TECHNICAL REVIEW OF COUNCIL HEALTH SERVICE BOARDS AND HEALTH FACILITY GOVERNING COMMITTEES IN TANZANIA

Final Report

12th December 2008
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<tbody>
<tr>
<td>ALAT</td>
<td>Association of Local Authorities in Tanzania</td>
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<td>CCHP</td>
<td>Comprehensive Council Health Plans</td>
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<td>CHBS</td>
<td>Council Health Service Board</td>
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<td>CHF</td>
<td>Community Health Fund</td>
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<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
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<tr>
<td>DbyD</td>
<td>Decentralization by Devolution</td>
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<td>DC</td>
<td>District Council</td>
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<td>DDH</td>
<td>District Designated Hospitals</td>
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<td>Dar es Salaam Public Health Delivery System Boards Association</td>
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<td>District Treasurer</td>
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<tr>
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<td>Ifakara health institute</td>
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<td>Joint Health Sector Review</td>
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<td>Health Sector Strategic Plan</td>
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<td>Local Government Reform Program</td>
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<td>Millennium Development Goals</td>
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<tr>
<td>MKUKUTA</td>
<td>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania</td>
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<tr>
<td>MMOH</td>
<td>Municipal Medical Officer of Health</td>
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<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>Medical Store Department</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>NSGRP</td>
<td>National Strategy for Growth and Reduction of Poverty</td>
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<tr>
<td>O&amp;OD</td>
<td>Opportunities and Obstacles to Development</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
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<td>SWAp</td>
<td>Sector Wide Approach</td>
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<td>TC</td>
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<td>TIKa</td>
<td>Tiba kwa Kadi</td>
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EXECUTIVE SUMMARY

INTRODUCTION

The government of the United Republic of Tanzania is implementing health sector reforms through Sector Wide Approaches (SWAPs). Among the objectives is delegation of responsibilities for service delivery from the central level to Councils and communities in line with the Government policy of Decentralization by Devolution (DbyD). Several institutions and organizations crucial in facilitating improvement of access to health care and quality of services delivered have since been created at local government and community levels. A major objective of these structures is to ensure greater participation of communities in planning and budgeting processes, implementation of programs to improve access to health services and monitoring quality of services delivered at the local level. The structures include, Council Health Service Boards (CHSB) and Facility Governing Committees (FGCs) established since mid 1990s. In line with this, community based health financing mechanisms such as Community Health Funds (CHF) in the rural Councils and *Tiba kwa Kadi* (TIKA) in urban Councils have been introduced.

CHSBs are specifically responsible for ensuring delivery of appropriate, equitable and adequate health care services and oversee functioning of the Council Health Management Teams (CHMTs). Below the CHSB are FGCs which are responsible for overseeing service delivery at facility level and foreseeing the functions of the Facility Health Management Teams. CHSBs and FGCs have been established throughout Tanzania and at the time of this review (October 2008) there were about 92 CHFs countrywide and all urban Councils have been sensitized on TIKA.

Several reviews of the performance of the health sector have revealed that many of CHSBs and FGCs are not operating optimally. These observations created interest in the Ministry of Health and Social Welfare (MoHSW) to understand what the reasons behind this state of affairs are. The MoHSW then commissioned this study to undertake an in-depth review of the way the boards and facility governing committees perform their duties and the challenges therein. Broadly the study was expected to achieve the following:

(i) Review the functioning of Council Health Services Boards and Facility Governing Committees in selected Councils and their relevance.

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(ii) Assess the level of understanding of the Council planning and budgeting process by the board and committee members.

(iii) Assess the power relations within the Council and how this impinges on performance of the CHSBs and FGCs.

(iv) Review the progress and functions of Community Health Fund (CHF) and TIK.

(v) Assess the functioning and relevance of the Dar es Salaam Public Health Delivery System Boards Association (DPHDSBA).

**METHODODOLOGY**

To achieve the above objectives, the study has been conducted through a two pronged approach: First, it involved in-depth review of existing literature on the functioning of the respective institutions, official documentations including Acts and Guidelines establishing them, published government reports as well as minutes of various meetings conducted by the boards and committees; and Second, interviews and focus group discussions with stakeholders at Council level (CHSB and CHMT) and community level (facility governing committee members and other stakeholders). The study covered the following fourteen Councils in mainland Tanzania: Ilala MC, Kinondoni MC, Temeke MC, Hai DC, Ulanga DC, Lindi TC, Hanang DC, Rombo DC, Igungu DC, Songea MC, Sengerema DC, Kyela DC, Liwale DC and Mbinga DC. Their selection was based on a multiple set of criteria to ensure that: boards and facilities from different phases of implementation of the health sector reform program are included; different health zones of the total 8 health zones in the country are covered; good performing as well as relatively poor performing Councils with respect to CHF are included; and that rural urban differentiations are taken into account.

**FUNCTION OF THE HEALTH BOARDS AND FACILITY COMMITTEE**

In reviewing the CHSB and FGCs functioning and relevance, the study has found out that in all the Councils there are critical issues affecting effectiveness with which these institutions perform their duties. As a result, while the CHSB, and FGCs have been very useful in some Councils and are considered important institutions, their relevance has been questioned in other Councils where these bodies are not functioning properly. The major reason leading to questions about their relevance is their limited capacity to deliver on responsibilities placed upon them through the guidelines. Other factors are management/operational related such as limited incentives to participate effectively in particular at the FGC level, limited financial means to carry out executive functions apart from meetings partly contributed by lack of annual action plan, and lack of platform for meeting and sharing experiences. High discretion of DMOs which leads to limited decision making power of these entities is another
impediment. Capacity challenges are also attributable to the uncompetitive selection process being practiced in some areas.

Councils in Dar es Salaam do not seem to suffer from the same capacity problem as Councils in rural areas, in part due to the fact that members in CHSBs in Dar es Salaam municipalities seem to command a higher level of understanding of the issues. This could be attributed to the fact that these institutions in Dar es Salaam have had an opportunity to attract members who are relatively more educated. But a fundamental problem that cuts across all Councils, is inadequate training provided to the CHSB and FGC members. This is a major reason for incomplete understanding among members of their responsibilities in many of the rural and urban Councils alike. It also limits understanding of the nature of relationship they ought to forge with other structures at the Council level. Further, in some Councils it was found that replacement of the elected community board members after the expiry of the tenure has not been done in a timely manner, which leads in many cases to stalling of board activities until such time when a new board is put in place.

**POWER RELATIONS WITHIN THE COUNCIL**

The assessment of power relations within the Councils with regard to how boards and their committees interact with other Council structures shows that there are some pertinent issues that need further attention. Even where the guidelines are available a problematic still exists in the sense that the guidelines fall short of explaining how power relations should work between various bodies created in the Councils to contribute to achievement of the goal of improving access to health care. For example, FGC and CHSB do not have an automatic mechanism for collaboration. As such the concerns of common interest are not synchronized and solved together; no sharing of experience and tapping of synergies and capabilities is facilitated; and even well functioning boards have not been able to contribute to build the capacities of their respective committees. These bodies tend to work parallel to one another with very little or no learning from each other even though they are supposed to be working for the same cause.

Although the line of authority between the board and Social Services Committee is clear, in majority of the cases the Social Services Committees do not really demands for the outputs from the boards and even care to see whether the boards meet as planned and the board has annual plan of action. This lack of checks and balances results to some kind of discretion on what the DMO presents to the Social Services Committee. Further, the structural link between the Ward Health Committees and the facility committees is weak since it is unidirectional, that is, Ward and Village Health Committees are represented in the FGCs and not vice versa. The wisdom of creating special governing committees for each health facility when village and ward level committees are already in place and functioning and are linked to local government authority was questioned.
Despite the fact that representatives from not for profit and for profit facilities have been elected, no meaningful achievements have been made in forging the Public Private Partnership (PPP). This is possibly caused by the fact that the national PPP framework/strategies are not clear to the boards and committees.

**IMPLEMENTATION OF COMMUNITY HEALTH FUND**

The Community Health Funds Act notes that the CHFs were instituted as possible mechanism that could help in granting access to basic health care services to populations in the rural areas and the informal sector in the country. The CHF Act (2001) also states the objectives of the CHF’s as being able to: (i) Mobilize financial resources from the community for provision of health care services to its members; (ii) Provide quality and affordable health care services through sustainable financial mechanism, and (iii) Improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.

A review of their functioning however shows that CHFs countrywide are suffering from both supply and demand side challenges which are detailed in the report. The major supply side factor is inadequacy in funding for achieving the CHFs objectives of extending coverage and ensuring high quality of services to the beneficiaries while the major demand side facto is low community sensitization. These have resulted in a slow progress in enrolment of members and in some places to withdrawal from membership. In effect even in some district Councils such as Hanang where CHF started with considerable force are starting to lose momentum.

The extent to which CHSB and FGC are involved in promoting enrolment into CHF and sensitizing communities varies across Councils but is generally limited. While funding constraints are clearly a limitation to their effectiveness in conducting sensitization campaigns, it also doesn’t appear that the CHSB and FGC adequately understand and appreciates usefulness of the CHF especially in terms of service delivered for the money invested.

**THE DAR ES SALAAM PUBLIC HEALTH DELIVERY SYSTEM BOARDS ASSOCIATION**

The review of the functioning and relevance of the Dar es Salaam Public Health Delivery System Boards Association (DPHDSBA) was undertaken with a view to draw lessons for other CHSBs. We find that the DPHDSBA has been able to achieve a lot more in
sensitization and mobilizing financial support for health service provision from interested stakeholders and its members has a clear understanding of the guidelines for CHSBs. This is in part attributed to their relatively high command of the issues involved and also because most of the members have higher capacity in terms of governance skills (leadership and management) and also in terms of formal education compared to other members of the CHSBs. There are other socio-economic related factors such as availability a vibrant private sector and local and international organizations interested in contributing to improving delivery of high quality health service, close vicinity to the services etc. With the available funding the DPHDSBA has been able to conduct some training to CHSB and FGC members in the three municipalities. But looking ahead, funding adequacy and sustainability will remain a challenge if new sources are not identified or if the current donor eventually phases out its contribution.

In terms of working together, the DPHDSBA has been able to establish positive platform for collaboration between the CHSBs and FGC. This is an important achievement that could also be replicated through promoting creation of associations of partners in health service in other Councils.

**LESSONS LEARNT AND RECOMMENDATION**

Several lessons emerge from this exercise. First it is clear that health boards and facility committees are important structures in three important ways:

(i) They can provide checks for accountability of CHMT and facility management teams;

(ii) They are useful in forging linkage between the technical teams and communities and also in ensuring communities’ views are represented;

(iii) They are crucial in sensitizing and mobilizing communities to participate in improving delivery of health services.

Unfortunately, they are weak in most cases which compromise their ability to deliver and raise important questions about their relevance in that context. Second, ability of boards and committees to deliver is also affected by the prevalent health system problems which the boards and committees have no immediate control and solution to. These include drug stock out at facilities, missing items at Medical Store Department, inadequate human resource, overcrowded health facilities, poor communication infrastructure particularly poor road networks, the government procurement system which involves long bureaucracy etc. These challenges frustrate the boards and committees as they perform their responsibilities. Third, the way D by D is unfolding has a lot to do with how the process was designed and initiated and the commitment of the technical people towards its proper implementation including by
making corrections before continuing where necessary. At the moment critical challenges remains at Council level as far as capacities, structures and incentives for accountability are concerned. It is therefore imperative that measures are taken to improve functioning of CHSBs and FGCs through empowering them to deliver. This would entail commitment to work in the following areas:

♦ Changes to Tenure of the Boards and Committees

  o Adjustment of the tenure of the boards and committees from the current three to four or five years.

  o Starting procedures for replacement of board and committee members at least six months before end of the tenure of the member to be replaced.

♦ Capacity Building and Strengthening of Working Environment

  o Establish a proper capacity building plan with tailored modules on the roles and functions of the boards and committees, leadership, management and governance, and planning and budgeting. Refresher courses could be included. Joint effort is required in this area between the MoHSW and PMO-RALG through the Zonal Training Centre (ZTC) and under supervision of RHMT.

  o Clarify how CHSB and FGC members should be involved in the Council and facility health planning processes, and establish a mechanism that ensures that they are appropriately involved, not only in reading and ratifying plans but also in the entire process from identification of priority interventions, to planning the resource needed, establishing sources of revenues to fund them and approving them.

  o Chairs of the boards ought to have office space and defined working hours. It is important this is created and all board records of meetings and other documentations are appropriately kept there. This is to be facilitated by the DEDs.

  o The MoHSW in collaboration with RHMT need to set indicators for monitoring and evaluation and include them in the routine supportive supervision.

  o Each board ought to sit down and prepare a costed annual action plan in order for their budgets and activities to be included in the CCHP. Appropriate bodies in the Councils ought to be closely working with the boards to ensure they are able to do this and submit their inputs on time.
Boards and committees be allocated a budget line in the CCHP for their executive functions in addition to the current allocation for meetings. They need this to be able to effectively do their jobs.

Financial incentives for example allowances at stipulated times and rates when they go out to work or at end of their tenure based on performance could partly compensate for the effort they make and encourage the members to perform better.

The annual plans of health facilities should be established and linked with the ward plans. This has to take place in line with the CCHP planning exercise.

The central ministries (MoHSW and PMO-RALG) in collaboration with Councils and Dar es Salaam Association of Boards should explore the modalities and challenges for forming Association of Rural Health Boards in Tanzania and Regional Health Boards Association under the jurisdiction of Association of Local Authorities in Tanzania, and formation of umbrella association of Community Health Funds which will bring together all CHF coordinators and representatives from all the Councils.

The Councils are urged to consider supporting the operations of these associations by addressing their financial needs. This can be accommodated in the CCHP.

♦ Clarifying Power Relations and Interactions

Work out a mechanism that reduces discretionary powers of the DMOs but which could also be used to forge a better collaboration between CHSB and FGCs members to do joint work in management process. Such a mechanism should include clarifying the nature of collaboration also between CHSB and FGC and establishing a platform for them to work jointly.

Rethinking the design of the accountability mechanisms to establish an accountability loop that ensures that all board members perform their roles and functions as stipulated in the guidelines.

Exercise the principle of subsidiary to ensure relevant decision making power with regard to expenditures is placed at the appropriate level. Currently most financial decisions are made at Council level and are imposed on FGC.

The Chair should take his/her duty to convene meetings and not leave this to the DMOs and should also be given mandate to represent the CHBS in Council meetings, supported in technical matters by the DMO.
Establish structural linkage between FGC and Ward and Village structures, to ensure FGCs are represented in the Ward and Village Committees.

We recommend tapping of political capability of Councilors in particular in community mobilization and sensitization for CHF contributions, so boards and committees can work with them as collaborators rather than competitors.

The boards can also be used to forge multi-sectoral approach to health matters and encourage Inter-Council cooperation between health-related departments.

**Strategies to Improve CHF Contribution**

- Most of the reasons for poor performance of CHFs lie on the supply side of the chain. Improving management of the way CHF funds are utilized and overall practical governance of the CHFs to ensure they deliver expected outputs/results should therefore be a high priority. On the demand side poverty and misinformation are the major deterrents to progress in CHF implementation and achievements.

- Tightening the conditions for paying out of pocket at the facility, for example by charging a higher fee when payment is made out of pocket at the facility, while at the same time improving quality of service given to CHF members.

- Allow the facilities to keep a certain percent of total monthly revenue for contingencies to increase responsiveness to needs and also enhance ownership.

- There is dire need for support of the districts to do thorough sensitization. Use different fora to sensitize communities, for instance, the traditional gathering and singers to sensitize people on CHF and other health campaigns is of essence.

- The CHSB, their associations and FGC as well as ward and village health committees are potential champions to work in sensitization and correcting the wrong perceptions about CHFs in some communities. It is thus important that they are equipped with the right information about the benefits, costs and their rights upon joining the CHFs.

- Establish vacancy of a district coordination officer whose role, among others, is to manage all finances from the complementary sources including CHF, NHIF, and TIKA.
• Establishment of CHF Committees and/or CHF promoters at ward level having a presence of Councilors and other members is imperative in providing the political boost for community sensitization.

• Promote regular supervision of CHF by CHSB: CHSB should have a special team for CHF administration whose role is to conduct regular management for CHF and other community contributions and reporting in the quarterly meetings.

• Promote enrollments by social groups in the society. Examples include cooperative societies, framers groups, faith groups, students etc.

• Prioritizing the use of CHF fund to procuring drugs. Drug stock out was a cry of all FGCs interviewed. The boards and committees should emulate the model of Igunga whereby drugs are procured in advance and delivered immediately when the need arises. This has to be coupled with identification of other drug supplier who can act as a buffer for taking care of missed items from MSD.

• The notion of risk pooling and risk sharing is not clear to the boards and committees. Training on these concepts is imperative as these concepts have implication on the claims and use of the CHF funds.

• The boards and committees should learn the models of contracting the private health facilities and district hospitals to act as referrals for CHF members. Again, Igunga has several examples to share. A national protocol for public private partnership could be established based on lessons from Igunga.

• It is imperative to use the Dar es Salaam Association of Boards to act as a nucleus of supporting the urban Boards in the TIKA process.

• With the support from the MoHSW, Councils should explore the modality used in Mbinga in defining benefit package, ie, having different packages for outpatient care and inpatient care.

• It is important to open facility bank accounts for CHF. Lessons could be drawn from the districts with Joint Rehabilitation Fund project on how the facility accounts are operated and the Ministry of Education and Vocational Training on the performance of school accounts.
1.0 INTRODUCTION

The government of the United Republic of Tanzania has been continuously applying Sector Wide Approach (SWAp) in its process of health sector reform. Much decentralization of health services has taken place, with substantial delegation of responsibilities for service delivery to local government authorities, that is, Decentralization by Devolution (D by D). The process of health sector reform is aimed at addressing the recognizable deficiencies in the sector in order to contribute to the achievement of the goals stipulated in the national and international frameworks such as Health Sector Strategic Plan (HSSP), the National Strategy for Growth and Reduction of Poverty (NSGRP) known in Kiswahili acronym as MKUKUTA, and the Millennium Development Goals (MDGs).

A key element in efforts to strengthen Councils’ health services has been establishment and strengthening of the institutions and organizations crucial in promoting good governance, planning, budgeting, implementation and monitoring of delivery of local services, and community participation in these processes. These institutions include Council Health Service Boards (CHSB) and Facility Governing Committees (FGC) which have been established since mid 1990’s. Among the functions of the boards include ensuring delivery of appropriate, equitable and adequate health care services and ensure accountability of the Council Health Management Teams (CHMTs) through review of implementation of the Comprehensive Council Health Plans (CCHPs). The health boards are also mandated to approve CHMT progress and financial reports and assist in mobilization of financial resources required for improved access to health services.

Various reviews conducted by the Ministry of Health and Social Welfare (MoHSW) of functioning of some of these committees and boards have shown that there are weaknesses in their functioning. For instance, the Joint Health Sector Review (JHSR) report of 2005 found that although CHSBs had at that time been established in almost all Councils, more than half of them were not functioning properly. In addition, a study conducted by a joint external evaluation team of the health sector in August 2007 covering six districts shows that in all the six districts visited, only one Council had a properly functioning board. Most of the other boards did not meet regularly, had little information about budgets or no budget at their disposal and were generally not able to fulfill their responsibilities as set out in the guidelines. Following the findings from the mentioned studies, the Ministry of Health and Social Welfare (MoHSW) commissioned this in-depth study on the way health service boards and their committees function. The objectives being to;

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3 Annex 1 provides the ToR for this review. Note that the objectives as stipulated in the ToR are numerous but in this report they have been lumped per broad thematic area.
1. Review the functioning of Council Health Services Boards and Facility Governing Committees in selected Councils and their relevance.

2. Assess the understanding of the Council planning and budgeting process by the boards and committees.

3. Assess the power relations within the Council.

4. Review the progress and functions of Community Health Fund (CHF) and *Tiba kwa Kadi* (TIKA).

5. Assess the functioning and relevance of the Dar es Salaam Public Health Delivery System Boards Association (DPHDSBA).

The report is organized as follows: After the presentation of the background and the context of this study in the introduction section, section two presents the methodology used in data collection and the sample. Section three presents findings on the review of functioning of the boards and committees. These include issues related to member selection process and the tenure of the boards and committees, training of the members on their roles and responsibilities, the capacity of the members to execute their roles and functions and their understanding of the Council planning and budgeting process. Other issues covered are the power relations within the Council and the relevance of the boards and committees. Section four presents the review of implementation of CHF in the sampled Councils and challenges faced. Section five focuses exclusively on the functioning and relevance of the Dar es Salaam Public Health Delivery System Boards Association. The last section details lessons learnt in this study and also puts forward recommendations for improvement of functioning of the boards and committees.
2.0 APPROACH AND METHODS

2.1 Document Review

A desk review of relevant documents on the functioning of the CHSB, including the Act and guidelines establishing the boards, CCHPs, board meetings reports, and action plans/milestones were done. Other documents reviewed include the external joint evaluation report of the health sector (2007), the 2007 CHF workshop report, and other relevant literature on health boards and facility committees and CHF studies.

2.2 Primary Data Collection

In addition to document review, the consultancy team undertook field visits to Councils that have established CHSB for primary data collection. Selection of these Councils was based on the following criteria:

(i) Phases of implementation of Local Government Reform Program (LGRP) whereby, Councils were selected from phase I, II and III of Health Sector Reform (HSR) implementation.

(ii) Health zones; for equity and wider coverage, at least one Council was selected from each health zone from the total of seven health zones in the country.\(^4\)

(iii) The Councils were also selected according to how they have performed in terms of CHF operations (covering some Councils that have been reported to perform well, as well as others which appear to be weak in terms of performance).

(iv) Rural-urban dichotomy was also observed during the selection of the districts.

Based on these criteria, 14 Councils presented in Table 1 were selected for this study. In a purposive way all Dar es Salaam Municipalities were picked in order to establish their functioning and the linkage with the Dar es Salaam Public Health Delivery System Boards Association (DPHDSBA). In each Council, the review team interviewed the CHMT, CHSB, and one hospital, health centre and dispensary FGC. In Councils with District Designated Hospital (DDH) such as Sengerema District Council (DC) and Rombo District Council the DDHs are governed by the Board of Trustees and no hospital committees have been formed. Thus, no interview was held with these hospitals. Other respondents include members of DPHDSBA, District Executive Directors (DEDs), CHF Coordinators, and Councilors.

\(^4\) Health zones: Northern Zone (Tanga, Kilimanjaro, Arusha); Eastern Zone (Dar es Salaam, Pwani, Morogoro); Lake Zone (Mwanza, Kagera, Mara, Shinyanga); Western Zone (Kigoma, Tabora); Southern Zone (Lindi, Mtwara); Central 6 (Dodoma, Singida, Manyara); Southern Highlands Zone (Iringa, Ruvuma, Mbeya, Rukwa).
### Table 1: Sampled Councils

<table>
<thead>
<tr>
<th>Council</th>
<th>Region</th>
<th>Type of Council</th>
<th>Phase of implementation of Health Sector Reform</th>
<th>Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ilala MC</td>
<td>Dar es Salaam</td>
<td>Urban</td>
<td>I</td>
<td>Eastern</td>
</tr>
<tr>
<td>2. Kinondoni MC</td>
<td>Dar es Salaam</td>
<td>Urban</td>
<td>I</td>
<td>Eastern</td>
</tr>
<tr>
<td>3. Temeke MC</td>
<td>Dar es Salaam</td>
<td>Urban</td>
<td>I</td>
<td>Eastern</td>
</tr>
<tr>
<td>4. Hai DC</td>
<td>Kilimanjaro</td>
<td>Rural</td>
<td>I</td>
<td>Northern</td>
</tr>
<tr>
<td>5. Ulanga DC</td>
<td>Morogoro</td>
<td>Rural</td>
<td>I</td>
<td>Eastern</td>
</tr>
<tr>
<td>6. Lindi TC</td>
<td>Lindi</td>
<td>Urban</td>
<td>I</td>
<td>Southern</td>
</tr>
<tr>
<td>7. Hanang DC</td>
<td>Manyara</td>
<td>Rural</td>
<td>I</td>
<td>Central</td>
</tr>
<tr>
<td>8. Rombo DC</td>
<td>Kilimanjaro</td>
<td>Rural</td>
<td>II</td>
<td>Northern</td>
</tr>
<tr>
<td>9. Igunga DC</td>
<td>Tabora</td>
<td>Rural</td>
<td>II</td>
<td>Western</td>
</tr>
<tr>
<td>10. Songea MC</td>
<td>Ruvuma</td>
<td>Urban</td>
<td>II</td>
<td>Southern Highlands</td>
</tr>
<tr>
<td>11. Sengerema DC</td>
<td>Mwanza</td>
<td>Rural</td>
<td>II</td>
<td>Lake</td>
</tr>
<tr>
<td>12. Kyela DC</td>
<td>Mbeya</td>
<td>Rural</td>
<td>II</td>
<td>Southern Highlands</td>
</tr>
<tr>
<td>13. Liwale DC</td>
<td>Lindi</td>
<td>Rural</td>
<td>III</td>
<td>Southern</td>
</tr>
<tr>
<td>14. Mbinga DC</td>
<td>Ruvuma</td>
<td>Rural</td>
<td>III</td>
<td>Southern Highlands</td>
</tr>
</tbody>
</table>

Primary data were collected from sampled members of the boards and committees and efforts were made to ensure members representing the community are included (see annex 2 for the list of categories of respondents). The main instruments used for data collection were quasi-structured and open-ended questionnaire guides containing guiding questions (see annex 3 for a generic interview guide). Table 2 summarizes the links between the objectives of the study, scope and the design of the study.

### Table 2: Objectives, Scope and the Design of the Study

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Scope</th>
<th>Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review the functioning of Council Health Services Boards and Facility Governing Committees</td>
<td>Review of the selection criteria and composition of the Boards and Committees; commenting on the tenure; knowledge of their roles and functions; capacity to undertake their roles and functions; and capacity building in terms of training provided.</td>
<td>Triangulation of information collected from CHMT, CBHS, and FGC members, and DED.</td>
</tr>
<tr>
<td>2. Assess the understanding of</td>
<td>Knowledge on the Council</td>
<td>Triangulation of information</td>
</tr>
</tbody>
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5 Sensitization of Councils to establish CHSB and FGC was embedded in the three Phases of Health Sector Reform. In Phase 1, 37 Councils were sensitized followed by 45 and 31 Councils in Phases II and III respectively. For details on Health Sector Reforms, see the Health Sector Reform Program of Work (1999-2002).
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Scope</th>
<th>Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>the Council planning and budgeting process</td>
<td>planning and budgeting process and planning guidelines; establish whether budget for regular CHSB and FGCs meetings is provided in the CCHP; and availability of work plans for CHSBs and FGCs.</td>
<td>collected from CHMT, CBHS, and FGC members.</td>
</tr>
<tr>
<td>3. Assess the power relations within the Council</td>
<td>Knowledge on the Council institutional structure/Organogram and who the boards and committees are answerable to; linkage with the Faith Based Organizations (FBOs) and private facilities; linkage with other Council structures such as Ward Health Committees.</td>
<td>Triangulation of information collected from CHMT, CBHS, and FGC members.</td>
</tr>
<tr>
<td>4. Review the progress and functions of Community Health Fund (CHF)</td>
<td>Overview of implementation of CHF in selected Councils and challenges faced</td>
<td>Triangulation of information collected from the Council CHF Coordinators and secondary information from the literature.</td>
</tr>
<tr>
<td>5. Assess the functioning and relevance of the Dar es Salaam Public Health Delivery System Boards Association (DPHDSBA).</td>
<td>Assess the relevance of the roles and functions; linkage with the respective boards and committees; achievements made and challenges.</td>
<td>Triangulation of data from the members of the Association of the Boards, CHMT, CHSB, and FGCs.</td>
</tr>
</tbody>
</table>

### 2.3 Limitation of the Review

1. One weakness of the study is the failure to conduct interviews with Regional Health Management Teams (RHMT) and the Council Directors. This has resulted to limited perceptions on their roles in strengthen the functioning of boards and committees and the implementation of CHF. The future roles of the RHMT and Social Welfare Officers with regard to supporting Councils for the implementation of CHF were also not explored.

2. The roles of CHSB and FGC with regard to National Health Insurance Fund (NHIF) claiming and reimbursement processes were beyond the terms of reference for this review and thus were not explored.

These limitations notwithstanding, the collected information is technically a fair representation of the facts about the functioning of the CHSB and FGCs. These limitations therefore, do not invalidate the findings of this review, and the generalizations that follow from the analysis, and the ensuing conclusions and recommendations.
3.0 FUNCTIONING OF THE HEALTH BOARDS AND FACILITY COMMITTEES

3.1 Selection Process and the Tenure of the Boards and Committees

In striving to improve the governance dimensions of health service delivery at the Council level, through decentralization process, the government established Council Health Service Boards (CHSB) and Facility Governing Committees (from hospital to primary health care facilities). The boards and committees are charged with different mandates but the ultimate goal is improvement of delivery of health services (see Table 3 below for the composition of the health boards and facility committees).

The guidelines/legal instruments establishing the health boards and facility committee stipulate the procedure and process to be followed in selecting the members, the composition of and the tenure of the boards and committees, and the qualification of the members (United Republic of Tanzania [URT], 2001). Recruitment of members is supposed to be a competitive process. In all the sampled Councils, the board members acknowledged that they were informed of the vacant positions through public announcement the most notable one being the newspapers and Council notice boards (from the district level to the village level). In Dar es Salaam, some members saw the advert on television. Despite this impressive process of advertising the vacancies, several irregularities were reported in the recruitment process;

- In five out of the 14 Council’s covered in this study, the board members were not interviewed; they submitted their application letters and were later on notified of their selection without being interviewed.

- In majority of the sampled districts, the process of replacing the board members after the expiry of the tenure of the incumbent board members took six months to one year. This is attributed to the fact that the recruitment process for replacement of the board members starts right after the expiry of the tenure of the incumbent board members. This means that in these Councils the activities of the board were frozen for six months to one year period. Commenting on this, one respondent in Ulanga district noted;

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“We were anxious to join the board, unfortunately the process was delayed for one year....finally our names were announced and we were called for inauguration of the board....none of us were interviewed nor expected to be called after a long silence. It appears that there was sloppiness on the part of the authority and something might have happened that they had to establish the board on ad hoc arrangements.”

Some boards had fewer members than what the guideline stipulates; members have died and others relocated to other areas without being replaced. This is in particular with community representative members. Thus, without a community representative in the committee, the essence of community participation is impaired. This was noted in both rural and urban Councils alike.

In majority of the cases the board relies on the District Medical Officer (DMO)/Municipal Medical Officer of Health (MMOH) to convene meetings. This is in contrast with the regulation which states clearly that the chairperson is responsible for convening meetings including scheduled and special or extraordinary meetings of the board. The practice is that the board waits for the DMO/MMOH to call for the meeting. The same is also experienced at the facility level where the medical officer in-charge is also responsible for convening meetings. This has made some boards and committees remain inactive with limited understanding of their roles and responsibilities. Interviewed board members were quoted as follows;

“...we wait for the DMO to call us. If he doesn’t call us we can not convene!”

The selection of the members for the primary health facility committees was noted to be more transparent when compared to that of the CHSB members. In most of the cases, these members were selected through village general meetings after submission of their application. Note also that FGC tend to be more representative of communities compared to the CHSB. By constitution, the CHSB is supposed to have four representatives from the community. However, community representation may not be ensured because only those with interest would send their application and it is possible that certain location or group of people may not be represented. This was found to be the situation in some Councils whereby at least two of the three members representing communities were found to be from the same Ward.
and other Wards had none. In most of the boards and committees, the gender balance of the committee members was met and members from private for profit and private not-for profit were represented (see Table 3 for the composition of boards and committees as stipulated in the guidelines).

The guidelines establishing the health boards and facility committees stipulate the age of members as 25 years to 70 years. This was found to be the case for all the districts except few which has members within >70 age bracket. This means that the youth and the old alike are represented in these organs.

Table 3: Composition of Health Service Boards and Facility Governing Committees

<table>
<thead>
<tr>
<th>The Council Health Service Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board consists of 11 members: Four non-vote members, including the DMO, who is the Secretary, representative from the Regional Health Management Team (RHMT), the Council Planning Officer, and one representative from the hospital; and seven vote members including four elected community members, the Chairperson of the Social Services Committee, and representatives from private for profit facility (NGOs/FBOs) and one from the private not for profit facilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Governing Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee consists of 10 members—three non-vote members including the medical officer in-charge of the district hospital who is the secretary, office of the DMO/MMOH, and a representative from the CHSB, and seven elected (vote members) three elected community members, Health Centre and Dispensary Committee representatives, and representatives from not for profit and one from the private for profit facilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Centre and Dispensary Governing Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Health Centre Governing Committee (HCGC) and Dispensary Governing Committee (DGC) consist of 8 members but with a slight difference in composition.</td>
</tr>
<tr>
<td>• HCGC—two non-vote members including the health centre in-charge who is the secretary and representative from the Ward Development Committee (WDC); and six elected (vote members) three elected community members, DGC representative, and representatives from the private not for profit and private for profit facilities.</td>
</tr>
<tr>
<td>• DGC—three non-vote members including the in-charge of the dispensary who is the secretary and representatives from WDC and the Village Government Committee; and five elected (vote members): three elected community members, and representatives from the private not for profit and private for profit facilities.</td>
</tr>
</tbody>
</table>

Interviewed board members had mixed opinion on the duration of tenure. While some pointed out that three years duration stipulated in the guidelines is adequate (this is enough time for the committee to be tested for its performance and to get rid of poor performers before they wreak significant damage), others pointed clearly that three years duration may not be adequate and suggested for a period of up to five years. The main argument is that the first year is used as a learning period and the second year as a planning year. Thus, in order to implement what they have planned they need another two to three years for implementation. The extension of the tenure was also supported by the fact that time is lost from when board finishes the term to when another one is inaugurated. The final (fifth year) is therefore meant for finalizing the activities planned by the board and initiating the procedures for recruitment of a new board.

3.2 The Relevance and Capacity of the Health Boards and Facility Committees

3.2.1 Relevance of the Health Boards and Facility Committees

The review team sought perceptions of the respondents on the relevance of the health boards and facility committees. In majority of the cases, based on experience and expectations, the boards and committees were mentioned to be a very relevant and crucial organ necessary for regulating the delivery of health services. Notably:

- These organs were mentioned to be relevant in linking the technical teams with the communities. Thus, the Board members do attend community meetings and act as a go-between community and technical people. This gives them the opportunity to clarify issues and offer advice to both community and technical people.

- The boards act as accountability structures as far as watching the activities and decisions of the technical teams are concerned.

- The boards are also deemed necessary in forging close collaboration with other sectors and partners implementing activities demanding joint efforts in priority areas of the Council in particular water and education.

It was only in four cases where DMOs mentioned that the boards were not effective because of the level of knowledge of the board members and therefore not relevant. In this case these DMOs see the members as lay people who are not conversant with technical issues. Further, these DMOs mentioned that there is no structure at the Council level which demands for the minutes of the board meetings and mentioning of the deliberations of the board to the Full Council was done at their (DMOs) discretion (taking aboard the board issues in his reports). This finding signifies that the level of understanding of DMOs and their willingness to
provide leadership and collaboration in working with the boards is critical determinant of how effective the boards can be.

- DMOs and in-charge of health facilities are seen as champions in making the boards and committees perform their roles. In the areas where the DMO is not cooperative, these organs are also not performing well.

- Reiterating the finding by the Joint Evaluation Report (2007), the functioning of the CHSB depends to a large extent on the willingness of the DMO to include them in key management process.

- The CHMT as quoted in the CHMT staffing establishment of 1999 is a technical structure for implementing decisions passed by the CHSB. This means that if the DMO is not interested in the boards, then their decisions can not be implemented.

The FGC in particular at the primary health facility were mentioned to be more important given the localized problems at that level and their level of involvement with the community. Given a clear mandate, these committees can also link easily with other structures at that level (Village and Ward Health Committees) for solving health related problems at the community.

### 3.2.2 Functions of the Health Boards and Facility Committees

Table 4 shows the functions of the boards and committees as per legal instrument. The boards and committees seem to be aware of *some* of their responsibilities although in many cases they have not executed their roles fully.

One area where the health boards and facility committees have not been successful is in mobilizing financial resources for improving health care. None of the sampled health boards have been able to raise funds for their facilities. However, committees at some sampled health facilities (Tandale dispensary in Kinondoni MC, Mjimwema dispensary in Temeke MC, Buguruni Health Centre Ilala MC, and Kyela district hospital) have been able to raise cash for supporting health delivery. Other FGCs have mostly mobilized labor for construction and rehabilitation of the facilities. Furthermore, sensitization of communities to contribute to the CHF was found to be weak across Councils (see performance of CHF in section 4.0 below). This poor performance in mobilizing resources has been attributed to three main reasons;

- The capacity of some members to mobilize funds; in many cases and in particular in the rural areas the capacity of the committees to mobilize funds is impeded by their powerlessness (as discussed in the section 3.4), lack of support by the district authorities, inadequate training and sensitization on resource mobilization, and
low academic achievement.\textsuperscript{7} In some cases there were obvious sources of funds but the facility committee members could not tap them, for example charging a certain amount of funds from each bag of crop sold through the primary cooperative societies.\textsuperscript{8} What is imperative from the findings is that being a committee or board member does not automatically translate to capability to mobilize funds. Skills on resource mobilization have to be imparted in line with forging linkages with tax authorities and other funding sources including the private sector.

- Notwithstanding the low capacity of members to mobilize funds, resource mobilization is seen as rather an individual issue, not a board issue, that is, for the health boards and facility committees that have been able to mobilize any resource (labor and financial), this was facilitated by certain influential individuals with particular capacity and comparative advantage.\textsuperscript{9} In the rural Councils the most members can do is to mobilize labor for construction and rehabilitation activities at the facility.

- Low awareness on the legitimacy invested on these organs as far as mobilization of the resources is concerned.

Thus, the capacity of members could be linked with their academic knowledge, experience in performing the same activities, and to the training provided after the inaugural ceremony of the boards/committees and championship of individuals. It was clear from the discussions held that the capacity to perform was limited because of the limited training provided at the onset. This was especially a big problem with newly inaugurated boards; except for inauguration speeches and provision of copies of their roles and responsibilities, no formal training has been provided. This is coupled by the fact that no refresher trainings have been organized. None of the committees had adequate training and the situation was worse with the rural and newly inaugurated committees. In most cases after inauguration of the board/committee training was done only once (the length of the training ranged from some hours to the maximum of 5 days—with an average of one day training). The repercussion was even worse for the members from community in particular in the rural areas who have not done such work before.

\textsuperscript{7} The requirement for the education background for the board members is Form IV education while it is Standard VII or knowing how to read and write Kiswahili for the FGC.

\textsuperscript{8} This example was mentioned in some districts with cash crops but it has to be taken with caution since the health boards and facility committees are not eligible for collecting taxes.

\textsuperscript{9} Comparative advantage could be in terms of having done similar activities before, knowing potential contributors to charity issues, having own company which supports charity work etc.
It was noted further that no monitoring and evaluation was done to ascertain whether the training received was adequate and that members were using it. Additionally, no monitoring and evaluation in place to make sure that after the training the committees implement their duties and that new committees are trained right after been instated. This can be a result of lack of supportive supervision from the Regional Health Management Teams (RHMT) notwithstanding its representation in the Board.

Apart from the technical capacity of the members, individual championship was considered key in effectiveness of the boards and committees. In cases where success has been registered there are individuals who have been extremely active. Examples were cited where some chairmen of some boards would not rest until the issues they had at hand are solved, but where individual championship was lacking, laxity prevailed and no follow up of issues was closely done. This boils down to the need of having “right persons” not just any representative.

Another impediment to execution of the facility committee’s activities was cited to be the bureaucratic processes in the Council. Some facility committees called themselves “orphans” meaning that they did not have any authority in decision making about the expenditures of the committee in particular at the health facility level. This was not uniform across Councils as some of them had an allowance of a reasonable petty cash which could be used without writing a request through the DMO to the District Executive Director (DED). Lack of adequate petty cash at the facility level has forced some providers to use their own funds to solve the facility emergency problems. In cases where no petty cash was allowed, the facility in-charge has to write a “dokezo” to the DMO even on expenditures on petty items like gloves and syringes. Commenting on this, one facility in-charge has the following to say;

“We have no powers to spend anything without prior agreement by the Municipal Medical Office…..it is regrettable that we have to send our intentions to purchase by writing a “dokezo” and wait up to 1 month, even more……this is unnecessary bureaucracy that impairs timely delivery of health service.”

Another FGC member added:

“We are excluded from handling of money possibly because we are less “educated” on financial matters….the technical people normally assume that we are mere informers.”

This unnecessary bureaucracy leads to the questioning of the D by D idea at the facility level; thus, powers have not been fully devolved to that level. Allowing for holding of a reasonable petty cash at the facility which the facility committee has discretion on the use as practiced at
Mji Mwema Dispensary (Temeke MC)\(^{10}\) and all facilities in Rombo DC is a best practice given the emergencies at that level. This would give facility committees a sense of power and ownership into the spending decisions at the facilities.

<table>
<thead>
<tr>
<th>Table 4: Functions of the Boards and Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Council Health Services Boards</strong></td>
</tr>
<tr>
<td>According to the 2001 guidelines for establishment of Council Health Service Boards, the CHSB shall ensure delivery of appropriate and affordable health care services and mobilize and allocate resources using criteria that ensure equity, cost-effectiveness and efficiency. Further, the board shall submit health plans and budget to the Council (the CCHP) for approval, analyze and approve CHMT progress reports, support CHMT in managing and administering health resources, promote community involvement through sensitization for own health care initiatives, promote sustainable health infrastructure and reliable logistics and supply system, and liaise with other health facility committees and partners with similar interest in health provision. CHSB is supposed to meet quarterly.</td>
</tr>
</tbody>
</table>

| **Hospital Governing Committees** |
| The Hospital Governing Committee (HGC) is responsible for receiving, discussing and approving annual hospital plans and progress reports and, monitor and follow up the availability of funds from different sources, including those from cost-sharing. The Committee also ensures that the hospital health services meet the required standards and satisfy the needs of the target population, and liaise with other health committees, partners in health provision and promotion, and ensure regular feedback to the community on health development and hospital matters relevant to the respective community. Governing Committees are charged to raise, supervise, monitor and control hospital resources and to administer and monitor the discipline of hospital personnel and their adherence to ethical codes of conduct. HGC is supposed to meet quarterly |

| **Health Centre and Dispensary Governing Committees** |
| These Committees are responsible for receiving, discussing and approving plans, budget and progress reports at their levels and ensure that the health services meet the required standards and satisfy the needs of the target population, identify and solicit financial resources for running the facilities and liaising with the CHSB and other committees and partners in health provision and promotion. These Committees are also charged with the responsibility of promoting health infrastructure, supplies and logistic system, advice the Council on human resources development in terms of recruitment, training, deployment and motivation, and to facilitate the management teams in planning and managing community based health initiatives within its catchment area in the context of the Ward Development Plans. Both HCGC and DGC are supposed to meet quarterly. |

\(^{10}\) The in charge is allowed to keep TSHs 200,000 per month as petty cash to take care of the facility’s immediate needs.
Guidelines were not available to health boards and facility committee members and again the problem was more acute in the rural areas than urban areas. In cases where the respondents have a copy of legal instruments it was a draft document and not the gazetted legal instrument. This is evidenced by the following quote from one FGC respondent:

“We do not follow any guideline from the government or any other source. Most of what we are doing is based on our own thinking and wisdom; we have never received any guideline from the government.”

The health boards and facility committees have not played any meaningful role in setting criteria for exempting the poorest members of the community (from contributing to CHF and/or paying for health services). All interviewed respondents reiterated what is stipulated in the CHF Act that powers to exempt community members from paying CHF is vested in the hands of Ward Health Committees and Village Councils. Thus, these organs are not directly been involved in determining the criteria for exemption of the vulnerable groups. However, since committees are charged with responsibility of ensuring adequate and equitable supply of health services, then it is imperative for them to partake in setting criteria for exemption; this is particularly so for the primary health care facilities.

Their capacity to deliver is also affected by the prevalent health system problems which the boards and committees have no immediate solution to. In almost every meeting that was held the following issues were raised as problematic: drug stock out at facilities, missing items at Medical Store Department (MSD), inadequate human resource, overcrowded health facilities, poor communication infrastructure particularly poor road networks. Other issues of concern included the government procurement system which involves long bureaucracy, difficulties in accessing National Health Insurance Fund (NHIF) and CHF funds etc. These challenges frustrate the boards and committees as they perform their responsibilities.

Despite the discussed limitations, several achievements have been recorded by the boards and committees. Note that these organs have made strides in particular on reprimanding irresponsible health workers; following up on the issues of staff recruitment and drug stock out; following up issues related to mismanagement of patients, rehabilitation and construction etc. Table 5 provides selected milestone achieved (with the name of the board and committee in parenthesis).

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Table 5: Achievements of the Health Boards and Facility Committees

- Lobbied for increased number of equipment and human resource which has resulted to reduced waiting time at the facility (Igunga DC CHSB, Buyuni HC in Ilala MC, Magomeni HC in Kinondoni MC)
- Solved immediate problems related to the mishandling of patients at the health facilities (Mwananyamala Hospital in Kinondoni MC).
- Mobilized labor for construction and rehabilitation of health facilities (this was evident in almost all rural FGCs)
- Mobilized cash for procuring equipment and improving infrastructure at health facilities (Mji Mwema dispensary in Temeke MC, Tandale dispensary in Kinondoni MC, Hai District Hospital in Hai DC, Kyela District Hospital in Kyela DC)
- Fought back for the reinstatement of health services after the closure of the facility by the Council authority due to floods (Kigamboni Health Centre in Temeke MC).
- Reinforcing the implementation of the exemption policy by making sure that pregnant women and under fives are exempted (almost all FGCs rural and urban alike)
- Sustained community sensitization and mobilization for CHF contribution (Liwumbu dispensary in Songea MC)
- Limits community/patients complains by forging a strong link between the community and authorities (Tandale Dispensary in Kinondoni MC, Kyela Hospital in Kyela DC, Ipinda Health Centre in Kyela DC)
- Boosting morale and enhancing workers responsiveness to the community and the public at large (Igunga District Hospital in Igunga DC, Mwananyamala Hospital in Kinondoni MC, Kigamboni Health Centre in Temeke MC, Kirokomu dispensary in Rombo DC, Songea CHSB in Songea MC)
- Supervision of collection of out of pocket funds at the facility level (Mwananyamala Hospital in Kinondoni MC, Magomeni Health Centre in Kinondoni MC)
- Supervision of construction and rehabilitation activities at facilities (all CHSB and FGCs, rural and urban alike)

3.3 Understanding of the Council Planning and Budgeting Process

The planning and budgeting process of the Council was conversant to few champion members. This is partly a result of limited training in planning and budgeting, but also of the initiative and readiness to learn among the members. In most cases members knew the CCHP but they did not know the principles on which it is based. Consequently, many of them appeared to have ratified the CCHPs without knowing its implication. In fact one of the DMOs interviewed questioned the whole process of review of the CCHP by the board in particular in the rural areas;

“Health board members are unable to comprehend the health planning, budgeting and delivery systems. The major reason is their education level, which is too low for the job. Being able to read and digest the information presented in the CCHP is not a simple task; the task needs a person with at least tertiary education to work effectively as outlined in the guidelines.”
Note that involvement of the board members in the drafting of CCHP was only evident in the Dar es Salaam municipalities whereby a meeting with representatives from the boards and committees is called to ponder on issues that have to be included in the CCHP. In this way the community representation is ensured in prioritizing issues for inclusion in the CCHP. However, in other Councils writing of the CCHP depends solely on the ideas presented in the Ward Plans and the boards and their committees are not involved. This process challenges the whole idea of involving the boards and their committees in the Council’s planning and budgeting processes. One respondent lamented;

“Most of the issues incorporated in the CCHP are obtained from the Opportunities and Obstacles to Development (O&OD) reports which we can say are updated now and then. While the use of O&OD is a good starting point for planning and budgeting, the “exclusion” of board members point to the possibilities that the planning process follows the “business as usual” process.”

None of the rural health facilities had an annual action plan. Health Centre and Dispensaries in Dar es Salaam had annual plans and FGC members have significant input in the preparation of the facility action plan. This can be correlated with their capacity whereby Dar es Salaam municipalities were found to have more knowledgeable members.

All CCHPs for the 2007/08 financial year had a budget for the boards meetings. It is important to note that while the budget for CHSB’s meeting is approved in the CCHP and is paid out from the CCHP funds, this is not the case for FGC in particular those at the primary health care and in the rural areas. This means that no honorarium is paid to them in form of sitting allowance. The current rate for sitting allowance for board members ranged from TShs 25,000 to TShs 60,000. Apart from sitting allowance, in districts like Igunga members mentioned that accommodation and traveling charges are paid for members residing away from the district headquarters. This, as noted by the members, is quite good and motivates them to meet. These arrangements are very favorable to the boards while the committees get nothing or very little. Starting this financial year (2008/09) some Councils (Igunga DC, Sengerema DC, and Rombo DC) have budgeted for a sitting allowance (TShs 5,000 in Igunga) per member for the scheduled sittings of FGC.

As pointed above, very few boards were meeting as scheduled and this was even evident in urban based Councils. The major reason given was lack of money. This does not seem to match with the finding that all CCHPs of the studied Councils have allocated money for boards regular meetings. This could mean that the funds allocated for the board meetings are sometimes channeled to other activities.

13 Although the rural facilities didn’t have annual work plans, we can not completely rule out their participation in the preparation of CCHPs since sometimes facility in charges are asked to forward their priorities to the Council although not necessary written in form of an action plan.
The study further noticed that none of CHSB had a clear and comprehensive annual plan of action implying that apart from regular meetings, CHSB do not plan for their executive functions. This has impeded their capacity for instance to do regular visits at the facilities since there is no budget for such activities. In most cases, the budget that was included in the CCHP was the budget for meetings but not budget for executing their other duties, such as sensitizing communities, visiting facilities etc. These activities are just agreed on ad hoc basis in meetings but their implementation is not captured within the CCHP.

While CHSB and FGC got some training, the common view was that training provided was not adequate especially at facility level. They noted that training should not only be confined to their specific roles and responsibilities but also cater for other aspects including planning, budgeting and governance of community health issues. Noting this anomaly, the Association of Boards in Dar es Salaam has initiated some training on governance, planning and budgeting for the board and FGC members. Igunga DC has also budgeted for governance training in the 2008/09 financial year.

3.4 Power Relations within the Council

3.4.1 The Power Channels

The assessment of power relations within the Council with regard to how boards and their committees interact with other Council structures shows there are some pertinent issues that need further attention. For example, although the guidelines for establishing the boards and committees show the position of the health service boards in relation to other structures in the Council, in more than 50% of the surveyed boards, members didn’t know who they are answerable to. In most cases the board members mentioned that they are answerable to the DMO while the guidelines mentioned that the boards are accountable to the Council. The Council health plans, quarterly and annual technical reports and financial reports are supposed to be reviewed by Social Services Committee, Financing and Planning Committee and finally approved by the Full Council. Thus, issues raised by the boards are supposed to be directly reported to the Full Council but this is assumed through the report of the DMO who presents all health related issues and who is the secretary to the board. There is much to be desired from this kind of arrangement:

- The line of authority between the board and Social Services Committee is not clear (see annex 4 for the institutional set up of the Council in relation to the boards).

• No structure that really demands for the outputs from the boards and even care to see whether the boards meet as planned and the board has annual plan of action. This lack of checks and balances result to some kind of discretion on what the DMO presents to the Social Services Committee.

• The DMO is found to be the planner, doer of technical functions, and the representative of the board in the Full Council meeting. Thus, community voice cannot be heard through him.

• In case of problems which the District Executive Director (DED) and DMO could not solve, the boards in particular in the rural areas could neither lodge claims nor meet the higher authority because of lack of understanding of their powers and structures above them (see annex 5 for the position of CHSB in relation to national health services institutional structure).

• As pointed out above, some DMOs do not see the need of the boards. DMOs and CHMTs are mostly accountable to the local government authorities represented by the DED. Thus, some DMOs are questioning the relevance of oversight bodies such as the CHSB in considering the weaknesses they harbor. The major weakness emanates from the fact that “non-technical body” which is the CHSB is made to oversee and approve the activities of a “technical body” the CHMT.

Notwithstanding the fact that the Chairperson of the Council Social Services Committee is a member to the board, the Social Services Committee could play a more supportive role in enhancing the functions of the boards by;

• Demanding for the plan of action of the boards, the performance report and the minutes of each meeting.

• Following up on the tenure of the board and make sure that it is replaced as soon as the tenure expires. Note that in all the Councils that have a new board it took 6-12 months before the incumbent board was replaced (for instance Ulanga DC, Sengerema DC, and Hai DC). Hanang DC didn’t have a health board at the time of this study.

• Making sure that all CCHPs contain a budget for executing boards and committees’ activities based on a clear costed annual action plan.

Improving the nature of relationship between the boards and the Social Services Committee is also imperative in the sense that this will make it possible for the board to work closely with the Councilors. Note that it was only in four Councils where the Councilors were found
to work hand in hand with the boards (Liwale DC, Songea MC, Lindi TC, Igunga DC) and this was only in sensitizing community members on CHF. In some cases (Hai DC, Kyela DC, Kinondoni DC, and Hanang DC) the Councilors see the boards as rivals and they see themselves as being displaced by these structures. For instance, in Hanang DC, when the tenure of the board expired, the Councilors took over the activities of the board for one year instead of catalyzing the process of forming a new board. In Sengerema DC Councilors were involved in sensitizing community members for CHF contributions but not in collaboration with the board.

Infrequent meetings as noted in several Councils apart from lack of funds, are also because of limited commitment on the leadership’s part and lack of understanding of the guidelines/legal instrument. In all the sampled Councils, the interviewed members mentioned that the DMO is the one responsible to convene meeting as the secretary of the board. However, according to the legal instrument, the chair of the board should convene the CHSB, not the DMO. Thus, as the Joint Evaluation Report (2007) recommended, if the boards are to be given an independent voice, the Chair should convene the meetings and should also be given mandate to represent the CHBS in Council meetings, supported in technical matters by the DMO.

3.4.2 Level of Interaction among Different Structures

3.4.2.1 The Boards and Committees

The link between the boards and their respective committees was found to be very weak with the exception of Dar es Salaam committees whereby the Association of Boards has organized several fora where the boards meet with their committees. The Temeke Board, for instance, indicated that they have organized meetings with FGCs, a forum where the two organs meet to exchange ideas and solve problems together. This forum is non existent in other Councils. The boards are mostly working parallel to the committees and assuming that having a member from the hospital committee sitting in the board and vice versa and having members from the health centre and dispensary committees sitting in the hospital committees is enough. The functional boards indicated that they do visit their respective health facilities but in majority of the cases, these boards have organized visits to the facilities without notifying the respective committees. As a result;

- The concerns of common interest are not synchronized and solved together.
- No sharing of experience and tapping of synergies and capabilities is facilitated.
- Even well functioning boards have not been able to contribute to build the capacities of the committees.\(^{15}\)

\(^{15}\) The requirement for the education background for the Board members is Form IV education while it is Standard VII or knowing how to read and write Kiswahili for the FGC.
Further, it stipulated in the guidelines establishing the boards and committees that quarterly and annual progress reports (financial and implementation) shall be presented to the CHSB by facility committees. This has not been the case in all Councils sampled and this is because no platform for meeting has been formerly established. Reading the collected agenda of the boards, none have had discussion of progress reports from the facility committees as part of the meeting agenda. This may be communicating the fact that four scheduled meetings per year (which in most cases not all are convened) are not enough for presentation of all issues including presenting of financial and implementation reports of all facilities in the Council.

3.4.2.2 The Board and CHMT

Except for the scheduled board meetings where respective CHMT members could be co-opted depending on issues to be discussed, no CHMT indicated to have organized any meeting with the boards to discuss pertinent issues. In most cases the board members didn’t even know the CHMT members and vice versa. Moreover, some CHMT members do not know the roles and functions of the health board.

3.4.2.3 The Board and RHMT

The Board has an RHMT representative as stated in the guidelines establishing the boards. However, one anomaly was noted as far as supportive supervision is concerned. RHMT has not been give mandate to conduct supportive supervision on boards’ activities. Given the role of the Region in provision of supportive supervision for all health care delivery activities, there is a need to give RHMT mandate to do supportive supervision on the activities of the boards in line with other health care delivery activities. Through these, weaknesses in performance of the boards can be noted and rectified. Indicators for monitoring and evaluation need to be set by MoHSW and RHMT.

3.4.2.4 The Board and Councilors

The relations between boards and Councilors were found to be complicated due to competing interests. Some Councilors do not see the need of the board and they think whatever the board is doing is their responsibility. For instance, in Hanang DC there is no board from 5th February 2006 to the time of conducting this study and Councilors have taken charge of all board’s activities. Fears of the Councilors to lose their popularity and power once the CHSB is grown strong and effective have also been reported in other studies, for instance in Kisarawe DC. Positive collaboration was found in Liwale DC where Councilors have

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joined hand with the board to sensitize communities for CHF contributions. Boards in other Councils were also in the process of forging ties to interact better with the Councilors, for instance, Sengerema DC. This is on understanding that the Councilors have a comparative advantage in community mobilization and sensitization given their political popularity.

### 3.4.2.5 The Health Boards and Structures of Other Sectors

The board is deemed necessary in forging close collaboration with other sectors in implementing activities that demand joint efforts in priority areas of the Council in particular water and education. However, no relationships have been forged and one reason being the fact that Education and Water Boards have not been established. Further, the guidelines have not clearly stated the nature of relationship. It is in only in one Council where issues of sanitation have been handled with the boards in a collaborative way. However, the Dar es Salaam Association of Boards apart from dealing with health issues has also been dealing with sanitation issues.

### 3.4.2.6 Public Private Partnership

Despite the fact that representatives from not for profit and for profit facilities have been elected, no meaningful achievements have been made in forging the Public Private Partnership (PPP). This is possibly caused by the fact that the national PPP framework/strategies are not clear to the boards and committees. In majority of the Councils visited, the members of the Council are not doing supervision visits to the private facilities and these facilities have not established the committees that follow the government structure.

Rombo DC and Sengerema DC were unique in the sense that there is a District Designated Hospital (DDH). The DDHs are governed by the Board of Trustees. It was not possible to convene an interview with the Board of Trustees but discussion with the CHMT members indicated that there is a weak relationship between the CHSB and the Board of Trustees. For example, at Huruma Hospital in Rombo DC while the chairperson of CHSB and the secretary are invited to attend Board of Trustees meetings, the management as a whole responds very weakly to the proposals/recommendations made by the CHMT and CHSB. The hospital nonetheless receives 30% of the Basket Fund and admits referred CHF members for up to 14 days free of charge.

### 3.4.2.7 Facility Governing Committees and the Ward and Village Health Committees

There isn’t any structural link between the Ward Health Committees and the facility committees. In fact some interviewed members questioned the wisdom of creating special governing committees for each health facility when village and ward level committees are already in place and functioning and are linked to local government authority. Some respondents pointed out radically that the ToR for the FGC (dispensary and health centre)
were supposed to be the ToR for the Ward and Village Health Committees. Given this confusion in structures and responsibilities, strengthening the links by co-opting a member from the FGC to sit in the Ward and Village Health Committees is imperative. Currently, FGCs have a representative from the Ward and Village Health Committees but not vice versa. In this way things discussed at Ward and Village levels will be taken aboard by committees and be addressed. Otherwise, there is a need to rethink on the ToRs of each of these bodies and whether the three committees (WHC, village health committees and FGC need to coexist.

3.5 Other Issues of Concern

For proper functioning of the boards, there are other issues that need to be addressed. These include;

- Availability of office space for the Chair of the boards. In all the Councils visited, the chair has no office and this makes his availability difficult. The proposal is to have an office for the chair who can stipulate his/her working hours.

- Financial incentives versus volunteerism: assuming that the community members can just volunteer to do facility activities in the spirit of community participation is a wrong assumption. Financial incentives to the committee members to compensate for their time might be needed similar to how it is practiced in other boards and committees in this country.

- Community awareness of the existence of the boards and committees and their functions is limited. Lack of awareness could be one factor that deters community members from applying for a position in the board. For instance, in Hanang, the DMO has made several announcements for the positions but hardly any of the community members is forthcoming for the position. The last advertisement was made on 27th July, 2007 and yet only 2 people applied.

- For no good reasons, some facilities have not established committees for instance Mbinga district hospital, Hanang DC district hospital, Mapera health centre in Songea MC, etc.
4.0 IMPLEMENTATION OF COMMUNITY HEALTH FUND

4.1 Overview of National Status

The Community Health Fund (CHF) started in 1996 in Igunga district as a pilot scheme and was later on expanded to cover other Councils with the expectation of eventually being able to cover the whole country. The CHF scheme is a form of pre-payment insurance scheme designed for rural people in Tanzania. It was identified as a possible mechanism for granting access to basic health care services to populations in the rural areas and the informal sector in the country. Being able to raise adequate funds to facilitate improved access to health care is crucial for sustainability of the scheme and delivery of health care services. It is based on the concept of risk pooling and sharing whereby members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount in health care through user fees if they fall sick.

According to the Community Health Fund Act of 2001 the objectives of the CHF are to:

(i) Mobilize financial resources from the community for provision of health care services to its members,

(ii) Provide quality and affordable health care services through sustainable financial mechanism, and

(iii) Improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.

Thus, one of the major core activities of the rural CHSB and their committees is to mobilize and sensitize committees for CHF contributions (see Table 4 above for all activities of the boards). Extension of CHF coverage started in 1997/98 after the Igunga DC pilot and by the end of 2006, CHF had been introduced in 69 district Councils (see Annex 6). This notwithstanding, the performance of CHFs has been less than satisfactory due to factors discussed in sections 4.2 and 4.3 of this report. The following can be noted from the Table in annex 6.

20 Note that todate CHF has been introduced in 92 councils and all urban Councils have been sensitized on Tiba Kwa Kadi (TIKA).
• No trend can be established from the statistics presented in Annex 6 because of missing information. Only few districts have data to establish a reasonable trend (Singida DC, Iramba DC, Igunga DC, Mbinga DC, and Iringa DC). The main question that remains unanswered is why no complete data set is available at the central level (MoHSW).

• Based on the statistics presented in annex 6 and assuming that 60% of the households are capable of joining CHF, majority of the districts have been able to enroll less than 15% of eligible household in 2005 and 2006.\textsuperscript{21}

• The once best performing districts like Mbinga DC and Hanang DC have lost momentum.

In trying to rescue the Fund, Mbinga DC set a different structure compared to other districts; which respondents called “a new CHF”. There are differentiated contribution rates whereby if one needs to access only OPD services one pays TShs 10,000 per household per year but if one wants to access both OPD and inpatient services one pays TShs 20,000. There is a special agent who is responsible for sensitizing and registering the members and this is the one who maintains the CHF cards and the communities are told to go and register to this agent. The agent is paid 5% of the contributions and it is approximated that the agent has managed to enroll 625 members. This new approach is authentic in the sense that it allows the CHF member to access care from any facility. However, no information was available from the DED or DMO office on the MoU between the Council and this agent. Further, there is no evidence that suggest that this kind of modality improves CHF enrollment. In general, coordination of CHF in this district is very weak and there is no centralized information on CHF even in the coordinators office.

In Hanang (note that there was no CHSB at the time of this study) it was noted from the CHMT that there are a lot of political interferences in the mobilization and administration of CHF. For example, in 1999, 50 million shillings were injected as CHF money by one of the prominent politician. As a result, CHF membership shot to 23% with more than 5,000 members in that year. Unfortunately, this intervention was not sustainable as it demoralized the necessity for community sensitization and willingness to contribute. As Figure 1 shows, year 2000 had 814 members which is a drop from 23% to 3.4%.

\textsuperscript{21} Note that data on the number of households per district are obtained from the population and housing census of 2002. In fact the number of households has increased since then and these percentages are overestimated.
4.2 Challenges Facing CHF Implementation: A Literature review

This section looks into factors behind the unsatisfactory performance of CHFs. Most of the challenges facing CHF implementation have been summarized in Mtei and Mulligan (2007)\(^22\) and in the proceedings of the CHF workshop held in February 2007. Some additional obstacles have been identified by other studies on experiences elsewhere in Africa. The challenges in most cases resonate around institutional and management limitations in administration of CHFs leading to low enrolment rates and/or irregular premium/membership fee payment which in turn result in low resource mobilization of prepayment schemes for healthcare services and limited benefit packages. Additionally, failure to improve the supply side factors of health care further deters households from contributing to the Fund. Table 6 provides a summary of institutional and management challenges facing CHFs (supply side factors).

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Table 6: CHF Institutional and Management Challenges

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>1. Poor design and lack of professional support</strong></td>
<td>Particularly during the start-up phase, most CHFs lacked professional technical support and back stops in relation to membership fee premium calculations and benefit package development as well as training in administrative and financial management and performance monitoring.</td>
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<tr>
<td><strong>2. Weak CHF management</strong></td>
<td>As a consequence of insufficient training and lack of continuing support, the CHF implementation process is characterized by poor management. Moreover, many CHFs are managed by district coordinators who have other primary roles. Thus, conducting CHF activities is seen as a subsidiary activity.</td>
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<td><strong>3. Weak institutional support</strong></td>
<td>CHF as any other community-based initiative depends on institutional support by governmental services and structures. If governmental authorities at the regional or district level block the empowerment of communities, e.g., through hindering their participation in designing and managing CHF, this can result in low enrolment rates.</td>
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<td><strong>4. Low quality of care and lack of choice</strong></td>
<td>If the quality of care of the contracted health services is low (drug availability and inadequate service provision), no incentive is given to join the CHF (see Bonu et al. 2003). Efforts to strengthen quality of care from the very beginning seem crucial to make a voluntary scheme attractive. Moreover, CHF members do not have the choice between different providers, either because there is no second provider, or because members have to choose one at the beginning of their membership and then have to remain with this provider.</td>
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<td><strong>5. Lack of cooperation between providers and CHF members</strong></td>
<td>In some cases, the lack of cooperation of the healthcare providers with the CHF as well as discrimination of the members may trigger withdrawal from CHF.</td>
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<td><strong>6. The exemption policy</strong></td>
<td>The exemption policy excludes under fives, pregnant women, and elderly from paying for the health care. As a matter of fact these groups are the ones that need health care most and frequently. Thus, households do not see the need of contributing since the neediest groups are already exempted.</td>
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<td><strong>7. Lack of nearby public facilities</strong></td>
<td>It was noted for instance in Sengerema DC that there are villages with no nearby public facility. The modality for entering contract with nearby private facilities was not clear to the board members.</td>
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<tr>
<td><strong>8. Other reasons</strong></td>
<td>Non-coverage of referral care and broad exemption policies which leave a limited number of people contributing to the CHF (see Mwendo, 2001; MoH, 2003; Mhina, 2005; MoHSW, 2006).</td>
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Several demand side related factors have also been cited. These include:

**Low trust in CHF management**

Low trust in CHF management by members leads to low enrolment numbers. Lack of trust may be due to insufficient management capacity of the responsible members and/or their sociopolitical position in a given target group. The lack of trust was observed at two levels of CHF management; the facility and district levels and this is linked to unavailability of desired health services after contribution by households.

**Lack of participation and involvement of communities**

In many cases, the target population does not actively participate in the setting up process, i.e. with regard to premium and benefit package definition, information campaigns etc. This may result in lack of ownership and interest from the very beginning.

**Insufficient sensitization**

It is often underestimated that the introduction of the insurance or prepayment principle needs time and sufficient sensitization. However, intense and continuous sensitization campaigns on the aims, principles and benefits of CHF have been rather the exception than the rule.

**Socio-cultural Factors**

- Preference for other healthcare providers than biomedical services which are usually the only ones contracted by CHF.
- Negative perception of prepayment principles since for some people saving for the unforeseen case of illness means attracting it.
- Mistrust of exogenous prepayment concept based on *anonymous* solidarity since for many people “direct” social relations (“knowing each other personally”) as a basis for mutual social security are crucial.
- Preference of existing social security mechanisms, for instance, family, social networks, savings such as animals.
- Negative experience with previous development initiatives.

**Economic factors**

It is often argued that many people cannot enroll because of the widespread poverty in the informal sector and among rural populations. Msuya et al. (2004) has cited low income and income un-reliability as major reasons for low enrolment. They found that 60% of richer households in Igunga district joined the scheme compared to 33% of the poorest
households. Yet, findings of a study conducted in Rwanda, does not seem to corroborate these findings as in this case membership rates did not differ from one socioeconomic quintile to the other (Schneider 2005). It is obvious that there is a group of poorest people that is not able to pay for membership fees and premiums. However, there is a lack of evidence concerning the quantification of this group.

Other economic factors include too many demands for community development activities, that is, community members are asked to pay for several development initiatives in the village and introduction of National Health Insurance Fund (NHIF) which took out public servants who were potential members of CHF.

4.3 Implementation of CHF in the Sampled Councils

Just like the overall national picture, implementation of CHF in the majority of the sampled districts has not picked the expected pace. This is evidenced by the trend in contributions which in some districts there is a reversal to what was observed in the initial stages of implementation (Table 7).

<table>
<thead>
<tr>
<th>Name of the Council</th>
<th>Status todate</th>
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<tbody>
<tr>
<td>1. Sengerema DC</td>
<td>CHF collections from September 2004 to June 2008 amounted to TShs 3,037,249 compared to TShs 68,232,000 which was collected from cost sharing (<em>papo kwa papo</em>). The Board has reviewed the fee from TShs 10,000 to TShs 5,000.</td>
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<tr>
<td>2. Ulanga DC</td>
<td>Only 2.9% of the expected households have joined the Fund. Since 2003 to date the district has managed to collect TShs 57,417,199 from CHF collections, matching fund from the central government, and cash collected through cost sharing. Of these only about TShs 9.7 million were collected through CHF. The fee is TShs 5,000 per household per year.</td>
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<td>3. Rombo DC</td>
<td>The district has made significant achievements with respect to CHF. Currently the district is having around 16,000 members representing around 25% of the existing potential. The Board has reviewed the CHF contribution from the former TShs 10,000 to affordable amount of TShs 5,000 per household per year.</td>
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<td>4. Hai DC</td>
<td>The district started with 3,100 members in 2004 out of 39,000 potential members. By the time of this study, there were only 738 members. The District has collected around TShs 29m. Unfortunately the money is used without requesting for matching funds from the MoHSW. The annual fee per household is TShs 10,000 per household per year.</td>
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<td>5. Liwale DC</td>
<td>The total CHF funds collected from January 2006 to May 30th 2008 amounted to TShs 2,595,000. The contribution per household per year is TShs 5,000.</td>
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<th>Name of the Council</th>
<th>Status todate</th>
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<tr>
<td>6. Kyela DC</td>
<td>CHF in Kyela started in 2004 and by 2007 457 members were registered mainly orphans financed by the Mango tree orphanage organization and old people financed by Johnhans Centre. By June 2008, about 29 households had joined on voluntary basis and 21 Counselors. The district has not requested for matching grant and at the time of this study CHF was approximately TShs 3,390,000. Contribution rate is TShs 10,000 per household per year.</td>
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<tr>
<td>7. Mbinga DC</td>
<td>The private agent commissioned to collect CHF has managed to enroll 625 members. No information was available from the DED or DMO office on the MoU between the Council and this agent. In general, coordination of CHF in this district is very weak and there is no centralized information of CHF even in the coordinators office. The fee is TShs 10,000 per household per year for OPD services only and TShs 20,000 for both OPD and inpatient services.</td>
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<tr>
<td>8. Songea MC(^{26})</td>
<td>There is no proper record on CHF. However, information from the DMO shows that, there is 1047 vulnerable children and 400 old people whose CHF contributions are paid by different NGOs. Contribution rate is TShs 10,000 per household.</td>
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<tr>
<td>9. Igunga DC</td>
<td>The CHF account is having a total of 125m and has registered 4,537 households across the district. The target is to register 7,000 members.</td>
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<tr>
<td>10. Hanang DC</td>
<td>In 1999 TShs 50 million were injected as CHF money by one of the prominent politician. As a result, CHF membership shot to 23% of households with more than 5,000 members in that year. Unfortunately, this intervention was not sustainable as it demoralized the necessity for community sensitization and willingness to contribute. By 2006, the number of enrolled households has dropped to 1,136. The contribution per household per year is TShs 10,000.</td>
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There were mixed impressions over the mobilization and administration of the CHF in the sampled Councils. Apart from the general challenges as presented in section 4.2 above, there are other salient issues as follows:

**Role of Boards and Committees**

The boards and committees have not been very instrumental in pushing for the CHF implementation. Major areas where these organs are expected to be active is on planning for and participating in sensitization campaigns, sending claims for the use of funds and deciding on the use of the funds. CHSB and FGC were found to have limited awareness of the fact that they are also responsible for CHF mobilization. This task is left in the hands of Medical Officers In-charges and other health officials. However, one specific case of Gidagamowd dispensary in Hanang and Liwumbu dispensary in Songea TC indicated that the concerted effort by the FGC has enhanced community sensitization and consequently, community members records relatively higher contributions compared to other facilities in the district.

\(^{26}\) Note that Songea MC introduced CHF in 1998 despite being an urban council. Some urban councils introduced CHF because the guidelines were not clear that CHF was only for the rural councils and had a different scheme (TIKA) for urban councils would be introduced. Other councils that introduced CHF include Moshi MC, Lindi TC etc. Sensitizations for TIKA were only carried from July 2008.
Knowledge on the number of CHF members and amount of fund that have been collected was limited among the board and facility committees. In other districts, like Mbinga DC, the task of mobilizing CHF membership has been left to an agent (Mbinga Community Bank). Community members are told to go and register to this agent and there is no clear established mechanism for managing the collected funds.

The instrument establishing the CHF stipulates that a CHF account has to be opened to maintain revenue from sales of CHF cards and collection of user fees from the Council health facilities. Signatory category group A contains the chairperson of the board and one member and signatory category B contains secretary of the boards who are the DMO/MMOH and the District Treasurer (DT). Despite this guideline, it was found that in some Councils the signatories of the CHF account are DED, DMO and DT only and there is no category A signatories. Thus, there is no transparency in the use of the fund because no representation of the community is sought in drawing the money. This is also attributed to the fact that the FGCs do not know how and where to request for the money. Boards and committees don’t have mandate on the utilization of the funds and the funds are managed at the district level.

Although some community members do not know what they would gain from contributing to CHF, the possibility that the CHSB and FGC members are themselves not convinced of the long term benefits of investing their money into the CHF, and therefore do not have the guts to sell the idea to other community members to do it, may not be overruled. Uncertainty and lack of clarity regarding the potential benefits from the CHF could be a deterring factor for their involvement. Examples include facility committee members at Uswaa dispensary in Hai DC and Mapera health centre in Mbinga, where the FGC members were not CHF members.

**The Use of CHF Fund**

There was a mixed understanding on the use of CHF. The following were the scenario given, the most dominant one being that the money has to be returned to the facility for the use by CHF members only. The concept of risk pooling and sharing is not understood and to majority of the interviewed members including some technical people, the facilities should be allocated money based on what they have contributed. The following are some of the transcripts from the respondents:

“The Fund is solely set for the purchase of drugs for CHF members only. The same cannot be used for other activities.”

“The fund can be used for all activities of the facility. For instance, here in Gidagamowd health centre (Hanang DC) the FGC is planning to use the same for the monthly allowances of the Laboratory Technician and the watchman.”
“Here (Igunga DC) CHF money is used to pay allowances for few workers, for instance, TShs 70,000 per month for the laboratory assistant at Ntumba dispensary and TShs 30,000 per person per month for watchmen in various facilities.”

“We (Kasungamile dispensary in Sengerema DC) use the CHF money to buy petty items such as cleaning brooms and buckets, and for paying monthly allowance to our watchman.”,

Furthermore, it is not clear whether each district has a CHF account or all the money is lumped in the district account number 6. In districts with Joint Rehabilitation Fund (JRF) project, facilities have bank accounts and these have been used to channel money for facility activities.

**Political Interferences**

As noted above, political interference was apparent. However, in a more positive note, Councilors have a potential to sensitize and mobilize communities to contribute for CHF. The CHF guidelines do not give them a specific mandate although their participation could be assumed through their roles in the Ward.

**Monitoring and Evaluation**

There is no clear mechanism for Monitoring and Evaluation at any point, that is, from the Ministry of Health and Social Welfare up to District level. This means that mechanisms for instantaneous feedback lack at all levels. Majority of FGC didn’t even know how much they have in their CHF account.

**Registering at the Hospital versus Primary Health Care Facilities**

It was noted from Hanang Council that community members prefer to be registered as members at the district hospital. As a result, facilities at the village level have few CHF members compared with the district hospital. This has a number of implications; most facilities have limited CHF money to improve health services; the district hospital OPD becomes crammed and the whole essence of using hospital for referral cases is defeated.

**Exempting the Poorest of the Poor**

Although the guidelines establishing the CHF indicate that the poorest of the poor who can not afford to pay should be exempted, this has not been the case in the sampled district. There is no proper exemption mechanism and the Board and Ward Health Committees have no clear guidelines on how to go about this.
5.0 THE DAR ES SALAAM PUBLIC HEALTH DELIVERY SYSTEM BOARDS ASSOCIATION

5.1 Objectives of the Association

The Dar es Salaam Health Boards Association was legally registered in April 2002 as an association under Ordinance of Societies based on the decision made in the general annual meeting of 1999. The Association draws members from the boards of the three municipalities and their respective public dispensaries, health centers, and hospitals. The main objectives and functions of the association include among other things:

- Promote the involvement of the population in management of its own health care delivery system.
- Sensitize related government authorities, Tanzanian associations and international organizations about the health status and needs of the Dar es Salaam city population.
- Develop its members’ management and administrative capacities.
- Support health boards in supervising drug procurement, use of funds and management and maintenance of the health facilities under their care.
- Liaise and co-operate with local, public, and central government or other charitable socio-economic institutions, donors and similar organizations in promoting effective and equitable delivery of health care.

Since its inception, the association has worked as part of civil society and has served as a channel for conveying the views of the people to the policy makers, and of mobilizing action, monitoring and influencing the performance of government on matters relating to health of Dar es Salaam population. In order to achieve its objectives, the Association mobilizes finances mostly from the private sector and individuals and uses the same to promote its objectives. The Association has a clear action plan which guides its daily operations.

5.2 Achievements of the Association

The Association has registered several achievements in enhancing the provision of health services in Dar es Salaam. The most notable achievement is facilitation of availability of four mobile clinics from the National Bank of Commerce (NBC). These mobile clinics are well

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equipped with all necessities for delivery of maternal and child health services. In promoting good governance, the Association has:

- Acted as a platform for bringing together all the boards and committees at least twice a year: This platform has been very useful in exchanging ideas and sharing best practices. As noted earlier, structural mechanisms at the three Municipals whereby the boards meet their respective committees on regular stipulated times were not existent. Thus, the Association has filled this vacuum.

- Organized several trainings for the board and committee members: Trainings have been organized in the areas of good governance including financial management, issues of corruption in the health sector, leadership skills, women and children vulnerability, primary health care delivery system, common diseases in the catchment area etc. In fact, some FGCs associate themselves more with the Association than their respective boards. Apart from the general trainings, two sessions of trainings are organized per year for the chairpersons and secretaries of the boards and their committees.

- Strengthened the Public Private Partnership (PPP) in delivery of health services: For instance, while the mobile clinics have been donated by NBC, the Municipal directors paid for the registration of the vehicles; the municipals are responsible for providing drugs, reagents, and the salaries for the operators; NBC pays for maintenance and insurance of these mobile clinics.

- Organized study tours locally and internationally for association members to learn by doing.

- Participated in several health related campaigns, for instance, the world health day, health and environmental related campaigns, maternal and child health campaigns such as vaccination campaigns etc.

- Organized fora to impart skills on the overall national issues that affect health care provision, for instance, the exemption policy.

- Have been involved in solving problems at different health facilities at their capacity as members of the Association of Boards and members of respective health boards and facility committees.
5.3 Challenges

- The main challenge facing the association is on getting tangible and sustainable source of income. The Association was dependent on one donor (Swiss Agency for Development and Cooperation). In absence of this donor, and other interested donors, the sustainability of the Association’s activities is questionable. This goes in line with the ability to get champions who are committed, willing and capable to push the activities of the Association forward (noting that most of these activities are done on voluntary basis) and individuals with capacity to mobilize resources.

- Understanding of the concept of community participation by community members is also limited.

- Overstretched health system; there are too many problems to solve and in most cases the capacity of the Association and its members is limited.

- The Association has not been able to tap the potentials in the private sector, for instance, forging productive collaboration with members from the boards of trustees of private facilities under the Public-Private-Partnership arrangement.

- The leaders of the Association are also leaders from respective boards and committees in the municipalities. Thus, sometimes there is a conflict of interest on what to do for their respective boards and committees on one hand and the Association on the other.

- Capacity of the members at the facility and community levels is limited. This results to difficulties in the implementation of planned activities.

- Coordinating health related activities that are not directly under the mandate of the MoHSW (for example sanitation activities) is a complicated task and cannot be sustainably addressed by the Association on its own.

5.4 Lessons Learnt from the Association

There are several lessons that can be learnt from the Dar es Salaam Association of Boards and which can be adapted and taken aboard in all rural and urban Councils of this country;

1. This kind of umbrella association falls directly under the administration of the local government authority in the Decentralization by Devolution system and under the Health Sector Reforms strategy seven—Public-Private-Partnership. Thus, the Association is a legal umbrella which can be adapted and emulated by rural and urban Councils in order to bring together all the Council health sector oversight bodies. Thus, using the same kind of modality, the Association can be instrumental in;
a. Promoting formation of the “Association of Urban Health Boards in Tanzania,” “Association of Rural Health Boards in Tanzania,” and “Regional Health Boards Association.” These Associations could fall under the jurisdiction of Association of Local Authorities in Tanzania (ALAT). Formation of these Associations may directly impact on strengthening CHSBs and FGCs countrywide.

b. Promoting the formation of umbrella Association of Community Health Funds which will bring together all CHF coordinators and representatives from all the Councils and again under the jurisdiction of ALAT.

c. Promoting implementation of arrangements stipulated in the Public-Private-Partnership national strategies.

2. Promotion of these kinds of Associations in the whole country is imperative as they can be used to;

   a. Mobilize and organize the boards and their committees in campaigning for Tika and CHF contributions

   b. Sensitize the Councils and private health facilities for formation of service contracts between the Councils and these facilities.

3. In addressing the financial needs for operations of these kinds of Associations, there is a cost centre under the health basket fund which is allocated 10% of the fund and is meant for funding the activities identified by the community. Furthermore, there is another cost centre for operations of the DMO’s office which is allocated 20% of the funds. Thus, given the importance of such Associations, a stipulated amount of funds from these cost centers can be used to fund operations of these Associations.

4. Such Associations are also seen as a platform for bringing together all the boards and committees for exchanging ideas, sharing best practices, and solving the Councils’ health problems in a harmonized manner.

5. Such Associations have mandate to solicit and attract funds which the Council may not have and where appropriate capacities are available could contribute to improved access to health services.

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28 Note that in adapting the boards to rural areas, several challenges have to be considered. These include the costs of establishing such entities, their terms of reference in specific local context, the opportunities that exist to facilitate their work etc.
6.0 MAIN CONCLUSIONS AND RECOMMENDATIONS

6.1 Main Conclusions

The boards and committees are seen as important accountability structures necessary for checking the accountability of management teams (CHMT and Facility Management Teams). Further, these structures are important in forging the linkage between the technical teams and communities and also in representing communities’ views. They are also important in sensitizing and mobilizing communities to partake in improving delivery of health services. However, several weaknesses were noted in their performance, raising questions regarding their relevance and which needs immediate attention. The following are main conclusions from the review:

6.1.1 Performance of Roles and Functions

1. The tenure of the boards and committees (three years) was mentioned to be short for effective implementation of their roles and functions.

2. The CHSB and FGCs meet quarterly. This is not enough to ponder on all the stipulated functions.

3. In several cases the process of replacing the boards and committees after the expiry of the incumbent ones took up to one year. This left a vacuum in the continuum of service provision.

4. Requisite capacity is lacking in particular with rural based boards and committees and this impairs effective performance of their roles and functions. This is somehow linked to the academic background of the members as well as limited training provided after their inauguration.

5. Participation in Council and facility planning processes was found to be weak. This could be attributed to the capacity of boards and committees members but more so on the lack of clarity as to how they should be involved which in turn gives a lot of discretion to the DMOs and in-charges in deciding whether to involve them or not in the planning and budgeting process.

6. In all the Councils visited, the Chairs of the boards neither had offices nor office hours. Lack of a place to meet the chair makes interactions of community members with the board virtually non-existence.

7. All the boards in the sampled Councils did not have annual action plan. This has made it difficult to plan and budget for their activities in the CCHP.
8. In the CCHPs the budget for boards meetings has been allocated. However, no budget has been indicated for training and for the FGCs meetings.

9. Incentive to serve as a member of the board/committee was found to be weak. Apart from the sitting allowance that members get per meeting, there is no other incentive in place.

10. No backstopping has been given by the central ministries to the districts in particular with organizing and providing refresher trainings after the initial trainings.

11. Unfolding of D by D depends largely on how the process was designed and initiated and the commitment of the technical people towards its proper implementation. There are critical challenges as far as capacities (capacity to implement and the ability to comprehend the contemporary policy dialogues and debates), structures and incentives for accountability are concerned.

12. The capacity of the boards and committees to deliver is also affected by the prevalent health system problems which the boards and committees have no immediate solution to. In every meeting that was held the issues of drug stock out at facilities, missing items at Medical Store Department, inadequate human resource, overcrowded health facilities, poor communication infrastructure particularly poor road networks, the government procurement system which involves long bureaucracy etc. These challenges frustrate the boards and committees as they perform their responsibilities.

13. Although it is clearly stated in the guidelines establishing the boards that the PMO-RALG and MoHSW shall give technical support to CHSBs by formulating policies, regulatory framework and monitoring of CHBS activities (sections 174A and 54A of Local Government Acts No. 7 & 8/1982), there is no evidence on clear structure for monitoring and evaluation of the whole process. The district Councils have also not set their own self monitoring and evaluation strategies for measuring progress and challenges. Lack of clear monitoring and evaluation mechanism has made it difficult for feedback to be received and worked on through proper actions.

14. The boards are accountable to the Council. However, little efforts have been put by the Council Directors in ensuring that these structures are functional and alternative health financing approaches are identified and supported.

15. The guideline does not stipulate the mandate of the CHSB and FGCs in determining who is eligible for exemption among the poorest members of the community.
6.1.2 Power Relations and Interactions

1. The DMOs and facility in-charges are seen as champions in making the boards and committees performance their roles smoothly. Thus, the functioning of the CHSB and FGCs depend to a large extent on the willingness of the DMOs and facility in-charges to include them in key management process.

2. There is no accountability mechanism to ensure that the boards perform their roles and functions as stipulated in the guidelines. Lack of this mechanism has given the DMOs a high discretion on all matters of the board (as the secretary of the board).

3. Although there were some strong dynamic FGC, the fact that decision making authority is centered predominantly at the Council’s level makes the whole setup poor. Some FGCs did not have the power to decide even on expenditure of petty cash.

4. In majority of the visited Councils, no forum has been created where the board meets with the FGC. As a result these organs work in isolation and no synergies are tapped from each other’s activities.

5. In most cases the DMO was the one responsible to convene meetings as the secretary of the board. However, according to the guidelines, the chair of the board should convene the CHSB, not the secretary who is the DMO/MMOH.

6. Structural linkage of the committees with community members was lacking. Although linkage with Ward Health Committees is seen as a mechanism where the FGC could interact with the community, this opportunity has not been taped. In most cases the members were not represented in the Ward Health Committee and they have not initiated some kind of linkage.

7. In the guidelines establishing the boards and committees, there is no structural relationship that involves the Councilors. Thus, these oversight organs were seen as rivals by Councilors.

6.1.3 The Dar es Salaam Association of Boards

1. The Association is a legal umbrella which can be adapted and emulated by rural and urban Councils in order to bring together all the Council health sector oversight bodies.

2. Promotion of these kinds of associations in the whole country is imperative as they can be used to; mobilize and organize the boards and their committees in campaigning for TIKa and CHF contributions; and sensitize the Councils and private health facilities for formation of service contracts between the Councils and these facilities.
3. The Councils are urged to consider supporting the operations of these associations by addressing their financial needs. This can be accommodated in the CCHP.

4. Such Associations are also seen as a platform for bringing together all the boards and committees for exchanging ideas, sharing best practices, organizing trainings, and solving the Councils’ health problems in a harmonized manner.

6.1.4 CHF Implementation

1. CHF implementation has dwindled; even some of the once good performing Councils have lost momentum. This is attributed to several factors ranging from the demand to the supply side of health care.

2. Thorough communitywide sensitization campaigns: Igunga District as one of the pilot districts was supported to conduct district-wide community sensitization and education. This could not have happened if the district had to use its own sources of money as has been the case in other districts.

3. Regular supervision by CHSB was lacking. As such, some CHSB members didn’t even know the status of CHF implementation in their district.

4. The notion of risk pooling and sharing was not clear to the boards and committees.

5. Several initiatives to boost up CHF contributions were observed in the field;
   a. Tightening the conditions for paying out of pocket at the facility: As a move to discourage paying out of pocket, FGCs in collaboration with DMO have increased the out of pocket fee and in some facilities the CHF patients are fast tracked.
   b. Some FGC committees have reviewed the exemption policy in which even under fives are included in the CHF arrangements notwithstanding the fact that review of policies is under jurisdiction of the central ministries. Thus, under fives, old people and pregnant women from wealthy households or who have wealthy relatives/children are not exempted. This is a regressive move which can result in fallback of achievements made in maternal and child health.
   c. Facilities are allowed to keep a certain percent of total monthly revenue for contingencies. This money is used to take care of emergencies at the facility and thus contributing to improved health care.
   d. Establishment of CHF Committees/CHF promoters at ward level having a presence of Councilors and other members in order to provide the political boost for community sensitization has been observed in some Councils.
e. Promoting enrollments by social groups in the society was underway. Examples include cooperative societies, farmers groups, faith groups, primary and secondary school students etc. Inclusion of primary and secondary school pupils to contribute to the fund (5 and 10 pupils are counted as one household for secondary and primary schools, respectively) was also noted during the field visits.

f. Involving the private sector in collecting CHF Fund. As noted in Mbinga, a private agent has been hired at the cost of 5% of the total collected funds. However, the modalities under which these arrangements work need to be explored first.

6.2 **Recommendations**

The following recommendations are drawn from the study;

6.2.1 **Measure to Improve the Performance of Boards and Committees**

1. For effective implementation of the boards’ roles and functions, it is proposed to increase tenure to four or five years. This calls for the review of the guidelines by the MoHSW. This goes in line with increasing the number of formal meetings which are currently undertaken quarterly.

2. In order to avoid the vacuum in the continuum of service provision, it is recommended to start the replacement procedures in the last year of service of the incumbent boards and committees.

3. In order to address the capacity gaps, we recommend for design of proper capacity building plan which among others will include modules on the roles and functions of the boards and committees, leadership, management and governance issues, and planning and budgeting and a provision for refresher courses. Development of capacity building plan has to be facilitated by the MoHSW and the PMO-RALG. This can be done through the health zonal training centers.

4. The Council authorities should establish a mechanism to promote more involvement of the boards and committees in the Council planning and budgeting processes; not only at reading and ratifying stages but from identification of priority interventions. This goes in line with capacity building on planning and budgeting process.

5. Creation of an office for the chair at the Council premises which has a sign clearly stipulating the office hours is imperative. All the records of the board will also be kept in this office.
6. Drafting of costed annual action plan by each board and committee is an important step towards integration of their activities in the CCHPs. This process should be facilitated by the DMO and Council economist.

7. The annual plans of health facilities should be established and linked with the ward plans. This has to take place in line with the CCHP planning exercise.

8. We recommend that a budget line be provided for undertaking capacity building activities and for facilitating meetings and activities of the FGCs.

9. Although serving in the board and FGC is considered as a voluntary thing, efforts should be made to make sure that there is incentive to serve in these organs. These organs could get a stipulated allowance/honorarium, at stipulated times, for instance, at the end of each year and at the end of the tenure.

10. As Decentralization by Devolution unfolds, the central ministers (the MoHSW and the PMO-RALG) should give backstopping to the districts in particular with organizing and providing initial and refresher trainings. This is on understanding that time is needed before the Councils are able to stand on their own.

11. There is a need to indicate clearly the structure for monitoring and evaluation of the activities of the boards and committee. The MoHSW in collaboration with RHMT need to set indicators for monitoring and evaluation and include them in the routine supportive supervision.

12. The boards are accountable to the Council. This calls for a more involvement of the DED in boards and intervene whenever the boards are not performing as expected.

13. For effective delivery of equitable health services, we recommend that the facility governing committees take part in setting criteria for exemption in collaboration with Ward Health Committees and Village Councils.

14. The central ministries (MoHSW and PMO-RALG) in collaboration with Councils and Dar es Salaam Association of Boards should explore the modalities and challenges for:  
   a. Forming Association of Rural Health Boards in Tanzania, Regional Health Boards Association under the jurisdiction of Association of Local Authorities in Tanzania;  
   b. Promoting the formation of umbrella association of Community Health Funds which will bring together all CHF coordinators and representatives from all the Councils; and promoting implementation of the arrangements stipulated in the Public-Private-Partnership national strategies.
15. The Councils are urged to consider supporting the operations of these associations by addressing their financial needs. This can be accommodated in the CCHP.

6.2.2 Strengthening Power Relations and Interactions

1. The functioning of the CHSB and FGCs depend to a large extent on the willingness of the DMOs and facility in-charges to include them in key management processes. Thus, DMOs should be sensitized on the relevance of the boards and committees.

2. We recommend for rethinking of the design of the accountability mechanisms which give the DMO high discretion powers;
   a. The Social Services Committee should take more active roles by demanding for the plans of action of the boards, the performance report and the minutes of each meeting.
   b. The Social Services Committee should also follow up on the tenure of the board members and make sure that they are replaced as soon as their tenure expires.
   c. If possible, the Chair of the board should be invited to the Full Council meetings.

3. Full devolution of decision making powers so that FGCs have authority to decide on the allocation of resources, and become part of signatories of the CHF bank account is also recommended.

4. There is a need to establish scheduled meetings between the Board and its respective FGC to share experiences, and solve problems together and tap the synergistic capacity of each other. Further, whenever the Board is visiting the facility, the FGC members should be notified so that they can make themselves available. Note that the Dar es Salaam Association of the Boards has created a forum which brings together the CHSB and FGC and is an example of best practice to be emulated.

5. If the boards are to be given an independent voice, the Chair should take his/her duty to convene meetings and should also be given mandate to represent the CHBS in Council meetings, supported in technical matters by the DMO. Best practice was noted in Igunga where the board has appointed one member to represent it in the CHMT to present and protect their agenda and interests.

6. The structural linkage between FGC and Ward and Village structures are weak. We recommend strengthening of this relationship by having representation of FGC members in the Ward and Village Committees.
7. Tapping of political capability of Councilors in particular in community mobilization and sensitization for CHF contributions is imperative. Thus, we recommend for the review of the guidelines in order to show clearly the role of the Councilors in whole functioning of the boards and committees.

8. The boards have also to be used to forge multi-sectoral approach to health matters and encourage Inter-Council cooperation between health-related departments

6.2.3 Strategies to Improve CHF Contribution

1. As a move to discourage paying out of pocket, the FGC in collaboration with DMO have increased the out of pocket fee and in some facilities the CHF patients are fast tracked.

2. Allowing the facilities to keep a certain percent of total monthly revenue for contingencies is imperative since it gives the FGC some decision making power and thus increase ownership.

3. There is dire need for support of the districts to do thorough sensitization. The use of different fora to sensitize communities, for instance, the traditional gathering and singers to sensitize people on CHF and other health campaigns is of essence.

4. Having a district CHF coordination officer whose role, among others, is to carry frequent supervision targeting CHF at facility and community levels and acting as a liaison officer between the Council and central ministries is necessary.

5. Establishment of CHF Committees and/or CHF promoters at ward level having a presence of Councilors and other members is imperative in providing the political boost for community sensitization.

6. Promoting enrollments by social groups in the society. Examples include cooperative societies, farmers groups, faith groups, student groups etc.

7. Regular supervision by CHSB: CHSB should have a special team for CHF administration. The team’s role is to conduct regular management for CHF and other community contributions. Performance of this activity should be budgeted for in the CCHP and activities done should be reported in the quarterly meetings.

8. Prioritizing the use of CHF fund to procuring drugs: The boards and committees should emulate the model of Igunga whereby drugs are procured in advance and delivered immediately when the need arises. This has to be coupled with identification of other drug suppliers who can act as a buffer for taking care of missed items from MSD.
9. The notion of risk pooling and risk sharing is not clear to the boards and committees. Training on these concepts is imperative as these concepts have implication on the claims and use of the CHF funds.

10. The boards and committees should learn the models of contracting the private health facilities and district hospitals to act as referrals for CHF members. Again, Igunga has several examples to share.

11. There is a need to produce national protocol based on the Igunga DC experiences. This protocol could be used nationwide for improved CHF implementation.

12. The need to open facility bank accounts for CHF and allowing the money to be used at the health facility has been reiterated in several studies. Lessons should be learnt from the districts with Joint Rehabilitation Fund project on how the facility accounts are performing and the Ministry of Education and Vocational Training on the performance of school accounts.
ANNEXES

ANNEX 1: TERMS OF REFERENCE

TERMS OF REFERENCE FOR TECHNICAL REVIEW OF COUNCIL HEALTH SERVICE BOARDS, HEALTH FACILITY GOVERNING COMMITTEES AND COMMUNITY HEALTH FUNDS DELIVERY IN TANZANIA – WHERE ARE WE IN TERMS OF IMPLEMENTATION

1.1 INTRODUCTION

The Government of United Republic of Tanzania has been implementing far reaching health sector reform through application of Health Sector Wide Approaches (SWAPs).

The Ministry of Health and Social Welfare (MoH&SW) in collaboration and coordination with ongoing local Government Reforms has decentralized health services to Local Government Authorities throughout the country. The implementation of sector reforms is in line with Second Health Sector Strategic Plan (July 2003 – June 2008) and Mkukuta strategy through three clusters of broad outcomes: (i) growth and reduction of income poverty (ii) improvement of quality of life and social wellbeing (iii) good governance. The health sector falls under the cluster (ii).

In order to improve the governance dimensions of health services, the Councils have been directed to establish Council Health Service Boards (CHSB) and Facility Governing Committees in all Local Authorities (LAs) since the year 2000.

The Joint Health Sector Review (JHSR) Report for 2005 noted that CHSBs had been established in all Councils but more than half were not functioning or not functioning properly.

The report of the review team which conducted the Joint External Evaluation of the health sector in August 2007, shows that, in all districts visited, (namely Same DC, Mwanza City Council, Kigoma Ujiji Town Council, Masasi DC, Singida DC and Njombe Town Council) only one Council, had a properly functioning Board. Most of the CHSBs do not meet regularly, have little or no budget at their disposal and are not able to fulfill their responsibilities.

According to the 2001 Instrument for CHSBs, the CHSBs are expected to ensure appropriate and affordable health care services, submit on behalf of CHMTs Comprehensive Council Health Plans (CCHP) for approval after reviewing and satisfied that they are ok.
The CHSBs are also mandated to approve CHMT progress reports and expected to assist mobilize financial resources and ensure equitable access to health services through

(i) Growth and reduction of income poverty;
(ii) Improvement of quality of life and social wellbeing;
(iii) Good governance.

1.2 OBJECTIVES OF THE STUDY

To assess the functional status of Council Health Services Boards and of District Hospital Governing Committees in selected Councils. Based on the findings the team should come up with recommendations to assess progress made by Council Health Services Boards in the following key areas:

(a) Monitoring of Community Health Fund operations and activities;
(b) Work in consultation with the Council Health Management Team to ensure quality health care and professionalism;
(c) Mobilize and administer funds for community health fund, NHIF and any other funds raised locally;
(d) Set and apply exemption &waiver criteria for users of the health care services including the poor.
(e) Document findings and come up with practical implementable recommendations to address shortcomings.

1.3 SCOPE OF WORK

The Review Team will mainly focus on following issues during its work:

The review team will provide an objective assessment of institutional arrangement at Council level by putting the governing system. Also check on functionality of CHSB and FGCs – Common Concerns:

- Review the functions of Council Health Service Boards and FGCs.
- Review progress and functions of CHF.
- Assess selection criteria and composition of members if adequate.
- Assess if adequate training was given to members on their roles and responsibilities.
- Whether duration of serving 3 years as a Board / committee member is shorter compared to the knowledge and experience gained.
- Assess CHSB members understanding of the Planning process and contents of the Planning Guidelines.
- Whether roles and responsibilities of CHSB and FGCs are adhered to Supervision of CHMT and implementation of CCHP.
- Whether power relations within the Council are clear.
• Whether budget for regular CHSB and FGCs meetings is provided from the CCHP.
• Whether FGCs are established in some facilities especially FBO/Private facilities.
• Review the role and analyze the functioning of Municipal Health Boards and Health Facility Committees.
• Assess the role of the Boards and Committees in the District based planning.
• Assess their representativity [public –private facilities, gender composition, migrants, youths, and minority groups.]
• Assess the involvement of the private sector [VAs and for profit.]
• Assess the role of the Association of Boards and their contribution to the quality of care.
• Compare the findings in the rural and urban areas and identity possible learning avenues.

1.4 METHODOLOGY/APPROACH

The teams should be able to review relevant documents. Studies available, milestones, progress reports, JAHSR reports on financing.

The teams should undertake field visits to assess and verify if the Board and committees at different levels are meeting as stipulated in the Instrument and whether the minutes are being taken during quarterly meeting/ad hoc meetings as related to the content. They will also assess issues related to functions of these structures and coverage decision making process, joint planning and participation of these structures in implementation. Also issues related on the review of plans as per instruction of law and if the organization structures do participate in supervision and decision making.

The date of observation should be supported by data obtained through questionnaire and focus group discussion. The Councils to study should include Councils of phase one, two and three of reforming Councils as they had different interval of establishment. This is so because level of establishment of this structure at different level was done at different intervals.

The teams will interview relevant staff of MoHSW, PMORALG, members of finance committee of the SWAp committee, some RMOs/RHMTs, CHMTs, Board members, DED and other Council local Authorities.

The assessment report should include
• Functions of each structure at all levels
• Viability of these structures
• Status of CHF
• Recommendations and way forward how to strengthen these structures.
You will be required to prepare an interview guide, questionnaire, and guide for focus group discussion.

1.5 COMPOSITION /EXPERTISE

The team should consist of the following professionals but with field experience on Health Sector Reforms with the focus on the mentioned activity.

- Economist
- Social Scientist
- Public Health Specialist.
- Two staff from DPP dealing with establishment of the Boards, CHF, and one from Association of Health Boards(Dar) to accompany the team as resource persons

1.6 REPORTING ARRANGEMENTS

The team through its Team leader should liaise with the Director of Policy and Planning/DPS, Ministry of Health through HSRS for coordination, logistics support and time tabling of the planned steps and activities by the team.

1.7 TIMING

The activity should be done at period of February 2008/ June 2008.

1. Inception report by 29th February 2008
2. Draft Report by 30th June 2008
3. A Power Point presentation of the main findings that will be used during debriefing meetings and workshop by 16th June

1.8 OUTPUTS

- An inception Report
- Debriefing Note including schedule of work
- Power point presentation on summary
- Final draft report
- Presentation of final report
- Electronic copies
- Hard copies.
## ANNEX 2: LIST OF INTERVIEWED ORGANS AND INDIVIDUALS

<table>
<thead>
<tr>
<th>Sn</th>
<th>Council</th>
<th>Organs/Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Kinondoni MC</td>
<td>CHSB, CHMT, Mwananyamala Hospital, Magomenci Health Centre, Tandale Dispensary,</td>
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<tr>
<td></td>
<td></td>
<td>Councilors (2), DED</td>
</tr>
<tr>
<td>2.</td>
<td>Temeke MC</td>
<td>CHSB, CHMT, Temeke Hospital, Kigamboni Health Centre, Mji Mwema Dispensary, DED</td>
</tr>
<tr>
<td>3.</td>
<td>Ilala MC</td>
<td>CHSB, CHMT, Amana Hospital, Buguruni Health Centre, Buyuni Dispensary</td>
</tr>
<tr>
<td>4.</td>
<td>Songea MC</td>
<td>CHSB, CHMT, Mji Mwema Health Centre, Liwumbu Dispensary, (No District Hospital)</td>
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<tr>
<td>5.</td>
<td>Liwale DC</td>
<td>CHSB, CHMT, Liwale District Hospital, Kibutuka Health Centre, Mbaya Dispensary, CHF</td>
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<tr>
<td></td>
<td></td>
<td>coordinator</td>
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<tr>
<td>6.</td>
<td>Lindi TC</td>
<td>CHSB, CHMT, Lindi Health Centre, Kineng’ene Dispensary, (No District Hospital)</td>
</tr>
<tr>
<td>7.</td>
<td>Hai DC</td>
<td>CHSB, CHMT, Hai District Hospital, Kiriki Health Centre, Uswaa Dispensary, CHF</td>
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<tr>
<td></td>
<td></td>
<td>coordinator</td>
</tr>
<tr>
<td>8.</td>
<td>Rombo</td>
<td>CHSB, CHMT, Karume Health Centre, Kirokomu Dispensary, CHF coordinator, (has DDH)</td>
</tr>
<tr>
<td>9.</td>
<td>Hanang</td>
<td>CHMT, Katesh Health Centre, Gidagabowd Dispensary, CHF coordinator, (no CHSB, no</td>
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<tr>
<td></td>
<td></td>
<td>hospital committee</td>
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<tr>
<td>10.</td>
<td>Ulanga DC</td>
<td>CHSB, CHMT, Ulanga District Hospital, Mwaya Health Centre, Kirumbora Dispensary, CHF</td>
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<tr>
<td>11.</td>
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<tr>
<td>12.</td>
<td>Mbinga DC</td>
<td>CHSB, CHMT, Mapera Health Centre, Ilongiro Dispensary, CHF coordinator, (district</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hospital has no committee</td>
</tr>
<tr>
<td>13.</td>
<td>Kyela</td>
<td>CHSB, CHMT, Kyela District Hospital, Ipinda Health Centre, Ikama Dispensary, CHF</td>
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<tr>
<td>14.</td>
<td>Sengerema DC</td>
<td>CHSB, CHMT, Katunguru Health Centre, Kasungamile Dispensary, CHF coordinator, (has DDH)</td>
</tr>
<tr>
<td>15.</td>
<td>Dar es Salaam Board of Association</td>
<td>Mr Jerome Ringo, Mr Walter Kiswaga, Mr Christopher Sechambo, Ms Zainabu Orty, Mr Essa Uswege, Mr Vedasto Rwiza, Ms Mwajuma Mmbaga</td>
</tr>
</tbody>
</table>
ANNEX 3: GENERIC INTERVIEW GUIDE FOR IN-DEPTH INTERVIEW WITH COUNCIL HEALTH SERVICES BOARD (CHSB) AND MEMBERS AND FACILITY GOVERNING COMMITTEES (FGCS)

This is a generic tool that was used to collect data. It was adapted accordingly depending on the type of respondents. The major section that was adapted is the roles of the boards and committees. The relevant questions for the CHMT were the roles of the boards and committees, their achievements and challenges, collaboration and linkages and the roles of the Dar es Salaam Associations of the Boards and its contribution in the delivery of quality health care.

SECTION A: GENERAL INFORMATION

1. Name of the Council (NAME)……………………………

2. When was the Board established in the Council? (YEAR)………………..

3. What is the current Board composition? (NUMBER OF MEMBERS BY LEVEL OF REPRESENTATION, AGE, PUBLIC-PRIVATE FACILITIES, GENDER, AND MIGRATORY GROUPS)

4. How are the members selected? (Probe for transparency in selection process in particular with non-fixed positions).

5. Tenure of the Board (how long has the current Board being in power?) (YEARS)………

6. By law each member is supposed to serve for how many years (YEARS)………

7. Comment on the tenure of the Board (probe on whether serving for three years is adequate or not. Why? Why not?)

8. Information on Interviewed Board Members

<table>
<thead>
<tr>
<th>Sn.</th>
<th>Name and Sex</th>
<th>Position in the Board</th>
<th>Occupation</th>
<th>Years as a member of the Board</th>
<th>Age</th>
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</thead>
<tbody>
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<td>9.</td>
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<td>10.</td>
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</table>
SECTION B: ROLES AND RESPONSIBILITIES OF THE BOARDS

1. What are the roles and responsibilities of the Board? (List the roles)

2. Please describe the Council planning and budgeting process (probe for their understanding on how budgets are prepared, what is the basis for preparing budgets, who prepares it, what period does the budget cover, what review mechanisms are in place for the budget, and approval process).

3. Please describe how the planning and budgeting process for the health sector is done (probe for their understanding of the health sector planning process and the content of the planning guidelines, that is, the guidelines for the preparation of the Council Comprehensive Plans).

4. Now, I would like to ask about specific roles of the Board Council in:
   a. District planning, budgeting and implementation process (probe for their involvement, if not involved why not, and why is it necessary to involve the Board).
   b. Monitoring Community Health Fund and Tiba kwa Kadi operations and activities (probe for the role of the Board in the whole process from community sensitization, enrolment and claiming the funds)
   c. Ensuring that quality health care and professionalism is achieved (probe on how this is done in collaboration with Council Health Management Team—CHMT)
   d. Mobilizing and administering the CHF/TIKA (probe on how this is done in collaboration with CHMT)
   e. Setting exemption criteria for users of health care services provided by the fund? (probe on how this was/is done)
   f. Management of provision of services at the health facilities (if any role)
   g. Ensuring that health services are allocated adequate resources and there is sustainability in financial flows? (probe for financial, material, infrastructure, and human resources)
   h. Setting the targets for the funds (get statistics per year for the past three years on the targets in terms of number of enrollees and funds to be collected)
   i. Reviewing reports from Ward Health Committees or any other source (probe on how regularly this is done and whether these reports are forthcoming)
   j. Monitoring and making verification on collection, expenditure and control of funds (probe for mechanisms in place for monitoring and making verification of collection, expenditure and control of funds).
   k. Designing an annual health plan for approval by the respective Council (probe on how this is done).

5. In fulfilling your roles, have you been given any training? (If yes, probe about the content of the training and if it was sufficient. If not probe on why? Probe also on how members fulfil their roles and responsibilities without proper and adequate training).

6. Is there budget provision in the Comprehensive Council Health Plans (CCHP) for the Board meetings? (If possible, get the budget allocation in the CCHP and actual expenditures for the past three years).

7. Now administer Tool E (part E1) then proceed with the following questions.
   a. Have the meetings been conducted as planned? Why? Why not?
   b. Have the planned activities conducted? Why? Why not?
   c. Are there action plans of the Board per year? Why? Why not?
   d. Are the agenda and minutes for the meetings available? Why? Why not?
SECTION C: COMMUNITY INVOLVEMENT

1. What strategies have been put forward by the Board to enhance community participation in health issues (probe on which areas and at what level).

2. In what areas and at which level is the community involved in health issues in the Council (probe for available best practices on community initiatives and community resource mobilization efforts).

3. Assess the participation of the community members in Board activities (in terms of comprehending issues and even offering solutions to key health challenges, even lodging claims on the quality of the services provided).

SECTION D: COLLABORATION AND LINKAGES

1. Have Facility Governing Committees (FGCs) established in some facilities? (Probe for the establishment in both public and FBO/private facilities. If not probe for why?)

2. What committees or sectors do you collaborate with? (Probe for the type of collaboration and why it is important to collaborate with that committee or sector. Probe also for the frequency of collaboration and whether there are scheduled meetings; if there are scheduled meetings probe for the frequency of meeting)
   a. Council Health Management Team (CHMT)
   b. Facility Governing Committees (FGCs)/Health Facility Committee
   c. Ward Health Committees
   d. Village Health Committees
   e. Ward Social Services Committees
   f. Village Social Services Committees
   g. Other stakeholders in health service provision in particular the private service providers (private for profit, private not for profit).

3. Assessment of the level of interaction with different committees/stakeholders

<table>
<thead>
<tr>
<th>Committee/Sector</th>
<th>Very High</th>
<th>High</th>
<th>Average</th>
<th>Low</th>
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<tbody>
<tr>
<td>(a) Council Health Management Team</td>
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<tr>
<td>(b) Facility Governing Committees</td>
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<td>(c) Ward Health Committees</td>
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<tr>
<td>(d) Village Health Committee</td>
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<td>(e) Village Social Services Committees</td>
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<tr>
<td>(f) Village Social Services Committees</td>
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<td>(g) Service providers (private not for profit)</td>
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<tr>
<td>(h) Service providers (private for profit)</td>
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<td>(j) Dar es Salaam Association of Boards</td>
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<tr>
<td>(k) Other (specify)</td>
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<tr>
<td>(l) Other (specify)</td>
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</table>

Probe for factors for low or high levels of collaboration and the added value of such collaboration;
4. In your opinion, what is the added value of collaborating with the private facilities [both private for profit and private not for profit] (probe also for the mechanisms for enhancing collaboration—mechanisms in place or envisaged).

5. What are the roles of the Dar es Salaam Association of the Boards and its contribution to the delivery of quality health care?

SECTION E: ACHIEVEMENTS AND CHALLENGES

1. What are the achievements of the Board since its establishment? (Probe on how effective the Board has been in performing its activities. Effectiveness can be measured by variables which measure achievements, for instance, increase in the number of CHF/TIKA members over time, ability to make claims for the CHF/TIKA funds etc). Use tool A for recording quantitative indicators.

2. What are the factors that have facilitated the mentioned effectiveness? (probe for best practises, probe also for the strengths of the Board)

3. What challenges has the Board faced in implementing its activities (probe for the challenges and how have they been addressed; if not addressed probe for why and how this has affected the provision of health services in the Council; Probe also for the weaknesses of the Board; Probe also for the incentives to serve in the Board and whether there is satisfactory incentive system).

4. In your opinion, what areas which deserve improvement for better functioning of the Board?

5. What are your opinions regarding the future functioning of the Board and what opportunities are available to strengthen its performance?

Thank you for accepting to participate in the study
ANNEX 4: THE COUNCIL HEALTH BOARD POSITION IN RELATION TO THE ORGANISATIONAL STRUCTURE OF THE COUNCIL

KEY:

CONSULTANCY/LIASON COORDINATION

POWER/CHANNEL OF AUTHORITY
ANNEX 5: COUNCIL HEALTH SERVICE BOARD POSITION IN RELATION TO NATIONAL HEALTH SERVICES INSTITUTIONAL STRUCTURE

KEY:
- Consultancy/Liaison Coordination/Technical
- Power/Channel of Authority/Administration
## ANNEX 6: COUNCILS WITH COMMUNITY HEALTH FUND IN TANZANIA

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Source: CHF 2005/06 Annual Report; MoHSW Budget Speech 2006/07