

Decentralization of Health Service Provision in Tanzania: Are Local Government Authorities Improving Anyway? Evidence from Local Government Authorities Audit Reports

Chakupewa Joseph Mpambije

Department of History, Political Science and Development Studies: Mkwawa University College of Education (MUCE)
Iringa- Tanzania

Abstract: The economic woes and crisis of the 1980s and 1990s made several countries turn to decentralization of health services as a panacea to the worsening health service provision. Like many other countries, Tanzania introduced decentralization system in health service provision. Through HSR, Local Government Authorities (LGAs) are empowered to run health service delivery while central government acts as an overseer by injecting financial resources to the LGAs. With slight improvements that have been recorded among the LGAs since the implementation of HSR, there is a staggering difference among LGAs between what was thought to be achieved in health service delivery and what is actually seen on the ground. Because the failure of LGAs to equitably deliver health service has been widely researched, this article focuses on the efficacy of the LGAs to make use of financial resources. Drawing data from LGAs Audit Reports for 2007/08-2013/14, the paper analyses the LGAs use of financial resource availed to them for health service delivery. The focus is on health development project/project of Community health Fund (CHF) and Primary Health Services Development Programme (PHSDP). The paper finds that the financial resources meant for health service provision is either put to use or no. Arguably, this is due to lack of political will, poor community participation, and mismanagement of public financial resources and endemic culture of corruption among LGAs.

Keywords: Decentralization, Local, Government, Tanzania.

1. INTRODUCTION

The quest to provide accessible, quality and affordable health care has been the most single core priority of the government in Tanzania (URT, 2008). This is because effective, prompt and high quality care has a multiplier effect to socio-economic development of the country (Grosse and Harkavy, 1980). While efforts by the government have been hailed, what has been evidenced not to stay permanent is the modality through which access to health care is delivered. Since attainment of independence in 1961 Tanzania has changed such a model of health care provision from Central Government (CG) to Local government Authorities (LGAs) (Challigha, 2008). For instance, from 1960s to 1980s the CG played a key role in providing health care in which modest success was recorded (Kupoka, 2002). However, as time goes on the CG faced numerous problems that led into the need to decentralize health service delivery in which LGAs became key providers of health service. Indeed, the decentralization of health service that is practiced through Health Sector Reform (HSR) gained much appreciation from scholars and policy analysts (for example, Mujinja and Kida, 2014; WHO, 1996; Chotara, and Tumusiime, 2004). It is said, for instance, that under decentralization of health service people could enjoy greater equity and quality of health, obtain greater value for money through cost effectiveness and improve functioning and performance of health systems (Cassel and Janovsky, 1996; Mujinja and Kida, 2014).

There has been a hot debate as to whether the fund received from the central government to the LGAs is sufficient to run the laid down programme. Most of scholars argue strongly that LGAs are seriously underfunded by the central government, and the anticipated fund does not reach the LGAs timely (Boex, 2015; REPOA, 2008; De Visser, 2005). This paper looks at the same issue from different angle. It argues that though the amount of money that has been sent to the LGAs is not sufficient to execute health programmes, still, the amount reached at the LGAs to run health programmes are not prudently utilized. It is mismanaged, diverted to non-priority areas, embezzled by the LGAs that ultimately lead to failure of anticipated health programme. This line of argument has received less analysis such that least is known over the failure of health programmes headed by the LGAs. To prove this argument, two health programmes are thoroughly unraveled which are Community Health Fund (CHF) and Primary Health Service Development Programme (PHSDP). The analysis of CHF and PHSDP programmes under the LGAs is undertaken through the use of document analysis, policy document and CAG report spanning from 2008/2009 to 2013/2014.

The rest of the article proceeds as follows. To start, the paper begins by historicizing the development of decentralization of health services in Tanzania. This is followed by a discussion on the role of LGAs in health service provision. The next part looks at the reality of LGAs spending of financial resources in the course of providing health service. This part surveys the amount of money provided to LGAs by the CG and the reality on how the amount is spent and what possibly can explain the disparity between disbursements and expenditure. Finally, some suggestions for the way forward are given as concluding remarks.

2. LOCAL GOVERNMENT AUTHORITY REFORM AND DECENTRALIZATION OF HEALTH SERVICES PROVISION IN TANZANIA

Decentralization of health services in Tanzania is said to have gone hand in hand with the decentralization of other social services in which LGAs were given mandate to provide such social services to people leaving CG an overseer for the service provided (Mollel, 2012; Mzenzi, 2015). This happened in 1980s when it became clear that centralization process failed to provide service to people. It ought to be recalled that 1980s was a decade of serious economic crisis which meant that the government could no longer keep to its promise of providing services to the citizen. During this decade, the economic performance of Tanzania was worsened mainly by the oil shock, collapse of the East African Community (EAC), the impact of the Uganda-Tanzania war, and persistent drought (Lunogelo, 2010; Bigsten, 1999). As a result, economic and governance reforms were to be introduced to try and bring the economy back to stability. This was the context in which in 1982, the government introduced Local Government Authority (LGAs). The LGAs were charged, among others with the role of promoting economic and social welfare of the people, ensuring effective and equitable delivery of qualitative and quantitative service like health, education, water supply and transport infrastructure within the area of jurisdiction (Chaligha, *et al*, 2005). To fulfill its roles, LGAs received sectoral block grants, financial resources and support for the provision of basic health services. The fund comes from the CG, international development partners, user fees and National Health Insurance Fund (Boex, 2015).

Decentralization of health service in 1990s under HSR was made possible through the LGA reform. Over-all, the goals of decentralization of health services under HSR, according to Cassel and Janovsky (1996) and Mujinja and Kida (2014), included: to improve health status and consumer satisfaction by increasing the effectiveness and quality of health services; and to obtain greater equity by improving the access of disadvantaged people to quality care. Other goals were to obtain greater value for money through cost effectiveness from health spending and the management and use of the resources that have been allocated. Also, improve the functioning and performance of health systems and consequently improve the quality and quantity of health service. For some time now, not all anticipated benefits are attained by the LGAs as health related programmes that are funded by the CG and implemented by the LGAs face severe problem chief of it being poor utilization of the allocated fund from the CG. This, in essence, has far reaching impact to a type of health care to be provided. In this paper, critical analysis is made through the use of CAG report of 2008/2009 to 2013/2014 to evaluate how funds through CHF and PHSDP programmes are utilized or not. However, before attempting to un-earth the actual money that were allocated and never spent in CHF and PHSDP, it is deemed important to first establish the total amount of funds that were allocated for different development programmes/projects from 2008/09 to 2013/2014 in Tanzania.

2.1 LGA's Spending On Development Projects/Programmes

Though not enough to adequately cover for all development needs, LGAs have been receiving financial resources from the CG to cater for different development programmes including agriculture, education, health, youth and women's development, among others. Specifically, these development programmes are financed under the Local Government

Capital Development Grants. Some of the programmes funded in this way are Primary Health Sector Development Programme, Primary Education Development Programme, Secondary Education Development Programme, Urban Local Government Strengthening Programme, Participatory Forestry Management (PFM), Women and Youth Development Fund, Community Health Funds, National Multisectoral Strategic Framework, Elizabeth Glaser Pediatric AIDS Foundations and Constituency Development Catalyst Fund (NAO, 2015). The ability of those programmes to achieve the goal is indeed, questionable since not all the money received is judiciously spent. Table 1 below presents a compiled amount of money received, spent and not spent for 6 consecutive years, 2008/09-2013/14.

Table 1: Development grants received, spent and unspent for 2008/09-2013/14

Financial Year	Development grant received	Development grant spent	Unspent Development grant	% of unspent amount	No of LGAs involved
2008/09	328,203,178,845	239,482,549,650	88,720,629,195	27	111
2009/10	507,866,599,666	332,092,443,562	175,774,156,104	35	116
2010/11	542,339,143,645	367,778,247,642	174,560,896,003	32	130
2011/12	533,017,077,030	346,716,653,619	188,405,740,589	35	132
2012/13	138,289,000,000	99,673,993,747	38,615,006,253	38	99
2013/14	102,697,992,948	73,520,175,201	29,177,817,748	28	66
Total	2,152,412,992,134	1,459,264,063,421	695,254,245,892	33	

Source: Auditor General reports, 2008/2009 to 2013/2014.

Table 1 above reveals that for 6 years LGAs received fund for development programmes but only spent two thirds of what they received. Failure to spend Tsh 695,254,245,892 (equivalent to 3% of received funds) on different programmes must have impaired possible achievement of peoples' development and health care in particular. Although it seems much of the received funds were put to use, it remains obvious that not all of the Tshs 1,459,264,063,421 that was put to use can be said to have been directed to the intended use. For instance, a physical performance evaluation review conducted by the Controller and Auditor General in 163 councils revealed several LGAs with unimplemented projects, projects which were implemented with considerable delay, lack of community contributions toward project implementation and completed projects with various defects (NAO 2015). Though the above analytical figure is too general, it gives a gist of the true situation in LGAs spending of development grants. Taking specific cases of health related programmes the situation is even worse as evidenced in the following section.

3. LGA'S SPENDING OF FINANCIAL RESOURCES IN HEALTH SERVICE PROVISION: THE CASE OF CHF AND PHSDP

Decentralization of health services that went hand in hand with Local Government Reform focused on improving health service delivery both qualitatively and quantitatively. Challenges remain, despite a number of efforts exerted to improve health services. Many of these challenges relate, partly, to poor utilization of disbursed funds from CG to LGAs. Apart from failure to spend the allocated fund to health related programmes, there is a tendency also of diverting fund allocated for health services to other non-priority areas. This is substantiated by the two health programmes, that is, Community Health Fund (CHF) and Primary Health Service Development Programme (PHSDP).

3.1 Community Health Fund (CHF)

Community Health Fund (CHF) was established in 1997 as one of the financial resources identified by the government to encourage communities on coast sharing in health sector in Tanzania (NAO, 2014). This was a government effort to make health care affordable to the rural population and those employed in non-formal sectors. CHF membership is voluntary where a household contributes an annual fee ranging from Tsh 5,000 to 20,000. The funds contributed are doubled by a "matching grant" from the national budget (Haazen, 2012; Borghi *et al*, 2014). The establishment of CHF was expected to be beneficial in a number of ways: establishing a complimentary financial resource base for the basic curative and preventive health financing; ensuring security of access and equity to health care to the community members as well as providing quality and affordable health care services through sustainable financial mechanism. Other benefits are to improve health care management in the communities through decentralization and to ensure equitable distribution of health care costs among different income groups (Kiwara and Kapinga, 2001; Shaw, 2002).

Several studies have commended CHF Basaza *et al.*, 2009; Msuya *et al.*, 2004; Kamuzora and Gilson 2007). For example, CHF has been hailed for increasing access to health care among peasants which has influenced health seeking behaviour among its members. Again, the out of pocket payment for health care has been reduced thus increasing protection to CHF members (Stoarmer, *et al.*, 2012; Henning, 2010). The programme, however, is facing several challenges that prevent it from attaining its target of enrolling 85% households Kamuzora and Gilson, 2007). In contrast to the government's expectation, enrollment rate has remained far down to 9.2% national wise. Worse still, not all those enrolled households in CHF enjoy what is promised from the programme. While there has been several reasons for the failure of CHF to reach its target (see Kamuzora and Gilson, 2007; Mubyazi and Borghi, 2012; Haazen, 2012; Borghi, *et al.*, 2014), the question of failure by LGAs to spend the allocated fund on CHF programme has not been given a special attention.

Decentralization of health service tasked LGAs to ensure that CHF operates successfully by strictly observing judicial spending of fund. Contrary to that, CHF funds have been spend indeed poorly which resulted to failure of CHF to meet set targets. The 1997 Ministry of Health Circular No 2 directs that the CHF fund can only be used for various approved activities like cost of medicine, drugs, hospital equipment, minor repairs, and fuel and night allowance. However, evidence shows that in many instances LGAs channel CHF funds to other expenditures that are not directly related to CHF or health service as revealed in table 2 below.

Table 2: Unspent money on Community Health Fund for 2008/09-2013/14

Financial Year	Amount Allocated (Tshs)	Unspent amount (Tshs)	% of unspent amount	No of LGAs involved	Average unspent balance per LGA (Tshs)
2008/09	770,785,187	292,970,727	38	6	48,828,454
2009/10	980,332,700	383,337,857	39.1	10	38,333,785
2010/11	5,463,660,702	2,963,900,725	54.2	33	89,815,173
2011/12	4,583,058,332	1,709,747,559	37.3	32	53,429,611
2012/13	4,118,548,131	2,070,366,726	50.3	81	25,560,083
2013/14	3,273,311,264	1,336,484,788	41	33	32,597,189
total	19,189,696,316	8,756,808,382	43		48,094,049

Source: Author compilation from Auditor General reports, 2008/2009 to 2013/2014.

Table 2 above signifies that although the funds availed to LGAs for CHF may not be enough; LGAs do not put all the received funds to use. In 2010/11 financial year, for example, a total of Tshs 2,963,900,725 (54.2%) remained unspent. On average, for the six consecutive years LGAs have failed to spend a total of Tshs. 8,756,808,382 (43%) earmarked for CHF activities.

In addition, although the table above gives a general picture of how CHF has been unspent, yet it does not depict clearly specific districts and the amount unspent. Indeed, there are some districts that have failed to spend the disbursed CHF fund. Table 3 below identifies few districts that have spent less than 20% of availed CHF funds for the 2013/14 financial year.

Table 3: Districts with very poor spending of CHF funds 2013/14

District	Funds available (Tshs)	Actual expenditure (Tshs)	Unspent amount (Tshs)	% of unspent amount
Bariadi DC	71,437,187	6,869,000	64,568,187	90
Simanjiro DC	24,372,962	2,950,000	21,422,962	88%
Ileje DC	55,767,012	4,245,400	51,521,612	92%
Kilosa DC	67,021,463	8,810,800	58,210,663	87%
Ukerewe DC	58,746,000	-	58,746,000	100%
Sumbawanga DC	56,728,885	7,979,733	48,749,152	86%

Source: Auditor General reports 2013/2014

Table 3 above realized that, though the CG disburses funds some LGAs are reluctant to spend the said fund on CHF. Indeed, having 100% of unspent CHF fund like in Ukerewe districts leaves a lot of questions in the respective LGAs. One

could not expect increasing enrollment in CHF in LGAs such as Ukerewe. As a result, this decelerates not only access to health care, but also necessitates deleterious consequences on health seeking behavior in the respective LGAs.

As if failure to spend CHF funds is not enough, the 2014 CAG report revealed that some CHF funds that appear to have been spent are actually diverted to other non-priority areas. For instance, in 2012/13 financial year, Meru District used Tshs. 9,000,000 to meet District Executive Director's administrative costs, Mwanga district paid CHF fund worth 17,430,000 to security guards and Mbozi District spent CHF fund worth 6,000,000 for purchase of primary school desks (NAO, 2014). The same trend was observed in NAO (2013) where Dodoma Municipal diverted CHF fund worth Tshs 30,011,290 to unrelated CHF activities. The CAG reports confirmed very surprisingly that LGAs failed to remit the funds that were diverted to other activities. Thus, not only do the LGAs fail to put to use CHF funds, they also spend some of the CHF funds on unrelated expenditure. A look at the Primary Health Service Development Programme (PHSDP) does not seem to change the picture either.

3.2 Primary Health Service Development Programme (PHSDP)

The PHSDP is one of the major undertakings in the social service sector with the major focus on health (URT, 2007). The programme is composed of seven key objectives including rehabilitating, upgrading, and establishing primary health centres, training institutions and increasing financial allocation to the sector. Others are: fast tracking capacity building, upgrading and development on job skills for allied health workers and providing standardized medical equipment, instruments, pharmaceuticals to all health facilities (URT, 2007). To realize the above objectives, the programme set almost 17 programme components which would have contributed to the attainment of the programmes. These include; Human resources for health, Districts Health Services, Maternal, New Born and Child Mortality, Malaria, HIV/AIDS, TB and Leprosy. Others are: Non communicable disease, Environmental Health Services, Health Promotion and Education Neglected Traditional Medicine to name just a few.

Thorough execution of the programme needs to be in place two important ingredients; financial and human resource committed to seeing that practical results from PHSDP are realized. On the part of the financial resources, the central government has been supplying funds to the LGAs for the undertaking of the PHSDP programme. The most daunting challenge among others has been laxity of the LGAs to make use of the remitted funds. Consequently, most of the PHSDP objectives fall short and the poor health provision continues to surface. Table 4 below puts it clear.

Table 4: Unspent money on primary health service development programme

Year	Funds available (Tshs)	Unspent amount (Tshs)	% of Unspent Amount	LGA Involved
2013/2014	6,779,885,784	2,500,977,854	37	41
2012/2013	25,229,000,000	10,975,907,846	43.5	81
2011/2012	6,391,771,465	2,586,057,984	40.5	32
2010/2011	13,843,002,738	5,848,929,864	42.3	48
2009/2010	1,768,616,114	787,229,499	44.5	5
Total	54,012,276,101	22,699,103,047	42	

Source: Author Compilation from Auditor General reports, 2009/2010 to 2013/2014

It is noticed from the table 4 above that PHSDP funds averaging to 42% of the allocated funds were not put to use. In the financial year 2012/2013 alone, of the Tshs 25,229,000,000 availed for PHSDP, a total of Tshs 10,975,907,846 (43.5%) was not spent. It is unfortunate to note that the CAG reports do not categorically state where the unspent amounts are sent or used for what purpose. This leaves a lot to be desired and gives room for speculation that in turn affects reaching the target of ensuring quality health care especially under PHSDP.

While the average of unspent PHSDP fund is 42%, there is a need to venture far deeper to find out few districts that have not spent even 20% of the allocated fund. Districts such as those in Table 5 below signify the fact that PHSDP does not suffer because there is no money but that the funds are not put to use.

Table 5: Districts with very poor spending of PHSDP fund 2012/2013

District spent PHSDP below 20%	Funds available (Tshs)	Actual expenditure (Tshs)	Unspent amount (Tshs)	% of unspent amount
Bahi DC	89,322,000	4,500,000	84,822,000	95
Chamwino DC	214,926,500	0	214,926,500	100
Makete DC	115,822,443	15,716,713	100,105,700	86
Bukoba MC	61,123,133	7,898,033	53,225,100	87
Ngara DC	305,249,002	14,187,113	291,061,889	95
Kasulu DC	456,890,100	6,880,052	450,010,048	98
Mbeya DC	191,230,700	5,596,800	185,633,900	97

Source: Author compilation from Auditor General Report, 2012/2013

While success of PHSDP depends entirely on effectiveness of LGAs to spend the availed funds on the programme, table 4 above tells a different story. It is however, sad to note that there are districts that in the year 2012/2013 failed to spend even a single coin on the programme. The table justifies that what constrains the success of PHSDP among other factors, lies within the LGAs effectiveness in spending the availed funds. If such a tendency of failure to spend the allocated funds to health program persists and LGAs continues to be allocated with fund, then the success of health related programmes will be seriously affected. Moreover, since such health related programmes are traced from when decentralization process took over, then it is obvious that a number of reasons can be drawn from this state of affairs.

4. REASONS FOR LGAS FAILURE TO SPEND FINANCIAL RESOURCES EQUITABLY

There is a systemic problem that has bedeviled LGAs to seriously spend the allocated funds as required. As a result, most of health programmes like CHF and PHSDP have seriously been impaired to attain expected targets. A lot have been said by scholars and policy analysts. While this paper does not aim to underrate the reasons aired, it seeks to complement them. Here below is an analytical review of those reasons.

There is a growing body of evidence that the lack of political will among the LGAs impairs much delivery of health services since it affects greatly possible implementation of set plans and policies (Esan *et al.*, 2014; Melena, 2009). Political will is a commitment of actors mostly bureaucrats and politicians to undertake actions to achieve set objectives and sustain the cost of those actions over time (Amundsen & Mathisen, 2006). Lack of political will has not only affected CHF and PHSDP, but also other sectors. Couzen & Mtengeti (2011) realized that the failure of creating space for child participation in local governance was indeed due to lack of political will as LGAs failed to allocate budget for child participation. In Nigeria also, lack of political will among the LGAs staff has affected delivery of health care particularly maternal and child health (Esan, *et al.*, 2014). Inadequate political will on the part of LGAs was identified as a root cause of performance gap for maternal and newborn health services in South West Nigeria Esan, *et al.*, 2014). Berry *et al.*, (2004) assert that where political will is lacking, certain groups may be deliberately excluded from social services on the basis of gender, ethnicity, religion, caste, tribe, race or political affiliation

Since Alma Ata declaration, the question of community participation was placed at the centre stage of provision of health service. However, among the LGAs the extent of community participation is indeed questionable as, a result, LGAs staff do not feel responsible to people they are meant to serve. Though the term community participation takes different forms and meaning, (Kessy, 2013), in this paper community participation is said to be “the redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future. It is the strategy by which the have-nots join in determining how information is shared, goals and policies are set, tax resources are allocated, programs are operated, and benefits like contracts and patronage are parceled out (Arnstein, 1969:1). In a study by Chaligha (2008) which involved six LGAs realized explicitly that community participation was lowly adhered to by the LGAs leaders. The study found that all six LGAs were marred by inadequate participation and lack of local consultation in the formulation of policies and plans at the local level and in the entire policy making process. Chaligha reiterated further that inadequate participations carry with it the risk that formulated policies and plans may push people toward impoverishment especially in access to health because their needs and aspiration are ignored. It is no wonder that in circumstances such as this one cannot expect LGAs to wisely spend the allocated CHF and PHSDP funds.

That Tanzania has for so long become a corrupt breeding place is a fact in which LGAs are of no exception. Perhaps, what might be different are the nature, form, intensity and volume of corrupt practices from CG to LGA. Indeed, the grim situation in LGA's provision of health services has largely been exacerbated by corrupt practices by public servants. Corruption in this aspect means the use of public office for private gain (Bardhen, 1997). For instance, there are no pleasing words to use for the unspent fund worth Tsh 8,756,808,382 for CHF and Tsh 22,699,103,047 of PHSDP than a smell of corrupt practices at the LGAs. It should be noted further that CAG never ever stated where these money went after failure to be spent. To paraphrase Achebe's words when asserting the scourge of corruption asserted that corruption has permeated the LGAs and anyone who can say that corruption in LGAs has not become alarming is either fool, a crook or else does not live in this country (Achebe, 1988 cited in Lawali, 2007). It is sad to note that those corrupt practices at LGAs hit hard the marginalized poor in society than one can imagine particularly in their effort to access health care. Any coin lost that was intended to rescue health care in the LGAs result into nothing else but suffering of the marginalized people. Indeed, corrupt practices at the LGAs that disproportionately affect the poor access to health service is summarized by Lumumba (2011) who strongly argued that the cost of corruption is pernicious and that no society can survive its grip.

Perhaps, poor access to health care among the LGAs would not have been so pronounced if not for endemic culture of financial mismanagement prevalent in the country. Financial mismanagement is pervasive in LGAs due to almost nonexistent of transparency and accountabilities among the LGAs (ALAT, 2011). The lack of accountability by the LGAs results into poor spending of the disbursed fund by the CG which leads into poor people dying of curable diseases. In 2011, for instance, the CAG undertook tighter scrutiny to the LGAs which revealed financial chaos in their record keepings. For instance, during the 2009/2010 financial year, 34 out of the 134 audited councils had effected payments amounting to \$1 million where supporting payment vouchers were not available for audit purposes. The council with the highest unsupported payment figures was Ruangwa District Council with \$273 million, followed by Kishapu District Council, with \$1.2 million (The East African, 2nd May, 2011).

Moreover, Mzenzi and Gasper (2015) underscored further that mismanaging of LGA in Tanzania takes different forms across the LGAs being engrained with negligence and self-interest behavior. In the same study findings revealed that due to mismanagement tendency, many LGAs had outstanding imprest indicating that their employees were unable to retire on time. Similarly, there were many problems with procurement and contract management, such as procurement of goods and services without the approval of the tender board, procurement of services from unapproved supplier, procurement without competitive bidding, the value of stores not being recorded in the ledgers, goods paid for but not delivered and inadequate documentation of projects and contracts. All these are coupled with the inability of poor people to hold LGAs staff accountable (ALAT,2011). Above all, Afrobarometor (2005) observed that citizen had no ways to hold their representatives accountable for their actions and councilors had limited power to remove non-performing council officers.

5. IMPLICATIONS FOR LGAS FAILURE TO SPEND CHF AND PHSDP

Decentralization of health services in Tanzania which left final execution of health related programmes in the hand of LGAs can be said to have partly succeeded and partly failed to achieve most of its set objectives. The success of health service might be taken from the situation during which centralization process was in operation. It is not the interest of this paper to jot down the success story of the decentralization instead, the article limits itself to implications of LGAs failure to judiciously spend allocated funds for CHF and PHSDP.

Failure to seriously account for the disbursed fund in health care aggravates the problem of human resource for health crisis in the country. This is because implementation of the programmes aims, among other things, to curb the health personnel problem from the recruiting process to the retention process. While the population has grown dramatically from 10 million people in 1961 to more than 44 million in 2012 (NBS, 2013), the number of trained health personnel remains wanting. According to the MoHSW (2008), by 2006 the country was experiencing a shortage of Human Resource for Health of 65% at all levels of the health sector. By 2010 when the two health related programmes were in operation the shortage was still alarming. For instance, the doctors (medical and specialized doctors) to population ratio stood at 1:64,000 (Sirili, *et al.*, 2014). The situation is even worse in rural areas. For instance, in 2010 Kigoma had a ratio of 1:308,000 for doctors. This ratio is far below the World Health Organization recommendation of doctors to population ratio of 1:5,000 (Sirili, *et al.*, 2014). With regard to the recruitment and retention of health workers, LGAs which are mandated with planning, implementing, monitoring and evaluating health workers within the districts are doing quite poor. For instance, by 2014 among 4812 health workers who were posted to their station 1780 (47%) did not report. Out

of the reported staff, 13% left the stations (MoHS, 2014). Among reasons stated for poor recruitments are inherently those within LGAs mandates like delays to clear subsistence allowance, moving costs and late incorporation into payroll, poor working environment, unavailability of staff houses and lack of essential social services.

The most notable failure to remit fund to CHF and PHSDP affects greatly the quality of health care provided by the health facilities in the LGAs. Though poor quality health service provision might be caused by several other factors, one cannot underestimate the fact that certain amounts of money earmarked for CHF and PHSDP remain unused or diverted to unrelated expenditures. According to Kwesigabo, *et al.*, (2012), Tanzania is severely facing a critical shortage of medical supplies/equipment and unreliability of supplies like vaccines, antibiotic and other essentials. Kwesigabo *et al.*, further argue that the country is facing irregular supply of essential drugs at all levels of the health delivery system which leads to unnecessary referrals. In the same line of argument Makwara and Tavuyanago (2012) state that most of health centres and dispensaries face greater problems of hygiene where water supply is often non-existent, erratic and unsafe. All these indicators of quality health compound to poor health provision. It needs to be recalled, for example, that according to the 1997 CHF circular No 2 the allocated CHF fund can be used among others for purchasing of medicine, drugs, hospital equipment and other essential hospital materials. Not spending the availed funds or diverting the funds to other health non-related expenditures serves to compound all these challenges.

Failure to tackle health problems caused by weak LGAs to make use of funds has resulted to the country being among the leading countries with the highest burden of diseases. According to Kalage, *et al.*, (2012), the country is confronted with “double burden of disease” that is communicable diseases (CD) and non-communicable disease (NCD). Statistics show that 65% of total deaths in all ages are due to CD in all ages with HIV/AIDS, TB, and Malaria being the most important (Kalage *et al.*, 2012). This also includes maternal, perinatal and nutritional cases. NCD on the other hand are estimated to account for 27% of all deaths and the remaining deaths occur due to injuries (Kalage *et al.*, 2012). With regard to specific CD, for instance, Kwesigabo *et al.*, (2012) argue that in Tanzania Malaria is the leading cause of morbidity and mortality for many years accounting for 40% of all outpatient attendance and 30% of the national disease burden. TB makes the country one of the 22 highest burden countries in the world. It is unfortunate to note that the highest burden of disease that Tanzania is facing is predominantly potentially preventable (Mhalu, 2005). In this context, one cannot help but place part of the blame on LGAs’ failures to judiciously spend funds on CHF and PHSDP.

Poor quality health care in the LGAs caused by poor utilization of allocated fund also affects health seeking behaviour (HSB) among Tanzanians. According to Atwine (2015), HSB is important because it is one of the factors determining the acceptance of health care and outcome especially in chronic conditions. Though a number of factors are considered when situating the causes of HSB like education level, socio-economic background, distance from the health facility; it is undeniably true that the quality of health provided plays a pivotal role. As argued by Corno (2014), patients who experience negative outcome (like not being cured despite having sought care) are less likely to seek care again in the following period. As a result, individuals switch away from formal health providers to informal providers. Studies by Sahn, *et al.*, (2002) and Muriithi (2013) found that medical quality assessed both in terms of health staff qualification and by availability of drugs increases the probability of a visiting to both private clinics and public hospitals. While the theory of HSB carries millions of truth, statistics show that in Tanzania 68% of the sick population does not seek health care and only 27% chooses formal health facilities such as hospitals, health centres and clinics (Corno, 2014). If poor quality distracts individuals from seeking health care to health facility in Tanzania, then it is logical to treat LGAs failure to spend funds allocated in health programme as one factor accounting for the decline in HSB. It is because of this state of affair that even CHF enrollment has by far remained very low compared to the government targets.

6. CONCLUSION AND WAY FORWARD

The paper has managed to establish that, over all the idea behind decentralization of health service was quite good because centralization process was already marred with severe problems. It has been found further that provision of health services through decentralization process has not improved as it was anticipated taking key examples from CHF and PHSDP. These programmes seem to have suffered greatly since a handful amount of money that was injected by the CG has not been judiciously spent. The article found that the root cause for LGAs failure to judiciously spent injected funds as desired for improvement of health care is due to a number of reasons. Those reasons include, shortage of leaders with highest political will, very low community participation such that LGAs staff do not feel responsible to people they are

meant to serve. Other causes for LGAs failure are due to endemic culture of financial mismanagement among the LGAs as well as gross corruption prevalent in the entire LGAs.

Given the reasons for LGAs failure to deliver health care through CHF and PHSDP, one may realize that to a large extent, most of the established problems are governance related issues that can be solved through governance means. For instance, one may be tempted to ask, how long will failure to spend CHF and PHSDP fund be allowed and in turn affect health care provision? Why should Auditors continue unearthing such atrocities in LGAs and the situation remain unattended by the CG? This paper is of the view that still a room to change such state of affairs is possible if the following three attempts will be undertaken.

The effort to reclaim the lost integrity of LGAs needs to be awakened. As Oluwatobi, (2012) asserted, lack of integrity is taking a leaving tool on the wellbeing of ordinary people particularly through denying them access to health care by damaging promises enshrined in CHF and PHSDP programme. Efforts to encourage, practice and enforce mechanisms of restoring integrity among LGA staff are of importance at this stage. Government machinery that has a role to instill ethical standards among LGAs staff needs to exert maximum energy. CAG reports alone without overt action against LGA staffs that crisscross governance principles cannot be any useful.

Effective and efficient community participation has a role to make LGAs staffs deliver the most in health care. This is important to inculcate accountability among LGAs staffs. The LGA staffs should not see local people as mere recipients of instructions. This will, in a long run, ensure transparency, accountability and inclusiveness at the LGAs level. To make this bear fruits, there is a need for existence of vibrant civil society from the local level. This is done through strengthening local communities by giving them formal and informal trainings by letting them aware of their rights and responsibilities to their LGAs. Failure of this, LGAs will relax knowing that there are no closer watchdogs. In the same vein, CG needs to ensure citizens participate fully in affairs affecting their wellbeing. Gone, are the days of seeing and underestimating people's capacities to plan, to prioritize and do things for themselves as colonial rulers did (Mkapa, 2008).

It is high time for the CG to give greater degree of autonomy to the LGAs to execute their role quite satisfactorily than it is today. Indeed, some of failures to enable local people access health service might be rooted through meager autonomy that LGAs are endowed with. Though the constitution of Tanzania recognizes LGAs as autonomous bodies with legal status (corporates bodies) operating with discretionary power over local affairs (REPOA, 2008), on the ground, the situation is different. As De Visser (2005) argued, if LGAs do not have sufficient and real power, they cannot respond adequately to the needs of the people they are meant to serve. According to REPOA (2008), conditions of services are centrally, councils have limited power over hire and fire and recruitment of key staff. Again, LGAs have no power to change any of the LGAs revenue sources without the minister's approval. By and large, this impediment that LGAs face has implication to health services delivery in its wider context.

REFERENCES

- [1] ALAT (2011). State of Democracy and Good Local Governance in Tanzania (LD&GLG) [Online] http://www.clgf.org.uk/userfiles/1/file/The_State_of_Local_Governance_and_Good_Local_Governance_in_Tanzania_2011.pdf accessed on 16/12/2015.
- [2] Amundsen, I. and Mathisen, H. (2006). Corruption, lack of Political Will and the Role of Donors in Uganda. Commissioned Study Chr. Michelsen Institute. Bergen –Norway
- [3] Armstein, S.R. (1969). A ladder of Citizen Participation. *Journal of the American Institute of Planners*, 35 (4): 216-224.
- [4] Atwine, F. Hultsjo, S. Albin, B. and Hjelm, K (2015). Health-care seeking behaviour and the use of traditional medicine among persons with type 2 diabetes in south-western Uganda: a study of focus group interviews. *The Pan African Medical Journal*. 20:76.doi:10.11604/pamj.2015.20.76.5497.
- [5] Bardhan, P. (1997). Corruption and Development: A Review of Issues. *Journal of Economic Literature*, Vol 35, No 3. (Sep., 1997), pp 1320-134.

- [6] Bardhan, P. (1997). Corruption and Development: A Review of Issues. *Journal of Economic Literature*, Vol. 35, No. 3), pp. 1320-1346.
- [7] Basaza, R. Pariyo, G. and Criel, B. (2009). What are the emerging features of Community Health Insurance schemes in East Africa. *Risk Management and Healthcare Policy Dove Press Journal*.
- [8] Berry, C. Forder, A. and Moreno-Torres, M. (2004). Approaches to Improving the Delivery of Social Services in Difficult Environments. PRDE Working Paper 3 UK Department for International Development.
- [9] Borghi, J.M. Makawia, S. and Kuwawaruwa, A. (2014). The administrative costs of Community Based Health Insurance: A case of the Community Health Fund in Tanzania. *Health Policy and Planning*, 1-9.
- [10] Cassel, A. and Janovsky, K. (1996). Reform of the Health Sector in Ghana and Zambia: Commonalities and Contrasts. Geneva: World Health Organization.
- [11] Chaligha, A. (2008). Local Autonomy and Citizen Participation in Tanzania: From a Local Government reform Perspective. Special Paper 08.26 REPOA, Mkuki na Nyota Publishers Dar Es Salaam, Tanzania.
- [12] Chaligha, A. Braathen, E. and Fjeldstad, O. (2005). Local Governance, Finance and Service Delivery in Tanzania. REPOA, Dar Es Salaam Tanzania.
- [13] Corno, L. (2014). Learning (or Not) in Health-Seeking Behavior: Evidence from Rural Tanzania. *Economic Development and Cultural Change*, Vol. 63, No. 1 (October 2014), pp. 27-72.
- [14] Couzens, M and Mtengeti, K. (2011). Creating Space for Children participation in Local Governance in Tanzania: Save the Children and Children's Councils. Research Paper 11/1. REPOA.
- [15] De Visse, J. (2005). Development of Local Government: A Case Study of South Africa. Intersentia, Antwerpen-Oxford.
- [16] Esan, O. T. and Fatus, A.O (2014). Performance Needs Assessment of Maternal and Newborn Health Service Delivery in Urban and Rural Areas of Osun State, South-West, Nigeria. *African Journal of Reproductive Health* Vol 18. No 12.
- [17] Grosse, R.N and Harkavy, O (1980) The Role of Health in Development. School of Public Health, University of Michigan and International Division Ford Foundation New York 10017, U.S.A
- [18] Haazen, D. (2012). Making Health Financing Work for the Poor People in Tanzania. Washington D.C. The World Bank. Henning, J. (2010). Using Private Companies to extend Health Insurance to the Informal Sector. Discussion Papers on Social Protection. GIZ Issue No 7.
- [19] Kalage, R. Blomstedt, Y. Hoffman, K. Bangha, M. and Kinsman, J. (2012) Tanzania Country Report. INDEPTH Training and Research Centres of Excellence (INTREC).
- [20] Kamuzora, P. and Gilson, L. (2007). Factors affecting the implementation of the Community Health Fund in Tanzania. *Health Policy and Planning* 22(2):95-102.
- [21] Kessy, A. (2013). Decentralization and Citizens' Participation: Some Theoretical and Conceptual Perspectives. *African Review* Vol. 40, No. 2, 2013: 215-239.
- [22] Kiwara, A and Kapinga, A. (2001). Quantitative Evaluation of the Community Health Fund in Igunga. Report submitted to the Ministry of Health and Social Welfare United Republic of Tanzania.
- [23] Kuriithi, M. (2013). The determinants of Health Seeking Behaviour in a Nairobi Slum, Kenya. *European Scientific Journal* edition Vol 9, No 8 1881-7881.
- [24] Kwesigabo, G, Mwangi, M.A Kakoko, D.C Warriner, I, Mkony, C.A, Killewo, J, Macfarlane, S.B, Kaaya, E.E Freeman, P (2012) Tanzania's health system and workforce crisis. *Journal of Public Health Policy* (2012) 33, S35-S44. doi:10.1057/jphp.2012.55.
- [25] Kwesigabo, G. Mwangi, A.M., Kakoko, D. and Killewo, J. (2012). Health challenges in Tanzania: Context for educating health professionals. *Journal of Public Health Policy* (2012) 33, S23-S34. doi:10.1057/jphp.2012.47.

- [26] Lawal, G (2007) Corruption and Development in Africa: Challenges for Political and Economic Change. *Humanity & Social Sciences Journal* 2 (1): 01-07.
- [27] Lumumba, P.L.O. (2011). The War against Corruption as a Poverty agenda in Africa. Paper presented during the 2nd Africa Governance, Leadership and management Convention Organized by Kenya Institute of Management available at <http://www.eacc.go.ke/docs/War-Against-Corruption-Poverty-Reduction-Africa.pdf>
- [28] Makwara, E. and Tavuyanago, B. (2012). Water Woes in Zimbabwe's Urban Areas in the Middist Of Plenty: 2000 – Present. *European Journal of Sustainable Development* 1, 2, 151-180.
- [29] Melena, C. (2009). Building Political Will for Participatory Governance: An Introduction in C. Melena,(eds) From Political Won't to Political Will: Building Support for Participatory Governance. Kimarian Press. Cirvicus.
- [30] Mhalu, F.S. (2005). Burden of diseases in poor resource countries: meeting the challenges of combating HIV/AIDS, tuberculosis and malaria. *Tanzania Health Research Bulletin* 7.
- [31] Mkapa, B.W. (2008). Leadership for Growth, development and Poverty Reduction: An African Viewpoint and Experience. Commission on Growth and Development Working Paper; No 8 Washington DC. World Bank.
- [32] MoHS. (2014). Human Resource for Health and Social Welfare Strategic Plan 2014-2019. Ministry of Health and Social Welfare 6 Samora, Machel Avenue. Dar Es Salaam.
- [33] MoHSW, (2008) Human Resource for Health Strategic Plan 2008 – 2013. Ministry of Health and Social Welfare, Dar es Salaam, Tanzania.
- [34] Msuya, J.M. Jutting, P.J. and Asfaw, A. (2004). Impacts of Community Health Insurance Schemes on Health Care Provision in Rural Tanzania. ZEF.
- [35] Mubyazi, G.M. and Borghi, J. (2012). Desirability, Challenges and Options for Launching a Community Health Fund Scheme in Tanzania: Interview Based views from Community Members and Health Managers in Kagera Region and Review of Lessons from other CHF Implementing District. *Africa Journal of Health Economics*.
- [36] Mujinja, G.M and Kida, T.M. (2014). Implication of Health Sector Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services. THDR2014: Background Paper No.8 ERSR Discussion Paper No 62. The Economic and Social Research Foundation (ERSRF).
- [37] Murith M. (2013). The Determinants of health Seeking Behaviour in Nairobi slums, Kenya. *European Scientific Journal* Vol 9 No 8.
- [38] Mzenzi, S, I and Gaspar, A.F. (2015). External auditing and accountability in the Tanzanian local government authorities. *Managerial Auditing Journal*, Vol. 30 Iss: 6/7, pp.681 – 70
- [39] NAO. (2009). Annual General Report of the Controller and Auditor General of the Financial Statements of the Local Government Authorities for the Financial Year 2007/2008. Available: http://nao.go.tz/?wpfb_dl=18. August 10, 2015
- [40] NAO. (2010). Annual General Report of the Controller and Auditor General on the Financial Statements of the Local Government Authorities for the Financial Year Ended 30th June, 2009. Available: http://nao.go.tz/?wpfb_dl=13. August 10, 2015.
- [41] NAO. (2011). Annual General Report of the Controller and Auditor General on the Financial Statements of the Local Government Authorities for the Financial Year Ended 30th June, 2010. Available: http://nao.go.tz/?wpfb_dl=82. August 10, 2015.
- [42] NAO. (2012). Annual General Report of the Controller and Auditor General on the Financial Statements of the Local Government Authorities for the Financial Year Ended 30th June, 2011. Available: http://nao.go.tz/?wpfb_dl=78. August 10, 2015.
- [43] NAO. (2013). Annual General Report of the Controller and Auditor General on the Financial Statements of the Local Government Authorities for the Financial Year Ended 30th June, 2012. [Online] Available: http://nao.go.tz/?wpfb_dl=91. August 10, 2015.

- [44] NAO. (2014). Annual General Report of the Controller and Auditor General on the Financial Statements of the Local Government Authorities For the Financial Year Ended 30th June, 2013. Available: http://nao.go.tz/?wpfb_dl=113. August 10, 2015.
- [45] Oluwatobi, A.O. (2012). Corruption and Local Government Administration In Nigeria: A Discourse Of Core Issues. *European Journal of Sustainable Development*, 1, 2, 183-198.
- [46] Poncian, J. and Mpambije C.J. (2015). The Fallacy of Limited Financial resources for development in Tanzania: Evidence from Local Government Authorities Audit Reports. *Public Policy and Administration Research*. Vol 5 No 2.
- [47] Quah, J.S.T (2013). Combating Corruption in Asian Countries: What Lesson Have we learnt? *Public Administration and Policy*. PAAP 16.1 15-3.
- [48] REPOA, (2008). The Oversight Processes of Local Councils in Tanzania Final Report. *Research on Poverty Alleviation (REPOA)*.
- [49] Sahn, D.E, Younger, S.D and Genicot, G. (2002). Demand for Health Care Services in Rural Tanzania. Available from <http://faculty.georgetown.edu/gg58/Tanzania.pdf> accessed on 16/12/2015.
- [50] Shaw, P. (2002). Tanzania's Community Health Fund: Prepayment as an Alternative to user fees. Washington, DC. World Bank Institute. Unpublished.
- [51] Sirili, N. Kiwara, A. Nyongole, O. Frumence, G. Semakafu, A. Hurting A. (2014) Addressing the Human Resource for Health Crisis in Tanzania: The lost in Transition Syndrome. *Tanzania Journal of Health Research* Volume 16, Number 2.
- [52] Stoarmer, M. Hanlon, P. Tawa, M. Macha, J and Mosha, D. (2012). Community Health Funds (CHFs) in Tanzania: Innovation Study. Draft Report Swiss tropical and Public Health Institute.
- [53] The East African. (2011). Tanzania's local governments in financial scandal. Accessed on 10/12/2015 from <http://www.theeastafrican.co.ke/news/-/2558/1153870/-/o38xrez/-/index.html>.
- [54] Tibandebange, P and Kida, T, Mackintosh, M and Ikungura, J (2013) Understandings of Ethics in Maternal Health Care: an Exploration of Evidence From Four Districts in Tanzania. Working Paper 13/2, Dar es Salaam, REPO