Decentralization in Tanzania: the View of District Health Management Teams

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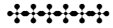

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DECENTRALIZATION IN TANZANIA: THE VIEW OF DISTRICT HEALTH MANAGEMENT TEAMS

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MEASURE *EVALUATION*
JANUARY, 2002[1]

Abstract

A 1999 survey of District Health Management Teams (DHMTs) in Tanzania provides information on the progress of the decentralization process in that country. The objectives of the survey were to monitor the extent of the decentralization process and to collect information on decentralization's achievements and limitations to date. The survey represents a unique source of data since information was collected from the actual "on-the-ground" implementors of the decentralization process. The survey found that while decentralization has been ongoing for over a decade, at least rhetorically, less than half of DHMTs report that decentralization is underway in their districts and the actual transfer of administrative and fiscal responsibilities is still limited for the majority of districts. Most districts are heavily reliant on external funding and report that they have control over only a small proportion of their budgets. For those districts in which decentralization is ongoing, the decentralization process is reported to be associated with improvements in a variety of areas: availability of district funds, coordination with donors, ability to attract and retain staff, and use of government health services.

1. Background

Decentralization has become an increasingly important component of health sector reform efforts in developing countries. A survey of developing and transitional nations in the mid-1990s indicated that out of the 75 such economies with populations greater than five million, all but 12 claim to have embarked on some type of transfer of power to local governments (Dillinger, 1994).

Decentralization can take many forms but is most commonly distinguished by the extent of control over specific types of responsibilities - administrative, political or fiscal. In most developing country health sectors, decentralization usually involves devolution of some administrative functions to lower levels of government or to local branches of national governments. These administrative functions often include control over personnel, supplies and equipment, hiring of staff, purchasing and ordering, and delivery of services. Fiscal decentralization, which generally involves granting control over allocation of resources for some proportion of health programs to local government or local health authorities, is less common in developing countries. Even in countries with a good deal of local control over resources, however, local health sectors generally remain reliant on outside sources of funding – the central government or donors. Political decentralization is usually initiated by forces outside of the health sector, though its effects are usually felt in the health sector (Hutchinson 1999).

[1] Thanks go to Joy Baumgarten for the translations of responses to the open-ended questions.

Many rationales are given for decentralization processes in developing countries. Most common is the need to address the difficulties of trying to coordinate disparate activities for different regions from a central location. Decentralizing decision-making to the local level can reduce the time required for making decisions, as well as increasing the likelihood that decisions will be made with the benefit of local knowledge of conditions. Decentralization is also believed to increase the sustainability of health sector activities by increasing the involvement of local communities. This rationale has its roots in the Primary Health Care movements reflected in the Declaration of Alma Ata in 1977. The economic rationales for decentralization, apart from the cost savings from reduced bureaucracy and faster decision-making, generally focus on the extent to which decentralization can lead to an increase in the welfare of local populations by allowing the supply of health services to be more in line with the services that local populations value more highly. Finally, by increasing community participation in health systems, decentralization can lead to greater accountability of health workers, thereby increasing the quality of health services and the efficiency by which they are produced.

Tanzania is currently divided into 25 regions and 118 districts, all with some form of representative (politically decentralized) government. Decentralization in Tanzania is an ongoing process having its origins in the one-party system established in the 1960s which increased community participation in local government. The current decentralization process dates back to the enactment of the 1983 Local Government Act, which re-instituted elections at the district level that had been abolished in 1972 (Gilson 1994; World Bank 1999). Local governments were given responsibility for delivering basic health services at the district hospital level and below. Currently, local government are also, at least on paper, the employers of health workers, although all health workers must be selected and approved centrally. Local governments have little say in who is hired, disciplined and rewarded. This creates a poor incentive system, since workers face little likelihood of punishment for poor performance nor reward for outstanding performance. Promotions are usually based on length of service (Gilson 1994; World Bank 1999).

Local governments are heavily dependent upon central transfers. Of the two types of budgets – development and recurrent – the development budget, which includes vertical programs, civil works and donor projects – is almost entirely centrally funded, while the recurrent budget is about 70 percent centrally funded (World Bank 1999). Local governments can raise funds from taxes, licenses and fees, user charges, rental income from council properties, government grants and government donations. Until the 1990s, the government had a policy of providing universal free health coverage at a widely dispersed system of rural clinics and district and regional hospitals. However, lack of resources meant that these facilities were plagued by lack of drugs and equipment, declining infrastructure, and absent employees. User charges were instituted in the early 1990s, but have made only minor contributions to overall revenues (World Bank 1999).

Decentralization in Tanzania, as elsewhere, has received only limited scrutiny. One study more than 10 years ago found that district managers had limited authority, particularly over financial resources. Study of district health managers – (Gilson et al 1994). At that

time, district health managers faced many of the same problems that they face now: lack of coordination, poor managerial capacity and shortages of fiscal resources.

2. Data

The principal source of data for this analysis is a survey of 81 District Health Management Teams in Tanzania conducted by the National Bureau of Statistics from September through December 1999.[2] These data were collected as part of the Tanzania Reproductive and Child Health Survey in 1999.

The DHMT questionnaire collected information on the following aspects of decentralization:

- Timing of implementation of decentralization
- Budgeting, sources of funds, and funding priorities
- Preparation of annual workplans and "bottom-up" planning
- Perceptions of changes in resource availability, quality and availability of health services, personnel issues, and accountability
- Adherence to reporting requirements
- Open-ended responses to assessments of impacts of decentralization, limitations of decentralization, impediments to implementation of activities, assignment of budgeting priorities, and improving donor and government coordination

Of the 81 District Health Management Teams interviewed, 77 interviews were completed. The questionnaires were given to the District Medical Officers in each district. The District Medical Officer was present at all but three of the interviews (Table 1). If the DMO was not present, the DMCHC was interviewed. In the event that neither of these people were present, another member of the DHMT was interviewed. In over 80 percent of interviews, the District Health Office (DHO) and District Nursing Office (DNO) were present. In all cases, the principal respondent was a resident of the district for at least one year.

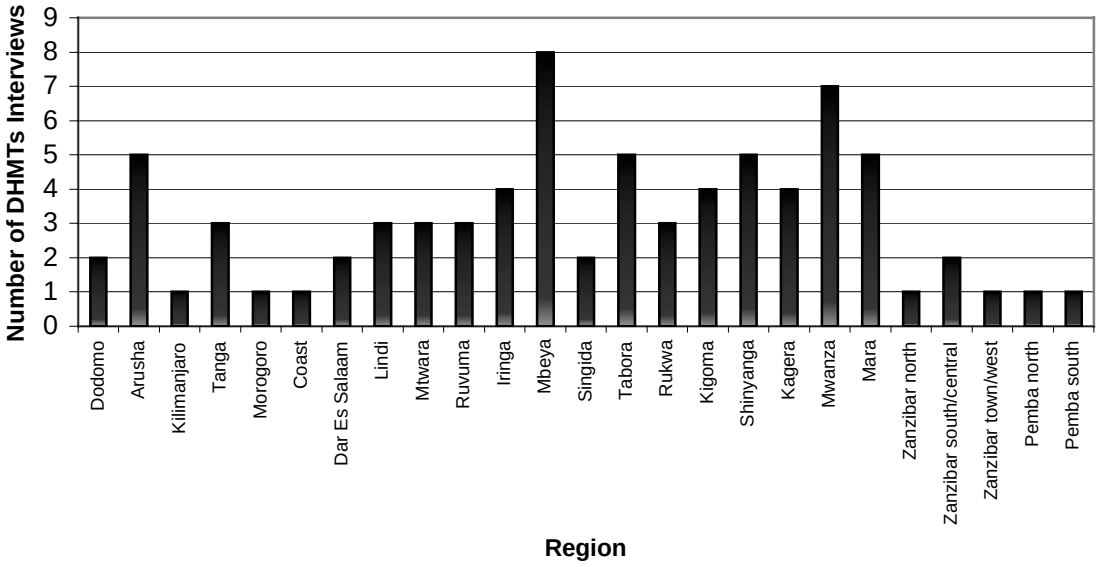
Table 1. Personnel Present at Interview

Respondent	Pct.	N
District Medical Officer (DMO)	96%	74
(DMCHC)	71%	55
District Health Officer (DHO)	82%	63
District Nursing Officer (DNO)	83%	64
District TB/Leprosy (DTBLC)	34%	26
(DAC)	29%	22
Other	48%	37

[2] In addition to the National Bureau of Statistics, contributors to the funding of the District Health Management Team Survey included the Planning Commission and the Reproductive and Child Health Section (RCHS) of the Ministry of Health; the United States Agency for International Development (USAID) Mission in Dar Es Salaam, Tanzania; the USAID-funded MEASURE *Evaluation* Project at the Carolina Population Center of the University of North Carolina, Chapel Hill; the United Nation's Population Fund (UNFPA); and the United Nations Children's Fund (UNICEF).

Interviews were conducted with DHMTs in all 25 regions in 77 out of 118 districts in the country. Selection of the districts to interview was non-random *per se* but was linked to selection of enumeration areas, which was itself based on a two-stage population-based sampling procedure.The most interviews were conducted in Mbeya region (8), followed by Mwanza (7) (Figure 1). Several regions had interviews in 5 districts: Arusha, Tabora, Shinyanga, and Mara.

Figure 1. Number of DHMT Interviews by Region



Many of the survey questions required subjective evaluations of the state of the decentralization process. This raises a potential bias in the analysis of these data as respondents may have many motivations in answering in the manner that they do. Some of these motivations may be related to the shifting powers inherent in decentralization processes. Under decentralized systems, DHMTs are likely to have increased powers and responsibilities. They may evaluate decentralization favorably, as a result, simply because for them decentralization may represent an improvement in the quality of their own jobs, in their own autonomy, or in their level of authority. At the central level, however, officials may be faced with diminished powers and responsibilities. They may evaluate decentralization less favorably because, on a professional level, decentralization may represent a loss of prestige, authority or autonomy. As a result, this evaluation may have an inherent bias towards a more favorable view of decentralization. A wider survey of other actors in the health sector – central government officials, NGOs or hospital administrators – would likely provide an alternative perspective but would face problems of respondent selection.

Other questions may be subject to substantial measurement error, since they required respondents to estimate values for information that they may not have had readily available. These included questions such as the percentage of budgets over which

DHMTs had control, the length of time until decentralization started or when it began, and the amount of salary arrears.

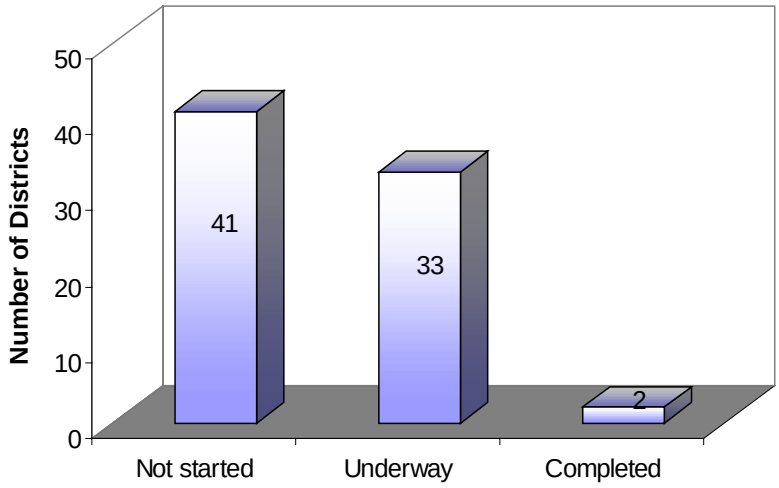
3. Results

Extent of the Decentralization Process

There is some question about the actual extent of decentralization in Tanzania. By some indications, the extent of decentralization is quite modest, restricted to only a few administrative functions. Three variables were used to evaluate the extent of the decentralization process: reports by DHMTs about the process of decentralization, the reported share of local government expenditures in total health expenditures, and DHMT reports about the percentage of district health funds that DHMTs could allocate as they choose.

For the first measure, DHMTs were asked to report whether the decentralization of health care planning in their district had not yet started, was underway, or had been completed. Most DHMTs said that decentralization had not yet started. Of the 77 interviews that were undertaken, 41 DHMTs (54 percent) said that decentralization had not yet started, 33 DHMTs (43 percent) reported that decentralization was underway, and 2 DHMTs (3 percent) reported that it was completed (Figure 2).[3]

Figure 2. Number of Districts Undergoing Decentralization, DHMT Reports

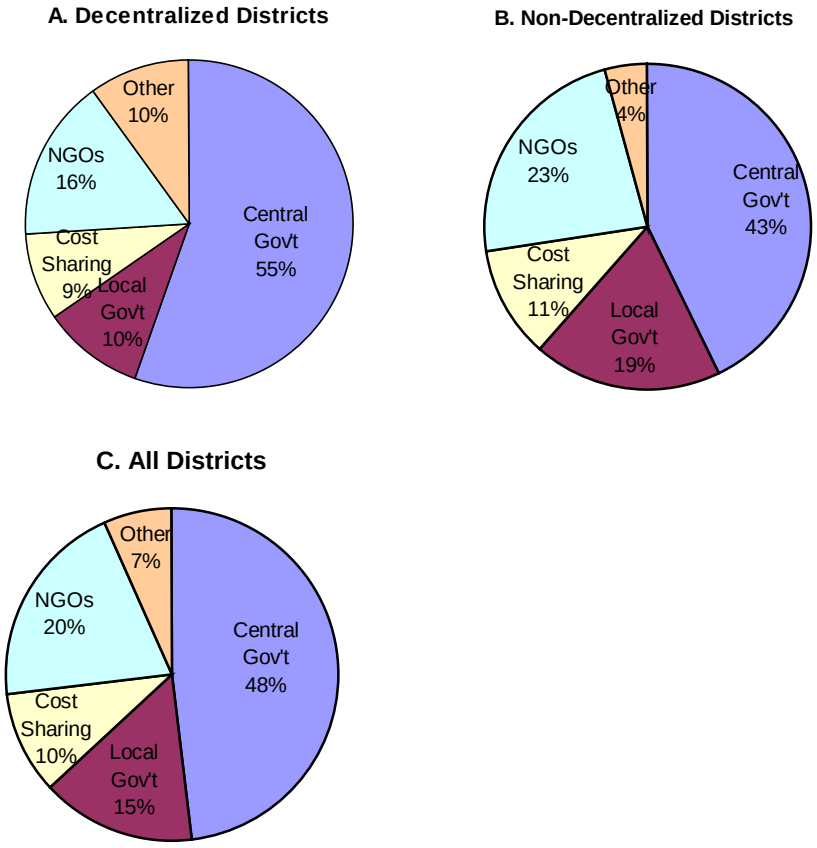


[3] There was some difficulty obtaining dates for the start or projected start of the decentralization process. Of the 41 DHMTs that reported that decentralization had not started, only 16 reported the number of months until it would start. Of the 33 DHMTs that said decentralization was underway, 16 reported how long ago it began but 15 reported the number of months previously that the process had been completed. Of the two DHMTs that reported that the process was complete, neither reported the number of months ago that the process had been completed.

The second measure, the reported share of local government expenditures in total health expenditures, serves as a proxy for the extent of fiscal decentralization. Local governments with a higher share of local expenditures in total health expenditures are assumed to have a greater degree of local autonomy in resource allocation decisions. Resources from the central government or donors, on the other hand, may be more likely to be earmarked for special programs or for activities frommwhich local governments cannot shift funds.

All DHMTs were asked to list the main sources of funding for health activities for the current fiscal year and the percentage of those sources in total funding. Of the 77 DHMT interviews, 66 DHMTs were able to ascribe percentages to different funding sources. For the districts as a whole, the central government was the largest source of funding, constituting close to half of all funding. However, when districts were stratified by whether or not the DHMTs classified themselves as undergoing decentralization, a peculiar pattern emerged. Districts that were not classified as decentralized had a larger share of local revenue (19 percent) than districts that were decentralized (10 percent) (Figure 3). For both types, the central government was the largest source of funding – 55 percent in decentralized districts and 43 percent in non-decentralized districts. NGOs made up a larger share in the non-decentralized but decentralized districts had a slightly larger share from "other" sources. Cost-sharing as a source of revenue was approximately equal across both types of districts.

Figure 3. Sources of Funding for District Health Activities



Finally, DHMTs were asked to approximate the percent of budgeted district health funds that they could allocate as they chose. Specifically, they were asked to estimate the percentage of the budget that was not earmarked for salaries or specific programs by the Ministry of Health or donors. It was believed that this estimate might be larger than the shares of local revenue in the total budget described above because DHMTs might actually be allowed by donors or the Ministry of Health to allocate some funds to specific activities that they saw fit. Alternatively, DHMTs might also be able to decide how cost sharing revenue was allocated.

In general, the estimates of local control were only slightly larger than the share of local revenue in the total health budget. DHMTs estimated that they could allocate approximately 20 percent of the budget as they saw fit. Again, this estimate was higher in districts classified as non-decentralized, where DHMTs estimated that they could control approximately 22 percent of the budget. In contrast, DHMTs in decentralized districts reported that they could control only 15 percent of their health budgets.

These mixed results indicate that there is some confusion over what was meant by being "decentralized" and how it is measured. Standard measures of fiscal decentralization do not appear to adequately measure the extent of decentralization. Part of the problem may lie in the interview question itself, which did not define what was meant by "decentralization." Respondents might then have imparted their own perceptions of what decentralization meant, whether administrative, fiscal or political.

Budgeting & Workplan Development

DHMTs – regardless of whether they reported that the decentralization process was underway - were asked questions about budget planning processes and workplan development. Specifically, they were asked whether a forum for planning existed involving central government and donors, how decisions were made as to what district health sector priorities were, what they considered to be their district's health priorities, and what impediments to implementation of activities existed.

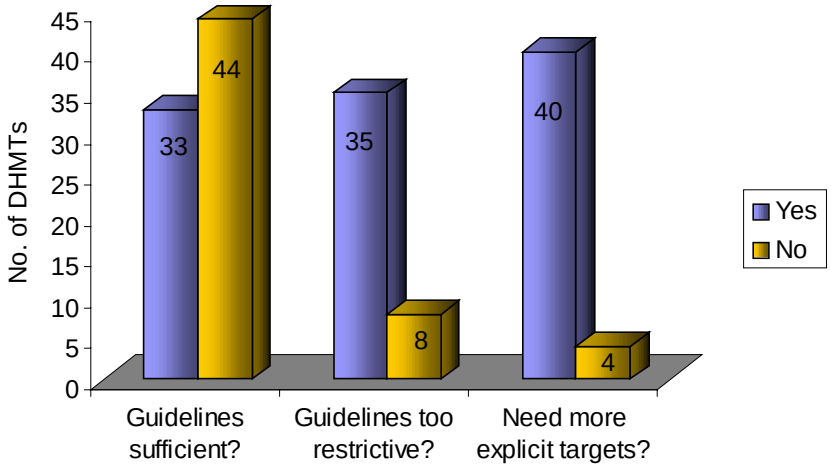
Nearly all DHMTs, 93 percent, reported that they were involved in preparing district annual health workplans, plans that listed the activities that will be carried out in the district in that fiscal year. The majority of districts – 87 percent - reported that district leaders met with local government officials and non-governmental organizations when planning for annual health activities. Only 8 DHMTs reported that no such forum existed. Three of those 8 were in Zanzibar, two were in Tabora, and one each were in Lindi, Mwanza and Shinyanga regions. Two thirds of districts reported that there was an annual conference with donors.

DHMTs were almost universal regarding the need to improve coordination between the DHMT, local leaders, the central government and donors. The most common mechanisms cited in open-ended questions for improving coordination were straightforward – better communication, direct meetings between donors and government

and local leaders, and more frequent meetings. Other suggestions also emerged. Several DHMTs mentioned that additional training in planning – from government or donors - would be useful. Other DHMTs felt that donors should better respect local priorities. One DHMT suggested that the central government and donors have contracts with districts specifying that needs be addressed within specified time periods.

DHMTs were asked about the adequacy of the guidelines for preparing workplans that they received from the Ministry of Health. Less than half of DHMTs (33 of 77) felt that the guidelines were adequate (Figure 4). Over 80 percent (35 of 43) of those who felt that guidelines were inadequate felt that the guidelines were too restrictive. In a seeming paradox, most of the DHMTs who thought that the guidelines were inadequate also thought that more explicit performance targets were required.

Figure 4. Adequacy of Ministry of Health Workplan Guidelines



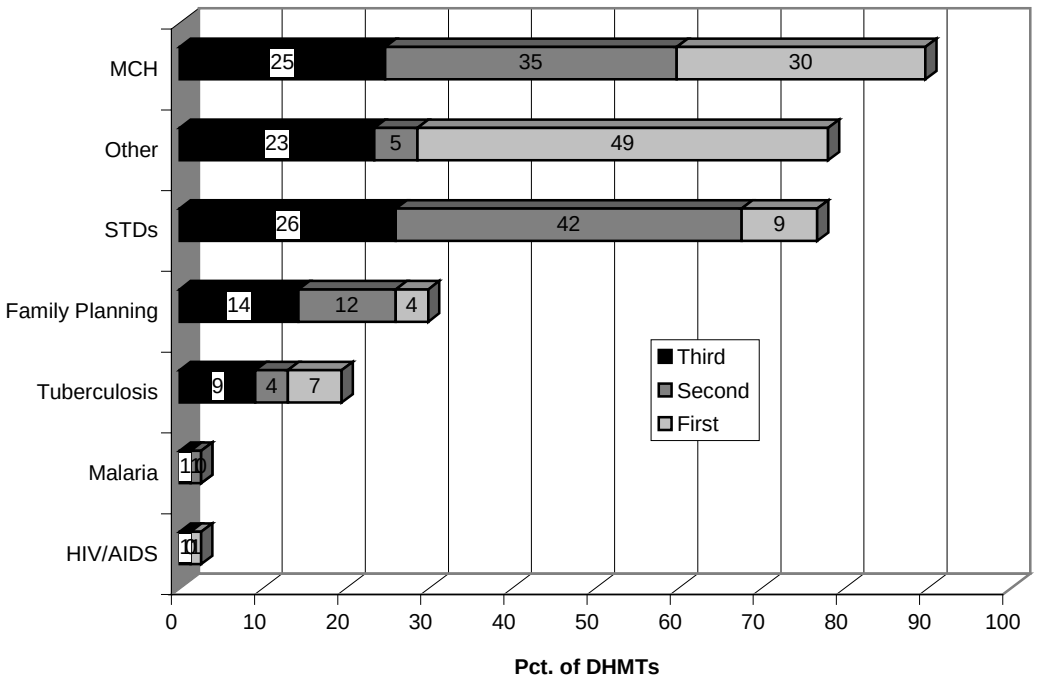
Nearly three quarters of the districts with a planning forum reported that the planning process was very transparent – that decisions coming from the forum were "clear, rational, and justified" and that the information going into the planning process was "available and accessible." For those districts that reported that the planning process was not transparent, some blame might lie within the DHMT itself. Of the fifteen districts that reported a non-transparent planning process, 4 DHMTs (36 percent) reported that the DHMT worked together only "moderately well." In contrast, of the DHMTs that reported that the planning process was transparent, only 24 percent (11 of 45) reported that the DHMT got along only "moderately well." Such comparisons, of course, should be taken with caution because of the small sample sizes. In general, the vast majority (77 percent) of DHMTs report that they worked together "very well."

District leaders were asked open-ended questions about the process they used for assigning budget priorities for various health services. Nearly all DHMTs said simply that they looked at the areas which presented the largest health problems. A small number reported that they used statistics or data collected from health stations. A few reported that they simply followed national priorities. None reported that priorities were

determined by availability of funds or by external pressures by donors or the central government.

DHMTs were asked to rank categories of health services – family planning, maternal and child health, sexually transmitted diseases, HIV/AIDS, Tuberculosis and malaria - in terms of the share of budget that the health service should receive – not what the health problem was actually receiving. Maternal and Child Health services were overwhelmingly considered to be the most important priority by DHMTs (Appendix Table A1) Nearly one-third ranked MCH as the most important priority (Figure 4). Approximately 90 percent of DHMTs ranked MCH services as one of the three most important areas. Nearly 50 percent of respondents identified "other – but not coded" health areas which they considered to be the most important for budget allocations. Sexually transmitted diseases were the next most important, identified by 50 percent of DHMTs as either the first or second most important health area. HIV/AIDS generally ranked low, lower even than tuberculosis. Only 10 percent of respondents identified HIV/AIDS as one of the top 4 priority areas and nearly half identified it as the fifth most important problem. Malaria too was considered to be a low priority, in fact it was ranked as the lowest priority – not a single DHMT ranked the disease as the most important health area, while close to 60 percent ranked it as the least important area. While not performed here, this information could potentially be linked with regional epidemiological data to evaluate the how proposed district budget priorities correspond to actual epidemiological information, e.g. whether regions with a greater prevalence of malaria actually consider malaria to be a larger priority.

Figure 5. Percentage of DHMTs identifying specific health areas as first, second or third most important health area for budgeting

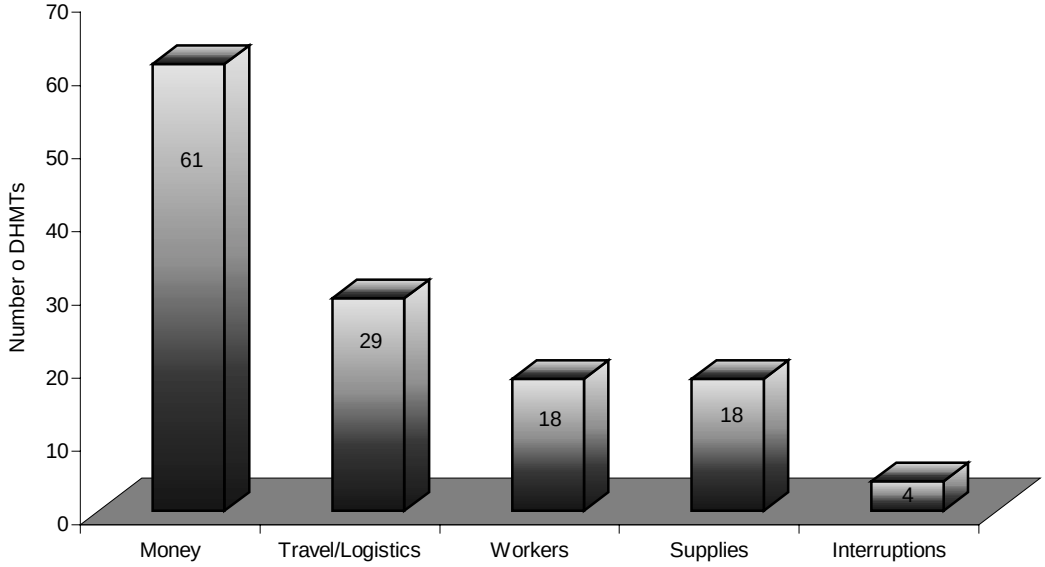


DHMTs were also asked to identify the health service categories experiencing the most growth in the budget over the past 3 years. The ranking of budget growth closely followed that of the areas which were considered to be the largest priorities. Maternal and child health had experienced the largest growth, followed by STDs, "other" health services, family planning, tuberculosis and malaria.

DHMTs were asked if impediments existed in implementing activities in their annual workplans, and, if so, to to identify the main impediments. Nearly all DHMTs reported that impediments generally existed in carrying out workplan activities. Not surprisingly perhaps, the most common impediments - mentioned in open-ended questions by 61 of the DHMTs - regarded money issues – either funds were received late from the Ministry of Finance or funds were insufficient for planned activities (Figure 6). The next most common impediments were with respect to logistics – poor communication, non-functioning vehicles, lack of vehicles, lack of petrol for vehicles, or bad roads. This was mentioned by 29 DHMTs as a problem in carrying out supervision, delivering supplies, and for general activity implementation. In a few instances, the logistics and financial problems were combined – there was not enough money for travel.

Another common problem had to do with the health workers in the system. Almost one-quarter of DHMTs mentioned that there was a shortage of trained health workers. Lack of specialists were identified by several DHMTs, as were lack of MCH workers. Shortages also plagued supplies in general – drugs, equipment – or available equipment were broken down. Finally, several DHMTs reported that epidemics prevented them from implementing planned activities.

Figure 6. Reported Impediments to Implementation of Activities



Bottom-up Planning

In many countries, decentralization of planning functions extends below the district level to the villages and wards. One form in which participation occurs is in the preparation of budgets or lists of activities at the village or health unit level. These budgets or activities, after negotiation and assessment of overall resources, can then be included in district or regional plans of activities.

Of the 77 districts in the sample, 43 districts (57 percent) engaged in bottom-up planning. Most of the DHMTs in districts in which bottom-up planning was occurring believed that it was either "very successful" (41 percent) or "somewhat successful" (54 percent). Only 2.4 percent said that bottom-up planning had been "not at all successful." For those districts that engaged in bottom-up planning, the most common sub-district level was the village level (84 percent), followed by the ward level (47 percent) or some other level (32.6 percent).

Table 2. Bottom-up Planning

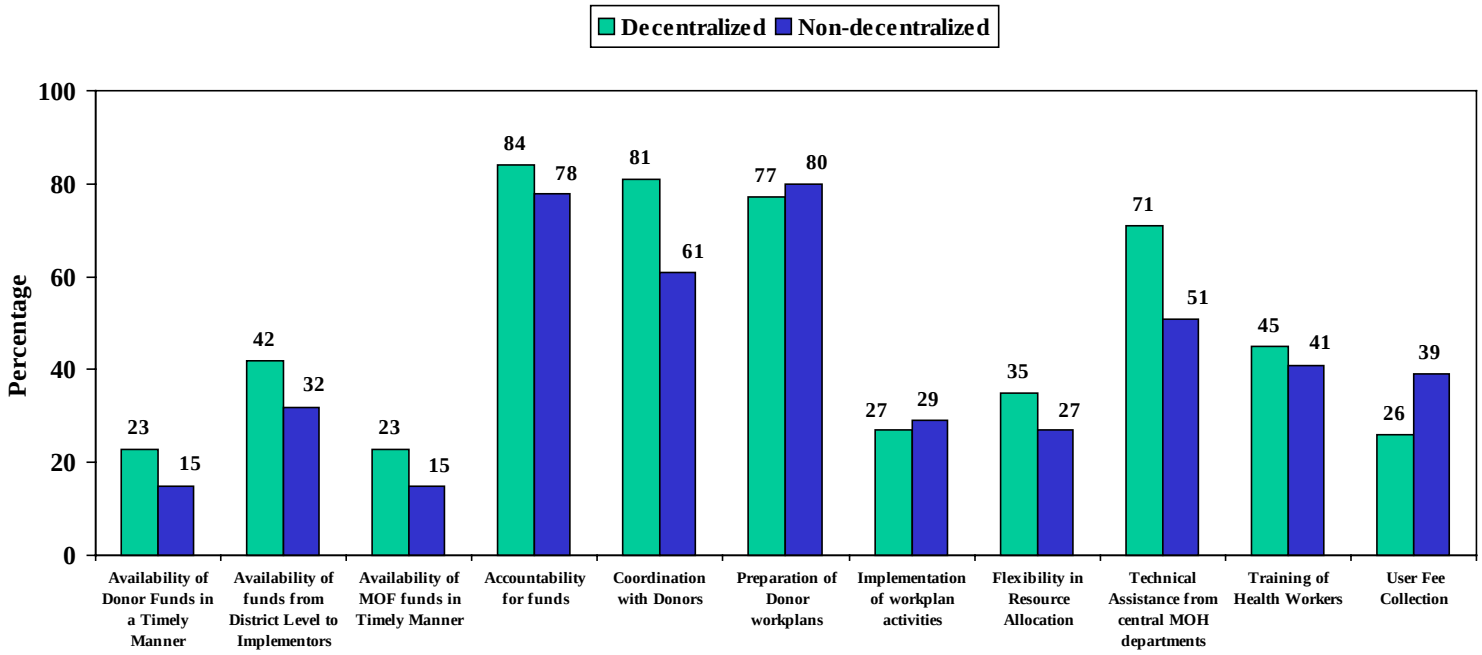
	N	Pct.	N	Pct.
Does this district engage in bottom-up planning?				
No	34	44.2%		
Yes	43	55.8%		
	77	100.0%		
How would you rate bottom-up planning?				
Very successful			17	40.5%
Somewhat successful			24	54.8%
No change			1	2.4%
Somewhat unsuccessful				
Not at all successful			1	2.4%
			43	100%
At what level(s) does bottom-up planning occur?				
Village Level			36	83.7%
Ward Level			21	46.7%
Other			14	32.6%

Outcomes

All DHMTs – both in districts reported to be decentralized and in those that were not – were asked to rate the status of specific aspects of the health sector in their districts. These aspects focused on resources and resource availability, outputs or outcomes in the health sector, and personnel issues.

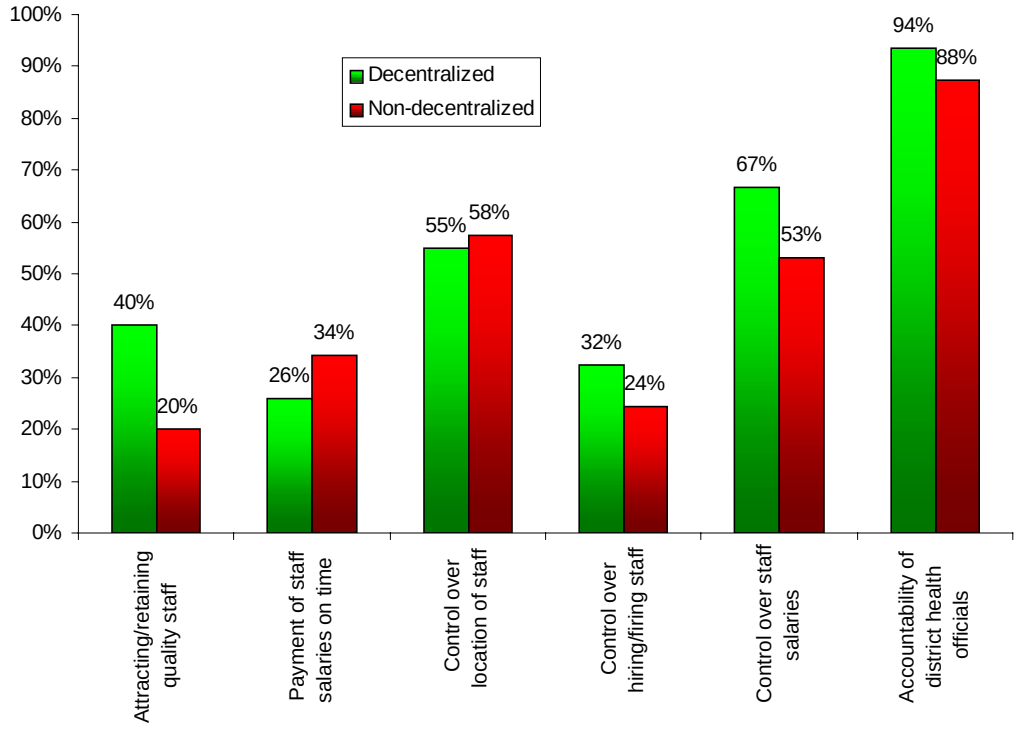
In general, districts that were decentralized reported better outcomes – or at least no significantly worse outcomes - related to resource availability than districts that were not decentralized (Figure 7). For example, 42 percent of DHMTs in decentralized districts reported that the availability of funds from the district level to implementers was "good/very good" as compared with 32 percent of DHMTs in non-decentralized districts. Similar differences were apparent for availability of donor funds in a timely manner (23 percent versus 15 percent) and availability of Ministry of Finance funds in a timely manner (23 percent versus 15 percent). Coordination with donors was much better in decentralized districts; 81 percent of DHMTs in decentralized districts rated coordination with donors as good or very good as compared with 61 percent of DHMTs in non-decentralized districts. Technical assistance from Ministry of Health departments was also rated higher in decentralized districts (71 percent versus 51 percent). Only a small difference in the rating of flexibility of resource allocation was apparent (35 percent versus 27 percent). Again, this may indicate that the extent of fiscal decentralization even in decentralized districts was still very limited.

Figure 7. Percent of DHMTs Rating the Status of Health Areas as "Good/Very Good," Decentralized versus Non-decentralized Districts



Small differences between decentralized and non-decentralized districts, generally in favor of decentralized districts, were apparent for personnel issues (Figure 8). Decentralized districts were more likely to rate as "good/very good" issues related to attracting/retaining quality staff (40 percent versus 20 percent), control over hiring/firing of staff (32 percent versus 24 percent), and control over staff salaries (67 percent versus 53 percent). For two other areas – payment of staff salaries on time, control over location of staff – ratings slightly favored non-decentralized districts. Accountability of district health officials – who were being interviewed - was unsurprisingly rated as "good/very good" in approximately 90 percent of decentralized and non-decentralized districts.

Figure 8. Percent of DHMTs Rating Personnel Issues as "Good/Very Good," Decentralized versus Non-decentralized Districts

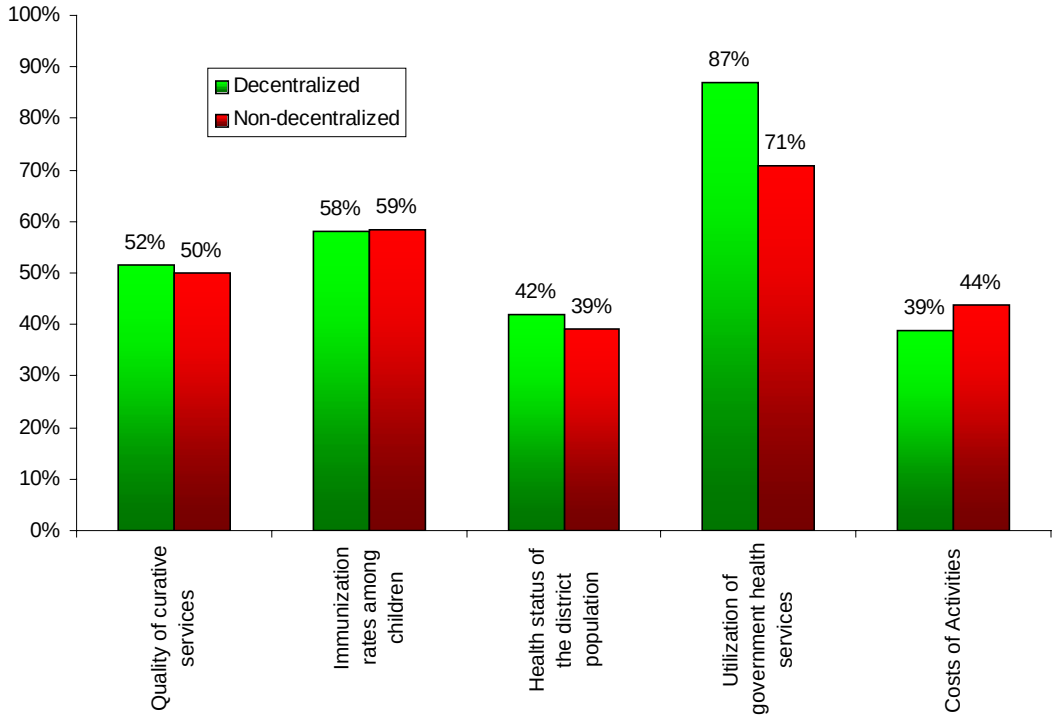


Ultimately the aim of most health sector reforms in developing countries is to improve the health status of the population. Subjective measures of the health status of district populations were collected in the DHMT questionnaire. Objective measures – fertility and mortality – were collected in other components of the TRCHS99 and could easily be linked with these data.

In terms of process and outcome indicators, there were only minor differences between decentralized and non-decentralized districts (Figure 9). The quality of curative services was rated as "good/very good" in 52 percent of decentralized districts and 50 percent of non-decentralized districts. The costs of activities was rated as "good/very good" in 39 percent of decentralized districts and 44 percent of non-decentralized districts. Utilization of government health services, however, was rated 16 percentage points higher in decentralized districts (87 percent) than in non-decentralized districts (71 percent).

In terms of health status, there were virtually no differences between decentralized and non-decentralized districts. Immunization rates were rated as "good/very good" in 58 percent of decentralized districts and 59 percent of non-decentralized districts. The health status of the population – while generally not rated highly – was rated as "good/very good" in 42 percent of decentralized districts and 39 percent of non-decentralized districts.

Figure 9. Pct. of DHMTs rating as "Good/Very Good" Indicators Related to Health Care Delivery and Health Status, Decentralized versus Non-Decentralized Districts

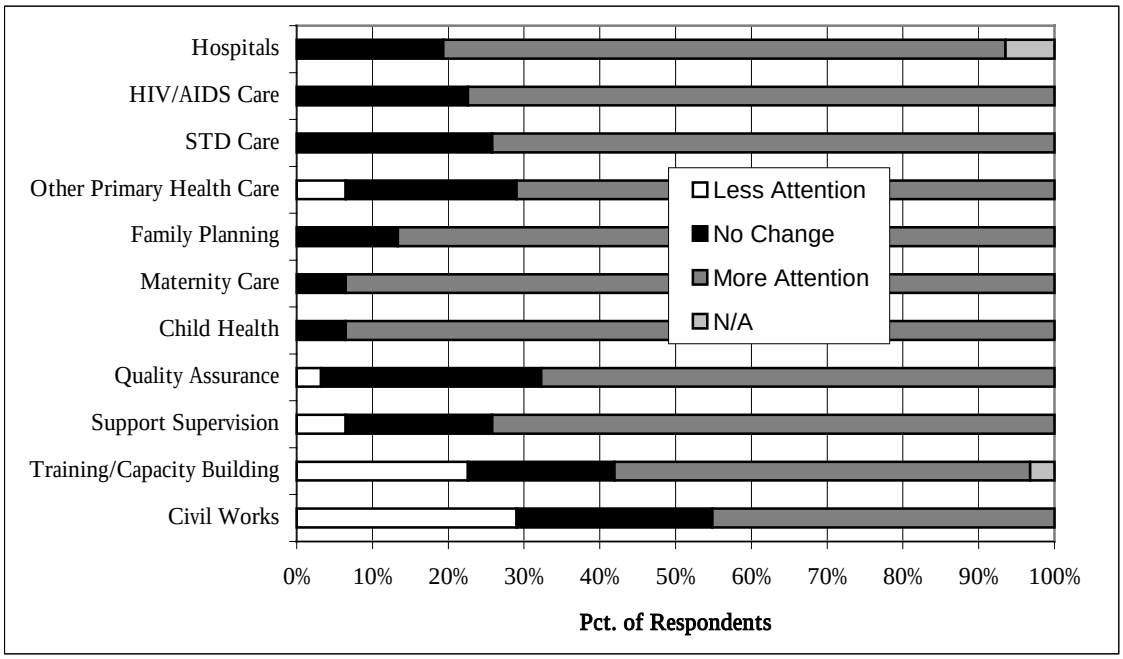


The above comparisons between decentralized districts and non-decentralized districts, however, should be taken with some degree of caution. Causal relations cannot in general be inferred from the data. In fact, without time series data, it is difficult to ascertain whether any differences between decentralized and non-decentralized districts pre-date the decentralization process or whether any differences can be linked to the decentralization process. It is possible that the initial decision over which districts to decentralize first could have been related to the level of capacity or the health status of the population there. Districts with greater capacity or with healthier populations could may have been chosen as better candidates for decentralization, thereby producing the result that decentralized districts are those with better indicators. Alternatively, districts with lower levels of capacity or worse health status could have been chosen as candidates for decentralization because they were in greater need of reform. Additional information, collected over time, would be necessary to more fully evaluate these ideas.

DHMTs were asked about whether key district health activities were receiving less attention, no change in attention or more attention as a result of decentralization. In other studies, concern has been expressed that under decentralization, primary health care activities will receive a declining share of attention at the expense of other activities such as health worker welfare, hospitals or civil works (Akin, Hutchinson, Strumpf, , 2001). While such questions may be considered leading and are certainly highly subjective, they may still be able to provide a picture of how districts prioritize.

There was little evidence of declining attention being paid to primary health care in favor of hospitals or unsustainable civil works. For most activities, most DHMTs in decentralized districts reported that decentralization had led to an increase in attention. Greater attention seemed to be paid to primary health care services – maternity care, child health, family planning, STD care and HIV/AIDS care. Maternity and Child Care were reported to have received greater attention for all but two districts. Nearly 90 percent of DHMTs reported that family planning was receving greater attention. Approximately 80 percent of DHMTs reported that greater attention was being paid to HIV/AIDs care and STD care. Support supervision was given greater attention by about three-quarters of DHMTs. Training and capacity building was given greater attention by about half of DHMTs. A significant proportion of respondents reported that no change had occurred regarding hospitals. Civil works, often used by politicians as demonstrable evidence of attention being paid to the health sector even when other more cost-effective activities might be available, were reported to have received less attention by a significant proportion, close to 30 percent, of DHMTs.

Figure 10. Change in Attention Given to District Health Activities, Decentralized Districts (N=31)



Finally, all but one district reported that arrears were owed to health care providers in their districts. The average length of time for which arrears were owed was 44.5 months. This was slightly less in decentralized districts, 38.7 months, as compared with 48.8 months in non-decentralized districts. The average amount of arrears was TSH 679m. (US$1 m.).

Conclusion

The evaluation of the decentralization process by District Health Management Teams presented here reflects the fact that decentralization is still far from complete. Most DHMTs report that decentralization has not yet started in their districts, a response that may reflect disparate understandings of how decentralization is being defined. Most districts report that they participate in planning of health activities but most districts also report only limited fiscal control over resources. These findings regarding limited fiscal control, in fact, are similar to those found in an evaluation of decentralization in Tanzania performed nearly a decade ago (Gilson 1994).

In aspects not related to fiscal decentralization, there was greater evidence of the potential benefits of decentralization. Many DHMTs reported that decentralization had led to improvements in training and capacity building, supervision, and attention to primary health care services. DHMTs in decentralized districts reported greater availability of district funds, better coordination with donors, greater ability to attract and retain staff, and higher use of government health services.

Additional data analysis is possible with the DHMT survey information and could potentially produce some very interesting results regarding the decentralization process. An important next step might be to link these data with data available elsewhere. Several possibilities exist. First, these data could be linked with responses to facility questionnaires also collected in the Tanzania Reproductive and Child Health Survey and in earlier surveys. One could examine changes in average government clinic quality and service availability at the district or regional level and trace this either to whether or not a district was decentralized or to the length of the decentralization process. In this manner, the impact of decentralization on government service availability and health service quality could be evaluated. Following from this, it would be interesting to examine whether decentralization has had an impact on improved health behaviors and health outcomes for the population of Tanzania. These same data could be linked with data from the household and individual portions of the TRCHS survey. One could assess whether districts with the most extensive efforts at decentralization have also produced the greatest improvements in health behaviors and health outcomes or whether improvements, if any, have been independent of the decentralization process.

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Appendix Tables

Table A1 Normative Ranking of Health Service Categories for Budgeting

	Family Planning		MCH		STDs		HIV/AIDS		Tuberculosis		Malaria		Other	
Rank	N	Pct	N	Pct	N	Pct.	N	Pct	N	Pct.	N	Pct	N	Pct
1	3	3.9	23	29.9	7	9.1	1	1.3	5	6.5			38	49.4
2	9	11.7	27	35.1	32	41.6			3	3.9	1	1.3	4	5.2
3	11	14.3	19	24.7	20	26.0	1	1.3	7	9.1	1	1.3	18	23.4
4	26	33.8	6	7.8	14	18.2	6	7.8	10	13.0	3	3.9	12	15.6
5	11	14.3	0	0.0	4	5.2	37	48.1	11	14.3	11	14.3	3	3.9
6	8	10.4	1	1.3			19	24.7	30	39.0	17	22.1	2	2.6
7	9	11.7	1	1.3			13	16.9	11	14.3	44	57.1		
Total	77	100.0	77	100.0	77	100.0	77	100.0	77	100.0	77	100.0	77	100.0
Average Rank	4.2		2.2		2.7		5.4		5.0		6.3		2.3	
Pct. In Top 3	29.9		89.6		76.6		2.6		19.5		2.6		77.9	

Table A.2 Ratings of Aspects of District Health Activities, Decentralized and non-Decentralized Districts Combined

Activity	Poor	Fair	Average	Good	Very Good	N/A	Total
Resources							
Availability of …							
Donor Funds in a Timely Manner	13%	19%	39%	23%	0%	6%	100%
Funds from District Level	16%	6%	26%	35%	6%	10%	100%
MOF funds in Timely Manner	32%	16%	26%	23%	0%	3%	100%
Accountability for funds	3%	0%	13%	77%	6%	0%	100%
Coordination with Donors	3%	0%	10%	74%	6%	6%	100%
Preparation of Donor workplans	3%	0%	13%	71%	6%	6%	100%
Implementation of workplan activities	17%	3%	50%	27%	0%	3%	100%
Flexibility in Resource Allocation	16%	10%	23%	32%	3%	16%	100%
Technical Assistance from central MOH departments	6%	10%	13%	68%	3%	0%	100%
Training of Health Workers	6%	6%	42%	35%	10%	0%	100%
User Fee Collection	10%	3%	32%	26%	0%	29%	100%
Outputs							
Quality of curative services	3%	3%	42%	45%	6%	0%	100%
Immunization rates among children	3%	3%	35%	52%	6%	0%	100%
Health status of the district population	13%	6%	39%	42%	0%	0%	100%
Utilization of government health services	0%	0%	13%	81%	6%	0%	100%
Costs of Activities	3%	6%	32%	35%	3%	19%	100%
Personnel							
Attracting/retaining quality staff	27%	13%	17%	40%	0%	3%	100%
Payment of staff salaries on time	35%	26%	13%	19%	6%	0%	100%
Control over location of staff	10%	13%	23%	48%	6%	0%	100%
Control over hiring/firing staff	13%	3%	6%	29%	3%	45%	100%
Control over staff salaries	0%	0%	8%	42%	25%	25%	100%
Intersectoral Collaboration	0%	0%	13%	71%	16%	0%	100%
Accountability of district health officials	6%	0%	0%	87%	6%	0%	100%

Figure A.1 Change in Status of Health Care Activities – Resources

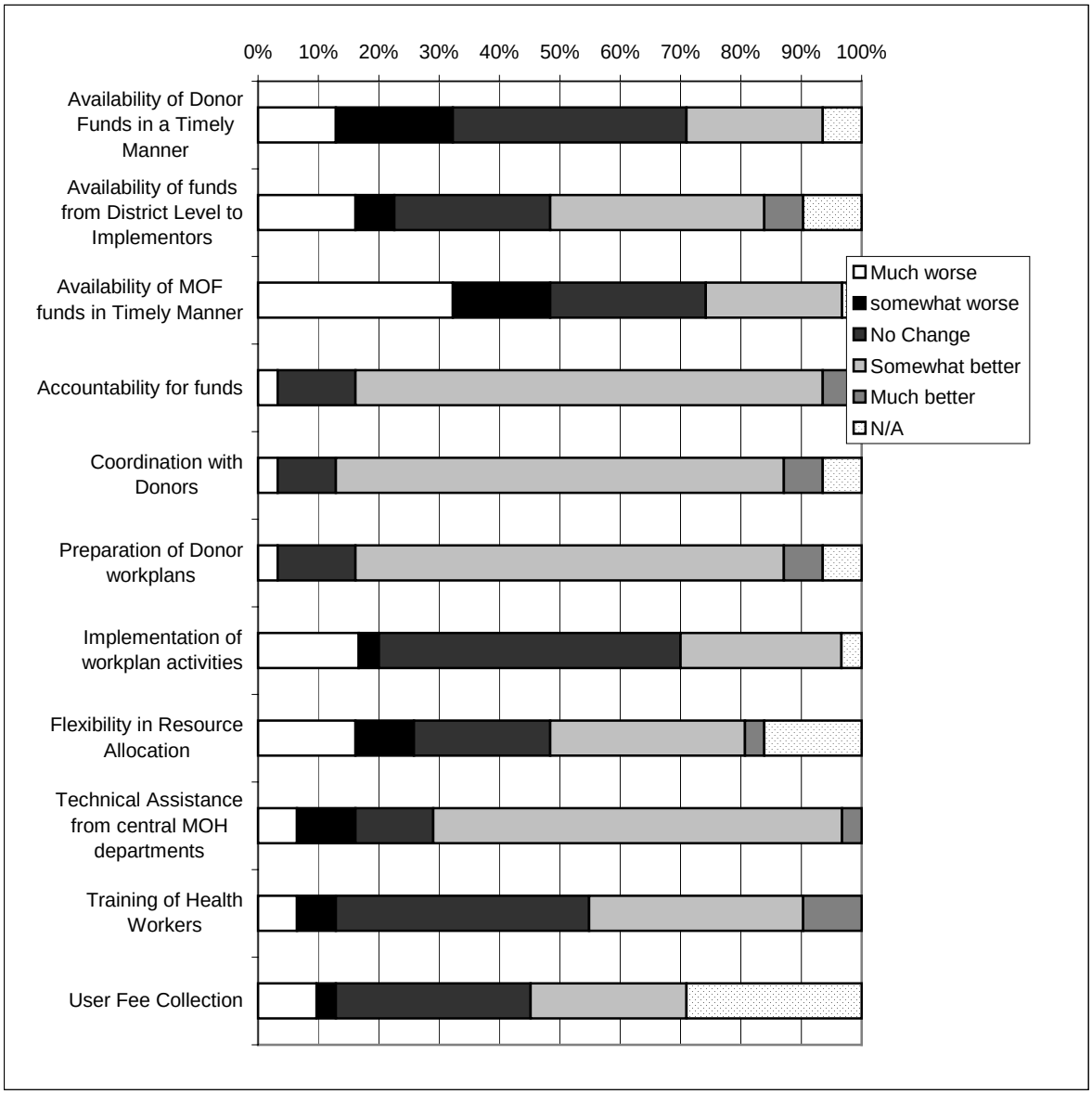

Figure A.2 Change in Status of Health Care Activities – Outputs

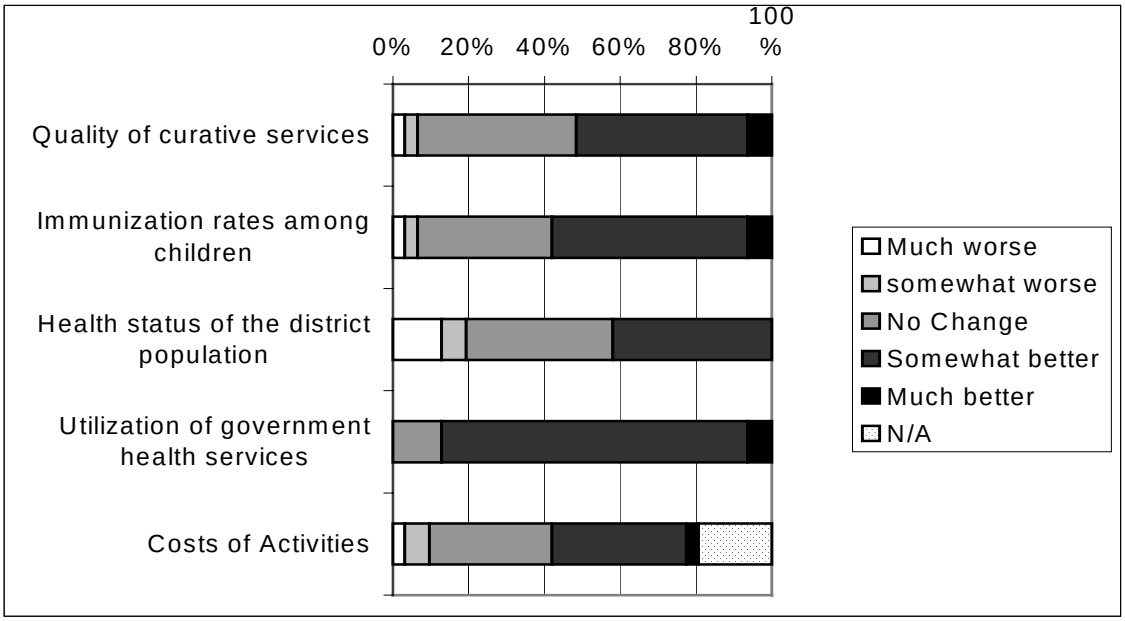

Figure A.3 Change in Status of Health Care Activities – Personnel