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THE DECENTRALIZED HEALTH DELIVERY SYSTEM IN TANZANIA: ANALYSIS OF IMPLEMENTATION PROBLEMS

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DEDICATION

I dedicate this study to my beloved ***"Wilfred"*** *the father of my son who passed away during my study and the writing of this paper. The short time we shared together gave us joy and a son* ***Matthew*** *who will always keep the memory of our union forever alive.* ***Matthew*** *remains the source of inspiration since the loss is unbearable in most times.* ***"Wilfred"*** *the meanings of life gave to me during the short period, enables me to keep on going. This meaning is what has helped me to complete this study which our son* ***Matthew*** *will read as part of "our" history together. To* ***Winfred-Matthew (Jr)*** *your daddy loved you, and gave me this encouragement to write something for you to understand our past. As this study forms part of our life together, and the moments both of us cherished.*

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ACRONYMS AND INITIALS USED IN THE TEXT.

CCM ..... CHAMA CHA MAPINDUZI (REVOLUTIONARY PARTY OF TANZANIA).

DMO ..... DISTRICT MEDICAL OFFICER.

DC ..... DISTRICT COUNCIL.

DAO ..... DISTRICT ADMINISTRATIVE OFFICER.

DED ..... DISTRICT EXECUTIVE DIRECTOR.

MOH ..... MINISTRY OF HEALTH.

PHC ..... PRIMARY HEALTH CARE.

PMO ..... PRIME MINISTERS OFFICE.

RC ..... REGIONAL COMMISSIONER.

RDD ..... REGIONAL DEVELOPMENT DIRECTOR.

RMO ..... REGIONAL MEDICAL OFFICER.

RHCs ..... RURAL HEALTH CENTRES.

UNICEF ..... UNITED NATIONS CHILDREN'S FUND.

VHWs ..... VILLAGE HEALTH WORKERS.

WHO ..... WORLD HEALTH ORGANIZATION.

WB ..... THE WORLD BANK.

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CHAPTER ONE: INTRODUCTION.

"Health development in decentralized system is not only ambitious, and may be unrealistic- it invites a number of methodological challenges" (Naustadalislid 1992:27).

1.0 Introduction.

Most countries in Africa inherited health systems from colonial government with management practices and administrative structures that were highly centralized, both geographically and hierarchically (World Bank 1993:86).

In Tanzania, the Ministry of Health (Herein after referred to as MoH) had the responsibility of health services through out the country. From the central to district levels. However this situation changed in 1972 when the government adopted the policy of decentralization which involved transfer of significant powers and functions to regional and district offices.

Health services in the regions and districts were vested to regional and district directorates respectively. The two directorates were placed under the Prime Ministers' Office (PMOs) which had the responsibility of coordinating all regions and districts in the country. The PMO was also responsible for providing policy directives and planning guidelines within which these bodies were required to make their decisions.

1.1 Background information.

The provision of health services has become an important issue in many developing countries today. The availability of health services, its quality, accessibility, efficiency and community participation are among factors of priority to any government which is committed to providing adequate and efficient health services to its citizen. This move was endorsed by the World Health Assembly in 1975/76 respectively whereby health was declared as: A universal human right and that governments should pursue policies

to provide accessible, affordable, socially relevant health care to all.[1]

In Tanzania, the efforts to make health services more accessible to the citizens can be traced as far back as 1961, when the country (formerly Tanganyika) attained its independence. During the colonial period, health services were mainly concentrated in the urban areas. In addition, emphasis was taken on curative services, with little or none attention to preventive services. It can be said that the colonial government made no effort whatsoever in trying to expand this fundamental service.

In an effort to provide a balanced and equitable distribution of health service, the first five year development plan of the Ministry of Health was endorsed in 1964. This plan aimed to build regional hospitals, equipped with the necessary technology, specialized skills and expertise. In respect of primary health services in the rural areas, the government planned to build 300 health centres which could cater for about 50,000 people each; thus people would receive basic health services in their vicinity.

The second five year plan (1969-1974) was endorsed after the Arusha declaration of 1967 which brought about the concept of "Ujamaa" (Tanzania's ideology based on socialism). This ideology was accompanied by socialization and nationalization of private property. In the health sector emphasis was given to equitable distribution of all health services.

The third five year plan (1976-1981 emphasized on provision of clean water and health services in urban and rural areas. It was also expected from the government to develop its policy on Universal Primary Education(U.P.E).

These activities were all important since they were part of the Alma Ata declaration of 1978, settled a primary health care strategy which was also endorsed by the government. The focus of PHC is to solve the health problems in the community, by providing

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1 Resolution WHA 28.88, adopted May 1975 and Resolution WHA 29.19, adopted May 1976.

promotive, curative, preventive and rehabilitative services to all individuals and families with their full participation.

It is important to note, along with the 2nd five year plan, an administrative reform was introduced in 1972 with the emphasis on decentralization. This involved the significant shift of powers and functions to regional and district offices administration. The Ministry of Health was restructured, important local government authorities were abolished and were replaced by regional and local level development bodies which were responsible for all development matters in their locality . " We have to work a system which gives more freedom for both decision and action on matters which are primarily of local impact, within a framework which ensures that the national policies of socialism and self reliance are followed every where" (Nyerere 1972:2).

It is interesting to note however that the MoH decentralized some of its functions to the District and Regional Directorates respectively, which were both under the Prime Minister's office - the central government.

1.2 <u>Indication of the problem area and hypotheses</u>.

Ten years after the introduction of decentralization policy in 1972, which involved transfer of significant powers and functions to the regions and districts. It was realized that the intended objectives of the policy were not achieved nor did the health situation significantly improved. In 1972 targets were set in respect of manpower requirements and the number of people to be served; the purpose of the health services was to make them more accessible to the people. However when a review was made in 1980, the results showed that the targets were far from reached(Hamel 1983:41). Thus <u>The Local Government Act</u> was passed in 1982 and an

operational system came into effect in 1984 [2].

In the health sector the MoH was not only responsible for coordinating health services in the country, policy making and planning, providing technical assistance and supporting regions and districts but also responsible for the development of vertical or centralized programmes. Currently there are about seventeen vertical programmes run by the MoH; most of them are well funded by donors and therefore implementors at the regional and district levels would concentrate more on them and ignore the ones formulated at the regional, district or village levels. This situation has raised a number of complaints especially by RMOs and DMOs because since these types of programmes are centrally controlled, programme coordinators have to receive directives from the MoH; some people have questioned whether the MoH has really decentralized its functions to lower levels or it has actually extended it.

The regional level remained with the responsibility of all health services in its area; while the district level was regarded as the most peripheral administrative level in which both local politicians and civil servants of the central government joined together to form local government. In the health sector the district was taken as the organizational level whereby it could promote health services and disease control programmes. In fact it was felt that the district could play a critical role of ensuring " bottom-up " needs of local communities and its health sector.

In line with what is said above, the DMO was given the responsibility of primary health activities at district level and the promotion of community participation through primary health care. Primary Health Care Committees were also established and were regarded as the base for community participation. However these committees were established outside the framework provided by The

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[2] The Decentralization which is going to be discussed in this paper, is that within the context of devolution and deconcentration of powers.Thus both the 1972 and 1982 policies will be referred to.

Local Government Act, no 7 of 1982.

This paper will focus on the question why the health policy objectives were not achieved. It hypothesizes that one of its instruments - decentralization of health services has not been adequately used and complemented. Sub-hypotheses which will also be used are as follows:

1.2.1 That lack of clarity in the local government law and in the related policy statements on how the roles to be performed by different levels of government and on how they should relate to each other contributed to poor implementation of the health policy.

1.2.2 That the absence of a well-developed, institutionalized mechanisms and a clearly framed strategy in an overall strategy towards community participation in health contributed to poor implementation as well.

1.2.3 That the actual instrumentalities adopted for involving community participation also defeated this implementation.

1.3 Clarification and definition of key terms.

Before presenting some of the arguments in this study; it is necessary to be clear on the meaning of the key terms to be used; however, where necessary, the terms will be elaborated further in their respective chapters or sections. The definitions are made as hereunder:

1.3.1 The health policy.

According to WHO, a national health policy is an expression of goals for improving the health situation, the priorities among those goals and the main directions for attaining them (WHO 1979:15). According to the Tanzania national health policy, a health policy has the overall objective of improving the health and well-being of all Tanzanians with the focus on those

most at risk, and to encourage the health system to be more responsive to the needs of the people (MoH 1992:1).

Moreover, the specific objectives among others are to: ensure that health services become available and accessible to all people wherever they are in the country, whether in urban or rural areas; move towards self sufficiency in manpower by training all cadres required at all levels from the village to the national level and sensitise the community on common preventable health problems; and, to improve the capability at all levels of the society, assess and analyze problems and design appropriate action through genuine community involvement (Ibid).

1.3.2 Decentralization and the Health Sector.

Decentralization is a recurrent theme in the literature of public administration and development. Only recently it has been promoted in the health sector as a key component of the strategies aimed at reaching Health for All by the Year 2000 (WHO 1980:). In this regard, the World Health Organization issued guidelines within which the MoH was required to operationalize a decentralized health system as a means of achieving greater coordination and responsiveness to local needs through delegation of responsibility, authority and resources to the community and to the intermediate levels (WHO 1980:). The transfer of power from the central government to more peripheral levels has been seen as a means for overcoming physical and administrative constraints to development, improving the management of resources, and increasing community participation (Vaughan et al 1984:).

Furthermore decentralization has been praised as a means of obtaining community participation and promoting local responsibility for Health (Mills et al 1987:). Decentralization in the field of public administration has been defined broadly as the transfer of responsibility for planning, management and resource generation and allocation from the central government and its agencies to: 1. field units or the central government ministries or agencies; 2. subordinate units on levels of

government; 3. semi-autonomous public authorities or corporation, 4. area-wide regional or functional authorities; or 5. non-governmental private or voluntary organizations (Rondinelli 1981:137).

Decentralization can be categorized in four main forms; depending on the degree of authority and power and on the scope of the state in transferring to or sharing with its jurisdiction. These are: deconcentration, delegation, devolution and privatization.

Deconcentration involves the handing over of some administrative authority to locally-based offices of central government (Mills 1990:16). Delegation refers to transferring of managerial possibility for specifically defined functions to organizations that are outside the regular bureaucratic structure, and thus indirectly controlled by the central government (Rondinelli & Cheema 1983: 18-19). Devolution embodies the creation or strengthening of sub-national units (often termed as local government or local authorities) of government activities which are substantially outside the central government's direct control. While privatization involves the transferring of government functions to voluntary organization or private profit-making or non-profit making enterprises with a variable degree of government regulation (ibid).

Decentralization of government authority can thus take in a variety of forms, depending on the situation. For example in Tanzania, the central government has devolved certain functions to the local government, while other functions have been deconcentrated to local administrations of government ministries. Anne Mills and others have identified the following expected benefits from decentralization of health services:

* a more rational and unified health service;
* greater involvement of local communities;
* containment of costs and a reduction in duplication of services;
* reduction in inequalities;

* integration of activities of different agencies;
* strengthening health policy and planning functions of ministries of health;
* improved implementation of health programmes;
* greater community financing and control;
* greater community coordination; and
* reduced communication problems and delays (Anne Mills et al , 1990:142).

In Tanzania, decentralization of health services is expected to increase greater involvement of local communities, improved implementation of health programmes and strengthening health policy and policy planning functions of the MoH.

1.3.3 Community participation/involvement. [3]

Community participation may assume variety of forms depending on the nature of activity or intended objectives. Community participation is generally defined as: An active process by which beneficiary/client groups influence the direction and execution of a development project with a view to enhancing their well-being in terms of income, personal growth, self reliance or other values they cherish (Paul 1988:2).

However according to WHO and UNICEF report of 1978, community participation or involvement in health is defined as a process whereby individuals and families would come to view health not only as a right but also a responsibility. The strategy would discourage passive acceptance of government-sponsored programmes, substituting active participation (or 'cooperation') at every stage.

Specifically the report stated categorically that: The

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[3]**Note**

It should be noted that the term community participation is often referred to as community involvement in most of the health literature; hence in this paper the term community participation will also mean community involvement.

community must first be involved in the assessment of the situation, the definition of the problems and the setting of the priorities. Then it helps to plan PHC activities and subsequently it cooperates fully when these activities are carried out. Such cooperation includes the acceptance by individuals of a high health style, by applying principles of good nutrition and hygiene, or by making use of immunization services. In addition, members of the community can contribute labour as well as financial and other resources to PHC (WHO and UNICEF 1978:21).

The above definition places greater responsibility on individuals for their own health, on what is called 'self-care'. Community participation is thus defined as a tool of government whereby communities are expected to cooperate with government initiatives.

The World Bank also embraces the question of community participation in the economic context. In the second edition of the Health sector policy paper issued in 1980, it is indicated that: "community participation in health may assume various forms including: self-help for construction of facilities; community contributions of construction materials; development of local cooperative mechanisms to finance drug purchases; unpaid volunteer workers, and community selection of health workers. Community participation requires that villagers be both willing and able to cooperate" (World Bank 1980:61). The main approach towards community participation in the Bank's vision is towards relieving government's financial burdens.

Community participation within the Tanzanian health context would mean not only active participation in health programmes but also decision making in terms of assessing problems and setting up of priorities.

1.3.4 Primary Health Care.

Primary Health Care herein after referred to as PHC is the essential health care based on practical scientifically sound and socially acceptable methods, and technology made universally

accessible to individuals and families in the community through their full participation...[4] This approach puts emphasis on activities that are not physician-centred, such as health education, preventive activities, family health care (including family planning) and the use of local health workers.[5] PHC includes: (1) community participation, (2) universal coverage and accessibility, (3) appropriate health technology and (4) care by community health workers or by traditional health workers (WHO 1978:2-4). Generally it can be said that PHC is an essential health care which is provided in the community by relying upon community resources and initiatives.

Therefore PHC is not only regarded as a means of promoting community participation but also for having an effective decentralized health system.

1.4 Justification of the study.

As an employee of the Ministry of Health, I observed that the ministry was facing a number of problems in developing a number of projects and programmes. This situation was manifested by unclear roles of different levels of health delivery system in the country; as such it was not clearly stipulated to what levels the power was decentralized, what types of activities were to be decentralized and what decision making procedures between the MoH and the lower levels should be followed.

Therefore in an attempt to search for reasoned solution to the above problems, I thought it was necessary to look at the decentralization policy as it has been so far implemented by the MoH.

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[4] Article 5 of Alma-Ata Declaration of 1978.

[5] In Tanzania these are popularly known as village health workers.

1.5 Methodology and sources of data.

This study will primarily be based on secondary data, such as information from the library books, journals and articles, and various reports related to the study. Personal experience as a government employee will also be used.

Various theories on policy implementation and design will be explored in order to establish a normative framework that will help me to critically review the implementation of the local government law in connection with hypothesis **1.2.1.** While establishing that framework, I will also take note of what has been done in the Philippines and particularly of that country's Local Government Code of 1991 (RA 7160) which has clearly specified devolution of powers, including the transfer of powers which should take place in the Department of Health (DoH). This specification is missing in the two Tanzanian legal instruments. A situation which has brought problems Vaughan has rightly observed that: "Confusion over management responsibility may allow individuals to take advantage of the situation, and in turn necessitates strong supervisory procedures and good financial control" (Vaughan 1990:141).

I will also try to review a number of literature sources on decentralization that exist in the field of public administration and will help in exploring decentralization within the context of the health system. I will do that because this will help me to critically review the efforts of the government in the field of transferring power to lower levels within the bureaucracy as related to sub-hypothesis **1.2.1** and the efforts of the government in the field of community participation as related to sub-hypotheses **1.2.2** and **1.2.3.**

1.6 Scope and Limitation of the study.

This study will be limited to the MoH - Tanzania Mainland because according to the constitution of the United Republic of

Tanzania, the Ministry of Health is not a Union matter [6].

Another limitation is due to the fact that, decentralization and health had been given due attention recently. Thus there is no much literature in this regard, much of this study will rely on WHO and World Bank publications and journals.

1.7 Organization of the Paper.

This study is structured into five chapters. Chapter one is the introduction to the research paper, where I present development plans in the health sector and also the administrative reform of the government which occurred in 1972. It spells out the background and indication of the problem area, justification of the study, the research methodology, scope and limitations of the paper and the structure of the paper.

Chapter two, will discuss various theories and concepts relevant to the study: important elements in a decentralized health management and a general decentralization concept as applied in a decentralized health system. It will also look at the theories on policy design and implementation.

Chapter three, will be descriptive whereby it will analyze health care delivery system in Tanzania. Special emphasis will be on various administrative reforms which has been taken place since the Country attained its independence in 1961. A brief account of what happened during the colonial time will be explored.

Chapter four will introduce the existing situation with analytical framework. In it, I will analyze theoretical approach and performance under a decentralized health management.

Chapter five will synthesise/summarise the findings, it will include recommendations and suggestions; it will also provide insight about the prospects of decentralization of health services.

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[6] Tanzania came into being in 1964 after the merger between Tanganyika and the Islands of Zanzibar and Pemba.

CHAPTER TWO: IMPLEMENTATION OF A DECENTRALIZED HEALTH SYSTEM : A THEORETICAL FRAMEWORK.

2.0. Introduction

In this chapter I will try to look at theories and related issues of policy implementation and problems emanating there from, policy design how do they relate to a decentralized health system.

Particularly it will reflect causes of failure of policy implementation with emphasis on the field of health . The discussion will try to revolve around the hypotheses of this study, ie policy design with regard to clarity of policies and instruments used to implement policies, lack of appropriate mechanism for community participation.

2.1. Policy Implementation and Related issues.

Implementation is a process whereby basic policy decisions, programmes and objectives are carried out in order to realize a specific goal being tangible or symbolic. It must be noted however that implementation is not a smooth process, because in the processes is possible to encounter various factors which may facilitate or block the whole process.

This process involves co-existence of government and non-government agencies both at macro and micro-levels (Altensetter and Björkman 1981:30). The most important aspect in implementation is always the extent to which the principal actors conceptualise the objective, the design of the objectives, the amount of resources (both financial and human), the degree of authority of the actors at different levels and the involvement and responsiveness of the intended beneficiaries.

Policy implementation is a process whereby certain intended objectives of a policy are to be achieved. Thus the task of implementation is to establish a link that allows the goals of public policies to be realized as outcome of governmental activity (Grindle 1980:6).

The task of implementation should be to establish a link

that allows the goals of public policies to be realized as outcome of governmental activities, hence the implementation of policies will largely depend **inter-alia** the nature and content of policy design and context within which a policy has to be implemented.

Implementation however, does not start until goals and objectives have been eloquently established prior to decision. It takes place only after legislation has been passed and funds committed. Pressman and Wildavsky observe that: "...the world is full of policy proposals that are aborted. You can not finish what you have not started. Lack of implementation should not refer to failure to get going but to inability to follow through (Pressman and Wildavsky 1984:xiv).

Generally, the study of implementation is aimed at examining those factors that contribute to realization of policy objectives (Van Meter and Van Horn 1975). When you look at implementation of social policies, health being among them; empirical evidence has shown that it is very difficult to implement.

According to Altenstetter and Björkman: "Social policy implementation is difficult because social services are delivered by local organizations like hospitals, clinics, and health care centres that are relatively independent of central control. Each of this two levels, central and local, has its own implementation problems, so the implementation of national policies consists of two separate classes of problems" (Altenstetter and Björkman 1981:30).

They observed further that: "A central government must execute its policy in order for local delivery organizations to behave in desired ways; this is macro-implementation problem. And response to those central government actions, the local organization must devise and execute their own internal policies; this is the micro-implementation problem" (Ibid).

In the similar vein, Berman observe that: "Essential differences between the process of micro-implementation and macro-implementation arise from their distinct institutional settings. Whereas the institutional setting for micro delivery organization,

the institutional setting for macro-implementation is an entire policy sector" (Berman 1978:168).

Björkman observe that; these propositions about implementation also apply when the best circumstances prevail...when, for example, the following exist:

(1) a hierarchically structured administrative system;
(2) a uniform and codified body of legal rules and norms;
(3) civil servants and service mangers with the same training; and
(4) considerable homogeneity in national, regional, and local politics.

Even under these circumstances, the delay encountered in the implementation process is directly related to the number of decision and clarence points and to the different views- to the refinements and the nuances, if you will held by diverse actors who intervene in the implementation of health program (Björkman 1993:3).

When you look at implementation of specific programme in health, for example decentralized health program. There are a number of factors which need to be considered before in order to have successful implementation of the program. This is due to the fact that it is more often that decentralization policy is initiated by the central government, and later each ministry is presumed to take sectoral steps.

Vaughan et al rightly observes that: "Much more work needs to be done sector by sector in seeing how effective decentralization linkage mechanism can be planned, designed and operated" (Vaughan et al 1985:3). However, this process has proved to be very difficult, as we shall see in the course of discussion of this paper. Mostly it is because of the complexity of the health sector. "Health is a many splintered thing. In bringing together the pieces, or managing, with a proper regard of public interest, the emerging inter-dependencies among the elements of the health field, of it is our own ambivalence we must face" (Mott 1976:1145). What can be gathered from the quotation is that; even

though the central government is always the one to initiate the policy, much work is expected from the sectoral ministries. However, experience has shown that, in the health sector the central office specialists are always able to resist successfully effective delegation of authority to its lower levels. Mustalish et al; look at this problem as a result of the dynamics of a dilemma inherent in an organization having field offices or service centres. It is a matter of the conflicting values (advantage and disadvantages) of centralization and decentralization of decision making (Kaufaman 1959)[7].

Thomas and Hilleboe put the problem in a set of two competing values in:

> **1.** the need to establish decision-making power in field offices where multitudes of varying challenges occur, and the information and understanding relevant to their solutions are most readily at hand; and **2.** the need to maintain decision-making power in the central office, where major policy directions must be determined and where the ultimate responsibility for actions taken and for overall coordination reside (Thomas and Hilleboe 1968: 1).

This dilemma is vividly seen in the health sector because of the dominance of the specialists. It is always the central office specialists who resist to transfer effective delegation of authorities to the district health officers. Various reasons have been advanced in favour of centralization such as: the authority of the functional bureaus should not be weakened, as the accomplishments of the department, which were considerable, are the products of the specialized bureaus; the technical excellence of the department would suffer if the authority of the district officers were increased; being generalists, they lack the specialized knowledge of the bureau chiefs and their staffs; a decentralized district system is disruptive of the pattern of professional and personal relationships at all levels, the quality

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[7] Quoted from Mott at. p. 1143.

of which is critical to the effectiveness of any health department etc(ibid).

Thomas and Hilleboe conceptualized further this problems to: two interacting problems in administrative decentralization-specialists viz generalists-each of which accelerates the complexity of others as the size the community (served) increases the greater the need for decentralization. The larger the community...the greater amount of specialization that is likely to occur. The more specialization, the more intricate become the patterns of relationship among generalists and specialists in both the central office and the field offices (Thomas and Hilleboe 1968:622). In this situation the question 'locus' of decision-making authority is always a controversial issue. Therefore unless you have a legal instrument which will provide a precise decision making powers and procedures the central office personnel would have the advantage of resisting the shifting of powers to its lower levels because of the positions and power they have; which will enable them to successful resist meaningful and genuine decentralization.

Another important factor is the question of political influence. This is manifested by the tendency in many countries for strong centralized government control of not only health but also other sectors. Although some may argue that centralization may permit a more equal distribution of services throughout the country, to the benefit of the poorer areas, still decentralization has many advantages in relation to developing support for community involvement. However Collins observes that: decentralization should be viewed as both a product and a determinant of political conflict (Collins 1989:168). This is so because decentralization concerned with the distribution of power and the allocation of resources. This is shown by the fact that many countries have attempted to decentralize administrative procedures, while at the same time centralizing control over policy, legislation and budgetary activities (Conyers 1983:113).

In the similar vein, Björkman says that: despite the abiding

interest in and justification of decentralization, however, center-periphery relations throughout the world reveal a privileged role for central authority. This empirical trend derives from three factors of a particular relevance to the Third World. First, central governments retain most of the formal constitutional powers. Second, given the control (both formal and informal) over the few resources available, central governments are the most visible wielders of authority. And third, deriving from the previous factors, citizen usually accord much more legitimacy to central governments than to local or regional levels (Björkman 1993:5).

Therefore in a very centralized system, definitely local activities will be directly and tightly controlled, both administratively and financially by the MoH and other central bodies. In a decentralized system, health staff are expected to form part of a strong local government, financed locally, with plans formulated and implemented locally, the MoH is expected to possess only limited responsibility for policy-making, standard setting, co-ordination and highly specialized services. Furthermore intermediary degrees on decentralization also exist, where the MoH retains some control but local authorities remain with substantial autonomy.

Some developing countries such as Papua New Guinea (Reagan 1991:36), and the Philippines have come up with very elaborate legal instruments. Particularly the Philippines, its Local Government Code of 1991 (RA 7160) has clearly describe how the Department of Health (DoH) is going to devolve its powers to lower levels.

By recognizing the fact that decentralization has some political nature which raises a number of challenges especially on the distribution of powers; this raises a need of having a legal instrument which would provide a clear delineation of functions at each level. The extent to which various functions are likely to be decentralized by the MoH, in particular types of decentralized systems, is shown in table 1 below.

TABLE 1-THE DECENTRALIZATION OF FUNCTIONS IN DIFFERENT TYPES OF HEALTH DECENTRALIZED SYSTEM. [8]

FUNCTIONS	DECONCENTRATION TO FIELD OFFICE	DEVOLUTION TO LOCAL GOVERNMENT	DELEGATION	PRIVATIZATION
1.Legislative	-	**	-	-
2.Revenue-Raising	*	**	**	***
3.Policy-Making	-	**	**	**
4.Regulation	-	**	*	-
5.Planning and resource allocation.	**	**	***	***
6.Management				
-Personnel.	*	**	***	***
-Budget and expenditure.	**	**	***	***
-Procurement of supplies.	*	**	***	***
-Maintenance.	*	**	***	***
7.Intersectoral collaboration.	*	**	***	***
8.Interagency coordination.	*	**	***	***
9.Training.	*	**	***	***

Key
- = No responsibility.
* = Limited responsibility.
** = Some responsibility.
*** = Extensive responsibilities.

[8] Mills 1990:26

Availability of skills at the local level is another important factor in any decentralized system. In the health sector a need for basic management to health managers is vital. It is submitted that prerequisites for successful management of a health system will include:

* personnel with technical knowledge and skills as well as management skills in the areas of evaluation, budgeting, supervision and planning.
* clearly delineated responsibility and lines of authority;
* logistical support for delivering supplies and making supervisory visits.
* an adequate budget (Outcalt & Newbrander 1991:119).

The management skills in a decentralized system are very important because the downward shift of responsibilities require middle and lower level managers to have, and exercise a greater range of management skills than under a centralized system. Management capabilities and health planning skills are usually very scarce at the lower levels before the introduction of decentralization policy. Most if not all policy decisions, planning and implementation had been taken place at the centre.

The need for availability of relevant skills at the local level is very important because it is always easy to spell out the theoretical advantages of decentralization; however, in practice the situation is considerably complicated. For example, "if those making decisions at the lower levels are inexperienced, inadequately qualified or corrupt, or merely overburdened, the quality of administration may actually deteriorate rather than improve"(Conyers 1983:115). Thus, before adopting decentralization policy there is a need of having institutional and capacity building to local levels about their new responsibilities; this needs extensive training both from the national to lower levels.

2.2. Policy Design:

Successful implementation of a policy largely depends on the formulation and design of the policy. If a policy is vague or equivocal definitely the result will be in the same direction. Policy formulation and design are not static processes but rather dynamic ones whereby, redesign or re-formulation can be done in the course of implementation. It is the intention of this section to look at various theories and related issues on policy formulation and policy design.

Policy design has been of interests to public policy scholars recently. However it is submitted that: policy design has existed as an applied methodology for many years. Policy design has received a number of interpretations from different scholars of public policy. Ingram and Schneider refer to policy design as either a process or a product (Ingram & Schneider 1985:5). They went on further to say that: The design process refers to the course of events through which problems are framed and defined, goals or purposes are set, and ideas for action are crafted into fully developed policy alternatives (ibid).

To them design as a process occurs at all levels of government and during all phases of policy cycles, from constitutional and statutory development through implementation by case workers in street-level agencies.

Bobrow and Dryzek on the other hand draw similarities between policy design and traditional designs. They define the former as the creation of an actionable form to promote valued outcomes in a particular context (Bobrow & Dryzek 1987:201). In this regard, policy design is seen to pursue values through purposeful activities specific to time and place. To them, context sensitivity, application of appropriately selected tools and a special focus on factors open to change by human agents, are key considerations in the conceptualization of design.

Policy content must be precise and concise; and, it must fit the political, socio-economic context in which is to operate otherwise it will fail. This contention is also supported by

Ingraham when she says: "An emphasis on policy design will raise new questions directed towards a new set of concerns, the match between problem and solution, the consideration of possible policy option and the extent to which more rigorous consideration of the components of design can realistically be incorporated into existing policy processes. These questions direct our attention to the broad significance of policy design activities. Unless we understand the problem we wish to solve and the technique we wish to utilize to solve it, we are likely to enter recurring cycles of policy failure" (Ingraham 1987:611).

Contrary to above, Smith has observed that policy-making becomes characterized by sudden policy announcements by government leaders without debate in legislative bodies (which may not exist) and without consultation with affected groups or individuals (Smith 1985:133). In this situation, the likely-hood of having a policy which is vague or not precise is high because the whole process was not consultative, deliberative or slow in order to allow time to all relevant parties participate in the debate.

Proper design of policy can be determined by a number of factors. According Bobrow and Dryzek policy design requires three core elements viz: "clarification of values to the extent where they can provide guidance for developing and weighing policy alternatives, characterization of the context of policy (policy analysis); and ascertaining the priorities of the audience of analysis. Furthermore they provide what they call as the heart of policy design: Interpretation of the social problems at hand; specification of goals of policy, identification of information needed for intelligent policy choice, actual gathering of that information, development of policy alternatives and assessment and comparison of alternatives" (Bobrow & Dryzek 1987:200-211).

The need for careful policy design has also been emphasised by Simon: "We need to understand not only how people reason about alternatives but where alternatives come from in the first place. The theory of the generation of alternatives deserves, and requires, a treatment that is just as definitive and thorough as

the treatment we give to the theory of choice among pre-specified alternatives" (Simon 1981:121).

A need for clarity is very vital especially for policies like decentralization, because decentralization is a very sensitive political issue, for it concerns the distribution of powers and allocation of resources (Vaughan 1990:150). Thus decentralization laws must be written concisely, regulations and directives should describe clearly the relationship among and obligation of officials and citizens, the allocation and functions among units, and the role and duties of leaders at each level (Rondinelli 1983:11-120). This is very important because empirical evidence has shown that; if policies are not precise it is more often that it results into ineffective implementation of a policy.

2.3. Community Participation a-Strategy.

Community participation or involvement is one of the key elements which were adopted in the Alma Ata conference of 1978 for successful implementation of PHC approach. The governments were advised to take measures to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments in the health of the people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care (WHO 1979:17).

With the promotion of decentralization policy in the health sector, the concept of community participation has been developed further. Decentralization is often seen as a means of enabling communities to participate in making decisions on their local health services in a more direct and immediate way than is permitted by representation on the type of health services board or by election of local councillors in a local government system (Mills 1991:31).

The significance of community participation may be regarded in different ways depending on circumstances. Within the MoH context, local participation is not only regarded as a device

for mobilizing additional resources at the local level, but also a shift from previous pattern whereby provision of health was seen as a government responsibility. Community participation is expected to make them more responsible to their health through contribution, sharing cost of vehicles or building new health facilities; others have organized themselves to demand a health facility from government and established goals and standards for programmes; some villages have organized parallel activities, including well-digging, drugs distribution, latrine construction, and gardening (Golladay 1980:34).

This transformation is however not an easy task, especially for a country like Tanzania whereby since we attained our independence in 1961 health services had been provided free. In this situation a precise strategy is needed in order to persuade and motivate the community to take health as their responsibility and not vice-versa. Formulating a strategy according to George and Smoke consists on: recognizing one's interests, assessing the interest of competing governments' signalled interest (Quoted in Elmore 1987:18).

Community's interest can also be among the relevant factors which have to be considered. Complementary policies with the same objective may be that those who gain influence at local level do not use it in the best interests of the entire community at large. For example, it is submitted that in India, the establishment of elective systems and institution of local government in early stages of development is likely to result in their capture by local magnates and dominant individuals, who thus obtain additional, institutionalized, and officially - supported power, patronage and subsidy (Hunter and Bottrall 1974:27).

Thus community participation or involvement is not as simple as one may think. Instead it is a very complex approach whereby clear, precise and concise instruments which will ensure effective participation are needed. In this respect, in order to have proper or effective linkages between policy formulation and policy implementation the question of 'policy instrument' is very

important. This is due to the fact that: a chosen policy instrument is a mode of intervention which is expected to set a motion in the desired changes which will lead to achievement of the stated objective (Moharir 1993:1).

Policy instrument is the generic term provided to encompass the myriad techniques at the disposal of governments to implement their public policy objectives. Sometimes are referred to as 'government instruments' or 'tools of government' (Howlett 1991:2). Elmore on the other hand defines policy instrument as an authoritative choice of means to accomplish a purpose (Elmore 1987:175). Other scholars regard policy as being determined by politics and therefore the question of choice must be there. Politics is always a matter of making choices from the possibilities offered by a given historical situation and cultural context. From this vantage point, the institution and procedure of the state to shape the course of economy and society become the equipment provided by a society to its leaders for the solution of public problems. They are tools of the trade of state craft (Anderson 1971:117-132).

Anderson submits further that: Instrument choice, from this perspective, is public policy making, and the role of the policy analyst is one of assisting 'in constructing an inventory of potential public capabilities and resources that might be pertinent in any problem-solving situation (ibid).

Therefore policy instruments are regarded as having particular capabilities and particular requisites that must be carefully matched to the job they are expected to perform. " If not all instruments are capable of addressing all problems, then a large part of the task before governments and policy analysts is to establish the technical specifications of each instrument to see which instruments are even theoretically capable of addressing a given problem (Howell 1991:3). Hence this will help the government to know the nature of the problem which is facing, look for the necessary resources and capabilities of relevant actors. In the final analysis it will be able to have an effective policy

instrument.

Thus appropriate instrument for community participation is very important; but how to achieve genuine community participation is always a problem. It is very easy for government to use rhetoric slogans that will ensure community participation; however, it is more often that the instrument chosen always eliminates the community.

2.4 Community Participation or Government Participation ?.

The issue of degree of citizen and community participation in government decisions is central to any discussion of decentralization (Outcalt and Newbrander 1993:352). Community participation in health has been further promoted as one of the component of PHC whereby it is expected that community participation would envisioned self-motivated rural communities working together with the state to design their own programs in order to improve health and development.

In the similar vein, the decentralized health system is also expected to act as a means or catalyst of ensuring community participation. However this grand vision has proven in practice difficulty to achieve.

Various authors tried to look at reasons why this is always the case. Masden has identified a number of factors which according to him impede effective participation such as: "Administrative structures and procedures associated with centralization of planning and decision making, restrictive and formalized channels which inhibits access by the poor, amongst others"(Masden 1991:34).

Another factor is legislative and operational which work against participation. Masden observes that; there are many places where there are limited rights of association, for self-employed, for landless labourers, for share-croppers, for tenants and for small farmers (Ibid). Generally there is unawareness of rights and availability of services.

Obstacles to participation can also be found within the community itself. There is frequently a lack of appropriate organization and organizational skills. There are poor communication facilities. Factionalism and different economic interests pull people in different directions, and the status quo often operates using patron-client relationships (Ibid).

All above factors show in one way or another that governments have not been able to provide appropriate mechanism for community participation. As we can recall from this discussion, the definition of community participation by WHO and UNICEF, show a utilitarian aspect of participation. Governments are assigned principal decision-making responsibility basing on the assumption that, the government would decide in the best interest of the communities. And the communities are expected to cooperate with governments plans.

Similarly, the World Bank's definition according to Morgan, is notable for its utilitarian, unidirectional bias: Communities are subordinate to governments, and should cooperate by relieving governments of financial burdens. There is no mention of community involvement in planning or decision making except to allow community members to select village health workers (Morgan 1993:69).

Thus unless governments are able to provide appropriate mechanism which will lead to legitimacy and in the final analysis institutionalization of community participation, community participation will always remain to be government participation.

CHAPTER THREE: A DESCRIPTION OF HEALTH POLICY AND HEALTH DELIVERY SYSTEM IN TANZANIA.

3.0 Introduction.

In this chapter I will look at health policy in Tanzania, its objectives, priorities, and its achievements if any. I will also describe health delivery system and how it operates. In the course of discussion I will also describe decentralization programs which took place in the country. This is important because decentralized system has been used as an instrument to pursue health objectives.

3.1 Health Policy, Its Objectives and Priorities.

The Ministry of Health has the overall responsibility of coordinating health activities in Tanzania. It has the responsibility of policy making planning, providing technical assistance and support to regions and districts. Organizing the training of health workers and administering directly the national or special hospitals in the country.

The overall health objective is to improve health and well-being of all Tanzanians with a focus on those most at risk, how to encourage the health system to be more responsive to the needs of the people.

The specific objectives of the health policy are to:

* Reduce infant and maternal morbidity and mortality rate, and to increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable and treatment common diseases.
* Ensure that health services are available and accessible to all people wherever they are in the country, whether in urban or rural areas.

* Move towards self sufficiency in manpower by training all cadres required at all levels from village to national levels.
* Sensitize the community on preventable health problems and improve the capabilities at all levels of society, to assess and to analyze problems and design appropriate action through genuine community involvement.
* Promote awareness in government and the community at large that health problems can only be adequately solved through multi-sectoral cooperation, involving such sectors as education, agriculture, water and sanitation, community development, women organization, the party and non-governmental organizations.
* create awareness through family health promotion, that the responsibility for ones health rests squarely with the able-bodied individual as an integral part of the family (PHC 1992:2).

The above objectives were seen as laudable and expected to be achieved through a coordinated action by all concerned ie the central government, local government, non-governmental and voluntary agencies and the community at large. When you consider how are these objectives going to be achieved the question of inputs become important, especially in terms of funding and human resources. Thus the MOH has been implementing above objectives while adhering to the following priorities.

* To improve the health status of its population by reducing infant mortality and increasing life expectancy through the control of infectious and parasitic diseases.
* To ensure that health care is distributed equitably throughout the country and is access to all people.
* To be self sufficient in basic health manpower and to improve management and administration in the

different levels of health delivery system.

With the above priorities, the government initiated the following programmes:

3.1.1 Health Manpower.

Since independence the government put emphasis on rural development, similarly the MoH carried out a manpower planning exercise which took into consideration the following:

* Increase health manpower in government and voluntary agency facilities, taking into account planned expansion of health services.
* Cost effectiveness of training and employing different manpower categories.
* Reduction on dependence on expatriate manpower.

When you look at table **no 3** concerning medical, para-medical and nursing professions from 1961 when the country got independence to 1991 (in selected years) we find that the number of doctors and other para-medical staff appeared to have increased magnificently. By such an increase with the potential demand for medical staff, one will note that the increase of the number of staff does not match with the population increase. In 1978, there were 768 doctors in the country, each doctor was available for every 22,757 individuals and in 1988 when there were 919 doctors each doctor was available for every 24,483 individuals. This indicates that one doctor had to serve a double number of patients because according WHO one doctor per population ratio is supposed to be 1:10,000.

On other para-medical staff, the number has also increased but does not reflect the increase of the population.

Capability of the MoH to implement its policies to a large extent depend on the financial resources allocated to it. In the following section I will look at financial resources.

3.1.2 Financial Resources.

The financing of the health sector in Tanzania is very

complex, with government funding channelled through four sources: 1). The MoH- which is responsible for financing national or vertical programmes eg AIDS control, referral hospital and the MoH itself; 2). The department of local government which provides the subvention to the districts in order to run dispensaries, RHCs and other key local programmes; 3). Revenues of district and urban councils from the development levy and other locally generated resources; 4). The Prime Minister's Office (PMO) budget which essentially covers regional and district hospitals.

Financial resources is very important especially when it comes to implementation of health policies. However this will depend on the amount of money allocated to it [9]. For-example over the period of 1980/81-1986/87, the central government expenditures on health rose nominally but declined 9 percent in real terms (World Bank 1990:28). In attempt to improve or increase the resource position of the sector, total central budgetary resources for the health sector were increased in nominal terms by 43 percent between 1986/87 and 1987/88 and by a further 41 percent between 1987/88 and 1988/89, was an increase of 11 percent in each year (**check table no 4**). This trend has significantly affected effective implementation of health policy.

Apart from above factors, there are certain national policies which had effect to implementation of health policies. For example the decentralized system in the country had impact in the organizational processes in the health sector also in terms of implementing its policies. Thus in the following section I will trace the historical development of the policy and how has it affected implementation of health policies.

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[9] The funds of the health sector referred to,is a combination of above mentioned different sources of health financing.

3.2 Decentralized Delivery System in Tanzania.

3.2.1 The Colonial Period.

The historical development of decentralized health system can not be discussed without tracing the decentralization policy. In Tanzania it can be traced as far back to the german rule in 1884-1918. Under the German administration they used 'direct rule' with little decentralization. One of the first actions taken by the German was to break down the then existing indigenous government institutions in favour of 'direct rule' (Mutahaba 1991:70). In the health sector the appearance of the German government in the late 1880s brought the establishment of the first governmental medical institutions. However it must be noted that these first hospitals were introduced for the purposes of treating colonial officers and their families, who were based largely in few existing towns (Gish 1978:14). Therefore no substantial efforts were made towards establishing health facilities for the local people.

Then follows the British administration after the 1st World War. Some changes were made and a system of local administration was introduced. The most significant change was the move from 'direct rule' of administration to 'indirect rule'. This system paved the way towards revival of the indigenous rulers which were abolished by the Germans. The legal frame work of this system was spell out in the Native Authorities Ordinance of 1927. This legislation introduced what was known as 'Democratized Native Authority' whereby chiefs of respective tribes in the concerned districts were involved in the decision making together with the elected members (Lopa 1991:3).

In practice, this tribal rulers acted as agents of the colonial administration. Only certain responsibilities were given to them while the ultimate local powers were in the hands of the colonial administration through the District and Provincial Commissioners.

The Native Authorities were given the responsibilities among others to: collect local rates on behalf of the central government

and maintain law and order. "These were often granted additional legislative and executive powers by territorial ordinances so that they could enforce the interest and development policies of colonial government" (Mutahaba 1991:70). On the health services "the British somewhat broadened the system of medical services, particularly by extending them into the country side with the creation of rural dispensaries" (Gish 1978:15). These dispensaries tended to function primarily as poor copies of the hospitals, in that they were mainly centres for curative medicine inspite of the stated intention of making them centres of preventive health care.

Further development was seen after the end of 2nd World War whereby a new framework for rural as well as urban administration which had the objective of creating elective local governments. In 1947 the tribal advisory council were established, then in 1953 the Local Government Ordinance cap 333 of the Tanganyika Laws was passed. The ordinance provided for the establishment of local councils, city, municipal and town councils in the urban areas, and district councils in rural areas, however, all were elected on restricted franchise and responsible for a very small range of functions. Few rural councils were ever established, since for a variety of reasons people were opposed to the new arrangement (Mutahaba 1991:71)[10].

This type of decentralization, according to Collins, was pursued as a means of dispersing and defusing social and political conflict in order to secure political domination. Infact, the system of 'indirect rule', and use of patron-client relations through the local chiefs, constituted a major constraints to horizontal linkages and African mobilization against colonialism

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10 It must be noted that in areas where there were local councils. Dispensary and health centres were under their jurisdiction. However as we have noted earlier the colonial government had no interest whatsoever of expanding this service. Very few local authorities had this responsibility as most of rural areas were served by missionary dispensaries which were not owned by the Government.

(Collins 1989:169).

3.2.2 Post Independence to 1981.

After Tanganyika attained her independence in 1961 there were a series of administrative amendments in order to eradicate the remnants of the past. A new system of local authority was introduced in 1962; the Minister through subsidiary legislation under the Local Government Code of 1953 made orders which confer upon the local bodies statutory instruments of establishment.

Even though each rural authority was established separately, the internal organization and the general functions of these authorities were fairly uniform:

(a) to assist the central government in the suppression of crime and maintenance of law and order;

(b) to maintain public roads in their areas, except the primary ones, which were in the care of the central government;

(c) to safeguard and promote public health for the rural areas. This responsibility entailing mainly the provision of curative medical facilities, like dispensaries and health centres;

(d) to become the local education authority for the primary schools in its area. This function not only involved the ownership and management of public schools, but in some cases also the ultimate supervision of non-council operated 'voluntary agency' or 'private schools';

(e) to make by-laws for the purpose of any of the functions conferred upon them, although as in the other functions, these by-laws needed to obtain the approval of the

Minister for local Government[11].

It has to be noted that, neither the Local Government Ordinance nor the specific instrument of establishment, detailed the organizational structure to be adopted by the councils. Nevertheless there were some clarifications issued from time to time by the Minister responsible for Local Government. However, this situation created problems. Professor Mutahaba referred to them as a lack of proper linkages on the wider national political and administrative system. He categorize the linkages into two: (1) non-authoritative linkages and (2) statutory or authoritative linkage. On the authoritative linkages the problems was the authority of Area Commissioners (ACs) over District Councils (DCs). Since ACs were presidential appointees were regarded as President's representatives in the District. They played a dominant role in the day to day running of the councils.

Mutahaba notes that the DCs were not subjected to authoritative controls of the national system, since the aim was to encourage citizen participation in the government. Whereas the defunct Native Authorities had previously been subjected to statutory control by District and Provisional Commissioners. The reorganization of regional administration removed such responsibilities from the domain of these officials; the only statutory linkage between the DC and the central government was in grants-in-aid (Mutahaba 1991:74-75). Even though the statute did not prescribe for direct control of the DC, empirical evidence shows that the ACs were actually controlling the DCs under the umbrella of Staff circular no 5 of 1963 which stated that among the job of ACs was "to improve political oversight and leadership of government services and development" (Central Establishment 1963:3). Thus this could and actually interpreted broadly to include what the DCs were doing.

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11 1. Emphasis in clause (c) is mine.
2. This is just a summary of the functions. For a detailed you can check the repealed Local Government Ordinance of 1953-cap 333, Article 52, 1.153.

Another development was made in 1967, whereby there was an introduction of the Arusha Declaration which aimed to give power to the people for their decision making and implementing their own development activities. It also called for institutionalization of planning process which had to start from the village to the National levels. It was based on African Socialism (Nyerere 1967:12) in which people were to carry out their activities collectively. This was popularly known in 'Kiswahili' as *Ujamaa* (Cooperative villages or family hood).

This was followed by the publication of the Tanganyika African National Union (TANU) party guidelines (Mwongozo) which was regarded as an instrument for citizen participation at the local level: " The duty of our Party is not to urge people to implement plans which have been decided upon by a few experts and leaders. The duty of our party is to ensure that the leaders and our experts implement the plans that have been agreed upon by the people themselves (Mwongozo 1971:S).

All above events were a prelude to decentralization policy of 1972. The 1972 decision to decentralized was designed to strengthen the role of the region and district in order to cut down the amount of decision making. Thus the traditional local governments were abolished. Local officers were absorbed into the national civil service and decentralized national Ministries. In justifying abolition of local government , the former President of the United Republic of Tanzania 'Mwalimu' Julius K. Nyerere had this to say: "The abolition of the present system of local government does not mean the abolition of local representation. On the contrary, the purpose of the new system is to increase the people's participation in decision-making, and it will therefore demand that the powers and responsibilities of local representatives are increased" (Nyerere 1972:3).

This new system had the following objectives: (1) to democratize and decentralize the planning and development activities of the country by bringing the rural masses into the development planning process; (2) to confer spending authority and

project development capacity on regional and local authorities as a way of reducing red-tapes and also as these authorities were closer to the people, they appreciated and understood more local problems than the bureaucrats at the centre; (3) to promote local self-help activities and integrate them into development process; (4) to promote inter-regional equity; and (5) to enable the party to have full participation in the process of country's development planning right from the grass-roots to the national level, thereby ensuring the implementation of the national objectives (Blue and Weaver 1977:8).

All district and urban councils were abolished under the new Decentralization Act no 25 of 1972. And paved the way to "Madaraka Mikoani" (power to the regions). This decision was however predictable, for over the years the local government authorities had been loosing their powers and functions. Since 1969, the Ministry of Communication has taken over the responsibility for maintaining district roads, **while the Ministry of Health took over the health centres**[12](Rweyemamu 1973:122).

In the similar vein, Picard observes that: There was a cruel irony to each of these political decisions. Each was designed to encourage rural development and popular participation in its planning and implementation. However, each of these decision took planning further away from the rural areas that was designed to serve and made popular participation in rural development increasingly more difficult (Picard 1980:440).

These changes enhanced the status of regional leaders and officials. The Regional Commissioner(RC) a presidential appointee, s/he as the official representative of the government was given the status of a cabinet minister. A new post of a

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12 During the colonial period, the then Department of Health (DoH) had responsibility of health services from the central to district levels. Except for the few health centres which were administered by the defunct Native Authorities. However in 1972 the MoH decentralized some of its functions to regional and district directorates.

Regional Development Director (RDD) was created and carried similar status as Principal Secretary. The RDD according to staff circular no 8 of 1972, was regarded as executive officer in the region, under the RC. The RDD was therefore, required to ensure that there was proper consultation with the RC rather than with the people in all decisions affecting development of the region.

The initiative and responsibility for development activities in the development ministries, such as ministries responsible for matters relating to **health,** education, agriculture, natural resources, commerce and industries, ujamaa and cooperative development, public works, water and land development were decentralized to the regions. This means that these departments ceased to be a collection of ministerial representatives, they become integrated into single administrative and development units to be known as Regional Development Directorates, under the leadership of the chief bureaucrat- the RDD.

Despite the above trends, the MoH was trying to fulfil the overall national objectives by putting more emphasis on the rural areas, and the decentralization policy. In its 2nd Five Year Development Plan (1969-1974) the health section stated that: " The principal objectives in medical development are to bring about society of healthy Tanzanians, in which the individual has a reasonable prospect of survival through childhood and normal adult years, free from incubus of infection of preventable disorders, and able to obtain medical aid when s/he needs it. These objectives will be pursued through a coordinated and increasingly integrated national health service, utilizing to the full the facilities made available by the central government and local authorities, and the voluntary and other agencies-the plan will increase emphasis on the development of preventive and rural health services, through agency of rural health centres[13] (SFYP,Vol 1).

Therefore the above quotation makes it clear that the objective of the SFYP was to integrate national health services

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13 Emphasis is mine.

with emphasis on the rural areas. However when a mid-plan review was done in 1971/72 it was noted that still there was imbalance between urban and rural health services, and actually it had even got worse. The review also identified that the problems at the MoH were especially inadequate planning capacity and lack of a machinery for control of development. In short, the plan was critical of both the lack of implementation of the second plan and conceptualization of the plan itself (Hamel 1981:11).

In order to rectify some of these problems, in 1972 the MoH adopted a new health plan which followed the spirit of the Arusha Declaration which aimed at a greater development of rural health centres, dispensaries and preventive services. This plan called for 25 RHCs and 100 dispensaries to be opened annually; resulting in a total of 300 RHCs and 2,300 dispensaries (one per 50,000 and 6,500 respectively) by the year 1980 (World Bank 1989:50).

Again, when a sector evaluation was conducted in 1979 it showed that the above targets were impossible to reach due to financial reasons. Thus in the late 1970s, a new 'Long Term Perspective Plan 1981-2000' was endorsed: The plan set objectives for the health sector in terms of mortality reduction, with a target of life expectancy of 60 years from the previous of 50 years, and infant mortality rate of 50 per 1000 from 137 per 1000, by the year 2000 . Instead of one dispensary per village, the aim was one village health post in every village that did not already have a dispensary or RHC (LTPP, 1981-2000).

Then follows the Alma-Ata declaration of 1978. The declaration proclaimed the PHC strategy which was welcomed by Tanzania's government , since the government had already been trying to put into practice the principal there established. To bring Tanzania's current strategies closer to the Alma-Ata conference recommendations, the Government decided to embark on a major effort to train village health workers (VHWs). Unfortunately a first attempt of training this type of workers had already failed in the early 1970s. The World Bank notes that: the causes for failure had not been adequately identified and apparently were not

taken into account in the new initiative (World Bank 1989:50).

In the 1984 MoH/WHO review of the Tanzania PHC strategy indicated that a major flow of the long-term plan, mainly the achievement of coverage of health facilities would require a doubling of health budgets by the year 2000, given the projected population growth . However health budget had been decreasing year after year. Table 2 presents a functional analysis of government expenditure by purpose since 1970/71 to 1986/87. The table shows that the total share of basic social services in the budget including health has decline from 25.01% in 1970/71 to only 19.83% in 1978/79 considering population rise.

While agreeing with the above contention, both the 1971/72 mid-year plan review and the World Bank observed that the causes of the failure had not been adequately identified; also there was lack of appropriate machinery for implementation. This indicates that despite decrease of health budget the main cause of the failure is lack of a proper strategy. Thus unless the MoH is able to formulate appropriate strategies all these plans will act just as bureaucratic or formalistic plans.

Ten years after introduction of decentralization policy, neither the MoH had a proper mechanism nor did the central government realize the intended objectives of involving the people to ensure development initiatives being generated at the grass root level. The government decided to introduce a different form of decentralization-devolution of powers to local government. Thus in the following section I will try to look at the 1982 policy, and how far does the MoH tried to operationalize its policies through the newly introduced system.

3.2.3 Re-Introduction of Local Government from 1982-1992.

The need for re-introducing local government in Tanzania was seen by the government of Tanzania as a condition *sine-qua non* for citizen participation at the local level. It was felt that one of the mechanisms for citizen participation in the district could not

be realized under the 1972 policy.

The ruling party C.C.M issued party guidelines of 1981 with the aim of enhancing democracy by involving people in making decisions through local government (C.C.M 1981:2). This move was adopted by the government when it passed the Local Government Act of 1982. It's operation came into effect in 1984; the Act states categorically that the aim of re-introducing local government was to provide a more meaningful decentralization of government administration, by facilitating the more effective democratic participation in decision making and implementation at the village, district and region levels (URT 1982:2). In trying to show its commitments towards forming a democratic form of government which would lead to effective participation; the government amended the constitution in 1985.

Article 145 of the constitution, provides that: There shall be established local government authorities in each region, district, urban area and village in the United Republic (URT 1985:85). Article 146 of the same constitution provide further that: **Local government authorities exist for the purposes of consolidating and giving more power to the people**[14]. The local government shall be entitled and competent to participate and involve the people in the planning and implementation of development programmes within their respective areas of authority and generally throughout the country (ibid). The sectoral ministry were required to operate in line with this overall national policy.

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1. Emphasis is mine.
2. Some legal analysts argue that; the amendment of the constitution would mean creation of a new type of local government. However it is not the intention of this study to go into details on those legal technicalities.

3.3 The Existing Health Delivery System in Tanzania.

The MoH since 1972 continued to have overall responsibility of coordinating health services in Tanzania. It had the responsibility of formulating health policy, strategies, planning, providing technical assistance and support to regions and districts, organizing training of health workers and administering directly the national consultants and special hospitals in the country[15].

The objectives of the Tanzania health policy were still carried out through an integrated national health service which utilized facilities and manpower made available by central government, local authorities , voluntary and other agencies. The MoH was ultimately responsible for all national health planning and health care programmes, but much of the implementation had been delegated to regional and district directorates. Since the 1972 the responsibility of health service was divided between the MoH and regions; thus the 1982 local government law didn't bring much changes on management and organization of health service in the regions and districts. Except for the Rural Health Centres (RHCs) which were taken by the MoH in 1969, were handed back to the newly re-introduced DCs.

The organization and management of the health sector at the regional level remained to be headed by the RMO. S/he is regarded as the director of regional health service and responsible for planning, managing and supervising the implementation of all health activities in the region. Administratively s/he answerable to the Regional Development Director (RDD) who is under Prime Minister's office (PMOs), in technical matters s/he is answerable to MoH.

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15 This study will only concentrate on bureaucratic organizations which provide health services in Tanzania. It has to be noted that apart from government institutions; health service is also provided by other institutions such as voluntary and charitable organizations, and private institutions or individuals.

The district level organization and management of the health service is headed by a DMO. S/he is in charge of both the district hospital and facilities are under the local authorities. DMO is also responsible for running of hospital and health services in a district. S/he is also responsible and answerable to the District Executive Director (DED) - executive head of the DC. On matters related to the running of health centres, dispensaries and PHC s/he is answerable to the District Council (DC).

Administratively DMO is supposed refer to RMO/RDD on matters relating to the running of district hospital. The finances for the district hospital are controlled by the District Administrative Officer (DAO) in the District Commissioner's Office. The DMO who is supposed to be the overseer of all health activities and implementation of health policies at the district level but he does not have powers to make decisions on expenditure which is a necessary condition of his/her planning and budgeting responsibilities. This power is fragmented and rests in large part with the District Commissioner (For District Health Expenditure and Programmes).

Under the PHC strategy, "the district level is the focus of decentralization of health services. The district level forms the main operational unit of PHC. This level is led by the DMO and it must be strengthened to provide the necessary for the peripheral health service. Quick, effective and relevant decisions need to be taken and implemented at this level" (PHC Strategy 1991:10). Therefore the DMO is regarded as a link between the central government (PMOs and MoH) and the DCs which runs the health centres.

The Harare Declaration also emphasised this: "It is particularly clear with regard to the requirements of 'a single health district authority, with power to decide and including health centres, specialized ambulatory clinics and a general hospital" (Harare Declaration 1987). The document stated further that: The unification command in a district should facilitate community involvement in the management and control of services.

At the district level, PHC committee is supposed to facilitate community participation by making guidelines and initiatives for the same purpose. However the committee is composed of bureaucrats; it is chaired by the DC, other members include:

- District Executive Director;
- District Agricultural Development Officer;
- District Livestock Development Officer;
- District Community Development Officer;
- Secretary Social Services & community of CCM;
- District Health Officer;
- District PHC coordinator and
- DMO - Secretary (PHC Strategy 1991:11).[16]

Contrary to above, United Kingdom has what is known as District Health Authorities (DHAs) which are responsible for the hospital and community services. Members of the DHAs are derived from a variety of disciplines to include a hospital consultant, a general medical practitioner, one nurse, midwife or health visitor, a nominee from a university with a medical school, four members appointed by local authorities, plus other members known as 'generalist', one of whom is recommended by the trade union movement (Baugh 1983:66).

In the local Government Act of 1982 there was no proper linkage, these local governments were re-created in order to improve management of public affairs at the local level . However the Act has general statements, for example in the health sector local government were created: for the furtherance and enhancement of the health, education and the social, cultural and recreational life of the people (Local Government Act 1982: S 111(2)(a)). If you look at this provision clearly, there is no much difference with the 1962 instrument which created the then Local Government law immediately after independence. This

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16 How this committee works from central to lower levels is shown in annex one.

structure has however created a number of problems especially at the district level which is regarded as operational unit for effective implementation of health policies.[17] A detailed analysis will be seen in chapter four of this paper.

The last level under Tanzania's political and governmental level are communities or villages which are expected to make their contribution to their health care. Their major inputs is supposed to be a support for the Village Health Workers (VHWs) who are trained by the MoH but are supposed to be paid either in cash, kind or services by the community. The VHWs are supposed to operate from the village health post and provide simple medicine, nutrition and health organization, and also to promote village sanitation. The DCs are responsible for maintaining the facility based services in health centres, dispensaries and village health posts.

In the following chapter I will try to analyze the problems in management and organizational processes from national level, with special emphasis of the district which have contributed to poor implementation of health policy.

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[17] For a detailed relationship between MoH, PMO, RMO, DMO and DC see annexes two and three.

CHAPTER FOUR: ANALYSIS OF IMPLEMENTATION OF HEALTH POLICY IN A DECENTRALIZED DELIVERY SYSTEM.

"The more one reads and hears about decentralization, the more one becomes sceptical and indeed suspicious of policy statements proclaiming its required implementation" (Collins 1989:168).

4.0 Introduction.

The decision to decentralize in Tanzania in 1972, and later in 1982 was a political one involving many sectors including health. Because of this, no specific objective was set with regard to sector by sector but rather it was taken as a general national policy; whereby each sector was obliged to further operationalize objectives of decentralization. Similarly in the health sector no specific objectives were set in line with the national policy.

Nevertheless, the MoH through its policies and plans made some efforts in order to conform with the overall national objective. However, as from the late 1970s and early 1980s after the Alma Ata Declaration, decentralization became the theme in the health sector. It was viewed as one of the key principles of PHC (Collins 1989:168) which also advocated for community participation.

It is the intention of this chapter therefore to analyze the problems of implementing of health policy in the context of a decentralized system. It will concentrate on the following factors: (a) Ambiguity in the relevant legislation; (b) Lack of appropriate strategy towards community participation; (c) Policy instruments for community participation and (d) Resource allocation and organizational problems.

4.1 Ambiguity in the relevant legislation.

Decentralization policy in Tanzania is governed by two legislation viz The Decentralization of Government Administration(interim) Act and The Local Government Act of 1982. The former legislation mainly governed the regional administration, while the latter is specifically for the local government. These two legislation are the base of the overall policy objective of the country; therefore, they were supposed to be as clear and concise as possible. "Ambiguity of goals make actors at different levels to perceive and interpret goals differently, ignore lessons or suppress them to their interest" (Hulme 191:16). This is an important factor especially in the decentralization adopted by the health system will to a considerable extent determine the functions that a decentralized health agency can perform

The two laws do not prescribe the roles to be performed by sectoral ministries. For the MoH nothing is said about the levels of authority and responsibilities to be performed by different levels in the health delivery system. "Confusion over management responsibility may individuals to take advantage of the situation, and in turn necessitates strong supervisory procedures and god financial control" (Vaughan 1990:141).

This situation, especially in the MoH where there is a dominance of specialists, explains why the few managed to control power at the centre [18].

In the Phillipines, its government has a very elaborate Local Government Code of 1991 (Republic Act 7160). The Act has clearly stipulated which functions and responsibilities are to be devolved from the Department of Health (DHO) to Regional Health

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18 I once had opportunity to talk to the former head of the hospital service department in the MoH about this issue, Dr Tarimo now the head of strengthening of district health services at the WHO headquarters- Geneva. He commented that since independence majority of ministers heading the MoH were specialist medical doctors. This indicates the reasons for resistance because specialists have tendencies of withholding powers at the centre.

Office (RHO), The Provincial Health Officer (PHO), the District Health Officer (DHO), and the Municipal Health Officer (MHO).

The Act went on further by providing a memorandum of agreement between the DHO and its lower levels. In the memorandum, specific functions, programmes and services to be devolved are:

- the provision of capital outlay for the hospital;
- purchase of drugs, medicine and medical supplies;
- appointment of all personnel according to DOH qualifications and standard; and
- all other assets, liabilities and records of devolved structures, programme and services (Tracena et-al 1993:32)

Apart from this kind of a binding agreement, the DOH has delegated the function of monitoring of health policies to its subordinates boards, whose members would serve as DHO representative and be answerable to the DOH.

4.2 <u>Lack of Appropriate Strategy towards community participation</u>.

The concern here is the strategy adopted to pursue a decentralized health system with emphasis on community participation. Decentralization has been taken by the MoH as an instrument to health policy, specifically with regard to community participation. However when you look at the MoH primary health care strategy together with community involvement in health document, both documents refer to decentralization as a magic box to realize health objectives. For example, the PHC strategy states: "...Quick, effective and relevant decisions need to be taken and implemented at the district level. This require affective decentralization not in terms of health care delivery but also for effective political and administrative purposes"(PHC Strategy 1991:10). While the community involvement in health document stated: "The government decentralization and local government system is meant for greater support to community effort" (Community Involvement 1989:1). The document does not say how can this policy be used not only to implement health policies but also

on how to encourage community participation. There was establishment of primary health committee with the aim of increasing community participation, however these committees have no legal status like other committees established under the local government law. Only committees established as sub-committees under this legislation have powers for setting or approving any district plans or budgets; unlike the committees established on the basis of ministerial policy papers.

Furthermore, the documents do not say how this instrument is going to be used in order to facilitate implementation. Andrew Dunsire in his paper titled "Theory of implementation" sees 'strategy implementation' as one which addresses itself to the question of how one can achieve its policy objectives, whether by direct means or imposing constraints on or offering facilities to other public agencies, such as local authorities or even private agencies" (Dunsire 1980:16). Even though the two documents indicate the use of local government and regional administration, still the question of how to achieve the intended health objectives through the said instruments remain to be unattended.

Apart from above, there is also a need of empowering the people/community. In such process of 'empowering' what matters most is not whether or not there are elected bodies at the local level and certainly not the presence of high-level civil servants with lots of authority delegated to them. Instead, empowering people must mean their awareness and involvement [19] (Pradhan and Reforma 1991) .

This process can not however be done over night. Instead it has to be part of cultural transformation over a period of time. Since government-community relationship has always been superior-subordinate; this transformation should start by bringing about changes in the perceptions and their relationship. In order to bring about these changes, Joshi has identified the following perceptions need to be changed:

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[19] Emphasis is mine.

(i) People in the districts perceive their destiny to be in their own hands rather than having to look for guidance from government officers or political leaders.

(ii) Government bureaucrats and elected office bearers are not seen as transformed version of old "Bada Hakims" (Governors). But rather, they are seen as public servants at the disposal of the local people.

(iii) Local elected bodies or local bureaucracies are seen as subordinates to the users' groups. In other words, user's groups, freely formed and independently operating, become the basic expression of the empowerment of the people (Joshi 1993:58).

Joshi observed further that: These transformation can not be realized unless there is a higher level of literacy and a higher level of awareness among the people but also until the elected officials and bureaucracies cease to view them selves as rulers in the district (Ibid). Thus this transformation has to be taken in two angles, first organizations and bureaucracies have to transform their perceptions and secondly the community.

World Bank has observed that: the prerequisites and conditions for community involvement are lacking in many countries despite symbolic commitments and international conferences on the subject (World Bank 1993:87). WHO on the other hand observe that, medical officers at the local level often fail to appreciate the value of community participation, nor are they sufficiently trained or motivated to facilitate community involvement. Hence the most critical requisites are sustained political commitment, and where necessary, retraining of staff (WHO 1988:56).

Thus there is a great need first of having political commitment which in the end would engeener retraining of bureaucrats in order to change their perceptions, and also the community should be made to feel as part and parcel of government's activities.

4.3 Instrumentalities adopted for Community Participation.

"One of the principal responsibilities of government is to match the available instruments of policy -the levers the public sector actually controls the objectives. Much of governments' failure to achieve better health outcomes derives not from the wrong objectives but rather from the wrong choice of instruments.." (World Bank 1993:71).

The aim of this section is to answer the last hypothesis whereby the argument is that, the instrumentality adopted for community participation actually eliminates it. In chapter three I showed that the district level has been identified as an appropriate level for not only implementation of health policies but also for initiating community participation. This is expected to be done through PHC committee as described in page 44 of this paper. However the committee is full of technocrats without a representation of the community. If you look at annex 1 which is supposed to be a mechanism for community participation from national to district level, however the community itself has been left.

This situation supports the definitions of community participation by WHO and the World Bank which indicate that the community is subordinate to the government hence community has to adhere to what governments prescribe to them. Other countries have promoted community participation through elected members of the local authority. Some countries have called such organizations as hospital management board or District Health Authority. Members can be elected by a general population or by a limited constituencies. Such organization exist in a number of countries both in developing and developed countries, Sri Lanka has hospital committees, administrative council at hospital levels and regional committee in Italy, health system agencies in the US, regional council in Canada, provincial and district health team in Zimbabwe, district and regional health authority in the UK (Baugh 1983:68).

4.4 Resource Allocation and Organizational Problems.

In chapter three I described the role and functions of the DMO in a district. In the Health Delivery system, the district has been identified as an ideal organization through which to introduce changes in the health system. At this level, health policies, plans and practical realities can meet and feasible solutions can be developed - that is provided sufficient responsibility and resources can be made available (Vaughan et al 1985: 9).

The finances of the health sectors are channelled through four sources as indicated in page 30 of this paper. One basic problem for district managers (DMO) is the way funds are channelled from the central to the district level - partly through the DED and partly through the District Administrative Officer (DAO). This situation has resulted in apparent chaos in the resource allocation process. This is reflected in the substantial differences within and between districts in budgets, allocations and expenditure levels, resulting from: the failure of the national level to pass to the district level the approved allocations. Such a practice within districts of making expenditure against the health account for other sectors, and the process of budgeting being undermined by the cut-backs made in each step of national budget developments.

The concern here is the power of the DMO over resources allocated to health sector in a district. Past experience show that since the DMO had no powers of resources allocated to health for primary health services under the DC; most of the funds were used for other purposes and not to the intended health programmes. However in 1991 the MoH had to intervene and introduce a special account (account no 6) whereby both the DMO and DED are signatories, hence it has helped the DMO to control health expenditure.

However when you look at the funds which are channelled through Prime Minister's office to District Commissioner's Office, it is the DAO who controlled it. Thus the DMO does not have power to make decisions on the expenditure which is a necessary corollary of his planning, budgeting responsibility and in the final

analysis implementation of health programmes and policies. This pattern of resource allocation at the district level has virtually undermine the authority of the DMO in not only initiating health programmes at that level but also implementing health programmes which the MOH would want him/her to do. Similarly at the regional level RMO faces the same problem because the funds are controlled by the RDD the RMO has no power whatsoever over those resources.[20]

Another factor is related to certain programmes which are directly administered by the MOH. These are retained by the MOH since are viewed as a national priority. These programme are such as maternal and child health programmes, Expanded Programmes of Immunization, child Immunization programme, Tuberculosis and leprosy control programme, diarrhoea control programme to mention only a few,

These are referred to as vertical or centralized programmes. Gonzalez took this vertical approach to mean: "call for solution of a given health problem through the application of a specific measures through single-purpose machinery" (Gonzalez 1965:17).

Currently the MoH runs about seventeen programmes which are well funded by donors and therefore the implementors at the region and district level would concentrate more on this type of projects and ignore the ones which were formulated at the district level. A lot of complaints have been raised to the MoH because of this type of projects which are centrally controlled and the programme managers have to get directives from the MoH; some people question whether the MoH is really decentralizing its functions or it has actually extended them.

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20 This situation was also observed by the former Principal Secretary in the MOH-the late Mwabulambo who once was RDD in one of the region in Tanzania. Since he had special interest in health he would always agree with what the RMO plans and recommends to him. This however is not a good trend because health programmes have to be implemented. Thus there is also a need of introducing a special mechanism, both at the district for the funds which are controlled by DAO and at the region for the funds which are controlled by RDD.

This problem is vividly seen in the district level. In the health sector, the district level is regarded as the organizational level that health policies can be implemented. Again the vertical programmes also tend to distort district level health priorities by securing personnel and time. Furthermore even though the DMO is suppose to be the counterpart to vertical programmes, practice has shown that it is often that the project coordinator who has direct access to the programme hierarchy and its funds, equipments and vehicles s/he even by-passes the DMO and works directly with rural staff who are supposed to be supervised by him/her.

The role of the DMO also creates problems, because s/he is in charge of the district hospital run by the central government and s/he also acts as a link between the central government and the district councils which are responsible for the rural health services. This situation requires the DMO to serve four masters. As a central government employee s/he refers to the RMO/RDD in administrative matters relating to the running of the hospitals; however, finances of the district hospital are controlled by district administrative officer (DAO) in the District Commissioner's office. In medical matters s/he refers to the RMO and to the MoH. In addition, the DMO being responsible for medical aspects of rural service must advice the DCs which runs them.

Another problem is that, even though the DMO is supposed to supervise implementation of various health programmes in RHCs, dispensaries and clinics are under the DC. However the DMO has no administrative powers for such aspects as employment and discipline over the council's staff that s/he supervised. No did the DMO have any executive powers within the council, his/her position can be described as advisory.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS.

5.0. SUMMARY.

At the opening of this study, I quoted Naustadalislid, who observed that health development in decentralized system is not only ambitious, and may be unrealistic, but it invites a number of methodological challenges (Naustadalislid 1992:27).

In this study I have looked at implementation of health policies under decentralized system. As we have seen, decentralization policy was first adopted as an over all national policy. However it was later adopted by the MOH as an effective means of implementing health policies at the local level and also as a means for community participation in health.

However the study has shown that' there was no effective implementation because of a number of methodological challenges. One lesson which we have learned from this study is on the theory of implementation for health and social development. Implementation largely depends on the functionary of multi-institutional, multi-actor and multi-level systems. Sometimes these complex systems already exists; sometimes they have to be set up by national mandate (Björkman 1993:3). The study has shown that, the health system in Tanzania is provided by various levels from national to village levels. The main problem is lack of a proper linkage or mechanism among various levels. Lack of a clearly defined division of responsibilities, authorities and powers especially for health managers at the district level have contributed poor implementation of the health policies.

Thus if MOH is to effectively implement its policies there is a great need of having systematic research into linkage between broadly decentralized development and administration and more narrowly focused on health care system (ibid). This will help to identify issues and resolve questions of responsibilities power and authorities which need to be resolved.

Apart from above general observation, the following are specific recommendations as mentioned hereunder.

5.1 RECOMMENDATIONS.

* If the MOH wants its policy to be effectively implemented, there is a need of adopting a health decentralized system. Whereby the MOH can delegate specific powers, functions and authorities to specific bodies, like what the Phillipines has adopted by devolving functions to Regional Health Offices, Provincial Health Office, District Health Office and Municipal Health Office. These level have powers and full autonomy in their respective levels with regard to implementation of Health policies. This power does not only include decision making but also administration of financial resources. The DOH remained with the responsibility of standard setting and policy formulation.

* "Decentralization will be successful only when local government, health agencies and hospitals have sound financial base, solid administrative efficiency" (World Bank 1993:163). It is important therefore while the MOH devolve some of its functions to lower levels.It has to make sure that, those levels have ability to raise revenue in order to implement local programmes. If big share is to come from the central government then it would mean another way of strengthening the central government.

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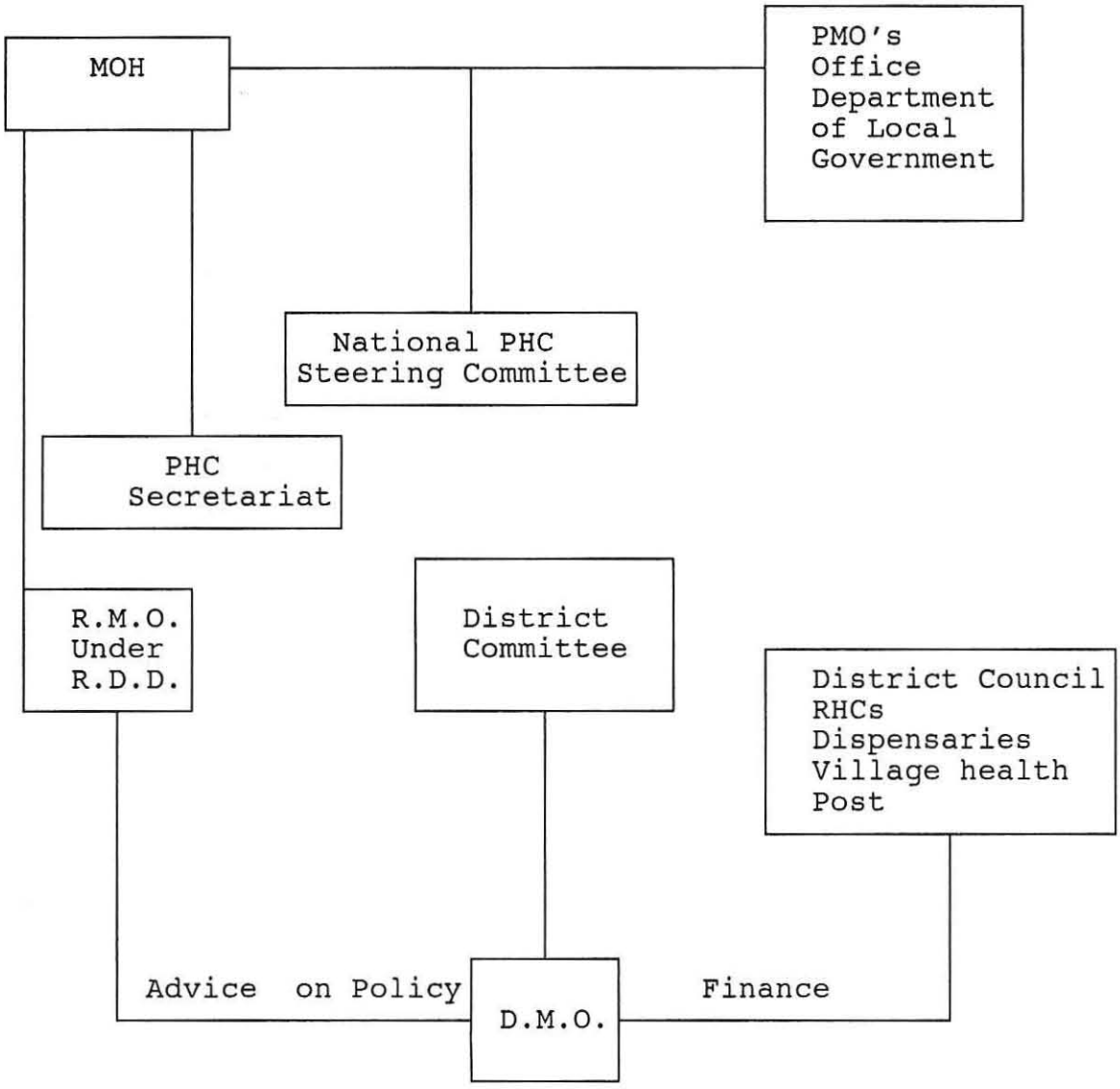
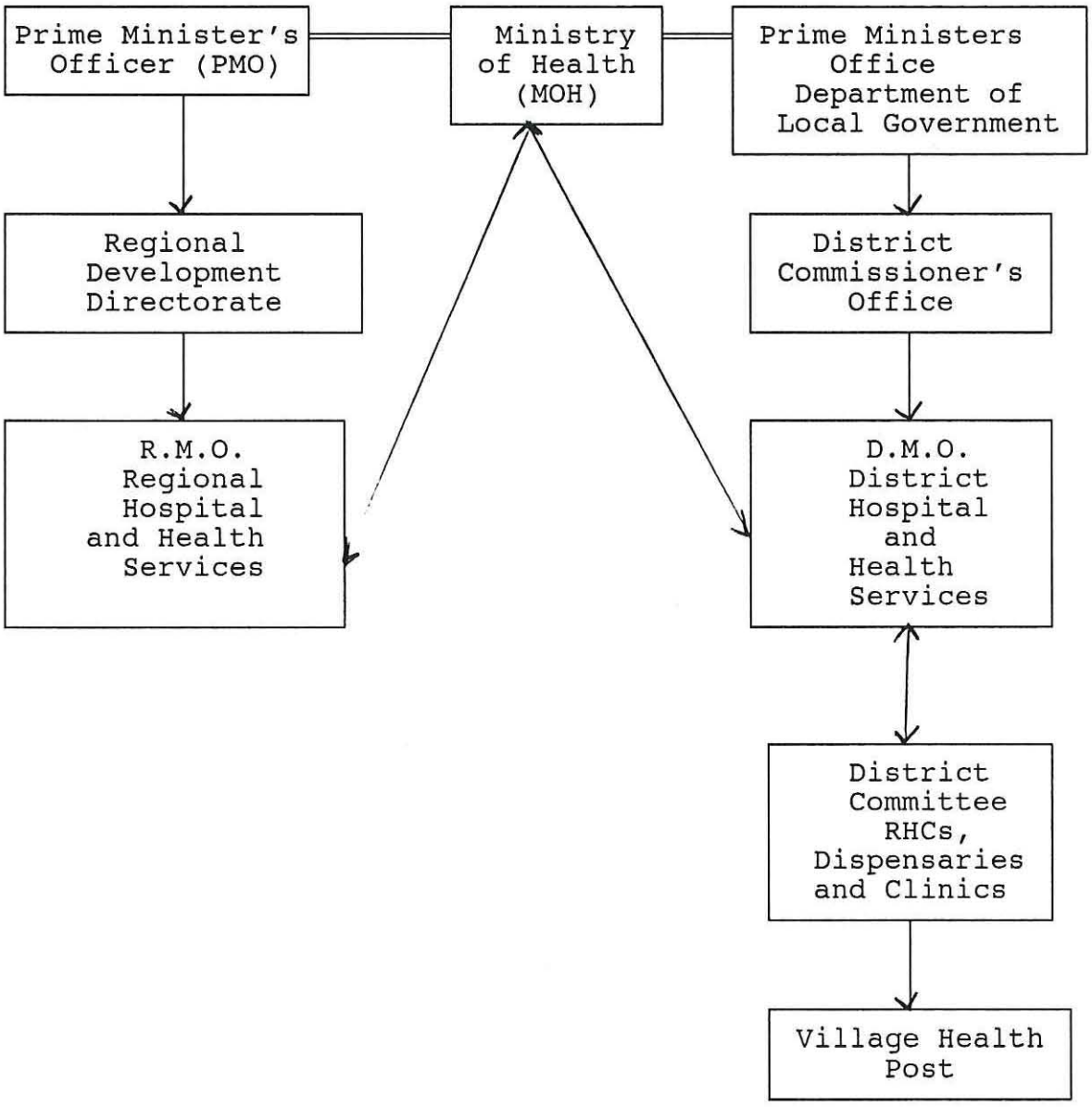
Annex no 1: <u>Strengthening of Community Participation through Rural PHC</u>.



Key:
Reporting Links

Source:
World Bank 1990:98.

Annex no 2:
Responsibility of the MOH in relatioon to the Regional and District Services in a Decentralized System.



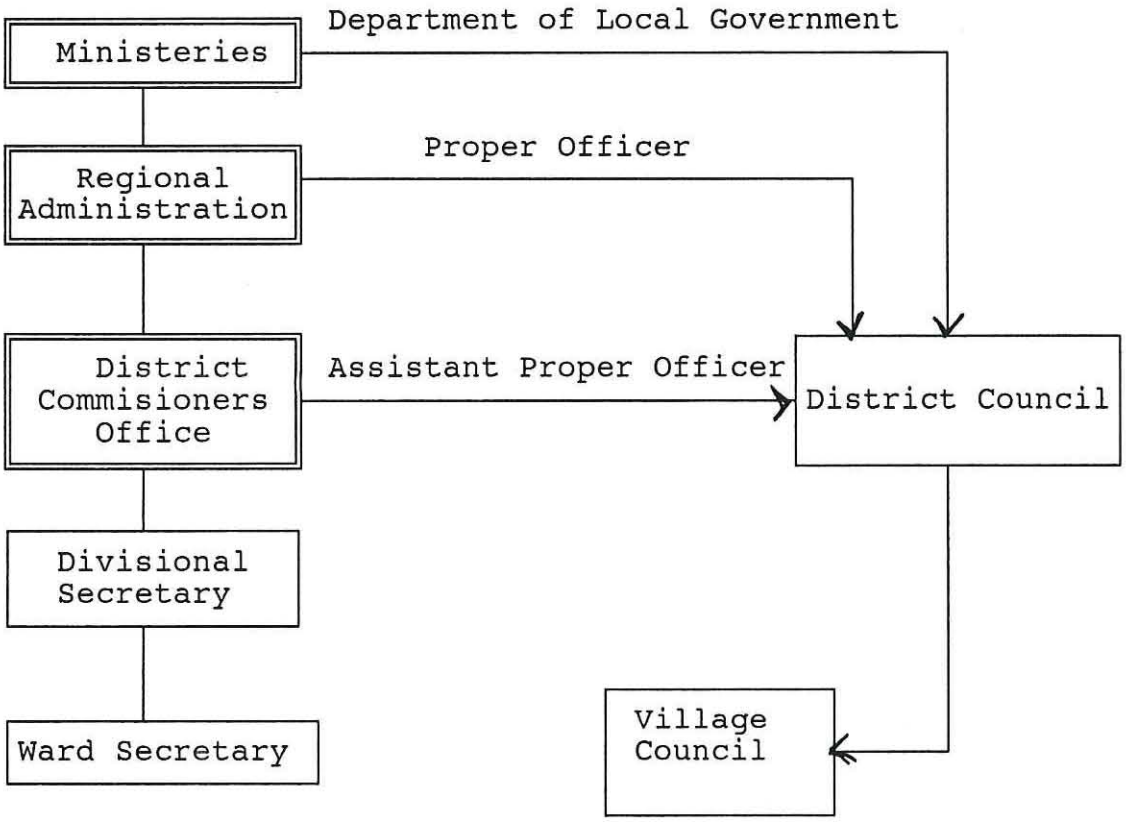
Key:

Inter Ministerial Communication
Direct Control on Administrative matters
Direct Control on Technica matters

Source: Derived from the discussion of this paper.

Annex no 3:
Simplified Administrative Structure of Central and Local Government.

General Government **Local Government**



Key:

=========== General Supreme Control

----------> Full Control

---------- Specific Control

Source: SOMBOJA 1991:49

Table no 2: Principal Categories of Health Personnel.

Category	1961	1984	1987	1988	1989	1990	1991
MD	415	1115	1053	919	978	1043	1112
AMO	181	436	283	3509	3836	4036	4081
MA	200	2383	3198	10049	10414	10492	10739
MMHA	n.a.	9598	10831	11988	12640	12913	13411
HO	n.a.	394	604	648	703	745	769
HA	n.a.	1247	2016	2179	3351	3438	3839

Source: 1. MOH, Extracted from Tanzania's Economic Survey, 1992:257.
2. WB 1990:60 for 1961 figures.

Key:

MD = Medial Doctors
AMO= Assitant Medical Officers
MA= Medical Assistant
NMWA A&B = Nurses/Midwives Grade "A" & "B".
HO = Health Officers.
HA = Health Auxiliaries.

Table No. 3.

Total Health Expenditures (Mainland) 1986/87-1988/89
(Tsh million)

	1986/87	19987/88	1988/89
Planning and Development			
Ministry of Health	69.4	76.0	285.9
Regional Authorities	62.5	57.3	124.5
District Council	64.4	61.1	78.9
Urbam Councils	42.5	28.2	68.3
	238.7	222.6	557.6
Recurrent Expenditures			
Ministry of Health	1,316.6	1,950.9	2,774.0
Regional Authorities	929.4	1,130.1	1,488.7
District Council	560.6	1,042.0	1,290.8
Urban Councils	210.9	315.0	457.4
	3017.5	4,438.0	6,009.9
Total	**3,256**	**4,660.6**	**6,567.5**

Source: Ministry Of Health, February 1989

Table no 4 FUNCTIONAL ANALYSIS OF GOVERNMENT EXPENDITURE BY PURPOSE 1970-1987
(PERCENTAGE)

Years	YEARS	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1970/71	20.01	7.05	13.68	6.17	0.47	2.19	2.50	37.98	9.96	26.01	
1971/72	17.06	9.85	14.35	**6.02**	1.12	1.38	1.78	37.05	11.39	24.66	
1972/73	18.95	9.05	13.39	**6.51**	0.40	1.17	2.14	36.78	11.71	23.51	
1973/74	16.22	10.72	11.80	**6.37**	0.44	1.90	1.66	40.37	6.59	22.17	
1974/75	16.05	11.73	12.22	**6.87**	0.33	1.62	2.09	42.63	6.45	23.13	
1975/76	15.83	12.16	14.10	**7.16**	0.37	1.84	2.43	36.91	9.21	25.90	
1976/77	17.40	12.27	13.58	**7.05**	0.24	1.16	2.28	38.02	7.86	24.31	
1977/78	14.99	15.09	14.34	**7.23**	0.24	0.89	2.04	36.37	8.80	24.74	
1978/79	14.44	24.40	11.64	**5.36**	0.26	0.88	1.69	32.10	9.22	49.83	
1979/80	16.65	8.70	12.64	**5.65**	0.41	1.15	2.17	40.74	9.37	22.02	
1980/81	10.47	11.09	12.55	**5.61**	0.31	1.31	1.21	37.06	12.40	20.99	
1981/82	17.95	12.53	12.47	**5.38**	0.28	1.03	2.07	29.82	18.49	21.23	
1982/83	17.09	8.06	13.09	**5.29**	0.31	1.09	2.00	26.99	20.95	21.78	
1983/84	22.02	12.79	11.85	**5.46**	0.29	0.98	2.05	25.97	18.77	20.63	
1984/85	29.93	13.89	7.29	**4.98**	0.47	0.98	2.24	24.17	16.06	15.95	
1985/86	26.21	9.09	7.51	**4.37**	0.38	0.64	1.91	24.29	26.60	14.81	
1986/87	25.50	14.58	6.45	**3.66**	0.28	0.50	0.50	16.49	32.15	11.39	

Source: Economic survey 1970 - 1986

Key for the table:
(1): General public service
(2): Defence
(3): Education
(4): Health
(5): Social security & welfare services
(6): Housing and community amenities
(7): Other community services
(8): Economic services
(9): Other purposes
(10): Total basic needs