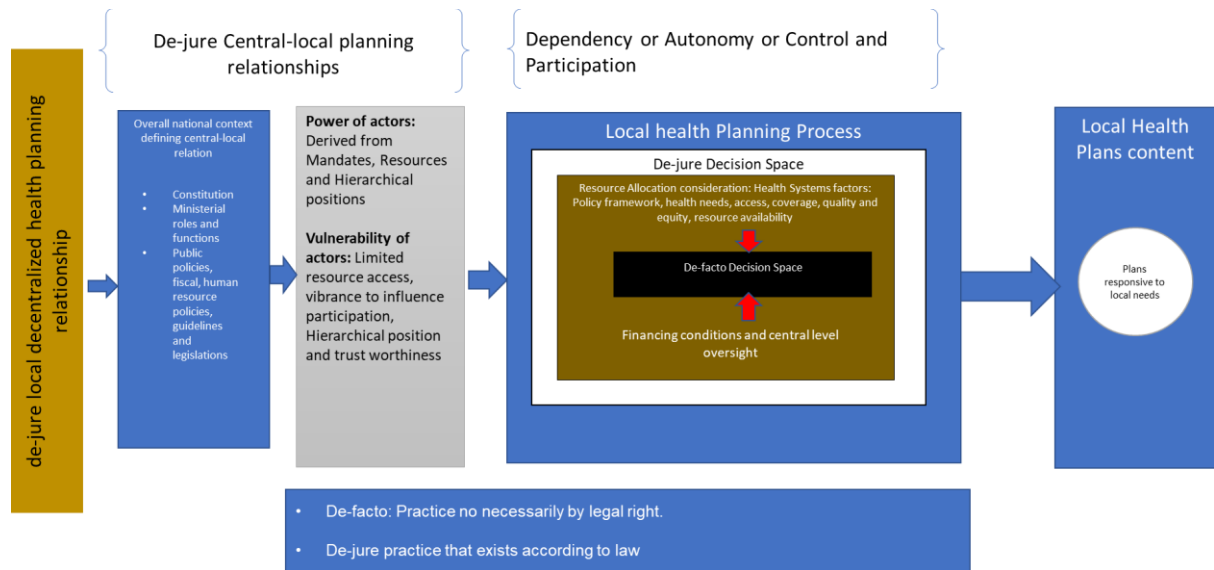


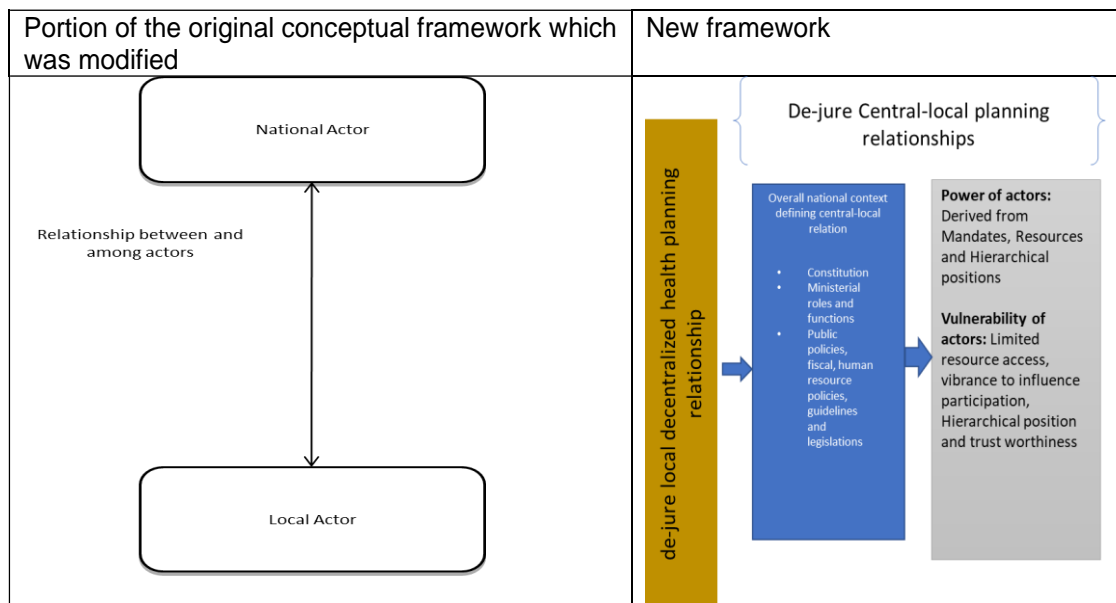
Figure:9.2: Revised study conceptual framework

#### 9.4.1 Description of conceptual framework

This part describes three components within the revised conceptual framework in more details

De-jure<sup>1</sup> central-local relations in planning: This component includes the official roles of central and local actors in the development of local health plans as presented in official document describing decentralisation and planning in Tanzania. The written or official central-local planning relationships as presented in decentralisation paper of 1998 and local government reform proposals, is regarded by the design where since independence the centre has always remained with more power (Babeiya, 2016; Kessy, 2018; Kessy and McCourt, 2010; Mollel and Tollenaar, 2013). This continues to fail the intention of decentralisation in local health planning process. The study findings suggest that deviations of de-jure central-local relations in a decentralised setting is an inherent product of balance of power between local and central government created by decentralisation design, the constitution as well as the ministerial responsibilities. The original conceptual framework has been modified as indicate in the figure 9.3 below. The previous framework had the following assumption which were changed following the study findings. The assumption included:

- Relationships of actors are independent of other influences of central – local relationships
- The relationship is closed and not interacting with the wider context
- Views actor separate from other processes determining their formulation and continued existence
- Views central-local actors operating in equal space disregarding their hierarchical position, access to resources and mandates



*Figure: 9.3: Changes into the conceptual framework*

Overall National Context: The overall national context of planning relationships includes policies, constitutions and frameworks describing the roles of local government and define their mandate administratively, technically and politically. These factors were the source of deviation from decentralisation intentions because they form the basis in which roles and power of different levels are defined and exercised. The constitutions and ministerial roles and functions set out who is the powerful actor and who is the less powerful actor given their defined mandates. The factors are the same though the influences of legal frameworks were found more significant

Power and Vulnerability of Actors: Includes members of local health departments and council level administration (CHMT and members of Council Management Team), councillors, members of Health Facility Governing Committees, members of Council Health Service Boards and local NGOs. It also includes national level actors: the central ministry staff, donors and members of national assembly. This category also includes actors' related factors influencing power or creating vulnerability which is additional focus included in the new framework. This includes: power, access to resources, skills, knowledge and attitude about decentralisation and position in the organization structure as well as mandates and accountability concerns. Power and vulnerability component is the additional thing in the new framework.

Local Health Planning Process: Local health planning process constitute activities done by local actors in identifying and analysing health needs of the population in their localities. It involves review of previous plans, identification and analysis of problems, choosing alternative solutions and programming. In this component the national directives in terms of priorities and resource allocation were considered. Generally, the planning process is standardised across all councils with directives on what to include in the plans and budget ceiling percentages. Whether decisions are top down or bottom up were determined by financial and technical capacity of local authorities and policy priorities to be addressed by local actors. Council respondents report that the planning process was a mix of top-down and bottom up. Local participation is highly formalised through community representation structures as mentioned earlier. Several studies in Tanzania report the limitation of the health facility governing committee and council health service board in enhancing local priorities inclusion into local health plans. The level of community participation is illustrated below:

Levels of community participation	Local government forums	Focus	Health sector structures	Focus
District	Full council	All sectors	Council Health Service boards	Health
Ward	Ward Development Committee		Health Facility Governing committees	Health
Village	Village Assembly			Health

Table 6.2: The level of local community participation in decision making space

**Decision Space:** The decisions space experience was mixed. Local administrators (council directors) consider decision making as broad because local health department prepare their annual health plans whereas some CHMTs thought the decision space is narrowed specifically for local priorities that do not converge with the national priorities. The findings indicate that the decision space is engulfed within two main set of determinants i) the health systems factors such as coverage and utilisation of service, equity concerns, resource availability and health needs and ii) national priorities and central actor's accountability concerns. These factors influencing de-jure decision space of the local planners specifically in allocating resources.

**Plans responsive to local needs:** This component focus on the chances at which local health priorities get approved. The findings indicate that local priorities have a greater chance for funding approval when priorities are closely aligned to central priorities. Local plans that identify local needs that are not explicit in national plans remain wishes.

#### 9.4.2 Application of the conceptual framework

Although the framework was applied on studying influences of central local relations in health planning, I hope it could as well be applied to understand influences of central – local relation on implementation of health plans. The framework also can be used in assessing policy implementation as similar processes between central and local levels exist.

## **9.5 Implication of Findings for Research, Policy and Practice**

The following section presents the implications of the research findings for research, policy, and practice discussed in relation to the main findings presented in earlier in this chapter. Implications for research are derived from questions that emerged as a result of study findings. Policy and practice implications were derived from recommendations in relation to the central-local relations in the development of local health plans from respondents and also from the researcher. The research findings and implications will be disseminated to the relevant bodies in Tanzania where applicable and feasible.

### **9.5.1 Research Implications**

### **9.5.2 Understanding the context of health planning**

As evidenced by the findings, there are multiple contextual factors that influence the local health planning process. Not all factors contextually shaped the central-local relations of local health planning process. Policy (decentralisation, fiscal), constitution, instruments defining roles and functions of ministries, and regulatory frameworks were found to have more influence in defining the power and vulnerability of actors. The study findings suggest that, in understanding the influences of central-local relations in the development of local health plans, it is therefore important to understand what shape them. The findings suggest the importance of situating the decentralised planning intentions or objectives within a wider policy and regulatory frameworks. The wider policy and regulatory frameworks were found to shape roles of actors at all levels, access to resources, mandates and define their powers. For decentralised health planning to work therefore, it is important to identify the contextual bottlenecks to granting and application of planning decisions space. This finding led to improvement on the study conceptual framework to include the following components- i) De-jure decentralised local health planning central-local relations ii) overall national context defining central-local relations (constitution, ministerial responsibilities and functions and relevant public policies iii) consist of actors their powers and their vulnerability the components were described earlier.

To understand further factors influencing decentralisation during implementation of plans beyond the current synergies of accountability, capacity and decision



space future research may dwell deeply to explore how other governing frameworks like constitutions, laws and policies describing overall structural arrangement impede decentralisation intention during planning process and implementation as this research did not collect much information on these factors.

### **9.5.3 Understanding influence to central-local relation in local health planning process**

The understanding of influences to central-local relations in local health planning enables the identification of factors that retard the success of decentralised local health planning. The evidence suggests that, the financial capacity limitation influence the extent to which local priorities are addressed. Strong upward accountability of local bureaucrats and local elected individuals or groups were reported to be less vibrant. Ideally local bureaucrats were expected to be also accountable to local elected groups. This is an inherent problem of Tanzania decentralisation where the centre retains more power (Kessy, 2018). The original focus of this study was central government Vis a vis local government. In the course of analysis, it was discovered that, central- local relations in local health planning process is not a single set of relationship. It is influenced by other relationships specifically the political arm. Literature described central-local relations broadly denoted two levels of government whose power and behaviour were mainly determined by their different political resources and constitutional norms (John, 1996). Therefore, it is important to explore the central-local relations of the political arm and their links with central-local relation of the executive arm to establish power and vulnerability aspects of these actors to promote local agenda in the planning process. This study ended up identifying the existence of this relationship but it did not explore much on this explore the central-local relations of the political arm and their links with central-local relation of the executive arm

### **9.5.4 Policy implication**

As indicated earlier, decentralisations objectives encounter some confounding factors that lead to its limited achievements especially in health planning. The challenges are not inherent flaws of decentralisation. Instead, they result from poor design, procedural weaknesses, political immaturity and capacity problems that ought to be addressed not only by local government reform programmes but also

public service reforms as mentioned in other studies (Collins and Green, 1994) Decentralisation is not a standalone phenomenon, as a change process decentralisation brings need for bureaucratic reorientation in terms of changes in tasks, roles and behaviors. Decentralisation has often been pushed forward or constrained without an adequate understanding of how best to structure it in order to maximise its effect. There are some misconceptions of decentralisation that without proper analysis it will render it a difficult endeavour especially in health planning

- i. Decentralisation is viewed as an activity rather than a process: The study revealed that decentralisation in health planning presents itself as a process bringing in an array of actors with different power space. The differences in power space alter relationships between actors sometimes contrary to decentralisations intentions
- ii. Decentralisation does works alone: Decentralisation does not work alone, in the planning process both decentralisation and planning manifest as two processes operating in tandem. Therefore making relationships of actors in the planning process fragile and dynamic

This study findings suggest that decentralisation policy or strategy does not operate in silo. It is complemented and conflicted by existing policy and instruments defining the roles, mandates and powers of actors. It is important to consider decentralisation as a systemic change that affects and is affected by other systems components. Therefore, necessary alignment with other relevant policy and regulations is important. This study ended up at identifying the existing synergy between decentralisation with other existing policy and instruments defining the roles, mandates and powers of actors, however further research is needed to establish how this synergy influence implementation of decentralisation especially in planning and make recommendations on how best to structure it

### **9.1 Opportunity Cost of Planning**

Health planning is gaining more buy in as one of the tools for improving health services. However, there have been different experiences on how planning meets its proponents expectations. This because planning process for example in Tanzania for example was said to be a cumbersome process. The emphasis is more on getting planning documents right as per the requirement of guideline. In addition, not always all what is planed get funded during implementation. Delayed disbursement of funds has been amongst the implementation challenges that are on records in Tanzania in several health sector reviews and evaluations. The fact that local ensure they include central priorities; the meagre resource is spread too thin and thereby leading to limited impact in some areas. This means the focus on the process and addressing planning process bottleneck may contribute to making planning exercise user friendly and probably more objective than it is currently

## **9.2 Recommendations**

### **9.2.1 Recommendations to improve actors' interactions in the planning process**

It is agreed that constitution it is hard to change as it may call for variety aspects which will be beyond the need of health planning. For the purpose of reducing contradictions in implementation. It is recommended that, MOH in collaboration with other sectors to prepare a national guiding document for implementation of decentralised health planning containing resolutions to reduce mismatches between regulatory frameworks. This proposal may be a remedy for mitigating risks of misalignment and misinterpretation of policies by technocrats who base on constitutions or other policies that contradict decentralisation

### **9.2.2 Recommendations on improving decisions space**

The findings indicate that central government has justifications in tightening rules in decentralised settings. It also illustrates that the benefits of decentralisation are calling for change in bureaucratic orientation to support decentralisation implementation. It is recommended that to improve local health planning there should be an environment where central government fears are minimised and local

government vulnerabilities are addressed. Adapting a structured mechanisms for communication, transparency and regulation of the periphery units without interfering with local autonomy is recommended. Some of the tools have been used in other countries and proved beneficial. This includes performance contracting. It is high time for Tanzania public service management arrangements to move out of permanent and pensionable mechanisms and institutionalise performance contracting. This has the potential of ensuring certain level of local accountability and thereby motivate central government to relax interference to local matters. It is recommended that, the implementation of the performance contracting mechanism are done under implementation research arrangements where the new set of central-local relations are defined and tested in few Councils with differing context.

In addition to this, it important for central-government to set mechanisms which district health systems can improve its revenue base by addressing three things. One strengthening health facilities revenue collection, two subsidising exemption and waivers and three increasing resources allocation for health promotion to reduce disease burden. This will reduce spending on curative and thereby increase chance for other priorities which cannot be covered by the existing budget. This is said so because one respondent mentioned the guidelines alienate issues on environmental and sanitation.

### **9.2.3 Recommendations on improving community participation in planning**

- Since MoH uses Health Facility Governing Committees and Health Service Boards as links to communities, it is recommended that these structures are empowered to promote local agenda in the local health planning process and support in resource mobilisation from the community.
- Although it was not part of this study, it is recommended to strengthen mechanisms for local engagement in preparation and reviews of health policies. This is because national health policies are linked to plans, so

indirectly if health policy becomes responsive to community needs then the plans will be responsive.

#### **9.2.4 Recommendation to manage risks of abuse of autonomy**

- Devise and institutionalise mechanisms where central-local agreements are made rather than overemphasising on rules and regulations. The agreement should focus on:
  - Setting long term (5 year) central and local priorities in order to create a shared vision on what is centrally a priority and what is locally a priority. This will allow local government to mobilise resources on areas where central government would not fund. This should go in tandem with capacity building for resource mobilisation and reviewing local revenue sources.
  - Capacity building of local planners is recommended, to include planning skills (including generation and use of local data, numeracy skills and enhanced communication skills both oral and written).

This chapter presented summary of findings and discussed the emerging conclusions. This study found that central-local relations influences on health planning were the same for both Ilala municipal and Morogoro district. This is because they all have to work with the same standardized planning framework and also both councils were highly dependent on central financing. It also found that there is a deviation between written relationships and practice. This is because other instruments defining roles, responsibilities and powers of actors operate in tandem with the decentralisation policy and shaped behaviors of actors. The instruments sometimes correspond with decentralisation intentions and sometimes contradict. Hence making local health planning process mostly to trade between bottom-up and top-down mode. For majority of aspect the local health planning process is deconcentrated than devolved. Furthermore, the chapter discussed the implications of influences of central-local relations on local health planning process where implications on decision space, local participation and responsiveness of plans to local needs were discussed. The chapter concluded

with a discussion of the implications of the findings for research, policy, and practice. Several reasons were identified to enrich the understanding on why decision space is not as broad as expected in some aspect especially budgeting and resource allocation. Theoretical progression identified additional component for analysis to expand the understanding on the matter. This includes the identified synergy between decision space, capacity and accountability. However, on the Tanzanian context, accountability of local bureaucrats was found to be strongly upward because of the nature of their appointments. Therefore, despite the findings of this study echoing the synergies identified previously, it also provides central-local relations analysis as an additional dimension of assessing factors influencing decisions space.

With regards to planning process, in chapter several planning frameworks were discussed and in the chapter it was pointed out Tanzania planning systems is organised in a cascade manner with long-term being a national level plan basically a sector strategic plan. The strategic plan translates party manifesto and five-year development plan. The strategic plan is divided into medium expenditure framework which in most cases have a time frame of three years. The medium-term expenditure framework operationalised by annual plans. The model that is an application is mostly mixed scanning where plans take into consideration technical, administrative and political justifications in prioritising and allocating funds

### **9.3 Study Limitation**

Highlighting the limitations of the study is a common practice for any research. This provides an opportunity for potential users of the findings to make informed decisions about validity and application in other settings (Eide, Johansson and Eide, 2020a). Although the design considered variety of variables that can make possibility for using the findings in areas with similar context, it hard to guarantee that the results can be used in other settings outside Tanzania because of differences in micro and macro context

- a) Despite the fact that different methods were used and different types of respondents were reached but the validity of findings is weakened by the time when data was collected some issues identified as a challenge may have been solved and possibly new challenges in the area may have emerged. Following this reason, the study provides broad recommendations.
- b) The study also has a limitation of stakeholders included. The professional associations and the private sector was not included. For example in Ilala more than 73% of dispensaries are owned by private, 50% of hospitals and health centres are owned by private. This group has a big stake when it comes to service delivery but it was not considered. The reasons was focus was more on those were considered explicitly in the guideline. This omission might have led to weaknesses in getting perspectives of the key players such as private sector
- c) The study used a qualitative approach, if I repeat study of this kind I will consider using both qualitative and quantitative data to quantify some of the claims made for or against central restrictions. Furthermore, the results presented come from different respondents and indicates varied opinions on some aspects of relationships and decisions space. A Focused Group Discussion would have increased understanding of why different levels have different opinions or why the center despite setting the policy of decentralization in practice sometime go against the decentralization objectives. In this study it was not possible to have FGDs due to time and financial constraints
- d) Another limitation is researcher bias. Given that the researcher is engaged with the health planning for several years in variety of capacity from a trainer of district health managers, assessor of health planners and reviewing and writing the current district health planning guidelines. This might have influenced the research design and interpretation of findings
- e) Another limitation is that I had formulated the research objectives too broadly which in actual fact led to too many information sources and had decide what to include or exclude or what are the most important sources of information. In future studies it is useful to link the influence of planning

relationship with specific aspect or stage of planning process such as budgeting or priority setting this may narrow research aims and objectives. This study focused on all stages of planning process.

- f) Literature review findings inform the design of the study, however, there were very limited literature that focused on planning relationships at least in the context of Tanzania.
- g) Lastly given that in most cases the research work I did was not individual, the scope and depth of discussion in this work could probably be limited compared to what an experience scholar would have presented

For future studies it is important to use both quantitative and qualitative techniques for studies of this kind. In addition, for qualitative study FGD is an important collection technique to be included.

#### **9.4 Potential for application of the fundings beyond Tanzania**

The findings of this study may be applicable to countries with similar context to Tanzania. For example, the concept of decision space was found broad and narrow in some aspects in studies that were conducted in Zambia, Uganda, Kenya and Ghana (Bossert, 1998a; Bossert, Chitah and Bowser, 2003; Bossert and Beauvais, 2002c). These studies looked at the implementation of plans. These countries may benefit from the findings of this study as it brings another dimension of assessing the effectiveness of their decentralization in health planning process and also in the implementation of plans. The findings further confirm existence of synergy between accountability, capacity and decision space (Bossert, 2016; Liwanag and Wyss, 2019) which is an important aspect for countries with similar context to Tanzania to reflect on opportunities and obstacles of their decentralization in health plans development and implementation



## References

- Agranoff, R. (2004) 'JPART Symposium Introduction: Researching Intergovernmental Relations', *Journal of Public Administration Research and Theory: J-PART*, 14(4), pp. 443-446.
- Agranoff, R. and McGuire, M. (2004) 'Another Look at Bargaining and Negotiating in Intergovernmental Management', *J Public Adm Res Theory*, 14(4), pp. 495-512.
- Agranoff, R. and Radin, B. A. 'Deil Wright's Overlapping Model of Intergovernmental Relations: The Basis for Contemporary Intergovernmental Relationships ', *ASPA 2014 Conference*
- Akbar and Zaidi, S. (1994) 'Planning in the health sector: For whom, by whom?', *Social Science & Medicine*, 39(9), pp. 1385-1393.
- Akbar Zaidi, S. (1994) 'Planning in the health sector: For whom, by whom?', *Social Science & Medicine*, 39(9), pp. 1385-1393.
- Assarroudi, A., Heshmati Nabavi, F., Armat, M. R., Ebadi, A. and Vaismoradi, M. (2018) 'Directed qualitative content analysis: the description and elaboration of its underpinning methods and data analysis process', *Journal of research in nursing*, 23(1), pp. 42-55.
- Atkinson, M. M. (2011) 'Lindblom's lament: Incrementalism and the persistent pull of the status quo', *Policy and Society*, 30(1), pp. 9-18.
- Atkinson, S., Fernandes, L., Caprara, A. and Gideon, J. (2005) 'Prevention and promotion in decentralized rural health systems: a comparative study from northeast Brazil', *Health Policy Plan.*, 20(2), pp. 69-79.
- Babeiya, E. (2016) 'Local Government in Tanzania and the Legacy of a Faulty Takeoff', *The African Review: A Journal of African Politics, Development and International Affairs*, 43(1), pp. 128-160.
- Bahrami, M. (2011) 'Meanings and aspects of quality of life for cancer patients: A descriptive exploratory qualitative study', *Contemporary Nurse*, 39(1), pp. 75-84.
- Baum, H. S. (1996) 'Why the Rational Paradigm Persists: Tales from the Field', *Journal of Planning Education and Research*, 15(2), pp. 127-135.
- Baxter, P. and Jack, S. (2010) 'Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers', *Qualitative Report*, 13.
- Bengtsson, M. (2016) 'How to plan and perform a qualitative study using content analysis', *NursingPlus Open*, 2, pp. 8-14.
- Berman, P. A. and Bossert, T. J. (2000) *A Decade of Health Sector Reform in Developing Countries What have we Learned?*
- Berry, D. E. (1974) 'The Transfer of Planning Theories to Health Planning Practice', *Policy Sciences*, 5(3), pp. 343-361.
- Bloor, M. and Wood, F. (2006) *Keywords in Qualitative Methods*. London: SAGE Publications Ltd.
- Boex, J. (2003) 'The incidence of local government allocations in Tanzania', *Public Administration and Development*, 23(5), pp. 381-391.
- Bossert, T. (1998a) 'Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance', *Social Science & Medicine*, 47(10), pp. 1513-1527.
- Bossert, T. (1998b) 'Analyzing the Decentralization of health systems in developing countries: Decision Space, innovation and Performance', *Social Science and Medicine*, 47(10), pp. 1513 - 1527.
- Bossert, T., Chitah, M. B. and Bowser, D. (2003) 'Decentralization in Zambia: resource allocation and district performance', *Health Policy Plan.*, 18(4), pp. 357-369.
- Bossert, T. J. (2016) 'Decision Space and Capacities in the Decentralization of Health Services in Fiji; Comment on "Decentralisation of Health Services in Fiji: A Decision Space Analysis"', *International Journal of Health Policy and Management*, 5(7), pp. 443-444.

- Bossert, T. J. and Beauvais, J. (2002a) 'Decentralization of Health Systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space', *Health Policy and Planning*, 17(1), pp. 14-31.
- Bossert, T. J. and Beauvais, J. (2002b) 'Decentralization of Health Systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space', *Health Policy and Planning*, 17(1), pp. 14-31.
- Bossert, T. J. and Beauvais, J. C. (2002c) 'Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space', *Health Policy Plan*, 17(1), pp. 14-31.
- Bossert, T. J. and Mitchell, A. D. (2011) 'Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan', *Social Science & Medicine*, 72(1), pp. 39-48.
- Brans, M. (1992) 'THEORIES OF LOCAL GOVERNMENT REORGANIZATION: AN EMPIRICAL EVALUATION', *Public Administration* 70 pp. 429-451.
- Brewer, G. A. and Selden, S. C. (2000) 'Why Elephants Gallop: Assessing and Predicting Organizational Performance in Federal Agencies', *J Public Adm Res Theory*, 10(4), pp. 685-712.
- Bryson, J. M., Edwards, L. H. and Van Slyke, D. M. (2018) 'Getting strategic about strategic planning research', *Public Management Review*, 20(3), pp. 317-339.
- Bulthuis, S. E., Kok, M. C., Amon, S., Agyemang, S. A., Nsabagasani, X., Sanudi, L., Raven, J., Finn, M., Gerold, J., Tulloch, O. and Dielema, M. A. (2021) 'How district health decision-making is shaped within decentralised contexts: A qualitative research in Malawi, Uganda and Ghana', *GLOBAL PUBLIC HEALTH*, 16(1), pp. 120-135.
- Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Berkshire: Open University Press.
- Carolan, M. (2003) 'Reflexivity: a personal journey during data collection', *Nurse Researcher (through 2013)*, 10(3), pp. 7.
- Cassels, A. and Janovsky, K. (1992) 'A time of change: health policy, planning and organization in Ghana', *Health Policy and Planning*, 7(2), pp. 144-154.
- Chandler, J. (2005) 'Comparative Inter-Governmental Relations: Models That Need to Travel', *Local Government Studies*, 31(3), pp. 269-284.
- Chandler, J. (2005) 'Comparative Inter-Governmental Relations: Models That Need to Travel', *Local Government Studies*, 31 (3).
- Chandler, J. (2010) 'A Rationale for Local Government', *Local Government Studies* 36 pp. 1
- Chansa, C., Sundewall, J., McIntyre, D., Tomson, G. and Forsberg, B. C. (2008) 'Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia', *Health Policy and Planning*, 23(4), pp. 244-251.
- Collins, C. (1989) 'Decentralization and the need for political and critical analysis', *Health Policy Plan.*, 4(2), pp. 168-171.
- Collins, C. and Green, A. (1994) 'Decentralization and Primary Health Care: Some Negative Implications in Developing Countries', *International Journal of Health Services*, 24(3), pp. 459-75.
- Conyers, D. (1983) 'Decentralization: The latest fashion in development administration?', *Public Administration and Development*, 3(2), pp. 97-109.
- Cook, J. A., Staniforth, D. and Stewart, J. (1997) *The learning organization in the public services*. Gower Publishing, Ltd.

- COOK, K. S. (1977) 'Exchange and Power in Networks of Interorganizational Relations', *The Sociological Quarterly* (18 ), pp. 62-82.
- Corbin, J. and Strauss, A. (2008) *Basics of Qualitative Research*. Thousand Oaks: Sage Publications. Inc.
- Creswell, J. (2009a) 'Research Design: Qualitative, Quantitative, and Mixed-Method Approaches'.
- Creswell, J. W. (2009b) *Research Design Qualitative, Quantitative and Mixed methods approaches*. Third edition edn.: SAGE Publications. Inc.
- Creswell, J. W. and Miller, D. L. (2000) 'Determining validity in qualitative inquiry', *Theory into practice*, 39(3), pp. 124-130.
- Crook, R. C. (2003) 'Decentralisation and poverty reduction in Africa: the politics of local–central relations', *Public Administration and Development*, 23(1), pp. 77-88.
- DeHart-Davis, L. (2009) 'Green Tape: A Theory of Effective Organizational Rules', *J Public Adm Res Theory*, 19(2), pp. 361-384.
- DeHart-Davis, L. and Pandey, S. (2009) 'Red Tape and Public Employees: Does Perceived Rule Dysfunction Alienate Managers?', *Journal of Public Administration Research and Theory*, 15.
- Denscombe, M. (2002) 'Ground Rules for Good Research'.
- Denscombe, M. (2007a) *The Good Research Guide for Small - Scale research projects*. Thid Edition edn. Madenhead: Open University Press.
- Denscombe, M. (2007b) *The Good Research Guide: For Small-Scale Social Research Projects*.
- Dery, D. (2002) 'Fuzzy Control', *Journal of Public Administration Research and Theory*, 12(2), pp. 191-216.
- deSavigny, D., Kasale, H., Mbuya, C. and Reid, G. (2004) *Fixing the Health System. 2nd Edition* edn. Nairobi: International Development Research Center, .
- Dunsire, A. (1981a) 'Central Control Over Local Authorities: A cybernetic approach', *Public Admin. Dev*, 59.
- Dunsire, A. (1981b) 'Central control over local authorities: a cybernetic approach', *Public Administration*, 59(2), pp. 173-188.
- Eide, W. M., Johansson, L. and Eide, L. S. (2020a) 'FIRST-YEAR nursing students' experiences of simulation involving care of older patients. A descriptive and exploratory study', *Nurse education in practice*, 45, pp. 102797.
- Eide, W. M., Johansson, L. and Eide, L. S. P. (2020b) 'FIRST-YEAR nursing students' experiences of simulation involving care of older patients. A descriptive and exploratory study', *Nurse education in practice*, 45, pp. 102797-102797.
- Elander, I. (1991) 'Analysing Central - Local Government Relations in Different Systems: A conceptual Framework and Emperical Illustrations', *Scandinavian Political Studies*, 14.
- Erasmus, V., Brouwer, W., van Beeck, E. Â F., Oenema, A., Daha, T. Â J., Richardus, J. Â H., Vos, M. Â C. and Brug, J. (2009) 'A Qualitative Exploration of Reasons for Poor Hand Hygiene Among Hospital Workers: Lack of Positive Role Models and of Convincing Evidence That Hand Hygiene Prevents Crossâ€•Infection', *Infection Control and Hospital Epidemiology*, 30(5), pp. 415-419.
- Mixed Scanning Revisited*, 1986a. Article. Directed by Etzioni, A.: Blackwell Publishing Limited.
- Etzioni, A. (1986b) 'Rationality as anti-entropic', *Journal of Economic Psychology*, 7(1), pp. 17-36.
- Flick, U. (2006) *An Introduction to Qualitative Reasearch*. Third Edition edn. London: SAGE Publications Ltd.
- Frumence, G., Nyamhanga, T., Mwangu, M. and Hurtig, A.-K. (2013) 'Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council', *Global Health Action*, 6(1), pp. 20983.

- Frumence, G., Nyamhanga, T., Mwangi, M. and Hurtig, A. K. (2014) 'Participation in health planning in a decentralised health system: Experiences from facility governing committees in the Kongwa district of Tanzania', *GLOBAL PUBLIC HEALTH*, 9(10), pp. 1125-1138.
- Furber, C. (2010) 'Framework analysis: a method for analysing qualitative data', *African Journal of Midwifery and Women's Health*, 4(2), pp. 97-100.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S. and Redwood, S. (2013) 'Using the framework method for the analysis of qualitative data in multi-disciplinary health research', *BMC Medical Research Methodology*, 13(1), pp. 117.
- Gee, J., Loewenthal, D. and Cayne, J. (2013) 'Phenomenological research: The case of Empirical Phenomenological Analysis and the possibility of reverie', *Counselling Psychology Review*.
- Gilson, E. E. a. L. (2008) 'How to do (or not to do) How to start thinking about investigating power in the organizational settings of policy implementation', *Health Policy and Planning*, 23, pp. 361 - 368.
- Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C. and Thomas, S. (2003) 'The SAZA study: implementing health financing reform in South Africa and Zambia', *Health Policy Plan.*, 18(1), pp. 31-46.
- Gilson, L. and Mills, A. (1995) 'Health sector reforms in sub-Saharan Africa: lessons of the last 10 years', *Health Policy*, 32(1-3), pp. 215-243.
- Gish, O. (1977) *Health Planning in Developing Countries*  
London: : Tri-Med.
- Golooba-Mutebi, F. (2003) 'Devolution and outsourcing of municipal services in Kampala city, Uganda: an early assessment', *Public Administration and Development*, 23(5), pp. 405-418.
- Gonzalez, J. L. (1996) 'Evolution of the Philippine Health Care System During the last Forty Years of Development Administration', *Asian Journal of Public Administration*, 18(2), pp. 168 -200.
- Gray, D. (2009) *Doing Research in the Real World*.
- Green, A. (1995) 'The state of health planning in the '90s', *Health Policy Plan.*, 10(1), pp. 22-28.
- Green, A. 1999. An Introduction to Health Planning in Developing countries. In: Book (ed.). Oxford University Press.
- Green, A. (2001) *An Introduction to Health Planning in Developing Countries*. Second Edition edn.: Oxford University Press.
- Green, A. 2007. Mode of decentralizations and effects on planning process. *Book*. New York: Oxford Press.
- Green, A., Collins, C., Stefanini, A., Ferrinho, P., Chapman, G., Hagos, B., Adams, Y. and Mayeh Omar (2007) 'The role of strategic health planning processes in the development of health care reform policies: a comparative study of Eritrea, Mozambique and Zimbabwe', *The International Journal of Health Planning and Management*, 22(2), pp. 113-131.
- Green., A. (2007) *Health Planning for Developing Health Systems*  
*Third Edition*. edn. Clarendon Street Oxford, Great Britain: Oxford University Press.
- Gudes, O., Kendall, E., Yigitcanlar, T., Pathak, V. and Baum, S. (2010) 'Rethinking Health Planning: A Framework for Organising Information to Underpin Collaborative Health Planning', *Health Information Management Journal*, 39(2), pp. 18-29.
- Guston, D. (1996) 'Theory Building Principal-Agent Theory and the Structure of Science Policy', *Science and Public Policy*, 23(4), pp. 229-240.
- Hallett, C. (1995) 'Understanding the phenomenological approach to research', *Nurse researcher*, 3(2), pp. 55-65.
- Hansen, E. C. (2006) *Successful Qualitative Health Research A practical introduction*. Berkshire: Open University Press.

- Hansen, E. C. (2020) *Successful Qualitative Health Research: A practical introduction*. Taylor & Francis.
- Harrison, R. P., Rafiq, Q. A. and Medcalf, N. (2018) 'Centralised versus decentralised manufacturing and the delivery of healthcare products: A United Kingdom exemplar', *Cytotherapy*, 20(6), pp. 873-890.
- Haynes, K. (2012) 'Reflexivity in qualitative research', *Qualitative Organizational Research: Core Methods and Current Challenges*, pp. 72-89.
- Henriksson, D. K., Ayebare, F., Waiswa, P., Peterson, S. S., Tumushabe, E. K. and Fredriksson, M. (2017) 'Enablers and barriers to evidence based planning in the district health system in Uganda; perceptions of district health managers', *BMC Health Services Research*, 17(1), pp. 103.
- Homedes, N. and Ugalde, A. (2005) 'Why neoliberal health reforms have failed in Latin America', *Health Policy* 71, pp. 83-96.
- Hunter, McCallum and Howes (2019) 'Defining Exploratory-Descriptive Qualitative (EDQ) research and considering its application to healthcare.', *GSTF Journal of Nursing and Health Care (JNHC)*, 4(1).
- Hupe, P. and Hill, M. (2007) 'STREET-LEVEL BUREAUCRACY AND PUBLIC ACCOUNTABILITY', *Public Administration*, 85(2), pp. 279-299.
- John, P. (1996) 'CENTRALIZATION, DECENTRALIZATION AND THE EUROPEAN UNION: THE DYNAMICS OF TRIADIC RELATIONSHIPS', *Public Administration*, 74(2), pp. 293-313.
- Jones, A. and Bugge, C. (2006) 'Improving understating and rigour through traingulation: an exemplary based on patient participation in interaction', *Journal of Advanced Nursing*, 55(5), pp. 612-621.
- Jones, G. W. (1982) *New approaches to the Study of Centra-local Government Relationship*. Gower Publishing Company.
- Kapiriri, L., Norheim, O. F. and Heggenhougen, K. (2003) 'Public participation in health planning and priority setting at the district level in Uganda', *Health Policy Plan.*, 18(2), pp. 205-213.
- Kapologwe, N. A., Meara, J. G., Kengia, J. T., Sonda, Y., Gwajima, D., Alidina, S. and Kalolo, A. (2020) 'Development and upgrading of public primary healthcare facilities with essential surgical services infrastructure: a strategy towards achieving universal health coverage in Tanzania', *BMC Health Services Research*, 20(1), pp. 218.
- Katz, A. S., Cheff, R. M. and O'Campo, P. (2015) 'Getting consensus of stakeholders is important. In practice there is no a situation whereby the plan is accepted by all stakeholders definitely there might be alternative opinions. It is worth knowing the situation ', *International Journal for Equity in Health* 14 (138).
- Kessy, A. (2018) 'Decentralisation, Local Governance and Path Dependency Theory', *Utafiti*, 13.
- Kessy, A. and McCourt, W. (2010) 'Is Decentralization Still Recentralization? The Local Government Reform Programme in Tanzania', *International Journal of Public Administration*, 33, pp. 689-697.
- Kigume, R. (2018) *Kigume, R. A. (2018). Decentralisation and health services delivery in Tanzania: analysis of decision space and organizational capacities*. Masters Dissertation, University of Dar es Salaam.
- Kigume, R. and Maluka, S. (2019) 'Health sector decentralisation in Tanzania: Analysis of decision space in human resources for health management', *INTERNATIONAL JOURNAL OF HEALTH PLANNING AND MANAGEMENT*, 34(4), pp. 1265-1276.
- Kigume, R., Maluka, S. and Kamuzora, P. (2018) 'Decentralisation and health services delivery in Tanzania: Analysis of decision space in planning, allocation, and use of financial resources', *INTERNATIONAL JOURNAL OF HEALTH PLANNING AND MANAGEMENT*, 33(2), pp. E621-E635.
- Koontz, H. (1993) *Management: A Global Perspective*, . McGraw-Hill.

- Koranteng, R. O. and Larbi, G. A. (2008) 'Policy networks, politics and decentralisation policies in Ghana', *Public Administration and Development*, 28(3), pp. 212-222.
- Kwete, X. J., Berhane, Y., Mwanyika-Sando, M., Oduola, A., Liu, Y., Workneh, F., Hagos, S., Killewo, J., Mosha, D., Chukwu, A., Salami, K., Yusuf, B., Tang, K., Zheng, Z.-J., Atun, R. and Fawzi, W. (2021) 'Health priority-setting for official development assistance in low-income and middle-income countries: a Best Fit Framework Synthesis study with primary data from Ethiopia, Nigeria and Tanzania', *BMC Public Health*, 21(1), pp. 2138.
- Lacey, A. and Luff, D. (2009) *Qualitative Research Analysis*. .
- Laffin, M. (2009) 'Central–Local Relations in an Era of Governance: Towards a New Research Agenda', *Local Government Studies*, 35(1), pp. 21-37.
- Lawrie, L., Ardal, S., Butler, J. and Edwards, R. (2006) *The Health Planners Toolkit*.
- Lindblom, C. E. (1959) 'The Science of "Muddling Through"', *Public Administration Review*, 19(2), pp. 79-88.
- Lindblom, C. E. (1979) 'Still Muddling, Not Yet Through', *Public Administration Review*, 39(6), pp. 517-526.
- Liwanag, H. J. and Wyss, K. (2019) 'Optimising decentralisation for the health sector by exploring the synergy of decision space, capacity and accountability: insights from the Philippines', *Health Research Policy and Systems*, 17(1), pp. 4.
- Loughlin, M. (1996) 'Understanding Central-Local Government Relations', *Public Policy and Administration*, 11(2), pp. 48-65.
- Lundah, L. (2002) 'From Centralisation to Decentralisation: governance of education in Sweden ', *European Educational Research Journal*,, 1 (4).
- Lustick, I. (1980) 'Explaining the Variable Utility of Disjointed Incrementalism: Four Propositions', *The American Political Science Review*, 74, pp. 342.
- Maluka, S. O. and Bukagile, G. (2016a) 'Community participation in the decentralised district health systems in Tanzania: why do some health committees perform better than others?', *The International Journal of Health Planning and Management*, 31(2), pp. E86-E104.
- Maluka, S. O. and Bukagile, G. (2016b) 'Community participation in the decentralised district health systems in Tanzania: why do some health committees perform better than others?', *Int J Health Plann Manage*, 31(2), pp. E86-e104.
- Mapunda, M. (2003) *Experiences in resource allocation in Tanzania, focusing on Sector Wide Approach (SWAp) and Health Basket Fund*
- Maxwell, J. (2010) 'Understanding and Validity in Qualitative Research', *Harvard Educational Review*, 62(3), pp. 279-301.
- Mayer, D., Warner, D. M., Siedel, G. J. and Lieberman, J. K. (2002) *The Legal Environment and Business Law: Executive MBA Edition*
- Mays, N. and Pope, C. (1995) 'Qualitative Research: Rigour and Qualitative Research', *British Medical Journal*, 311(8), pp. 109-112.
- Mills, A. (1994) 'Decentralization and accountability in the health sector from an international perspective: What are the choices?', *Public Administration and Development*, 14(3), pp. 281-292.
- Mills, A., Vaughan, J. P., Smith, D. L. and Tabibzadeh, I. (eds.) (1990a) *Health Systems Decentralization, Concepts, Issues and Countries Experience*: World Health Organization.
- Mills, A., Vaughan, J. P., Smith, D. L., Tabibzadeh, I. and Organization, W. H. (1990b) *Health system decentralization: concepts, issues and country experience*. World Health Organization.
- Ministry of Health, C. D. G. E., Children - Mo, H. T. M., Ministry of Health - Mo, H. Z., National Bureau of Statistics, N. B. S. T., Office of Chief Government Statistician, O. Z. and Icf (2016) *Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015-2016*, Dar es

Salaam, Tanzania: MoHCDGEC, MoH, NBS, OCGS, and ICF. Available at:

<http://dhsprogram.com/pubs/pdf/FR321/FR321.pdf>.

Mintzberg, H. (1980) 'STRUCTURE IN 5'S: A SYNTHESIS OF THE RESEARCH ON ORGANIZATION DESIGN', *Management Science (pre-1986)*, 26(3), pp. 322.

MOH&SW, U. R. o. T., Education, C. (2000) *District Health management Training- Module One: Health Sector Reform* Dar es salaam.

MOH&SW, U. R. o. T. (2004) *Health Bof Fundsasket Fund and Health Block Grants Guidelines for Disbursement*.

MOH&SW, U. R. o. T. (2007) *Health Sector Evaluation*.

MOH&SW, U. R. o. T. (2008) *Health Sector Strategic Plan III*.

MOHCDGEC, Policy and Planning Ministry of Health Community Development Gender Elderly and Children, U.R.o.T. (2019) *Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020*.

Mollet, H. A. and Tollenaar, A. (2013) 'Decentralization in Tanzania: Design and Application in Planning Decisions', *International Journal of Public Administration*, 36(5), pp. 344-353.

Morgan, P. J. and Trinh, L. Q. (2016) *Frameworks for Central–Local Government Relations*

*and Fiscal Sustainability*., Asian Development Bank. Available at:

<http://www.adb.org/publications/frameworks-central-local-governmentrelations-and-fiscal-sustainability/>.

Nightingale, A. J. (2020) 'Triangulation', in Kobayashi, A. (ed.) *International Encyclopedia of Human Geography (Second Edition)*. Oxford: Elsevier, pp. 477-480.

Noble, H. and Smith, J. (2015) 'Issues of validity and reliability in qualitative research', *Evidence Based Nursing*, 18(2), pp. 34-35.

Nutt, P. C. (1984) *Planning Methods for Health and Related Organizations*. New York: John Wiley and Sons.

Oiler, C. (1982) 'The phenomenological approach in nursing research', *Nursing research*, 31(3), pp. 178-181.

Okuonzi, S. A. and Macrae, J. (1995) 'Whose policy is it anyway? International and national influences on health policy development in Uganda', *Health Policy Plan*, 10(2), pp. 122-32.

Pissourios, I. (2014) 'Top-Down and Bottom-Up Urban and Regional Planning: Towards a Framework for The Use of Planning Standards', *European Spatial Research and Policy*, 21.

Pope, C., Ziebland, S. and Mays, N. (2000) 'Qualitative research in health care: Analysing qualitative data', *BMJ*, 320(7227), pp. 114-116.

Prinsen, G. and Titeca, K. (2008) 'Uganda's decentralised primary education: musical chairs and inverted elite capture in School Management Committees', *Public Administration and Development*, 28(2), pp. 149-164.

Raelin, J. A. (1982) 'A Policy Output Model of Interorganizational Relations', *Organization Studies (Walter de Gruyter GmbH & Co. KG.)*, 3(3), pp. 243-267.

Ramani, K. V., Mavalankar, D. and Govil, D. (2008) *Strategic Issues and Challenges in Health Management*. London: SAGE.

Rhodes, R. (1981a) 'Control and power in central-local government relations'.

Rhodes, R. A. W. (1981b) *CONTROL AND POWER IN CENTRAL-LOCAL GOVERNMENT RELATIONS*

Farnborough: S.S.R.C Gower

p. 194 pp. .

Rhodes, R. A. W. (1981c) 'CONTROL AND POWER IN CENTRAL-LOCAL GOVERNMENT RELATIONS',

: S.S.R.C/Gower, Farnborough,.

Rhodes, R. A. W. (1999a) *Control and Power in Central-Local Government Relations*. Second Edition edn.: Ashgate.

Rhodes, R. A. W. (1999b) *Control and power in central-local government relations*. Farnborough: S.S.R.C/Gower.

Rhodes, R. A. W. (2018) *Control and power in central-local government relations*. Routledge.

Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice—A Guide for Social Science Students and Researchers*. London, Thousand Oaks, CA: Sage Publications Ltd.

Rocco, T. S. and Plakhotnik, M. S. (2009) 'Literature Reviews, Conceptual Frameworks, and Theoretical Frameworks: Terms, Functions, and Distinctions', *Human Resource Development Review*, 8(1), pp. 120-130.

Roman, T. E., Cleary, S. and McIntyre, D. (2017) 'Exploring the Functioning of Decision Space: A Review of the Available Health Systems Literature', *International Journal of Health Policy and Management*, 6(7), pp. 365-376.

Rondinelli, D. A., Nellis, J. R. and Cheema, G. S. (1983) 'Decentralization in developing countries', *World Bank staff working paper*, 581, pp. 13-28.

Saint Arnault, D. and Sinko, L. (2021) 'Comparative Ethnographic Narrative Analysis Method: Comparing Culture in Narratives', *Global qualitative nursing research*, 8, pp. 233339362110207-23333936211020722.

Saunders, B., Kitzinger, J. and Kitzinger, C. (2015) 'Anonymising interview data: challenges and compromise in practice', *Qualitative research : QR*, 15(5), pp. 616-632.

Saunders, P. (1982) 'Why study central-local relations?', *Local Government Studies*, 8(2), pp. 55-66.

Sbaraini, A., Carter, S. M., Evans, R. W. and Blinkhorn, A. (2011) 'How to do a grounded theory study: a worked example of a study of dental practices', *BMC Medical Research Methodology*, 11(1), pp. 128.

Scott, P. and Pandey, S. (2005) 'Red Tape and Public Service Motivation', *Review of Public Personnel Administration*, 25, pp. 155-180.

Seale, C. and Silverman, D. (1997) 'Ensuring rigour in qualitative research', *The European journal of public health*, 7(4), pp. 379-384.

Segal, L. (1997) 'The Pitfalls of Political Decentralization and Proposals for Reform: The Case of New York City Public Schools', *Public Administration Review*, 57(2), pp. 141-149.

Semali, I. A., deSavigny, D. and Tanner, M. (2005) 'Health Sector Reform and Decentralization in Tanzania: The Case of the expanded Programme on Immunization at district level', *Journal of Health and Population in Developing Countries*.

Shah, S., Inamullah, E. and Khayyam, U. (2017) 'Assessing Elite Capture and its linkage with the Resource Hijack: Empirical Evidences from FATA, Pakistan', *Transylvanian Review*, XXV.

Smiddy, H. F. and Naum, L. (1954) 'Evolution of Science of Managing in America', *Management Science*, 1(1).

Smoke, P. (2003) 'Decentralisation in Africa: goals, dimensions, myths and challenges', *Public Administration and Development*, 23(1), pp. 7-16.

Stebbins, R. (2001) 'Exploratory research in the social sciences: what is exploration?', *Exploratory Research in the Social Sciences*, pp. 2-18.

Steiner, S. (2010) 'How Important is the Capacity of Local Governments for Improvements in Welfare? Evidence from Decentralised Uganda', *The Journal of Development Studies*, 46(4), pp. 644-661.

Thompson, W. A., Vertinsky, I., Kira, D. and Scharpf, F. W. (1982) 'PERFORMANCE OF A REGULATORY AGENCY AS A FUNCTION OF ITS STRUCTURE AND CLIENT ENVIRONMENT: A SIMULATION STUDY', *Management Science (pre-1986)*, 28(1), pp. 57.



- Tillquist, J. (2002) 'Strategic Connectivity in Extended Enterprise Networks', *J. Electron. Commerce Res.*, 3, pp. 77-85.
- Tillquist, J. (2002) 'Strategic Connectivity in Extended Enterprise Network', *Electronic Commerce Research*, 3(2).
- Tobin, G. A. and Begley, C. M. (2004) 'Methodological Rigour within a qualitative framework', *Journal of Advanced Nursing*, 48(4), pp. 388-396.
- Tsofa, B., Molyneux, S., Gilson, L. and Goodman, C. (2017) 'How does decentralisation affect health sector planning and financial management? a case study of early effects of devolution in Kilifi County, Kenya', *International Journal for Equity in Health*, 16.
- Tsofa, B., Molyneux, S. and Goodman, C. (2016) 'Health sector operational planning and budgeting processes in Kenya-"never the twain shall meet"', *The International journal of health planning and management*, 31(3), pp. 260-276.
- Turner, M. (2002) 'Whatever happened to deconcentration? Recent initiatives in Cambodia', *Public Administration and Development*, 22(4), pp. 353-364.
- U.R.T (1977) *Constitution of the United Republic of Tanzania (last amended 1985) [I]*, 26 April 1977, : available at: <https://www.refworld.org/docid/3ae6b50c4.html> (Accessed: accessed 9 January 2022).
- U.R.T, Planning, M.o.H.a.S.w.-H.P.a. (2011) *Comprehensive Council Health Planning Guidelines Tanzania*.  
*This Act may be cited as the Local Government and Urban Authorities Act, 1982.*
- URT, Treasury (2017) *Guidelines for the preparation of plans and budget for 2017/18*.
- Venugopal, V. and Yilmaz, S. (2009) 'Decentralization in Kerala: Panchayat government discretion and accountability', *Public Administration and Development*, 29(4), pp. 316-329.
- Venugopal, V. and Yilmaz, S. (2010) 'Decentralization in Tanzania: An assessment of local government discretion and accountability', *Public Administration and Development*, 30(3), pp. 215-231.
- Verhoest, K., Peters, B. G., Bouckaert, G. and Verschuere, B. (2004) 'The study of organisational autonomy: a conceptual review', *Public Administration and Development*, 24(2), pp. 101-118.
- Walt, G. (1994) *Health Policy an Introduction to Process and Power*. Johannesburg: Witwatersrand University Press.
- Walt, G. and Gilson, L. (1994) 'Reforming the health sector in developing countries: the role of policy analysis', *Health Policy and Planning*, 9(4), pp. 353 -370.
- Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R. and Gilson, L. (2008) "'Doing' health policy analysis: methodological and conceptual reflections and challenges", *Health Policy Plan.*, 23(5), pp. 308-317.
- Wang, C. L. and Ahmed, P. K. (2002) 'The Informal Structures: hidden energies within the organisation', *Management Research Center*.
- Ward, J. K., Comer, U. and Stone, S. (2018) 'On Qualifying Qualitative Research: Emerging Perspectives and the "Deer" (Descriptive, Exploratory, Evolutionary, Repeat) Paradigm', *Interchange*, 49(1), pp. 133-146.
- Ward, R. C. (2007) 'The Outsourcing of Public Library Management: An Analysis of the Application of New Public Management Theories From the Principal-Agent Perspective', *Administration & Society*, 38(6), pp. 627-648.
- Wehrich, H. and Koontz, H. (1993) *Management A Global Perspective*. 10th edn.: McGraw\_Hill. Inc.
- Weissert, C. S. (1994) 'Beyond the Organization: The Influence of Community and Personal Values on Street-Level Bureaucrats' Responsiveness', *J Public Adm Res Theory*, 4(2), pp. 225-254.
- WHO (1971) *The Principles of Health Planning in USSR*. Available at: [https://extranet.who.int/iris/restricted/bitstream/10665/39761/1/WHO\\_PHP\\_43.pdf](https://extranet.who.int/iris/restricted/bitstream/10665/39761/1/WHO_PHP_43.pdf).

WHO 'When do vertical (stand-alone) programmes have a place in health systems?', *WHO European Ministerial Conference on Health Systems, 25–27 June 2008*, Tallinn, Estonia: World Health Organization 2008 and World Health Organization, on behalf of the European Observatory

on Health Systems and Policies.

Williamson, K. and Johanson, G. (2018) *Research Methods: Information, Systems, and Contexts*

Wilson, A. (2015) 'A guide to phenomenological research', *Nursing Standard (2014+)*, 29(34), pp. 38.

Wright, D. S. (1982) 'JonesGeorge W. (ed.), *New Approaches to the Study of Central-Local Relationships*, Gower, £11; RhodesR. A. W., *Control and Power in Central-Local Government Relations*, Gower, £11.50', *Journal of Public Policy*, 2(4), pp. 413-417.

Yahya, T. and Mohamed, M. (2018) 'Raising a mirror to quality of care in Tanzania: the five-star assessment', *The Lancet Global Health*, 6(11), pp. e1155-e1157.

Yin, R. K. (2009a) *Case Study Research Design and Methods. Applied Social Research Methods Series* Fourth Edition edn. Thousand Oaks: SAGE Inc.

Yin, R. K. (2009b) *Case study research : design and methods*. Los Angeles: Sage.

Zaidi, S. A., Bigdeli, M., Langlois, E. V., Riaz, A., Orr, D. W., Idrees, N. and Bump, J. B. (2019) 'Health systems changes after decentralisation: progress, challenges and dynamics in Pakistan', *BMJ Global Health*, 4(1), pp. e001013.

Zannetos, Z. S. (1965) 'ON THE THEORY OF DIVISIONAL STRUCTURES: SOME ASPECTS OF CENTRALIZATION AND DECENTRALIZATION OF CONTROL AND DECISION MAKING', *Management Science (pre-1986)*, 12(4), pp. 20.

## Appendix A: Literature search Strategy and Search terms

Stages of the research project	Health Planning			Relationships		
	Search terms	Search strategy	Duration	Search terms	Search strategy	Duration
Research Design and data collections stage	<ul style="list-style-type: none"> <li>Health planning definition</li> <li>Health planning process</li> <li>Planning Models/approaches</li> <li>Health planning process in Africa</li> <li>Health planning in Tanzania</li> <li>Health planning and local government</li> <li>Planning techniques Health Planning Process</li> <li>Health Planning and Decentralisation</li> <li>Health Planning in Africa</li> <li>Health planning and participation</li> <li>Health Planning and Decision space</li> <li>Health Planning and</li> </ul>	Any field Contains the terms in [title, abstract, heading word, table of contents, key concepts, original title] cited reference, and citation tracing	1/1/2002 to 1/1/2010 And 2011-2015	<ul style="list-style-type: none"> <li>Central government</li> <li>Local government</li> <li>Intergovernmental relationships</li> <li>Central-local government relations</li> <li>Local government and health planning</li> <li>Local government and health planning and Africa</li> <li>Local government and health planning and Tanzania</li> <li>Decentralisation Africa</li> <li>Decentralisation and Health</li> <li>Decentralisation and Health Africa</li> <li>Decentralisation and Health Tanzani</li> </ul>	Any field Contains the terms in [title, abstract, heading word, table of contents, key concepts, original title] cited reference, and citation tracing	1/1/2002 to 1/1/2010 2011-2015 2015-2021

Stages of the research project	Health Planning			Relationships		
	Search terms	Search strategy	Duration	Search terms	Search strategy	Duration
	Local capacity <ul style="list-style-type: none"> <li>• Health planning approaches</li> <li>• Health planning in Tanzania</li> </ul>			<ul style="list-style-type: none"> <li>• Decentralisation and Tanzania</li> <li>• Health planning and decentralisation</li> <li>• Health planning and decentralisation and Tanzania</li> <li>• Framework for analysing central-local relations</li> <li>• Central-local relations and health planning</li> <li>• Central-local relations challenges</li> <li>• Central-local relations and decision space</li> <li>• Capacity and decision space</li> <li>• Capacity and accountability and decision space</li> </ul>		

Stages of the research project	Health Planning			Relationships		
	Search terms	Search strategy	Duration	Search terms	Search strategy	Duration
				<ul style="list-style-type: none"> <li>• Decision space and power</li> <li>• Decision space and responsiveness to local needs</li> <li>• Health Planning and Financing and Decision space</li> </ul>		

**B: Search terms and strategies for Research thematic areas**

- Research design approaches
- Research methods
- Research methodology
- Conceptual framework
- Interviews
- Focus Group discussions
- Observations
- Qualitative analysis methods
- Qualitative analysis approaches

## Appendix B: Ethical Approval Leeds and Ifakara

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UNIVERSITY OF LEEDS

Hadija Kweka  
P.O.Box 78373  
Dar-es-salaam  
TANZANIA

13 December 2011

Dear Hadija

**Re ref no:** HSLTLM/11/003

**Title:** **The relationships between central organisations and local government and their influence on local health planning processes: A case of Council Health Management Team in Tanzania**

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics and Leeds Institute of Molecular Medicine (LIHS/LIGHT/LIMM) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation as submitted at date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information ([r.e.desouza@leeds.ac.uk](mailto:r.e.desouza@leeds.ac.uk))

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

*Please note:* You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely

**Professor Alastair Hay/Mrs Laura Stroud/Dr David Jayne  
Chairs, LIHS/LIGHT/LIMM Joint REC**



INSTITUTIONAL REVIEW BOARD  
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07 October, 2011

Hadija Kweka  
 Ifakara Health Institute  
 P O Box 78373  
 Dar Es Salaam

IHI/IRB/AMM 18 -2011

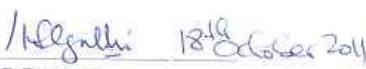
#### AMMENDMENT 1 APPROVAL

On 02 September 2011, the Ifakara Health Institute Review Board (IHI IRB) reviewed Amendment 1 to a study titled "*The relationship between central organization and Local Government and their influence on local health planning process: A case of Council Health management Team in Tanzania*", submitted by Project Leader Hadija Kweka. The study with previous approval number IHI/IRB/No. 27 – 2011.

#### Amendment includes:

- Change of study area: Morogoro rural and Ilala to replace Kilombero and Babati

*The IRB reserves the right to undertake field inspections to check on the protocol compliance*

  
 IRB Secretary

**BEVERLY L. MSAMBICHAKA**



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### Appendix D:- Data Collection Time Table

Phase of Data Collection	Months								
	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Phase one was April 2015- June 2015									
phase two August 2015 – December 2015 data collection National level									

## Appendix E: Interview Guide

### INTERVIEW GUIDE FOR COUNCIL HEALTH SERVICE BOARD AND HOSPITAL MANAGEMENT COMMITTEE

#### Preliminaries:

- i. Check that you have considered focal points of interview in relation to the research objectives
- ii. Did respondent receive background document on research (letter) (Take additional copies)
- iii. Clarify time available for interview
- iv. Include relevant extra questions or probes based on information received to date from other informants or background documents

District: \_\_\_\_\_

Region: \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

#### 1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What is your designation?
- 1.2. What are your responsibilities and duties with respect to health planning?
- 1.3. For how long have you been holding this position?

#### 2. THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. What are the key health and health systems challenges in your council?
- 2.2. Are you familiar with the current decentralisation policy/strategy?
- 2.3. Are there any aspects of decentralisation that you particularly like, or don't like? And why?
- 2.4. What functions have been decentralised to CHMT? (in practice)?
- 2.5. What benefits have you realised in your council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)
  - Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills

- Addressing local priorities
  - Addressing national priorities
  - Guidance
- 2.6. What difficulties have you encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples
- Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills
  - Addressing local priorities
  - Addressing national priorities
  - Guidance
- 2.7. How could this be improved?
- 2.8. To whom is CHMT accountable in a decentralised setting
- 2.9. In what way
- financially
  - technically
  - organisationally/Administrative
- 2.10. What are the strengths and challenges of the current accountability system?
- 2.11. Why do you think so?
- 2.12. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

- 3.1. How do you participate in council health planning?
- 3.2. What influence do you have in the process? Probe for examples
- 3.3. Are you familiar with the mechanism that the central Ministry uses to communicate its policies and guidelines?
- 3.3.1. How effective are the current approaches/mechanisms?
  - 3.3.2. Can you provide specific examples of particularly good or poor practices/mechanisms?
  - 3.3.3. Why do you think so?
  - 3.3.4. How could the situation be improved?
- 3.4. How are the policies, guidelines enforced by the centre with regard to health planning?
- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact
- 3.4.1. How well do you think these are functioning and why? (probe for examples)

- 3.5. How and to what extent is the CHMT's performance in planning in line with or different from government expectations?
- 3.6. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
  - 3.6.1. Are you familiar with the criteria used to assess the Comprehensive Council Health Plans?
  - 3.6.2. What are your opinions regarding these criteria: are they good, or there are things that need to change and what are these and why?
  - 3.6.3. What could be improved and how?
  - 3.6.4. What aspects do you like or dislike regarding the CCHP approval process?
  - 3.6.5. What could be improved and how?
- 3.7. How is local planning capacity developed?
  - Training
  - Supervision and on job support
  - Manuals
  - Provision of planning tools
  - Issuing guidelines
- 3.8. Who is responsible for the development of local planning capacity?
- 3.9. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

- 4.1. Who are the main actors in the council health planning process?
  - 4.1.1. Why do you consider them as main actors?
  - 4.1.2. Who are missing?
- 4.2. How do they engage with council health planning process?
- 4.3. What are their relative roles in the council health planning process?
- 4.4. Can you describe your relationships with CHMT?
- 4.5. How does the existing relationship influence council health planning?
  - 4.5.1. How could the relationship be improved?
- 4.6. What factors enhance or constrain CHMTs to involve other actors in council health planning process?
  - 4.6.1. How is health planning affected by the limited of participation of these actors? Probe for example
  - 4.6.2. Why do you think so? Probe for example?
  - 4.6.3. How could the situation be improved?
- 4.7. What factors enhance or constrain other actors to participate in local health planning process?

4.7.1. Why do you think so?

4.7.2. How could this be improved?

**4.8.** Who determines the content of the Council Health Plan?

**4.8.1.** How do they determine the content of council health plan?

**4.8.2.** What things do you like or dislike?

**4.8.3.** What could be improved and how?

## **5. THE COUNCIL HEALTH PLANNING CONTENT**

5.1. In your opinion what are the attribute of a good council health plan?

5.2. Why do you think so?

5.3. What does the centre consider to be a good council health plan?

5.4. How do you rate your council's planning capacity

- Good
- Average
- Poor

**5.4.1.** Why do you think so

5.5. Are you familiar with planning guideline?

5.6. In particular what things are emphasised in the planning guideline?

**5.6.1.** Why do you think so? (Give example of what respondents mentioned in qn 5.6)

5.7. In particular what things are not receiving due emphasis in the planning guideline?

5.7.1. Why do you think this is the case?

5.7.2. How is council health planning affected by this?

**5.7.3.** What could be improved and how?

## **6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING**

6.1. To what extent do the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)

- Finances e.g. allocation of expenditure
- Spending the collected revenues e.g. cost sharing, community health funds
- Procurement e.g. equipment, drugs, service etc
- Human resources management e.g. employee transfer, training, promotion, recruitment

- Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
- 6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.
- 6.3. What are your views regarding the way the centre influences CHMTs to adhere to its policy goals?
- 6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe CHMT relationship with them?
- Collaborative
  - Control
  - Partnership
- 6.5. Are there mechanisms in which CHMT use to reduce the influences of the centre to the planning process?
- 6.6. How effective are they? What do you think is missing in CHMT's current practices?
- Research
  - Meetings
  - Informal ways- mention
  - Evidence based argument to persuade government
  - Reports
- 6.7. Are there any tensions between local and centre- hidden or visible? Why do you think so? Probe for examples
- 6.7.1. How does this affect council health planning?
- 6.7.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans?

Is there any other respondent you would particularly recommend?

## INTERVIEW GUIDE FOR District Executive Director

### Preliminaries:

- v. *Check that you have considered focal points of interview in relation to the research objectives*
- vi. *Did respondent receive background document on research (letter) (Take additional copies)*
- vii. *Clarify time available for interview*
- viii. *Include relevant extra questions or probes based on information received to date from other informants or background documents*

District: \_\_\_\_\_

Region: \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

### 1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What are your responsibilities and duties?
- 1.2. For how long have you been holding this position? (it does not matter whether in same station or different)

### 2. THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. Are there any aspects of decentralisation that you particularly like, or don't like and why?
- 2.2. What functions have been decentralised to councils (in practice)?
- 2.3. What benefits have you realised in your council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)
  - Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills
  - Addressing local priorities

- Addressing national priorities
  - Guidance
- 2.4. What difficulties have you encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples
- Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills
  - Addressing local priorities
  - Addressing national priorities
  - Guidance
- 2.4.1. How could this be improved?
- 2.5. To whom is CHMT accountable in a decentralised setting
- 2.5.1. In what way
- financially
  - technically
  - organisationally/Administrative
- 2.5.2. What are the strengths and challenges of the current accountability system?
- 2.5.3. Why do you think so?
- 2.5.4. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

- 3.1. How does the centre communicate its policies and guidelines?
- 3.1.1. How effective are the current approaches/mechanisms?
- 3.1.2. Can you provide specific examples of particularly good or poor practices/mechanisms?
- 3.1.3. Why do you think so?
- 3.1.4. How could the situation be improved?
- 3.2. How are the policies, guidelines enforced by the centre with regard to health planning?
- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact
- 3.2.1. How well do you think these are functioning and why? (probe for examples)
- 3.3. How and to what extent is the CHMT's performance in planning in line with or different from government expectations?
- 3.4. Are you familiar with the criteria used to assess the Comprehensive Council Health Plans?



- 3.5. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
  - 3.5.1. What are your opinions regarding these criteria: are they good, or there are things that need to change and what are these and why?
  - 3.5.2. What could be improved and how?
  - 3.5.3. What aspects do you like or dislike regarding the CCHP approval process?
  - 3.5.4.** What could be improved and how?
- 3.6. How is local planning capacity developed?
  - Training
  - Supervision and on job support
  - Manuals
  - Provision of planning tools
  - Issuing guidelines
- 3.7. Who is responsible for the development of local planning capacity?
- 3.8. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

- 3.1. Who are the main actors in the council health planning process?
  - 3.1.1. Why do you consider them as main actors?
  - 3.1.2. Who is missing
- 3.2. What are their relative roles in the council health planning process?
- 3.3. What factors enhance or constrain CHMTs to involve other actors in council health planning process?
  - 3.3.1. How is health planning affected by the level of participation of these actors? Probe for example
  - 3.3.2. Why do you think so? Probe for example?
  - 3.3.3. How could the situation be improved?
- 3.4. What factors enhance or constrain other actors to participate in local health planning process?
  - 3.4.1. Why do you think so?
  - 3.4.2. How could this be improved?

#### **5. THE COUNCIL HEALTH PLANNING CONTENT**

- 5.1. In your opinion what are the attribute of a good council health plan?
- 5.2. Why do you think so?
- 5.3. What does the centre consider to be a good council health plan?
- 5.4. What do you consider to be a good council health plan?
- 5.5. How do you rate your council's planning capacity
  - Good
  - Average
  - Poor

- 5.5.1. Why do you think so
- 5.6. In particular what things are emphasised in the planning guideline?
- 5.6.1. Why do you think so? (Give example of what respondents mentioned in qn 5.6)
- 5.7. In particular what things are not receiving due emphasis in the planning guideline?
- 5.7.1. Why do you think this is the case?
- 5.7.2. How is council health planning affected by this?
- 5.7.3. What could be improved and how?
- 6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING**
- 6.1. To what extent do the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)
- Finances e.g. allocation of expenditure
  - Spending the collected revenues e.g. cost sharing, community health funds
  - Procurement e.g. equipment, drugs, service etc
  - Human resources management e.g. employee transfer, training, promotion, recruitment
  - Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
- 6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.
- 6.3. What are your views regarding the way the centre influences CHMTs to adhere to its policy goals?
- 6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe CHMT relationship with them?
- Collaborative
  - Control
  - Partnership
- 6.5. Are there mechanisms in which CHMT use to reduce the influences of the centre to the planning process?
- 6.6. How effective are they? What do you think is missing in CHMT's current practices?
- Research
  - Meetings
  - Informal ways- mention
  - Evidence based argument to persuade government

- Reports

6.7. Are there any tensions between local and centre- hidden or visible?

Why do you think so? Probe for examples

6.7.1. How does this affect council health planning?

6.7.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans

Is there any other respondent you would particularly recommend talking to?

## Interview Guide for Development partners

## Preliminaries:

- ix. Check that you have considered focal points of interview in relation to the research objectives*
- x. Did respondent receive background document on research (letter) (Take additional copies)*
- xi. Clarify time available for interview*
- xii. Include relevant extra questions or probes based on information received to date from other informants or background documents*

Organization \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

## **1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS**

- 1.1. What is your designation?
- 1.2. For how long have you been holding this position? (it does not matter whether in same station or different)
- 1.3. Briefly talk about your organisation roles and responsibilities

## **2. THE COUNCIL HEALTH PLANNING CONTEXT**

- 2.1. How do you support the health sector?
  - Financial support through basket
  - Financial outside basket
  - Programmatic support (probe what areas)
  - Others specify
- 2.2. How is your organisation engaged with Council Health planning process in decentralised settings?
  - 2.2.1.** Are there any aspects that you particularly like, or don't like with respect to the way decentralisation is implemented? And why?
  - 2.2.2. What benefits have been realised with respect to council health planning that is attributable to health sector decentralisation? (Probe for examples)
  - 2.2.3.** What difficulties are encountered with respect to council health planning process that is attributable to health sector decentralisation? Probe for examples

**2.2.3.1.** How could this be improved?

## **3. THE COUNCIL HEALTH PLANNING PROCESS**

**3.1.** How policies and guidelines from central level are communicated to CHMT?

- 3.1.1.** How effective in your views is this approach/mechanism?
- 3.1.2. Can you provide specific examples of particularly good or poor practices/mechanisms?
- 3.1.3. Why do you think so?
- 3.1.4. How could the situation be improved?
- 3.1.5. How do you influence the contents of these guidelines?
- 3.1.6. Why
- 3.1.7. In your views what are benefits and challenges of these guidelines?
- 3.1.8.** Is there anything that needs improvement, why and how?

**3.2.** In particular what things are emphasised in the planning guideline?

- 3.2.1.** Why do you think so? (Give example of what respondents mentioned in qn 5.8)
- 3.2.2. Have you had any influence on this
- 3.2.3. Why
- 3.2.4.** How

**3.3.** In particular what things are not receiving due emphasis in the planning guideline?

- 3.3.1. Why do you think so?
- 3.3.2. How council health planning is affected by this?
- 3.3.3. What are you missing as the result of this omission? Probe for examples
- 3.3.4.** What could be improved and how?

**3.4.** How do you communicate important information for planning to the center and to CHMT?

- 3.4.1.** What do you think work or do not work with respect to the way you provide this information?
- 3.4.2. How does this influence the council health planning?
- 3.4.3.** What could be improved?

**3.5.** What mechanisms do you use to ensure that CHMT adhere to your conditions with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalise, by whom, impact

- 3.5.1.** How well do you think these are functioning and why? (probe for examples)
- 3.5.2. What are your views regarding the way you influence CHMTs to adhere to these conditions?

- 3.5.3. Are there open or hidden tensions between you and the centre?
- 3.5.4. What could be improved?
- 3.5.5. How?
- 3.6. How could the situation be improved?
- 3.7. How local planning capacity is developed?
- 3.8. Who is responsible for developing the local planning capacity?
  - 3.8.1. What are the strengths and weaknesses of the current approaches to strengthen the planning capacity?
- 3.9. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
- 3.10. Are you familiar with the criteria used to assess CCHP?
  - 3.10.1. Have had any influence to these in a way?
  - 3.10.2. What influence
  - 3.10.3. How
  - 3.10.4. Why
  - 3.10.5. What could be improved and how?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

- 4.1. Who are the main actors with respect to council health planning process at national level?
  - 4.1.1. Why do you consider them as main actors?
  - 4.1.2. Who is missing?
  - 4.1.3. What are their relative roles in the council health planning process?
  - 4.1.4. What are their influences?
  - 4.1.5. How useful or constraining is their engagement to council health planning?
  - 4.1.6. What could be improved and how?

#### **5. THE COUNCIL HEALTH PLANNING CONTENT**

- 5.1. In your opinion what are the attributes of a good council health plan?
- 5.2. Why do you think so?
- 5.3. How do you rate council's planning capacity in general?
  - Good
  - Average

- Poor

5.3.1. Why do you think so

## 6. RESULTING RELATIONSHIPS AND ITS INFLUENCE ON HEALTH PLANNING

6.1. To what extent the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences

- Finances e.g. allocation of expenditure
- Spending the collected revenues e.g. cost sharing, community health funds
- Procurement e.g. equipment, drugs, service etc
- Human resources management e.g. employee transfer, training, promotion, recruitment
- Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals

6.1.1. What are the advantages and disadvantages of the wide or narrow discretion with respect to council health planning?

Probe for example.

6.2. How does the center ensure the granted discretion is exercised as expected?

6.3. Are there instances where the councils abuse the granted discretion? Probe for examples

6.3.1. Why do you think they do so?

6.3.2. How does the center deal with these instances?

6.3.3. How do you react on this?

6.4. As a result are there any tensions hidden or visible between you and the center? Probe for examples

6.4.1. What mechanisms formal or informal the center uses to react to this?

6.4.2. What mechanisms formal or informal you are using to react to this?

6.4.3. How effective are these

6.4.4. How health planning at council level is influenced as a result?

6.5. How would you describe the relationship between the center and CHMT

- Facilitative
- Control
- Collaborative

6.5.1. How does this influence health planning?

- 6.5.2. How could this be improved?
- 6.6. Are there any tensions between CHMT and the centre- hidden or visible?
  - 6.6.1. Why do you think so? Probe for examples
  - 6.6.2. How does this affect council health planning?
  - 6.6.3. How could this be improved?

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidential. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans

Is there any other respondent you would particularly recommend talking to?



**INTERVIEW GUIDE – DISTRICT MANAGEMENT TEAM  
( PLANNING OFFICER, DISTRICT TRESURER)**

Preliminaries:

- xiii. Check that you have considered focal points of interview in relation to the research objectives*
- xiv. Did respondent receive background document on research (letter) (Take additional copies)*
- xv. Clarify time available for interview*
- xvi. Include relevant extra questions or probes based on information received to date from other informants or background documents*

District: \_\_\_\_\_

Region: \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

**1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS**

- 1.1. What is your designation
- 1.2. What are your responsibilities and duties?
- 1.3. For how long have you been holding this position? (it does not matter whether in same station or different)

**2. THE COUNCIL HEALTH PLANNING CONTEXT**

- 2.1. Are there any aspects of decentralisation that you particularly like, or don't like? And why?
- 2.2. What functions have been decentralised to your level (in practice)?
- 2.3. What benefits have you realised in your council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)
  - Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills
  - Addressing local priorities

- Addressing national priorities
  - Guidance
- 2.4. What difficulties have you encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples
- Resource allocation
  - Partnerships
  - Community engagement
  - Resource availability
  - Skills
  - Addressing local priorities
  - Addressing national priorities
  - Guidance

**2.4.1.** How could this be improved?

- 2.5. To whom is CHMT accountable in a decentralised setting

**2.5.1.** In what way

- financially
- technically
- organisationally/Administrative

2.5.2. What are the strengths and challenges of the current accountability system?

2.5.3. Why do you think so?

2.5.4. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

- 3.1. How does the centre communicate its policies and guidelines?

**3.1.1.** How effective are the current approaches/mechanisms?

3.1.2. Can you provide specific examples of particularly good or poor practices/mechanisms?

3.1.3. Why do you think so?

**3.1.4.** How could the situation be improved?

- 3.2. How are the policies, guidelines enforced by the centre with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact

**3.2.1.** How well do you think these are functioning and why? (probe for examples)

- 3.3. How and to what extent is the CHMT's performance in planning in line with or different from government expectations?

- 3.4. Are you familiar with the criteria used to assess the Comprehensive Council Health Plans?

- 3.5. What are your opinions regarding these criteria: are they good, or there are things that need to change and what are these and why?
- 3.5.1. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
- 3.5.2. What could be improved and how?
- 3.5.3.** What aspects do you like or dislike regarding the CCHP approval process? And why?
- 3.6. How is local planning capacity developed?
- Training
  - Supervision and on job support
  - Manuals
  - Provision of planning tools
  - Issuing guidelines
- 3.7. Who is responsible for the development of local planning capacity?
- 3.8. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS**

- 4.1. Who are the main actors in the council health planning process?
- 4.1.1. Why do you consider them as main actors?
- 4.2. What are their relative roles in the council health planning process?
- 4.3. What factors enhance or constrain CHMTs to involve other actors in council health planning process?
- 4.3.1. How is health planning affected by the limited of participation of these actors? Probe for example
- 4.3.2. Why do you think so? Probe for example?
- 4.3.3. How could the situation be improved?
- 4.4. What factors enhance or constrain other actors to participate in local health planning process?
- 4.4.1. Why do you think so?
- 4.4.2. How could this be improved?

#### **5. THE COUNCIL HEALTH PLANNING CONTENT**

- 5.1. In your opinion what are the attribute of a good council health plan?
- 5.2. Why do you think so?
- 5.3. What does the centre consider to be a good council health plan?
- 5.4. How do you rate your council's planning capacity
- Good
  - Average
  - Poor
- 5.4.1. Why do you think so
- 5.5. What determines the quality of Council Health Plan?
- 5.5.1. Why do you think so? Probe for example

- 5.6. In particular what things are emphasised in the planning guideline?
- 5.6.1. Why do you think so? (Give example of what respondents mentioned in qn 5.6)
- 5.7. In particular what things are not receiving due emphasis in the planning guideline?
- 5.7.1. Why do you think this is the case?
- 5.7.2. How is council health planning affected by this?
- 5.7.3. What could be improved and how?

## **6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING**

- 6.1. To what extent do the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)
- Finances e.g. allocation of expenditure
  - Spending the collected revenues e.g. cost sharing, community health funds
  - Procurement e.g. equipment, drugs, service etc
  - Human resources management e.g. employee transfer, training, promotion, recruitment
  - Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
- 6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.
- 6.3. What are your views regarding the way the centre's influences CHMTs to adhere to its policy goals?
- 6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe CHMT relationship with them?
- Collaborative
  - Control
  - Partnership
- 6.5. Are there mechanisms in which CHMT use to reduce the influences of the centre to the planning process?
- 6.6. How effective are they? What do you think is missing in CHMT's current practices?
- Research
  - Meetings
  - Informal ways- mention

- Evidence based argument to persuade government
  - Reports
- 6.7. Are there any tensions between local and centre- hidden or visible?  
Why do you think so? Probe for examples
- 6.7.1. How does this affect council health planning?
- 6.7.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans

Is there any other respondent you would particularly recommend talking to?

## Interview guide for CHMTS

### Preliminaries:

- xvii. *Check that you have considered focal points of interview in relation to the research objectives*
- xviii. *Did respondent receive background document on research (letter) (Take additional copies)*
- xix. *Check if respondent has any quick questions on the project and answer these*
- xx. *Clarify time available for interview*
- xxi. *Include relevant extra questions or probes based on information received to date from other informants or background documents*

District: \_\_\_\_\_

Region: \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

### 1: RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What is your designation?
- 1.2. What are your responsibilities and duties?
- 1.3. For how long have you been holding this position? (it does not matter whether in same station or different)

### 2: THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. What are the key health and health systems challenges in your council?
- 2.2. Are you familiar with the current decentralisation policy/strategy?
- 2.3. Are there any aspects of decentralisation that you particularly like, or don't like and why?
- 2.4. What functions have been decentralised to your level (in practice)?
- 2.5. What benefits have you realised in your council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)

- *Resource allocation*
- *Partnerships*
- *Community engagement*
- *Resource availability*
- *Skills*
- *Addressing local priorities*
- *Addressing national priorities*
- *Guidance*

2.6. What difficulties have you encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples

- Resource allocation
- Partnerships
- Community engagement
- Resource availability
- Skills
- Addressing local priorities
- Addressing national priorities
- Guidance

2.7. How could this be improved?

2.8. To whom is CHMT accountable in a decentralised setting

2.8.1. In what way

- *financially*
- *technically*
- *organisationally/Administrative*

2.8.2. What are the strengths and challenges of the current accountability system?

2.8.3. Why do you think so?

2.8.4. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

3.1. How does the centre communicate its policies and guidelines?

3.2. How effective are the current approaches/mechanisms?

3.3. Can you provide specific examples of particularly good or poor practices/mechanisms?

3.4. Why do you think so?

3.5. How could the situation be improved?

3.6. How are the policies, guidelines enforced by the centre with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact
  - 3.6.1. How well do you think these are functioning and why? (probe for examples)
- 3.7. How and to what extent is the CHMT's performance in planning in line with or different from government expectations?
- 3.8. Are you familiar with the criteria used to assess the Comprehensive Council Health Plans?
- 3.9. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
  - 3.9.1. What are your opinions regarding these criteria: are they good, or there are things that need to change and what are these and why?
  - 3.9.2. What could be improved and how?
  - 3.9.3. What aspects do you like or dislike regarding the CCHP approval process?
  - 3.9.4. What could be improved and how?
- 3.10. How is local planning capacity developed?
  - Training
  - Supervision and on job support
  - Manuals
  - Provision of planning tools
  - Issuing guidelines
- 3.11. Who is responsible for the development of local planning capacity?
- 3.12. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4: THE COUNCIL HEALTH PLANNING ACTORS:**

- 4.5. Who are the main actors in the council health planning process?
  - 4.5.1. Why do you consider them as main actors?
  - 4.5.2. Who are missing?
- 4.6. Which actors actually get involved in health planning process at council level?
  - 4.6.1. Why do you think they get involved?
  - 4.6.2. How do they get involved?
  - 4.6.3. What are their relative roles in the council health planning process?
- 4.7. Can you describe your relationships with them?
- 4.8. How does the existing relationship influence CHMT with respect to health planning?



- 4.8.1. How could the relationship be improved?
- 4.9. What factors enhance or constrain CHMTs to involve other actors in council health planning process?
  - 4.9.1. How is health planning affected by the level of participation of these actors? Probe for example
  - 4.9.2. Why do you think so? Probe for example?
  - 4.9.3. How could the situation be improved?
- 4.10. What factors enhance or constrain other actors to participate in local health planning process?
  - 4.10.1. Why do you think so?
  - 4.10.2. How could this be improved?

## 5. THE COUNCIL HEALTH PLANNING CONTENT

- 5.1. In your opinion what are the attribute of a good council health plan?
- 5.2. Why do you think so?
- 5.3. What does the centre consider to be a good council health plan?
- 5.4. What do you consider to be a good plan?
- 5.5. How do you rate your council's planning capacity
  - Good
  - Average
  - Poor
  - Why do you think so
- 5.6. In particular what things are emphasised in the planning guideline?
  - 5.6.1. Why do you think so? (Give example of what respondents mentioned in qn 5.5)
- 5.7. In particular what things are not receiving due emphasis in the planning guideline?
  - 5.7.1. Why do you think this is the case?
  - 5.7.2. How is council health planning affected by this?
  - 5.7.3. What could be improved and how?

## 6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING

- 6.1. To what extent do the existing guidelines broaden or narrow your ability to make decisions. (use the following probes, ask for examples and evidences) Function
  - Finances e.g. allocation of expenditure
  - Spending the collected revenues e.g. cost sharing, community health funds
  - Procurement e.g. equipment, drugs, service etc
  - Human resources management e.g. employee transfer, training, promotion, recruitment

- Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
- 6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.
- 6.3. What are your views regarding the way the centre influences you to adhere to its policy goals?
- 6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe your relationship with them?
- Collaborative
  - Control
  - Partnership
- 6.5. Are there instances where the councils abuse the granted discretion? Probe for examples
- 6.5.1. Why do you think they do so?
- 6.5.2. How does the center deal with these instances?
- 6.5.3. Are there mechanisms in which CHMT use to reduce the influences of the centre to the planning process?
- 6.5.4. How effective are they? What do you think is missing in CHMT's current practices?
- Research
  - Meetings
  - Informal ways- mention
  - Evidence based argument to persuade government
  - Reports
- 6.6. Are there any tensions between local and centre- hidden or visible? Why do you think so? Probe for examples
- 6.6.1. How does this affect council health planning?
- 6.6.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans

Is there any other respondent you would particularly recommend talking to?

### Interview Guide for Government Officials- national level

Preliminaries:

- xxii. *Check that you have considered focal points of interview in relation to the research objectives*
- xxiii. *Did respondent receive background document on research (letter) (Take additional copies)*
- xxiv. *Clarify time available for interview*
- xxv. *Include relevant extra questions or probes based on information received to date from other informants or background documents*

Department \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

## 1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What is your designation?
- 1.2. For how long have you been holding this position? (it does not matter whether in same station or different)
- 1.3. Briefly talk about your department role and responsibilities
- 1.4. What are your responsibilities and duties?
- 1.5. How do you link with CHMT?

## 2. THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. How do you engage with CHMTs specifically in planning?
- 2.2. What functions have been decentralised to CHMTs (in practice)?
- 2.3. How have they been decentralised?
- 2.4. Are there any aspects that you particularly like, or don't like? And why
- 2.5. What benefits have you realised with respect to council health planning that is attributable to health sector decentralisation? (Probe for examples)

2.6. What difficulties do you encountered with respect to council health planning process that is attributable to health sector decentralisation? Probe for examples

**2.6.1.** How could this be improved?

2.7. To whom is CHMT accountable under this settings

**2.7.1.** In what way

- financially
- technically
- organisationally/Administrative

2.7.2. What are the strengths and challenges of the current accountability system?

2.7.3. Why do you think so?

**2.7.4.** How could this be improved?

### 3. THE COUNCIL HEALTH PLANNING PROCESS

3.1. How do you communicate policies and guidelines to CHMT?

**3.1.1.** How effective in your views is this approach/mechanism?

3.1.2. Can you provide specific examples of particularly good or poor practices/mechanisms?

3.1.3. Why do you think so?

**3.1.4.** How could the situation be improved?

3.2. How do you communicate important information for planning to CHMT?

**3.2.1.** What do you think works or does not work with respect to the way you provide this information to CHMT?

3.2.2. How does this influence the council health planning?

**3.2.3.** What could be improved?

3.3. What mechanisms do you use to ensure that CHMT adhere to the policies, guidelines with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalise, by whom, impact

3.3.1. How well do you think these are functioning and why? (probe for examples)

3.3.2. What are your views regarding the way you influence CHMTs to adhere to your policy goals?

3.3.3. What could be improved?

3.3.4. How?

3.4. How and to what extent is the CHMT's performance in health planning in line with or different from your expectations? Probe for examples

3.5. How could the situation be improved?

3.6. How local planning capacity is developed?

3.7. Who develops the local planning capacity?

- 3.8. What are the strengths and weaknesses of the current approaches?
- 3.8.1.** Are you familiar with the criteria used to assess CCHP?
- 3.8.2. What are your opinions regarding the criteria used to assess CCHP: are they good, or there are things that need to change and what are these and why?
- 3.8.3. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?
- 3.8.4.** What could be improved and how?
- 3.9. *What aspects do you like or dislike regarding the CCHP approval process?*
- 3.10. What could be improved and how?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

- 4.1. Who are the main actors with respect to council health planning process at national level?
- 4.1.1. Why do you consider them as main actors?
- 4.1.2. Who are missing?
- 4.1.3. How do they engage with council health planning process?
- 4.1.4. What are their relative roles in the council health planning process?
- 4.1.5. What are their influences?
- *Budget allocation*
  - *Ceilings*
  - *contents*
- 4.1.6. How useful or constraining is their engagement to council health planning?
- 4.1.7. What could be improved and how?
- 4.1.8. Which actors do you expect CHMTs will involve them in planning?
- 4.1.9. Why?
- 4.1.10. What actually happen in practice?
- 4.1.11. Why?
- 4.2. What factors enhance or constrain CHMTs to involve other actors in council health planning process?

- 4.2.1. How health planning is affected by the level of participation of these actors? Probe for example
- 4.2.2. Why do you think so? Probe for example?
- 4.2.3. How could the situation be improved?
- 4.3. What factors enhance or constrain other actors to participate in local health planning process?
  - 4.3.1. Why do you think so?
  - 4.3.2. How could this be improved?

## 5. THE COUNCIL HEALTH PLANNING CONTENT

- 5.1. In your opinion what are the attributes of a good council health plan?
- 5.2. Why do you think so?
- 5.3. How do you rate council's planning capacity in general?
  - Good
  - Average
  - Poor
  - 5.3.1. Why do you think so
- 5.4. What tools do CHMTs use in developing the council health plan?
  - 5.4.1. How useful are these tools to them and to you?
  - 5.4.2. What could be improved?
- 5.5. In particular what things are emphasised in the planning guideline?
  - 5.5.1. Why do you think so? (Give example of what respondents mentioned in qn 5.6)
- 5.6. In particular what things are not receiving due emphasis in the planning guideline?
  - 5.6.1. Why do you think this is the case?
  - 5.6.2. How council health planning is affected by this?
  - 5.6.3. What are you (the center) missing as the result of this omission? Probe for examples
  - 5.6.4. What could be improved and how?

## 6. RESULTING RELATIONSHIPS AND ITS INFLUENCE ON HEALTH PLANNING

- 6.1. To what extent the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)
  - Finances e.g. allocation of expenditure
  - Spending the collected revenues e.g. cost sharing, community health funds
  - Procurement e.g. equipment, drugs, service etc
  - Human resources management e.g. employee transfer, training, promotion, recruitment

- Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
- 6.1.1. What are the advantages and disadvantages of the wide or narrow discretion with respect to council health planning? Probe for example.
- 6.2. How do you ensure the granted discretion is exercised as expected?
- 6.3. Are there instances where the councils abuse the granted discretion? Probe for examples
- 6.3.1. Why do you think they do so?
- 6.3.2. How does the center deal with these instances?
- 6.4. Are there mechanisms in which CHMT use to reduce the influences to the planning process?
- *Research*
  - *Meetings*
  - *Informal ways- mention*
  - *Evidence based argument to persuade government*
  - *Reports*
- 6.4.1. How effective are they?
- 6.5. Following the mechanisms used by the centre to enforce adherence to its guidelines how would you describe your relationship with them?
- Facilitative
  - Control
  - Collaborative
- 6.6. Do you consider central influence optimal or too much
- 6.6.1. Why do you think so probe for examples
- 6.7. Are there any tensions between CHMT and the centre- hidden or visible?
- 6.7.1. Why do you think so? Probe for examples
- 6.7.2. How does this affect council health planning?
- 6.7.3. How could this be improved?

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans  
Is there any other respondent you would particularly recommend talking to?

## INTERVIEW GUIDE NGO DISTRICT LEVEL

Preliminaries:

- xxvi. *Check that you have considered focal points of interview in relation to the research objectives*
- xxvii. *Did respondent receive background document on research (letter) (Take additional copies)*
- xxviii. *Check if respondent has any quick questions on the project and answer these*
- xxix. *Clarify time available for interview*
- xxx. *Include relevant extra questions or probes based on information received to date from other informants or background documents*

District: \_\_\_\_\_

Region: \_\_\_\_\_

NGO Name \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

### 1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What is your designation?
- 1.2. What are your responsibilities and duties?
- 1.3. For how long have you been holding this position? (it does not matter whether in same station or different)

### 2. THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. What are the key health and health systems challenges in your council?
- 2.2. Are you familiar with the current decentralisation policy/strategy?
- 2.3. Are there any aspects of decentralisation that you particularly like, or don't like?- and why?



- 2.4. What functions have been decentralised to councils (in practice)?
- 2.5. What benefits have you realised in your council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)

- *Resource allocation*
- *Partnerships*
- *Community engagement*
- *Resource availability*
- *Skills*
- *Addressing local priorities*
- *Addressing national priorities*
- *Guidance*

- 2.6. What difficulties have you encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples

- *Resource allocation*
- *Partnerships*
- *Community engagement*
- *Resource availability*
- *Skills*
- *Addressing local priorities*
- *Addressing national priorities*
- *Guidance*

**2.6.1.** How could this be improved?

- 2.7. To whom is CHMT accountable in a decentralised setting

**2.7.1.** In what way

- *financially*
- *technically*
- *organisationally/Administrative*

2.7.2. What are the strengths and challenges of the current accountability system?

2.7.3. Why do you think so?

- 2.8. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

- 3.1. Do you participate in council health planning and if so, how?

- 3.2. Are you familiar with the mechanism that the government uses to communicate its policies and guidelines?

**3.2.1.** How effective are the current approaches/mechanisms?

3.2.2. Can you provide specific examples of particularly good or poor practices/mechanisms?

3.2.3. Why do you think so?

**3.2.4.** How could the situation be improved?

3.3. How are the policies, guidelines enforced by the centre with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact

**3.3.1.** How well do you think these are functioning and why? (probe for examples)

3.4. How and to what extent is the CHMT's performance in planning in line with or different from national government expectations?

3.5. What aspects do you like or dislike regarding CCHP assessment and outcomes of the assessments?

3.6. Are you familiar with the criteria used to assess the Comprehensive Council Health Plans?

3.6.1. What are your opinions regarding these criteria: are they good, or there are things that need to change and what are these and why?

3.6.2. What could be improved and how?

3.6.3. What aspects do you like or dislike regarding the CCHP approval process?

**3.6.4.** What could be improved and how?

3.7. How is local planning capacity developed?

- Training
- Supervision and on job support
- Manuals
- Provision of planning tools
- Issuing guidelines

3.8. Who is responsible for the development of local planning capacity?

3.9. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

4.1. Who are the main actors in the council health planning process?

4.1.1. Why do you consider them as main actors?

4.1.2. Who are missing?

4.2. How do they engage with council health planning process and how effective is it?

4.3. What are their relative roles in the council health planning process?

4.4. What factors enhance or constrain CHMTs to involve other actors in council health planning process?

4.4.1. How is health planning affected by the level of participation of these actors? Probe for example

4.4.2. Why do you think so? Probe for example?

4.4.3. How could the situation be improved?

- 4.5. What factors enhance or constrain other actors to participate in local health planning process?
  - 4.5.1. Why do you think so?
  - 4.5.2. How could this be improved?
5. THE COUNCIL HEALTH PLANNING CONTENT
  - 5.1. In your opinion what are the attributes of a good council health plan?
  - 5.2. Why do you think so?
  - 5.3. What does the centre consider to be a good council health plan?
  - 5.4. What does the CHMT consider to be a good council health plan?
  - 5.5. How do you rate your council's planning capacity
    - Good
    - Average
    - Poor
    - 5.5.1. Why do you think so
  - 5.6. In **particular** what things are emphasised in the planning guideline?
    - 5.6.1. Why do you think so? (Give example of what respondents mentioned in qn 5.6)
  - 5.7. In **particular** what things are not receiving due emphasis in the planning guideline?
    - 5.7.1. Why do you think this is the case?
    - 5.7.2. How is council health planning affected by this?
    - 5.7.3. What could be improved and how?
6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING
  - 6.1. To what extent do the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)
    - Finances e.g. allocation of expenditure
    - Spending the collected revenues e.g. cost sharing, community health funds
    - Procurement e.g. equipment, drugs, service etc
    - Human resources management e.g. employee transfer, training, promotion, recruitment
    - Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals
  - 6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.
  - 6.3. What are your views regarding the way the centre influences CHMTs to adhere to its policy goals?

6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe CHMT relationship with them?

- Collaborative
- Control
- Partnership

6.5. Are there mechanisms which CHMT use to reduce the influences of the centre to the planning process?

6.6. How effective are they? What do you think is missing in CHMT's current practices?

- Research
- Meetings
- Informal ways- mention
- Evidence based argument to persuade government
- Reports

6.7. Are there any tensions between local and centre- hidden or visible? Why do you think so? Probe for examples

6.7.1. How does this affect council health planning?

6.7.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans

Is there any other respondent you would particularly recommend talking to?

## INTERVIEW GUIDE – POLITICIANS (CENTRAL AND DISTRICT LEVEL)

### Preliminaries:

- xxxi. *Check that you have considered focal points of interview in relation to the research objectives*
- xxxii. *Did respondent receive background document on research (letter) (Take additional copies)*
- xxxiii. *Clarify time available for interview*
- xxxiv. *Include relevant extra questions or probes based on information received to date from other informants or background documents*

District or Parliamentary committee: \_\_\_\_\_

Region: \_\_\_\_\_

Date: \_\_\_\_\_

Start time: \_\_\_\_\_

Completion time: \_\_\_\_\_

Interview code number: \_\_\_\_\_

### 1. RESPONDENTS AND FOCAL ORGANISATION CHARACTERISTICS

- 1.1. What is your designation
- 1.2. What are your responsibilities and duties with respect to health planning?
- 1.3. For how long have you been holding this position?

### 2. THE COUNCIL HEALTH PLANNING CONTEXT

- 2.1. Are there any aspects of decentralisation that you particularly like, or don't like?
- 2.2. What functions have been decentralised to councils -in practice?
- 2.3. What benefits have been realised in council health planning process that is attributable to health sector decentralisation? (*Probe for examples*)
  - *Resource allocation*
  - *Partnerships*
  - *Community engagement*
  - *Resource availability*
  - *Skills*
  - *Addressing local priorities*

- *Addressing national priorities*
  - *Guidance*
- 2.4. What difficulties are encountered in council health planning process that is attributable to health sector decentralisation? Probe for examples
- *Resource allocation*
  - *Partnerships*
  - *Community engagement*
  - *Resource availability*
  - *Skills*
  - *Addressing local priorities*
  - *Addressing national priorities*
  - *Guidance*

**2.4.1.** How could this be improved?

- 2.5. To whom is CHMT accountable in a decentralised setting

**2.5.1.** In what way

- *financially*
- *technically*
- *organisationally/Administrative*

2.5.2. What are the strengths and challenges of the current accountability system?

2.5.3. Why do you think so?

2.5.4. How could this be improved?

### **3. THE COUNCIL HEALTH PLANNING PROCESS**

- 3.1. How does the centre communicate its policies and guidelines?

**3.1.1.** How effective are the current approaches/mechanisms?

3.1.2. Can you provide specific examples of particularly good or poor practices/mechanisms?

3.1.3. Why do you think so?

**3.1.4.** How could the situation be improved?

- 3.2. How are the policies, guidelines enforced by the centre with regard to health planning?

- Rewards or Sanctions: What type, how are they operationalised, by whom, what impact

**3.2.1.** How well do you think these are functioning and why? (probe for examples)

- 3.3. How and to what extent is the CHMT's performance in planning in line with or different from government expectations?

- 3.4. How is local planning capacity developed?

- *Training*
- *Supervision and on job support*

- *Manuals*
- *Provision of planning tools*
- *Issuing guidelines*

- 3.5. Who is responsible for the development of local planning capacity?
- 3.6. What are the strengths and weaknesses of the current approaches to strengthening capacity?

#### **4. THE COUNCIL HEALTH PLANNING ACTORS:**

- 4.1. Who are the main actors in the council health planning process?
- 4.1.1. Why do you consider them as main actors?
- 4.1.2. Who are missing?
- 4.2. What are their relative roles in the council health planning process?
- 4.3. What factors enhance or constrain CHMTs to involve other actors in council health planning process?
- 4.3.1. How is health planning affected by the level of participation of these actors? Probe for example
- 4.3.2. Why do you think so? Probe for example?
- 4.3.3. How could the situation be improved?
- 4.4. What factors enhance or constrain other actors to participate in local health planning process?
- 4.4.1. Why do you think so?
- 4.4.2. How could this be improved?

#### **5. THE COUNCIL HEALTH PLANNING CONTENT**

- 5.1. In your opinion what are the attribute of a good council health plan?
- 5.2. Why do you think so?
- 5.3. What does the centre consider to be a good council health plan?
- 5.4. How do you rate your council's planning capacity
- *Good*
  - *Average*
  - *Poor*
- 5.4.1. Why do you think so
- 5.5. In particular what things are emphasised in the planning guideline?
- 5.5.1. Why do you think so? (Give example of what respondents mentioned in qn 5.6)
- 5.6. In particular what things are not receiving due emphasis in the planning guideline?
- 5.6.1. Why do you think this is the case?
- 5.6.2. How is council health planning affected by this?
- 5.6.3. What could be improved and how?

## 6. RESULTING RELATIONSHIPS AND THEIR INFLUENCE ON HEALTH PLANNING

6.1. To what extent do the existing guidelines broaden or narrow council's ability to make decisions. (use the following probes, ask for examples and evidences)

- *Finances e.g. allocation of expenditure*
- *Spending the collected revenues e.g. cost sharing, community health funds*
- *Procurement e.g. equipment, drugs, service etc*
- *Human resources management e.g. employee transfer, training, promotion, recruitment*
- *Service organisation e.g. managing the service agreements with private providers e.g. Council designated hospitals*

6.2. What are the advantages and disadvantages of giving wide or narrow discretion to CHMTs with respect to council health planning? Probe for example.

6.3. What are your views regarding the way the centre influences CHMTs to adhere to its policy goals?

6.4. Considering the mechanisms used by the centre to enforce adherence to its guidelines how would you describe CHMT relationship with them?

- *Collaborative*
- *Control*
- *Partnership*

6.5. Are there any tensions between local and centre- hidden or visible? Why do you think so? Probe for examples

6.5.1. How does this affect council health planning?

6.5.2. How could this be improved

END

Do you have any question you would like to ask me or anything else you want to clarify more?

"Thank you for your time. As I said earlier, this information will be treated confidentially. I may come back to you for further information if necessary; I hope that will be alright."

Thanks for your time

Ask for copy of any relevant documents such as annual reports, policies or plans  
Is there any other respondent you would particularly recommend talking to?



## Appendix F: Document review proforma

The proforma consist of four sections

1. **Document Identifier:** This section was used to record all relevant information that identify the document e.g. full reference and type of document
2. **Content:** In this section information regarding major research questions were recorded
3. **Other key findings:** designed to summarise any other key issues from the reading of this document, which were not covered in the major content areas
4. **Document context:** Designed to highlight issues about the document such as – Who this is aimed at any obvious bias identified, implication on relationship between the centre and Council Health Management Team and the ideology behind the document, and the relationship between the Centre and Council Health Management Team?

Section	Information/findings
<b>1. Document Identifier</b>	
1.1. Full reference of document	
1.2. Type of document (e.g. Govt policy/regulation, academic paper, unpublished report, etc)	
<b>2. Content</b>	
<b>2.1. Information about the health systems context</b> <ul style="list-style-type: none"> <li>• <i>Political context (National and district level)</i></li> <li>• <i>Economic context (National and district level)</i></li> <li>• <i>Social context (National and district level)</i></li> </ul>	

Section	Information/findings
<ul style="list-style-type: none"> <li>• <i>Health systems context (National and district level)</i></li> <li>• <i>Health and health related policies</i></li> </ul>	
<p><b>2.2. Information on decentralisation and accountability system</b></p> <ul style="list-style-type: none"> <li>• <i>Forms of decentralisation</i></li> <li>• <i>Roles and responsibilities of different levels</i></li> <li>• <i>Structures and levels of decentralisation and inter-sectoral linkages</i></li> <li>• <i>Accountability system</i></li> <li>• <i>Management of decentralisation: Tools and communication mechanisms</i></li> </ul>	
<p><b>2.3. Information on health planning process</b></p> <ul style="list-style-type: none"> <li>• <i>Levels of plans exist?</i></li> <li>• <i>How is the planning process guided and why?</i></li> <li>• <i>The budgeting cycle for different types of plans</i></li> <li>• <i>The approval processes, criteria and outcomes</i></li> <li>• <i>Existing Guidelines</i></li> </ul>	

Section	Information/findings
<p><b>2.4. Information on involvement of Actors</b></p> <ul style="list-style-type: none"> <li>• <i>Who participated in the planning process- from planning workshops reports</i></li> <li>• <i>Who should participate- from guidelines</i></li> <li>• <i>Who influence the process – donors, e.g. basket funding committee members etc meetings</i></li> </ul>	
<p><b>3. Any other key findings</b></p>	
<p><b>4. Document context</b></p>	

## Appendix G – Participant Information Sheet

**Name of Centre: Nuffield Center for International Health and Development - University of Leeds**



**UNIVERSITY OF LEEDS**

### Participant Information Sheet

#### Title of Study

A qualitative Study on the Relationships between Central Organizations and Local Government and Their Influence on Local Planning Process: A Case of Council Health Management Team Planning in Tanzania.

I kindly request you to take part in the above named study. The participation will be either in interview or focus group discussion. This leaflet highlights answers to most probable questions that you might think of for you to decide whether to participate or not. Kindly read carefully. Should you need more clarification please ask me by email, telephone or just before we start the interview.

My Email: [mphak@leeds.ac.uk](mailto:mphak@leeds.ac.uk) or [hkweka@ihi.or.tz](mailto:hkweka@ihi.or.tz)

Office telephone number: **Tel** +255 222 774 756

#### **What is the purpose of this study?**

##### **Brief Background**

Tanzania In its efforts to strengthen district health planning, the Ministry of Health and Social Welfare's focus has been on improving the technical part of the planning process. This is done through training, development of standardised format planning tools such as burden of disease, district health account tool and guidelines that are geared towards enabling the district to produce plans that address the national policy goals. However, there are still some perceived weaknesses in council health planning. In particular, the quality of health plans is not dependent on technical issues alone; there are political and organisational factors that influence this process which are often ignored or misunderstood

**Purpose of the Study:** In addressing this gap this study seeks to explore the influences of the existing relationships between Central organisations such as the Ministry of Health and local government on local health planning in Tanzania.

**Who is doing the study?**

My name is Hadija Kweka. I am working with Ifakara Health Institute as a research scientist. I am a PhD student at the Nuffield Center for International Health and Development - University of Leeds. I am the one conducting this study as the requirement for my PhD programme. I will be collecting data from two districts namely Kilombero and Babati. In addition I will be conducting interviews at national level.

**Who is being asked to participate? or Why have I been asked to participate?**

You are being asked to participate in this study because of the roles that you play in council health planning. The roles include

- Coordination
- Approval
- Actual planning
- Training
- Integration of service at district level
- Financing

By design therefore the study seeks information from various levels. The key informants are:

- Ministry of Health and Social Welfare (MOH&SW)- Informants recruited from national regional and district level.
- Prime Minister Office Regional Administration and Local Government (ministry of local government) Informants recruited from national regional and district level.
- Partners- NGOs, Privates, Government agencies- UN agencies- Informants recruited from national and district level.
- Community representatives

- Politicians- Informants recruited from national and district level.

-

### **What will be involved if I take part in this study?**

I am requesting for your time during interview which will take about an hour and a half in the venue that is convenient to you. In order to ensure that all your responses are captured well I would request if you feel comfortable to record the interview. There are no risks in participating to this study. The information that is collected from this may be used in future researcher by me or other researchers.

### **What are the advantages and disadvantages of taking part?**

The information gathered will be used to inform the planning system in Tanzania on areas that need improvements in the planning process and relationships of actors.

### **Can I withdraw from the study at any time?**

You do not need to answer any question that you do not want to. If you decide you do not want to take part in this study, it will not affect you in any way. You may stop the interview at any time for any reason and this will not have any implication on you as a person or on your office. However, once the interview has been completed the answers cannot be withdrawn.

### **Will the information obtained in the study be confidential? or Will the information I give be kept confidential?**

Your name will not be listed in any report that comes out of this study. All that you say will be treated as confidential and anonymous. Personal data linking the identities of respondents to anonymised transcripts will be kept in encrypted and password-protected portable hard drive. Interview transcripts will be given another identifier rather than a name of interviewee; files that have the identifier and the respective names will be kept under locked storage and destroyed three years after the study is completed. If other researchers would need to use the data they

will be made to sign a non-disclosure form except the research team and the supervisors.

### **What will happen to the results of the study?**

The results of this study will be disseminated to the Ministry of Health and Social Welfare and the districts where data is collected as first consumers of this information. In addition, issues for publication will be extracted and published in various journals. If chances occur, presentations will be made in various local and international fora.

### **Who has reviewed this study?**

This research has been approved by the Institutional Review Board of Ifakara Health Institute and the ethical review board of the University of Leeds. See a copy of ethical approval certificate.

**If you agree to take part, would like more information or have any questions or concerns about the study please contact.....(Name, position and contact details of researcher/s)**

### **Appendix H: Coding frame**

<ol style="list-style-type: none"> <li>1. Council Characteristics               <ol style="list-style-type: none"> <li>1.1. Location</li> <li>1.2. Population</li> <li>1.3. Health systems strengths and challenges                   <ol style="list-style-type: none"> <li>1.3.1. Budern of disease</li> <li>1.3.2. Staff for planning</li> <li>1.3.3. Status of health infrastructure</li> <li>1.3.4. Council revenue base</li> <li>1.3.5. Existence of non-governmental support</li> </ol> </li> <li>Emerging</li> <li>1.4. Private sector</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>2. Decentralisation               <ol style="list-style-type: none"> <li>2.1. Respondents familiarity with decentralisation</li> <li>2.2. The benefits of decentralisation in health planning</li> <li>2.3. Challenges of decentralisation in health planning</li> <li>2.4. Opinions on how to improve or reduce decentralisation impact on planning</li> <li>2.5. <b>Emerging themes</b> <ol style="list-style-type: none"> <li>2.5.1. Accountability</li> <li>2.5.2. Responsibility</li> <li>2.5.3. Answerability</li> <li>2.5.4. Capacity of decentralised units</li> <li>2.5.5. Institutional arrangements of decentralisation</li> <li>2.5.6. Ministerial roles and functions</li> </ol> </li> </ol> </li> </ol>
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	<p>2.5.7. Decentralization and resource mobilization – Delegation and utilization of resources</p> <p>2.5.8. Decentralization procedures – Producers followed during decentralization</p>
<p>3. Health Planning Process</p> <p>3.1. Participation</p> <p>3.2. Factors promoting participation</p> <p>3.3. Factors hindering participation</p> <p>3.4. Planning guidance</p> <p>3.5. Process of communicating guidelines</p> <p>3.6. Strengths of communicating guidelines</p> <p>3.7. Challenges of communicating guidelines</p> <p>3.8. Assessment of plans</p> <p>3.9. Local health planning process</p> <p><b>3.10. Emerging themes</b></p> <p>3.10.1. Pre-planning activities</p> <p>3.10.2. Actual planning activities</p> <p>3.10.2.1. Problem identification</p> <p>3.10.2.2. Priority setting</p> <p>3.10.2.3. Resource allocation</p> <p>3.10.3. Actors in health planning</p> <p>3.10.4. Roles of actors in health planning</p> <p>3.11. Planning guidelines</p> <p>3.11.1. Strengths</p> <p>3.11.2. Challenges</p> <p>3.12. Planning capacity</p> <p>3.12.1. Training and the advantages – different types of training provided and attended by the study participants along with the advantages mentioned.</p> <p>3.13. Recommendations – Way forward/solutions/suggestions as provided with the study participants.</p> <p>3.14. Proposal for improvement of planning process</p>	<p>4. Planning Relationships</p> <p>4.1. The features of central government</p> <p>4.2. The features of local government</p> <p>4.3. Local governments</p> <p>4.4. Central governments</p> <p>4.5. Decentralisation</p> <p>4.6. Devolution</p> <p>4.7. Deconcentration</p> <p>4.8. Central-local relations</p> <p>4.9.</p> <p>4.10. Types of central-local relations</p> <p>4.11. Actors -types</p> <p>4.12. Roles of actors</p> <p>4.13. Influences to the relationships</p> <p>4.14. Implication of influences</p> <p>4.15. Ways of improving</p> <p><b>4.16. Emerging</b></p> <p>4.16.1. Power dynamics</p> <p>4.16.2. Central -local relations challenges</p> <p>4.16.3. decision space</p> <p>4.16.4. Capacity</p> <p>4.16.5. RHMT – operations/functionality in relation to decentralization.</p> <p>4.16.6.</p> <p>4.16.7. accountability</p> <p>4.16.8. Challenges with the decentralization process – Challenges/difficulties encounter during decentralization.</p> <p>4.16.9. Challenges facing accountability system - Challenges/difficulties encounter with the accountability system</p>



	4.16.10. Ways of dealing with the challenges – different alternatives on problem solving as mentioned during the interview
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## Appendix I: Participant Consent Form

**Title of Research Project:**

A qualitative Study on the Relationships between Central Organizations and Local Government and Their Influence on Local Planning Process: A Case of Council Health Management Team Planning in Tanzania.

**Name of Researcher:**

Hadija Kweka

I had sent to you an information sheet elaborating various issues regarding the above mentioned research. Please tick the following boxes with Y= yes or N = no and NS for not sure.

Please initial box

1. I confirm that I have read and understand the information sheet dated ----- *explaining* the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. You may call this number for any change of timing or date of interview or if you wish to decline (0786524040).
3. I understand that my responses will be kept strictly confidential (only if true). I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree for the data collected from me to be used in future research

5. I agree to take part in the above research project.

\_\_\_\_\_  
 Name of Participant  
 (or legal representative)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Name of person taking consent  
 (if different from lead researcher)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

*Signed and dated in presence of the participant*

\_\_\_\_\_  
 Lead Researcher

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

*signed and dated in presence of the participant*

Copies:

*Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.*

**Title of Research Project:**

A qualitative Study on the Relationships between Central Organizations and Local Government and Their Influence on Local Planning Process: A Case of Council Health Management Team Planning in Tanzania.

**Name of Researcher:**

Hadija Kweka

I had sent to you an information sheet elaborating various issues regarding the above mentioned research. Please tick the following boxes with Y= yes or N = no and NS for not sure.

Please initial box

4. I confirm that I have read and understand the information sheet dated ----- *explaining* the above research project and I have had the opportunity to ask questions about the project.
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. You may call this number for any change of timing or date of interview or if you wish to decline (0786524040).
6. I understand that my responses will be kept strictly confidential (only if true). I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
4. I agree for the data collected from me to be used in future research
5. I agree to take part in the above research project.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

(or legal representative)

\_\_\_\_\_  
Name of person taking consent      Date      Signature  
*(if different from lead researcher)*  
*Signed and dated in presence of the participant*

\_\_\_\_\_  
Lead Researcher      Date      Signature  
*signed and dated in presence of the participant*

**Copies:**

*Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.*